Joint Commissioning Plan for Older People – Consultation Feedback and Response

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**Links**

- **Coalition pledges**: P36, P37, P43
- **Council outcomes**: CO10, CO11, CO12, CO13, CO14, CO15, CO16, CO23, CO24, CO25, CO26, CO27
- **Single Outcome Agreement**: SO2, SO4

**Peter Gabbitas**

Director of Health and Social Care

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Executive summary

Joint Commissioning Plan for Older People – Consultation Feedback and Response

Summary

This report presents the following:

- a Consultation Report which includes a summary of the consultation responses and a partnership response to the issues raised
- the final Live Well in Later Life, Joint Commissioning Plan for Older People 2012-22.

Recommendations

It is recommended that the Health, Housing and Wellbeing Committee:

- notes the findings of the consultation exercise
- agrees the response to the consultation feedback, as presented in the Consultation Report
- approves the final Joint Commissioning Plan for Older People.

Measures of success

The success of the Plan will be measured in the following ways:

- an Evaluation Framework is in place to monitor and report on the progress of the Change Fund for Older People
- a draft action plan has been developed for the Joint Commissioning Plan for Older People, the implementation of this will be overseen by the Joint Older People’s Management Group
- bi-annual progress reports will be produced and reported to the relevant Council and NHS committees.

Financial impact

The Joint Commissioning Plan includes a Financial Framework section with the commitment for improved joint financial planning between Health and Social Care, NHS
Lothian and key partners in the planning and allocation of financial resources for older people’s services. The Plan estimates the total financial resources for older people’s care and support as almost £217m. It is imperative that a joint financial strategy is developed which 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.

**Equalities impact**

The Joint Commissioning Plan for Older People aims to contribute to the three Public Sector Equality Duty (PSED) general duties which are to (i) eliminate unlawful discrimination, harassment and victimisation, (ii) advance equality of opportunity and (iii) foster good relations, and the ten key areas of rights.

An Equalities and Rights Impact Assessment (ERIA) has been undertaken, involving members of the Checkpoint Group and including feedback received as part of the consultation process. The ERIA includes further details of how the Plan will contribute to these areas and also highlights potential negative impacts and how these will be mitigated. 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.

Engagement with older LGBT people was a particular strength of the consultation, thanks in particular to the work of the Chair of the Checkpoint Group and members of the LGBT Age project. A comprehensive response was provided by LGBT Age as part of the consultation and this has led to further work in relation to Health and Social Care contracts, engagement with service managers and providers and a workshop on equalities and rights with managers from older people’s services.

**Sustainability impact**

The impacts of this report in relation to Climate Change (Scotland) Act 2009 Public Bodies Duties have been considered. The proposals in this report will not directly impact on carbon emissions or climate change. There are elements of the Plan which will require further analysis as specific developments progress, for example in related areas such as accessible transport, the development of health, social care and housing facilities, the use of telehealthcare technology etc. The Change Fund is supporting a project to assist older people to have energy efficient homes.

Social justice and economic wellbeing are important elements of the Plan, through its aims to improve the physical, mental and economic wellbeing of older people.

**Consultation and engagement**

The report provides details of the considerable consultation and engagement activity which has been undertaken in the development of the Joint Commissioning Plan for Older People.
Background reading / external references

Live Well in Later Life 2012-22 - Edinburgh's Joint Commissioning Plan for Older People - Consultation Arrangements, Health, Social Care and Housing Committee 11 September 2012

Joint Strategic Commissioning Plans and the Change Fund: Guidance for Local Partnerships 2013/14, Joint Improvement Team, 2012
Joint Commissioning Plan for Older People – Consultation Feedback and Response

1. Background

1.1 As part of its Reshaping Care for Older People and associated Change Fund programme, the Scottish Government requires all health and social care partnerships to produce a Joint Commissioning Plan for Older People.

1.2 The Joint Commissioning Plan for Older People 2012-22 builds on ‘Live Well in Later Life 2008-18’, the City of Edinburgh Council and NHS Lothian’s previous Joint Capacity Plan. Much of the content of the original ‘Live Well in Later Life’ is still relevant, but with many of the service changes set out in the document now implemented, and significant changes developing within the wider policy and planning landscape, the plan provides an updated vision for the next ten years.

1.3 The development of the plan has been overseen by the Edinburgh Joint Older People’s Management Group which includes senior managers from older people’s services across health, social care and housing, voluntary and independent sectors and older people representatives.

1.4 A report to the Health, Social Care and Housing Committee on 11 September 2012 set out arrangements for consultation on the draft plan.

2. Main report

Consultation Process

2.1 The consultation was held from 18 September – 21 December 2012. A small number of responses were received after this date and these were incorporated into the analysis.

2.2 Based on a model used in previous successful consultations, a Checkpoint Group (Appendix 2 of the attached Consultation Report) was established to provide advice on the approach to communication and engagement. The Checkpoint Group has been instrumental in developing the draft vision for the Plan along with engagement tools and materials used during the consultation.

2.3 The consultation was open to any member of the public who wished to contribute. A consultation summary document (Appendix 3 of the attached
Consultation Report) was produced which included a summary of the Plan along with ten questions. The ten questions could also be responded to through an e-consultation on the Council’s website. The full Plan was available on the Council’s website or paper copies could be requested. Submissions were also received by email. A phone number was also given for any queries.

2.4 A range of promotional activity took place from August 2012 to raise awareness of the consultation and to encourage responses to be made. This included:

- **general promotion**, including 2000 flyers mailed to a random sample of social care service users, circulation of an electronic newsletter to networks including over 500 people and promotion on the Council website homepage and partner websites
- presentations were made and feedback recorded at a range of **management and team meetings**
- presentations/ discussions were held with a range of **external service providers**
- a range of **consultation forums** and groups were held for service users and stakeholders. The total number of individuals taking part in group consultation activities is estimated to be over 230.

2.5 Further information about the promotional activity undertaken is provided in Appendix 1 of the attached Consultation Report.

**Responses Received**

2.6 102 responses were received (37 received over the internet and 62 on paper and three by email). Of these 78 were from individuals and 24 were from groups or organisations.

2.7 A list of the organisations/ groups that responded is provided in the attached Consultation Report.

**Response to the Plan’s Vision**

2.8 Those respondents who commented on whether or not they supported the vision, did support it. There were no respondents who stated that they disagreed with the vision. Following consideration of the suggestions made through the consultation, the Checkpoint Group approved the final vision for the plan as:

2.9 “**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.”

2.10 Many respondents highlighted areas of the vision that they believed were a priority, or concerns about the affordability and/ or deliverability of the vision. These issues are discussed further in the Consultation Report (see section 2.2 of the Consultation Report).

Key Themes

2.11 There were a number of key themes which recurred throughout the responses to the consultation questions. Detailed responses for these, and all issues raised, are provided in the Consultation Report (Appendix 1 of this report). Key themes included:

Social integration

2.12 Respondents were keen to emphasise the importance of social integration. This was a theme which appeared strongly across questions in the consultation. Respondents both stressed how important it was to keep people connected to their communities and suggested potential gaps in current provision.

2.13 Social isolation and the importance of supporting older people to be connected to their communities is a strong theme within the Plan. There is growing evidence of the significant risks to health and wellbeing posed by being lonely and isolated. The Plan supports the development of a preventative approach and the Consultation Report includes details of relevant services and sources of information such as day services for older people, the Community Connecting service, the Get Up and Go publication and the range of voluntary and community based organisations that have an important role in reducing the isolation of older people (see sections 1.1.1 and 3.1 of the Consultation Report).

Sheltered housing

2.14 A group response from residents of a housing association sheltered housing scheme and a number of individuals expressed support for an ongoing role for wardens in sheltered housing.

2.15 Warden services are highly valued in providing low level preventative support and access to social activities. However, these are only available to a small number of people in some sheltered housing. Demographic and financial pressures mean it is not possible to provide this for all older people. The Council is currently carrying out extensive consultation on proposed changes to Council managed Sheltered Housing as reported to Health, Wellbeing and Housing Committee on 23 April 2013. These consider whether there is potential to change the role of wardens in Council owned sheltered housing.
Housing

2.16 Generally, respondents were supportive of the aims of the Plan, to support older people to live in their homes where possible and noted the services and supports that enable this to happen. Comments were raised on the availability of suitable housing for older people and housing support services, which were both felt to be important in supporting people to live independently in the community. Other feedback related to housing included points about aids, adaptations and telecare. See section 4 of the Consultation Report.

Advice and information provision

2.17 The need for good quality and accessible information provision to underpin successful delivery of the aims in the consultation document were raised repeatedly. Sections 1.2.2, 3.3, and 4.8 of the Consultation Report provide details of actions underway to improve the availability and accessibility of information, including a series of local information days for older people, improved engagement with and information for health professionals about the services available for older people within the community and the development of a comprehensive directory of services.

Joint working

2.18 This was raised throughout the consultation, both by organisations and by individuals. There were calls for improved joint working both in terms of better communication between agencies, improved location of services (particularly health services) in communities, better sharing of information and expertise and in terms of better strategic partnership working.

2.19 The Plan sets out a commitment to continue to build relationships and further develop the processes and supports required to continue to improve partnership working in Edinburgh. This includes working in partnership at all levels from strategic decision making to working in partnership with individuals in planning and arranging care. Forthcoming legislation for the Integration of Health and Social Care will further support joint working between the NHS, Council and partners. See sections 3.9, 5.6 and 7.3 of the Consultation Report.

Finance

2.20 There was support for the plans but fears that sufficient funding is not available for them to be delivered.

2.21 Section 1.2.1 of the Consultation Report responds to the issues raised. The response acknowledges that funding pressures for public services are very challenging. The Plan sets out how the challenges of limited funding, increasing demands and the need to improve outcomes for older people will be tackled, this includes:

- a focus on preventative rather than reactive care
- shifting the balance of care from institutional to community based care
- redesigning services to be more effective and efficient
- jointly planning future investment and disinvestment, considering the totality of resources available.

Monitoring

2.22 The need for careful monitoring and scrutiny of services as well as of decision making processes was raised by a small number of respondents throughout the questionnaire.

2.23 Ensuring good quality services is a priority within the Plan. The Consultation Report and the Plan provide information about the quality assurance mechanisms in place which include the role of national regulatory bodies such as Healthcare Improvement Scotland and the Care Inspectorate, and local monitoring arrangements, which for social care were set out in a previous report to committee Quality Assurance for Care Provided in People’s Home and in Residential Care. See sections 6.1.4, 7.2.3 and 8.2 of the Consultation Report for further detail.

Transport

2.24 The importance of accessible transport options that can help people to remain connected and reduce social isolation was raised through the consultation, in addition to the particular need for transport to hospital and medical appointments.

2.25 The Plan acknowledges that transport is vital in supporting older people to live in the community and in maintaining connections. In recognition of this important role, arrangements are being finalised to review Community and Accessible Transport across the city. The Review will consider many issues including those identified through the Plan and raised through the consultation feedback. See section 3.5 of the Consultation Report for further detail.

Needs of particular groups

2.26 The needs of the following groups were highlighted through the consultation and responses provided within the relevant sections of the Consultation Report:

- LGBT people (see sections 1.1.6 and 8.1.3)
- older people with drug dependency (2.1.6 and 3.8)
- older homeless people (1.1.6)
- people with Parkinson’s disease (1.1.6)
- services for the hearing impaired (8.1.4)
- older people with mental health issues (3.8, 4.10 and 5.3).
Response

2.27 A response to the issues raised through the consultation process has been developed with input from Council and NHS Lothian partners and this is provided in red italics throughout the Consultation Report (Appendix 1). Many of the issues raised relate to wider work being progressed and the response makes these links and refers to other sources. The response also directs readers to the final Joint Commissioning Plan for Older People, with page numbers to allow for ease of reference.

Final Joint Commissioning Plan for Older People

2.28 The draft plan has been amended to reflect feedback received through the consultation process. The final Joint Commissioning Plan for Older People is attached for Committee consideration and approval (Appendix 2).

Next Steps

2.29 Once approved, the final Joint Commissioning Plan for Older People will be published. A summary document will be produced and key messages from the plan will be communicated to a wide range of stakeholders. The Checkpoint Group will continue to be instrumental in this process, and will also assist with communicating the results of the consultation to those that took the time to respond.

2.30 The final plan includes specific actions within Part Two and these are shown in the draft action plan in Appendix 3 of this report. The implementation of the action plan will be overseen by the Joint Older People’s Management Group. Many of the issues raised require action by other Council departments and partner organisations and links will be made to ensure actions are progressed and monitored. A bi-annual progress report will be produced and reported to the relevant Council and NHS committees.

3. Recommendations

3.1 It is recommended that the Health, Housing and Wellbeing Committee:

- notes the findings of the consultation exercise
- agrees the response to the consultation feedback, as presented in the Consultation Report
- approves the final Joint Commissioning Plan for Older People.

Peter Gabbitas

Director of Health and Social Care

Links
**Coalition pledges**

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<td>P36</td>
<td>Develop improved partnership working across the Capital and with the voluntary sector to build on the “total Craigroyston” model</td>
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<td>P37</td>
<td>Examine ways to bring the Council, care home staff and users together into co-operatives to provide the means to make life better for care home users</td>
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<td>P43</td>
<td>Invest in healthy living and fitness advice for those most in need</td>
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**Council outcomes**

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<tr>
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<th>Description</th>
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<td>CO10</td>
<td>Improved health and reduced inequalities</td>
</tr>
<tr>
<td>CO11</td>
<td>Preventative and personalised support in place</td>
</tr>
<tr>
<td>CO12</td>
<td>Edinburgh’s carers are supported</td>
</tr>
<tr>
<td>CO13</td>
<td>People are supported to live at home</td>
</tr>
<tr>
<td>CO14</td>
<td>Communities have the capacity to help support people</td>
</tr>
<tr>
<td>CO15</td>
<td>The public is protected</td>
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<tr>
<td>CO16</td>
<td>Well-housed – People live in a good quality home that is affordable and meets their needs in a well managed neighbourhood</td>
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<tr>
<td>CO23</td>
<td>Well engaged and well informed – Communities and individual are empowered and supported to improve local outcomes and foster a sense of community</td>
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<tr>
<td>CO24</td>
<td>The Council communicates effectively internally and externally and has an excellent reputation for customer care</td>
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<tr>
<td>CO25</td>
<td>The Council has efficient and effective services that deliver on objectives</td>
</tr>
<tr>
<td>CO26</td>
<td>The Council engages with stakeholders and works in partnership to improve services and deliver on agreed objectives</td>
</tr>
<tr>
<td>CO27</td>
<td>The Council supports, invests in and develops our people</td>
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**Single Outcome Agreement**

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<th>Outcome</th>
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<tr>
<td>SO2</td>
<td>Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health</td>
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<tr>
<td>SO4</td>
<td>Edinburgh’s communities are safer and have improved physical and social fabric</td>
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**Appendices**

- Appendix 1 – Consultation Report and Response
- Appendix 2 – Live Well in Later Life, the Joint Commissioning Plan for Older People 2012-22
- Appendix 3 – Draft Action Plan
JOINT COMMISSIONING PLAN FOR OLDER PEOPLE
2012-2022

CONSULTATION REPORT

What is this report about?
This report presents the findings of a consultation on the draft Joint Commissioning Plan for Older People 2012-22 (referred to as ‘the Plan’). It also provides a response to the issues raised through the consultation process (shown in red italics throughout the report).

Many of the issues raised relate to wider work being progressed and the response makes these links and refers to other sources. The response also directs readers to the final Joint Commissioning Plan for Older People, with page numbers to allow for ease of reference.

What difference will the consultation make?
The views raised in this consultation are important and will be used to inform the development of older people’s services in Edinburgh. This will happen in a number of ways:

- this report provides a detailed summary of what people said during the consultation and has been read and considered by a wide range of people including officers of the Council, NHS Lothian, voluntary and independent partners and Elected Members
- the points made through the consultation have led to changes being made to the final Joint Commissioning Plan for Older People
- an action plan has been developed based on the Joint Commissioning Plan for Older People and the consultation feedback, which is available along with this report on the Council’s website
- the implementation of the action plan will be overseen by the Joint Older People’s Management Group (shown within the Governance section on p69 of the Plan). Progress reports will be produced and reported to the relevant Council and NHS committees.

When was the consultation?
The consultation was held from 18 September – 21 December 2012. A small number of responses were received after this date and these were incorporated into the analysis.

Who was consulted?
The consultation was open to any member of the public who wished to contribute. Responses were received from individuals and groups. This report is anonymised but a list of groups and organisations that responded is shown below.
How were they consulted?
Based on a model used in previous successful consultations, a Checkpoint Group (Appendix 2) was established to provide advice on the approach to communication and engagement. The Checkpoint Group has been instrumental in developing the draft vision for the Plan along with engagement tools and materials used during the consultation.

A consultation summary document was produced which included a summary of the Plan along with ten questions. The ten questions could also be responded to through an e-consultation on the Council’s website. The full Plan was available on the Council’s website or paper copies could be requested. Submissions were also received by email. A phone number was also given for any queries.

A range of promotional activity took place from August 2012 to raise awareness of the consultation and to encourage responses to be made. This included:

- **general promotion**, including 2000 flyers mailed to a random sample of social care service users, circulation of an electronic newsletter to networks including over 500 people and promotion on the Council website homepage and partner websites
- presentations were made and feedback recorded at a range of **management and team meetings**
- presentations/discussions were held with a range of **external service providers**
- a range of **consultation forums** and groups were held for service users and stakeholders. The total number of individuals taking part in group consultation activities is estimated to be over 230.

Further information about the promotional activity undertaken is provided in Appendix 1.

How many responses were received?
102 responses were received (37 received over the internet and 62 on paper and three by email). Of these 78 were from individuals and 24 were from groups or organisations. These latter responses were comprised of both a single response on behalf of an organisation and responses which contained disparate views of people from a focus group or similar consultation event.

How will the results of the consultation and the final Plan be communicated?
Once approved, the final Joint Commissioning Plan for Older People will be published. A summary document will be produced and key messages from the Plan will be communicated to a wide range of stakeholders. A Communications Plan is being developed to ensure that we feedback to all who took part in the consultation the action that has taken place (“You Said, We Did”). The Checkpoint Group will continue to be instrumental in this process, and will also assist with communicating the results of the consultation to those that took the time to respond.
How were the consultation responses analysed?
This report attempts to represent all comments received. However, some have not been able to be included. Reasons for this include:
  • the meaning of the response was unclear or ambiguous
  • the writing could not be deciphered.

