‘Live Well in Later Life’

Edinburgh’s Joint Commissioning Plan for Older People 2012-22

THE CITY OF EDINBURGH COUNCIL

NHS Lothian

In partnership with

evoc

ScottishCare
The voice of the Independent Care Sector in Scotland

Foreword

Older people use our health and social care services more than any other group of service users. We also know that the number of older people is growing faster than any other age group and their preferences and expectations are changing. In order to meet the needs of older people in Edinburgh, now and in the future, it is essential that we have robust plans in place.

It is key that these plans are developed and delivered in partnership with all providers of health, social care and support for older people, whether these be in the NHS, Council, voluntary or independent sector. It is only by working together that we can deliver the best outcomes for older people within the challenging financial and demographic context that we face.

This ten year plan sets out the strategic direction for older people's services ranging from acute hospital care through to lower levels of support provided within the community. The plan covers a wide range of services and support and recognises the important contribution made to the health and wellbeing of older people living in Edinburgh.

Within the lifetime of this plan, the health and social care landscape will change significantly. National policy changes including the Integration of Health and Social Care and the Personalisation of services (which includes the introduction of Self Directed Support legislation) will transform the way that care and support is delivered. We are working with our partners to deliver this transformational change, to give older people more choice and control over the care and support they receive and to ensure that health and social care services are of high quality, are joined up and are focused on individuals.

Whilst this plan sets out our direction of travel for services for older people, it does not have all of the answers and given the pace of change outlined above, these services are likely to look very different in ten years time. This plan is the result of extensive consultation and we are committed to continuing to engage with our partners, providers, services users and carers in shaping the future of health and social care services in Edinburgh.

Peter Gabbitas

Director of Health and Social Care
NHS Lothian/ City of Edinburgh Council

Working in partnership has been a central focus of the Reshaping Care for Older People programme, both at a national and local level. Within Edinburgh, the development of this Joint Commissioning Plan for Older People, and the associated Change Fund, has been an opportunity to build on and strengthen existing relationships.

The voluntary sector makes a huge contribution to supporting older people to live independently within their communities. Voluntary organisations are ideally placed to support individuals and communities to identify and build on their individual and collective strengths. The principles of holistic care and support being developed around the goals and desires of the individual are embedded within the work of many voluntary organisations and groups and this will enable them to respond positively to the transformation agenda.

The recognition of the voluntary sector as a key partner has been both welcomed and embraced and we look forward to continuing to work with our partners to ensure that we have services and opportunities for older people that Edinburgh can be proud of.

Ella Simpson

Director
Edinburgh Voluntary Organisations Council (EVOC)

Scottish Care is the principal representative body for independent registered care providers in Scotland. Through its membership, and with our locally based Edinburgh Development Officer, it provides a voice for the independent care sector. From the start of the Reshaping Care agenda, Scottish Care has been engaged both locally and nationally as a key partner and as such has had membership on a number of key decision making groups within the Edinburgh partnership.

In Edinburgh there are forty one care homes provided by the independent sector of which thirty nine are care homes and two are residential homes. The independent sector also provides care at home, with 17 providers contracted with the City of Edinburgh Council and many other agencies working within the city. As key partners in Edinburgh we acknowledge that this document, and the plans and actions that it will lead to, will have a direct impact upon the older people and services in Edinburgh. We will therefore ensure that we will work positively with all of our partners to influence and facilitate the on-going Joint Commissioning process.

Over the next ten years the social care landscape will change significantly. This will take account of changing demographics, including an ageing population; an increase in demand for services; while facing considerable financial constraints on already strained budgets. Notwithstanding these extensive challenges, there is an opportunity to strengthen an outcome focused approach that is centred on the individual and embraces the principles of personalisation and the requirements of Self Directed Support legislation. The required values of this partnership are in place with all sectors.

We all have our own stakeholders, whom we are responsible to and provide leadership for; a joint understanding of this will help each of us to move forward with this agenda alongside a commitment to advocate and enact good practice. We will share this Joint Strategic Commissioning Plan with our stakeholders and providers on a continuing basis to ensure they are informed about and contribute to the aspirations for the future.

Rene F.Rigby

Development Officer for the Independent Sector
Scottish Care

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Introduction

The Joint Commissioning Plan for Older People 2012-2022 covers care and support services to older people over 65 years of age, which are delivered by the following partners:

- City of Edinburgh Council
- NHS Lothian
- voluntary sector providers
- independent sector providers.

Our new plan outlines the partnership's vision for the next ten years. It explains how we will improve outcomes for older people and the approaches we are taking.

We recognise the value that older people bring to our communities and will focus on what they can offer, as well as on care and support for those who need it. Our aspiration is for older people to have long and fulfilling lives, lived on their own terms and in their own communities. We want older people to be in control of their futures as they age and we want to make sure services engage with them in ways that enhance rather than reduce their control and independence.

The plan sets out a high level vision and future direction, along with specific areas for action, to show how we will work in partnership to develop new models of care and support to reshape services and improve outcome for older people, their families and carers.

The plan has been developed within a challenging and ever-changing context where public services are facing financial constraints while demand for services is increasing.

Major policy changes are also in development that will reshape services for older people, including the integration of health and social care services and the introduction of legislation to support self-directed support and the delivery of more personalised services. These changes are described in more detail throughout this document.

Vision

A draft vision for this plan was developed through the Checkpoint Group which includes members from a range of older people's interest groups and organisations.

The vision reads:

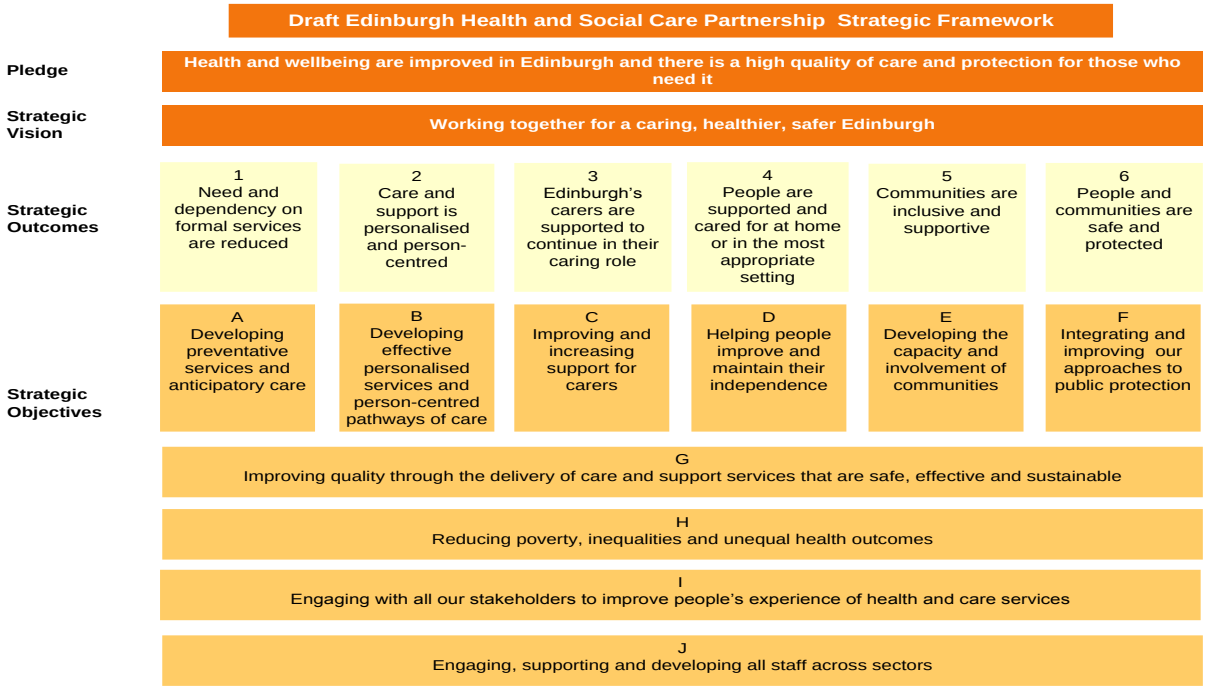
"In Edinburgh, we value older people and respect their dignity. Our vision is that older people:

- *feel safe, feel equal and are supported to be as independent as possible for as long as possible*

- *can participate in and contribute to their communities*
- *are involved in the development of services*
- *can access and receive quality care and support that takes account of their needs and preferences."*

Strategic Outcomes

The partnership is working to deliver a high level vision for all health and social care services. The diagram below sets out this vision along with the partnership's strategic outcomes and objectives.



Taken from the "Draft Health and Social Care Strategic Work Plan" 2013.

What does this mean for older people?

Many elements of the vision developed for this older people's plan are included in the strategic objectives and outcomes above. It is important that all services and support for older people focuses on outcomes that are important to older people.

The following outcomes have been identified as important to people using services:

Quality of Life	Process	Change
• Feeling safe • Having things to do • Seeing people • Staying as well as you can • Living where you want/as you want • Dealing with stigma/ discrimination	• Listened to • Having a say • Treated with respect • Responded to • Reliability	• Improved confidence/morale • Improved skills • Improved mobility • Reduced symptoms

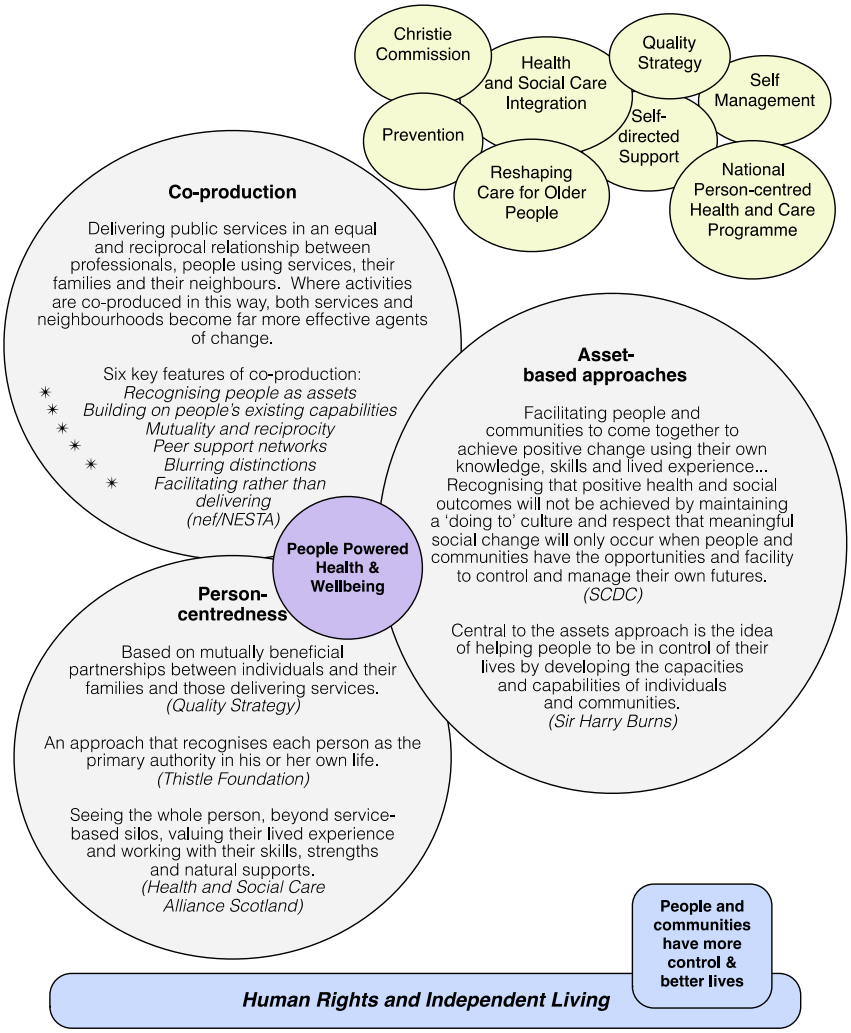
Taken from "Talking Points: Personal Outcomes Approach" Joint Improvement Team 2012

The partnership is committed to implementing a 'personal outcomes approach' within all services and support for older people in Edinburgh. This is being taken forward in a number of ways, including supporting and developing the workforce to ensure that outcomes are a focus for assessment and the delivery of care and support, and by developing service plans, contracts and evaluation frameworks that are based on outcomes. Developing a personal outcomes approach is a key element of the wider Personalisation Programme (p75).

Key to delivering the vision and outcomes above is the idea of viewing older people as assets, focusing on what older people and their communities can offer rather than focusing on problems and deficits.

An assets-based approach might include services or projects that increase the resilience of individuals and communities (eg time-banking, community connecting, supporting volunteering), maximise independence by focussing on what older people can do rather than what they cannot (re-ablement approach) and deliver personalised care and support based on an individual's abilities and needs.

Terms such as "person-centred", "asset-based" and "co-production", feature heavily in emerging health and social care policy, form the basis of the transformation of services, and are referred to within this Plan. The diagram below provides definitions for these closely linked terms and further information can be found in Appendix 1.



"Co-production – driving change in health and social care", Health and Social Care Alliance Scotland (www.alliance-scotland.org.uk), 2013

Services in scope

This plan covers adult health and social care services and support used by people aged 65 and over. Services for all adults tend to be commissioned based on a general categorisation of their needs, such as:

- older people (over 65 or selected age groups above that age)
- mental health and wellbeing
- learning disability and autism
- physical disability
- substance misuse
- HIV/AIDS

Our plan recognises that every adult is an individual who may not neatly fit into one of the above groups or may identify with more than one grouping. We also recognise the different meanings which these categories have for

different people, including very different impacts and understandings of age. We need to ensure that care and support arrangements are tailored to individual needs and not restricted by labelling in particular categories, so that transitions between care services, and between the categories above, are as seamless as possible.

This plan will take a 'pathways' approach to identifying which services are in scope. This means that rather than focussing only on specified services for older people, which may change over the lifetime of this document, we will consider any service which is involved in the delivery of care and/ or support to older people along their life journey. The scope of this plan includes (but is not limited to) the following services, functions and facilities:

Preventative Services	Proactive care and support at home	Effective care at times of transition	Intensive care and specialist support	Enablers
• lunch and day clubs • community connecting • befriending services • volunteering • community transport • support for carers • information and advice • case finding and anticipatory care planning • health promotion • housing support	•self care • care and repair • housing support • care at home • telehealthcare • community alarm telecare service • social care day services • equipment & adaptations • housing with care & support • management of long term conditions • community nursing	• re-ablement • rehabilitation • intermediate care services • residential respite care • short breaks and breaks from caring • comprehensive assessment (COMPASS) • care pathways • palliative care • medicines management • step up/ step down • post diagnostic support • day hospitals	• care homes • specialist hospital assessment • treatment & rehabilitation • NHS inpatient complex care • acute hospital care	• general practitioners (GPs) • assessment teams • training and development • research, information and evaluation • planning and commissioning • outcomes focussed assessment • integrated working • co-production • data sharing • communication & engagement

As well the services mentioned above, there are many related services or agendas important to older people which may be referred to in this plan but are covered by other strategies and functions within the NHS, Council, voluntary and independent sectors. These include:

- employment
- active citizenship
- intergenerational relationships
- leisure
- transport
- environment and landscape
- poverty
- housing

- community safety.

Partnership working

Within Edinburgh, a mature and robust health and social care partnership has developed over many years, which allows services to be planned as a 'whole system'. New funding from the Scottish Government, known as the Change, Fund has given this relationship increased momentum.

This plan builds upon substantial experience of proven joint working with a range of partners from the NHS, the Council, the voluntary and independent sectors and, most importantly of all, older people who use health and care services, their carers, friends and families, and wider communities. The plan considers unpaid carers as equal partners in care.

Our aim is for all partners to be able to contribute to future models of care for older people that achieve better outcomes for older people, created through shared ownership and co-production. This plan confirms the commitment of the partnership to continue to build relationships and further develop the processes and supports required to achieve this aim. Examples are provided throughout the plan which demonstrate the partnership approach being taken in many areas of work.

Engagement and communication

Engaging with people who use services and their unpaid carers is at the heart of good commissioning. This includes talking to people who may use services in the future. As part of this plan, we have engaged with the community (including the voluntary and independent sector) to make sure we are meeting the needs, preferences and aspirations of current and future service users and carers.

Our engagement strategy is based on the National Standards for Community Engagement and the Council's Good Practice Guide on Service User Involvement. Learning gained from engagement and communication activity is used to regularly review and update our approach.

A Checkpoint Group was created to inform the development of this plan, with representation from a range of older people's interest groups and organisations. The group had a particular role in developing a vision for the plan, advising on communication methods and agreeing a communication and engagement strategy.

Engagement of Older People - A City for All Ages Advisory Group

A key theme of the A City for All Ages Strategy is the involvement of older people in the development of Edinburgh's plans and strategies, to share information and to encourage older people to take responsibility in planning for their own future. The A City for All Ages Advisory Group includes individual older volunteers who support the development of A City for All Ages and representatives (volunteer or staff members) from groups and organisations that represent older people on issues of health and support.

Through A City for All Ages, a variety of opportunities for older people and younger people to interact positively have been created in a range of settings in Edinburgh, including schools, education centres, youth work and care homes for older people. The work is led by Generations Working Together, the Scottish Centre for Intergenerational Practice which is supported by the Scottish Government. The Edinburgh Network is facilitated through A City for All Ages and Community Services in Children and Families to encourage work with public, private and voluntary sector organisations, and to support, and develop new opportunities for intergenerational working in communities.

The Advisory Group which includes people from all equality communities has enabled older people to "co-produce" policies and programmes which are crucial to future provision. An example of this was the group's involvement in shaping the Home Care Re-ablement service. A Checkpoint reference group representing service users' and carers' organisations, was established in August 2008 and was facilitated by A City for All Ages contacts. This model has since been adopted for other Health and Social Care projects. Further information on the Advisory Group can be obtained on www.edinburgh.gov.uk/acfaa

Timescale and review

This document presents a ten year plan for older people's services from 2012-2022. It is based on the best available data and reflects the policy and context of 2012/13. The plan will continue to be reviewed during its lifetime and will be amended and updated to meet the needs expressed by service users and to reflect financial, policy changes and priorities as determined by the partnership, including service users and carers.

Part One: Background to the plan

1) Policy context

This plan builds on “Live Well in Later Life”, the City of Edinburgh Council and NHS Lothian Joint Capacity Plan 2008-2018. Much of the content of “Live Well in Later Life” is still relevant, but with many of the service changes now implemented, and significant changes developing within the wider policy and planning landscape, our new plan provides an updated vision for the next ten years.

The services that we provide and commission for older people are delivered within a changing policy environment: this includes national legislation and strategies as well as key local plans.

This plan recognises the need to reflect this policy context – a number of the most important policies are illustrated below:

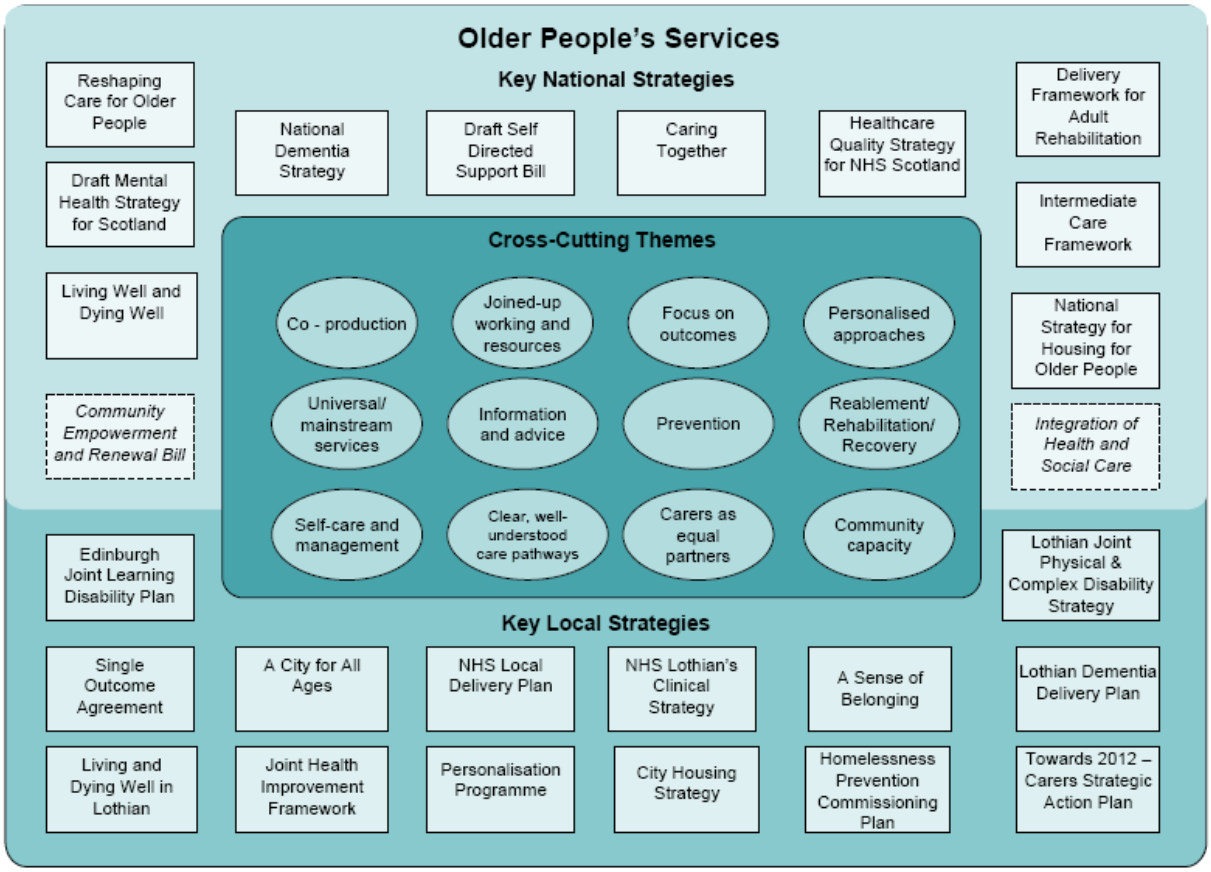


Figure 1: Key national strategies.

These strategies and plans – and how they impact upon the work we are doing in Edinburgh are outlined in detail in Appendix 1.

2) The Edinburgh Context

Current service volumes

The following list gives an idea of the current volumes of some, but not all, services for older people provided by a range of partner organisations within Edinburgh:

- 34,691 hours of home care to 3,480 people per week
- 24,000 hours of intermediate care in 2011
- care home places for around 2,770 older people at any one time
- 8,425 weeks of respite for people aged 65+ during 2011-12
- 2,496 places within older people's day centre, day clubs and lunch clubs
- aids, adaptations and equipment to 6,200 older people in 2012
- 828 direct payment recipients at the end of March 2012, a third of whom (274) were aged 65+
- 15,636 unplanned admissions to hospital in 2011/12
- 23,811 planned admissions to hospital in 2011/12
- 8,193 nights of respite in hospital in 2011

Services for older people in Edinburgh are delivered by many different providers including NHS Lothian, the City of Edinburgh Council, voluntary and private sector organisations.

The Commissioning Plan for Adult Social Care (referred to further in Part Two, section 3) sets out current arrangements for purchasing social care services for older people.

Voluntary and private organisations are essential in delivering the range of services and support available to older people in Edinburgh, including the following key areas of service:

Preventative Services

There are a wide range of services for older people in Edinburgh that could be described as 'preventative'; it could be argued that all health and social care and many housing services have a 'preventative' role in relation to the definition below:

Services and spending which:

- promotes and improve people's quality of life, independence, engagement with the community, learning, or which create healthy and supportive environments
- prevents or delays the need for more costly health, housing, care and support services by reducing people's ill-health or disability, or by increasing self-care abilities and resilience
- prevents inappropriate use of more intensive services where needs could be met by lower cost services or interventions.

The table on page 10 shows just some of the preventative services provided by NHS Lothian, the City of Edinburgh Council, voluntary and independent partners. The voluntary sector make a particular contribution in the provision of low level, 'preventative' services and support, provided by organisations that range from national to local community groups. NHS Lothian and the City of Edinburgh Council fund many of these organisations through grant and contractual arrangements which amount to approximately £4.2m per year. This figure does not include the significant additional financial resources that are leveraged by organisations through fundraising and volunteering and the large number of services that receive funding from other sources.

Voluntary and private partners are key to the delivery of aims of this plan; improving outcomes for older people, shifting the balance of care and an increased focus on prevention, co-production and community capacity building. The developing policy context, particularly in relation to personalisation and self-directed support, will change the way that services are commissioned and organisations are funded in the future. We are committed to working in partnership with providers as these changes are implemented.

Day Services

Day service provision includes:

- Registered day centre services – there are 1621 registered day centre places provided each week in Edinburgh. These are day centre services which are registered with the Care Inspectorate and which provide support to older people who have been assessed as eligible.
- Registered one to one day services - non-centre based day services which are registered with the Care Inspectorate and provide a personalised and flexible service for older people.
- Day clubs and lunch clubs - centre based clubs which provide support to older people who do not require personal care support. Approximately 300 lunches are provided each week through Council funded organisations. However, many other small community groups / cafes / churches provide lunch clubs independently.

The City of Edinburgh Council's total investment in day services for older people is approximately £4.7 million per annum. Of this sum, £1.2 million (26%) is allocated to Council day services and £3.5 million (74%) to voluntary sector day services.

Homecare

Homecare is one of the core services that can support older people to remain independently in their own homes. The proportion of homecare hours delivered by the independent sector (private and voluntary organisations) has increased steadily over the past decade, from 5% in 1998 to 71% in 2012. During this time the total number of hours of homecare has also increased significantly from 35,500 to 44,200 hours (includes all age/ care groups).

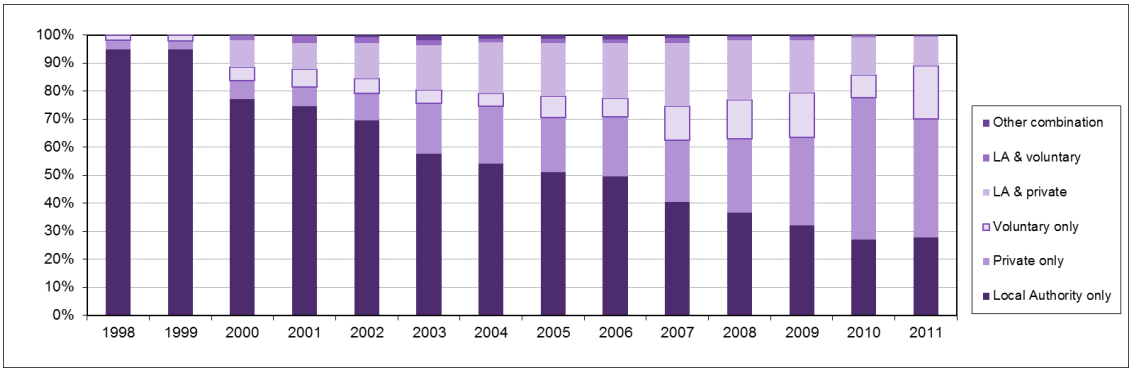


Figure 2: Proportion of homecare hours delivered by sector in Edinburgh 1998-2011. Source: Scottish Government

Intermediate Care

Intermediate Care provides services which:

- facilitate hospital discharge
- prevent unnecessary admission to hospital
- support people to gain and retain independence in their own home.

Intermediate Care Services are jointly provided by the Health and Social Care Department and the Edinburgh Community Health Partnership (NHS Lothian).

Other services that support older people to live in the community

There are a wide range of services that support people to live in the community provided by the Council, NHS and a range of voluntary and independent sector organisations, these might include:

- self care
- telecare and community alarms
- equipment and adaptations
- short break services
- housing support
- care and repair
- carer support services
- mental health services and support
- disability services and support
- substance misuse services and support
- services and support for people with HIV/ AIDS
- advocacy services.

Care Homes

Care homes are an important part of the health and social care system and can provide a positive and caring environment with 24 hour care for people that require it.

Currently in Edinburgh, around 80% of care home places are located within private and voluntary sector care homes.

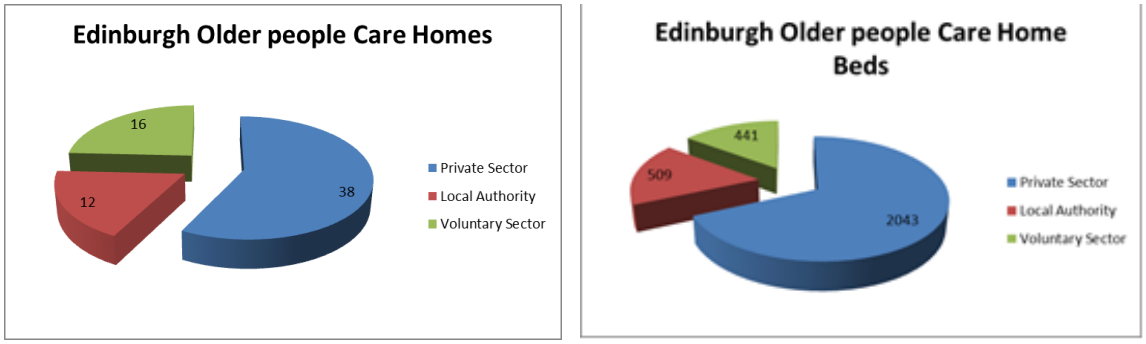


Figure 3: Care home places in Edinburgh by sector. Source: Scottish Government

Further information on our plans for care homes can be found in Part Two, section 4 (p58) and future projections (p63).

Primary and Community Health Care

Edinburgh Community Health Partnership provides primary and community health care services including:

- GPs
- district nurses
- health visitors
- practice nurses
- occupational therapists
- podiatrists
- pharmacists
- dentists
- opticians
- dieticians.

The majority of these services are directly provided by NHS Lothian/ Edinburgh Community Health Partnership, except GPs and dentists, the majority of whom are independently contracted by NHS Lothian.

Hospital Based Services

Hospital based services within Edinburgh include:

- acute hospitals (the Royal Infirmary of Edinburgh and the Western General Hospital)
- rehabilitation and specialist non-acute sites (Astley Ainslie Hospital, Royal Victoria Building (on the Western General Hospital site), Royal Victoria Hospital, Liberton Hospital)

- psychiatric and mental health services (Royal Edinburgh Hospital)
- Inpatient Complex Care (formerly Continuing Care) (includes services based at Corstorphine Hospital, Ellen's Glen, Ferryfield House and Findlay House)
- Day hospitals for older people
- other specialist services provided from the Princess Alexandra Eye Pavilion, Chalmers Sexual Health Centre, Lauriston Building etc.