This report has generally not stated the number of people who gave a particular answer. This is for a number of reasons. Firstly, there is a risk of misrepresenting the exact number of people who held a particular view as responses cannot always be clearly categorised in this way. Also some group responses contain disparate views so it is impossible to know how many people at a consultation event held the view reported. Given these problems, trying to count the number of people who held each and every view reported in this paper would give a misleadingly quantitative nature to what is essentially a qualitative consultation and report. Where the number of respondents are counted this is usually because there were very small numbers of people who held a particular view.

This report thematically presents the responses given under each consultation question. The report reflects the most common issues raised under each question, illustrated by quotations where appropriate. There is no reference to names or personal details in the report. A summary of the responses to each question is given at the end of each chapter.

Whilst it was challenging to construct this summary due to the disparate nature of the comments, it is important to note that all responses have been read in full to inform changes to the Plan and to provide input to future planning and decision making. Where relevant, specific comments have been shared with the responsible department of the Council and NHS to which they relate, for example transport and housing.

There is a final section which briefly outlines the key themes which appeared repeatedly throughout each or most of the consultation question responses.

Group/ organisational responses were received from:

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<td>1</td>
<td>Abbeyhill Tenants Organisation</td>
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<td>A city of all ages consultation group</td>
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<td>3</td>
<td>A city of all ages consultation group</td>
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<td>4</td>
<td>Broomhouse Centre ( Beacon Club , Elderly Befriending Project, Adult Carers project)</td>
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<td>5</td>
<td>City of Edinburgh Council Health and Social Care sector managers meeting</td>
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<td>6</td>
<td>City of Edinburgh Council Health and Social Care home care managers meeting</td>
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<td>7</td>
<td>City of Edinburgh Council Health and Social Care day service managers</td>
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<td>8</td>
<td>City of Edinburgh Council libraries and information senior management team</td>
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<td>9</td>
<td>City of Edinburgh Council Services for Communities managers, senior officers, assessment, homelessness and support</td>
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<td>Edinburgh Voluntary Organisations Council (EVOC)</td>
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<td>11</td>
<td>John Kerr Court Group</td>
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<td>Lesbian, Gay and Transgender Centre for Health and Wellbeing</td>
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<td>13</td>
<td>Lothian Centre for Inclusive Living (LCiL)</td>
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<td>14</td>
<td>MILAN consultation group</td>
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<td>15</td>
<td>(Name not decipherable)</td>
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<td>16</td>
<td>Nari Kallyan Shangho (NKS) (South Asian Older Women’s Group)</td>
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<td>17</td>
<td>Parkinson's UK</td>
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<td>18</td>
<td>Residents from Deanhaugh Street Sheltered housing (Trust HA)</td>
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<td>Scottish Care</td>
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1 OUR VISION

75 of the 102 responses commented on the vision under question 1, Our Vision. The draft vision read:

“Edinburgh is a city which values older people and respects 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 their communities
- have choice and control to access quality care and support.”

Those respondents who commented on whether or not they supported the vision, did support it. There were no respondents who stated that they disagreed with the vision. Most respondents highlighted areas that they believed were a priority, or supported the vision but had doubts about the deliverability of all or aspects of it.

Responses are divided into two main categories: areas that respondents wanted prioritised and comments relating to the deliverability of the vision.

1.1 AREAS FOR PRIORITISATION

1.1.1 Social integration (see also paragraph 3.1)

Respondents were keen to emphasise the importance of social integration. This was a theme which appeared strongly across questions in the consultation. Respondents both stressed how important it was to keep people connected to their communities and commented on the inadequacy of current provision.

In terms of current provision comments included:

- ‘Where are the lunch clubs?’
- ‘Integration with locals in the Old Town has disintegrated over the years.’
- ‘There are not enough activities for older people.’
- ‘Need better quality day centres with more variety of things to do.’
- ‘Some communities are much better placed to serve older people. Others can be completely without facilities.’

In terms of solutions, one respondent stated that media collaboration is required to raise awareness of the need for volunteers. Another suggestion was for befrienders to reduce social isolation.
Social isolation and the importance of supporting older people to be connected to their communities is a strong theme within the Plan (see p42 of the Plan).

The Commissioning Plan for Social Care Day Services for Older People 2012-17 sets out the Council’s commitment to support and further develop day services in the city. Priorities 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 occupational therapists.

The above plan for Day Services for Older People builds on the findings of the Review of Lunch and Day Clubs undertaken in 2010-11. The review confirmed the significant impact that attending a lunch or day club can have on improving the quality of life of service users and volunteers.

Information about current day services and lunch clubs in the city is available through a directory on the Council’s website www.edinburgh.gov.uk/directory/105/day_services

A city wide Community Connecting service has recently been established to work 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. Further information about the service can be found at www.edinburgh.gov.uk/info/1456/older_people/1857/community_connecting

Another good source of information about opportunities for older people is the Get Up and Go programme which is available from Council offices, Edinburgh Leisure sports centres, libraries and medical centres or you can request a copy from getupandgo@edinburgh.gov.uk 0131 529 7844.

An online directory is being developed to provide comprehensive information about services and activities in Edinburgh, which will also be available for print.

1.1.2 Social integration for those with particular needs

Several respondents also commented on the importance of socially integrating those with particular needs. Two of these comments related to people with dementia. One stated that people with dementia are left home
alone for too long. Another stated that people with dementia will need a consistent volunteer throughout the duration of their illness if they are to remain connected to communities.

The Edinburgh Dementia Implementation Plan (see p55 and p74 of the Plan) is currently being developed to ensure that people with dementia and their unpaid carers can access the support that they need when they need it. An important aspect of the plan will be supporting people with dementia and their unpaid carers to remain connected to their communities.

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 and integrated care pathway
- Quality of dementia care in care homes and hospitals
- Ensuring services and support is in place for people with early onset dementia.

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. Funding has been agreed as part of the Change Fund for a two year period from 2013, to establish dementia link workers in Edinburgh. A link worker will be assigned to work with the person with dementia, their family and carers in co-ordinating support and building a person-centred plan.

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.

One person asked how those who are housebound will be supported to participate in the community.

People who are housebound can be supported through a range of opportunities including centre based day services, one to one day services, lunch and day clubs, Community Connecting and other voluntary sector services and supports for older people.

The Innovation Fund, part of the Change Fund for Older People, has invested in around 20 voluntary sector projects, many of which support older people who are housebound. Additional funding has also been provided to
Community Transport operators in Edinburgh to support older housebound individuals who find it difficult to access public transport.

One respondent stated that care homes often do not prioritise going into the community, concentrating instead on in-house activities. They cited one gentleman who had not been outside his care home for three years, despite being able to do so, and enjoying doing so, when matched with a volunteer.

We are concerned if people are not supported to engage in activities outside of a care home. The importance of care homes being part of the local community is highlighted in the Plan (p58). The National Care Home Contract also includes this within clause B.2.1, which states that services should be tailored to suit each individual resident to promote a number of outcomes, including: “to see people and engage socially”, “to have things to do that they enjoy” and “to feel part of a community”.

Within Edinburgh work is underway to support the development of these links includes:
- funding and implementation of the ‘My Home Life’ programme within 30 care homes in the city (independent and Council care homes)
- establishment of a care homes investment fund for care homes to develop innovative work, with a focus on making connections with the local community and improving outcomes for residents
- the development of tools to support the personalisation of care home services including life story work, reminiscence therapy and meaningful activities (eg ‘Making Every Moment Count’).

1.1.3 Access for those with physical disabilities

Linked to comments on social integration were those on the need to improve the accessibility of the city and its facilities. This included improved accessibility of buses, push button crossing at all bus stops, improved bus routes, handrails by steps, more benches needed in city centres and shops.

The need to improve accessibility of the city and its facilities is recognised and these comments have been passed on to relevant Council departments. Some examples of work underway to address these issues are provided below.

The ‘Streets Ahead’ Road Safety Partnership (includes the Council, NHS Lothian, police and other partners) includes older people as one of the priority groups in delivering safer roads.

A City for All Ages Advisory Group is working with Edinburgh College of Art - based I’DGO (Inclusive Design for Getting Outdoors), the College’s multi-disciplinary research centre which specialises in providing evidence that access to outdoor spaces matters for people of all ages and abilities because it has “a valuable approach to realising age-friendly cities”. Edinburgh is now recognised by the World Health Organization as an Age-Friendly city.
Neighbourhood Partnerships across the city provide a forum for concerns and suggestions to be raised with the Council staff responsible for environmental and infrastructure improvements:  www.edinburghnp.org.uk

1.1.4 Housing

Two respondents commented on the need to support people to remain at home for as long as possible. There was one comment that telecare and telehealth should be available in private retirement flats.

There were a small number of comments under the vision relating to the role of sheltered housing and wardens. Two respondents raised concerns about the availability of services for people with mental health problems. There was one concern that older homeless people are often excluded from sheltered housing due to previous behaviour often linked to mental health issues.

Most older people live in mainstream housing. As a result the Council’s priority is to support people to remain in their own home. The Community Alarm Telecare Services mean older people can receive on call services regardless of where they live. Telecare allows a variety of technology supports to be provided irrespective of location. For example, fall detectors, heat and smoke detectors, cooker isolators, flood detectors, bed occupancy sensors and GPS safer walking systems.

Telecare is available across all tenures. Further information about how to access these services is available on the Council’s website at www.edinburgh.gov.uk/info/1453/care_and_support_at_home/1220/personal_alarms_and_monitors.

Warden services are highly valued in providing low level preventative support and access to social activities. However, these are only available to a small number of people in some sheltered housing. Demographic and financial pressures mean it is not possible to provide this for all older people. The Council is currently carrying out extensive consultation on proposed changes to Council managed Sheltered Housing as reported to Health, Wellbeing and Housing Committee on 23 April 2013. These consider whether there is potential to change the role of wardens in Council owned sheltered housing.

The Commissioning Plan for Homelessness Prevention 2011-2016 outlined a move to targeting funding at housing advice and support for individual older people. This involves working with other sheltered housing providers to look at ways in which low level support and community links can be delivered to those in mainstream accommodation as well as sheltered units. It also includes a continued focus on services which help people to stay in their own homes where appropriate. This includes Community Alarm and Telecare Services, advice services and the provision of adaptations.

People with mental health issues are not excluded from sheltered housing and additional support services are available for those who need them.
Specialist accommodation services are available for those with the most complex needs.

1.1.5 Independence

A number of responses stressed the importance of supporting independence for as long as possible. However, there was one response suggesting that sometimes maximising independence may not be a person’s priority, for example if they wish to save energy for work or a certain activity they may require more assistance with personal care.

*We want all services for older people to work in a person-centred way, focusing on building on an individual’s abilities rather than focusing on the things that they are unable to do. However, in being person-centred, services will also be built around an individual’s own goals and priorities and will recognise that there are times when, and activities with which, they need support.*

Specific comments on the wording of the vision included:

- change ‘older people feel’ to ‘older people are’:
- a city where older people are safe, are involved
- the city enables, encourages interdependence
- the city supports people to be as independent as possible for as long as possible
- the city responds well and sensitively to dependency.

*All comments received in relation to the wording of the vision were considered by the Checkpoint Group who agreed the final wording to be included in the Plan.*

1.1.6 Requirements of specific groups

*Parkinson’s*

A response from an organisation that supports people with Parkinson’s stated that people with this condition under 65 can find it harder to acquire services than those who are older. They welcomed the recognition of the need for specialist services and stated that specialist professionals are vital for people with Parkinson’s. They further stated that people with Parkinson’s require ongoing or repeated interventions rather than one off re-ablement.

*The response received is welcomed by the Partnership, in both highlighting issues that specifically relate to people with Parkinson’s, and also points that have relevance for people with other conditions. We will also share these comments with colleagues who are developing services for younger people.*

*It is acknowledged that there can be issues in the transition from services for ‘adults’ to ‘older people’. The response gives an example of people under 65 with Parkinson’s who find it more difficult to access services than people over 65. We are however also aware that some people are able to access services*
related to their condition or disability when they are under 65 and feel that more generic services for over 65s do not meet their specific needs. The Plan states a commitment to ensuring that care and support arrangements are tailored to individual needs and are not restricted by categories such as age (p9 of the Plan). Many services including Homecare, Re-ablement and Intermediate Care are for people under and over 65 years of age. The Personalisation agenda should also help to address these issues.

Lesbian, Gay, Bisexual and Transgender (LGBT)
A response from an LGBT organisation suggested that the plan should more explicitly state how the vision of care applies to LGBT people. They stated that more needs to be done to ensure services are emphatically welcoming to LGBT people and that this is actively communicated to people from these communities. They stated that fear of discrimination by providers or other service users leads LGBT people to access services at a later point than the mainstream population (the Social Attitudes Survey reported that prejudiced attitudes are most prevalent amongst older people). They felt that the move to home based and peripatetic services would be preferable to LGBT people.

The level of consultation and response provided from the LGBT community has been gratefully received by the Partnership.

Funding has been awarded through the Change Fund for Older People, for the LGBT Age Capacity Building Project, which is working with mainstream organisations to increase understanding and enable organisations to better meet the needs of older lesbian, gay, bisexual and transgender (LGBT) people and to comply with the Equality Act (2010)’s general equality duties. The need for all services to do more to welcome LGBT people has been acknowledged and the Council, NHS, voluntary and private sector providers are working with the LGBT Age project to address issues raised through this consultation and more broadly.

Further information is provided in section 8 Equalities.

Homelessness
One respondent commented that the plan does not state how it will meet the needs of homeless people, beyond a reference to the homelessness prevention plan. It was stated that solutions do not exist for this very vulnerable group who at present who are often excluded from sheltered housing due to previous behaviour.

The issue of homelessness is dealt with through the Commissioning Plan for Homelessness Prevention 2011-2016. This Plan sets out how the Council will commission services to prevent homelessness across all groups of people including vulnerable people and those with complex needs. Some housing is available specifically for older people with complex needs. There are also additional support and care services for those who need them whether they live in sheltered housing or in mainstream housing.

1.2 DELIVERABILITY OF VISION
1.2.1 Finance

Concerns were raised about the affordability of the vision. This was a concern which appeared across questions.

There were also individual requests to protect the funding of equipment services and sheltered housing. There was one request not to have means testing.

The Partnership acknowledges that whilst a vision is intended to be aspirational, it also needs to be achievable. The strategy sets a vision that all partners can contribute to the delivery of, over the life of the Plan.

Funding pressures for public services are very challenging and the Plan sets out how the challenges of limited funding, increasing demands and the need to improve outcomes for older people will be tackled, this includes:

- a focus on preventative rather than reactive care
- shifting the balance of care from institutional to community based care
- redesigning services to be more effective and efficient
- jointly planning future investment and disinvestment, considering the totality of resources available.

Whilst public finances are under significant pressure, the importance of health and social care and the growing demands of the population have been recognised. For example, 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 living with complex conditions. The Council agreed the 2013/14 budget on 7 February, and this included an additional £2.25 million to provide care for older people in their own homes, along with other decisions to support people with physical and learning disabilities, unpaid carers and continued grant funding for voluntary and community organisations.

The Joint Commissioning Plan sets out specific actions that will contribute to the delivery of the vision, many of which already have funded committed and are underway. The actions will be monitored and evaluated to inform future investment and disinvestment decisions.

1.2.2 Information provision and access (see also paragraphs 3.3, 4.8, 5.11)

There were several comments on the need for improved information if the vision was to be deliverable. This included information on services, referral routes and criteria. This information needs to be available to those who do not have computers.

The importance of good quality information which is available in a range of formats, when people need it, is recognised to be key, not only to the delivery of the aims of the Plan (p44), but to wider health and social care strategies. In
order to deliver choice and control to people, they need to have good information about what support is available and how to access it. This is a key priority for the Partnership in relation to the Reshaping Care for Older People and Personalisation programmes. Examples of work underway include:

- a ‘Live Well in Later Life’ Information Day was held on 27 November 2012 at the Assembly Rooms, promoting support for older people provided by over 30 organisations
- building on the success of the above event, a series of local information days are being planned for 2013, starting in the West of the city on 23 April
- information packs have been developed and shared with primary and secondary health teams
- a mapping exercise is being undertaken of all providers of care services, including grass roots groups and organisations
- development of a comprehensive online directory of services
- a ‘Life Planning’ campaign is planned to raise awareness of some of the important issues for older people and encourage early consideration and planning for the future.

One response stated that there is a strong feeling that the current system only works for those who have someone to fight on their behalf.

Many older people have friends, family or carers that help them to ‘navigate’ the care system and to speak on their behalf when they feel unable to. However, we need to make sure that the right care and support is available to everyone who needs it, including those who do not have anyone to act on their behalf.

All individuals receiving a social care service will have their needs assessed and have a written care plan which will be regularly reviewed. Social care teams (which include social workers, occupational therapists and/or community care assistants) have a care management role which includes ensuring that appropriate services are in place to meet the needs of the individual.

For those that require additional support in having their views and opinions represented, the Council and NHS Lothian fund independent advocacy services, further information is available at www.edinburgh.gov.uk/info/1350/asking_for_support/733/independent_advocacy/1

Many local voluntary organisations based in communities can provide information and advice on the above.

1.2.3 Choice and Control

Whilst there were comments supporting choice and control, there was also one concern about the administrative hurdles this would create.
One group stated that self directed support was not mentioned in the questionnaire and that they wish to see all four options available to older people.

The Personalisation Programme being taken forward in Edinburgh (see p75 of the Plan) focuses on investment in prevention, promoting independence, choice and control for people who use service and supporting them to achieve their desired outcomes. Options offered through Self Directed Support legislation will allow people to have greater choice and control. The four options are detailed below, people will also be able to choose to maintain their existing service arrangements if they wish. Processes to support Personalisation and Self Directed Support are being very carefully considered to ensure that any ‘administrative hurdles’ are minimised.

The four options to be made available as part of the Self Directed Support legislation are set out in the Plan, on p75, and are:

- **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.


A ‘Network’ has been established to engage with people who use or have used social care services, carers and other interested members of public, to help shape future services. A series of events are being held, if you would like to be involved in the Network please contact Glenda Watt glenda.watt@edinburgh.gov.uk or telephone 0131 469 3806.

Web pages are currently being developed to ensure that the public, service users, providers and staff are kept informed of how the Personalisation Programme is progressing, in preparation for the national commencement date of 1 April 2014.

One response suggested moving to a model used in France where groups of older people come together to employ care workers to help them.

The model described is a form of cooperative. The City of Edinburgh Council are committed to a cooperative approach and have produced a ‘Framework to
Advance a Cooperative Capital 2012/17: This includes consideration of how such a model could be developed within social care services in Edinburgh.

Voluntary organisations such as Lothian Centre for Inclusive Living exist to work with people in receipt of Direct Payments to help organise solutions that work for the people involved.

There were two comments that currently City of Edinburgh Council’s care services do not take account of clients’ needs and preferences.

When people are assessed for a service, the needs and preferences of the service user should be discussed and a personal plan developed. The partnership is committed to improving this process by further developing a ‘personal outcomes approach’ within all services and support for older people in Edinburgh. We acknowledge that there is much work to be done. This work 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 of the Plan). Many services already use tools such as ‘Talking Points’ which is an evidence based approach to care planning based on individual outcomes.

1.2.4 Joint working (see also paragraphs 2.1.4, 3.9, 5.7)

Two responses from organisations raised concerns about the inadequacy of current joint working. One stated that poor communication led to inappropriate support packages, delays in care packages and resulted in stress and inefficiency. A second response related to including the voluntary sector more effectively. Firstly they stated that third sector professionals, and not just health professionals, should be enabled to assist people to direct their own support. Secondly they stated that transport operators should work with commissioning partners to resolve issues around investment in community transport.

The Plan sets out a commitment to continue to build relationships and further develop the processes and supports required to continue to improve partnership working in Edinburgh (p11 of the Plan). This includes working in partnership at all levels from strategic decision making to working in partnership with individuals in planning and arranging care. Key themes in the Plan include Co-production, Asset-based approaches and Person-centred care, which all emphasise the importance of joint working and the development of reciprocal relationships (p9 of the Plan).

The voluntary sector are a key partner in the development of the Personalisation Programme and wider change programmes and further engagement and consultation is planned to develop the points raised through
this consultation further. See section 3.5 for further information about transport.

1.2.5 Other comments

Other comments included:
‘Nothing really changes. Good to have dreams but not going to happen.’
‘Would like to feel EQUAL and not treated as OLD.’
‘Equal is not something you feel when you are ill and vulnerable.’
Recognise and value older people’s skills.
Keep universal benefits for older people, but consider taxing.
(Unpaid) Carers need step by step training and monitoring.
Edinburgh Council is excellent.
Delivery is important in bullet three of the vision ie ‘access to and receive quality care and support’.

SUMMARY OF RESPONSES TO THE VISION

The vision was supported by respondents.

To deliver the vision, people were concerned that there needs to be adequate financing and resources, better provision of information and advice, better attention to people’s needs and preferences and improved joint working.

In terms of priorities, people spoke about the need for social integration of older people, improved physical accessibility of the city for people with disabilities, and supporting independence. There was also concern that the particular needs of people with Parkinson’s disease, people who are homeless and LGBT people should be recognised and catered for.
2 FINANCIAL IMPLICATIONS

86 of the 102 responses commented on question 2, the financial implications of the plan.

Responses were supportive of the move to preventative services. However, there were some concerns raised about taking money from hospital services to support community services and concerns that caring for some people in the community was inappropriate or placed additional pressure on unpaid carers.

Responses divide into two main categories, ‘priorities’ and ‘concerns about plans.’

2.1 PRIORITIES

2.1.1 Support to stay at home

Comments were made about the investment that was required in care workers and equipment to enable people to stay at home.

*The partnership acknowledge that investment is required to ensure that the services and supports are available to enable people to live at home (see p32, the Financial Framework section of the Plan). Significant additional investment in care workers and equipment has been made through the Change Fund, including an additional £1m for the Re-ablement service, £1m in Intermediate Care services, £1.5m in Care at Home services and £200k in equipment and adaptations.*

There were a small number of criticisms of current home support, such as very small time allocations for care workers’ visits, and also the low pay of care workers and poor organisation of care workers.

*See response under section 7 “Our Workforce”.*

There were three comments about improving after hospital care, including the need for hospital staff to highlight when patients need home adaptations.

2.1.2 Support in the community

A range of suggestions were made about reducing social isolation and improving health including, inter-generational activities, community Hubs, befriending services, increasing ease of access to day centres, providing door to door transport and involving older people in useful ways in community activities, access to advice and advocacy, access to gyms and health promotion activities. There was praise for the ‘Ageing Well’ programme run by Edinburgh Leisure.
See response under 1.1 and 3.1 of this report which relate to social isolation.

There was a comment that preventative services should be made quickly available when needed (avoiding long waits, form filling and means testing) if there are to be effective in reducing the need for more intensive or hospital services.

There was a statement that there is a need for strategic thinking, including transport and increased support for Local Area Co-ordinators.

See section 3.5 of this report for further information about transport.

There was a comment that cuts to community services, such as district nursing, should be stopped.

The economic and demographic pressures faced by NHS, Council, third and independent sector services are acknowledged and the Plan sets out a commitment to work together to make the fullest use of available resources. All services are expected to be as efficient as possible and to work in new ways to deliver the best outcomes for older people. With specific regards to community nursing services, there have been considerable investments made recently to a range of community based services, including enhancements made to specialist community nursing services (£180k per year) via the Edinburgh Change Fund.

There was one comment that that those ‘on the dole’ should be used as community volunteers.

Many people who are out of work access volunteering opportunities. Volunteers make a huge contribution to supporting older people, and this is recognised in the Plan (p43). Volunteering can also have many positive outcomes for those that volunteer, including improving their own health and wellbeing, and supporting a route into paid employment. Edinburgh’s volunteering strategy ‘Inspiring Edinburgh’s Volunteers – Building on Success 2012-2017’ states that: “approximately 60% of volunteers accessing Volunteer Centre services in 2010-11 reported help into paid work as their primary motivator for volunteering.” The Partnership supports this Strategy.

2.1.3 Sheltered housing (see also paragraphs 3.2, 4.2, 5.9)

A group response from residents of a housing association sheltered housing scheme and a number of individuals expressed support for an ongoing role for wardens in sheltered housing. It was suggested that a cost benefit analysis should be undertaken before any decisions are made about changes. There was one comment about the need for an equalities review of sheltered housing.

There was one comment that there is a need for housing which gives greater support than sheltered housing but is not a care home.
The response outlined in section 1.1.4 gives further details about the future approach to sheltered housing. The cost benefit analysis suggestion is a good one and any review of services will include a cost benefit analysis.

An Equalities Impact Assessment would be undertaken as part of any service change.

There was one comment that there is a need for housing which gives greater support than sheltered housing but is not a care home.

There are a number of very sheltered or extra care housing developments in the City which can be an option for those who need additional care. Elizabeth Maginnis Court is a good example of housing with care. This model of housing allows additional support to be tailored to individual needs therefore helping tenants to retain as much of their independence as possible. Support can be increased or decreased over time as needs change. However, the use of adaptations, community alarms, telecare and care and support packages can also help some people to remain in their own home for longer than was previously possible.

2.1.4 Joint working

There were several comments about the need for joint working between health and social care. One stated that there was a need for visits from a multi-disciplinary team for people at high risk of admission. One stated that there should one bank of healthcare/social care workers, with the same job description, status and training, to provide emergency care at home. Related to this, there was also a comment that staff need to provide holistic support rather than sticking rigidly to parameters, such as only providing housing support.

The Plan sets out the Partnership’s clear commitment to improved joint working (p11 of the Plan). Forthcoming legislation will support the further Integration of Health and Social Care.

The COMPASS model (p54 of the Plan) of enhanced care for older people has been tested in the South East of the city. A key element of this work has been the establishment of multi-disciplinary working arrangements to identify older people at high risk of hospital admission and jointly plan care to support the individual and avoid hospital admission where appropriate.

There were two comments about the need for greater partnership working with the voluntary sector. One response stated that the voluntary sector should be invested in as they have expertise in community based services. A second response stated that commissioning needs to move to a partnership approach and encourage a range of providers.

There is a strong history of partnership working with the voluntary sector in Edinburgh, from a strategic level such as the Edinburgh Partnership, through
to joint working at a local level. The development of the Joint Commissioning Plan for Older People, and the associated Change Fund, has been an opportunity to build on and strengthen existing relationships.

Significant investment has been made in the voluntary sector, recognising their expertise in community based services for older people and demonstrating a commitment towards partnership working. £1.2m was allocated through the Change Fund for a range of developments lead by the voluntary sector, including the Innovation Fund which has supported more than 20 innovative projects which support older people in the community. This work is being closely evaluated (p67 of the Plan), the results of which will inform future funding decisions.

Health and social commissioning is increasingly using a partnership approach and this is emphasised in the Plan (p40). Examples include the Reprovisioning of the Royal Edinburgh Hospital which is using a Public Social Partnership model.

Work is currently underway to develop a Market Shaping Strategy which sets out how we will work with providers to ensure the provision of diverse, appropriate and affordable health and social care services, to meet the needs and deliver effective outcomes now and in the future.

2.1.5 Health care

There were two comments that there is a need to improve waiting times. There was a comment that there is a need for more rehabilitation, more investment in allied health professionals to allow patients to go home earlier and better transport to hospital.

Waiting times is a key measure in monitoring the performance of all health and social care services. Issues around waiting times in hospitals have been widely reported in the media. NHS Lothian treats the need to meet waiting times targets as one of its main priorities, and it is now a legal requirement for NHS organisations to meet these targets. Substantial staffing and financial resources are being invested to improve waiting lists within NHS Lothian.

The Plan states that rehabilitation is integral to delivering the aims of Reshaping Care for Older People (p47). The Change Fund in Edinburgh is supporting increased levels of therapy for patients. This is within some hospital services, but mostly within the community. The Intermediate Care Service in Edinburgh provides therapy to patients within their own homes. This service has had an increase of more than 12 members of staff from the Change Fund, which is allowing it to increase the number of patients who can benefit from home-based therapy.

The redesign of orthopaedic and stroke pathways for older people (p35 of the Plan) is a good example of how investment in rehabilitation at home can reduce an individual’s length of stay in hospital, delivering better outcomes for the individual as well as being a more cost effective service model. The
Partnership continues to explore how services can be re-shaped to better meet the needs of the older people who use our services, along with how to do this in the most cost effective way.

Step Down beds are currently being developed within Edinburgh and will provide a place for people who are medically able to leave hospital but who are not ready or able to return straight home. The Step Down beds which are to be provided within a small number of care homes in Edinburgh from October 2013, will provide an opportunity for time (up to around 6 weeks) for further recovery and rehabilitation and time to prepare for moving on to an appropriate setting, which in many cases will be back home.

2.1.6 Needs of particular groups

Several respondents highlighted the importance of early diagnosis in dementia and appropriate information and support following this up.

Early diagnosis and post diagnostic support for people with dementia is a national priority and a national ‘HEAT’ target will be implemented by 2015. Within Edinburgh, proposals are currently being developed for how this will be implemented, as part of the Dementia Implementation Plan (see section 1.1.2).

Funding has been agreed as part of the Change Fund for a two year period from 2013, to establish dementia link workers in Edinburgh. A link worker will be assigned to work with the person with dementia, their family and carers in co-ordinating support and building a person-centred plan.

One response stated the need for specialist staff for people with Parkinson’s.

Specialist support – see comments above at 1.1.6.

There was one comment that staff should be trained in the needs of older people with drug dependency.

An allocation has been made from the Change Fund to consider the current and future needs of older people that misuse substances and also the training requirements of staff supporting these people. Links are made with the “Edinburgh Alcohol and Drug Partnership Commissioning Plan: Commissioning For Recovery 2012-15”.

One response stated that some people have cultural needs.

See section 8.1.7 of this report about recognising and responding to different needs of service users.

2.1.7 Monitoring

There were a number of comments relating to monitoring and decision making. These included that services need to be rigorously monitored,
reviewed, Best Value options appraisal test applied to decisions and services funded if they can evidence efficiency and reductions in hospital admissions.

Health and social care services are subject to external scrutiny from Healthcare Improvement Scotland and the Care Inspectorate (p30 of the Plan). In addition, local quality assurance frameworks are in place which take a proactive approach to risk management and support intervention where necessary. A report from November 2012 outlines arrangements for Quality Assurance for Care Provided in People’s Home and in Residential Care.

Options appraisal is an important part of the commissioning cycle (p39 of the Plan) and is clearly built into the Council’s Contract Standing Orders [www.edinburgh.gov.uk/downloads/file/8897/contract_standing_orders](http://www.edinburgh.gov.uk/downloads/file/8897/contract_standing_orders). Further information about evaluation and monitoring of the Plan is provided on p67 of the Plan.

### 2.2 CONCERNS ABOUT PLANS

#### 2.2.1 Concerns about shifting funding from hospital to community based services

Several respondents stated that it was unrealistic to expect hospital and long stay services to receive less funding, especially due to changing demographics. There were concerns about the impact on patient care if this happened. It was stated that community services need to be built up before hospital services can be reduced.

However one group response explicitly stated their support of releasing finances from Health into community based services.

There was one comment that it is right to shift the balance but there is a still a need for medicalised respite services.

There was one comment that it will take 20 to 25 years to reach the proportions of resource redistribution stated in the consultation chart.

The Partnership acknowledges the challenges outlined in the responses above. The Scottish Government’s Reshaping Care for Older People strategy emphasises the shift in resources required. The strategy focuses on the national spend on emergency hospital admissions for +65s of £1.4b (32% of total spend) set against only a 7% spend on homecare. The national strategy suggests that whilst some emergency hospital admissions are necessary, many are avoidable through effective preventative action and if the right supports are available in the community. The purpose of the Change Fund for Older People was to enhance community and preventative services in order to reduce the number of avoidable admissions to hospital and to facilitate a shift in the current balance of care and resources towards the community.
To release funding from a hospital setting is very challenging and will require investment in prevention and community-based services to enable the release of resources. Delivering new models of care may require the closure of hospital beds and this will require political and public support. The Plan also emphasises the need to change the way that services are designed and delivered and provides examples for how it is possible to deliver more cost-effective services that also deliver better outcomes for older people, for example the improvements in orthopaedic and stroke pathways for older people outlined on p35 and the Re-ablement service on p48 of the Plan.

2.2.2 Concerns about the implications of supporting people at home

A couple of concerns were raised about the impact on people of being supported at home. Concerns were raised about dementia patients being expected to manage at home, about home-based support being able to prevent issues such as depression and alcohol abuse, and about the impact on unpaid carers. There was one comment that more care homes are desperately needed.

Research shows that most older people, including those with dementia, want to stay in their own home for as long as possible. The Plan aims to ensure that support is available to allow people to live well at home wherever this is possible and that care and support is tailored to the preferences of the individual.

Delivering a shift in balance of care requires the appropriate services to be available in the community, both in terms of capacity and responsiveness. Significant additional investment has been made through the Change Fund, including an additional £1m for the Re-ablement service, £1m in Intermediate Care services, £1.5m in Care at Home services, £300k for the Homecare Overnight Service and £200k in equipment and adaptations. Further detailed capacity planning work is underway to determine the number of beds and service capacities required to meet future demands.

The Plan recognises the essential contribution made by unpaid carers in providing the majority of care and support in Edinburgh (p27 and 45). The Plan includes specific actions to support unpaid carers, also linked to Edinburgh’s Carers’ Plan (Towards 2012) which is currently being reviewed. See section 3.7 of this report for further information.

Unpaid carers have a right to a carers’ assessment of their own needs. We need to work with unpaid carer organisations to increase awareness of the carers’ assessment and the support options available.

A particular focus on people with dementia and their unpaid carers is being developed through the Edinburgh Dementia Implementation Plan, considering what is already available across the city and where the gaps are. The work streams being progressed are outlined at section 1.1.2.

2.2.3 Concerns about levels of resources
One group response stated that direct payments are currently often not enough to cover care needs, requiring people to supplement from their own resources. They doubted that funding would be sufficient to allow people to receive respite at home without reducing the duration of this.

Concerns were raised about a two tier system with some people being able to top up their care and others not being able to.

These concerns are recognised and are being considered through the developing work of the Personalisation Programme (p75 of the Plan). The Financial Framework work stream has been charged with taking work on the development of a funding allocation system forward and part of this work will be to ensure that funding allocations are sufficient to meet care needs. A ‘Network’ has been established to engage with people who use or have used social care services, carers and other interested members of public, to help shape future services. A series of events are being held, if you would like to be involved in the Network please contact Glenda Watt glenda.watt@edinburgh.gov.uk or telephone 0131 469 3806.

2.2.4 Concerns about contracts

One response raised concerns about the ending of block contracts and increase in direct payments leading to an atomised and fragmented market of many different small care organisations who may not be able to provide a high level of quality care due to lack of volume of users.

One group requested a consultation on the move to contract ‘bundles’ based on the level of intervention of the persons’ needs.

These are important points that will continue to be considered through the development of the Personalisation programme. Work is currently underway to develop a Market Shaping Strategy which will set out how the Council proposes to facilitate the provision of diverse, appropriate and affordable health and social care services to meet needs and deliver effective outcomes, now and in the future. The draft strategy will be published in summer 2013 and will undergo a full consultation. The Strategy will:

- offer provider organisations assistance with their business planning processes by providing access to detailed intelligence on current and future health and social care needs in Edinburgh, and by identifying opportunities to fill gaps in current provision and deliver innovative service solutions as a means of redressing health inequalities
- allow providers to understand the Council’s view of how social care market structures need to adapt to the anticipated growth in self directed support and the Council’s cooperative agenda
- explain how the Council will intervene in the market to meet its new duty to make sufficient information available to allow people to make an informed decision about how to meet their needs and ensure the provision of diverse, appropriate and affordable health and social care services.
2.2.5 Concerns about volunteers

Concern was raised about the apparent reliance on volunteers. A comment was made that volunteers should be invested in as without them the system would not work.

Volunteers make a huge contribution to supporting older people and are recognised in the Plan (p43 and p78). Edinburgh’s volunteering strategy ‘Inspiring Edinburgh’s Volunteers – Building on Success 2012-2017’ includes an action plan for how volunteers are supported. The Innovation Fund has included a number of projects that specifically focus on supporting and developing volunteering opportunities within services for older people, with an investment of around £150,000 per year.

2.2.6 Other comments

Other comments included:

- There is a need for middle ground services and not just advice or high level services.

The Plan shows the range of services and supports available, from advice and information, preventative services such as Community Connecting and lunch and day clubs, support at home through to hospital care.

- There was one comment that the right to die should be strengthened by legalising drugs suitable for euthanasia.

This is a national issue and is out-with the scope of the Plan.