Whilst specialist services for older people are available (Medicine of the Elderly and Psychiatry of Old Age services), the majority of people within all hospital wards are aged over 65 (approx 70%).

3) Recent Service Developments

"Live Well in Later Life" outlined new models of care for health and social care services to be developed from 2008. Significant progress has been made since then and a Progress Report, published in April 2010 provided details of the positive developments made towards those objectives.

Some of the key service model developments are shown in the diagram below and further detail of these changes can be found in Appendix 3.

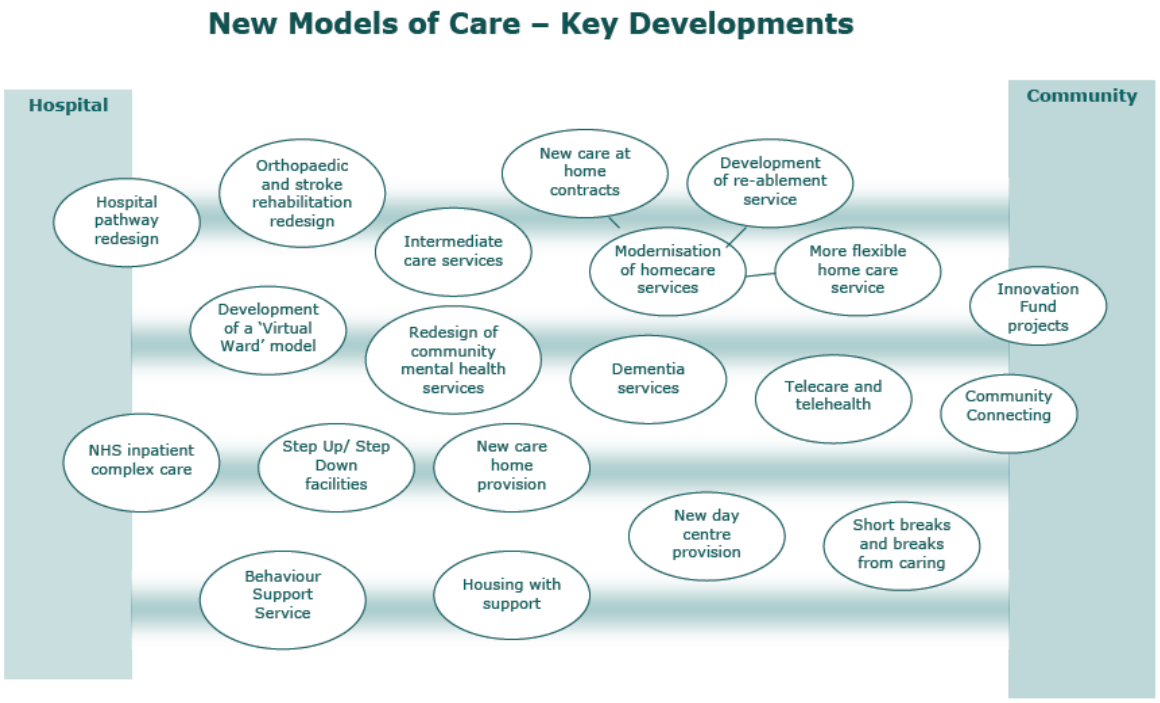


Figure 4: Key services developments since "Live Well in Later Life 2008".

Key developments since "Live Well in Later Life"

- The reablement service was rolled out across the city in 2009 which has proved a success with service users, staff and delivered financial savings.

- A new model of care was developed within orthopaedic and stroke services which allowed people to leave hospital and have rehabilitation and support provided at home.

- Telecare and telehealth services in Edinburgh have developed further, with some exciting examples of how technology can be used to support people at home.

- New housing developments with support including Madelvic Square, Brandfield Street and Elizabeth Maginnis Court provide flexible alternatives to hospital or care home stays.

4) Current performance and targets

The developments made since “Live Well in Later Life” have delivered better outcomes for older people. The changes have also contributed to improvements for many of the indicators we use to measure our performance. However increasing demand for services mean that we cannot be complacent and we continue to work hard to improve our performance against a wide range of measures. Some of the key measures are discussed below.

It is important that targets are used as an indicator of the quality of an individual’s experience of our care services, not as an end in itself. We need to use a range of indicators, along with outcome measures, to determine how we are performing and to inform improvements that can be made. Further information about how we evaluate our performance can be found in Part Three in the ‘Monitoring and Evaluation’ section.

Shifting the balance of care

In order to achieve the aim of the national “Reshaping Care for Older People” strategy, to optimise the independence and wellbeing of older people at home or in a homely setting, a shift in the focus of care from institutional settings to care provided at home is required.

Significant progress has been made in Edinburgh to achieve this shift in the balance of care. The percentage of older people with high level needs who are cared for at home has increased from 14% in 2002 to 30% in 2012. We have done this through investment in community based services and by changing the way that services are provided to benefit more older people. The target for 2018 is to have a balance of care of 40%.

Delayed discharges

Council and health care teams work particularly hard to ensure that older people are in the right place for the right treatment, rehabilitation and care for the right amount of time. When older people are delayed in hospital it can

undermine their confidence and independence and can help encourage an unnecessary dependency, which can ultimately reduce their ability to care for themselves or be cared for at home or in a place in their own community.

Reducing the number of people whose discharge from hospital is delayed has been a priority for Edinburgh's Health and Social Care services since 2005. Through significant and sustained work, the number of delays has reduced dramatically from 2004 levels, as shown below.

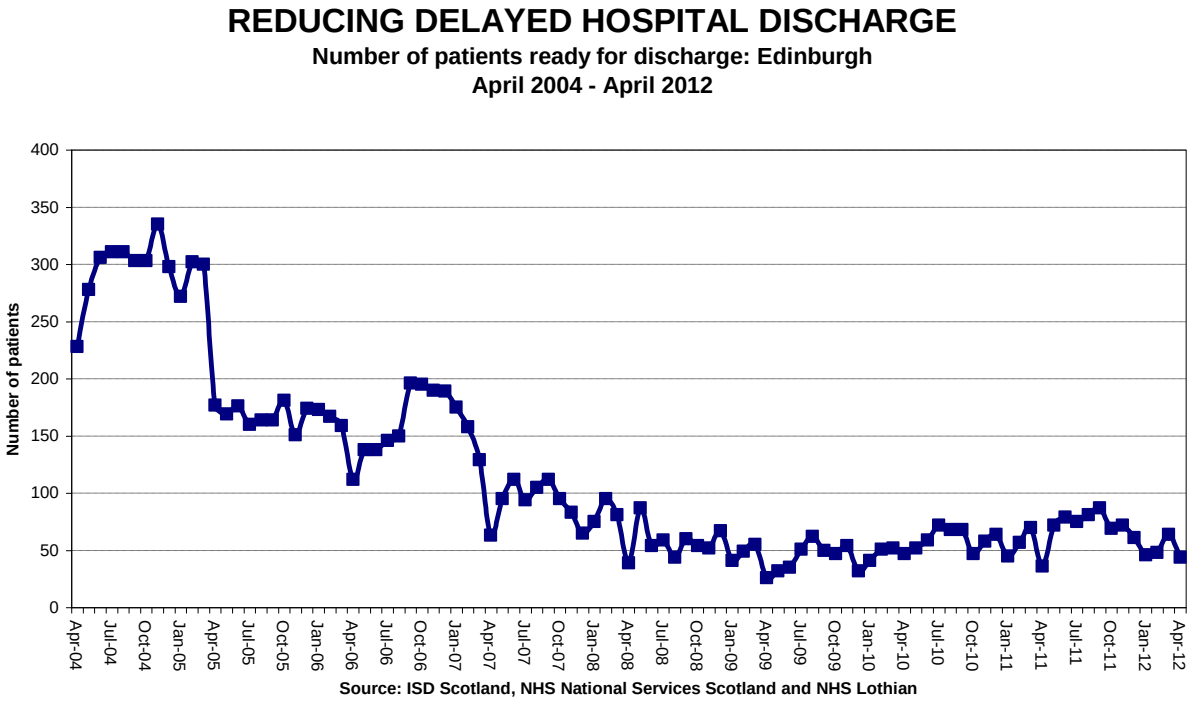


Figure 5: Delayed Discharge trends April 2004 – April 2012

Nationally, local authorities, NHS Boards and the Scottish Executive have agreed that a reasonable period to assess, make plans for and then arrange the discharge of someone who needs community support or nursing home care after leaving hospital is six weeks. The national target is therefore that no patient is delayed for more than six weeks. From April 2013, this reduces to 28 days and from April 2014, reduces further to 14 days.

In recent years, Edinburgh has continued to face significant challenges in ensuring that people were supported to leave hospital within target times, and key national and local targets were not been met. The reasons for people being delayed can be complex, but the availability of community services that meet the needs of people being discharged from hospital is essential to ensure a smooth and timely transition. Investments have been made in intermediate care services, re-ablement and home care services to increase the number of people that can be supported when they leave hospital. Another cause for delays can be people waiting for a care home place, which can be difficult if people have particular needs, such as challenging behaviour. The development of Step Down beds (p60) aims to facilitate timely discharge from hospital for people who do not require hospital based medical care but

need short term treatment and therapy in order maximise their opportunity to return home.

Emergency bed days for people over 75

The Scottish Government has issued a target[1] to reduce the number of days spent in hospital by older patients who are admitted following an emergency.

The target recognises that effective care arrangements for people as they get older will see less need for people to be brought into hospital as emergency admissions. This recognises the contributions made through a range of interventions that work towards this outcome, including:

- preventative and anticipatory supports
- palliative care management
- home-based care and rehabilitation interventions

Within NHS Lothian, the targeted reduction of 12% has been achieved against 2009/10 performance, and it is the intention to continue to meet and surpass this target going forward to 2014/15.

Length of stay in care homes and hospitals

Within care homes and hospitals, lengths of stay are expected to reduce as older people increasingly only use these services in the very last stages of their lives, while community-based services support older people with higher levels of need than previously achievable.

National guidance was updated for the Inpatient Complex Healthcare (formerly Continuing Care[2]) in 2008. This meant a policy change within NHS Lothian whereby placement is no longer for life and reviews are undertaken in order that people are reassessed against eligibility criteria and assisted to be placed in the most appropriate environment to meet their ongoing needs. As a consequence, average duration within hospital care is now reduced to around six months, with many more patients now also moving back home or to other settings for periods of time as their health and needs allow.

Lengths of stay within many hospital services are also being reduced as a consequence of increased care and rehabilitation available for patients within the community. Enhanced homecare, reablement and rehabilitation available to older people in their own homes is allowing for timely discharge from hospital in more instances.

Within care homes, lengths of stay have remained relatively stable between 2007 and 2011, as summarised in the table below (see Appendix 4 for further details):

[1] HEAT – T12: Emergency Bedday rate of persons 75+
[2] CEL, 2008 (6) NHS Continuing Healthcare – February 2008

	2007	2011
Proportion of residents whose stay was less than two years	51%	56%
Proportion of residents whose stay was five years or more	18%	15%

Figure 6: Length of stay to date of Edinburgh care home residents at March 2007 and March 2011.

Direct admissions to long stay care homes from hospital

It is the aspiration of health and social care services within Edinburgh that older people do not go to long stay care homes directly following an acute admission into hospital.

When people are in hospital following an acute episode of ill health, it can be difficult to plan for what a person needs in the longer term and there is a risk that arrangements for care home or complex care hospital stays that are made at that time do not turn out to be appropriate.

We recognise the distress that can arise when an older person is not able to return home and we aim to work with people to ensure that they can get home if at all possible.

In many circumstances acute admissions arise as a sign that people have been struggling to cope at home and have gone beyond the point at which home-based interventions can be put in place to support them at home following their hospital stay. It is recognised that in such circumstances, transfer from an acute hospital such as the Western General Hospital or Royal Infirmary of Edinburgh, directly to a care home or other complex care setting, is what is best for people and their families.

Outcome measures/ quality

Traditionally, many health and social services have been evaluated on measures of volume of activity and work delivered, rather than a more specific focus on the quality of outcomes achieved for patients, their families and carers.

Going forward, and in keeping with the nationally-led directive to provide greater focus on quality, this plan will evaluate and commission services with a specific emphasis on the outcomes those services achieve. This will include giving due weight to how patients and clients themselves rate their experiences of services, what they have received, and the quality of outcomes delivered.

Considerable efforts have been made by all partner organisations to gather evaluation data that gives sufficient consideration to measures of both quality and outcomes.

Much of this drive has been achieved via the Change Fund partnership. The benefits of these efforts will now be able to be applied to the wider context of commissioned services through this plan.

5) Reasons for change

"Live Well in Later Life" set out some of the key supply and demand issues facing older people's services in 2008. While many of these issues are still relevant, the current and future financial context means services are under increasing pressure to meet the increasing demand for service with reduced budgets.

This plan recognises that for many services we cannot maintain our current ways of working into the future. Instead we will take a 'transformational' approach to our commissioning so that the fullest use of all the resources available to us is achieved for the people who need our services.

Demographic change: opportunities and challenges

Whilst demographic change presents challenges for health and social care services, it also offers many opportunities. Advances in health care and healthier lifestyles mean that people are living longer generally and almost 90% of people over 65 years are not in the care system at all.

The growing number of older people, many of whom are increasingly fit and active until much later in life, can be regarded as a significant resource, with a great contribution to make to society.

A significant amount of caring for children, adults with disabilities or learning difficulties and older people is provided by people over retirement ages, and many community assets and activities depend on the voluntary contributions of this age group. We need to value older people as assets by supporting them in their caring roles and in the development of volunteering opportunities.

However, with increasing age; there is also an increase in the number of people living with long-term conditions, disabilities and complex needs. The Scottish Government has indicated that one in three people over the age of 75 years will have two or more long term conditions.

Over the next 20 years, large increases are expected in the number of people in each of the three older persons age groups: 65-74, 75-84 and 85+. In particular, the number of persons in the 85+ age group is expected to almost double by 2032, from the present number of 11,040 in 2012, to 19,294. In contrast, the traditional working age population will remain comparatively steady, increasing by only about 15%, which will have an impact on funding available through income tax.

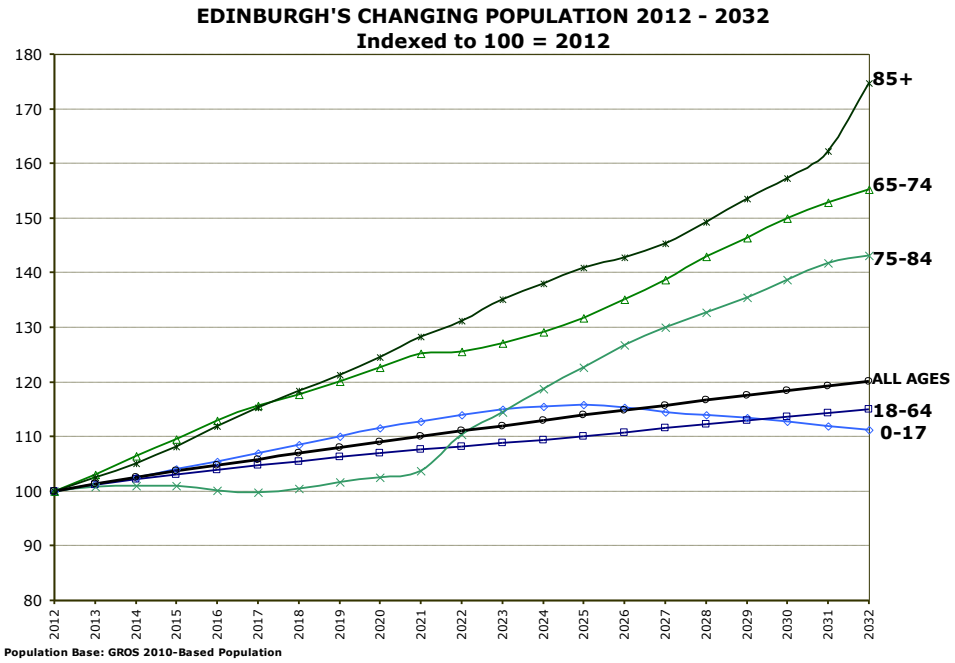


Figure 7: Edinburgh's projected population 2012-2032

An estimate of the number of older people with continuous care needs is shown in the chart below. The number of older people who will require intensive levels of support is expected to increase by 61% over the next 20 years due to demographic factors alone. The anticipated increase is particularly marked for those aged 85+ (Appendix 4 provides further details).

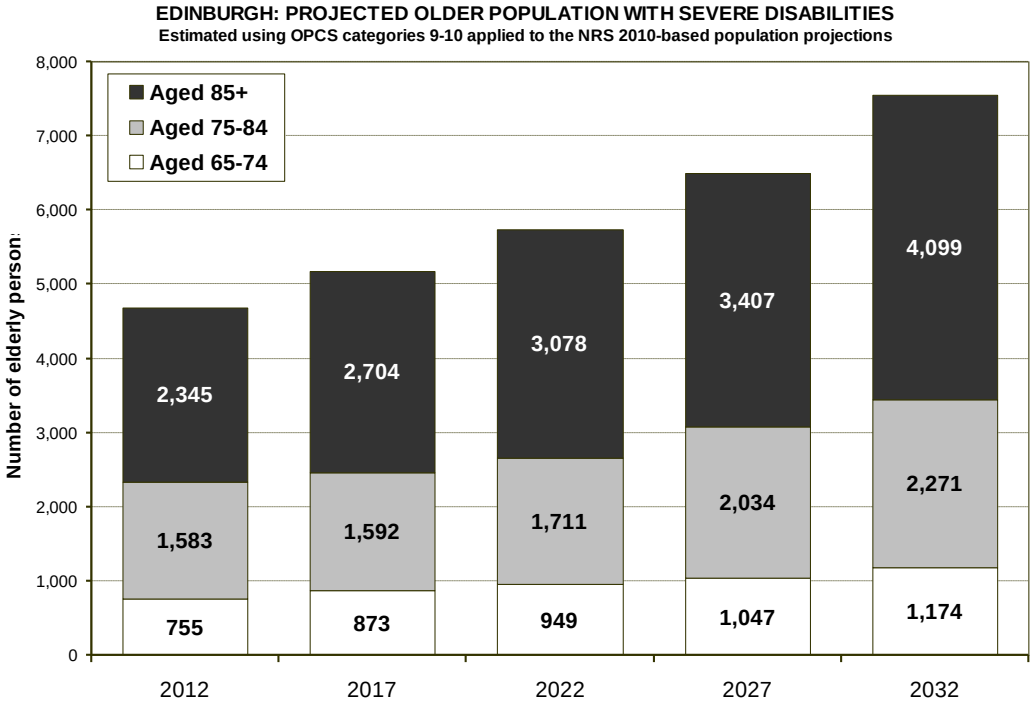


Figure 8: Projected older people with severe disabilities in Edinburgh 2012-2032

Dementia

The number of people living with dementia is projected to increase in line with demographic change.

It is estimated that there are currently 7,142 people over the age of 65 with dementia living in Edinburgh. In ten years, time the number is likely to rise by 22.4% to 8,745 people and in 20 years the number could rise by 61.7% to 11,548 people. Of these, 1 in 8 (12.5%) have severe dementia; 1 in 3 (32.1%) have moderate dementia and just over half (55.4%) have mild dementia. Dementia is a progressive illness - the incidence of severe dementia increases with age and the incidence of mild dementia decreases with age. Around one-half of all persons with dementia do not have a formal medical diagnosis of their condition and these are likely to be persons with mild dementia.

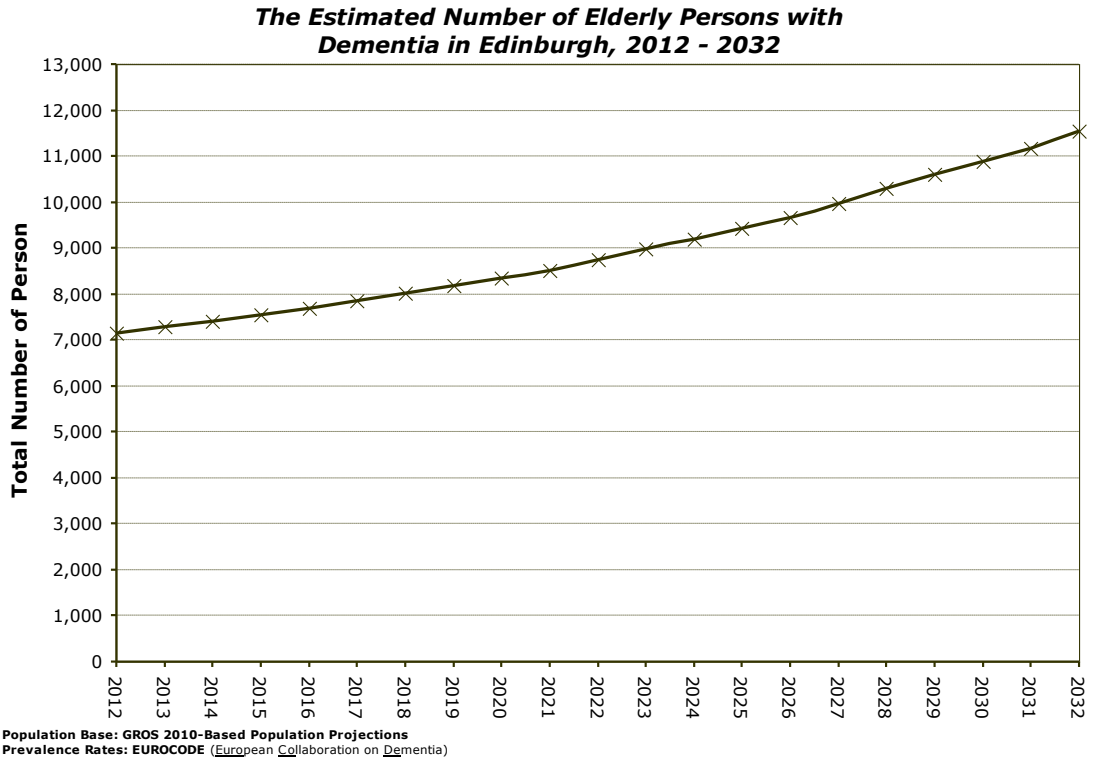


Figure 9: Estimated number of people with dementia 2012-2032

Around two-thirds of older people with a medically diagnosed form of dementia currently live in care homes and the remainder live in their own homes in the community. The national 2011 Care Home Census reported that in Edinburgh over half (51%) of people living in care homes have medically diagnosed dementia and a further 10% are considered to have dementia by the care home staff. A survey of needs and dependency of older people in Edinburgh care homes carried out by the NHS in 2011 found that the proportion of residents with a high 'Mental Health' score (Augmented IoRN component) had risen from 9% in 2000 to 36% in 2011. This compares to a rise from 8% to 18% in voluntary sector homes and a rise from 9% to 23% in private sector homes.

Alongside this, it is estimated that 60%[3] of patients over the age of 65 in general hospital beds have, or will develop, a mental health problem, including dementia, delirium and depression. Alzheimer's Society's 'Counting the Cost' report considers the cost of people with dementia being inappropriately placed in hospital. Evidence shows that the longer people with dementia are in hospital, the worse the effect on the symptoms of dementia and the individual's physical health. The report states that people with dementia stay far longer in hospital than other people who go in for the same procedure and as well as the cost to the person with dementia, increased length of stay is placing financial pressure on the NHS. The report makes recommendations to reduce the number of people with dementia being cared for in hospital in order to create a more cost-effective system that provides good quality care to people with dementia and carers.

In Edinburgh we are learning more about the care and support needs of an increasing number of people living with dementia and their carers and are developing our services to meet these needs. See further information about the Edinburgh Dementia Implementation Plan on p56 and p74.

Sensory Impairment

Action on Hearing Loss Scotland and RNIB Scotland projects the number of people with hearing loss in Scotland will rise from the current 850,000 to 1.2 million by 2031. The number with sight loss (without intervention beyond the current provision) is projected to double from around 180,000 to almost 400,000 by 2031[4]. Specialist sensory impairment services are available in Edinburgh and we continue to work with specialist providers to ensure that support is available for older people that require it.

Older people with conditions related to alcohol and drug misuse

There are a growing number of older people in Edinburgh who have drug and alcohol problems and related health conditions. Many people with drug and alcohol related conditions are living longer and as they age, their care needs develop and change. This can present a particular challenge for health and social care services. These people often need high levels of care as they grow older and they are also at risk of stigma and discrimination.

Many people remain in hospital care due to the difficulty in making other care arrangements. Others receive care at home, but have no access to long-term accommodation, respite or day care placements due to the complex issues attached to their health problems and the implications of purchasing and using substances, some of which are illegal.

[3] Goldberg SE et al: The prevalence of mental health problems among older adults admitted as an emergency to a general hospital. Sept 2011 Age and Ageing 2011, 0: 1-7
[4] Scottish Parliament Finance Committee Inquiry into Demographic Change and an Ageing Population, 2013

A high number of older people who use alcohol are also homeless or in temporary accommodation. Health and social care purchases accommodation for older men who have alcohol problems and/or mental health issues and is developing a strategy to address accommodation issues for people who have alcohol related problems. An allocation has been made from the Change Fund to develop our understanding about older people with substance misuse issues and how services can develop to meet this area of growing need.

The Council is working with Edinburgh Alcohol and Drug Partnership (EADP) to jointly review housing support services for people recovering from problem drug and alcohol use, to ensure that future services prevent homelessness and support recovery.

Unpaid carers

The majority of older people do not need to use health and social care services on a regular basis. Almost 90% of over 65s do not receive any formal care at all and often this is due to the valuable work of unpaid carers. Without this care, health and social care services in Scotland would be required to provide services to far more people than they currently do, and it has been estimated that this could require an additional £7b per year. Research also shows that a breakdown in carer support contributes to approx 62% of older people unplanned admission to hospital.

It is estimated that there are around 39,000 unpaid carers[5] in Edinburgh, which represents 8.7% of the total population. Of these, around one-fifth were providing 50 or more hours per week to the cared for person and 10% were providing between 20 and 49 hours per week. We assume that the number of carers will rise in future, however the rate is uncertain, as the increase in need for care may not necessarily be reflected in the number of people able to provide it.

We continue to engage with carers and carer organisations to ensure that the objectives of Towards 2012 and successive carers strategies are met. A number of reports consider the needs of carers in Edinburgh and are used to inform future service planning, including “Support Needs of Older Carers in Edinburgh” (OPM, March 2011) and VOCAL’s Annual Carers Survey Report. The needs of specific carer groups are considered when developing services, examples of recent work include carers from gypsy/ traveller communities (Hidden Carers Unheard Voices, MECOPP 2012), and consultation with carers of people with dementia (Alzheimer Scotland, Signposts to support: Understanding the special needs of carers of people with dementia, Jan 2003).

Equalities

Edinburgh hosts a multi cultural society. The 2001 census indicated that approximately 1% of people aged 65+ consider themselves to be from black

[5] 2001 Census

and minority ethnic groups. These groups of older people highlight the need for services to be culturally sensitive as well as maintaining the high quality expected to everyone.

The UK Government estimates that lesbian, gay and bisexual people comprise approximately 5-7% of the population. As a result we anticipate that by 2016 there will be approximately 2,000 LGBT older people over the age of 75 years living in Edinburgh. These people are likely to face many of the same issues as other older people, but research suggests that older LGBT people are also:

- 2½ times more likely to live alone
- twice as likely to be single as they age
- 4½ times more likely to have no children to call upon in times of need
- 10 times more likely to indicate that they have no-one to call on in times of crisis or difficulty.

Coupled with this increased need for support is a greater reluctance among older LGBT people to access services due to concerns over discrimination, fear of harassment and loss of privacy.

Gypsy Traveller Communities are often determined to be a 'hard to reach' group in the planning and delivery of health and social care services. Recent work undertaken by MECOPP (Minority Ethnic Carers of People Project) within three localities in Scotland, including Edinburgh, highlights the needs of informal carers from gypsy/ traveller communities and recommends how health and social care agencies can improve how they engage with these groups. (Hidden Carers Unheard Voices, MECOPP, 2012)

It is imperative that all services are accessible, appropriate and inclusive of and sensitive to the needs of those with protected characteristics and that consideration is given to barriers that can limit access for particular groups. Actions being taken to address some of these issues are provided in Part Two (p46) and Part Three (p70).

Housing need

The SESplan (Strategic Development Planning Authority for Edinburgh and South East Scotland) Housing Needs and Demand Assessment Study found that Edinburgh would need 36,000 new homes over the next 10 years if all housing need and demand is to be met in Edinburgh. 16,600 of these homes need to be affordable. The Council is working to maximise the supply of new homes across the city and in 2011/12, 1,558 new affordable homes were approved for development.

New homes are more energy efficient, more accessible and easier to adapt over time as people's needs change. However the majority of older people live in existing mainstream housing and it is important to ensure that these homes are suitable for the needs of people as they grow older.

Edinburgh has the second highest proportion of flats in Scotland at 65%. Flatted homes can be difficult for people with mobility problems to access, especially flats above the ground floor. Nearly half (48%) of all homes in Edinburgh were built before 1945 compared to the Scottish average of 36%. Older homes can be more difficult to maintain and adapt and it can also be more difficult and expensive to improve the energy efficiency of older homes and help reduce fuel bills.

Energy costs are increasing and this is a growing concern, especially for vulnerable groups and people on low incomes. In Edinburgh, 52% of households of pensionable age are classed as being in fuel poverty.

Eleven thousand households in Edinburgh report that they need an adaptation. The Council invests in adaptations to help people remain in their own homes for as long as possible while it is still safe and practical for them to do so. The projected spend on adaptations in for Council tenants and homeowners in 2012/13 is over £2.3 million. Investment requirements will be kept under review in light of the increasing population of older people in Edinburgh and demands on the service. Under the Housing (Scotland) Act 2006, local authorities are obliged to fund certain structural adaptations in private homes where they have been assessed as necessary by an Occupational Therapist.

In addition, the Council administers grants for adaptations to Registered Social Landlord (RSL) homes through the Affordable Housing Supply Programme. In 2012/13, funding of £400,000 has been made available to RSLs for this purpose.

The total number of people who receive housing support increased from 3,374 to 4,900 between 2007/08 and 2011/12. The Homelessness Prevention Commissioning Plan acknowledges that shifting the balance of care to the community is likely to increase the demand for support services, adaptations and preventative advice services that can help people plan for the future before reaching a crisis point.

Transport

Transport services play an essential role in helping older people access care services and local activities that keep people connected to their communities and prevent social isolation.