SUMMARY OF RESPONSES TO THE FINANCIAL IMPLICATIONS

Priority areas for spend and investment include: supporting people at home, community services including those addressing social isolation and health, retaining sheltered housing with wardens, early diagnosis and support for people with dementia, improved joint working and effective monitoring and decision making regarding resources.

Concerns included whether hospitals can manage with reduced funding, whether certain groups of people, such as those with dementia, can manage at home and whether direct payment levels will be sufficient to provide the care that people need.
3 HEALTH AND WELLBEING

89 responses of 102 commented on the proposals under question 3, promoting health and wellbeing.

Responses supported the proposals. Comments focussed on how to make the proposals work, concerns about barriers to making proposals work, areas to prioritise and areas that respondents thought had been missed from the proposals.

3.1 Social integration

The importance of social integration was the theme that attracted most comments in this section. Comments included:

- the need to promote friendships and enable continuation of existing networks and relationships.
- the importance of day and community centres.
- the importance of befrienders. One response stated the importance of extending the befriending plan to LGBT people.
- the importance of providing transport.
- need for outreach work for older people living at home
- intergenerational projects that show the value of older people.
- investing in communities requires appropriate financing.

An LGBT support organisation stated that isolation can arise as the consequence of rejection by parts of the wider community or the lack of a supportive family, as well as the reasons that affect the mainstream population. They stated that services which present themselves as local (lunch clubs, day services etc.) need to be proactive about being truly local for all. Many LGBT older people would be unlikely to attend a Christian (or other) faith based service (such as a lunch club) at present because they would not feel that they would be welcomed.

The libraries and information senior management team reported that they already do much work around social integration and are keen to work with others to develop ideas.

One response feared that the use of technology would increase isolation and stressed the importance of human face to face contact with kind people to combat loneliness. This respondent wanted work put into encouraging the whole community to see older people as people.

Social isolation and the importance of supporting older people to be connected to their communities is a strong theme within the Plan (see p42 of the Plan). See section 1.1.1 of this report for a full response.

The particular risk of isolation for LGBT older people is recognised in the Plan (p28). Council funding has been agreed to support the LGBT befriending
project which has been recognised as having a positive impact for isolated older people.

The Partnership is working with Queen Margaret University to develop the understanding and evidence base around how resilience amongst older people is built and maintained. This work will inform our planning and development of services to support older people to live well in the community.

Also see response under 1.1 about social integration and section 4.5 about telecare. The work of A City for All Ages has been established since 2000 with the aim ensuring the views of older people in Edinburgh are listened to, addressing issues faced by older people and encouraging communities to see older people as people.

The work of local voluntary organisations and community centres are essential to support the social integration of older people in their local communities. Social connectedness is recognised as important in improving health and wellbeing. A Preventative Strategy is being developed which includes promoting a better understanding of preventative services and activities amongst the public and staff, to improve referrals to the wide range of services available.

3.2 Sheltered housing and social integration

One organisation’s response commented specifically on sheltered housing and social integration. They gave examples of the variety of activities that residents are able to enjoy as a result of having a co-ordinator. They stated that reducing the hours of this worker would impact negatively on their quality of life. They stated that the co-ordinator has a preventative role in reducing need for higher level services.

In Council managed sheltered housing, programmes of community activity in community rooms are supported and developed with residents. There are no proposals to reduce the level of community activities in sheltered housing.

One group response stated that supporting people funding should be unfrozen and on-site support staff should oversee more services. This will reduce isolation.

There are no current plans to increase funding for housing support. The financial pressures on the Council mean it is important to maximise the use of existing funding. This means looking at how people can link into existing activities and considering whether activities within sheltered housing units can be made available to people in the wider community. See section 1.1.1 for further information about action to reduce isolation and develop a community connecting approach.

3.3 Advice and Information
After social integration, the most comments were received on advice and information.

People commented on the importance of people being able to find out about activities and support, with comments that improvements were needed to current provision of information.

A variety of suggestions were made as to how information should be made available including: Booklet form, not just electronic, Web, face to face, phone, smart phone, tablet, t.v., use of agreed set of databases, regularly updated, one stop shop, written information in libraries, use of t.v.s in hospitals.

GPs and assessment teams were also highlighted as key sources of information. It was stated that appropriate training should be given to these workers to enable them to signpost effectively.

One response stated that CEC, NHSL and the voluntary sector should work together to develop the correct model to deliver information.

There were a couple of comments about provision of welfare advice. The importance of good advice was highlighted alongside concerns that the Advice Shop is unable to deal with the current volume of demand and that this will increase as the Welfare Reform Act takes effect. One group stated that expenditure and financial planning advice is also needed.

See sections 1.1.1 and 1.2.2 for responses about information provision and access.

We are working with GPs, WRVS, local libraries and hospital staff to ensure information about services and support available is more widely available in a range of different formats.

3.4 Housing

There was support for funding for housing and support, Sheltered Housing, telecare and telehealth, adaptations.

There was a comment that a specialist housing options service exists for young people but not older people.

The Commissioning Plan for Homelessness Prevention 2011-16 recognises the need to provide advice to older people in all tenures when they need to move home or need help to live independently in their existing home.

While there is no specialist allocation service for older people, the EdIndex Team does provide support to help vulnerable clients to identify and bid for suitable homes. This service is open to all vulnerable clients including older people.
It is recognised that there is a need to invest in homes and services that can meet the needs of older households. In order to achieve this, the Council is focusing on the following areas:

- Investing in the development of new homes that are accessible and more energy efficient
- Improving existing homes and working to reduce fuel poverty through review of future capital investment programme
- Investment in adaptations and Telecare services to help people remain in their own home
- Looking at options for improved advice and befriending services.

One respondent commented that attention to detail can make a difference, such as colour coding aids given to older people.

Two comments suggested that shopping and housework are the services that people really need. One group response also stated that being able to heat homes is important.

Shopping and housework are provided if identified as a required part of a care package through a social care assessment. A range of voluntary and private agencies also provide these services and support.

Investment has been made in the Changeworks Heat Heroes project as part of the Innovation Fund (additional funding being distributed as part of the Change Fund). The project works with older people to improve the warmth of their home in a way that is affordable for the older person.

Improving energy efficiency in Council homes, investing in new energy efficient homes and tackling fuel poverty are housing priorities for the Council. 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 easier to heat. As of April 2012, 75% of Council homes were compliant with SHQS and continued investment is expected to ensure that 100% of Council homes achieve the SHQS by 2015.

3.5 Transport and physical environment

There were several comments that suitable transport is needed for those with mobility problems. There was a comment that public transport in the south west is very poor. One group of service users stated that more frequent buses with more suitable seats for older people were needed. There was a comment that the physical environment can reduce independence. One person said maintaining the free bus pass is the most cost effective way to help people.

Transport is vital in supporting older people to live in the community and in maintaining connections (see p29 of the Plan). In recognition of this important role, arrangements are being finalised to review Community and Accessible
Transport across the city. The Review will consider many issues including those identified through the Plan and raised through the consultation feedback.

It is anticipated that the Review, scheduled to start in April 2013, will take account of the need to establish a clear framework which enables a mixed economy approach allowing all key stakeholders work in partnership to deliver / enhance the required services to older people in an efficient, user friendly and affordable way.

The Review will need to take account of likely demographic changes, the financial environment both in terms of revenue costs and future capital investments requirements needed to sustain current services and will seek solutions to reshape services to meet future needs consistent with service users needs.

In achieving this, the planned Review will also take full account of the opportunities presented as a consequence of the Integration of the Council’s Adult Social Care Services and NHS Lothian and explore the possibility of a ‘Shared Services’ platform for all Social Care / Health related transport requirements.

Finally, the Review will also look to create future-proofed solutions and as part of this aspect will seek to consider carefully the welfare reform agenda and moves to a Universal Benefit.

3.6 Physical Health/ counselling

There were two comments on the importance of affordable gyms and exercise for older people.

The importance of supporting older people to remain active is recognised within national and local plans. Within Edinburgh Get Up and Go programme provides information about a wide range of opportunities for older people. The Partnership works closely with Edinburgh Leisure in supporting older people to remain active, including the Ageing Well and Active Lives projects and an Innovation Fund project which aims to prevent falls.

One group response commented on the lack of pro-active regular health checks for the elderly.

NHS Lothian uses local GP services as one of the main ways of identifying the health needs of older people. GPs are encouraged through their contract with the NHS to provide screening for patients with known conditions such as COPD, diabetes and heart failure.

One person commented on the need for counselling for the partner of the person who has gone into residential care.
Information about counselling and other mental health services available in Edinburgh can be found on EdSpace. This includes information for carers.

3.7 Unpaid Carers

There were a small number of comments about the need for support and information for unpaid carers. There was a comment that self carers are not mentioned and need to be taken into account. There was a query about where the Edinburgh Carers’ plan was.

There was a comment that people who are cared for, as well as unpaid carers, should be involved in reviews of the Edinburgh carers’ plan.

There was a statement on the importance of respite for people. There was another call for the need for more support for unpaid carers.

There was a concern to ensure that family carers are always the best people to provide care as in a small minority of cases they may not be.

There was a statement that people with dementia can give a false impression that they are coping.

The Edinburgh Carers’ plan “Towards 2012” can be found on the Council’s website. This plan is currently being reviewed and a new plan will be available for consultation in Autumn 2013. The review is being led by a multi-agency working group. The consultation will be open to everyone, and the views of people who are cared for, as well as people who are carers, will be encouraged.

Respite is consistently reported to be the number one priority for carers and this is reinforced by the feedback received through the recent review of Edinburgh’s Carers’ Plan “Towards 2012”. Additional support has been made available for carers in Edinburgh, through ongoing Scottish Government funding allocated to Edinburgh CHP and through additional investments made in the 2012/13 and 2013/14 Council budgets. See the “Support to Carers” report to Committee in September 2012.

The ongoing assessment and review process is designed to ensure that an individual’s needs are accurately understood. The assessment and review process is undertaken by skilled assessors who develop an understanding of need through discussion and observation involving the service user and their carer. Further information about support and advice available for carers is available on the Council’s website www.edinburgh.gov.uk/info/1352/carers-adult/759/carer_support_and_advice/1.

Supporting people to self care or self manage their condition on a day to day basis is recognised to be very important. A person centred approach which supports and empowers individuals to have management over their lives and conditions is key to the development of all older people’s services and particularly in supporting people with long term conditions (p52 of the Plan).
3.8 Equalities

There were a number of comments around equality issues. These included:

- ensuring lunch clubs have hearing loop systems.
- large hospitals should directly employ translators on site so that they are there when needed.
- support people with mental health issues.
- no references are made in the plan to commissioning mental health services. They stated that the voluntary sector would welcome involvement in the redesign of these services.
- ensure recruitment weeds out staff with prejudices against certain groups.
- support for LGBT people.
- ensure people in care homes have access to the outside for fresh air, sun and nature which are important for mental and physical health.
- promote networking between dementia projects to share knowledge and experience. Promote information on dementia in communities to make them dementia friendly.

Most of these comments are covered by the responses in the ‘Equalities’ section 8 of this report.

The full range of mental health services are not specifically included in this Plan. The Plan refers to ‘A Sense of Belonging – a joint strategy for improving the mental health and wellbeing of Lothian’s population 2011-2016’ (p82 of the Plan), which was consulted on during 2011, and all the priorities within ‘A Sense of Belonging’ are applicable to older people.

Networking between dementia projects is being supported through the Edinburgh Dementia Implementation Plan and wider information sharing events. A ‘Life Planning Campaign’ is being developed and this will initially focus on dementia.

There were a couple of comments around people with addictions. There was one comment that drug and alcohol dependent people should not live in sheltered housing as this has a negative effect on other residents. There was one comment that addictions support for older people needs to be put in place.

An allocation has been made from the Change Fund to consider the current and future needs of older people that substance misuse and also the training requirements of staff supporting these people. Another important element is improving education and understanding of the issues faced by people with addictions. Links are made with the “Edinburgh Alcohol and Drug Partnership Commissioning Plan: Commissioning For Recovery 2012-15”.

There was one comment that the plans sound sensible as long as equalities groups do not receive excessive preferential treatment. There were
comments from a group of service users group that services for white people have better facilities for people with disabilities.

See section 8, 'Equalities'.

3.9 Joint working

One group response commented on the need to improve joint working with the voluntary sector, as this sector is vital for the delivery of preventative service. They expressed concerns about cuts in grant funding for the organisations that deliver these services. These concerns were shared by another respondent.

The voluntary sector is a key partner in the development of this Plan and wider transformation of services and are integrated into a wide range of forums from Edinburgh Partnership and the Joint Older People’s Management Group, through to local provider meetings and forums, Checkpoint Groups etc. The partnership will continue to consider how the views of the voluntary sector are represented and incorporated into service planning and delivery.

A recent Council budget decision on 7 February 2013 reversed a previously made decision to cut grant funding to voluntary and community organisations.

One consultation group also said more should be invested in MILAN, not less.

Funding to MILAN has remained constant. The Council agreed the 2013/14 budget on 7 February which continued grant funding levels for voluntary and community organisations.

One group response commented on the need for a development worker to pull together organisations working around Change Fund projects to share learning and resources. A second also commented on the need to share learning from the Change Fund.

The Evaluation Framework for the Change Fund is outlined in Part Three of the Plan. A range of methods will be used to share learning from this work, both locally and nationally. Events have been arranged, including the Information Days held in November 2012 and April 2013, which have brought together organisations to share information and learning and further local events are planned. Funding from the Change Fund has been made available to cascade the learning from the Innovation Fund in 2013/14.

There was one comment that the work should be done by all members of the Edinburgh Partnership including police, fire and compact partners.

This work is linked into local community planning structures and the Edinburgh Partnership through the Edinburgh Joint Older People’s Management Group strategic partnership.
There was a comment on the need to build links with the Scottish Ambulance Service especially around transport, falls, inter professional dialogues and transport.

Following the consultation, a number of meetings have been held to further discuss the potential links between the Scottish Ambulance Service and Social Care. The Scottish Ambulance Service will also be engaged as part of the wider review of transport, see section 3.5 of this report.

One group stated that the plan needs to incorporate co-production.

The Plan includes numerous references to co-production see p8, 11, 15, 76.

There was one comment that efforts to get involved in planning services had been rebuffed, and that an EQIA around shift working had not allowed proper engagement.

3.10 Other comments

One group stated that there is a need to map existing preventative services and develop pathways of prevention.

EVOC have received funding to undertake community mapping work, with a focus on preventative services for older people, linked to the ‘A Stitch in Time’ project which is evaluating the third sector contribution to care for older people. Refer to 1.1.1.

There was a suggestion that links be made for CEC Community Learning and Development for early intervention.

There are existing links between older people’s services and Community Learning and Development which can continue to be built upon, for example many older people take part in the Adult Education Programme (36% of all students in 2012 were over 60, 70% for day classes). Community Centres across the city offer a wide range of programmes and activities for older people which contribute to their health and well being. See 1.1.1.

One group stated that the plan needs to be more ‘nourishing’, for example by including references to good food and pleasure. They also stated that all services need support to develop communication plans.

One group stated that the plan does not address how services will be targeted at the right people and expressed concern that current eligibility is set at the very highest level.

Some health and social care services do have eligibility criteria, but there is increasing emphasis, both nationally and locally, on prevention and this includes services that have lower criteria levels, or are universally available. We need to work with partners to ensure we can identify and target the people
in greatest need, this can be difficult, for example identifying the most isolated, or the ‘hardest to reach’ groups.

Decisions about who can receive social care and support are based on an assessment of need. There are four categories of risk used in the criteria for adult social care services – critical, substantial, moderate and low. Priority is given to people who are assessed as being within the critical and substantial categories, however people who are assessed as being in the moderate or low categories can receive help to maintain or develop their abilities or stop them getting worse. A wide range of preventative services and support is available for older people in Edinburgh and how we take these forward in future is currently being considered as part of the wider Personalisation agenda. As part of the Commissioning Plan for Social Care Day Services for Older People 2012-17, local partnerships are being established to look at local service provision and gaps for older people with lower levels of need, see 1.1.1.

The Council’s Guide to Adult Social Care Services (December 2010) gives further details about eligibility criteria for adult social care; here is the website link:
www.edinburgh.gov.uk/download/downloads/id/3499/guide_to_adult_social_care_services_december_2010

There was a query about how this was going to be achieved with limited resources.

See response under Section 2 – Financial Implications.

One group said the consultation was wasting their time and that money spent on the consultation and plan should instead be spent on services such as lunch clubs.

The Council, NHS and partners want to involve service users and stakeholders in the development of services to ensure that their views are taken into account and that the right services are developed. We also have a duty to consult on all service developments and plans. We appreciate that people give their time to input to many consultations and their views are greatly valued. Effort is made to limit the amount of consultations groups receive for example by producing summaries, keeping questionnaires short yet meaningful, and also to report back to those who contributed to consultations on how their feedback has been used. Taking part in consultations is optional.

**SUMMARY OF HEALTH AND WELLBEING**

The need to keep people social integrated was identified as a major way to promote health and wellbeing. The role of sheltered housing and housing support in keeping people integrated was also highlighted.
To enable people to keep themselves well, good information provision was key but good transport and a suitable physical environment was also important.

Good joint working was also highlighted as necessary to enable services to deliver effective interventions around health and wellbeing.

The needs of particular equality groups were also highlighted, with groups missing from the plan said to be those with hearing impairments and those with mental health issues.
4 CARE AND SUPPORT AT HOME

86 responses of 102 commented on question 4, care and support at home.

Overall, respondents were supportive of proposals for care and support at home. However concerns were raised and these often related to current provision. Most comments related to care workers supporting people in their own homes.

4.1 Help to remain at home – care workers

The largest number of responses dealt with respondents’ views on care workers in terms of help to remain at home.

People had concerns about the current service and the way that it is organised. Concerns included:

- a need to use care and support at home to encourage independence
- a need to ensure that people have continuity of service
- stopping the reductions in the length of time of visits
- the need to build up good relationships between workers and clients
- the need for appropriate training for staff
- ensuring visits are at reasonable times
- ensuring good communication when there are changes, e.g. changed time of visit
- workers ensuring people eat and drink well
- the need for help with shopping and housework
- the length of time it takes to get home care organised, including clients deteriorating in hospital whilst they wait for packages.

One group response raised issues relating to older LGBT people and care workers. They stated that people should not be engaged in dialogue about issues of religion/ belief by care workers unless they initiate these conversations. They spoke of people ‘degaying’ their homes for fear of the response of the care worker if they knew they were gay. They also stated that in their consultation people had voiced grave concerns and stated that they were reluctant to allow people to enter their homes.

There were also supportive comments on specific elements in the consultation plan, such as extending the principles and practice of reablement beyond in-house and care at home services and the extension of night-time care.

*Care in the home might include homecare services (delivered by Council and external voluntary and private sector organisations), homecare overnight service, re-ablement service, Intermediate Care Service, District Nursing service, one to one day services. These services are key to enabling many older people to live independently in their own homes and they have received significant investment from the Change Fund of over £6m per year.*
In terms of homecare services, significant changes have been made in the last few years to modernise the service to meet the needs expressed by service users, including many of the issues raised above. Changes outlined in the Appendix 3 of the Plan (p94), include:

- development of a re-ablement service which aims to support people to maximise their independence
- changes to homecare services to ensure flexibility and to address concerns raised in relation to punctuality of care workers, duration of visits and care worker consistency.

These issues continue to be closely monitored and reviewed. The support and development of workers is also very important for care workers across all sectors, as emphasised in the Plan (p66).

4.2 Sheltered housing

Two group responses were received which supported sheltered housing and the retention of on-site staff. Comments included a request for on-site staff to deliver personal care so that this housing can provide a real alternative to care homes, a concern about the loss of regulation by the Care Commission if the service is changed and concern about the lack of support if co-ordinators are removed. There was a comment that it would be inappropriate to downgrade sheltered housing to retirement housing when people with dementia lived there.

There were also comments on the remit of the review of sheltered housing including:

- does the review cover all sheltered, amenity, alarmed and retirement housing regardless of provider?
- does the review covering physical environment, equalities issues, staffing and common areas, (eg considering the creation of meeting places and activities to reduce isolation, including use of Skype)?
- does the review include the availability of sheltered housing, is it only for council tenants?,
- allocation should be based on needs not voids
- the rules should be reviewed that people with anti-social histories cannot access sheltered housing.

A review of the model of support provision within Council managed sheltered housing is underway and a consultation programme with residents and other stakeholders is being planned. This does not cover sheltered housing provided by Housing Associations or any provider other than the Council.

4.3 Housing and Support
There were a number of comments on the current provision of housing and support and how it could be improved. These included:

- the importance of accessible housing
- 24 hour visiting support being needed
- provide long term housing support options
- concerns that people are left without attention when need it in supported housing
- the need to develop the extra care housing model over five sites to improve choice and add step up /step down option at each site. There was a further comment on the need to plug the gap between sheltered housing and care homes.
- concerns over length of time waiting for response to alarms
- need to have mixed aged groups in housing, co-location of young people who need care could make a big difference.

New homes need to be accessible and adaptable. Most new affordable homes in Edinburgh have been built to at least Housing for Varying Needs (HFVN) standards of accessibility in recent years. In addition, 242 wheelchair accessible homes have been delivered through the Affordable Housing Investment Programme (AHIP) between 2004/05 and 2011/12.

However, most people live in older homes. The Council also provides funding for adaptations for Council homes and private homes and administers funding for adaptations to RSL homes. This can help people to stay in their own home for as long as possible.

The Council and other providers offer 24 hour telecare services which ensure that people can receive help when it is needed. The Council’s Community Alarm Telecare Service (CATS) has received financial support through the Change Fund and currently supports approximately 8,000 customers. In 2011/12, the service answered 218,157 emergency alarm calls, with 94.59% per cent answered within one minute. 97% of the customers who received a visit following an alarm call remained at home.

Community alarms, telecare and adaptations provide a long term solution to allow people to remain in their own homes. This also allows people to remain in communities where there is a mix of ages of households.

There are a number of very sheltered or extra care housing developments in the City which can be an option for those who need additional care. Elizabeth Maginnis Court is a good example of housing with care. This model of housing allows additional support to be tailored to individual needs therefore helping tenants to retain as much of their independence as possible. Support can be increased or decreased over time as needs change. However, the use of adaptations, community alarms, telecare and care and support packages can also help some people to remain in their own home for longer than was previously possible.

4.4 Aids and adaptations
There were a small number of comments about the current provision of aids and adaptations and how it could be improved. These included:

- concerns on the length of time waiting for major adaptations
- the need to improve consistency of decision making around adaptations, including offering young and older people the same service
- unsustainability of putting in adaptations in private households which are scrapped when person dies
- delivering adaptations proactively, for example installing when properties are empty and between lets.

Timescales for adaptations can vary depending on the type and complexity of the adaptation required to meet the individual customer’s needs. Some applications also require complex funding arrangements, particularly those involving grant funded adaptations where there may be a funding shortfall (80% grant funded) and this can also impact on timescales. Partnership working between Services for Communities, Health & Social Care and Children & Families has improved response times. However, it is recognised that there is no end to end process measurement yet in place to capture the time element. Work is currently ongoing to improve the ability to identify any blocking points that may cause delays in the end to end process and to further improve waiting times through defining and implementing revised, more streamlined processes.

The City of Edinburgh Council views adaptations for the needs of all disabled persons as only one element of an overall package. To allow consistency across a wide range of individual cases of all age groups with varying needs, an assessment of an individual’s needs is carried out by an Occupational Therapist following a referral through Social Care Direct. The customer’s assessed needs will be then be determined by use of the “Adaptation & Equipment Provision in People’s Homes and Practice Guide”. Depending on the complexity of the case, it may need to be presented to the local Occupational Therapy panel. More complex or extensive adaptations, which can involve construction of extensions or reconfiguring the internal layout of a home, will be presented to the City wide Adaptation panel, consisting of H&SC, C&F & SfC partners, to discuss and decide on best technical and funding solutions as well as to challenge and address any identified inconsistencies.

Adaptations are put into people’s homes, where appropriate, to help them live independently. Sometimes it won’t be possible to use the adaptation when the person moves or dies. However, there can be a cost benefit to providing adaptations as it will often keep people out of hospital or more expensive housing or care options. 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.

The Council recognises there is scope to investigate how future investment can be used to make homes more flexible over the long term and how the
Council’s Housing Capital Investment Programme can help meet the requirements of the ageing population.

One group asked if there will be funding coming through for telecare, telehealth and adaptations so that all sheltered housing stock meets a minimum standard for the ageing population? There was another comment on the need to increase the stock of adapted sheltered housing.

Where appropriate mainstream properties can be adapted, in a way that is sustainable for the needs of both the current and future tenants. Telecare is available across all tenures. Further information about how to access these services is available on the Council’s website at www.edinburgh.gov.uk/info/1453/care_and_support_at_home/1220/personal_alarms_and_monitors

4.5 Telecare/telehealth

There were a small number of comments about telecare/health, most supporting this but one arguing for the primacy of human contact.

One group welcomed the use of technology but questioned whether people were given information at the right time and said training was needed for information providers. Another response welcomed the expansion of telecare and out of hours services.

There was one response that mainstream funding is required for telehealth. One group called for a pilot of telehealth.

There was one comment against technology, arguing instead that human presence is all important to older people who are lonely or fearful. They argued for volunteer counsellors to be used as part of health care. There was another comment that technology is not for everyone and that choice should be offered.

There is always an assessment for telehealth and telecare services prior to these being put in place. Part of that assessment includes whether people are suitable for that type of support, so it is never a ‘one size fits all’ approach.

Many telehealth and telecare supports enhance the work done by care workers and are not provided as an alternative to actual care workers providing a service.

Further information about how to access these services is available on the Council’s website at www.edinburgh.gov.uk/info/1453/care_and_support_at_home/1220/personal_alarms_and_monitors

4.6 Health
There were calls for improvements for health services, especially podiatry (The author of this consultation paper has been involved in consultations with older people for eight years and the issue of the need for a toenail cutting service comes up each time) and two calls for better integration of health with community services.

There were several responses relating to podiatry as this service does not cut nails which leads to older people becoming disabled due to their inability to cut their toenails. There was a call for cancelled podiatrists posts to be reinstated and a statement that appointments are difficult to make and a telephone appointment system should be devised.

Good foot care is recognised as very important in helping people to remain active, mobile and independent for as long as possible. A consultation was recently undertaken nationally on the National Personal Footcare Draft Guidance. This guidance aims to address some of the issues raised above, including confusion over what is meant by personal footcare and the difference between this and podiatry. Simple foot and nail care does not need the skills of a highly qualified podiatrist. Keeping fingernails and toenails trimmed is covered in the legislation as one of the personal hygiene aspects of free personal care for those people who are assessed as requiring it. Once finalised, NHS Lothian and its partners will work to ensure that the guidance is implemented locally, including clear advice for people about the services available and signposting to other relevant services where appropriate.

One group stated that primary care services could be available at voluntary sector settings.

There was a comment that there is a need for closer working between medical and community services in dementia care. There was a call for more geriatric services.

See section 5.1 for further information about actions to improve dementia services in Edinburgh. One strand of this work is specifically about developing a more ‘integrated pathway’, which includes improved working between medical and community services. A proposal has recently been approved to provide ‘link workers’ to support people diagnosed with dementia and to improve links between medical and community dementia services.

A group of service users commented on the long wait for psychiatric services which they said can be over a year. They also commented on how long one can wait for a GP appointment.

There was a call for support for people with long term conditions.

Support is provided to people with long term conditions through a range of health and social care services (p52 of the Plan). The IMPACT (Improving Anticipatory Care and Treatment) nursing service works specifically with people to support them to proactively manage their long term conditions such as COPD, diabetes and frail older people with complex needs. The use of
telehealthcare to support people with long term conditions is an important part of this work.

There was a call to continue and expand specialist day services and hospitals.

See section 1.1.1 for more information about day services.

There was a call to provide alternative therapies at affordable prices.

There is an ongoing review of homeopathy within NHS Lothian

4.7 Social integration

There were a small number of responses relating to social integration. One respondent stated that people can become isolated at home so keeping people at home should not be the sole aim. There was a statement that people getting care and support may just need company.

See sections 1.1.1 and 3.1 of this report.

One group response stated that capital funding should be made available so that activity rooms can be attached to care homes for the whole community to use.

One group stated that care homes have a role in enabling people to remain part of their communities and they should not have been placed next to hospitals in section five of the consultation.

The Scottish Government issued five categories to be used as the basis of all Joint Commissioning Plans, which placed care homes and hospital settings together. We agree with the view that care homes should be seen as part of the community, and this is reflected along with specific actions in the Plan (p58).

One group said that specialist day services for people with dementia are vital.

4.8 Advice and information

There was one comment that all of this will require a good information network. There was one comment that the partner needs to be told more about their loved one’s illness e.g. dementia or any long term illness, so they are not ignorant of the serious of the cause and how to cope.

See section 1.2.2 on ‘Information provision and access’. Information needs for carers of people with dementia is a specific focus for the Edinburgh Dementia Implementation Plan (p55 of the Plan). This includes information about dementia and also information about services and support available to carers. Organisations such a VOCAL and Care for Carers provide support and information for carers of people with dementia.
There was one comment that there is a need to go back to the time when people could phone someone if something went wrong, such as a social worker or support worker.

*When something goes wrong there is always someone to contact. If someone has an assigned social worker, OT or carer then they should know how to contact them. If someone does not have an assigned worker, Social Care Direct is the main point of contact for all social care queries, 0131 200 2324.*

### 4.9 Equalities

There was one comment that the council is contracting out to organisations and not looking at whether they have equal opportunities policies in place.

*All contracts and grant arrangements require providers to have a range of policies and standards in place, including equal opportunities. All providers have a legal requirement to comply with the Equalities Act. A report from November 2012 outlines arrangements for how service quality is monitored, “Quality Assurance for Care Provided in People’s Home and in Residential Care”. In addition, the Council’s Health and Social Care Contracts Team is working with organisations such as LGBT Age, to consider how further improvements can be made to equalities monitoring for external contracts.*

One group that there should not be an expectation that families will provide support, but that outside help is also needed.

*Any assessment for a service will consider how much support families and unpaid carers are willing and able to provide and arrange additional support packages based on this.*

### 4.10 Services for particular groups

Some responses cited the need for more support for particular groups. These included:

- need for psychological services.
- ensure appropriate temporary accommodation options for older people who are homeless
- support for methadone users. The Home Care service will not collect methadone prescriptions from chemists because it is a controlled substance and neither will most chemists deliver it. This is an issue which is going to be increasingly prominent as the drug dependent population are aging.

*Psychological services are included in ‘A Sense of Belonging – a joint strategy for improving the mental health and wellbeing of Lothian’s population 2011–2016’ (p82 of the Plan).*

*See section 1.1.6 in relation to older people who are homeless.*
The issue of methadone will be included in the work to consider the current and future needs of older people that substance misuse and also the training requirements of staff supporting these people. Also see “Edinburgh Alcohol and Drug Partnership Commissioning Plan: Commissioning For Recovery 2012-15”.

4.11 Organisational issues

There were a small number of comments on organisation issues. These included:

- when mistakes happen, quick response and acceptance of responsibility
- mobile devices shared by all to improve communication
- access to services such as SWIFT
- up to date case files and accessed by all care support.

IT and sharing of information is a key issue raised by front line staff, continues to be addressed and is a key part of the integration of Health and Social Care programme.

4.12 Other comments

A number of responses raised concerns about the affordability of the proposals. One group stated that the plan needs to state that hospital beds will be closed and funding released or people will not believe the plans are deliverable.

See the Financial section 2 of this report.

Other comments included:

- many older people do not wish to direct their own support. This frightens them because they think they will need to become employers, with all that this entails.

Self Directed Support legislation will include four options that must be made available to service users. One of these options is that the local authority selects the appropriate support and makes arrangements for its provision (see section 1.2.3 of this report or p74 of the Plan for further details of the four options).

- use term good care rather than high quality
- changes in TV channels are confusing and upsetting for people with dementia
- current issue with changes to medication procedure meant that existing medication was going to be thrown away because it wasn’t in the right kind of packs. A huge waste.
This particular issue was raised at a focus group, following which a visit was made to the gentleman’s home and the issue was resolved.

<table>
<thead>
<tr>
<th>SUMMARY OF CARE AND SUPPORT AT HOME</th>
</tr>
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<tbody>
<tr>
<td>Residents were generally supportive of the proposals for care and support, although there were some concerns about the funding of this. People expressed concerns about current provision and how this could be improved. The organisation of care workers who come into people’s homes was a key issue for respondents. Housing support, including aid and adaptations, telecare/health and sheltered housing also drew comments on current provision and how this could be improved.</td>
</tr>
</tbody>
</table>
5 SUPPORT AT TIMES OF CHANGE

78 responses of 102 commented on question 5, support at times of change. Key issues for respondents were dementia care and palliative care.

5.1 Dementia

The greatest number of responses related to support for people who have dementia. Comments related to primary care, hospital and community services.

The need for early diagnosis of dementia was mentioned by a couple of respondents, along with the need for GPs and other professionals to have access to information on local support services to assist people at the initial diagnosis.

There was a comment that support for people with early onset dementia was poor, with people being placed on a mental illness ward full of older people.

One response stated that around 300 people in Edinburgh have Parkinson’s and dementia. They said that services need to be able to accommodate people with the physical disabilities and communication issues which affect people with Parkinson’s and dementia.

For those living in the community, the need for consistency of care workers was raised in two responses.

There was one comment that there is an urgent need for closer working between medical and community services.

One response called for education in schools to reduce the stigma of dementia.

All of these points are very valid and echo issues raised at a seminar held in June 2012 which involved staff from across NHS, Council, voluntary and independent organisations, along with people with dementia and their unpaid carers. Following the seminar the Edinburgh Dementia Delivery Group was established to take forward a number of specific tasks to improve services and support for people with Dementia and their unpaid carers. The tasks include:

- 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 and integrated care pathway
- Quality of dementia care in care homes and hospitals
- Ensuring services and support is in place for people with early onset dementia.
Another seminar is arranged for June 2013 and progress will be reported to committee later in the year.

5.2 Palliative Care

The next highest number of responses related to palliative care.

Concerns were expressed about the current provision of palliative care. This was both in terms of one report of a lack of care shown by NHS Lothian staff, a comment that the hospice movement offered better care than the NHS and a lack of recognition of the palliative care needs of people with Parkinson’s. A group response stated that a recent Audit Scotland review of palliative care services in Scotland showed that there are particularly significant gaps in the provision of appropriate end of life support for people with neurological conditions like Parkinson’s. Those with neurological conditions are much less likely to receive end of life care support from a specialist nurse and are less likely to die at home than people with cancer, organ failure or other conditions. Another respondent stated that respiratory sufferers are especially neglected in terms of palliative care. There was a call to respect wishes such as Living Wills and Do Not Resuscitate requests.

Solutions suggested included investing in specially trained nurses or letting the hospice movement lead on palliative care. Another respondent stated that palliative care should be in the community. A group response called for better interagency working to ensure packages of care are in place and to cut delayed discharges.

One response reported that their consultees were at pains to make clear that at the end of life, when one is at one’s most vulnerable, it is most inappropriate to engage in unwanted discussions about religion and faith (which can have painful connotations for LGBT people).

A group response stated that voluntary sector agencies are well placed to assist people with making plans for old age, care and death.

Lothian Palliative Care Service Redesign Programme is being led in partnership between Marie Curie and NHS Lothian and will involve a wide range of stakeholders as it develops over the next 2 years. The number of people being supported with palliative care in the community is increasing but the aim of the redesign is to ensure that the services and support are in place to allow people to receive palliative and end of life care in the setting of their choice. The views expressed as part of the consultation are very valid and will be fed into the service redesign work.

5.3 Health and related services

The Falls pathway was reported as a positive development.
Continuing to develop an integrated, responsive and proactive pathway for people at risk of falling or who have fallen, is a key contributor to improving the health and the outcomes experienced by older people.

One group response stated that responsiveness to emergencies is key and said the diminishing of Crisis Care services could have a negative impact. They called for a focus on prevention of admission to hospital rather than just on discharge.

The ‘Crisis Care’ service has been integrated with ‘Rapid Response’ and ‘Community Rehabilitation’ services to form the Intermediate Care service (p95 of the Plan) to provide a quick, comprehensive response to people in need of support at times when they are at risk of hospital admission and to support them to come home from hospital at the earliest point.

The number of staff available to provide care and support within Intermediate Care has increased and the Care Inspectorate (in their report from December 2012) noted the improvements in the service which these developments have delivered.

We are conscious that, as with other services, there is increased demand for Intermediate Care and people accessing the service have increasingly complex needs. We are monitoring this and working to ensure that our services develop to keep pace with demand and the expectations of people who need them. We also recognise that flow through our service is influenced by changes in process and practice in other parts of the wider system and this is a further area where we are seeking to deliver improvements.