There is a wide range of different transport options and providers supporting older people, ranging from journeys made to and from hospital with the ambulance service, through to the use of volunteer drivers supporting older people make more local journeys within their communities.

The development of strategies that impact on transport issues will take place out with the scope of this plan. However, more discreet local developments will be made regarding community transport and the relationships amongst the range of transport providers, to ensure older people can access services as they need.

Quality, Best Value and Continuous Improvement

Delivering good quality services is central to the vision of this plan. NHS Lothian and the City of Edinburgh Council continually strive to improve the quality of their services and those of external providers. Quality assurance frameworks are in place to ensure that care services meet agreed standards and deliver Best Value.

The overarching "Commissioning Strategy for Care and Support 2011-16" includes delivering 'Best Value for all services' as one of the nine key principles in commissioning care and support services. Best Value is the requirement placed on health boards and local authorities to deliver services that are value for money. Best Value is a key driver for how investment decisions are made, ensures that an appropriate balance between quality and cost is maintained and requires continuous improvements in performance. Best Value is implemented by carrying out reviews, consultations and monitoring of performance indicators.

Further information in relation to the Council's agreed standards for care and support service quality and how this will be achieved through procurement choices and options is contained in the "Commissioning Strategy for Care and Support 2011-16".

In addition to local quality assurance frameworks, services that deliver health and social care services are also subject to external scrutiny. This applies to services provided by the Council, NHS, voluntary and private sector organisations.

- *Healthcare Improvement Scotland* has the key responsibility to help NHS and independent healthcare providers deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise services to provide public assurance about the quality and safety of that care.

- *The Care Inspectorate* is the independent scrutiny and improvement body for care and children's services. Their role is to regulate and inspect care services and carry out social work and child protection inspections, to make sure that people receive the highest quality of care and that their rights are promoted and protected.

Self Directed Support

Self-directed support aims to empower people to direct their own care and support and to make informed choices about how their support is provided. There are a range of mechanisms available to people to direct their support, including the use of direct payments and individual budgets (see Appendix 1).

The number of people in Edinburgh receiving social care support in the form of direct payments has increased over 1000% from 67 at March 2001 to 679 at March 2011. As can be seen from the graph below the rate of increase in direct payments locally has been ahead of the national trend.

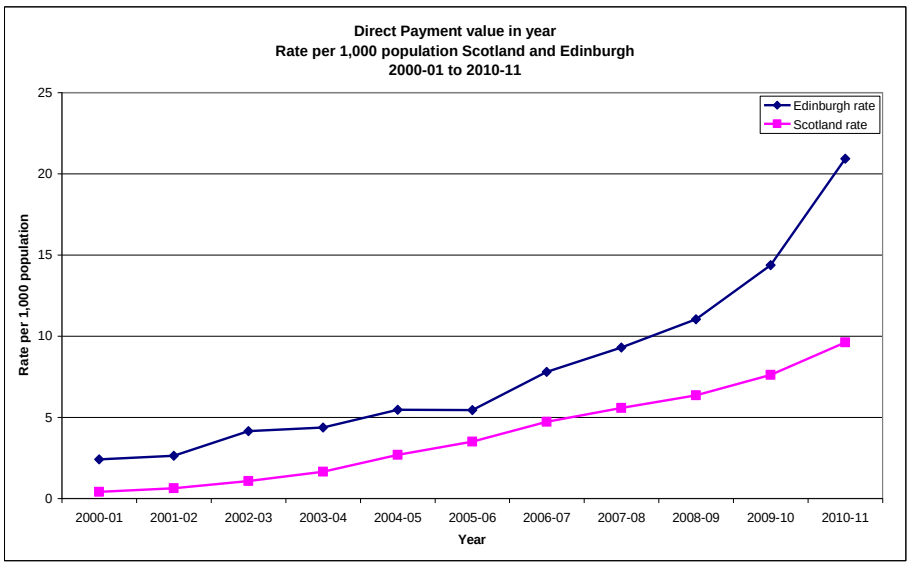


Figure 10: Direct Payment rates in Scotland and Edinburgh 2000-2011

In 2010/11 Edinburgh spent £10.7million on direct payments which accounted for just over one-fifth of the total Scottish spend.

It is difficult to predict the impact that the Social Care (Self-directed Support) Scotland Bill is likely to have on the take up of direct payments. There can be little doubt that the number of people choosing to direct their own support will increase in future years. What is less clear is how many people will ask the local authority or another agency to arrange the support they have chosen on their behalf rather than purchasing it themselves through a direct payment. In the financial memorandum accompanying the draft Bill the Scottish Government has identified three variables which it is not possible to quantify. This makes it difficult if not impossible to estimate with any accuracy the impact of the Bill on the demand for direct payments, the other self-directed support options and the services people might chose to meet their care and support needs. The variables are:

- the number of people who will choose to change the mechanism by which their support is provided;
- the mechanism chosen by an individual wanting more control over their support; and
- the number of people choosing to direct their own support who seek radical change.

Predictions based on the take up of self-directed support in other parts of the UK suggest that we might expect around £40m to be transferred to individuals by 2019. This is approximately 20% of the Council's current spend on social care services and will have significant implications for future commissioning and contracting arrangements, with the scale of our contracting activity decreasing by a corresponding amount.

Ensuring responsiveness and meeting needs

We recognise that some people have unmet needs. We will use this plan to identify where these gaps are and to address those gaps.

Our vision is for our services to be responsive to people's needs, to be accessible and available when they are needed and for people not to be delayed or moved inappropriately because the care that they need is not available at that time. This will require our services to have greater responsiveness than is always achievable within the current system – it will be a purpose of this plan to work towards creating services for people that knit together effectively throughout pathways of care.

This will mean that our some of our services must build capacity to allow them to be responsive. We must also try to remove waiting lists for services where this creates unacceptable delays for people in accessing what they need.

We will use the information available to us from a range of data sources to increase our understanding of the changes that need to be made to services. And as we make services more accessible and responsive, we must ensure we maintain and improve the quality of service that people experience. These services will become more personalised to what individual people need and want, and we will reflect that in the way our services are shaped and designed.

6) Financial framework

The partnership wishes to make the fullest use of all available financial resources in order to best meet the needs of older people. To ensure this is achieved, the plan considers services across the entire pathway experienced by older people, which might include services funded by NHS Lothian and/or the City of Edinburgh Council. We aim to coordinate the efforts of different services to achieve the greatest possible impact. As needs change, the partnership will consider resources in totality, with a view to making investments in areas that are needed and disinvesting in areas that will no longer be required.

The approach is consistent with the national government's commitment to increased integration of health and social care services and providers. This plan provides an opportunity for such integration to be achieved for the care and support services for older people within Edinburgh.

Self directed support will also have implications for how resources are used in the future. Implementation of self directed support will require a move away from block contracts with service providers, to direct payments or individual budgets which will give service users more control over the type of care they receive. This will have implications for financial planning as an increasing proportion of the total budget for older people's care and that of other client groups, will be required for self directed support.

Change Fund for Older People

The Scottish Government created a Change Fund to support the transformation of older people's services, in line with the "Reshaping Care" national strategy. This fund has been available to local partnerships from 2011-15. Edinburgh's share of the fund is shown below.

Year	National Change Fund	Edinburgh's allocation
2011-12	£70m	£6.013m
2012-13	£80m	£6.872m
2013-14	£80m	£6.872m
2014-15	£70m	£6.013m

Figure 11: Change Fund allocations 2011-2015

Many of the areas of Change Fund investment are key to the new models of care described in Part Two of this plan. A summary of the Change Fund plan is provided in Appendix 5. The Change Fund has acted as a catalyst by providing funding to deliver the changes that were already planned to achieve the aims of the previous "Live Well in Later Life" plan. These changes need to be sustained and further developed after the end of the Change Fund through joint financial planning.

Estimating future levels of need

Analysis has been undertaken to estimate the number of older people who will require health and social care services in the future.

The methodology used includes older people (aged 65+) with low levels of disability or need within the 'preventative services' category. Some of the preventative services included in this plan are universal i.e. can be accessed by all, irrespective of need, for example information and advice services. The number of people accessing preventative services is therefore likely to be higher than stated.

	Estimated number of people 2012	Estimated number of people 2022
Preventative services	17,250	20,900
Proactive care and support at homes	33,000	39,900
Effective care at times of transition	5,800	7,050
Intensive care and specialist support	4,700	5,750

Figure 12: Estimated number of people by service categories 2012 and 2022 (rounded to nearest 50)

The methodology used and further details are available in Appendix 4.

Rebalancing the allocation of financial resources

The diagram below shows how the totality of resources for older people's services (including the Change Fund), are allocated in 2012.

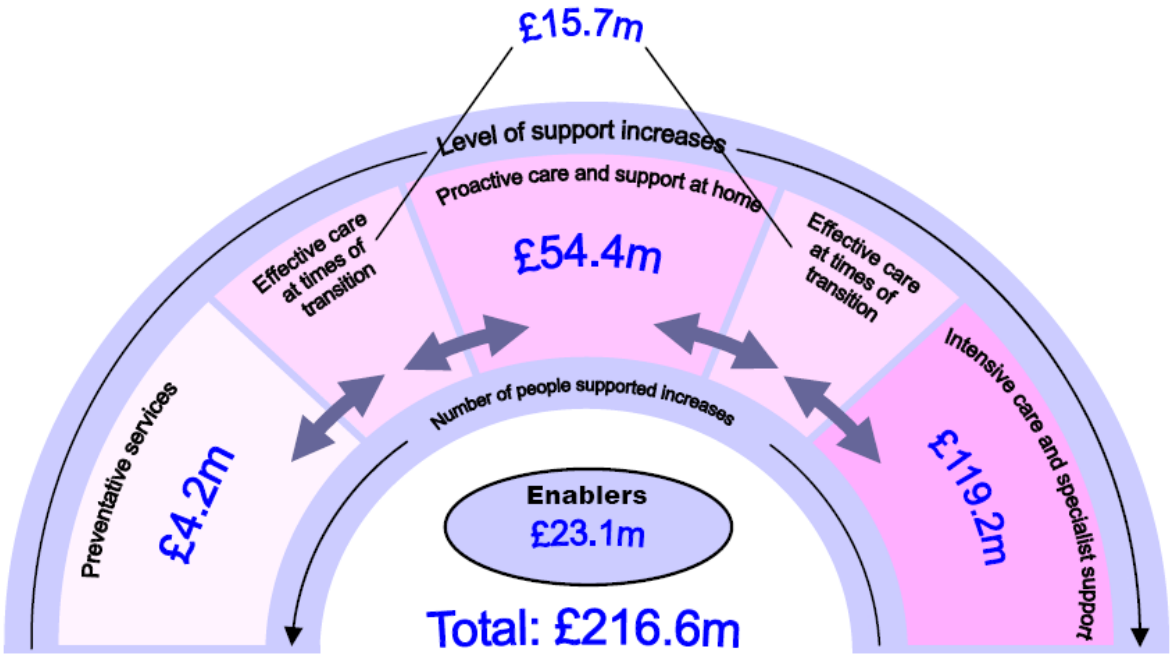


Figure 13: Total financial resources for older people's care and support by service categories (2012/13)

Using the headings from the diagram above, we can show how financial resources are currently allocated and how this compares with the number of people needing different levels of service.

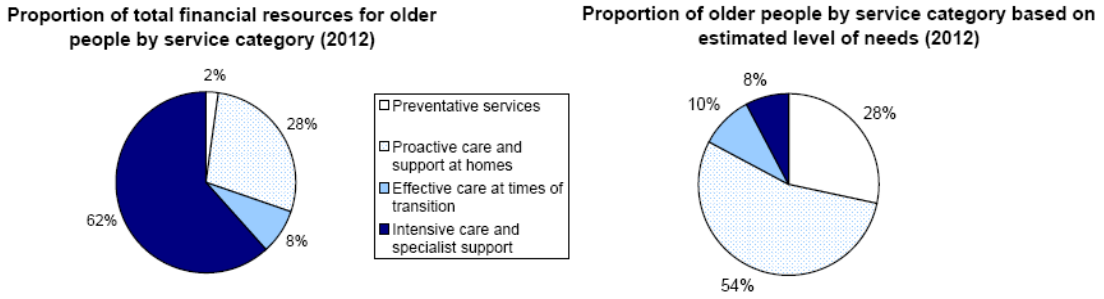


Figure 14: Charts showing the allocation of financial resources (2012) and estimated numbers of older people (2012) by service category

The comparison of these two pie charts shows that the allocation of resources is focused on the provision of intensive care and specialist support while the proportion of older people requiring access to these services is very small.

Intensive care and specialist support services are understandably more expensive than preventative services as they include 24 hour and specialist services such as care homes and acute hospital beds. However, by investing more in preventative and community based care, we aim to reduce the need for costly emergency admissions.

The example below helps to illustrate how investing in community based support can free up resources from hospital settings whilst also improving the experience and outcomes for older people.

Improving orthopaedic and stroke pathways for older people

During 2010/11 a new model of care was developed for people within orthopaedic and stroke rehabilitation pathways. The purpose of the model was to shift the balance of care from hospital to community settings. This was done by enhancing rehabilitation in hospital to increase the functional level of patients at their point of discharge and by providing increased levels of rehabilitation and care once people had returned home.

Additional investment of around £500,000 was made to enhance rehabilitation and social care support. The new model was successful as it allowed people to be discharged from hospital at an earlier stage, freeing up bed capacity whilst also delivering improved outcomes for older people. An evaluation concluded that the new model of care was more cost effective than the traditional model due to reduced hospital lengths of stay. The model of care was key to enabling the move of wards within the new Royal Victoria Hospital which included a reduction of orthopaedic and stroke beds.

How will these changes be made?

This plan sets out the requirement to shift the balance of care and develop new models of older people's services in order to meet future needs.

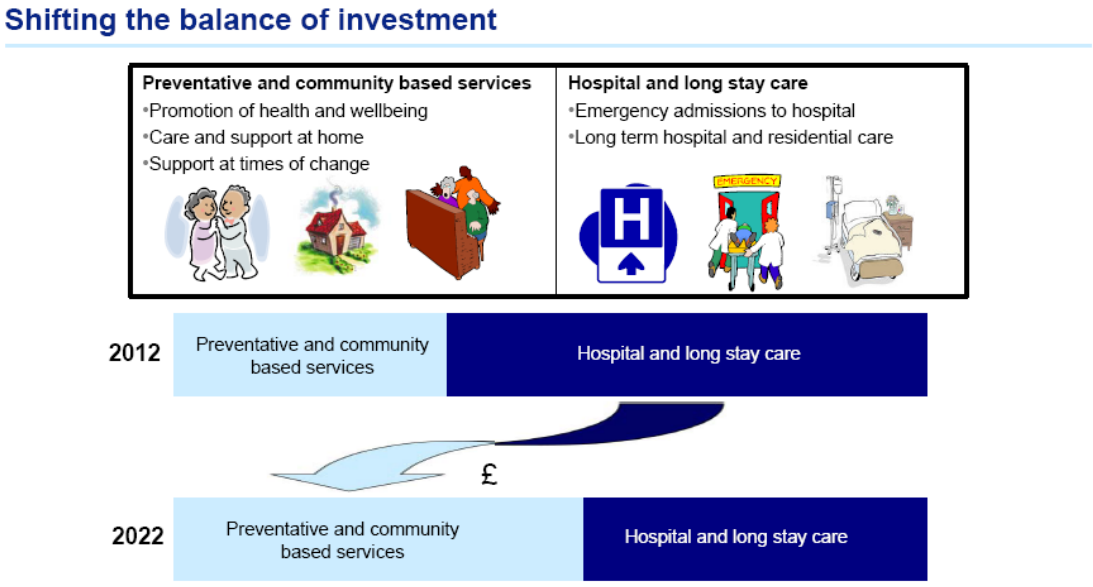


Figure 15: Shifting the balance

The partnership has committed to the development of a joint financial strategy to plan how resources are allocated across health and social care in order to best meet the future needs of older people within a financially challenging context.

We will do this by jointly planning future investment and disinvestment in services and rebalancing the allocation of resources by:

- redesigning hospital services and reducing the length of time people stay in hospital which will enable the planned bed closure of some areas of hospital beds
- investing in community based and preventative services to allow more people to be supported in their home or a homely setting
- improving the health and wellbeing of older people and their carers to prevent or delay the need for higher levels of care
- developing innovative solutions, evaluating 'what works' and using this information to design and plan future services.

The City of Edinburgh Council's Long Term Financial Plan, includes additional funding for social care to meet the needs of growing numbers of older people and people living with complex conditions.

NHS Lothian's funding is determined by the Scottish Government, through a formula known as NHSScotland Resource Allocation Committee (NRAC). This model is relatively new and there is an adjustment process underway which is moving Scottish Health Boards from their previous allocation model towards the NRAC model. Currently, NHS Lothian is slightly under NRAC parity and it is planned that it will receive greater than baseline adjustments over the next few years until it reaches its NRAC position. NHS Lothian, working with its partners, is committed to utilising additional investments to support the development of joint older peoples' services.

NHS Lothian, the City of Edinburgh Council and their partners, take a planned approach to delivering savings through improving the efficiency of the services delivered. Whilst some of the savings made are required to meet the reductions in total public spend available, there are also opportunities to reinvest savings to address the priorities of the partnership.

The funding arrangements outlined above will form the basis of the joint financial strategy to ensure that the commitments within this plan for older people's services can be met and sustained. It is imperative that the joint financial strategy takes into account wider changes and pressures such as legislative changes, funding pressures and demographic changes relating to the ageing population's demand for health and social care services and also facilitates a shift in investment towards preventative services.

The further integration of health and social care services will facilitate joint financial planning as the proposals include the role of a 'single accountable officer' who would have responsibility for shared resources.

7) Conclusions

This section has outlined some of the significant pressures that our services are currently facing.

Our analysis shows that the demands for and pressures on current service models will continue to increase over the life of this strategy. If we match existing levels of service to population growth, by 2022 we would need to provide:

- 428,000 additional hours of home care per year
- 748 additional care home beds
- 7,900 additional intermediate care hours per year
- 150 additional long stay hospital beds for older people (inpatient complex care beds).

Our analysis supports the national “Reshaping Care for Older People" strategy which states that existing models of care are not affordable and continuing to deliver care and support in the same way is not sustainable. Part Two of this plan considers how we will change our models of care to meet this challenge.

Part Two: The Plan

1) Strategic framework

Older people in Edinburgh, as well as the wider population, expect high quality services which meet their aspirations for quality of life. Our joint plan aims to meet this outcome through commissioning and procuring the best possible services at the best balance of quality and cost, and in a way that is fair, equitable, and efficient.

The City of Edinburgh Council and NHS Lothian between them spend around £217 million on services for older people in Edinburgh which are either directly provided or procured externally from the independent or voluntary sectors. The City of Edinburgh Council purchases 66%[6] of its health and social care services for older people from independent or voluntary sector providers, while NHS Lothian directly provides nearly all of its services for older people.

There is increasing demand for the services provided by these budgets, while agencies are also under pressure to reduce costs. Planning for the longer term therefore requires us to jointly consider how the resources available are best allocated to successfully shift the balance of care in line with what people tell us they want and in a way that is sustainable. A 'whole system' approach is needed, so that decisions are made jointly, with an awareness of impacts that changes can have on other parts of the health and social care system.

2) Future models of care

The Scottish Government's "Reshaping Care for Older People" strategy describes a new philosophy of care that promotes an 'enabling' approach and supports people to maximise their independence and quality of life. Some of the differences between the 'old' and 'new' models of care are highlighted below:

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

[6] Source: Commissioning Strategy for Care and Support 2011-16

Figure 1: Based on Scottish Government “Reshaping Care for Older People”, Information Booklet

Within Edinburgh, new models of care are already being developed that support this new philosophy along with the investments made from the Change Fund for Older People. Some of the key developments underway, and progress made since “Live Well in Later Life”, are described in more detail in the Appendix 3.

3) The commissioning cycle

Commissioning is the process of planning and delivering services. This involves understanding needs, planning how these should be met and putting services in place, either by delivering services directly or purchasing them.

Our plan will use a commissioning cycle which has four stages as described in the diagram below;

- Analyse
- Plan
- Do
- Review

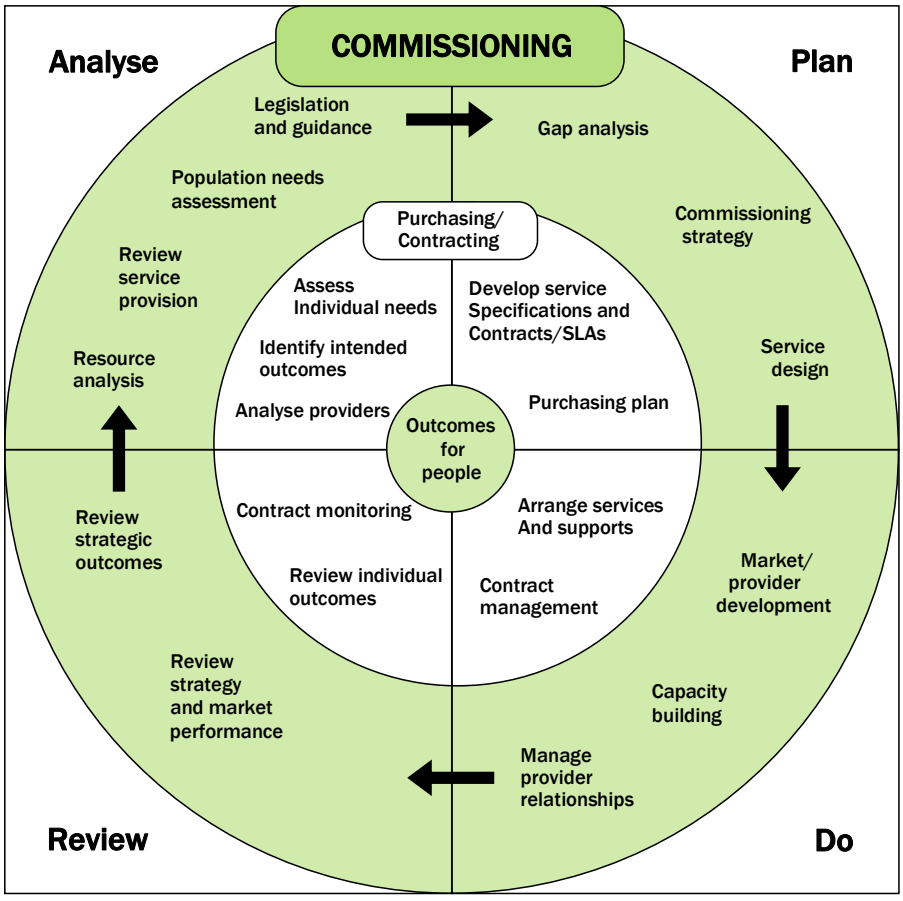


Figure 2: Social Work Inspection Agency (SWIA) Guide to Strategic Commissioning 2009

How the cycle works

These are the four stages of the commissioning cycle:

Analyse. Partners consider all the information available from consultations, census information, the way people use services currently, gaps in services, and by monitoring service quality.

Plan. Partners work with stakeholders in an inclusive manner to create a picture of how services need to be shaped in the future.

Do. Individual service areas will describe how they will implement the longer term commissioning plan through shorter term delivery plans. These may include developing or purchasing new services, and reshaping or ending existing services that are no longer as relevant to what people need or want.

Review. The plan will be reviewed, including looking at whether it is in itself still relevant to changing conditions. Feedback (from people who use services, unpaid carers and other partners) is an essential part of this stage.

Commissioning principles and plans

In 2011, the City of Edinburgh Council, supported by NHS Lothian, produced an overarching plan, "Edinburgh Commissioning Strategy for Care and Support", which sets out the principles that will be followed when commissioning care and support services. These principles are:

- services to be personalised and offer choice
- self management, promoting wellbeing and independence through to the end of life
- unpaid carers are equal partners
- communications and engagement
- equality of opportunity
- Best Value for all services
- supporting our providers
- assessment of benefit and risk in service redesign
- promoting sustainable procurement by means of community benefits and social issues.

This joint plan follows these principles with a clear expectation that the process will be undertaken in a partnership involving older people and their carers and the main providers, which are the City of Edinburgh Council, NHS Lothian, voluntary sector and independent sector agencies.

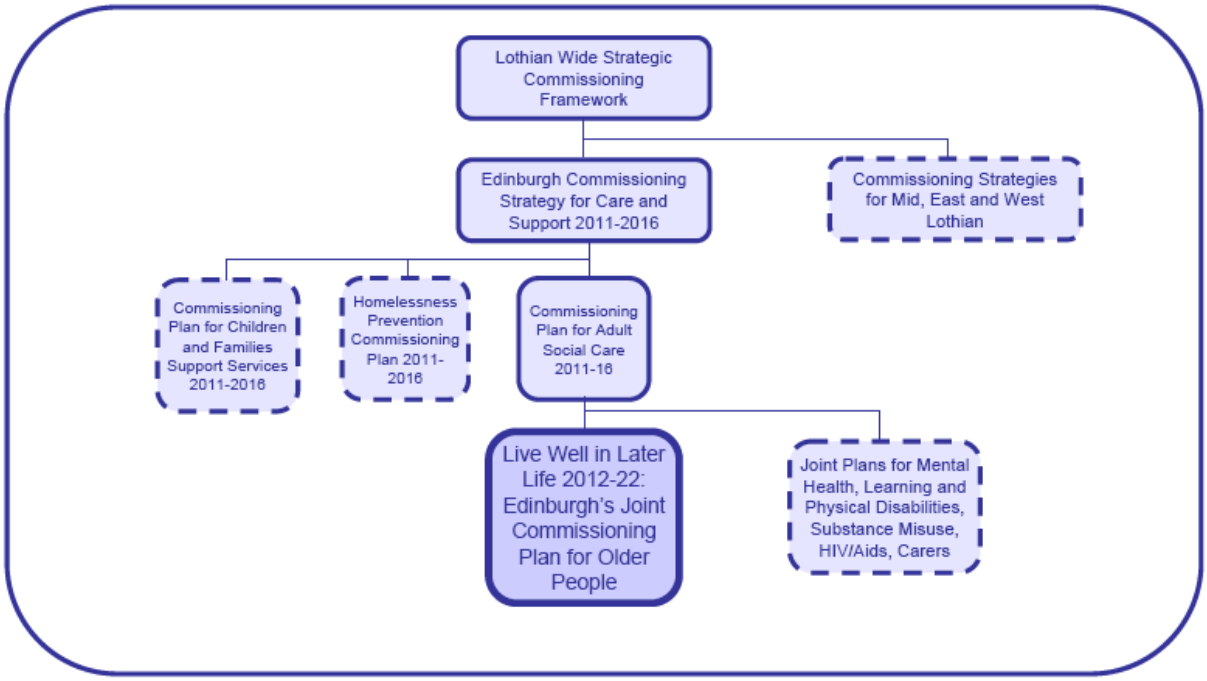


Figure 3: The local commissioning context

Three individual Commissioning Plans set out how services will be commissioned in future, based on three service groupings:

- Homelessness Prevention Commissioning Plan
- Children and Families Support Services
- Commissioning Plan for Adult Social Care

This plan is part of the broader Commissioning Plan for Adult Social Care which sets out how the Council's social care services for older people are currently provided and how these services will be commissioned and procured over the next 5-10 years.

Joint plans between NHS Lothian and the City of Edinburgh Council are also in place for the major care categories such as mental health, learning disabilities, physical disabilities, substance misuse, HIV/Aids and carers.

Self-directed support will have a significant impact on the way that services are commissioned and procured in the future. Self directed support enables people to have more flexibility, choice and control over their care and support arrangements, and provides the opportunity for more people to control or arrange their care through the use of direct payments or individual budgets.

The Personalisation Programme comprises of a number of work streams to develop more personalised care and support and to meet the requirements of the Self Directed Support legislation. Engagement of external providers, service users and staff is an integral part of this programme. Work is currently underway to develop a Market Shaping Strategy which sets out how the provision of diverse, appropriate and affordable health and social care

services will be facilitated, to meet the needs and deliver effective outcomes now and in the future.

4) Plans for services

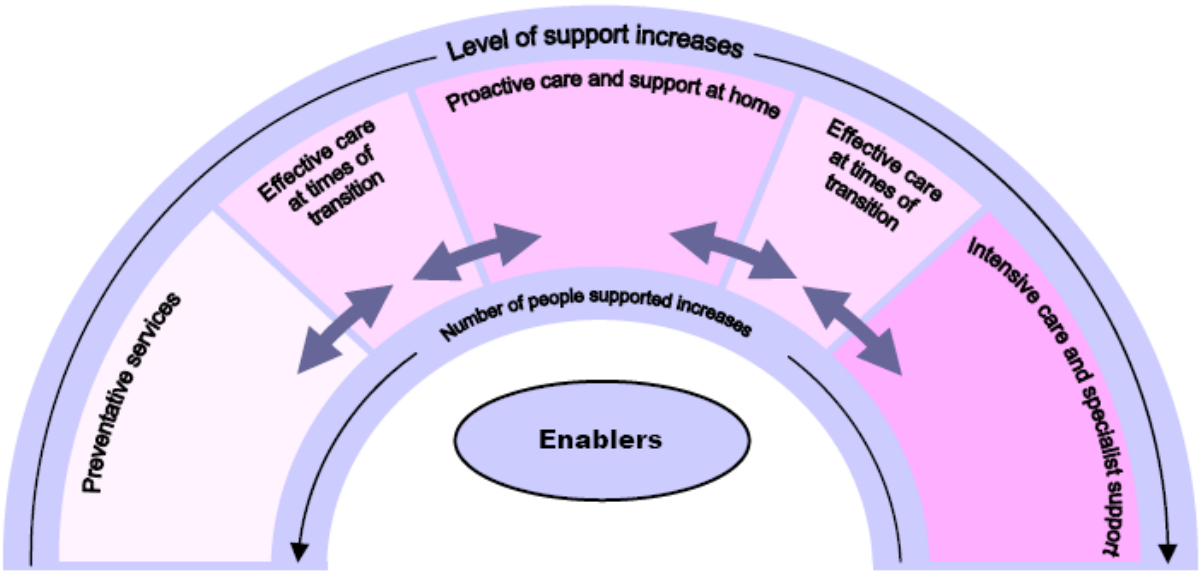


Figure 4: Plans for services

Our plans for the future are outlined in the following pages, using the categories from the diagram above, although many services relate to more than one heading.

Our long term commitments for this ten year plan are outlined under each subheading, with short to medium term (1-3 years) actions identified within the boxes. An action plan will be developed based on the short term actions which will be monitored as part of our wider evaluation framework.