One group asked where tele-health fitted into support at times of change.

One group stated that safeguards are needed on how information on sexuality will be shared so that people’s wishes are respected. Information on sexuality will not be relevant for all health workers to know.

There was one request for nurses to do home visits to take bloods etc. for older people who cannot walk to surgeries.

Many community nurse services are able to take bloods and other samples, and monitor the conditions of housebound patients. However it does not require a qualified nurse to take bloods this task can be undertaken by a phlebotomist allowing nurses to concentrate on providing the care that only nurses can deliver.

In terms of mental health, there was a comment that there is very little in the consultation document related to older people’s psychiatric services.

The full range of mental health services are not specifically included in this Plan. The Plan refers to ‘A Sense of Belonging – a joint strategy for improving the mental health and wellbeing of Lothian’s population 2011-2016’ (p82 of
the Plan), which was consulted on during 2011, and all the priorities within ‘A Sense of Belonging’ are applicable to older people.

5.4  Transport

There were two calls for improved transport to day hospitals, rehabilitation centres, and transport home from hospital.

*Improvements are being made to transport arrangements for patients who need to go to and from hospital and other health services. A transport hub has been developed within the Royal Infirmary to organise the transport needs for patients being discharged from hospital. It is important to recognise that patients’ own families make a considerable contribution when a person is leaving hospital.*

*See section 3.5 of this report for a further response about Transport.*

5.5  Intermediate care

There was a comment from a group of service users that personal assistants can sometimes provide the support that people need to enable them to be safely discharged from hospital.

There was a comment that Community Therapy assistants are vital to maintaining a responsive service.

*This role supports the increased levels of rehabilitation being provided in the community (see p35 and p47 of the Plan).*

5.6  Joint working

There were calls for improved joint working and communication between community and medical services; between health and social care. One group response called for independent and third sector agencies to be involved in the solutions developed.

*The need for improved joint working, between health and social care and involving partners in the development of solutions, is acknowledged and will continue to be progressed through the Integration of Health and Social Care programme.*

5.7  Locally based services

There were two calls specifically for locally based services. One was for locally based reablement and intermediate care. One was for the widest range of community based services and day hospitals.

*Services are arranged to best meet the needs of local people, whilst also being efficient and responsive. Re-ablement services are managed by 6 local teams. The Intermediate Care Service has a smaller number of staff and has*
city wide coverage to ensure that staff can respond flexibly based on the need of service users. These services work closely at a local level.

There has been considerable investment recently to a range of community based services (over £6m per year), via the Edinburgh Change Fund.

The Commissioning Plan for Social Care Day Services for Older People 2012-17 includes the development of local forums to improve local information and integration of services and to ensure that local older people are involved in the design of local services.

### 5.8 Housing

There was one comment that accommodation and housing options need to be part of the range of responses as an alternative to care homes and hospitals.

Housing options and advice is an effective way of identifying suitable accommodation for people, as an alternative to a care home or hospital. There are a variety of accommodation types, as well as telecare and assistive technology, that may allow individuals to remain within their own home for as long as is practically possible. Ideally these options will be considered before the stage where people are admitted to hospital.

One consultation group stated that the points system was hard for young people to understand. They also stated that high rise flats are not good for older people as they lead to isolation. They further stated that the area that people live is important so that they can be near community facilities such as mosques. In some areas people face discrimination.

Applicants may be awarded waiting time or priority depending on their housing circumstances. If applicants are having difficulty understanding how the system works, information can be provided by the EdIndex Team on 0131 529 5080, or by the local neighbourhood offices.

Edinburgh operates a Choice Based Lettings system. This means that applicants registered on EdIndex (Edinburgh’s common housing register) are able to bid for homes that they are interested in. If a multi storey flat would lead to isolation, the applicant could bid for alternative types of property. Applicants on EdIndex do need to be realistic when they are bidding, and there are not always properties available in all areas of the city.

In addition, the Edinburgh House Exchange is available to all Council and housing association tenants (who are not in breach of their tenancy conditions). This allows tenants to swap homes so that both households obtain homes that are more suitable for their needs. In 2012/13, approximately 2,400 tenants were registered for an exchange and 230 exchanges took place.
If people are facing discrimination they can contact the police, the Council’s Antisocial Behaviour Service or Neighbourhood Office.

A consultation group stated that telecare can be difficult to use because of the language barrier.

Any barriers to using telecare are identified as part of the assessment process along with ways of overcoming any issues, such as language, which are built into a response protocol for the service.

5.9 Sheltered housing

One group stated that hospital discharges are facilitated by the co-ordinators in sheltered housing complexes, but because they do not work weekends this can delay discharges.

Another consultation group stated that sheltered housing is better than a care home.

Residents living in sheltered housing are discharged when assessed as fit for discharge by the medical team, the availability of a support worker at any given time is not a defining factor in discharge planning and would not delay a discharge from hospital. Services such as Homecare Re-ablement and Intermediate Care will be arranged to support someone following their discharge from hospital.

5.10 Social Isolation

One group stated that a community connecting approach was missing from the named actions. It is important that older people do not become isolated at times of change. This work should be thought of as the social equivalent of physical reablement.

Community Connecting is a city wide service, but also an approach that we are keen to be adopted in other services for example day services and care homes. Also see 1.1.1.

5.11 Advice and information

Seven responses called for improved information about services available and about access and referral pathways.

See sections 1.22, 3.3 and 4.8.

5.12 Other comments

One group asked how the success of actions in this section will be measured.

An action plan will be developed and the implementation will be overseen by the Joint Older People’s Management Group (shown within the Governance
section on p69 of the Plan). An annual progress report will be produced and reported to the relevant Council and NHS committees.

The wider monitoring and evaluation framework is outlined on p67 of the Plan and includes a range of national and local performance measures and outcomes.

One person called for an affordable shopping service.

If people are assessed as eligible, assistance with shopping can be given via a home care or housing support service. In addition some voluntary sector organisations will assist with shopping or provide training for people to undertake on-line shopping.

### SUMMARY OF SUPPORT AT TIMES OF CHANGE
The areas of interest to the most respondents were dementia care and palliative care. In particular, concerns were raised about current provision by the NHS of palliative care. Disparate comments were made on a number of other areas, many of which are consistent with issues in previous questions including, joint working, social isolation, advice and information and sheltered housing.
6 HOSPITAL AND RESIDENTIAL CARE

81 responses of 102 commented under question 6 on hospital and residential care.

Respondents commented on three main areas, care homes, hospital care and care at home.

6.1 CARE HOMES

6.1.1 Staff

Most comments were received on staff in care homes.

Respondents talked about the importance of staff to the quality of residents’ experiences. One respondent stated that this was not mentioned in the Live Well consultation document. Several respondents talked about the need to invest in staff through training, pay levels, terms and conditions and career structures, support structures, and through adequate staffing levels so that staff can provide the care resident’s need for a good quality of life. The low levels of pay were said to lead to a high turnover. One group strongly recommended that the Council extend the expectation of paying a living wage to all outsourced contracts and to reflect this in their pricing of contracts. They further stated that current fees do not meet the cost of caring for very frail older people.

One respondent praised the return of community occupational therapists to care homes.

There was one comment that qualification levels have to be upgraded. There was one comment that the homes are staffed with people who cannot speak enough English.

There were a couple of statements on standards that must be met. One that people must be guided to eat if unable to do so themselves and have fluid intake monitored. And one about understanding of the needs of transgender people, gay people and disabled people.

Staff are recognised as a key part of a person’s experience within a care home. The National Care Home Contract includes the clause “The provider shall employ and ensure that at all times sufficient qualified and suitably trained and experienced staff are available to deliver the service”. The Plan includes a number of initiatives underway to support and develop staff within care homes (p59).

Care home fee rates are negotiated and agreed nationally as part of the National Care Homes Contract, through which it is noted that care homes have received a higher uplift than other sectors. The Council encourages
providers to pay the living wage, but this is determined by individual providers. Also see sections 7 and 8.4 in relation to staff.

6.1.2 Activities

There were several comments on the need for activities in care homes. These included:

- Yoga, meditation and other calming activities
- Community involvement by neighbourhood groups/volunteers to integrate residents into the community
- Offering step up and step down care.

Many care homes have interesting and exciting programmes of activities on offer to residents, for example involving volunteers, linking with local schools and community groups and providing intergenerational activities. Care homes need to ensure that activities are person-centred so that residents can take part in activities that they are interested in. An investment fund has been created as part of the Change Fund to support innovative work in care homes, including a Small Investment Fund for Care Homes and supporting 30 homes to take part in the My Home Life programme, the learning from this will be shared across all homes in Edinburgh.

The development of Step Up/Step Down beds in care homes is currently being progressed (p97 of the Plan).

6.1.3 Quantity and design of care homes

Responses were received on the number of care homes needed and on the desirable design of care homes.

Seven responses called for more care homes to be built than outlined in the consultation. One group asked to be involved in further discussions about this as they questioned the legitimacy of the statement that care home beds are likely to reduce.

The consultation summary referred to the Council’s refurbishment and new build programme for care homes and specifically the Drumbrae care home which is due to open in 2013. Appendix 3 of the Plan (p92) notes that the care home at Drumbrae is the fifth new Council care home to be built in recent years:

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Date opened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marionville</td>
<td>2007</td>
</tr>
<tr>
<td>Castlegreen</td>
<td>2007</td>
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<td>North Merchiston</td>
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<td>Inchview</td>
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<td>Drumbrae</td>
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Further to the draft Plan being written, funding for a further new care home
was agreed as part of the 2013/14 Council budget, with work planned to start in 2014. In addition to the Council care homes listed above, several independent sector new care homes are opening in 2013.

The projected number of care home beds (p64) is based on modelling of the number of people expected to require a care home place, assuming that a shift in the balance of care is achieved and that more older people are supported to live at home. The modelling also assumes a slight reduction in the proportion of long stay care home beds that the Council owns to 15%, as set out in the Accommodation Strategy (p92), with a projected increase in the number of independent sector care home beds. The bed numbers are for long stay care home beds only and there is an expectation that there will be an increase in the number of beds used for short term respite and step up/step down care. Further discussions will be held with key partners as more detailed capacity plans are developed.

On the design, there was one call for more specialist design in care homes for people with dementia; there were two calls for care homes to be smaller and to look more homely.

The council’s effort to refurbish and develop more council care homes was welcomed. The response called for more proactive co-operation from the council with people who want to build care homes in Edinburgh.

There are some excellent examples of dementia friendly care home design in Edinburgh, particularly within some of the new care homes. The Council works closely with developers and providers who are interested in building care homes in Edinburgh. There are four new care homes opening in Edinburgh in 2013, including three independent sector and one Council care home.

6.1.4 Monitoring

One group asked for more detail on the proposed scrutiny of care homes. Another group wished to see a commitment to embed a Best Value Options Appraisal approach, stating that investment decisions appear to have been reached without the rigour of this approach.

The Care Inspectorate is responsible for scrutiny and improvement within care homes (p30 of the Plan). The Council has a quality assurance framework which, whilst avoiding duplication of the Care Inspectorate’s role, enables any concerns to be followed up with local providers.

Options appraisal is an important part of the commissioning cycle (p39) and is clearly built into the Council’s Contract Standing Orders www.edinburgh.gov.uk/downloads/file/8897/contract_standing_orders

6.1.5 Other comments on care homes
A number of other comments were received. One group disagreed with the negative portrayal of care homes on page 12 as places to receive end of life care. They stated that the Plan should help people to understand the positive value of care homes in enhancing quality of life outcomes for people who can no longer manage on their own.

*Care homes can offer very positive outcomes for older people and the Plan has been amended to better reflect this.*

One group asked whether respite could be provided at lesser cost at home rather than in a care homes.

*Respite can be provided in different ways to suit the needs of the individual and their unpaid carer. Older people can access Short Break opportunities whereby a direct payment can be used for flexible respite which might take many forms eg a sitter or sleep over service in the home, a day out or holiday break. Care home respite is just one option, but it is recognised as the preferred option for some people. The Plan includes an action to develop care home respite provision for people with dementia (p56) as this is recognised as a gap in current provision.*

There were calls for care homes to be better integrated into communities and one comment that council care homes are better than housing associations.

*See response under 1.1.2.*

One group response said that consultation document is too positive about additional support being provided in the community without being explicit in some key messages:

- we will be reducing the number of beds in hospital/ care homes
- the choice of residential care homes currently available will not be there in the future
- the 'default' position will be home
- the composition and role of care homes is changing.

They stated that there is a need to change public attitudes in expecting that they/ their family members will be able to move into a care home later in life and that the plan should be clear about this. They further stated that criteria for accessing care homes needs to be reviewed.

*There is a challenge for a high level strategy to achieve the right balance in presenting the long term vision and actions to deliver this, whilst also recognising the very real current pressures that services and staff face.*

*It is recognised that in order to achieve a shift in the balance of care where more older people are supported at home, a change in public attitudes is required. Many people have an expectation that once they, or their relatives, are a certain age, they will move into a care home, and yet the majority of people also express a wish to live at home for as long as possible. We will aim to address such issues within our communication strategy, including the*
6.2 HOSPITAL SERVICES

6.2.1 Dementia

Respondents supported efforts to improve hospital care for people suffering from dementia.

Improvements called for included:
- more crossover of information when patients with dementia are in general wards for medical/surgical treatment

‘Getting to Know Me’ is a practical tool which has been developed to improve how information about a person with dementia, for example their needs, preferences, likes and dislikes, is shared with hospital staff (developed from the previous ‘This is Me’ tool). Having this information available aims to help health and social care professionals to get to know the person and deliver person-centred care. Carers are also key to completing the tool, helping to ensure that they are engaged in relation to the person’s care.

- training for hospital staff in how to support people with dementia

The importance of all health and social care staff being well trained in supporting people with dementia is recognised. Within hospital settings the following are examples of how this is being developed:
- mandatory dementia training is completed by all staff through the Learn Pro module (approx 10,000 people have completed this training)
- dementia awareness sessions (2hrs) are provided through the clinical education team
- information is provided to all hospital wards including ‘dementia in the general hospital’, ‘informed about dementia’, based on the Promoting Excellence Framework
- the recently established ‘Bridging Team’ (Older People’s Mental Health Liaison service) provide on the spot, flexible and informal education and support to ward staff working with older people with mental health issues including dementia and delirium.

- more support for nurses to enable them to engage with patients with dementia

See above.

- there was a call for staff not to assume that older people who are in pain or tired have dementia and a call for staff to be alert for signs of dementia in people who are admitted for other reasons
Appropriate assessment of dementia is important. Screening tools are used to accurately detect dementia and delirium.

- people with dementia should not be sedated.

Education/training is ongoing to ensure hospital staff are aware of other options for supporting and treating people with dementia, with the aim of reducing medication used for sedation.

6.2.2 Quality of services

There were a number of criticisms, including from personal experiences, of the way people are treated in hospital, these included:

- a lack of kindness and helpfulness from staff
- lack of stimulation for people when in hospital
- lower paid social care workers relating to older people better than hospital staff

NHS Lothian acknowledges that the quality of services for older people needs to continually be reviewed and improved. We have a dedicated workforce within our hospitals and we are committed to providing high quality, safe and person-centred care. We have a range of policies and procedures in place to improve care for older people in our hospitals. Out internal reviews and external inspections have identified areas of good practice, but have also highlighted a number of areas for improvement and we are working hard to address these issues. Some examples of action being taken to improve services for older people are provided below:

A ‘Delivering Better Care’ hub has been established to bring together specialists, for example in palliative care, wound management, dementia care, to deliver actions to improve the quality of care for older and vulnerable patients.

- Occupational Therapists not having time to do proper rehabilitation, more funding needed for this service

Service models are being redesigned, for example by enhancing the number of community therapists (over £1m has been invested per year from the Change Fund) and by providing in-reach into hospital, people can be supported to return home sooner and to have increased level of rehabilitation once home. Further information is provided on p35 of the Plan on how the redesign of orthopaedic and stroke pathways has delivered improved outcomes for older people.

- lack of understanding of transgender (eg of one male transgender being admitted to female ward)
- food in hospital not being suitable for ethnic minorities and staff not being well informed about different cultures and food
Food is recognised as being an important part of a stay in hospital and a person’s care and recovery. There is a need for ongoing education and awareness-raising to ensure that hospital staff are well informed about different cultures and food. Developments to improve person-centred care, for example the ‘Getting to Know Me’ tool, will help to clearly communicate with staff an individual’s preferences.

- poor hygiene standards in hospitals

Infection control audits show that levels of hygiene within hospitals has improved over recent years and we continue to monitor this closely. We unfortunately do experience outbreaks of infections in hospital from time to time and increasingly virulent bacteria present a challenge for our services.

There are various ways in which hygiene standards within hospital settings are monitored, including:

- daily monitoring at a ward level
- Healthcare Associated Infection Audit Programme Environmental Audits carried out on a 6 monthly basis with examples submitted to Healthcare Environment Inspectorate (HEI) as part of the self assessment evidence
- reports as part of the National Monitoring Framework, reported to the NHS Board, Health Facilities Scotland (HFS) and Scottish Government
- HEI Inspections, with reports published online
- Patient Quality Indicator (PQI) Audits which include indicators of patient experience.

- lack of privacy

We recognise the importance of privacy for people in hospital and continue to take action to improve this wherever possible. The new wards within the Royal Victoria Building at the Western General Hospital have been built to the latest standards and include individual rooms with en-suite bathrooms for all patients.

- lack on information about how to access hospital transport if cannot use bus or taxi.

See sections 3.5 and 5.4 of this report for responses about transport.

6.2.3 Other comments on hospitals

Other comments included:

- there need to be shorter waiting lists for services and treatment
• work is required to determine the correct number of beds that are needed
• hospitals need to focus less on meeting targets when doing this can be detrimental to patients
• discharge planning protocols are required for all clients
• more help need on discharge
• there was a question about whether all of this can be achieved with a smaller Royal Victoria hospital.

Joint capacity planning work is underway to plan the number of beds and service capacity required to meet future demands.

Discharge from hospital is an important point of transition and work is ongoing to improve how this is planned and achieved. The Change Fund has invested in a Carer Hospital Discharge Service, led by both the NHS with support from MECOPP, to support carers during this process.

The Plan notes the importance of targets being used as an indicator of performance rather than as an end in itself (p19 of the Plan). Work is underway to develop an outcomes approach which focuses on the service user or patient in the planning and delivery of care and support.

6.3 CARE AT HOME

6.3.1 Care staff

In terms of people moving home from hospital, respondents made comments about what needs to be in place in the community.