A) Preventative services

1) Communities are more resilient and older people are less isolated

The majority of care for older people, even where there are significant dependencies, is still provided by family and other informal carers who are now often over retirement ages themselves. Supporting these carers is the first priority for a sustainable system meeting care needs.

There is a wealth of support from the communities and networks in the city, and from local, community based services, organised support networks and activities that support the health, wellbeing, independence and social engagement of Edinburgh's older people and their carers. These opportunities and activities are crucial to promoting health and wellbeing and preventing and delaying older people needing to access higher levels of care. Some of these services can be accessed directly without the need for a formal assessment. Services are delivered by a range of providers, many of which

are voluntary or charitable organisations. Volunteers and informal carers are essential in providing many preventative services and investment needs to be made to sustain and build this support.

Research demonstrates that loneliness has a significant effect on mortality. Supporting older people to make connections and reducing social isolation is a focus of this plan, with the aim of improving mental health and wellbeing and delaying or preventing older people needing to access higher levels of care.

Other factors important in preventing ill-health, which are particularly relevant to older people include good nutrition, physical activity and exercise, strong engagement with the surrounding community including intergenerational activities, and living in a home that is suitable for their needs and affordable to heat. These factors are included in many of the service developments in this plan and will also be addressed through work being led by the Council and its partners on how to build community capacity and preventative services in Edinburgh.

In the short to medium term (1-3 years) we will:

- invest in building community capacity with an emphasis on preventative services:
    - by allocating at least 20% of Edinburgh's Change Fund to projects that build the capacity of communities and support volunteers
    - by developing a community connecting service for all areas of the city
    - by investing in an Innovation Fund focusing on preventative and anticipatory care, adopting an asset based approach, and using principles of co-production and volunteering. Evaluation of these projects will inform future planning of older people's services.
    - by supporting transport options that people can easily access
- continue to support and develop lunch and day clubs
- develop evidence-based action to build resilient communities
    - by working with Queen Margaret's University to develop our understanding and evidence of how resilient communities are developed, which will include specific actions and change
- increase awareness of community based services and support
- continue to support and develop health promotion
- encourage older people to take advantage of community learning and activities

Community Connecting

Community Connecting is a support service for older people in Edinburgh. The service works with older people with a range of needs who are socially isolated or at risk of becoming socially isolated, to help them build social networks and link into local opportunities and activities with the support of volunteers.

Community Connectors and volunteers work with the older person to identify things they would like to do and support them to achieve these goals. The activities that people choose to take part in are wide ranging such as playing pool or bingo, attending art galleries or classes. Often people have lost confidence after experiencing a fall, illness or bereavement and need a bit of support in getting out and about, to the local coffee shop or using public transport.

The service provides opportunities for volunteers from a range of ages and backgrounds, to give something back or broaden their experience, which can have a positive impact on their own health and wellbeing. The service is provided for around 4 months by which time it is hoped that connections have been made that can be maintained. Many friendships continue beyond this point and some older people who have received the service have even gone on to be volunteers.

2) Older people and their carers can access the information they need, when they need it

Ensuring that older people and their carers can access the information they need about opportunities and support available when they need it is essential to maximising health and well being.

Personalisation and self directed support will require good quality information to be available to allow people to make informed choices about the way they live their lives: from improving their health and wellbeing to ways of meeting their care and support needs. Being able to access information and advice about welfare support and pensions is valued highly by older people. Advice on housing and income maximisation are important, particularly at a time when household costs, such as energy costs, are increasing.

Planning ahead can assist older people, their carers and families make clear, informed decisions about their future. Older people need to be supported to plan their future finances, accommodation and care arrangements as early as possible. The Council will work closely with other service providers to establish how investment in this area can be maximised and how services can be best integrated.

In the short to medium term (1-3 years) we will:

- continue to provide information on various activities and opportunities available for older people across the city
- ensure that citizens and professionals across the city can access high quality information and advice, including people from ‘hard to reach’ groups and those with communication difficulties
- promote links to information sources about health conditions and how to better manage them
- encourage people to plan for the future including making wills and provision for power of attorney
- ensure adequate housing options advice is available, so that older people can make choices about staying in their home or moving to a more suitable one
- enable choice by providing the balanced information that people need to make informed decisions about their care and support

3) Unpaid carers are supported to continue their caring role for as long as they wish

Unpaid carers support the large majority (90%) of people over 65 that do not receive any formal care and we recognise the huge contribution that they make. This plan is based on a commitment to treat unpaid carers as equal partners and to work in partnership to develop future services and support for older people and their carers.

Many people provide unpaid care for their relatives and gain satisfaction from doing so. However, in certain situations such as where caring responsibilities are intensive or longer term, caring can have a negative impact on health and wellbeing, social opportunities and financial circumstances. This may result in carers needing to access health and social care services themselves, and can sometimes lead to a breakdown of caring arrangements.

It is therefore essential carers feel supported to continue their caring role and to maintain their own health and wellbeing. Shifting the balance of care requires appropriate community services to be in place to prevent additional burdens being placed on informal carers and to ensure carers are supported to enjoy a good quality of life. The report "Support Needs of Older Carers in Edinburgh" (OPM, March 2011) considers the needs of carers in Edinburgh and we continue to learn from such research to inform future service planning.

Towards 2012, the Carers Strategic Action Plan for Edinburgh will be reviewed and will identify and take forward carers' priorities in the city. The specific needs of carers of older people and older carers will be considered during all major service developments and we will engage carers in shaping future services and support.

In the short to medium term (1-3 years) we will:

- improve support for carers within the hospital discharge process
- provide support for carers of people with dementia and employ people with lived experience of caring through the Edinburgh Behaviour Support Service
- invest at least 20% of Edinburgh's Change Fund to supporting carers
- provide additional flexible respite/ short breaks for carers
- invest in specialist respite beds for people with dementia
- engage with carers of people with dementia to agree priorities for action
- continue to support carers with information, advice, training and support
- engage with carers in reviewing Edinburgh's Carers' Strategy
- develop and implement plans for investing additional funding for carers available (Carers Information Strategy funding from the Scottish Government and an additional £500,000 allocated within the City of Edinburgh Council 2013/14 budget)

Short Breaks for Older People

We know that having time away or a break from caring for an older person can make a big difference to both the carer and the person being cared for. Traditionally, short breaks were offered in care homes across the city and whilst this service continues to work very well for some people, service users and carers told the City of Edinburgh Council that they would like to have more choice and flexibility.

Direct Payments are available to allow older people and their carers to arrange a flexible break that best suits both of their needs. These opportunities have been very positive for many older people and their carers, for example:

"Bill got so worked up about going into the respite home, he got ill, and I couldn't relax knowing he was unhappy. But now I get a break because we have arranged for someone to come in and sit with him once a week, so I can go to my evening classes. They got on really well, and now I have even managed to have the odd night away with friends. I don't know what I would do without this now." (Carer of husband who has had a stroke.)

"My wife loves doing watercolours and last year we used a Direct Payment to book her into a residential art course instead of her respite nursing home. She was supported by two care workers to provide the health and personal care I would normally do myself. Knowing my wife was happy meant I could get the break I needed. It didn't cost the Council any more money to do this and it worked so much better for both of us." (Husband of an older woman with severe disabilities.)

4) Services are accessible to all older people

Older citizens come from diverse backgrounds, including people from black and ethnic minority groups, from lesbian, gay, transgender and bi-sexual communities, and people with lifelong disabilities or learning difficulties. By putting the older person at the centre when identifying their needs and through planning and delivering care and support which takes account of their preferences, we aim to ensure that their individual needs are met.

The specific needs of older people with protected characteristics are a key consideration in the planning and delivery of all services and support. We recognise that there is more that can be done to ensure that older people feel confident to access the services and support they need without the fear of discrimination and the partnership will continue to work with providers from all sectors to address these issues.

Similarly, a proportion of older people will face socio-economic disadvantages or deprivation, and these effects are often increased by the reduced income after retirement ages. Low incomes impact on health and wellbeing, particularly for older people who need good standards of heating and nutrition to maintain health. Older people are also more likely to face limits on their vital social networks and contacts from transport or safety issues. Preventive approaches are needed to ensure equality of access to social capital, to mainstream services such as shopping and leisure, and also to target services to reduce the effect of inequalities on the health and wellbeing of older people.

In the short to medium term (1-3 years) we will:

- undertake equalities impact assessments to identify any impact that service changes may have on particular groups of older people and mitigate the effect
- consider the specific needs of older people from protected characteristic groups in the planning of services, examples include:
    - a review of black and minority ethnic day services is underway as part of the Commissioning Plan for Social Care Day Services for Older People
    - funding has been awarded through the Change Fund to LGBT Age to increase the engagement of older LGBT people with the Age Project and to work with mainstream organisations to increase understanding and enable organisations to better meet the needs of older LGBT people
- continue to focus on reducing health inequalities

B) Proactive care and support at home

1) High quality care is provided within people's homes

As more older people are supported to live at home for longer, and with increasingly complex conditions, we need to ensure that the support required is available when needed. The Change Fund is being used to enhance a range of core services that help to maximise older people's independence at home such as re-ablement, intermediate care, home care, telehealthcare and community based therapy support.

Re-ablement, recovery and rehabilitation are concepts that are integral to delivering the aims of "Reshaping Care for Older People". Many services for older people already work to enable individuals to maximise their independence, focussing on the abilities of older people rather than 'deficits'. The re-ablement service in Edinburgh has shown to be very successful and a re-ablement approach now needs to be incorporated into all services for older people.

Re-ablement

The City of Edinburgh Council has provided a Home Care Re-ablement Service across the city since April 2009. The Re-ablement approach has transformed the way that services are delivered, to provide better outcomes for service users referred for a home care service from hospital and the community. An intensive service is provided for around 6 weeks, during which time Re-ablement staff work with the service user to maximise their independence and achieve their goals, rather than doing tasks to and for them.

An objective evaluation of the Edinburgh model commissioned by the Scottish Government was published in November 2009. This indicated better outcomes and high levels of satisfaction from service users, family/ carers, staff and managers as well as appropriately reducing care hours by up to 40% and reducing the whole life-cost of care.

Edinburgh's Re-ablement Service has received a number of national awards and has established links with other areas of the country that are implementing similar services. Consideration is now being made to how a re-ablement approach can be applied across other health and social care services.

Where people have ongoing care needs which are assessed as being eligible for social care support they will be offered the choice of having a direct payment or the Council arranging services for them. Once the Self-Directed Support Bill is enacted the local authority will have a legal duty to offer them a choice of the four self-directed support options (see Appendix 1 for details of these options).

If self-directed support is to be a reality for as many people as wish this to be possible, different types of services will be required to support people in directing their own support. These will range from the provision of information and advice to supporting people to manage their direct payments by using a payroll service or assisting them to recruit a Personal Assistant. Work is underway to develop proposals to ensure that sufficient good quality support is available to enable people to direct their own support successfully.

In the short to medium term (1-3 years) we will:

- continue to modernise our home care service (see Appendix 2)
- increase the capacity of the home care overnight service from 3 teams to 5
- enhance the home care and care at home services to meet the demands of demography and shifting the balance of care
- support the health care needs of people in the community through community nursing, allied health professionals, general practitioners, dentists, ophthalmologists and podiatrists
- enhance out of hours health and social care services
- develop services to support and encourage people to direct their own support

Home Care Overnight Service

Supporting people overnight is often key to enabling them to live independently in their own home. The Overnight Service helps people who might otherwise need to go into hospital or a care home. It also helps carers who need a break.

For those people assessed as needing the Overnight Service, the team can provide support including:

- toileting and turning in bed
- checking people are safe and well
- taking action in an emergency.

The Change Fund has allowed the expansion of the Overnight Service from 3 teams to 5 and the teams now make around 90 visits per night.

2) Appropriate housing options are available for older people

It is important that new homes are being built with adaptability and accessibility in mind. This can support people to remain in their homes as they grow older and their needs change.

The vast majority of affordable homes have been built to at least Housing for Varying Needs (HFVN) standards of accessibility in recent years. Between 2004/05 and 2011/12, 242 wheelchair accessible homes have been built with funding from the Affordable Housing Investment Programme.

Specialist housing for older people also has a role to play in ensuring that a range of different support needs can be met. Elizabeth Maginnis Court is a good example of housing with additional support which can be tailored to individual needs and increased or decreased as required. This is a joint venture between Health & Social Care, Services for Communities, Dunedin Canmore Housing Association and Edinburgh Community Health Partnership. More details are provided in the case study below.

The Scottish Government has committed to preparing a practical guide to the redevelopment of existing sheltered housing to provide a varied and flexible range of supported housing for older people. This is in recognition of the fact that many social landlords have sheltered housing which is no longer fit for purpose or which could be used more effectively.

The Council is investing in improvements to existing stock. Between 2006/07 and 2011/12, the Council invested £149 million in bringing existing Council homes up to the Scottish Housing Quality Standard (SHQS). This includes a minimum energy efficiency rating making homes more efficient and cheaper to heat. As of April 2012, 75% of Council homes were compliant with SHQS and continued investment is expected to ensure that 100% achieve the SHQS by 2015.

When reviewing its Housing Capital Investment Programme the Council will take account of requirements of the ageing population and new energy efficiency and fuel poverty requirements.

The Council is also working with the Scottish Cities Alliance to explore how to best support people in the private rented sector and home owners to improve the energy efficiency of the homes by taking advantage of Government initiatives such as the Green Deal.

In the short to medium term (1-3 years) we will:

- deliver accessible and wheelchair accessible homes through the Strategic Housing Investment Plan (SHIP)
- review provision of Council and partner sheltered housing to ensure most effective use
- ensure Change Fund projects are integrated into wider housing and support strategies
- develop improved housing options advice covering all tenures
- provide accurate and relevant information and advice to improve the quality of homes
- provide a support service that considers the needs of older people in all tenures to increase their independence and ability to remain in the community of their choice.

Elizabeth Maginnis Court

Elizabeth Maginnis Court is a joint initiative between Health and Social Care, Services for Communities, Dunedin Canmore Housing Association, and Edinburgh Community Health Partnership and is a key element of the Accommodation Strategy for Older People. The overall development provides an exciting mix of services which will provide long term supported accommodation for older people with a range of support needs which may change over time.

All the flats have access to basic telecare linked to Community Alarms Service. All tenants benefit from the services of a concierge who manages the building, and have access to a laundry and to communal sitting areas. 32 people aged over 50 have been allocated mainstream flats through the Council's Key to Choice letting system.

23 flats provide tenancies for older people with complex care needs nominated by Health and Social Care and an additional 8 flats for people with learning disabilities.

The complex also houses the Granton Day Service and a meals service is provided for both day care users and tenants with complex care needs.

3) People are supported to live safely and independently at home with adaptations and equipment

Many existing houses can be made more suitable for use for those with mobility and associated health issues through the use of adaptations and equipment. The Council funds adaptations for Council tenants and private owners as well as administering funding for adaptations to Registered Social Landlord (RSL) homes.

Adaptations for Council properties are needs-based following an assessment by an occupational therapist. Where adaptations are required the potential long-term needs of the tenant are also considered to ensure further adaptations can be carried out if required. This ensures the most effective use of housing stock, appropriate re-letting of adapted properties and where appropriate assistance to move to a more suitable home to meet the individual's long-term housing needs. This has resulted in a higher proportion

of adaptations in Edinburgh than the Scottish average and will build up a stock of accessible and adapted properties for the future.

An Edinburgh Adaptations and Equipment Partnership was set up as part of a review of the adaptations process which looked at increasing choice and flexibility for customers. This group, which includes the Council and RSLs, will continue its work to further streamline processes and will consider options to expand the range of adaptations available.

Many older people can be supported to live longer and more safely at home through the use of equipment. The installation of equipment can support older people to leave hospital earlier and to maintain or regain confidence. Equipment can range from simple items such as pick-up reachers, dressing sticks and grab rails, which can be requested directly, to items that require a professional assessment such as bath seats, toilet seats, walking frames, and bed rails. An important factor for people being able to manage at home is their ability and confidence to access their bathing facilities. The bathing assessment service focuses on assessing people's needs and can make changes to improve people's ability to bath, whilst referring people with more complex needs on for further support.

In the short to medium term (1-3 years) we will:

- continue to develop the adaptations process
- further develop our flexible approach to adaptations and expand the range of adaptations available
- increase the provision of equipment to support more people to live safely and independently in the community
- increase the number of bathing and toileting assessments undertaken by the equipment and adaptations service
- review capital investment requirements, to consider, amongst other things, the needs of the growing population of older people.

4) Day services support people to continue to live in the community

Day services, which are registered to provide personal care by the Care Inspectorate, are an important part of the spectrum of services which support older people to remain at home in the community for as long as possible. These services provide a choice of centre or non-centre based provision for older people who are unable to use their local community groups and resources, even with the additional support of community connectors. The registered Day Services focus on the maintenance of independence and the promotion of mental and physical health through a reduction in social isolation, meaningful activity and a short break for the carer, where appropriate.

A Commissioning Plan for Social Care Day Services for Older People was finalised in June 2012, following consultation with older people and stakeholders. The plan sets out an agreed vision and future direction for these services.

In the short to medium term (1-3 years) we will:

- implement the developments contained within the Commissioning Plan for Social Care Day Services for Older People which include:
    - development of a community connecting approach in all day services for older people
    - development of local partnerships to support and stimulate the local community infrastructure to improve local information and integration of services. The partnerships would include representation from wider community resources in order to improve choice, promote early intervention and prevention and ensure the involvement of local older people in the design of local services
    - continuation of specialist day services, where appropriate, with supported integration into mainstream services as an alternative
    - development of a re-ablement approach within registered day centre services through the appointment of two new occupational therapists.

5) People with long term conditions are well supported

As people live longer, many will do so with conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and other long term conditions. People with these conditions will need to maintain relationships with many health and care services in order to manage their health into older age.

In the short to medium term (1-3 years) we will:

- extend the reach of the current IMPACT (Improving Anticipatory Care and Treatment) nursing service, to ensure a greater number of patients benefit from the proactive management of long term conditions
- continue to identify numbers of people who would benefit from earlier interventions and active case management in order to maintain their health and prevent future risks of acute ill-health arising. Where ill health is unavoidable, we will manage their access to the most appropriate levels of healthcare, and support them to be in control of their own health for as long as possible

6) Technology is used to help people to stay safely in their own home

There is a raft of technologies available that can support people to stay in their own homes for longer, even as their care needs become more complex and demanding. These technologies present an opportunity for our care services to work differently for people and can provide essential support for carers.

Telecare and telehealth services are likely to become more important in the future. Telecare equipment and services support people's safety and independence in their own home: examples include personal alarms, smoke sensors, cooker isolators, etc. Telehealth equipment and services allow people with health conditions to better manage these in the community; examples include blood pressure or blood glucose monitoring, medication reminders etc.

The Council recognises the role of technology in helping people to remain safely in their own homes and has successfully integrated its Telecare service with the Community Alarm Service to provide high quality response, call handling and installation service to residents across the city. The Community Alarm Telecare Service (CATS) has received financial support through the Change Fund and currently supports approximately 8,000 customers.

CATS provides a service to enable people to remain in their own homes and prevent admission to hospital or long term care. 63% of CATS customers' are over 75 years of age, 73% (5562) of response visits are to customers within this age range. However, only 2.8% (220) of all response visits are admitted to hospital for further treatment after activating an alarm, compared to an 88% transfer rate by the Scottish Ambulance Service for this age range. 72% (160) of all admissions to hospital following a response visit are over 75.

In the short to medium term (1-3 years) we will:

- increase the number of complex telecare packages for people aged 75+ by 10% by 2015
- pilot the use of many new telehealth care technologies as a means of supporting people at home for longer
- use telehealth care to underpin changes to working practice so that services can concentrate on providing high quality support to people
- continue to be one of the leading health and social care partnerships within Scotland around the innovative development and use of telehealth care to achieve high quality care for people

C) Effective care at times of transition

1) Older people experience a seamless and effective range of intermediate care services

Increasingly, more care is being provided for people in their own homes. This will mean that the community services provided for people will need to work differently with one another to deliver more co-ordinated and effective care. Intermediate care services provide a set of 'bridges' at points of transition, particularly between hospital and home. We are changing the way our services link with services in hospital and other settings, so that people experience as smooth transitions as possible.

In the short to medium term (1-3 years) we will:

- enhance many community-based services including:
    - intermediate care services that provide rehabilitation
    - the re-ablement service, to ensure the service is available for all that need it
    - the Domiciliary Physiotherapy Service
    - the community speech and language and dietetic services
    - community pharmacy to review medication packages.
- test the COMPASS (Comprehensive Assessment) model (below) in South East Edinburgh from April 2012, using evaluation of the trial to shape future services
- evaluate the 'step down' from hospital model within Elizabeth Maginnis Court to inform the development of 'step up'/ 'step down' models within care homes
- establish in-reach arrangements for many community-based services to improve the transition from hospital to home that people experience
- increase the levels of joint working that take place between hospital and community-based services, to increase the continuity of care that people experience and reduce delays in the journey

COMPASS (COMPrehensive ASSessment service for frail older people)

COMPASS is a model of enhanced care for older people being trialled within South East Edinburgh in 2012/13 and funded through the Edinburgh Change Fund partnership.

The service provides assessment and subsequent clinical case management, monitoring and review of frail elderly patients both within and out-with hospital. The role of a Consultant Medicine of the Elderly Physician and an Advanced Nurse Practitioner working in hospital and the community, are central to the model, with strong links to local General Practitioners. The model is built around existing mainstream services, including intermediate care, homecare, re-ablement, telehealthcare and care homes.

A multi-disciplinary team focuses on improved joint working between hospital and community based services to benefit the older people that they support and care for, with the aim of reducing unplanned, emergency admissions to hospital and improving discharges from hospital. Good links have also been made with other 'preventative' services in the area such as lunch and day clubs and voluntary sector support.

The service aims to:

- identify older people in the community at high risk of admission to hospital and to work in a proactive way to prevent emergency admissions by making appropriate support and care arrangements
- when required, facilitate the planned admission of patients to hospital
- conduct comprehensive assessment for patients in hospital, and make care arrangements to facilitate their discharge and prevent later readmission

Initial findings have been positive, with reduced emergency admissions, increased planned admissions and referrals to day hospitals, and reduced length of stay in hospital. Further evaluation is required to quantify the impact and this will inform any further development of the model.

2) Effective care pathways are developed

Having good quality services that work in isolation does not meet the needs of older people. We are working to improve linkages between services so that continuity of care is improved for people as they progress through their care journey. Care pathways help to focus on the way services are experienced by the individual rather than thinking about services being delivered by different organisations or teams. The connections between services are central to provide a smooth journey, where the care required is delivered when the person needs it.

In the short to medium term (1-3 years) we will:

- continue to develop the falls and fractures prevention pathway to reduce the likelihood of falls by working with older people across a range of settings
- embed the Falls Emergency Pathway (below) into practice and evaluate the results
- make enhancements to some condition-specific pathways such as stroke care, through the investment in the Edinburgh Community Stroke Service
- review the ways our services work with one another, so that people receive care that is comprehensive and well managed
- continue to redesign hospital pathways to ensure effective capacity and flow.

Edinburgh Falls Emergency Pathway

The Scottish Ambulance Service (SAS), Edinburgh Community Health Partnership (ECHP), Intermediate Care, Community Alarm and Telecare Service (CATS), Social Care Direct, Primary Care, and NHS 24 have worked in partnership to develop an integrated pathway with the aim of reducing the number of unnecessary presentations at A&E.

The ambulance service is now able to make referrals for the following falls services:

1. Alternative to Conveyance to Hospital

The SAS crew can complete an agreed protocol that will guide a decision about whether a person requires to be conveyed to hospital or whether accessing a team that can carry out an urgent assessment at home is a more appropriate option. The crew can contact a call handler (in hours and out-of-hours) directly from the house to discuss the person's needs and options for assessment. The Rapid Response teams (Intermediate Care) in Edinburgh provide assessment and rehabilitation on same or next day to prevent unnecessary admission to hospital. An OT and Physiotherapist carry out an urgent assessment in the patient's home and arrange support and intervention as required for up to 5 weeks. The person can also be supported with a telecare package, including a response service.

2. Multifactorial Falls & Fracture Assessment

The SAS crews can use the same protocol to refer for falls assessment and intervention targeted at modifiable risk factors, provided by intermediate care teams within 7-10 days, for those who have had a fall and are at high risk of further falls.

3. Fallen Uninjured Person Pathway

If a 999 call is received by SAS and the caller can be identified as uninjured, the paramedic advisors can direct the referral to the Mobile Response Service (CATS) who will go out to assist the person and refer on for falls assessment and telecare package as required.

3) People with dementia and their carers are well supported

As the population ages, we recognise the increased prevalence of dementia amongst many of the older people who will use our services.

Supporting people with dementia is now the business for all older people services and is not an 'extra' service requirement. Our aim must therefore be to ensure that all mainstream services for older people are "dementia friendly" and, in addition, develop specialist dementia services which will support people with particularly complex needs and their carers. We are developing a local plan to achieve the aims of the National Dementia Strategy and deliver the national commitment for improved early diagnosis and post diagnostic support. The Edinburgh Dementia Implementation Plan includes the following areas of focus:

- raising awareness of the importance of living well with dementia

- developing peer support across Edinburgh for people with dementia and their carers
- enhancing post diagnostic support and producing an integrated care pathway
- improving the quality of dementia care in care homes and hospitals
- ensuring services and support is in place for people with early onset dementia.

In the short to medium term (1-3 years) we will:

- increase the effective early diagnosis of dementia
- develop and implement the Edinburgh Dementia Implementation Plan
- implement the Edinburgh Behaviour Support Service, with funding from the Change Fund, to provide support for unpaid carers and care homes in dealing with people whose behaviour is distressed and distressing
- invest in and evaluate the following capacity building projects as part of the Change Fund:
    - Still Caring – developing a range of support services for carers of people with dementia
    - Canalside Connections – flexible support service to people with dementia who are living at home
    - Senior Saheliya – support earlier diagnosis and interventions for people with dementia amongst black and ethnic minority women in Edinburgh
    - Almond Supper Club – support for people with dementia and their carers.
- continue to support our staff in raising awareness of dementia
- adapt our care services to provide the most appropriate interventions for people with dementia
- improve the management of people's dementia by keeping them in familiar, homely environments for as long as is appropriate through a range of enhanced community-based care and support services
- develop specialist respite services which meet the needs of people living with dementia
- develop links with Community Alarm Telecare Service to identify where technology can support older people and their carers to remain in their own home. e.g Safer Walking GPS (Global Positioning System) project
- encourage people to plan for the future at as early a stage as possible.

4) Day hospitals/ assessment and rehabilitation centres are available for those that need them

Services provided to people within day hospitals will act as a first point of contact to assess and treat patients who are showing signs of needing care that might otherwise have required admission to hospital.

Similarly, when people have had to be treated as inpatients, follow up appointments within day hospitals will provide continuing rehabilitation while allowing patients to be at home.

In the short to medium term (1-3 years) we will:

- enhance the availability of assessments within day hospital for older people who are at risk of a hospital admission
- amend our care pathways to ensure more people can access day hospital as a part of their care arrangements following an inpatient stay within hospital

5) People experience good quality end of life care in their chosen setting

Palliative and end of life care are integral aspects of the care delivered to those living with and dying from any advanced, progressive or incurable condition.

Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards.

Palliative care 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 facing progressive illness and carers facing bereavement.

As more older people are living and dying at home, it is important that our services deliver good quality palliative care, allow people to take as much control as they wish in relation to the way that they live and die, and that our staff and carers are supported and trained to do so.

There is a dedicated strategy within NHS Lothian that will take forward a new model of integrated palliative and end of life care. The vision of this strategy is for high quality palliative and end of life care available in all settings, utilised by all who require it, and prioritised according to the patient's need, rather than medical condition.

By 2015, clinical teams in all settings across Lothian will be reliably identifying and assessing patients as they reach a palliative phase of their illness, and developing and updating integrated care plans for them and their carers, based on patients and family preferences.

Our aim is to ensure access to high quality palliative care to all who need it, irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation, and socioeconomic status.

In the short to medium term (1-3 years) we will:

- through the Lothian Palliative Care Service Redesign Programme being led by NHS Lothian and Marie Curie, implement 'Living and Dying Well in Lothian' Strategy, and associated delivery plan. Actions include:
    - identify people who would benefit from palliative care, and to develop care plans with people which include establishing preferred place of care and preferred place of death
    - maximise the time spent in people's preferred place of care (home, care home, and community hospital)
    - minimise emergency admissions where these could be avoided by good anticipatory care planning
    - support realistic choice of place of death (taking into account a holistic assessment of patient, family and carer needs).
- work with people with long term conditions to make sure that the need for palliative care is identified as part of routine care at the earliest stage appropriate
- continue to support our staff in raising awareness of living and dying well and end of life care
- continue to invest in general practitioner (GP) enhanced contracts which include the development of anticipatory care plans, specifically for people in care homes and the use of the Palliative Care Register
- encourage older people to make plans for old age, including end of life, advanced directives, guardianships and wills
- continue to engage with the University of Edinburgh Primary Palliative Care Research Group to take forward action research in palliative and end of life care.

D) Intensive care and specialist support

Care homes continue to have an important role for people with more intensive and complex care and support needs and many people will continue routinely to need high quality specialist hospital services as part of their ongoing complex care and support. We are committed to ensuring that good quality care home and hospital services are available for people who need them. Many of the themes detailed elsewhere in this plan such as the development of personalised services that are focus around individual needs and outcomes, also apply to more intensive levels of care.

1) Good quality residential care is available for those who need it

Care homes are an important part of the health and social care system and can offer a positive and caring environment with 24 hour care for people that require it. We recognise the important role of care homes in supporting residents to enjoy independent and fulfilling lives, and being involved in meaningful activities both within the care home and as part of the wider local community.

Work is underway to enhance person-centred care within care homes in Edinburgh, by working with Council and independent sector providers to encourage innovative ideas, the sharing of good practice and by investing in

support and training for staff. Some of this work is included in the short to medium term actions below.

Health, social care and independent providers are continually working to provide the best quality of care possible in Edinburgh's care homes. There is a multi-disciplinary Care Home Providers Reference Group that meets bi-monthly supporting partnership working. The agenda is wide reaching covering both business issues as well as "good practice" issues. The Council leads on a multi-disciplinary Quality Assurance Framework which now covers all care services but which was developed originally to monitor and support care homes.

There is an agreed "Live Well in Later Life Accommodation Strategy" which sets out the Council's aims to re-provide its own care homes and to work closely with care home providers in planning future services (Appendix 3).

In the short to medium term (1-3 years) we will:

- continue the refurbishment and new build programme for Council care homes, including opening a new care home at Drumbrae in 2013 and funding for a further new care home was agreed as part of the 2013/14 Council budget
- improve quality assurance for all Edinburgh care homes
- support care homes in caring for increasingly frail residents and people with dementia eg by:
    - implementing the Edinburgh Behaviour Support Service to support those caring for people with distressed behaviour,
    - considering how specialist nursing support can be provided to care homes (Care Home Liaison Service)
- develop care home respite by concentrating provision in self-contained units with separate staffing arrangements
- commission additional specialist dementia respite within the independent sector
- work closely with independent sector providers to develop intermediate care (step up/ step down) beds in care homes
- apply dementia friendly standards to building design
- review NHS inpatient complex care requirements and projections for the future
- encourage opportunities for care home residents to remain active and connect with local community (through intergenerational work, volunteers etc), including the creation of an investment fund for innovative ideas
- implement the 'My Home Life' programme in 30 care homes in Edinburgh
- provide funding and co-ordination for a programme of dementia training in all care homes (Council and independent sector) in Edinburgh

Step Down in Care Homes

Step Down facilities provide less intensive care than a hospital for people who are medically well, but are not ready or able to return straight home. For people who do not need hospital based care and treatment, Step Down offers time in an appropriate care setting (up to around 6 weeks) for further recovery, rehabilitation, assessment, and for the individual, their families and carers to plan their future care arrangements. Step Down care is person-centred, focused on rehabilitation and delivered by a combination of professional groups.

The opportunity to develop Step Down beds within care homes in Edinburgh has not previously been available due to the limited number of care home beds in the city. New care home capacity has been established in 2013 and this has provided the opportunity to develop this new model, which has the potential to support people to return to living in their own home and reduce delays in hospital.

Step Down beds will be implemented within Edinburgh from October 2013.

2) Good quality hospital care is available for those who need it

Services within hospitals provide care to patients as a part of wider care pathways, and for that reason, the way these services work together is of great importance. There are strong relationships between community and hospital services, and these will continue to be strengthened further going into the future.

When emergencies arise, many people will continue to need immediate access to life-saving services. The emergency functions of the Ambulance Service's response to '999' calls and the A&E departments at the hospitals are out with the scope of this plan. However, as with other specialist hospital services, many people will experience care pathways that begin with an emergency. For that reason, engagement with emergency services will be a part of the wider communication of this plan, so that pathways can be as integrated and effective as possible for people.

In the short to medium term (1-3 years) we will:

- reduce the number of emergency admissions to hospital while increasing the number of planned admissions for older people
- develop services that focus on the personalised care needs of individuals, enabling patients to have choice and control wherever possible
- improve care for people with dementia and delirium in acute hospital ward settings
- implement acute care standards for mental health and older people's services.

Dementia Beacon Wards

In recent years hospitals have come under increasing scrutiny and criticism for the care and treatment of people with dementia. In October 2009, NHS Lothian appointed the first Alzheimer Scotland Nurse Consultant in Scotland and one of their main objectives was to support and improve dementia care in Royal Infirmary of Edinburgh.

Five "beacon" wards were chosen to take part in a one year dementia audit project. The beacon wards were chosen from a range of wards who either volunteered to be part of the project, or where there was a high throughput of people with dementia. The wards represented a cross section of specialities and included: acute assessment; stroke unit; medicine of elderly, orthopaedic and community hospital assessment.

What did we do?
Routine support and contact details
The Alzheimer Scotland Nurse consultant provided weekly "drop-in" sessions to each clinical area. Contact details were made available for concerns or advice outwith these routine visits.

Signing up to good practice statements
During this audit project, there were no clear guidelines or standards on dementia care available (subsequently launched in 2011). Each clinical area was asked to sign up to 10 "good practice statements".

Environmental audit and adaptations
This helped to identify simple and practical solutions towards dementia friendly principles. In the first instance this included improved signage and clocks.

Dementia training and awareness sessions
Priority was given to beacon wards. Frequent 2-hourly dementia awareness sessions were provided. "Handover" and case discussions were also offered.

Providing educational resources and tools
A resource pack or "toolkit" was provided to each clinical area for reference (this included policy documents and guidance; assessment tools; and good practice guidelines and protocols).

What were the results?
The results were very encouraging and highlighted positive trends in care practices and outcomes for people with dementia. Some of these included:

- shorter length of stay in hospital
- reduced discharges to long stay care
- less psychotropic medications being prescribed
- reduced use of catheters (for incontinence)
- improved carer satisfaction
- more confident and competent staff workforce.

There is more work to do, but there is evidence that if staff in hospitals, are given the right guidelines, direction and support, to increase their awareness and confidence, then the outcomes for people with dementia (and the health care system) can improve.

E) Enablers

There are a number of services, processes and support structures that need to be in place to deliver the aims of this plan and these are shown in the table on p10 as 'enablers'.

Effective, early assessment and access to services are important enablers in ensuring that older people can access appropriate support and services when they need them. We continue to work to improve the pathway which older people take to access services, with the aim of simplifying the journey and improving how information is shared between health, social care and housing professionals. In order to simplify access to services there is now one citywide telephone number which older people, carers and professionals can use to

refer for a wide range of social care services (Social Care Direct, 0131 200 2324).

General Practitioners (GPs) are the first point of call for many older people, providing diagnosis and care, and in referring people on to appropriate services. It is essential that GPs are aware of the wide range of support services available delivered by health, social care, voluntary and independent organisations.

Housing staff who are dealing with Council tenants in their own homes on a regular basis can also provide a valuable link with older people. All frontline Housing Property Services (HPS) staff have received mental health awareness training. This helps them to deal with vulnerable people who may not otherwise have any contact with the Council. For example, if a repair is being carried out and the staff member identifies that the tenant may need additional support, they would be expected to raise this with their line manager who could refer the tenant to the relevant neighbourhood support team.

Once care and support arrangements are in place, it is important that they are reviewed to ensure that older people's changing needs are met. Assessments and reviews should focus on the outcomes that are important to older people and support services that will work with the older person to achieve these individual aims.

In the short to medium term (1-3 years) we will:

- continue to develop Social Care Direct as a single point of contact for all social care referrals
- ensure that professionals across the city are aware of the range of services available and how to signpost or refer people to them
- increase the number of social care reviews carried out
- continue to develop an outcomes approach to assessments, reviews and service delivery

Part Three: Future planning

1) Future projections

Balance of care - modelling

In order to achieve the aim of “Reshaping Care for Older People”, to optimise the independence and wellbeing of older people at home or in a homely setting, a shift in the focus of care from institutional settings to care provided at home is required.

Significant progress has been made in Edinburgh to achieve this shift in the balance of care. The percentage of older people with high level needs who are cared for at home has increased from 14% in 2002 to 30% in 2012. This has been achieved through investment in community based services and by changing the way that services are provided to benefit more older people with the resources available.

We anticipate that, by 2022, there will be around 5,750 older people who have intensive levels of need. Within “Live Well in Later Life”, we set a target of 40% of people with high needs being supported at home. The diagram below shows the balance of services required to meet the 40% target or a more ambitious target of 50% in line with the aims of “Reshaping Care for Older People”.

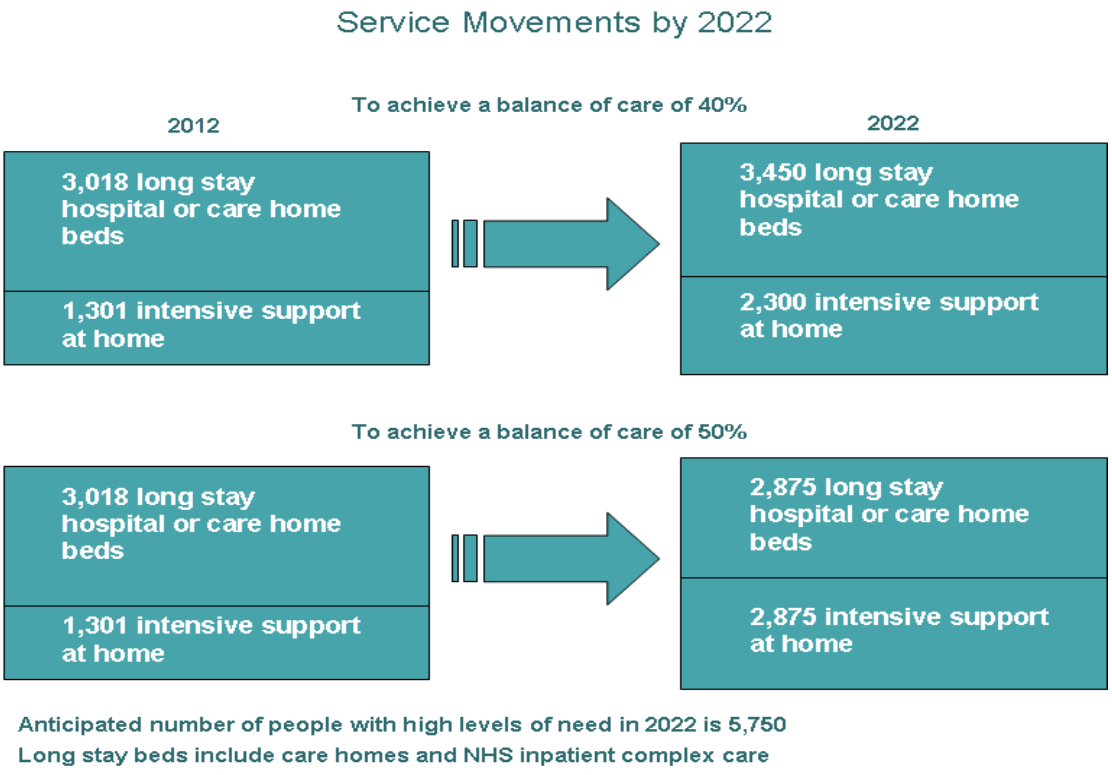


Figure 1: Service movements required by 2022 to achieve 40% and 50% balance of care, based on estimated numbers of older people with high level needs.

We can develop these projections further by including future projections of a range of health and social care services.

	2012	2018	2022 Scenario 1 40%	2022 Scenario 2 50%
	Actual	**Projected**		
% at home with high needs	**30%**	**40%**	**40%**	**50%**
People supported in NHS long stay beds	261	250	250	250
People supported in long stay care home beds **(excludes respite and step up/ step down)**:	2,762	2,900	3,200	2,625
CEC long stay care home places (assuming a 15% share of within-Edinburgh places)	567	374	419	333
Voluntary and private sector long stay care home places	2,195	2,526	2,781	2,292
Intensive packages at home	1,301	2,100	2,300	2,875
Total number of people with high level needs supported	4,324	5,250	5,750	5,750
Estimated number of older people with high level needs	4,700	5,250	5,750	5,750

Figure 2: Supporting older people (65+) with high level of needs – service composition

Short term stays in hospital

The table below uses a four stage model to illustrate the anticipated changes in the need for mainstream hospital beds for people aged over 65, based on demographic changes and planned service reconfigurations, including enhanced support provided in the community.

	Stage 1	Stage 2	Stage 3	Stage 4
	2010/11 Baseline	Projection including enhanced community rehabilitation/support functions	Projection including impact of initiatives to reduce the length of stay in acute hospital beds	Projection including demographic impact to 2020
Total beds required	688	582	526	549

Figure 3: Mainstream hospital beds for older people: modelling the impact of demography and planning service changes on the number of beds required.

Supporting people with high level needs at home and preventing admissions to hospital

Figure 2 gives a broad illustration of the numbers of people with high levels of need and, of those people, the numbers which would need to be supported in the community or in a care home/hospital if we are to achieve a balance of care of 50% by 2022.

A proxy measure is used to reflect “intensive packages of support” which includes the anticipated demand for intensive domiciliary care (ten or more hours per week). However, we recognise that a wide range of other services will also be needed to support people with high needs living at home. For example, intermediate care services will play a key role in supporting people who are at risk of going into hospital, or who are being discharged. In 2012, we estimated that 1,960 older people received support from the Intermediate Care service and this is likely to increase in future years. The impact of demography alone is expected to lead to around a further 420 people requiring this service by 2022. Further work is needed to estimate how many additional people will need this service if the model of care is shifted towards prevention.

We continue to use modelling to project future demands and capacity for our services. Modelling is a useful tool to show a general direction of travel and this work will continue to be refined as new service models are developed. The modelling work in this section does not include the impact that self-directed support will have on the future shape of services.

How do we expect the shape of services to change?

The changing shape of services that we expect to see over the life of this plan includes:

- a further shift in the balance of care up to 50%, with an increasing proportion of older people with high level needs to be cared for at home in relation to the proportion in long stay hospitals or care homes
- increased numbers of older people receiving support from community based services including homecare services (provided by the Council’s homecare teams or external voluntary or private sector agencies), re-ablement, intermediate care, community nursing and community based therapy teams
- a change in the way that care home places are used, with a reduction in the proportion of long stay care home places and an increase in the number of beds used for respite and step up/ step down care
- reduced length of stay and reduced delays for people in hospital due to increased capacity within community based services, which will enable improved flow and a reduction in the number of hospital beds.

2) Workforce development

The workforce is the backbone to the provision of health, social care and support for older people in Edinburgh. If we are to meet the vision of this plan, in delivering care and support that is person centred and respects the dignity of older people, it is vital that we have a workforce that is skilled, dedicated, valued and supported to do its best.

Joint planning for the future is fundamental to ensuring that we develop the workforce capacity and capabilities needed to meet the future care and support requirements of older people. Many of the priorities identified and issues faced are relevant for all partners across the care sector. We need to work together to create the workforce that we will need to deliver the outcomes of this plan.

We are working towards a joint approach to planning and developing our future workforce involving the City of Edinburgh Council, NHS Lothian and voluntary and independent partners. Some of the key areas of work underway are summarised below.

Developing our understanding of the existing health and social care workforce in the city to inform how we plan to meet future demands
We aim to undertake analysis of the current health and social care workforce that support older people in the city, including people working in the statutory, voluntary and independent sectors. This will enable us to have a realistic workforce plan for the sector to meet the projected demand for older people's services.

Working jointly with all partners to raise the profile of care as a career choice
We will seek to market the health and social care sector together to raise the profile of care as a career choice in the city. This will involve sharing good practice and developing joint recruitment where possible. We are already working with partners to explore opportunities for joint pre-employment training academies and other approaches to create a sustainable and flexible workforce.

Continuing to develop joint learning and development opportunities to ensure that Edinburgh has a confident and competent workforce
A joint learning and development framework is in place for the City of Edinburgh Council and NHS Lothian which provides a range of training opportunities for staff from both organisations. Examples of training developed in partnership include administration of medication, continence and catheter care and e-learning courses such as Adult Support and Protection and Manual Handling.

It is essential that care staff are able to meet the changing needs of older people and support people with complex long term conditions in the community. Key areas for development include:

- complex care

- reablement
- palliative and end of life care
- management of violence, aggression and behaviour that challenges.

These developments are helping to ensure that standards of care are consistent across City of Edinburgh Council and NHS Lothian services. There are plans to continue developing partnership approaches to workforce planning with our partners in the NHS and the voluntary and independent sectors.

This plan outlines some major policy changes including the proposed implementation of Self-Directed Support legislation, further development of personalised services and support based on outcomes that are important to people, and the integration of community health and adult social services. Work is underway to ensure that our workforce is engaged and supported to deliver these major programmes of change.

We will:

- work towards a joint framework for Organisational Development and Workforce Planning and Development in partnership between Health and Social Care and NHS Lothian and other key relevant partners
- identify further learning needs and develop programmes of learning to provide staff with the knowledge, skills, and abilities required to care for and support people with long term complex conditions
- ensure dementia training is incorporated into workforce development plans
- deliver a programme of organisational development activities to support the transformation of Health and Social Care
- develop and implement a sustainable health and social care worker recruitment strategy.

3) Monitoring and evaluation

Agreed outcomes, performance management, evaluation and analysis

Our commissioning plan will be supported through a comprehensive evaluation framework that will help us to know whether services are effective and are making a positive contribution to people's lives.

Our evaluation will recognise what service users tell us of their experiences, what they value and what they do not. In addition, we will monitor the activity levels and performance of all our services to ensure good returns are provided on our investments.

A robust performance framework is required to evaluate the impact of the work of all partners. The development of this framework is not easy and will take time, but the work underway to evaluate the impact of the Change Fund can be built upon. Our performance framework for the Change Fund is based on a range of national and local evaluation activity, including the following:

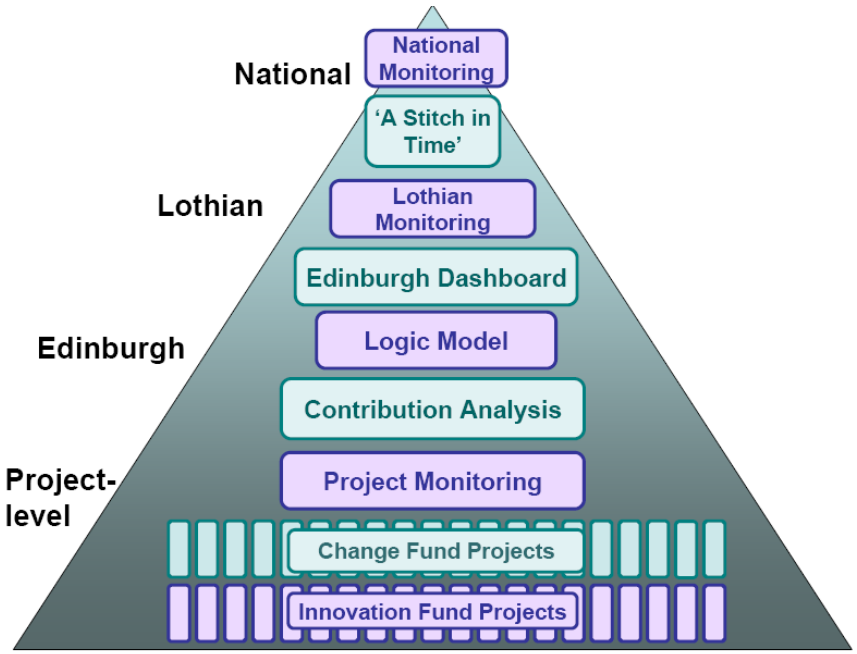


Figure 4: The Edinburgh Evaluation Framework for the Change Fund which will be built on to evaluate the impact of this plan.

National Monitoring

Work is underway to demonstrate the impact of the Change Fund and wider Reshaping Care for Older People at a national level. This includes the monitoring of high level performance measures and summarising and sharing good practice from local partnerships. The 'A Stitch in Time' project aims to demonstrate the contribution the Scottish third sector makes to care for older people.

Local Monitoring

An Evaluation Framework has been developed in Edinburgh to monitor and evaluate progress against the agreed outcomes for older people. The evaluation results are key to informing the future planning and investment decisions of the partnership. Local monitoring includes a range of quantitative and qualitative data, including case studies and personal outcomes. A logic model has been developed which shows how all of the Change Fund work streams are working to achieve consistent high level outcomes. A 'contribution analysis' approach is also currently being piloted in Edinburgh as a tool to help in the evaluation of cross-cutting work streams.

Governance

There is a national commitment in Scotland for increasing the level of integration of health and social care services in the future.

Within Edinburgh, there is already a high level of joint accountability is in place and this will be strengthened as legislation and arrangements for further integration are implemented. The recently established Health and Social Care

Partnership provides a basis for developing integrated governance arrangements.

The majority of adult social care services and community health services, those provided respectively by the City of Edinburgh Council Health and Social Care Department and NHS Lothian's Edinburgh Community Health Partnership, are under the single management of the Director of Health and Social Care.

The Edinburgh Joint Older People's Management Group was established in late 2009 and provides a forum for overseeing the range of services provided for Older People within Edinburgh. The group is comprised of a range of NHS and local authority senior service managers, with further representation from older people and the voluntary and independent sectors. This group has a key role in overseeing the development, implementation and review of this plan.

Wider linkages to other statutory functions such as policing and fire and rescue are achieved through the Edinburgh Partnership Board.

Through these governance arrangements, the impact of this plan will continue to be reviewed.

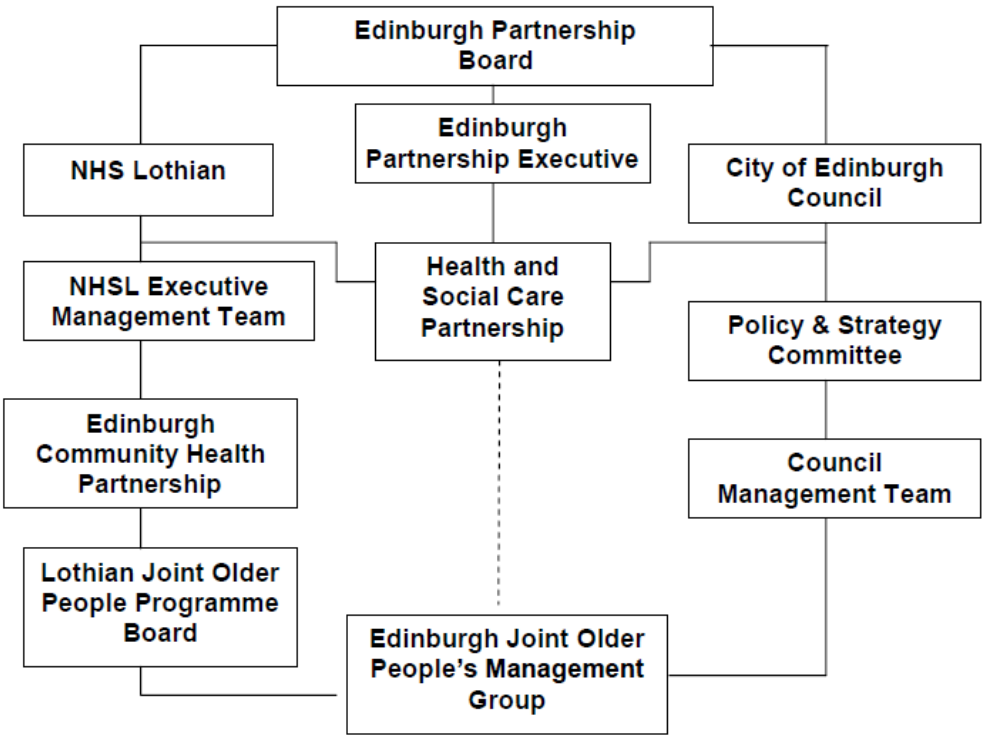


Figure 5: Governance arrangements for "Live Well in Later Life" and the Change Fund in 2012. These arrangements are likely to be further integrated over the life of this plan.

Equality and Rights

All policy decisions impacting upon care and support services are required to meet equalities and rights duties, both in their conception and drafting as well as in their subsequent practical implementation.

Of particular relevance to the Council, NHS and the organisations they conduct all partnership and contractual work with, is the Equality Act 2010 which came into force across the UK on 1 October 2010. The Act introduced revised general and specific equality duties for public sector organisations. The general duty requires organisations to have a due regard to advance equality of opportunity, to tackle discrimination, harassment or victimisation, and to foster good relations between those with protected characteristics and others. The range of protected characteristics have also been expanded to include age, disability, faith/ belief, gender identity, marriage/ civil partnership, pregnancy/ maternity, race, sex and sexual orientation.

The Council and NHS Lothian have frameworks in place to advance equalities and rights in all areas of work, including internal services and those delivered by partner organisations. This includes staff recruitment, service delivery, performance monitoring and review. Impact assessments are a tool used to identify potential positive and negative impacts of service delivery or planned changes. An emphasis on mainstreaming aims to ensure that an equalities and rights perspective becomes an integral part of decision making and action across all areas of governance, management, policy making and service delivery.

An equalities and rights impact assessment of this plan has been conducted, with input from the Checkpoint Group, and this will continue to be developed during the consultation, implementation and life of the plan. The assessment aims to ensure that people are not affected negatively as an unintended consequence of the plan and that mitigating actions are put in place where necessary. More broadly, action is being taken to consider how key areas of service for older people can improve their approach to equalities and rights, to ensure that the needs of all older people are appropriately met (included in the actions on p47).

Appendix 1: Local and national policy contexts

Local Policy Context
The Single Outcome Agreement

The relationship between the Scottish Government and local authorities is based on a concordat signed by COSLA and the Scottish Government in November 2007. The principles of set out the terms mutual respect and commitment and joint priority are based on a Single Outcome Agreement for each area. The vision for Edinburgh's Single Outcome Agreement for 2012-15 is that Edinburgh is a thriving, successful and sustainable capital city in which all forms of deprivation and inequality are reduced.

Action to deliver this vision will be concentrated on four high level outcomes outlined in the diagram below. Reducing inequalities is integral to all four outcomes because this is the most effective preventative action for many social and health problems.
The vision and four accompanying outcomes capture the essence of the Partnership's
ambition for the city and its citizens. The outcomes and actions in this SOA are designed to tackle some of the key economic, health, educational, and social priorities in the city. The Partnership also wants improved outcomes in these areas to bring benefits to as many citizens as possible, to reduce poverty, inequality and
disadvantage and provide a positive legacy for future generations.

Partners' resources will be harnessed efficiently and effectively and better targeted to tackle these priority issues. The partners will provide services which embrace the approaches of prevention, early intervention and innovation, based on evidence and with citizens at the heart of what we do.

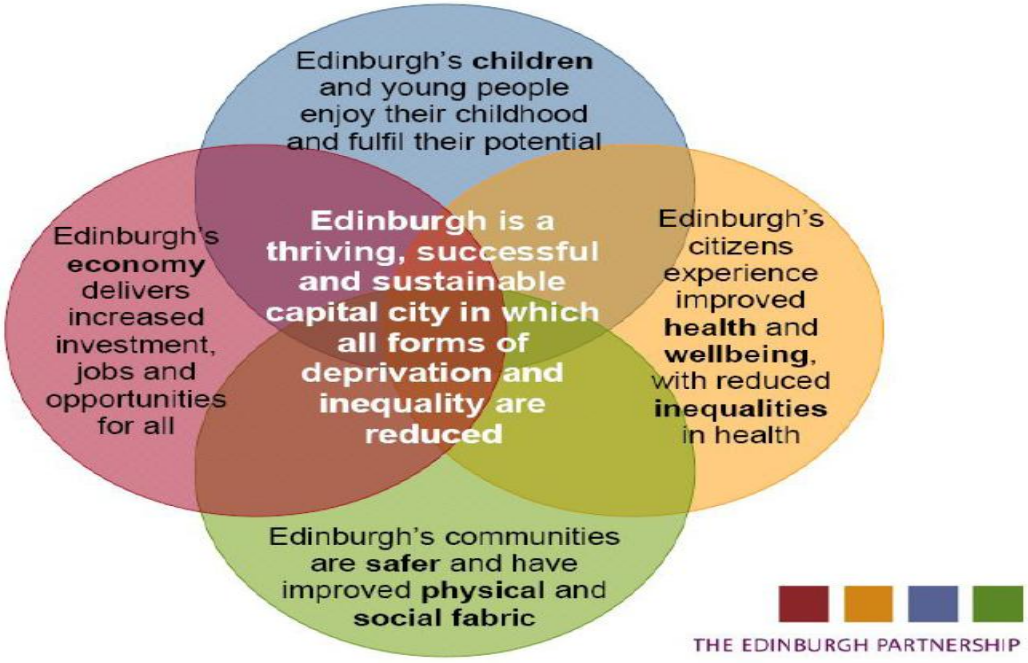


Figure 1: The Edinburgh Partnership Single Outcome Agreement

NHS Local Delivery Plan

The performance of NHS Lothian is recorded annually within its local delivery plan. This plan focuses on the outcomes to be achieved for patients and clients through the services that NHS Lothian provides. The plan provides evidence to NHS Scotland on the levels of performance being achieved by NHS Lothian and therefore provides key evidence for the accountability of health services.

Ultimately, the local delivery plan relates to the high level outcomes and targets of the National Performance Framework of the Scottish Government.

National Policy - Reshaping Care for Older People

The Scottish Government's "Reshaping Care for Older People" change programme provides a long term and strategic approach to delivering a vision for the future care for older people in Scotland. The Scottish Government's vision is as follows:

'Older People in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own homes or in a homely setting'.

However it is recognised that change needs to take place in order to implement this vision. One of the key focuses of the "Reshaping Care" programme is to reduce the number of bed days used as a result of emergency admissions to hospital by older people, a proportion of which can be avoided. Another focus is to take the opportunity afforded by more local preventative and anticipatory care services.

Key themes of "Reshaping Care for Older People":

- improved outcomes for older people
- maximising independence, rehabilitation and re-ablement
- personalised care, based on individual outcomes and goals
- development of low level, preventative services
- developing community capacity and resilience, recognising older people as assets
- support for carers
- integrated and effective care pathways
- co-production of services

The Scottish Government's Change Fund has acted as a catalyst for changing the way services for older people are delivered in line with the aims of "Reshaping Care for Older People". Guidance from the Scottish Government has required local partnerships involving local authority, NHS, voluntary and independent sector representatives to work together to drive this change.

What are we doing in Edinburgh?

"Live Well in Later Life" is the joint plan in Edinburgh setting out how we will meet the aims of "Reshaping Care for Older People". The key themes of "Reshaping Care for Older People" are reflected throughout this document, with actions detailing how they will be achieved.

National Policy - Scotland's National Dementia Strategy

Scotland's National Dementia Strategy was published in June 2010 and sets out actions to improve services and support for people with dementia and their carers. The strategy focuses on two main areas of change:

- following diagnosis, by providing excellent support and information to people with dementia and their carers; and
- in general hospital settings, by improving the response to dementia, including through alternatives to admission and better planning for discharge.

In 2012, the Scottish Government made a commitment to guarantee that people receiving a diagnosis of dementia will be offered a minimum of one year of post-diagnostic support. This commitment will involve a link worker who will be assigned to work with the person, their family and carers in co-ordinating support and building a person-centred plan based on Alzheimer Scotland's "5-Pillar" model.