There were two calls for consistency of workers, especially for people with dementia. Suggestions included relying on a bank of staff rather than agency staff and a criticism of four on and four off shift working.

Development of homecare service outlined in section 4, “Care and Support at Home” which includes action to address issues of punctuality and duration of care visits and consistency in care workers, which we know is important, particularly for service users with dementia. A small number of people have raised concerns about a change in working hours of the Council Homecare service, which was done to provide more flexibility to meet the needs expressed to us by service users. The majority of staff and service users have responded positively to the change.

One respondent called for more care workers, realistic workloads and making care providers accountable for meeting care agreements.

Significant additional investment in care workers has been made through the Change Fund, including an additional £1m for the Re-ablement service, £1m in Intermediate Care services, £1.5m in Care at Home services and £200k in
equipment and adaptations. Also see section 7.2.2 in relation to ‘adequacy of staffing’.

See section 2.1.7 ‘monitoring’ in relation to making care providers accountable for meeting care arrangements.

6.3.2 Unpaid carers

Two responses called for more involvement of, and support for, unpaid carers.

See section 3.7 in relation to support for unpaid carers. The need for greater involvement of, and support for, unpaid carers during the hospital discharge process is recognised and the Change Fund has invested in a Carer Hospital Discharge Service to support carers during this process.

6.3.3 Housing

There were three responses relating to housing. These included:

- a need to design housing with ageing in mind
- develop cores and cluster housing over five sites, including step up and step down support
- have a supply of appropriate housing adaptations.

The City Housing Strategy has identified growing and ageing population as a challenge for the future. There is a need to ensure that new affordable homes are being built to address this ageing population. Affordable housing delivered and funded by the Council is built to at least Housing for Varying Needs Standards. These homes are more accessible and adaptable.

There are no current plans to develop core and cluster housing for older people. The Council’s main priority is to help people to live independently in their own homes. Visiting support and telecare make this easier. The Council also funds adaptations for Council homes and private homes and administers funding for adaptations to RSL homes.

6.4 OTHER COMMENTS ON HOSPITALS AND CARE HOMES

Other comments included:

- a reduction in occupational therapists in NHS continuing care and consequent impact on patients’ quality of life
- Step Up and Step Down care is an excellent idea.

Changes have occurred within the provision of inpatient complex healthcare (formally known as NHS Continuing Care) following the Scottish Government’s issuing of guidance in February 2008. The model for this care supports the move from institutional-based services to one more suited to the personalisation agenda of caring for people within wider community settings. Further information is provided on p86 of the Plan.
The proposal to develop Step Up/ Step Down beds (p97) has been welcomed by a wide range of health and social care professionals and older people, and this is being progressed.

### SUMMARY OF SECTION SIX ON HOSPITAL AND RESIDENTIAL CARE

**Care homes**
Most comments related to the need to invest in staff through pay, training and terms of employment and career structures. There was considerable concern that the consultation plan underestimated the number of care homes required.

**Hospital**
Respondents welcome efforts to improve care for people with dementia and made suggestions as to improvements required. Criticisms/ areas for improvement in hospital largely focussed on the communication and interpersonal skills of staff.

**Care at home**
Most comments related to care workers needing a manageable workload and having suitable housing to support people moving to the community from hospital.
7 OUR WORKFORCE

79 responses of 102 commented under question 7 on the workforce.

Comments in this section fell into three main categories: investing in staff, staffing issues and joint working. The great majority of comments received related to the need to invest in staff.

7.1 Investing in Staff

Training
The greatest number of comments about investing in staff were about training.

Specific training needs
Comments were received on the specific training needs of staff. This included raising awareness of the needs of the client groups they work with and more ‘technical’ training.

The most calls came for training in working with people with dementia, including recognising that people could display behaviour which challenges or be violent. One group stated that training needs to be better resourced and more widespread.

Dementia training
The Plan highlights dementia as a key area of focus in terms of service development, staff training and development and wider awareness-raising (p25 and 55 of the Plan).

The Council currently has various programmes of dementia training available to staff, however it is acknowledged that a comprehensive approach to dementia training and development is required. An appointment has recently been made to a new post within the Health and Social Care Workforce Development Team, to focus specifically on dementia training, aligned with the national Promoting Excellence framework. In this, as in all areas of workforce development, we will seek to work with partners in health, voluntary and private sectors.

Investment has been made from the Change Fund to provide dementia training in all care homes in the city. The Edinburgh Behaviour Support Service (EBSS) (p99 of the Plan) will also provide support and advice for paid and unpaid carers of people with challenging behaviour. A pilot has also been established as part of the EBSS to identify and develop Liaison Support Workers, which to date has involved 28 workers from 10 care homes, who have completed additional training and will take part in ongoing peer supervision.

Details of dementia training within hospitals is provided in section 6.2 of this report.

In support of Scotland’s National Dementia Strategy, a range of initiatives are
in place to support and develop the health and social care workforce, including:

- 41 Dementia Champions from Lothian have been trained as part of this national programme (provided on behalf of NES/SSSC by the University of the West of Scotland in partnership with Alzheimer Scotland). These Dementia Champions work in a range of settings across health and social care services and are change agents in improving the experience, care, treatment and outcomes for people with dementia.

- the establishment of Alzheimer Scotland Nurse Consultants/Specialists in NHS Scotland Boards. Within Edinburgh we have one Alzheimer Scotland Nurse Consultant and one AHP consultant who are working with health and social care services and staff to improve dementia care.

There were calls for training on equality and LGBT issues to ensure that staff understand the needs of these groups. There was one suggestion that this should have the same importance as health and safety and be included in employees’ contracts and assessed annually. There was a suggestion that speakers from the LGBT community be included in the training programme. One consultation group called for training on cultural issues.

**See 8.4.1 on equalities training.**

One group offered to work with care planners and providers to improve their knowledge of Parkinson’s.

*This offer is welcomed. The Partnership recognises that specialist organisations, service users and carers have much to contribute in the development of training and information.*

One group response stated that the workforce will have to be ready to face up to the cultural shift brought by the self directed support agenda and the integration of health and social care.

*The transformation of older people’s services and wider health and social care services, requires significant change in cultures and practices and workforce development is central to the transformation programme.*

The “Workforce, Organisational Development and Quality” work stream is leading this change. Work is underway to use a ‘collaborative inquiry’ approach to work with Health and Social Care staff to consider how Self Directed Support and more personalised services will be delivered in the future. Staff are heavily engaged in taking this work forward and regular workshops are taking place. Focused work is also underway with teams that have a specific role in relation to implementing Self Directed Support, to improve and develop the processes and cultures required.
A group of services users commented that many previous home helps are now social care workers and some are not fit for the tasks they need to perform.

Significant investment was made in the Council’s Homecare workforce through the Homecare Modernisation Programme (see p81 of the Plan) to ensure that staff are able to provide the level of care required. Additional training was developed to ensure that Social Care Workers are skilled in areas such as continence care, administration of medication, manual handling, eye care, skin care etc. An investment was made at the time the Modernisation Programme was implemented, to support the transition from Home Helps to Social Care Workers through the Home Care Practice Licence. Most Social Care Workers in the service are now qualified to SVQ level 2.

There was one statement that paramedic training should be given to all those working with older people.

All social care workers receive ‘coping in an emergency’ training.

There was one statement that all staff should improve and maintain their knowledge about resources in the community.

The provision of good quality information and raising awareness of resources available within the community are priorities within the Plan (see section 1.2.2 of this report). A Communication Strategy has been developed which includes information for service users, carers, staff, and other stakeholders.

A ‘Live Well in Later Life’ Information Day was held on 27 November 2012 at the Assembly Rooms, raising awareness of the support available for older people living in the community and this was well attended by the general public and staff. A second event was held on 23 April in the North West of the city and a series of local events is now planned. Information packs are also being widely distributed to health and social care staff.

There was one statement that care workers should all have quality ongoing training.

A wide range of training is already available for care workers. The training and development opportunities for staff are continually reviewed and developed.

There were two statements that all care at home should be provided by the City of Edinburgh Council where it can be better monitored and managed, staff can be trained and supervised properly and paid decently.

Homecare services are provided by both internal and external (voluntary and private sector) providers. The Council made this decision as part of the Homecare Modernisation programme, which set out the rationale for the balance of care provision including the development of an in-house Re-ablement Service, the retention of an in-house Homecare Service for people
with more complex needs and working with external Care at Home providers to meet the long term needs of the service. The implementation of Self-Directed Support legislation will enable service users to choose how their care arrangements are made, including who provides the service. We work closely with all providers to ensure that appropriate training and supervision arrangements are in place, along with robust arrangements for quality assurance monitoring and review.

There was one statement that there should be joint training across all City of Edinburgh Council Departments.

There are many opportunities that are provided jointly, not only with other departments in the Council but also with the NHS and other partners.

Cross-Council training programmes include the Leadership Matters programme, health and safety and equalities training. Shared training between NHS Lothian and the Council includes areas such as continence and catheter care and medication training.

Adult support and protection training has been developed jointly between NHS Boards, Police Boards and Local Authorities in South East Scotland. Manual handling training has been developed in partnership with other Local Authorities.

The Plan includes a commitment to continue to review and develop learning and development opportunities further, working with voluntary and independent sector partners (p66).

There was one statement that older people and their organisations should input into training.

The Plan emphasises the importance of working in partnership with older people to develop our services (p11 of the Plan) and an element of this may be the involvement of older people in developing and delivering training.

An example is the involvement of older people in the Homecare Modernisation Programme (p94 of the Plan) and the development of a Re-ablement service (p94 and p48 of the Plan). A ‘Checkpoint’ reference group, representing people who use services and carers’ organisations, was established in August 2008, facilitated by A City of All Ages (p12 of the Plan). Members of the group contributed to the training of home care staff and to the training of social work students at the University of Edinburgh. Another example is the LGBT Age project which uses Community Champions to work with service providers to support and develop equalities training. Plans are under development now to include people who use services and carers in the personalisation of social care.

There was a criticism from day service managers that social work training concentrates on children and families rather than older people services.
The Council has well established links with the Open University, due to the range of modules offered which provide a balance towards adult social care.

7.1.1 Pay

There were two comments that it is necessary to pay staff a decent wage to avoid high turnover and low quality staff. There was one comment that salary should reflect the responsibility that comes with the job. There was one comment that staff must be paid enough to ensure they have good spoken and written English skills.

Amongst a group of services users some were concerned about the low level of pay received by workers in some external agencies compared to the fee charged to clients.

Work towards a joint approach to planning and developing our future workforce is outlined on p66 of the Plan. This includes developing our understanding of the existing workforce in the city, with consideration of terms and conditions, levels of pay etc to ensure that sustainable plans can be developed for the future. The Council has committed to the ‘Living Wage’; the majority of providers are already paying staff at or above this level and the Council is working with other providers to address this further.

7.1.2 Positive career choice

There were a number of responses stating the need to promote social care as a positive career choice.

Two of these comments advocated promoting social care as a career in schools, including promoting work experience, apprenticeships and monitoring. Another comment suggested promoting social care as a career amongst people in their teens and early twenties.

There are a number of significant developments underway to promote care as a career amongst younger people.

The Edinburgh Guarantee partnership of public, private and voluntary organisations is working to increase the number of jobs, education or training opportunities available to young people in Edinburgh.

Eight Modern Apprentices are currently employed within care homes across the city and a further group of 11 have recently been recruited. Feedback from care home staff, residents and the apprentices has been very positive.

The Pre-Employment Academy offers a 12 week programme delivered through Edinburgh College and targets group is 19-24 year olds who have been unemployed for 12 months or more. Young people will be supported to prepare for employment within either the NHS or Council.
The Senior Phase H&SC Academy is a partnership programme between Edinburgh College, NHS, CEC and East Lothian Council targeting school age (S4, S5 and S6) pupils who may be considering a career in care or science or are unsure of a career path. The programme offers them an opportunity of undertaking a placement experience within the NHS or Health and Social Care. Pupils will also be working towards a qualification which may assist them in gaining employment within a health care, social care or science occupation.

The importance of offering structured academic routes into the care professions is recognised as critical to developing the skills and capability levels of our future workforce. The NHS and Council work closely with Further and Higher Education providers to develop these opportunities.

There were two more general comments about raising the profile of social care as a career.

Further information is available on the Council’s website which also includes a video created to promote the range of roles available within health and social care services.

There were two comments that social care should have a clear career and advancement structure to attract people to work in the sector.

One group commented that bad news stories are affecting the ability to present care as an attractive career. They welcomed working with partners to present positive news stories in media.

There was one comment that the consultation document makes cold and impersonal reference to the ‘workforce’ meeting ‘future demands’ rather that really valuing care as a positive career choice.

Work towards a joint approach to planning and developing our future workforce is outlined on p66 of the Plan. This includes working jointly with partners to raise the profile of care as a career choice. The comments received through the consultation are supportive, recognising the need for positive promotion of the health and social care profession.

The comment suggesting that the wording of the consultation document was cold and impersonal was taken on board and the wording of the final Plan was amended to emphasise the value that is given to the care workforce (p66).

7.1.3 Recruitment

There were two statements that there should be a focus on recruiting skilled staff, and two that ‘natural carers’ or people with good empathy skills should be recruited.

The recruitment and retention of staff is a key pressure for many areas of service and many of the issues faced are relevant across the care and
support sector. Efforts are made to ensure skilled, caring staff are recruited. This also links to the need to develop and promote care as a positive career choice in order to attract a high calibre of recruits.

7.1.4 Good managers

There was one statement that good managers are needed to recruit and train staff.

There was one statement that the Home Care Service would benefit from an enhanced supervision role/team leader.

7.1.5 Parity across sectors

There were two comments that staff across sectors should have the same working conditions including access to training and courses and the same pay. There was one concern that differences across sectors may cause resentment.

See section 7.1.2 in relation to 'Pay' and 7.1.1. 'Training'. The Plan includes a commitment to a joint approach to planning and developing our future workforce.

7.1.6 Status

One group stated that there is little difference in the roles of social care workers and nursing, but this is not generally recognised. They called for an increased understanding of the complexity of the role and, in turn, and increase in the value given to social care roles.

There was another comment that the public is not aware of the complexity of the caring role and that there needs to be greater awareness and respect.

This relates to promotion of care as a career choice and also improving the awareness and understanding of the complexity of roles, but also the rewards from working in care. See p66 of the Plan.

7.2 STAFFING ISSUES

7.2.1 Organisation of staff

There were several negative comments about the new four days on and four days off shift pattern. Two of these comments in particular mentioned the underoccupation of workers at weekends due to lack of clients.

See sections 6.3.1 and 8.7.

There was one criticism of 15-20 minute time slots with no allowance for travel time. It was stated that this did not allow time to cook meals or to ensure that clients ate frozen meals. It was further stated that isolation and mental ill health results due to the limited opportunity for social interaction. There was
another comment that care workers need to be given more time with each client and visits should not be cut short by workers who need to rush

Punctuality and the length of visits were key points raised through the consultation on homecare services, which informed the developments underway within the service, as outlined under section 4 of this report and p94 of the Plan.

People’s needs are assessed within eligibility criteria and service time is allocated to meet those needs. This includes up to 45 minutes for meal preparation. We agree that punctuality and the length of visit is crucial to wellbeing. We aim to let service users know if their carer will be significantly delayed.

7.2.2 Adequacy of staffing

Four responses stated that the consultation document did not mention the need for more staff.

In planning our future workforce we will consider the numbers of staff along with the skill mix required. Whilst there is likely to be a need for more staff in some areas, finances are limited and the Plan also sets out how service models are changing – which may require a different mix of staff working in a different way, rather than simply more staff – which may not be sustainable. Investments have been made in additional staffing for many community services, including the Change Fund investments set out in Appendix 5 of the Plan.

There was one comment that staffing levels in hospitals are too low and nurses are overworked.

All NHS Lothian’s hospital wards work within agreed levels for nurse staffing. In NHS Lothian nursing staffing levels are reviewed on an annual basis using a nationally recognised tool; the Nursing Midwifery Workforce and Workload Planning Tool.

There was one comment that there is an over-reliance on agency staff.

We agree that it is desirable to reduce the number of agency staff used in care homes. Our recruitment strategy aims to increase the numbers of permanent staff in care homes. The use of agency staff in in-house home care services is minimal.

There was one comment that it is not always a good idea to substitute qualified professionals for unskilled staff.

The Council and NHS Lothian do not substitute qualified professionals with unskilled staff. The appropriate level and mix of skills are carefully considered across all service areas to ensure the most effective and efficient staffing structure.
7.2.3 Monitoring

There was one question about what was being done about the regulation of the workforce.

*In April 2009, the Scottish Government passed Statutory Regulations about a phased programme of compulsory registration of key groups of social services workers in: residential child care, day care services for children, adult residential care, care at home and other support services and school care accommodation. The Care Inspectorate has the responsibility for enforcing required registration on behalf of Government.*

There was one statement that care homes need to be monitored as they don’t have a very good record.

*See details provided under section 6.1.4 about Care Home monitoring.*

7.2.4 Volunteers

There was one comment that there needs to be more use of volunteers, and that this increases empathy and sympathy.

*See section 2.2 about the contribution made by volunteers.*

7.2.5 Attitudes/ approaches of professionals

There were a small number of comments that health professionals need to see the whole person, to be compassionate and caring and that too much power is in the hand of professionals.

There were three statements that people should be treated with respect, care and dignity and that people should be taught to live compassionate lives and to incorporate that into all aspects of their work. One of the respondents complained that staff have failed to behave respectfully, asking questions such as ‘Do you have a social life?’

There were two comments about under par professional attitudes to patients. One stating that people are sometimes treated as commodities and not individuals, another that it is too easy for people to give a less than good service.

One group stated the importance of listening to the person and their unpaid carer about what is needed. They gave an example of a person who was given an expensive but inappropriate package of care which led to poorer outcomes for the person and his unpaid carer. Another stated that people should be consulted about services and treatment and their compliance obtained.
Dignity, compassion and respect are essential elements of any care or support that is provided, by any service or sector. In order to achieve the vision of the Plan, these elements need to be prioritised in all aspects of care provision including service design, training and development, service delivery, monitoring and review. Seeing the ‘whole person’ is key to the Personalisation agenda.

7.3 JOINT WORKING

There were a number of comments about the need for effective joint working.

Two group responses stated that the workforce should be clearly seen as the whole sector, rather than the Council and externals. It was stated that there should be a clear direction on the strategy between all sectors. There was another comment that care providers should work together to share good practice and suggestions.