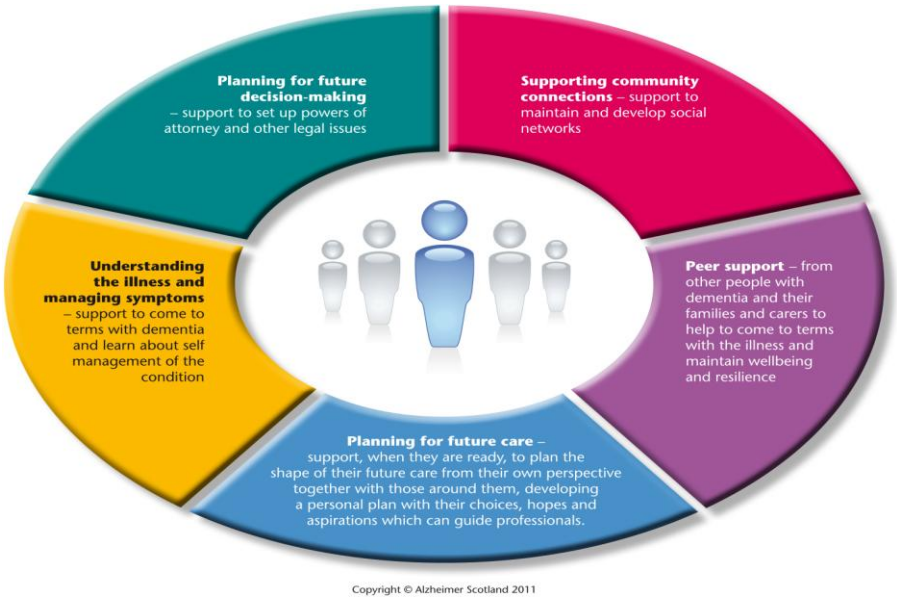


Figure 2: Alzheimer Scotland's "5-Pillar" model - outlines five key pillars recognised as essential to supporting people after their diagnosis.

What are we doing in Edinburgh?
Lothian Dementia Delivery Plan and Edinburgh Dementia Implementation Plan

NHS Lothian and partners developed a Dementia Action Plan in October 2009. This plan sits within A Sense of Belonging, a joint strategy to improve the mental health and well-being of the population of Lothian (2011 - 2016)

and focuses on the same five work streams which are contained within the National Strategy:

- treatment and improving the response to behaviours that carers and staff find challenging
- assessment, diagnosis and the patient pathway - improving the journey of people with dementia and their carers
- improving the general service response to dementia
- rights, dignity and personalisation
- health improvement, public attitudes and stigma.

A local joint dementia implementation plan is being developed to set out how the priorities of the National and Lothian Dementia Plans will be implemented in Edinburgh.

The plan acknowledges that the increasing numbers of older people with dementia means that dementia is the business of all older people services and is not an 'add on'. Our aim must therefore be to ensure that all mainstream services for older people are "dementia friendly" and then, in addition, develop some specific specialist dementia services which will meet the needs of people with particularly complex needs. Supporting the carers of people living with dementia is a key priority.

The Edinburgh Dementia Implementation Plan includes the following areas of focus:

- Raising awareness of the importance of living well with dementia
- Developing peer support across Edinburgh for people with dementia and their carers
- Enhancing post diagnostic support and producing an integrated care pathway
- Improving the quality of dementia care in care homes and hospitals
- Ensuring services and support is in place for people with early onset dementia.

A Dementia seminar was held in June 2012 and a second is being planned for June 2013, involving a range of stakeholders including unpaid carers and people with dementia, health and social care staff, third sector partners, academics, Councillors and NHS non-Executive Board members.

Following the report "Services to People with Dementia and their Carers in Edinburgh" in June 2012, a further report will be available in the Autumn 2013.

National Policy - Self Directed Support

Self-directed support aims to empower people to direct their own care and support and to make informed choices about how their support is provided. There are a range of mechanisms available to people to direct their support, including the use of direct payments and individual budgets.

In 2010 the Scottish Government published a 10-year strategy to grow self-directed support and in November 2012 the Self-Directed Support Act was

passed by the Scottish Parliament. When implemented, the Act will require local authorities (and health boards where local authorities have delegated powers to provide care) to offer four options when people are assessed as being eligible for support with their social care needs:

- Direct payment – the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support;
- Direct available resource – the supported person chooses their support and the local authority, or another organisation, makes arrangements for the support on behalf of the supported person;
- Local authority arranged support – the local authority selects the appropriate support and makes arrangements for its provision by the local authority; or
- A mix of options 1,2 & 3 – this recognises that some individuals may wish to take one of the options for particular aspects of their support needs, but to receive their remaining support under one of the other options.

What are we doing in Edinburgh?
A Whole Systems Approach to Personalisation of Health and Social Care

The transformational scale of the changes required in order to implement the key national policies and strategies for health and social care has been recognised and in response a 'Whole Systems Approach to Personalisation of Health and Social Care in Edinburgh' is being adopted.

This will involve:

- Greater investment in preventative services and a focus on maximising independence and promoting good health wherever possible, in order to reduce the likelihood of health and social care intervention being required in future.
- Supporting those people who are eligible for social care support with as much real choice and control as they wish and is appropriate, over the way in which their needs are met, in order to deliver agreed outcomes.

The self-directed support legislation will mainly apply to local authorities and the City of Edinburgh Council has established a Personalisation Programme to build upon the many examples of good practice that already exist in the City, working in partnership with staff, citizens and other key partners in the NHS, voluntary and independent sectors, to drive forward the personalisation agenda (which includes self directed support). NHS Lothian was funded by the Scottish Government to be part of a self-directed support test site from 2009-2012 which explored how self-directed support might operate within a health service. Learning from the test site will inform how NHS Lothian can work with social care services in the future development of self-directed support.

The key work streams being progressed as part of the Personalisation Programme are shown below:

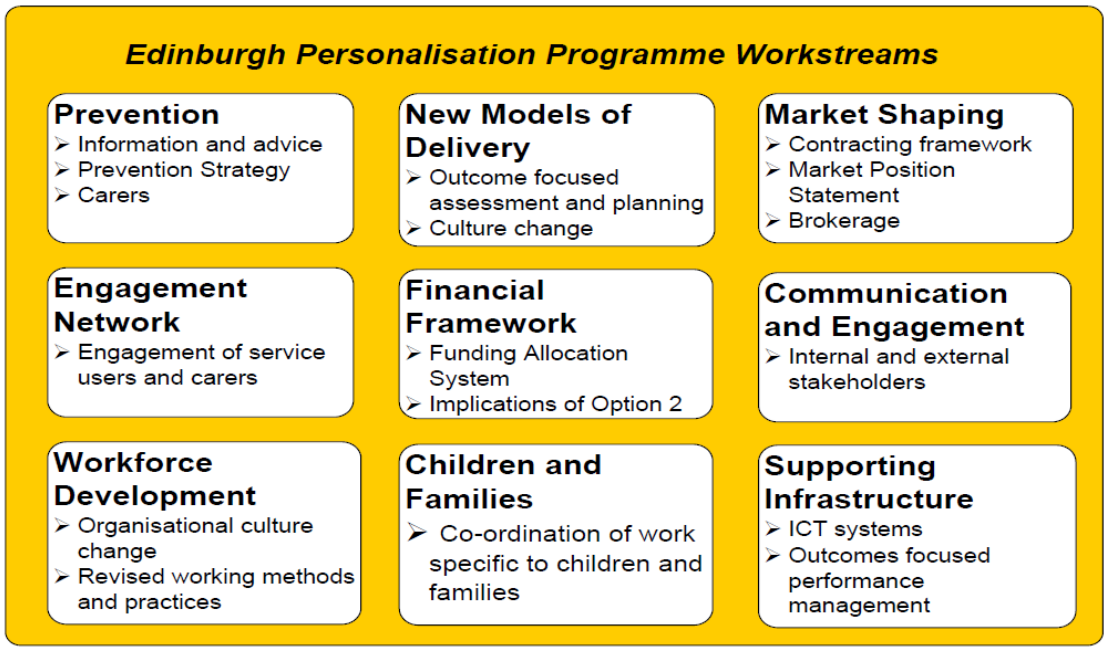


Figure 3: Edinburgh Personalisation Programme

National Policy - Community Empowerment and Renewal Bill

The Scottish Government are consulting on a proposed Bill to support communities to achieve their own goals and aspirations through taking independent action and by having their voices heard in the decisions that affect their area. The concepts of co-production, community capacity building and prevention are central to the aims of the proposed Bill and are explained further below.

Co-production and community capacity building

There is growing support for adopting the principles of co-production to transform the way public services are delivered. These principles were a significant focus of the Christie Commission report on the future delivery of public services, published in June 2011. Co-production has been defined as:

> *"delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."*
> *(NESTA The Challenge of Co-production)*
> *http://www.nesta.org.uk/library/documents/Co-production-report.pdf*

A co-production approach includes the following key characteristics:

- Recognising people as assets.
- Building on people's existing capabilities.
- Promoting mutuality and reciprocity.

- Developing peer support networks.
- Breaking down barriers between professionals and recipients.
- Facilitating rather than delivering.

Many services for older people already adopt some or all of these principles. However for the approach to be mainstreamed would require a fundamental shift in the way that services are designed, commissioned and managed.

Community capacity building has been defined as:

> *"Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities" (Strengthening Communities, S. Skinner, CDF publications, 2006).*

Co production and community capacity building are prioritised as areas for investment within the national guidance on the Change Fund. The Edinburgh Partnership have committed to invest 20% of the Change Fund in this area.

Prevention

Investing in preventative services is also a focus for recent national health and social care policies. The Christie Commission report on the future delivery of public services, published in June 2011 stated a need to "prioritise expenditure on public services which prevent negative outcomes from arising". "Reshaping Care for Older People" and the national guidance on the Change Fund emphasised the need for partnerships to have "a clear strategy to invest upstream in anticipatory and preventative approaches that will help to both manage demand for formal care, and support carers when more older people are at home".

What are we doing in Edinburgh?

There is a wide range of work ongoing in Edinburgh to engage and empower local people in decision making (see for example the work of Neighbourhood Partnerships and A City for Ages below) and to build community capacity by investing in local projects and supporting volunteering. This plan includes a commitment to invest in services that 'prevent negative outcomes from arising', through investment in opportunities to reduce social isolation and loneliness, support for carers and the promotion of positive health and wellbeing (see Part 2 for further details).

A City for All Ages

A City for All Ages is Edinburgh's long term strategy to improve quality of life and social inclusion for older citizens. It aims to reduce discrimination and provide better opportunities and services for older people in the city. The strategy focuses at the broadly preventive level of improving opportunities for better quality of life and less dependence through mainly non -care facilities and assets. It also contributes to service planning for directly preventative anticipatory care services and mainstream care services, particularly through engagement with older people themselves.

A City for All Ages undertakes extensive engagement with older people and their groups in the city to identify the values and principles that older people in Edinburgh hold to be important. The vision and actions that are outlined in this plan in relation to care and support services share these values and principles.

A City for All Ages was evaluated in 2010 and recommendations were made for the continued mainstreaming of key components. An advisory group of older people has been of significant value to the strategy's implementation and has been involved in a wide range of issues including care and support, transport, community safety, social inclusion, prosperity and knowledge and learning. This pattern of engagement is a key asset which is used to support and develop the engagement and communication in this joint plan for care and support services to enable older people to "Live Well in Later Life".

Neighbourhood Plans

Each of the twelve Neighbourhood Partnership areas in Edinburgh produces a local community plan which outlines the priorities of local people based around five themes:

- Early Intervention
- Health and Wellbeing
- Employability
- Safer Communities
- Environment

Many of these plans include actions to support older people in their neighbourhood, through encouraging agencies to work together, helping older people to stay active and connected, and by improving access to information on services available.

Inspiring Volunteering Edinburgh – Building on Success 2012-2017

The approach to volunteering in Edinburgh is set out through the Edinburgh Compact which has agreed a strategy for "Inspiring Volunteering Edinburgh – Building on Success 2012-2017". This seeks to achieve a vision *"of a city where Edinburgh's population is inspired and supported to volunteer".*

The value of volunteering is widely recognised and the Volunteering Strategy seeks to support and encourage people across Edinburgh to volunteer. The three main objectives of the strategy are to:

- recognise and harness volunteer potential as a strategic force for change
- increase the number and diversity of people volunteering
- maximise good practice and quality standards

The strategy reinforces the roles which volunteering plays in the delivery of the core aim of Edinburgh's Single Outcome Agreement, i.e. to reduce deprivation and inequality and in the delivery of all 4 Strategic Outcomes.

Specifically, volunteers play a vital role in the provision of services to older people and, by volunteering themselves, it has been shown that older people can improve their health and well-being and reduce their social isolation.

Actions included in the strategy in relation to commissioning for older people include to:

- ensure volunteering is a reported outcome in purchasing and commissioning agreements
- ensure community benefit clauses are further developed to include reference to volunteers
- increase the number of volunteer opportunities for older people.

National Policy – Integration of Health and Social Care

The Scottish Government provided details of its plans to further integrate health and social care services in December 2012 and a consultation was launched in May 2012 by the Cabinet Secretary for Health, Wellbeing and Cities Strategy. Key elements of the new system will include:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint responsibility of the NHS and local authority, and will work in partnership with the third and independent sectors.
- Partnerships will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people's care and are set to include measures such as reducing delayed discharges, reducing unplanned admissions to hospital and increasing the number of older people who live in their own home rather than a care home or hospital.
- NHS Boards and local authorities will be required to produce integrated budgets for older people's services to bring an end to the 'cost-shunting' that currently exists.
- The role of clinicians and social care professionals in the planning of services for older people will be strengthened.
- A smaller proportion of resources - money and staff - will be directed towards institutional care and more resources will be invested in community provision. This will mean creating new or different job opportunities in the community. This is in line with the commitment to support people to stay at home or in another homely setting, as independent as possible, for as long as possible. The Change Fund for older people's services is already helping to deliver these improvements.

What are we doing in Edinburgh?

Many of the proposed elements for integrating health and social care services are already being addressed through the development of older people's services in Edinburgh. This plan supports the integration agenda by setting out the total resources currently allocated to older people's care and support services in Edinburgh and stating a commitment for partners to jointly plan how these should be allocated in the future.

A Health and Social Care Partnership has been established and further details on what these changes will mean in practice in Edinburgh are currently being developed. The integration agenda will have an important influence on the implementation of this Joint Commissioning Plan for Older People.

National Policy - Healthcare Quality Strategy for NHS Scotland

The Healthcare Quality Strategy for NHS Scotland, published in May 2010, is a development of Better Health, Better Care which builds on the significant achievements already made within the NHS over the last few years. It aims to deliver safe, effective and person centred care, supporting people to manage their own conditions and making individual outcomes and experience integral to services.

What are we doing in Edinburgh?
NHS Lothian's Clinical Strategy – Our Health, Our Future 2012-2020

Safe, effective, person-centred care is at the heart of NHS Lothian's approach to providing healthcare and promoting positive health for the people of Lothian'

One key aim of the strategy is to develop integrated pathways for all major patient groups and conditions during the next five years. This is a key development to help NHS Lothian achieve its corporate goal of being at the level of Scotland's best health organisation.

The Clinical Strategy sets out our approach to deliver the redesign of our clinical services over the next five to ten years. The key challenges and opportunities the strategy addresses are:

- Redressing the balance in capacity and demand for our emergency and elective acute care services
- Supporting longer healthier lives for the population as a whole
- Reducing health inequalities
- Improving the health of the increasing numbers of older people in Lothian
- Using our changing workforce more effectively

Engagement with a wide range of staff groups, patients, public, voluntary organisations, local authority colleagues and other partners has helped confirm the priorities and the principles that will underpin future services.

Through a programme of clinical-led service redesign, we expect to deliver the following for patients and the public:

- Safe effective person centred care - every person, every time
- More focus on maintaining existing health
- More support to anticipate health problems and prevent or minimise these
- More and better care at home and in community settings
- Day case and out-patient treatment as the norm for most planned hospital care
- Safe, timely admission and discharge for those who do require inpatient care
- No avoidable re-admission to hospital
- More focus on use of telehealthcare to help people to manage their own health conditions at home
- Information about you and your care to be confidential, but available to you and appropriate health and care professionals when needed

National Policy - Caring Together: The Carers Strategy for Scotland 2010 – 2015

Caring Together acknowledges the vital contribution carers make to the health and social care system and commits to work with carers as equal partners in the planning and delivery of care and support.

The strategy sets out 10 key actions to improve support to carers over the next five years. The focus is on improved identification of carers, assessment, information and advice, health and wellbeing, carer support, participation and partnership.

What are we doing in Edinburgh?
Towards 2012 – Carers Strategic Action Plan for Edinburgh 2007-2012

Towards 2012 was the third strategic action plan for carers in Edinburgh and states the following vision:

The vision for unpaid carers in Edinburgh is that by 2012, all carers are seen as key partners in the provision of care. Carers across the city will be supported to access services and personalised support which meets their needs and enables them to manage their caring role with confidence. All agencies involved in the provision of carer support will work in partnership for the benefit of carers and the people they care for.

The plan sets out strategic objectives for areas such as carer identification, assessment, support and training, with associated actions. The plan is being reviewed during 2012 and a new plan will be available for consultation in Autumn 2013.

National Policy – Mental Health Strategy for Scotland 2011-15

The National Mental Health Strategy for Scotland 2011-15 builds on previous mental health strategies and related policies including Scotland's National Dementia Strategy. The Strategy includes 14 high level outcomes that an effective mental health system should deliver.

What are we doing in Edinburgh?
A Sense of Belonging - A joint strategy for improving the mental health and wellbeing of Lothian's population 2011-2016

A Sense of Belonging sets out a clear vision, principles and approach for how the public, people with lived and living experience of mental illness and mental health problems, people who use services, carers, the third sector, the four local authorities and NHS Lothian, will work together across Lothian to improve our mental health and wellbeing for people of all ages and ensure that the services delivered have an ethos of recovery embedded within them.

All priorities in A Sense of Belonging are applicable to older people.

National Policy - Tackling poverty and inequality, and health inequality

National policies clearly prioritise work to reduce poverty and inequality as a central part of improving social and economic quality of life for the whole community. This approach also forms the main vision of the Single Outcome Agreement 2012-15 between the Scottish Government and all the main partner agencies in Edinburgh. The community planning partners seek to achieve a city which is thriving, successful and sustainable, in which all forms of deprivation and inequality are reduced.

Four main priorities are set out in the agreement to support this vision through practical action. One of the four main priorities is to improve health and wellbeing and reduce unequal health outcomes and life expectancy in the city, which particularly affect people in their later years. The Community Health Partnership has agreed a strategic framework to provide local action on the principles set out in the national policy Equally Well, one of a an interlinked set of national policies to reduce poverty and inequality.

What are we doing in Edinburgh?
Reducing health inequality

The four main priorities set out above are to support this vision through practical action. One of the main priorities is to improve health and wellbeing and reduce unequal health outcomes and life expectancy in the city, which particularly affect people in their later years. The Community Health Partnership has agreed a strategic framework to acts on health inequality through the principle of equity – meaning that outcomes should show fairness in social and economic opportunities and outcomes.

Action on health inequality will follow two strategic objectives to improve outcomes for the communities and individuals suffering the worst inequality, and to reduce the gradient of inequality across the city. The Community Health Partnership's integrated plan seeks to draw together action through all mainstream services to mesh with the equity objectives. A vital tool to achieve this is to test all actions for their impact on unequal health outcomes .

Four outcomes from the framework will apply particularly to older citizens:

- enable all adults to maximise their capabilities and have control over their lives
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill-health prevention.

National Policy - National Strategy for Housing for Older People

The National Strategy for Housing for Older People, *'Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012-2021',* was launched in December 2011. The strategy confirms the Scottish Government's commitment to 'shifting the balance of care' and helping people to remain independent in their own home for as long as possible. The strategy acknowledges that achieving this in the current economic climate will create challenges.

The strategy highlights the need for joint working between organisations, the importance of preventative measures and advice and information services and highlights the fact that the housing sector has a vital role to play in providing these services.

The strategy is based on five key outcomes for housing and related support for older people:

- clear strategic leadership;
- information and advice;
- better use of existing housing;
- preventative support; and
- new housing provision.

The strategy is intended to set the policy direction for housing for older people for Scotland as a whole while leaving enough flexibility for local decisions to be made which reflect the differing needs of older people at a local level. In order to achieve this, the Strategy advocates joint working between housing, health and social care as well as other departments such as planning and transport.

What are we doing in Edinburgh?
City Housing Strategy

The City Housing Strategy (2012-2017) is the Council's key strategic document for housing and sets out the housing outcomes which the Council will work towards. It brings together all the partners needed to make an impact on the housing system in Edinburgh and covers all housing tenures. The strategy aims to deliver three outcomes:

- people live in a home they can afford

- people live in a warm, safe home in a well managed neighbourhood; and
- people can move home if they need to.

The Strategy will be reviewed annually and implementation will be monitored by a Joint Implementation Working Group.

Ensuring that older people have access to appropriate housing and support plays an important role in preventing inappropriate admission to hospital and residential care. Challenges outlined in the City Housing Strategy include the need to ensure that people know how to access relevant information. It is estimated that around 88% of people aged 65 and over in Edinburgh are living in mainstream housing and many may not know that adaptations and other forms of help and advice are available. While the majority may never want to move, good quality advice and information, at the right time, is essential to help people make informed decisions about their home and support needs. This can avoid more costly intervention later.

The ageing population presents particular challenges since the city has the second highest proportion of flats in Scotland. Many of these are in older, tenement blocks which can be difficult for people with mobility issues to access, especially flats above ground floor level. Older homes may also be more expensive and difficult to adapt, maintain and carry out energy efficiency improvements. This means that people living in older homes are more likely to be at risk of fuel poverty, especially those on a low income.

The vast majority of affordable new build homes are built to a more accessible standard and the 2010 Building Standards Building Regulations have also improved accessibility standards for all newly built homes. However, new build accounts for less than 1% of the total stock each year. Much of these new homes are for general needs rather than being specifically reserved for those with mobility difficulties. The amount of specialist housing is limited and the current funding situation means this is not likely to change soon.

Edinburgh's Homelessness Prevention Commissioning Plan

The Homelessness Prevention Commissioning Plan 2011-2016 has a clear focus on advice and information to help people plan ahead and deal with changing circumstances. The need for good quality accessible advice and information is well recognised and this approach is also reflected in the Scottish Government's National Strategy for Housing for Older People.

Alongside the general focus on the prevention of homelessness there are specific actions relating to older people's housing and support within the Homelessness Prevention Commissioning Plan which focus on targeting funding at housing advice and support for a greater number of older people rather than focusing all funding on sheltered housing. This will be a programmed approach to take time to consult with service users and providers. The role played by sheltered housing managers in providing low-

level preventative support, contact and access to social activities is valued by tenants. The development of services will involve looking at ways in which low level support and community links can be delivered to those in mainstream accommodation as well as sheltered units. There will continue to be a focus on services which help people to stay in their own homes where appropriate.

National Policy - Living and Dying Well: A national action plan for palliative and end of life care in Scotland

Living and Dying Well aims to enable all NHS Boards to plan and develop services which will embed a cohesive and equitable approach to the delivery of palliative and end of life care for patients and families living with and dying from any advanced, progressive or incurable condition across all care settings in Scotland.

What are we doing in Edinburgh?
Living and Dying Well in Lothian

Lothian's Palliative and End of Life Care Strategy for 2010 - 2015 – 'Living & Dying Well in Lothian' covers generalist and specialist services in community and hospital settings and was jointly developed in collaboration with both of the independent hospices in Lothian.

The strategy's vision is for high quality Palliative and End of Life care available in all settings, utilised by all who require it, and prioritised according to the patient's need, rather than medical condition. The strategy states that by 2015, clinical teams in all settings across Lothian will be reliably identifying and assessing patients as they reach a palliative phase of their illness, and developing and updating integrated care plans for them and their carers, based on patients and family preferences.

National Policy – The Same as You? A review of services for people with learning disabilities

The Same as You? report followed a review of services for people with learning disabilities in Scotland. The main aim of the report is to help people with learning disabilities to be included - in community life, in education, in leisure and recreation, in day opportunities and particularly in employment. They should also have far greater access to mainstream services and rely less on specialist services. The report sets out 29 recommendations for the Scottish Government, NHS Boards and Local Authorities to improve services for people with learning disabilities.

What are we doing in Edinburgh?
Edinburgh Joint Learning Disability Plan: 2010-2020/25

The Plan sets out proposals for developing sustainable models of learning disability services for the 21st century. The Plan identifies some immediate actions to develop more choice and control, develop more local services for people with complex needs, make the money go further and respond to the

needs of older carers. One of the targets for 2012/13 it to identify the best models of support for older adults with learning disabilities, including those who have dementia.

Older carers of people with learning disabilities can have particular needs due to their role as lifelong carers who are caring for adult children, and they frequently have additional roles in caring for a spouse and/or older parents as well. Work is ongoing to address the specific needs of this group of carers.

Our Lives, Our Way: Lothian Joint Physical and Complex Disability Strategy

The strategy was produced in partnership between NHS Lothian, the four local authorities, voluntary organisations and independent providers and service users and carers and addresses the needs of people from 16 – 65 years of age who have physical and complex disability. This age cut off reflects the need to focus on these issues for the younger adult, due to the relative lack of services for the working aged adult with physical and complex disabilities. Additionally, it is recognised that the prevalence of disability within older adults is so high that to have a separate strategy solely for physical and complex disabilities would have been an artificial distinction.

It is well recognised that increased disability is related directly to increasing age. Public Health Information for Scotland (ScotPho) reports, 2010, indicate the following increasing profile of physical and complex disability for both men and women with increasing age:

Scottish Population 2010	**% of Males with disability**	**% of Females with disability**
Age Group 60 - 69	35	30
Age Group 70+	48	52

Figure 4: Profile of physical and complex disability for both men and women with age.

There are some specific key areas that are actively being taken forward for people with physical disability and disabling conditions either within Edinburgh, or jointly with Edinburgh and other Lothian local authorities. These include services for people with progressive conditions such as Huntington's disease; Multiple Sclerosis; services for people with needs arising from alcohol related brain damage (ARBD); people with needs arising from an Acquired Brain Injury (ABI); and services for people with lower limb amputation.

Many service users within all of these groupings are over 65. Their primary requirements are for equipment and adaptations to support them in their homes; ongoing therapeutic interventions as opposed to therapies provided with an emphasis upon re-ablement; respite services both for patients and clients themselves, but also for their carers and wider families, and general person-centred personal care needs.

Besides physical considerations, these services also appreciate the wider social, emotional and economic disadvantages and poor outcomes experiences in regard to their health and wellbeing that are associated with many individuals using these services.

National Legislation – Equality Act 2010

The Equality Act 2010 places duties on bodies, including service providers in statutory, voluntary and independent sectors, not to discriminate on the basis of certain protected characteristics and to make 'reasonable adjustments' in certain situations.

What are we doing in Edinburgh?
A Framework to Advance Equality and Rights

A Framework to Advance Equality and Rights 2012-2017 has been developed within the Council to ensure those most vulnerable are supported and provided with opportunities to have their quality of life and human rights enhanced, to attract and harness the skills, experience and knowledge of diverse communities and to ensure the Council meets its legal obligations. NHS Lothian has a similar framework and the two organisations work closely together to ensure that the same standards are met across all health and social care services.

For Older People's services implementation of the Framework will improve the diversity, skills, experience and knowledge of the people it employs, (ii) better define performance with regard to its priority equality and rights outcomes and indicators, (iii) enable a preventative approach through impact assessment and the mainstreaming of equality and rights and (iv) improve partnership activity through joint approaches to evidence gathering and analysis, impact assessment, community involvement, procurement and outcome delivery.

The Framework complements other policy drivers promoting personalisation, productivity, participation, prevention and partnership.

The full set of equality and rights outcomes, indicators and actions can be found at: www.edinburgh.gov.uk/equalities

National Framework - Maximising Recovery and Promoting Independence: Intermediate Care's Contribution to Reshaping Care

Launched in 2012, this national framework seeks to raise the profile of intermediate care services and their impact within health and social care services providing rehabilitative and enabling support to patients and clients.

The framework seeks to provide greater consistency of approach to intermediate care provision across Scotland, and to establish a common understanding of the services that provide functions supporting preventative measures to maintain patients' abilities, as well as the rehabilitation, enablement and recovery of ability for patients following illness or injury.

What are we doing in Edinburgh?
The Development of Intermediate Care Services

Intermediate care services are central to the development of new models of care for older people which facilitate older people's discharge from hospital and prevent unnecessary and unplanned admissions to hospital. The points raised in the national framework are being taken forward through the development of intermediate care services in Edinburgh, which is described further in Part Two of this plan.

Appendix 2: Legal framework

The key pieces of legislation that shape the approach to providing health and social care services are noted below.

National Assistance Act 1948 places duties on councils to make provision for residential accommodation for certain categories of people and sets out the mechanism for charging for that accommodation.

Social Work (Scotland) Act 1968 sets out the powers and responsibilities of councils in relation to social work services.

Local Government (Scotland) Act 1973 provides for the powers and duties of councils and the way in which they operate.

National Health Service Act 1978 makes various provisions in relation to the organisation of the National Health Service.

Housing (Scotland) Act 1987 outlines the duties on councils to provide for individuals and families who are homeless or at risk of homelessness. It describes councils' responsibility to produce strategies to address homelessness in their area.

NHS and Community Care Act 1990 makes councils responsible for assessment and care management of people in need of social care.

Carers (Recognition and Services) Act 1995 places a duty on councils to offer a carer's assessment to an unpaid carer who undertakes a 'regular and substantial' amount of care for another person.

Community Care (Direct Payments) Act 1996 gives councils the power to make direct payments to individuals who could then purchase services and facilities themselves.

Human Rights Act 1998 places duties on public authorities (such as the Council) to act in away that complies with protections under the European Convention on Human Rights

Adults with Incapacity (Scotland) Act 2000 makes provision for adults who do not have the capacity to make decisions about their finances or welfare and places councils under certain duties in relation to such adults.

Regulation of Care (Scotland) Act 2001 introduced National Care Standards (standards for a range of services, including care homes, services to people in their own home and adult placement schemes), and set up arrangements for the registration and inspection of services through the Care Commission (now Social Care and Social Work Improvement Scotland), and the registration of the social care workforce through the Scottish Social Services Council.

Housing (Scotland) Act 2001 introduces Housing Support into legislation for the beginning of what was the "Supporting People programme". Subsequent regulations further define Housing Support in terms of twenty-one types of activity.

Community Care and Health (Scotland) Act 2002 provides for free personal care for older people, free nursing care, expanded access to direct payments, and extended to unpaid carers the right to an assessment.

Homelessness, etc, (Scotland) 2003 plans the abolishment of priority need in homelessness assessments. This is to be implemented by 2012.

Local Government in Scotland Act 2003 imposes a duty on councils to secure 'best value' and provided councils with the 'power to advance wellbeing'. The Act also places a duty on councils to lead on community planning.

Mental Health (Care and Treatment) (Scotland) Act 2003 makes various provisions in relation to the assessment, care and detention of people with mental health issues.

Community Care (Direct Payments) (Scotland) Regulations 2003 and Community Care (Direct Payments) (Scotland) Amendment Regulations 2005 extends the Community Care (Direct Payments) Act 1996 to place a duty on councils to make direct payments available to almost all people using social care services (with the exception of people subject to compulsory measures of care under mental health and criminal justice legislation).

National Health Service Reform (Scotland) Act 2004 makes provision for Community Health Partnerships.

Management of Offenders etc (Scotland) Act 2005 places a duty to co-operate on Community Justice Authorities, their consistent councils and Scottish Ministers. It requires councils and other "responsible authorities" to establish joint arrangements for the assessment and management of high risk offenders.

Public Contracts (Scotland) Regulations 2006 implements the European Procurement Directives in national law.

Adult Support and Protection (Scotland) Act 2007 gives powers to and places responsibilities on councils to investigate risk of harm to or abuse of adults in the community or in care homes.

Protection of Vulnerable Groups (Scotland) Act 2007 sets up a list and referral system for individuals who may pose a risk to vulnerable people.

Equality Act 2010 places duties on bodies (including 'service providers') not to discriminate on the basis of certain protected characteristics and to make 'reasonable adjustments' in certain situations.

Housing (Scotland) Act 2010 describes, as an amendment to the Housing (Scotland) 2001 Act, the responsibility of all councils to assess the Housing Support needs of all people who have been assessed as homeless.

Self Directed Support Bill introduces the term “self-directed support” into statute, provides general principles on service user choice and control, consolidates and modernises current legislation on direct payments, and improves support to unpaid carers. The legislation will place a duty on councils to provide people with a range of options so that the citizen can decide how much choice and control they want. The Bill completed the Scottish Parliament's Stage 3 consideration at the end of 2012 and will now progress for Royal Ascent and for a commencement date to be agreed.

Appendix 3: New Models of Care – key developments

This section provides details of some of the key developments that have taken place since the previous "Live Well in Later Life" published in 2008.

Accommodation Strategy

The accommodation strategy is an integral part of 'Live Well in Later Life' which was agreed by the Health, Social Care and Housing Committee in December 2008. The key objectives of the accommodation strategy were:

- Shift the balance of care towards more older people living in their own homes
- Develop more accessible housing with care
- Address fitness of purpose of care homes owned by the City of Edinburgh Council
- Address demographic growth
- Invest in different models of care in the community, including residential respite care
- Make links where appropriate in the longer term with NHS long stay facilities

The accommodation strategy provided analysis which concluded that by 2018 the aim should be to develop a service mix as follows:

- 40% of older people with high level needs being cared for at home
- City of Edinburgh Council owning a market share of 15%

The accommodation strategy provided the following proposed service mix for 2018. Progress to date has been added to the table.

Older people (65+) with high level needs service composition			
	2008 (Actual)	2012 Actual (March)	2018 (Projections)
All care home places in Edinburgh	2,943	2,894	2,785
CEC care home places (includes Castlegreen and North Merchiston)	652	625	418
Independent Sector places	2,291	2,269	2,367
CEC care home market share	22%	21.6%	15%

The planned change within the accommodation strategy was to reduce the overall number of care home places in Edinburgh and reduce the Council's market share to 15%. This was to be achieved through:

- replacing 14 of the Council's older care homes with 6 new homes
- increasing the number of Independent sector care home places.

As part of the accommodation strategy, four new care homes have opened in Edinburgh, and a further is planned to open this year:

	Date opened
Marionville	2007
Castlegreen	2007
North Merchiston	2009
Inchview	2010
Drumbrae	2012

To date, the Council has closed the following care homes:

- Sighthill (closed March 2009)
- Liberton (closed March 2009
- Balmwell (closed March 2011)
- Craigour (closed March 2011)
- Chalmers (leased. Closed 2007)
- Greenhill Park (leased. Closed 2007)
- Kirkland (leased. Closed 2007)
- Drumbrae care home will replace two older care homes – Clermiston and The Tower.

Once the new care home at Drumbrae opens, there will be 5 new care homes and 8 remaining older care homes. The timescale for the provision of further new care homes is being reviewed to take into account the availability of capital and the timing of capital receipts. Recommendations on whether to refurbish or replace the 8 remaining older care homes, whilst ensuring that that the Council continues to retain a market share of 15% will then be made to Committee.

Edinburgh needs approximately 36,000 new homes over the next 10 year if all housing need and demand is to be met within Edinburgh. 16,600 of these need to be affordable. The majority of people want to remain in their own homes and much of the focus of the City Housing Strategy is on enabling people to live as independently as possible in an appropriate home. Some flexible housing has been developed in recent years which helps meet the objectives of shifting the balance of care and creating independence and choice but the amount of new build specialist housing in the city is limited and the current funding situation will mean that this is likely to remain the case for the next few years.

Elizabeth Maginnis Court, is a partnership between the City of Edinburgh Council and Dunedin Canmore Housing Association. It was originally designed to replace sheltered housing that was no longer fit for purpose in the same area. The flats are provided with care and support for residents, and a focus on wider community integrated accommodation which increases the independent accommodation for frail or elderly people in the city. 34 of the 68 flats in the complex are for people who would otherwise need to be accommodated in hospital or a care home.

Home Care Modernisation

A programme of change has been underway since 2008 to modernise the provision of home care services in Edinburgh, for both in-house and externally provided services. The changes have been made to develop a service that meets the needs of users of the service, is flexible and cost effective. Shifting the balance of care means that the provision of home care services has increased significantly (430 to 470 hours per week per thousand population 65+ between 2008 and February 2012) and the needs of service users have become more complex, reflected in the 17% increase in the number of older people receiving intensive levels of support at home (from 1,063 in March 2008 to 1,248 in January 2012). The home care service needs to be flexible to ensure that a service is available when the service user needs it.

The Home Care Modernisation programme has included the following changes and these are explained further below:

- the development of a re-ablement service
- changes to make the Council's home care service more flexible
- a planned change in the balance of service provision to 75% of services delivered by external provider, with the in-house service focusing on re-ablement and complex care
- new contracts and monitoring arrangements for external Care at Home service providers.

Re-ablement service

The City of Edinburgh Council has provided a Home Care Re-ablement Service across the city since April 2009. The Re-ablement approach has transformed the way that services are delivered, to provide better outcomes for service users referred for a home care service from hospital and the community. An intensive service is provided for around 6 weeks, during which time Re-ablement staff work with the service user to maximise their independence, rather than doing tasks to and for them.

Flexible Home Care service

As more older people are being supported at home, further changes are underway within the Council's home care service to ensure that staff are able to provide more complex care tasks. The service also needs to be flexible and responsive to people's needs and working patterns are being adjusted to

ensure the service is available seven days a week, 24 hours a day.

Care at Home Services

The Council purchases approximately 75% of homecare from voluntary and private sector organisations. The contracts for these Care at Home services were recently renewed following a significant consultation exercise. Key issues raised during the consultation included punctuality of carers, duration of service and care worker consistency. Electronic monitoring is being introduced to help us address the concerns of service users and carers, to ensure clients are charged for the care that they receive and to allow us to better understand the service that is being delivered by the providers that we fund.

Intermediate Care Services

Intermediate Care provides services which:

- facilitate hospital discharge
- prevent unnecessary admission to hospital
- support people to gain and retain independence in their own home.

Intermediate Care Services are jointly provided by the Health and Social Care Department and the Edinburgh Community Health Partnership.

A review of Intermediate Care Services was completed in July 2007. The review made a number of recommendations including the remodelling of existing services into a more streamlined structure. Recommendations from the review are currently being implemented with the aim of improving ease of access, service responsiveness, and the overall service offered to support people to live independently at home.

Investments have been made as part of the Change Fund to expand the Intermediate Care Service. The service works closely with a range of related services including the NHS Domiciliary Physiotherapy service, Speech and Language Therapy, Re-ablement and home care services, hospital discharge and hospital based rehabilitation services.

Intermediate Care services will also be an important part of the 'Virtual Ward' developments (see below), linking closely with Consultant Geriatricians and medical teams to help to support older people in the community and to avoid unnecessary and unplanned admission to hospital.

Telecare

The Community Alarm Telecare service has developed since 2008, initially with funding from Scottish Government through Joint Improvement Team which enabled the service to develop the technology available to support individuals to remain in their own homes, support carers and prevent or delay admission into Long Term Care settings.

Telecare is a preventative service with approx 8000 residents within City of Edinburgh receiving a service, 67% of all service users are over 75, 73% (5562) of response visits (2011) were to customers within this age range, however only 2.8% (220) of all response visits are admitted to hospital for further treatment after activating an alarm, compared to an 88% transfer rate by the Scottish Ambulance Service for this age range. 72% (160) of all admissions to hospital following a response visit, are over 75.

The service has continued to develop a wider scope, working within the hospitals, Reablement, homecare, mental health and 3rd sector.

Review of Out of Hours Services

The Out of Hours Review was started in 2009. The original scope of the review was very large and it was agreed to split it into 3 phases.

Phase 1: Creation of consolidated call handling facility to manage contacts for Emergency Social Work Services (ESWS), Emergency Home Care (EHC) and Central Emergency Services (CES), the Council's corporate emergency service. This was completed in November 2010.

Phase 2: Development of revised back office professional support across EHC, ESWS and Intermediate Care (IC) to streamline customer interfaces and business processes and Contact Centre handling of IC calls out of hours. This phase is the subject of this consultation.

Phase 3: Expansion of the Out of Hours service to offer support to other services both within the Council (e.g. Community Alarm Service) and externally, e.g. other authorities, NHS etc. This phase is not yet scoped.

Social Care Day Services

Day Services are an important part of the spectrum of services to older people in the City of Edinburgh. They range from small locality based clubs through visiting support day services to the larger centre based day services which can offer personal care and support services. Day Services aim to focus on prevention and maintenance of independence which are central goals of the national “Reshaping Care for Older People” programme.

Following the review of day services published in 2007, there has been investment in and modernisation of day services across the city in order to meet the needs of the growing numbers of older people across Edinburgh.

A Draft Commissioning Plan for Social Care Day Services for Older People: 2012 – 2017 has been developed and consultation is currently underway.

The Plan recommends development rather than major redesign of current provision. In addition, the following improvements are proposed. These are in line with the “Reshaping Care for Older People” programme and include:

- An updated vision which incorporates a stronger personalised and individual approach

- Community Connecting service to be available within each sector of the City which links older people into local social networks; promotes choice and control and supports reablement.
- Non-centre based services to develop a 'community connecting' approach where appropriate which will aim to impact on current waiting lists
- Extension of the referral processes to include Healthy Living Partnerships (working title) in each sector of the city which will include wider community resources in order to improve choice; promote early intervention and prevention and ensure the involvement of local older people in the design of local services
- Ensure specialist day services are available where appropriate as well as supported integration into mainstream services as an alternative option.

Development of Step Up/ Step Down

The development of a number of transitional or intermediate beds within care homes is being progressed. Step-up beds provide increased support without which a person would likely be admitted to hospital, whilst step-down beds would facilitate timely discharge from hospital for people who do not require hospital based medical care but need short term treatment and therapy in order maximise their opportunity to return home.

New care home capacity is due to be established in Edinburgh in 2013 and this has provided the opportunity to develop this new model, which has the potential to reduce inappropriate admissions to hospital and care homes, reduce delays in hospital, and provide an appropriate setting for rehabilitation, assessment and time to plan future care. For care home step up/down to be successful close links and arrangements with hospital and community based services are required and engagement with key stakeholders is underway.

Five flats within Elizabeth Maginnis Court are currently being used to provide a Step Down facility to support people on discharge from hospital. This work will be closely monitored and evaluated and will inform future planning of the 'Step Down' model.

Dementia Services

The Scottish Government and its partners in local government and the voluntary and private sectors are committed to delivering world class dementia services in Scotland by:

- Developing and implementing standards of care for dementia, drawing on the Charter of Rights produced by the Scottish Parliament's Cross Party Group on Dementia
- Improving staff skills and knowledge in both health and social care settings

- Providing integrated support for local change through implementation of the dementia care pathway standards and better information about the impact of services and the outcomes they achieve
- Continuing to increase the number of people with dementia who have a diagnosis to enable them to have better access to information and support
- Ensuring that people receiving care in all settings get access to treatment and support that is appropriate, with a particular focus on reducing the inappropriate use of psychoactive medication
- Continuing to support dementia research in Scotland.

NHS Lothian and partners developed a Dementia Action Plan in October 2009. This focused on the same five work streams which are contained within the National Strategy:

- Treatment and improving the response to behaviours that carers and staff find challenging
- Assessment, diagnosis and the patient pathway - improving the journey of people with dementia and their carers
- Improving the general service response to dementia
- Rights, dignity and personalisation
- Health improvement, public attitudes and stigma

A great deal of work is currently underway across Lothian which will contribute to Lothian delivering on the national strategy. Examples include:

- The Lothian Diagnostic Support Pilot which is being delivered by the Dementia Services Development Centre. This focuses on providing information and training for NHS and social care staff, including giving general practitioners good information about local post-diagnostic support services for people with dementia and their carers, providing training to acute general hospital staff, running local information days and visits for staff and offering formal accredited dementia training. The pilot is being formally evaluated.
- Improving the patient care pathway for people with delirium and dementia in acute hospital settings. This is focusing on staff values, knowledge, education and training in relation to the identification and subsequent care and treatment of people with dementia.
- Midlothian is one of three national exemplar projects funded by the Scottish Government to improve service provision for people with dementia. The focus of the Midlothian project is on patient and carer narratives and how these can be used to inform service redesign and delivery.
- The Integrated Care Pathway for people with dementia has begun a phased implementation.

- NHS Lothian is one of three Health Board areas funded by the Scottish Government to employ an Allied Health Professional Consultant in Dementia. The focus of this post will be to support and build capacity for early intervention, post diagnostic support and self management.
- Introducing new person-centred planning tools, including the Wellness Action Plan, which are proving to offer a simple yet hugely effective way of helping individuals with dementia and supporting the needs of carers or supporters to be an integral part of a person with dementia's care.

A local dementia plan is being developed to set out how the priorities of the National and Lothian Dementia Plans will be implemented in Edinburgh.

The Edinburgh Dementia Strategy will highlight that dementia is already becoming a focus of mainstream services and that there is a great deal of development work underway in Edinburgh. The Strategy will also respond to the following points:

- How well do our current services meet the specific needs of people with dementia and their carers?
- What plans are currently in place to improve and develop services?
- What gaps in services, support and training have been identified?
- What actions will we take forward to address these gaps and improve our support for people with dementia and their carers?

Edinburgh Behaviour Support Service

A Behaviour Support Service (BSS) is to be developed as part of a wider redesign of older people's mental health and wellbeing services, including dementia. The BSS will provide preventative and education strategies and support on understanding and managing behaviour to informal carers, care homes, supported housing and inpatient facilities.

The service will also include an innovative and transformative approach which will employ people with lived experience of caring as Carer Mentors as part of the multi-professional Edinburgh Behaviour Support Service.

Inpatient Complex Healthcare (formerly Continuing Care)

Changes have occurred within the provision of inpatient complex healthcare following the Scottish Government's issuing of CEL (6) 2008 *NHS Continuing Healthcare*, published in February 2008. This guidance emphasises that, for a small number of people, there may be requirement for a more intensive level of NHS intervention which may, again, occur in various settings.

The model for these care needs increasingly is moving from institutional-based services to one more suited to the personalisation agenda of caring for people within wider community settings.

Scottish Government policy is to continue to rebalance care for all adults, providing care and treatments nearer to people's homes, allowing people to be supported to maintain independence for as long as possible, and to be supported to end of life, at home or in a homely setting.
NHS Lothian, with local authority and third sector partners has implemented changes which support this shift in care, including:

- investment in management of long term conditions
- increased alternatives to hospital admission
- development of the palliative care and end of life strategy: 'Living and Dying Well' Action Plan
- supported discharge
- redesigned models of care including re-ablement and intermediate care, which support the fundamental philosophy that healthcare needs will be provided wherever the person may be.

This policy on the assessment of eligibility for a level of complex, specialist and intensive health care in Lothian has been developed in line with the most recent guidance from the Scottish Government. In the national guidance, this level of health care is defined as a package of continuing health care provided and solely funded by the NHS. Guidance also states that this level of care may be for prolonged periods, but not necessarily for life, and entitlement should be subject to regular review, and is not associated with any diagnosis or prognosis.

Reasons for eligibility should be based on ongoing clinical needs as assessed by a multi-disciplinary team, led by the consultant/GP. There is no distinction between any client groups and eligibility is not condition specific. Regular reviews of individual circumstances should take place to ensure the care package continues to meet the individual's needs within the context of personalised care. People can move in and out of eligibility as their needs change.

In addition to clinical needs, during the assessment process, account will be taken of behaviour that challenges, levels of cognitive impairment and any issues that might be a risk to individuals or others.

Medicine of the Elderly Pathways

Partners within UHD, the CHPs and local authorities are working together to design and implement the required models for older people's pathways. The underpinning strategic framework through which this work is being progressed is the "Reshaping Care for Older People" agenda. Redesigning the patient pathway for Elderly patients will help us deliver high quality care which is safe, effective and efficient and meets the needs of the Elderly population which is continuing to grow.

The main workstreams identified are as follows:

- Strategic redesign of MoE and rehabilitation pathways with an emphasis on shifting the balance of care towards community-provided interventions allowing for reductions in bed capacity
- Enhancements to functions that prevent hospital admission and facilitate earlier discharge, in order to avoid and/or reduce necessary hospital lengths of stay
- Consolidation of neuro-rehabilitative hospital functions into a single setting within the south of Edinburgh .Whilst this is not directly part of the MoE workstreams this pathway project would help to facilitate this objective.
- Consolidation of existing orthopaedic rehabilitation on the south side into Liberton Hospital from AAH – aligning appropriately with the other elderly rehabilitation functions on this site. In the north orthopaedic rehabilitation
- The reduction of delayed discharges within MoE, rehabilitation and Old Age Psychiatry resulting from difficulties in accessing onward packages of care
- The redesign and transfer of services to allow for closure of hospital facilities that are no longer fit for purpose including Corstorphine.
- Increased usage of day hospital capacity as a means of supporting discharge and admission avoidance
- The review of current inpatient respite utilisation to explore potential efficiencies

The main outcomes to be achieved by these workstreams are as follows. These outcomes will be monitored, measured and evaluated throughout the duration of the work being conducted.

- The occupancy of beds within OP pathways to be managed at 90% and 85% capacity (in acute and post-acute sites respectively) in order to safe guard adequate flow
- Reduced admission rate of OP into MoE through enhanced preventative functions
- Facilitated discharge of OP from MoE areas within RIE via COMPASS service leading to reduced length of stay for patients within MoE areas
- Integration of day hospital into routine admission avoidance and facilitated discharge planning in order for hospital stays to be avoided and/or reduced in length
- Reducing readmission rates for MoE through improved discharge planning

Phased Implementation of the model of care for older people – orthopaedic and stroke rehabilitation pathways

In 2006 the NHS Lothian Strategic Model of Care and Capacity Review for Older People indicated that to meet the demand for higher volumes of older people using services in the future, the model of care required to change to increase the throughput within hospitals and to support more people at home for longer.

Agreement was reached across NHS Lothian and City of Edinburgh Council to implement the new model of care for Older People's services in a phased way, in order that changes could be incremental and continuous improvement and adjustments to the model could be made as the practical application of the model was experienced. The areas considered to have most value from application of the model, based on benchmark information, were within orthopaedic and stroke rehabilitation pathways.

The phased implementation was planned to be applied during 2010/11. The purpose of the model was to shift the balance of care from hospital to community settings, with a related objective to enhance rehabilitation in hospital to increase the functional level of patients at their point of discharge. Ongoing rehabilitation and care needs would be delivered to patients within their own homes, through enhanced rehabilitation and social care support. This would in turn support a higher volume of earlier discharges from hospital for patients.

Performance targets were set to test the implementation of the model, including measures such as inpatient length of stay.

Additional resources were targeted across hospital and community settings, comprising the orthopaedic wards at Royal Victoria Hospital (RVH) wards 5 & 6, the stroke ward, East Pavilion, at Astley Ainslie Hospital (AAH), and a range of existing community services, including City of Edinburgh Council's reablement service, Community Rehabilitation Service (CRS), the Domiciliary Physiotherapy Service, other community therapy functions and community nursing.

The main outputs achieved through the implementation of the model were as follows:

- Average Length of Stay for inpatients in RVH wards 5 and 6 was reduced by just under 14 days
- Average Length of Stay for Stroke inpatients at East Pavilion was reduced by just under 13 days
- The number of orthopaedic patients required to board out to other wards within RIE reduced by over 50%
- Over a quarter of all packages provided by the Community Rehabilitation Service was attributable to areas within the scope of the Phased Implementation
- A net increase of 36% was recorded for the reablement caseload attributable to patients being discharged via the orthopaedic rehabilitation pathway via RVH
- A net total increase of 10% was recorded for the entire reablement service against performance within the previous year

The above outputs supported the following outcomes for patients:

- Patients were found to be able to access downstream hospital and community services more quickly than previously.

- Fewer waits for onward care were experienced by patients within acute hospital.
- Fewer waits for onward care were experienced by patients within RVH and East Pavilion for those requiring community care arrangements.
- A higher throughput of patients from rehabilitative hospital settings out into the community was achieved against baseline.
- Reduced numbers of patients were waiting on the transfer list for rehabilitation at RVH

Funding for the range of additional NHS and Local Authority resources was provided via NHS Lothian's Strategic Reserve for Older People to test the implementation of the model. In total, just in excess of £500,000 was spent through the model across a time span of almost ten months.

Initial analysis conducted on the model suggests the total costs of providing enhanced ward-based Allied Health Professionals(AHP) services and additional community services is more cost effective than the traditional model due to reduced hospital lengths of stay. A full financial evaluation will be conducted when the revised Integrated Resource Framework (IRF) tool is fully updated with information from the period of time during which the exercise was conducted.

COMPASS (Comprehensive Assessment)

COMPASS is a model of enhanced care for older people being tested within South East Edinburgh in 2012/13 and funded through the Edinburgh Change Fund partnership.

The service is known as COMPASS as it will provide *COMP*rehensive *ASS*essment service for frail older people. It will provide assessment and subsequent clinical case management, monitoring and review of frail elderly patients both within and out with hospital.

Its main actions will be:

- To identify those patients in community at high risk of imminent admission to hospital (e.g. within 48 hours or similar)
- To provide proactive case management and anticipatory care planning for those at risk of admission
- To prevent the admission of patients to hospital by providing alternative timely access to comprehensive geriatric assessment in a range of settings
- When required, to facilitate the planned admission of patients to hospital for comprehensive geriatric assessment and care
- To conduct comprehensive assessment for admitted patients
- To facilitate the discharge and prevent later readmission of patients from hospital following a planned or emergency admission

Patients who require the following input will be suitable to be referred to COMPASS:

- Urgent home assessment by MoE consultant
- Urgent access to Day Hospital for assessment and care
- Urgent access to outpatients and investigations via ambulatory care in Primary Assessment Area (PAA) or Medical Outpatient Department 2 in RIE
- Admission to A&E or PAA at RIE
- Early access to comprehensive geriatric assessment
- Direct admissions to MoE wards, bypassing Accident & Emergency (A&E) and the acute medical assessment unit
- Polypharmacy review

In the hospital and community, COMPASS will work in conjunction with a range of clinical and social care services to provide comprehensive care and rehabilitation packages for patients.

Community Mental Health Services

General mental health services offer people with severe mental health problems effective and comprehensive treatment in a range of settings and in a manner which respects their personal preferences and protects them from neglect and abuse.

Community-based services for those with severe mental health problems have advanced rapidly across Lothian during the last 5-10 years. Through the establishment of Community Mental Health Teams and Intensive Home Treatment Teams there is a robust network of community mental health services. These developments have focused mainly on the 18-64 population. Recent investment in Child and Adolescent Mental Health Services has resulted in the creation of an Intensive Home Treatment Team for children and young people living in Lothian.

There are key issues for older people around mental health care - potentially being carers and having needs themselves, particular needs around shifting the balance of care, and awareness of the use of alcohol and substances in this group. This does not mean there is a need for specific services for this age group, but that all services need to be informed of the needs across the lifespan, and be cognisant of individual and community needs/ assets.

Priorities for Action:

- The next five years will focus on ensuring that older people have equitable access to the range of community services currently targeted at the working age adult population. Working age services will move away from a strict chronological age limit reflecting expressed needs and preferences of service users, carers and staff. This was an agreed consensus view from our engagement and consultation event - “Why Change at 65” (October, 2009)

- Continue to redesign services reflecting the outputs from evaluations

- There have been positive developments with 3rd sector agencies in the provision of crisis services and the establishment of the Edinburgh Crisis Centre. There will be a renewed focus on understanding how services are being used and the impact they have on the use of more traditional statutory services

- Explore opportunities to ensure that these alternatives are available to wider communities of interest and geographical communities.

Appendix 4: Technical annexe

This section provides further detail of the analysis presented in the main plan.

Community Care Services: Summary of Volumes of Provision to People aged 65+ during 2011

Service	Unit	Volume
Referrals		
	Total number	61,962
Assessments and reviews		
	Total number	22,334
Care homes - total nights for people in a long stay place (includes FPC, FNC)		
CEC care homes	Nights	136,881
Independent sector	Nights	447,647
Free personal care	Nights	476,405
	Total nights	1,060,933
Accommodation with support e.g. tenancy support, supported lodgings		
	Nights	25,381
Domiciliary Care		
Mainstream CEC in house	Hours	476,201
Reablement CEC	Hours	164,625
Mainstream: independent sector	Hours	1,151,901
	Total hours	1,792,726
Intermediate Care		
	Hours	22,631
	Overnights	87
Respite care		
	Total (weeks)	8,113
Other home-based services		
Aids, Adaptations and Equipment	People receiving	6,472
	Items provided	17,823
Frozen Meals	People receiving	120
Day services		
Total	People attending	2,069
Direct Payments		
	Payments in year (£)	1,587,675
	People receiving	189

Care home length of stay

The tables in this section were provided by ISD (Information Services: A division of NHS National Services Scotland) and relate to people staying in care homes on a long term basis.

The first table comes from their report: Survey of Needs and Dependency of Older People in City of Edinburgh Care Homes -2010/2011. The second table, for 2006-07, uses data from the national annual care home census. Both show the length of stay of **all care home residents in Edinburgh** at the time of the annual survey (i.e. it is based on incomplete length of stay).

Comparing the two tables shows that there has been little change in the proportion of residents whose stay is less than two years (56% in 2010-11 and 51% in 2006-07) and those whose stay is more than five years (15% in 2010-11 and 18% in 2006-07).

Length of stay to date of older people living in Edinburgh care homes, 2010/11

	Local Authority		Private		Voluntary		Total	
LOS Grouping	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
less than 3 months	18	5	117	10	40	10	175	9
3-<6months	24	7	81	7	28	7	133	7
6 months - <1 year	47	14	187	17	58	15	292	16
1 year - < 2 years	105	30	246	22	88	22	439	24
2 years - <3 years	59	17	166	15	45	11	270	15
3 years - <4 years	44	13	98	9	39	10	181	10
4 years - <5 years	13	4	62	6	25	6	100	5
5 years plus	38	11	161	14	73	18	272	15
Total	348		1118		396		1862	

Length of stay to date of older people living in Edinburgh care homes, 2006/07

	Local Authority		Private		Voluntary		Total	
LOS Grouping	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
less than 3 months	55	9	100	9	57	12	212	10
3-<6months	32	6	73	6	28	6	133	6
6 months - <1 year	82	14	144	13	50	10	276	13
1 year - < 2 years	133	23	235	21	109	23	477	22
2 years - <3 years	82	14	145	13	55	11	282	13
3 years - <4 years	50	9	140	12	55	11	245	11
4 years - <5 years	46	8	84	7	41	9	171	8
5 years plus	101	17	207	18	87	18	395	18
Total	581		1128		482		2191	

The pattern across Scotland is similar: there has been relatively little change over the last four years in the proportion of people staying less than one year (32% in 2008 and 36% in 2011) and on those staying three or more years (37% in 2008 and 33% in 2011).

Length of stay to date of older people living in care homes in Scotland, 2006/07

	less than 3 months	3 - <6 months	6 months - < 1 year	1 year - < 2 years	2 years - < 3 years	3 years - < 4 years	4 years - < 5 years	5 years and above
2008	12%	7%	13%	17%	14%	10%	8%	19%
2009	10%	8%	12%	19%	15%	10%	8%	17%
2010	12%	8%	11%	19%	15%	10%	8%	17%
2011	15%	9%	12%	18%	14%	10%	8%	15%

NB: Data provided by ISD, and are based on a sample of care home residents

Estimating future levels of need

Previous estimates of future need e.g. for "Live Well in Later Life", were made using prevalence rates established by the OPCS disability surveys, which were carried out over the period 1985-88. As these prevalence rates are based on surveys which are now 30 years old, a review was undertaken to establish whether any alternative (more recent) sources of prevalence have been developed, and to make a judgement on the most appropriate to use for current planning purposes. A detailed technical report describing this review is available on request.

Further work will be done in the near future to:

- Consider the results of current work (June 2012) within Health and Social Care on long term financial planning, considering current patterns of resource use and their costs and projecting these for future years
- Consider the results of the 2011 census (the results will be available in 2013)

This further work may lead to revisions to estimations of future levels of need and service requirements arising through disability.

Current method of estimation

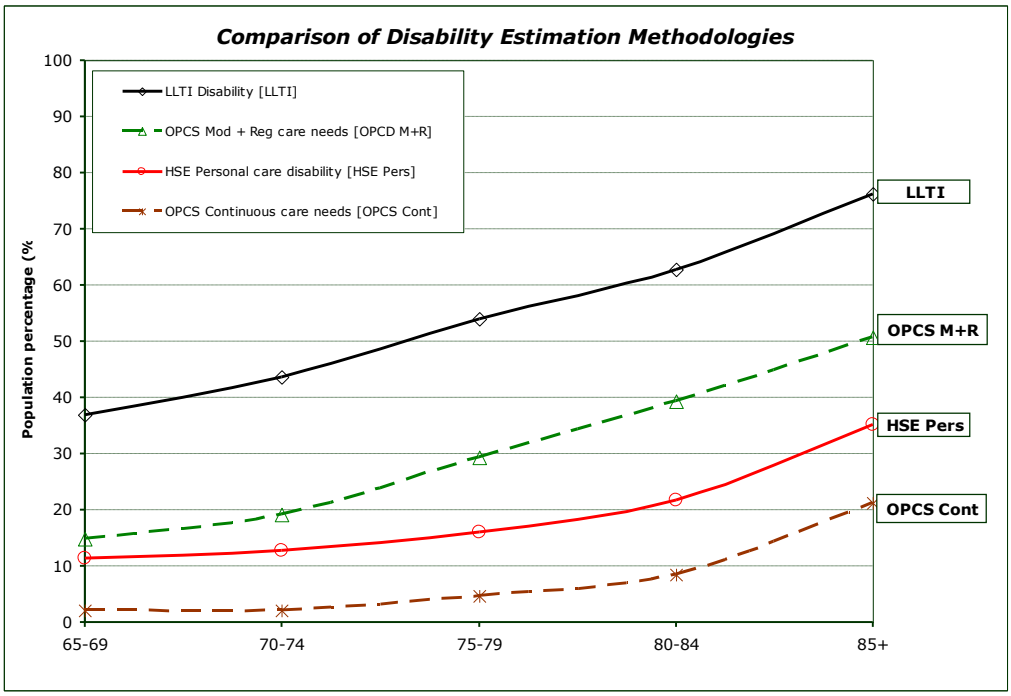
A key alternative source of prevalence rates to the OPCS rates has been developed by Alan Marshall and published by the Cathie Marsh Centre for Census and Survey Research (CCSR). This method combines data from the 2001 census and from the Health Survey for England (HSE), and includes the following disability domains: **locomotion** (mobility), **personal care, sight, hearing** and **communication**.

Following work undertaken within Health and Social Care to compare the Marshall rates with the OPCS rates, the recommendation for this Joint Commissioning Strategy is to use a combination of sources to give four categories, as follows:

- **LLTI** (Activity Limiting Long Term Illness via the census) to give an overall rate of disability – all levels of severity
- the **OPCS Moderate plus Regular care needs** - for the number of elderly persons with a disability requiring some form of intervention
- The **HSE Personal Care disability –** for older persons requiring formal or informal help with personal care at home
- **OPCS Continuous care needs** – for the non-home based older population i.e. people requiring a care home place (or long stay NHS place)

Note that these categories are not mutually exclusive: the LLTI measure gives an estimate of the total level of disability, and the personal care category will include

people with moderate plus regular needs. However, they will enable estimates to be made of the scale of support required at each stage of the pathway.
The chart below illustrates the proportion of the population estimated to be in each of the four categories by age groupings within the 65+ population.



The table below shows these four disability estimates for selected years for people aged 65+:-

LLTI [2001 Census]	2001	2010	2012	2015	2020	2025	2030	2035
People aged 65+	35,119	35,986	**35,095**	35,101	35,090	35,158	35,279	35,480

OPCS Mod+Reg [3-8]	2001	2010	2012	2015	2020	2025	2030	2035
People aged 65+	18,633	19,426	**20,128**	21,213	23,183	26,097	29,746	33,752

HSE Personal care disability	2001	2010	2012	2015	2020	2025	2030	2035
People aged 65+	11,887	12,389	**12,893**	13,661	14,976	16,821	19,142	21,768

OPCS Continious care needs [9-10]	2001	2010	2012	2015	2020	2025	2030	2035
People aged 65+	4,091	4,482	**4,683**	4,965	5,476	6,173	7,043	8,262
People aged 85+	**1,840**	**2,206**	**2,345**	**2,535**	**2,920**	**3,304**	**3,689**	**4,674**

Note that estimates were based on selected adult age groups (18-24; 25-49; 50-64; 65-69; 70-74; 75-79; 80-84; and 85+); no gender split was used (there was little difference between male and female rates).

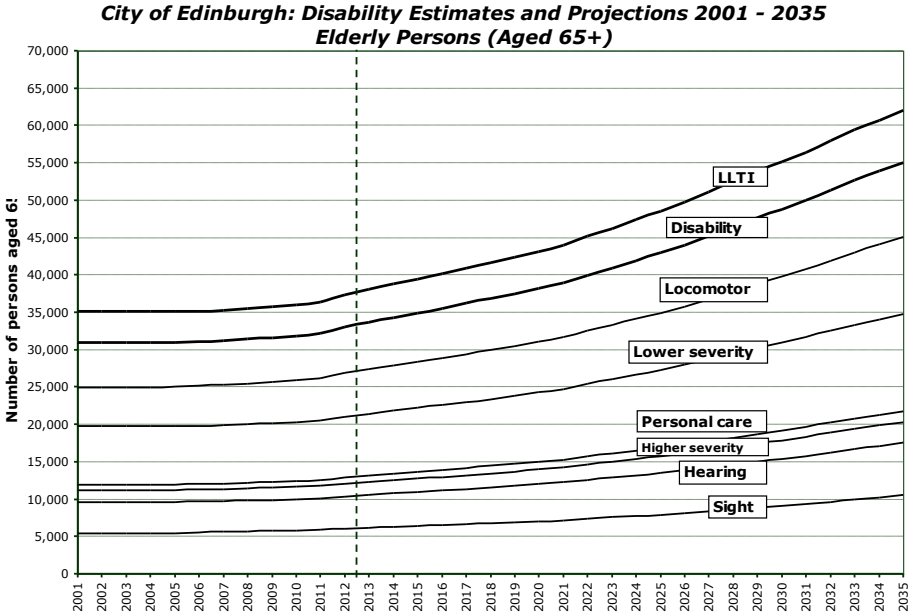
The levels outlined above can be mapped to three of the four levels of the Joint Commissioning Pathway as shown in the table below. Note that this is intended to be

illustrative of the types of support required by people at each stage of the pathway, rather than inferring eligibility. Note also that the range of services shown in the pathways diagram for the “proactive care and support” category covers a fairly wide spectrum of need.

Stage of pathway	Estimation method	Rationale	Illustrative support types	Estimated no. people 2012	Estimated no. people 2022
Preventative and anticipatory care	Derived: LLTI minus OPCS regular and moderate	Some level of disability/need present, but low	Preventative services, lunch and day clubs etc	17,227	20,889
Proactive care and support at home	OPCS moderate and regular	Disability level likely to require intervention	Self care, care and repair, housing support, community alarm, unregistered social day care services, day hospitals	20,128	24,271
	HSE personal care disability	Higher level of need than those requiring “proactive care and support at home”	Care at home, telehealthcare, day hospitals, short breaks and breaks from caring; registered day services	12,893	15,664
Effective care at times of transition	Number of individuals using the service during 2011-12 and volume provided - projecting	Individuals will be in this group for a short time, depending on their current needs and circumstances	Reablement, intermediate care, rehabilitation, care pathways, medicines management	3,636 people using reablement; 2,180 people using intermediate care	4,400 people using reablement; 2,640 using intermediate care
Hospital and care homes	OPCS continuous care needs			4,683	5,739

Apart from the actual *numbers* in each disability category being of interest we also want to ascertain what the *rate of increase* is that is caused due to the projected demographic changes.

The chart below illustrates the numerical changes shown in the 8 disability types used by Marshall from 2001 to 2035 for older people (aged 65+). It can be seen that the changes are virtually all year on year increases.

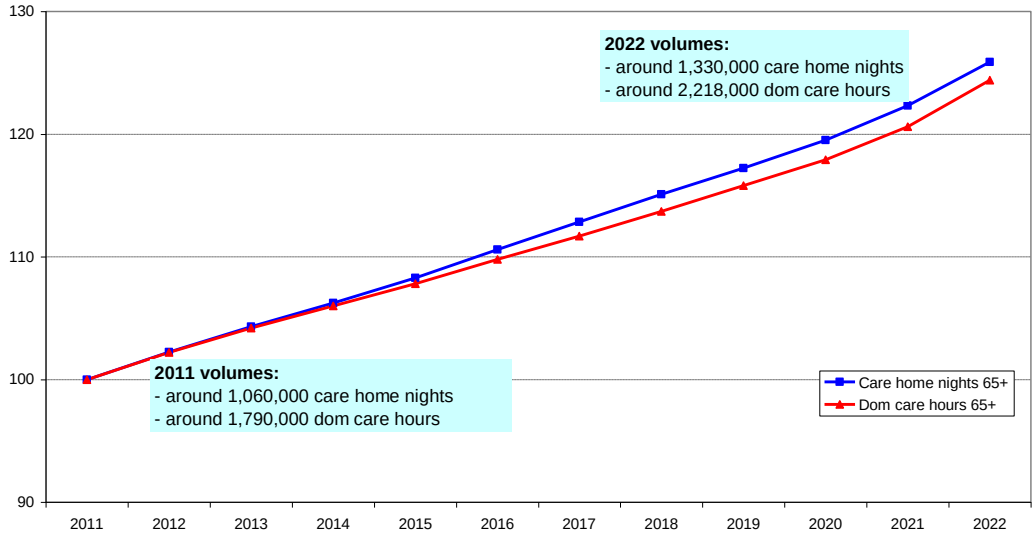


The post 2012 increases in the disability estimates are almost linear (the technical paper gives statistical evidence of this). The average annual increase in disability measures is around 2%. For example, the number of older people with a personal care disability is increasing by 2.3% per annum (on average) due to demographic factors alone.

Projections for current services – based on current models

The chart below shows the increased volumes of domiciliary care and care home provision which would be needed by 2020 if we continue to provide these services at 2011 levels. It shows that we would need a 20% increase in care home nights and a 15% increase in domiciliary care hours. (Note that these figures will be updated following work on Long Term Financial Planning, being carried out during June 2012).

Projected Service Volume Requirements: 2011 to 2022
Domiciliary Care and Care Homes for people aged 65+
Indexed to 100 for 2011, 2010 based population projections, NRS



Appendix 5: Edinburgh Change Fund Plan 2013/14

Care pathways (including intermediate and short term care)			
Work stream	**2013/14 Investment**	**Summary**	**Key outcomes/ outputs**
Re-ablement Lead: Andy Shanks	£1,145,060 + staff transport provision (upto £100,000 allocated for community based staff)	Further development of the Re-ablement service to enable all those discharged from hospital, referred for home care in the community or requiring additional support to keep them at home, go through the re-ablement process.	• Increase balance of care • Reduce length of hospital stay • Number and % of people referred for support at home receiving the re-ablement service • Reduction in the size of care packages achieved through the re-ablement service • Number of contacts to reablement teams in the period
Community Therapy Services Lead: Fiona Stratton/ Mark Smith/ Linda Gibson/ Michelle Brogan/ Fiona Huffer	£1,122,871 + staff transport provision	Building on learning from the model of care within orthopaedic and stroke services, and augmenting existing Intermediate Care services to meet increased demand for community based rehabilitation services, including stroke, physiotherapy and speech and language therapy.	• Increase balance of care • Reduce length of hospital stay • Reduce number of delayed discharges • Reduce emergency inpatient bed days rates for people aged 75+ • Reduce number of people 65+ age group admitted as an emergency twice or more to acute specialities per 1,000 pop.
Day Services Lead: Doreen Copeland	£208,000	Expanding a re-ablement approach to day care services and extending opening of day services at weekends, to provide more flexible services and essential respite for carers. Funding for OTs to work in Council and voluntary sector registered day services for older people.	• Increase balance of care • Quality outcomes for those with dementia • Improved support for carers • Impact of Re-ablement approach on individual goals
Community Nursing,	£187,917	Increase capacity of the IMPACT nursing team and to	• Increase balance of care

case finding, identification and management of patients Lead: Lynda Cowie		allow closer working with Re-ablement and Intermediate Care services.	• Reduce length of hospital stay • Reduce number of delayed discharges • Reduce emergency inpatient bed days rates for people aged 75+ • Reduce number of people 65+ age group admitted as an emergency twice or more to acute specialities per 1,000 pop.
Virtual Ward/ COMPASS Lead: Dr Andrew Coull	£0 Funding mainstreamed from 2013/14	Funding for South East test site to inform future development. The service aims to promote and respect the autonomy and resilience of older people by providing an easily accessible, responsive, individualised, comprehensive assessment in a range of settings, with safety, quality and choice at the heart of that process. The service will provide a single point of contact to support a more seamless pathway for older people, between and through any community and hospital settings, by engaging and collaborating with existing services.	• Increase balance of care • Reduce emergency inpatient bed days rates for people aged 75+ • Reduce number of people 65+ age group admitted as an emergency twice or more to acute specialities per 1,000 pop. • Improved facilitation of admissions • Improved case management of patients throughout care pathways • Improved integration of services contributing to holistic care

Longer term care services and settings (including complex care and overnight services)			
TeleHealth Lead: Ruth Burns	£183,260	Additional funding for telehealth services and equipment to support people with long term conditions in the community.	• Increase balance of care • Reduce rates of emergency bed days for the 75+ age group per 1,000 pop, • % 65+ patients with complex care needs being cared for at home via telehealth • Increase number of installations • Quality outcomes: increased feelings of safety
Telecare Lead: Heather Laing	£285,228	Additional funding for telecare services and equipment to support people with health and social care needs in the community.	• Increase balance of care • Percentage of hospital admissions of all call outs

			• Number of call outs per month • Improved response times
Overnight Service Lead: Sylvia McGowan	£300,000	Expansion of the overnight homecare service from 3 teams to 5 to enable people to come home from hospital, prevent them being admitted and provide important respite for their carers.	• Increase balance of care • Reduce number of delayed discharges • Reduce emergency inpatient bed days rates for people aged 75+
Home Care/ Care at Home Lead: Chris Whelan	£2,000,000	Additional capacity for home care/ care at home to meet demand from shifting the balance of care.	• Increase balance of care • Reduce number of delayed discharges • Reduced waiting list for care package • Reduced blocking of other services
Edinburgh Behaviour Support Service Lead: Ken Laidlaw	£409,865	Service will provide preventative and education strategies on understanding and managing challenging behaviour of people with dementia, to informal carers, care homes, supported housing and inpatient facilities. Team will include people with lived experience of dementia as Carer Mentors.	• Reduce number of people 65+ age group admitted as an emergency twice or more to acute specialities per 1,000 pop. • Reduced difficulty placing people with challenging behaviour • Reduced carer stress (paid and informal)
Medication review Lead: Alpana Mair	£60,130	Additional capacity within community pharmacy to review medication packages. To target older people who receive regular home visits to dispense medication.	• Reduction in number of home visits required for medication. • Reduced emergency admissions due to medication errors
Medication procedures – care at home Lead: Tricia Campbell/ Chris Whelan	£120,000	Supporting independent sector providers to progress adoption of Council Medication procedures to consistency in training and procedures across in house and externally provided home care services.	• Balance of care • Reduce rates of emergency bed days for the 75+ age group per 1,000 pop, • Reduced delays for waits for medication support to be arranged • Number of people provided with MAR sheets
Equipment and adaptations	£206,715	Allocation to meet the increased demand for equipment and adaptations in people's homes to support the shift to more community based services.	• Balance of care • Reduce rates of emergency bed days for the 75+ age

Lead: Linda Bertram			group per 1,000 pop, • % 65+ patients with complex care needs being cared for at home • Increase number of equipment packages • Reduced waiting times for deliveries • Quality outcomes: increased feelings of safety

Co-production and community capacity			
Community connecting Lead: Caroline Clark	£400,000	Expand the community connecting projects currently being piloted in Western and South Central Neighbourhood Partnerships to support older people to connect with local community activities, helping to regain skills, confidence and prevent social isolation.	• Reduce social isolation • Reduce rates of emergency bed days for the 75+ age group per 1,000 pop • Reduce number of delayed discharges • Improved mental health & wellbeing • Improved support for carers
Carer Support Hospital Discharge Service Lead: Carole Kelly	£100,000	The Carer Support Hospital Discharge service will work alongside unpaid carers of older people and older carers aged 65+, in pre hospital discharge planning to inform care package decisions and provide better outcomes to carers.	• Improved support for carers • Reduce rates of emergency admission due to carer break down • Personalisation of carer support
Community transport Lead: Ian Brooke	£150,000	Options under consideration within the context of development of a wider community transport strategy for Edinburgh.	• Reduced isolation • Improved mental health & wellbeing
Innovation Fund Lead: Ian Brooke	£552,600	A significant proportion of the Change Fund budget for Community Capacity Building and Co-production has been allocated to investment in low-intensity services with high impact for older people. These services will contribute to the overall Change Fund objectives by focusing on preventative and anticipatory care, adopting an asset based approach, and using principles of co-production and volunteering.	• Reduced isolation • Improved mental health & wellbeing • Building community capacity • Increasing social capital • Reduction in delayed discharges • Reduction in hospital admissions • Increased care & resilience

		See list of 20 successful projects.	• Increased flexibility in support provision • Intergenerational work

Training, communication and culture change			
Transformation Station Lead: Jacqueline Whitehead	£135,000	Build on successful work within mental health services which uses a research and evidence based approach to change culture and transform services. The work will focus on building community resilience.	• To inform planning based on evidence to achieve key outcomes. • To improve programme evaluation.
Communication, engagement, organisational development support and evaluation Lead: Dorothy Hill/ Evaluation Group	£150,000	Communications and engagement work including a two year Communications Officer post to lead the life Planning Campaign. Organisational development and support costs.	• To develop shared understanding across system • To effectively engage with staff, service users and carers
Project infrastructure and support	£247,659	Communications, planning and commissioning, finance, research and information, evaluation and cultural change support. Includes Independent Sector Development Officer and voluntary sector evaluation and development work.	• To support the effective delivery of the change fund

Total recurring allocations 2013/14: £8,064,305

Further developments under consideration

Step Up Step Down	TBC	Procurement process is underway. Change Fund funding for 2013/14 is yet to be confirmed.	

Care Home Nursing Liaison Service	£122,000	Proposal yet to be confirmed but agreed in principle and funding ear marked for concept testing in 2013/14.	

One off funding for 2013/14

Dementia Link Workers Lead: Ewan Blain	£530,636 (£265,318 per year for 2 years)	Funding for 6 Link Workers and an Implementation Worker for two years to develop a model to improve post diagnostic support for people with dementia in Edinburgh.	• Prevent adverse events including unnecessary hospital admissions by earlier interventions and preventative approach • More appropriate focused and co-ordinated use of medical and non medical professionals, avoiding unnecessary duplications • Reduce inequalities in accessing services across Edinburgh • Development of person-centred support plans
AHP enhancement in Orthopaedic Rehabilitation Service	£150,879	Enhancements be made to the therapy staffing model within Astley Ainslie Hospital's Orthopaedic Rehabilitation Service	• Improve patient experience and achieve quality outcomes • Improve flow within patient pathways • Maximise use of existing bed-based resources • Reduce capacity pressures within acute stages of scheduled and unscheduled care pathways
Equipment for voluntary sector day services	£140,000	Funding for moving and handling equipment to support voluntary sector day services to work with increasingly frail service users.	• Support older people to live independently within the community for longer • Improve service user experience and quality of care within voluntary sector day services • Improve staff safety and skill levels
Dementia	£13,602	Purchase a small number of My Life Software units to	• Improve communication and engagement with people

reminiscence software		trial within care homes and day services for older people.	with dementia • Develop meaningful activities for people with dementia and their families and carers • Improve wellbeing of care home residents and older people attending day services
Dementia training for all care homes in Edinburgh	£124,293	Provide a consistent programme of dementia training for independent, voluntary and CEC care homes	• Develop confidence and competence of care home staff working with people with dementia. • Ensure all Edinburgh care homes have access to appropriate dementia training in line with Promoting Excellence Framework (informed and skilled levels). • Promote greater understanding of dementia including its impact upon individuals; engagement in reflective evaluation of interventions to promote practice development; develop further person-centered approaches to care for people with dementia and their families.
COMPASS admin support worker	£12,000	Funding for a six month admin post to support the COMPASS model (see above). Will move to mainstream funding from April 2013.	• See COMPASS objectives above
IPads for volunteers in care homes	£5,600	Provide a small number of IPads to enhance the work of Moose in the Hoose volunteers working in care homes. Evaluation from test period to inform future service development.	• Improve communication and engagement with people with dementia • Develop meaningful activities for care home residents • Improve wellbeing of care home residents
Research project on older people with substance misuse	£40,000	Research work to scope the numbers of older people affected by both illicit and prescribed drug use, the needs of staff, (development of skills and/or increased knowledge base of substance misuse), and how to manage it. Funding to then support training and development of staff to meet the needs identified.	• Identify the problem of substance misuse for Older People. • Provide an evidence base by which informed planning and decision making can be carried out in order to shift the balance of care. • Help identify where we need to focus our provision of

			services for older people. • Provide a proposal for potential training required in the community, i.e. CEC day services, and in CEC/independent sector care homes to help shift the balance of care.
Voluntary sector - investment in training	£20,000	Investment in training for community based older people's organisations in core skills such as: • Emergency First Aid • Passenger Assistance for Community Transport services • Food Hygiene • Personal care • Moving & handling • Health & Safety • Infection Control • Dementia	• Improved training for voluntary sector providers • Improved outcomes for service users
Voluntary sector resilience small investment fund	£175,000	Investment fund to support voluntary organisations already providing essential services to local older people in the community, who can evidence their preventative role.	• Sustainability/ continuity of existing preventative services • Development of new ways of working
Care Homes small investment fund	£175,000	Investment fund to support innovative developments in care homes in Edinburgh, learning from which will be shared within Edinburgh and nationally.	• Improved outcomes for older care homes residents • Development of innovative, meaningful activities • Improved links between care homes and the local community
My Home Life	£73,736	Fund 30 care homes to take part in My Home Life, a fourteen month programme of community and practice development, leadership support and training to help improve quality of life in care homes.	• Improved quality of life of those living, dying, visiting and working in care homes • Turn managers into leaders, transforming care homes • Perceived reduction in management burnout • More innovative care homes, responsive and ready to meet future need

			• Development of personalisation in care homes • Development of the care homes role in the local community • Care homes in your partnership driving forward their own quality agenda • Increasing managers' skills in relationship-building with NHS colleagues to reduce inappropriate hospital admissions
Community Connecting for inpatients in Royal Victoria Building	£100,000	Develop a community connecting 'in-reach' service to reduce social isolation for patients within the RVB and to provide support during and following their discharge home. Funding is for a 2 year pilot, learning from which will inform future service development.	• Meet the needs of socially isolated people in single rooms at the RVB, as identified by the clinical staff • Provide support through the discharge process • Provide the ongoing objectives of the Community Connecting service once home.

One off funding for 2013/14 (funded from previous years slippage): £1,560,746

Summary

Total recurring allocations 2013/14: £8,064,305
One off funding for 2013/14 (funded from previous years' slippage): £1,560,746
Further developments under consideration: Step Down and Care Home Liaison (costs TBC, expected £1m+)

Appendix 6: Glossary

Advocacy
Help given to people to enable them to express their opinions, e.g. regarding what care and support services they require, and/or rights to which they or their advocates believe they are entitled. An advocate can be a friend or relative authorised to speak or act on behalf of a person.

Best Value
A legal requirement of all local authorities to make sure that they deliver value for money across their services. In more detail, councils are required to secure continuous improvements in performance while maintaining an appropriate balance between quality and cost. They must also have regard to economy, efficiency, effectiveness, equalities requirements and contribute to sustainable development. This is implemented by carrying out reviews, consultations and monitoring of Best Value performance indicators.

Change Fund
The Scottish Government established a Change Fund of £70 million for 2011/12 to enable health and social care partners to implement local plans for making better use of their combined resources for older people's services. Edinburgh's share of the £70 million is just over £6 million for 2011/12.

Contract
A legally binding agreement between the Council and an external provider of services.

Commissioning
The process of planning and delivering services. This involves understanding needs, planning how these should be met and putting services in place, either by delivering services directly or purchasing them.

Community connecting
Projects that support older people who are isolated and lack confidence to get out and about.

Day care
Day-time care, usually provided in a centre away from a person's home, covering a wide range of services from social and educational activities to training, therapy and personal care.

Dementia
A term for a range of illnesses, the most common of which is Alzheimer's disease, in which brain cells deteriorate through the build up of a protein. About 75 per cent of people who are diagnosed with dementia will have either Alzheimer's or vascular dementia (another form of dementia), or a combination of the two.

Direct Payments

Payments from the Council so that people have the means of controlling their own care at home, allowing more choice and flexibility.

They can be used, for example, to employ a personal assistant; buy agency services from private providers, or services from a voluntary organisation; buy local authority services, and so on.

Dietetic services
Specialist advice on diet and nutrition

Edinburgh Carers' Plan
Known as "Towards 2012", this is the Carers' Strategic Action Plan for Edinburgh, jointly developed by NHS Lothian and the City of Edinburgh Council.

Equality
An equal society protects and promotes equal, real freedom and opportunity to live in the way people value and would choose, so that everyone can flourish, regardless of any protected characteristics.

An equal society recognises people's different needs, situations and goals, and removes the barriers that limit what people can do and be. The definition recognises that:

- equality is an issue for us all
- we don't all start from the same place
- to create a fairer society we need to acknowledge and respond to different needs

(see also **Public Sector Equality Duty**)

Equality and Rights Impact Assessment (ERIA)
This is an analysis of a policy, service or function to assess the implications of decisions on the whole community. The assessment helps agencies to:

- eliminate discrimination
- tackle inequality
- develop a better understanding of the community we serve
- target resources efficiently

ERIAs help staff plan and deliver services that reflect the needs of the community as well as ensuring that they meet the requirements of anti-discrimination and equalities legislation.

Equality of Opportunity
The prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, race, disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions.

Home care

Care and support for people in their own home to help them with personal and other essential tasks. Examples include helping to wash, dress and prepare meals.

Independent living
Independent living means disabled people of all ages having the same freedom, choice, dignity and control as other citizens at home, work and in the community. It does not mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

Independent Sector
An umbrella term for all non-statutory organisations delivering public care, including a wide range of private companies and voluntary organisations.

Individual Budgets
Individual budgets bring together a variety of income streams from different public care agencies to provide a sum for an individual, who has control over the way the money is spent to meet his or her care needs.

Intermediate care
An umbrella term describing services that provide a 'bridge' at key points of transition in a person's life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence.

Joint Commissioning
The process in which two or more organisations act to co-ordinate the commissioning of services, taking joint responsibility for the translation of strategy into action.

Live Well in Later Life
A joint plan, developed between the Council and NHS Lothian for the care and support of older people. The plan covers 2008 to 2018.

Occupational therapist (OT)
Occupational therapists work in hospital and various community settings. They help people re-learn skills for daily living, using specific, purposeful activity to prevent disability and promote independent function in all aspects of daily life. This can include offering advice on adapting someone's home or assess and recommend equipment to help around the home in order to meet the person's needs.

Ophthalmologist
A specialist in medical and surgical eye problems.

Palliative care
The treatment of symptoms where cure is no longer considered an option, usually when someone is dying. It focuses on controlling pain and other symptoms, improving quality of life and meeting social, emotional and spiritual needs.

Personalisation
An approach to social care which gives people greater choice, control and flexibility over the kind of care they want. Choices may include having a **direct payment** managed by a third party, directing an **individual budget**, support from the local authority or from another provider. The choice can also be for a combination of these. See also **self directed support**.

Physiotherapist
Physiotherapists help and treat people of all ages with physical problems caused by illness, accident or ageing.

Podiatrist
A specialist in the diagnosis and medical treatment of problems with the foot and ankle.

Preventative services
The term “prevention” has at least three different meanings. Each refers to services and spending that:

- promotes and improve people’s quality of life, independence, engagement with the community, learning, or which create healthy and supportive environments
- prevents or delays the need for more costly health, housing, care and support services by reducing people’s ill-health or disability, or by increasing self-care abilities and resilience
- prevents inappropriate use of more intensive services where needs could be met by lower cost services or interventions.

Procurement
Procurement is the process by which public bodies purchase goods, services and work from third parties. It is not the only method of securing services; other options include the provision of services in-house, shared services arrangements or grant funding (where the provision of the grant, and the conditions attached to it, do not constitute a procurement). Procurement is one element of the wider commissioning process.

Protected Characteristics or Protected Grounds
The reasons why people might be protected from discrimination in the Equality Act 2010. The following are protected characteristics:

- age
- disability
- gender reassignment (whether someone has gone through or is going through a sex change)
- marriage and civil partnerships
- pregnancy and maternity
- race
- religion or belief

- sex
- sexual orientation.

Providers
Any person, group of people or organisation supplying goods or services. Providers may be in the statutory or non-statutory sectors.

Public Sector Equality Duty
A duty on public authorities, under the UK Equality Act 2010, to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Re-ablement
Care services that encourage people to learn or re-learn the skills necessary for daily living.

Reshaping Care for Older People
A ten year Scottish Government programme to address the challenges of supporting and caring for Scotland's growing older population.

Resilient communities
The ability to withstand or recover from difficult conditions. Resilience in older people has been widely researched to better understand why some people bounce back from negative life events more successfully than others.

Self Directed Support (SDS)
Self directed support is a term that describes the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including **direct payments** and **individual budgets**.

Self Directed Support Bill (Scotland)
This new bill was introduced to the Scottish Parliament in February 2012 and is now going through the legislative process. If enacted, the bill will:

- introduce the language and terminology of self directed support into law
- impose firm duties on local authorities to provide the various options available to citizens – making it clear that it is the citizen's choice as to how much choice and control they want to have
- widen eligibility to those who have been excluded up to this point, such as carers
- consolidate, modernise and clarify existing laws on direct payments.

Self management
This is the process each person develops to manage their conditions. It is a person-centred approach in which the individual is empowered and has ownership over the management of their life and conditions.

Step up/step down care
A facility that provides less intensive care than a hospital. A Step Up service provides increased support without which a person would likely be admitted to hospital. A Step Down service is for a person who no longer requires hospital based medical care but is not ready or able to return straight home. These services are short term and can be provided in a range of settings.

Telecare
Equipment and services that support people's safety and independence in their own home. Examples include personal alarms, smoke sensors, etc.

Telehealth
Equipment and services that allow people with health conditions to better manage these in the community. Examples include blood pressure or blood glucose monitoring, medication reminders etc.

Third Sector
The full range of non-public, non-private and non-governmental organisations, which are motivated by the desire to further social, environmental or cultural objectives, rather than to make a profit.

Unpaid carer
An unpaid carer is a person, of any age (including children) who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the unpaid carer's help, due to frailty, illness, disability or addiction.

Voluntary sector
An 'umbrella term', referring to registered charities as well as non-charitable non-profit organisations, associations, self-help and community groups, which operate on a non-profit making basis, to provide help and support to the group of people they exist to serve. They may be local or national and they may employ staff or depend entirely on volunteers.