There was one comment that services should be truly joined up with professionals sharing knowledge and information about people using their services.

The need for improved joint working is recognised (see below). There are examples of multi-agency working where professionals from a range of hospital and community-based services come together (both physically and virtually) to discuss and develop the best care arrangements based on the needs of the individual. An example is the development of the COMPASS model (see p54 of the Joint Commissioning Plan for Older People).

There was one comment that consideration should be given to working with other local authorities to increase buying power for external care agencies and to reduce costs.

There was one comment about the potential for increased joint working with the Scottish Ambulance Service. This is reproduced below.

“Professional to Professional dialogue is an area of focus for the Scottish Ambulance service. This is mainly related to how SAS crews contact NHS medical professionals to seek advice and discuss cases. Links are also well established with the police in relation to child/adult protection (mainly related to drugs and alcohol). There may be opportunities for improving links with social care professionals - who would also be able to provide useful information about a person’s care and support arrangements when ambulance crews are responding to a 999 call. Do SAS staff know about/ use Social Care Direct as a point of contact? Could this be built on?

Opportunities for working with the SAS include:

- workforce planning - what are the training and development needs of the SAS workforce given the older people’s plan and shifting the balance of care? E.g. dementia training?
- joint protocols to be developed
- links and sharing of information with health and social care
• exposure of managers in other partner organisations
• how will the SAS be included in the Health and Social Care Partnership/integrated H&SC service?

Following the consultation, a number of meetings have been held to further discuss the potential links between the Scottish Ambulance Service and Social Care Direct.

There were also several comments about the need to work with unpaid carers and regard them as part of the workforce caring for an individual.

The need for better joint working, between health and social care and involving partners in the development of solutions, is a common theme throughout this report. This is essential to the transformation of services and will be progressed through the Integration of Health & Social Care programme.

7.4 OTHER COMMENTS

There was one query about who will pay for the outlined plans and one comment about the cuts in the NHS making the proposals difficult to achieve.

See response under 1.2 about deliverability of the vision.

One group stated that the reluctance of LGBT people to access services needs to be overcome by addressing their justified anxieties. They suggested that this can be achieved through:
• ensuring that properly monitored services are provided in line with the most current care standards and that monitoring is followed up by commissioners
• suppliers of services publishing and making people aware of their equal opportunities policy
• suppliers of services ensuring that their policies are adhered to
• the Council, as commissioner, working to reassure members of the community by undertaking an advertising/information/awareness campaign (for example)
• requiring providers to have a documented equalities approach
• an action plan to ensure that commissioned services and other suppliers apply these policies throughout the supply-chain.

The level of consultation and response provided from the LGBT community has been gratefully received by the Partnership. See response under section 1.1.

One consultation group stated that care homes need to have better facilities, understanding of cultural needs and language support. They further stated that language and staff attitudes can be a big problem with staff support at home.

See sections 7 and 8 in relation to staff training and language.
<table>
<thead>
<tr>
<th>SUMMARY OF COMMENTS ABOUT THE WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most comments related to the need to invest in staff, and particularly in their training needs. Training needs included understanding the needs of different client groups and more 'technical training' such as knowledge of self directed support and local community resources. There were also considerable calls for social care to be more actively promoted as a positive career choice.</td>
</tr>
<tr>
<td>Joint working also drew comments, including calls for a clear strategy for the whole workforce, regardless of the sector that they work in, as well as sharing of information and good practice.</td>
</tr>
</tbody>
</table>
8 EQUALITIES STANDARDS

Three equalities questions were included in the consultation questionnaire: on meeting equalities standards, meeting the needs of specific groups and any risks to human rights or discrimination of any person or group. The equalities questions produced fewer responses than the other sections, and with each equalities question, fewer responses were given.

66 of the 102 respondents commented on question 8 - Equality Standards
52 of the 102 respondents commented on question 9 - Equality Needs
42 of the 102 respondents commented on question 10 - Equality Risks.

This may have been because some respondents said all they wanted to on this topic in the first or second questions. Comments on equalities issues also appeared throughout responses to all questions in the consultation. Issues raised within the three questions have therefore been analysed thematically and presented below.

8.1 Improving services for particular groups

Most responses were given on the need to improve services for particular groups.

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.

8.1.1 Language, interpretation and translation
Several respondents referred to issues with language and the need for interpretation and translation services.

A number of responses stated a need for better services for those who don’t speak English well, including more care workers who can speak particular languages. Clients often complain that, due to both having a different first language, they cannot understand what care workers say. One consultation group stated that if people cannot read in their own ethnic language it is better than they get information in English so that someone can read it and help them to understand.

There were three comments on the need for staff to be able to speak more than one language to be able to meet the language needs of BME clients.

There were also calls for more interpretation/translation services. One consultation group stated that language was the biggest barrier especially in hospitals.

There was one comment that those who cannot speak English should go someway to alleviate this themselves and that translation services should be reserved to explain technical or difficult things.

The Council and NHS Lothian have policies in place to ensure equality and diversity in the recruitment and selection of employees and this is closely monitored. Monitoring information shows that the Health and Social Care (H&SC) workforce meets the target of reflecting the ethnic make-up of the city, for example 4.63% of H&SC employees are of Black Minority Ethnic (BME) origin against a general population of 4.2%. Language and communication skills are a key consideration in matching staff with service users. Self Directed Support will provide increased choice and control for service users to direct their own support to meet their particular needs.

The Council uses the ‘Happy to Translate’ logo on printed leaflets and materials. This is a national scheme which means that information will be provided in a range of languages or formats to meet the needs of the individual. The Happy to Translate initiative was developed with the input of service users and language professionals throughout Scotland.

The Council and NHS Lothian have an Interpretation and Translation Service for customers who need language and communication support to access services. [http://www.edinburgh.gov.uk/info/238/interpreting_and_translating_services/699/interpretation_and_translation]

8.1.2 Communication and printed materials

One group of services users stated printed material needs to be more accessible. Orange strips and white writing used on the ‘Edinburgh Card’ and other material is not easy to read. See guidance from Communication Forum Scotland.
One consultation group stated that easy to understand language should be used and that they should be visited in person to be told what has happened with the information that they gave.

One group called for a variety of methods to distribute information, including those who cannot read and are homeless.

*We aim to use easy read English wherever possible. In 2013, the Council is commissioning training for staff responsible for written communications to ensure all materials are more accessible.*

*Efforts have been made to make the Plan as easy to understand as possible by using ‘plain English’. The consultation document acknowledged that health and social care language can be complex and a glossary was included in both the consultation document and the full Plan. All documents can also be requested in a range of formats and languages.*

There was one comment that if services are not meeting the Care Inspectorate’s gold standard in consultation then they should be held to account.

*All providers are required to communicate effectively with service users, this is included within our contracts and is also an important part of external monitoring by the Care Inspectorate. The Council will suspend providers that do not meet grades 1 or 2 and will work with providers to address issues identified.*

### 8.1.3 Lesbian, Gay, Bisexual and Transgender (LGBT)

One group response stated that until more work is done to make mainstream services accessible, and to make older LGBT people confident that they are accessible, there is a need for specialised services.

In terms of improving mainstream services, they stated that one of the main aims of the Joint Commissioning plan should be to ensure that services are swift to address issues that may arise around transphobia and homophobia and to ensure that older LGBT people, who may not currently use services, are aware that transphobia and homophobia will not be tolerated.

One group stated that there is a need for LGBT people to have their own services where they feel safe to be themselves, alongside a need for other services to become accessible to and welcoming of LGBT people. There was one statement that LGBT people should not be outed if they are not out.

*See section 8.1 above which outlines the ongoing work of the Council and NHS Lothian to advance equalities and rights. Within older people’s services, work is underway to consider how services can improve their approach to equalities and rights, to ensure that the needs of all older people are appropriately met.*
Specialist services and support for LGBT people in Edinburgh are provided by the LGBT Health and Wellbeing Centre. The Partnership recognise the positive work of this unique centre and is committed to work with the centre, and particularly the LGBT Age project, funded through the Change Fund, to improve the accessibility of mainstream services. We also recognise that services need to be accessible and welcoming of LGBT people, but also respect people’s privacy and choice to either withhold or reveal information about their personal lives.

It is acknowledged that further work is required by all partners to promote services to ensure that all older people, including LGBT older people, are aware that prejudice will not be tolerated and any cases of this will be dealt with seriously. All services are required to have an effective complaints procedure (see section 8.2) and if issues such as transphobia and homophobia are experienced, this should be reported.

There were concerns of people being exposed to anti-LGBT beliefs and actions from poorly recruited and ill trained staff coming into people’s homes. There were concerns that many commissioned services are provided by faith groups and that these may expose LGBT people to inappropriate treatment. There were concerns that people may be forced out of the closet to address inappropriate behaviour they had been exposed to and a suggestion that a strictly anonymous whistle blowing policy for all commissioned services may make it easier for people to report such behaviour.

There was one comment that the plan may make isolation worse.

The level of consultation and response provided from the LGBT community has been gratefully received by the Partnership. Issues raised here relate specifically to staff training and the policies and practices of external providers. These issues are being taken forward through working with the LGBT Age project.

The risk of isolation is a key theme raised through the consultation responses for all older people. The particular risk for LGBT older people is recognised in the Plan (p28). Also see the response under section 1.1.

8.1.4 Sensory impairment

There was one statement that special services are required for people who are blind, deaf and people who have learning disabilities.

One response commented that the plan does not mention the need for good quality hearing services. There was stated to be a stigma around hearing loss within BME communities and that people with these difficulties can feel very excluded even in lunch clubs. Hearing loops would help.

The Plan recognises that more older people are living with long term conditions, disabilities and complex needs, including sensory impairment p26.
Specialist sensory impairment assessment and care management services are currently commissioned from RNIB and Deaf Action agencies. Further information is available on the Council’s website http://www.edinburgh.gov.uk/info/1397/disabilities/1129/sensory_impairment

A wide range of services are available for people with learning disabilities, and further information is provided in the Edinburgh Joint Learning Disability Plan.

8.1.5 Disabilities

There was one comment that there is a need to ensure that older disabled people receive equivalent services to younger disabled people.

See response in section 1.1.6 of this report about transitions between ‘adult’ and ‘older people’s’ services.

There was a call for transport for disabled people.

The Council and NHS Lothian work with a range of accessible transport providers to ensure that the transport needs of people with disabilities are met. See the response under section 3.5 ‘transport and physical environment’ for further information on the review of Community and Accessible Transport.

8.1.6 Dementia/ mental health

It was stated that older people should be treated with dignity and respect whether they live in the community or in a care home. One group called for dementia friendly communities, and for unpaid carers and people with dementia to be involved in designing care homes.

The Edinburgh Dementia Implementation Plan is currently being developed to ensure that people with dementia and their unpaid carers can access the support that they need when they need it. This work includes action that can develop dementia friendly communities and the quality of dementia care in 24 hour settings. There are some very good examples of planning and design for people with dementia within care homes in Edinburgh, including learning from the Dementia Services Development Centre in Stirling.

8.1.7 Cultural groups

One consultation group stated that more work was needed in care homes and hospitals to understand people’s cultural food choices.

Understanding people’s cultural food choices is an important part of broader awareness-raising of cultural issues. There are good examples where efforts have been made to cater for the needs service users, for example day services which source food from local Asian food providers.

A consultation group called for more in the plan on specialised cultural groupings as there were benefits to meeting each other to share problems.
We are aware that within any cultural grouping, there may be many sub groupings and that people within these groupings may benefit from meeting together. Grant funding is provided to support voluntary sector organisations that represent cultural grouping including:

- MILAN (supports older people from Indian, Pakistani, Bangladeshi & Mauritian Communities)
- NKS (Nari Kallyan Shangho, a health and welfare project for South Asian women and their families)
- MECOPP (supports Minority Ethnic Carers)
- Sikh Sanjog (supports women and families from Sikh and minority ethnic communities)
- Edinburgh Chinese Elderly Support Association
- Pakistan Society

A number of the groups listed above are involved in the review of minority ethnic day services (p47 of the Plan).

### 8.1.8 Faith

There was one call for spiritual care advisors.

There was a call for consideration of how services can help people to pursue their faith.

*The Council and NHS work closely with faith organisations. Health and social care services respect cultural practices.*

### 8.1.9 Matching workers and service users

One service user group commented on the need to look at a variety of issues in matching clients and workers. Examples included older women not being cared for by younger men, pregnant women not being matched with clients who need lifting and cultural restrictions on women and men mixing.

There was a further comment that consideration should be given to cultural issues, such as whether care workers should be the same sex as the client.

There was one comment that women should always have a female member of staff unless they specify that a male is acceptable.

*Careful consideration is made to appropriately match service users and workers and all service providers are required to actively accommodate service users' wishes wherever possible. Occasionally this is not possible due to the availability of staff. Further information about the diversity of staff recruited within health and social care is provided in section 8.4.2.*

### 8.2 Planning and monitoring
There were several calls to ensure proper representation of the diverse range of older people in planning services. This included talking to friends (who may be closer to the older person than family), families and care providers as well as older people.

There was one call to use questionnaires and focus groups. There was one call from services to communities to take account of the changing demographics of ethnic groups.

There were five suggestions that equality organisations or representatives from equality groups should be involved in planning services and identifying gaps.

The Council and NHS work closely with equality organisations and involve representatives from equality groups in developing plans. Examples of this might include engaging with existing forums such as the strategic Edinburgh Equalities Network and the City for All Ages Advisory Group, consulting with members of voluntary sector organisations that represent different groups, and establishing Checkpoint Groups or working groups to steer the development of specific services such as the review of ethnic minority day services.

There was one call for services to have a rapid impact assessment to ensure they are meeting the needs of people in equality groups. There were two calls for monitoring.

P70 of the Plan outlines how equalities and rights issues are advanced in all areas of work. This includes the use of impact assessments and ongoing monitoring of how these duties are being met. The partnership is committed to continue to mainstream this work 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.

One group stated that care will need to be taken that older people do not feel discriminated against in the way that services are configured and funding is prioritised.

There were two comments that careful monitoring is needed and one that unresolved cases should be taken to the ombudsman or a tribunal.

Health and social care services are subject to external scrutiny from Healthcare Improvement Scotland and the Care Inspectorate (p30 of the Plan). In addition, local quality assurance frameworks are in place which take a proactive approach to risk management and support intervention where necessary. A report from November 2012 outlines arrangements for Quality Assurance for Care Provided in People’s Home and in Residential Care.

All providers are required to have complaints procedures in place and complaints can also be made to the Council, NHS Lothian or the Care
Inspectorate. Unresolved cases can be taken to the Scottish Public Services Ombudsman.

There was one comment that consultation should be wide enough to be representative, and as the Joint Commissioning plan did not ask for details of respondents it was not seen how this representation can be achieved.

The consultation was open to all and efforts were made to encourage participation from as wide a range and large a number of people as possible with the time and resources available. Views were sought from equalities groups including minority ethnic older people’s groups and an offer was made to arrange consultation events with groups or individuals. The organisations that took up this offer are listed in Appendix 1. Other groups could take part in the consultation by completing the paper or online questionnaire which was made widely available. Further detail of the consultation activity undertaken is provided as part of this report. The partnership acknowledges that this is a qualitative consultation, which does not attempt to provide a statistically representative sample of the population. This report responds to the comments made on this basis, grouping comments by themes rather than attempting to weight or rank responses by prevalence.

There was one comment that the possible infringement of human rights should never deter actions that will help most people most of the time. There was another comment that everyone has rights.

An Equalities and Rights Impact Assessment is used to help to identify any positive and negative impacts that a service development may have. Wherever possible, action is taken to mitigate against potential negative impacts. Positive and negative impacts are weighed up and a recommendation made (see p70 of the Plan.)

8.3 Mainstream/ specialist services

Responses were divided between arguing for the needs of particular groups to be met and arguing that there is no need for specific services for particular equality groups.

There was one comment that other than disability, there should not be any extra effort, work or money given to any one group as all should be treated equally.

Nine responses stated that everybody should be treated the same, with the focus being on the illness and remedy, rather than the protected characteristics. There was a statement that people should not be pigeon-holed nor false divisions created. There was one statement that positive discrimination should not go too far.

There was one statement that everyone should have an opportunity to share their views regardless of their characteristics.
One group stated that it is difficult to get a balance between specialist services and reinforcing barriers between groups.

Ten responses called for people to be treated equally and fairly in good quality services rather than having specific services for specific groups. These responses stated that if an inclusive approach is adopted then specific services for particular groups are not required. One person stated that if the principles which govern care were met, not much more would be required for equality needs. Another stated that people from equality groups were no different from anyone else.

One response specifically addressed LGBT people and stated that they wanted to see integration rather than groups specifically for LGBT people, but that services needed to be accessible.

There was one statement that if certain requirements are outside medical needs then the patient should take responsibility to alleviate this, although some needs, such as for vegetarian food and perhaps halal/kosher, should be provided as a matter of course.

There was one comment that people live in the UK by choice and if the culture, food and facilities are unsuited to their needs then they should not expect special treatment.

The Partnership is committed to ensuring that services are accessible to all older people (p46). All service providers (including the Council, NHS, voluntary and private sector organisations) have a duty (part of the Equality Act 2010) not to discriminate on the basis of certain ‘protected characteristics’ and to make ‘reasonable adjustments’ in certain situations (see p70 and p87 of the Plan). The aim is to promote equity – not to treat everyone as the same, but to ensure that all older people experience an approved and equal standard of service.

There is therefore both a moral and legal imperative to consider how all services and service developments meet the needs of all older people, and if a need is not being met (for example through a fear of prejudice as raised by the LGBT consultation response) then extra effort, work or money may be required to ensure equality for all.

Our aim is for all mainstream services to be accessible to all older people. However, we do recognise that consideration needs to be given to specialist services to ensure that specific needs are met. We involve service users and relevant organisations in the development of such services, for example in the review of day services for minority ethnic groups. Specialist services will increasingly be required to demonstrate that they are developing ‘bridging’ or links with mainstream services.

The consultation was open to all and efforts were made to reach as many people as possible, through a range of consultation activity as outlined on p2 of this report.
8.4 Staff training and recruitment

8.4.1 Training

There were a number of calls for staff to receive training on equality issues.

There was one comment that staff should be educated as to disability and sexuality and keep their religious beliefs to themselves.

There were four calls for training workers in the needs of different equality groups, including in gender dysmorphia and gender identity.

There was a call for increased knowledge of disabilities, including those with sensory disabilities, and of LGBT people. There was one comment that it is shocking that so many staff in council services are discriminatory in their attitude to people with drug dependency.

Other risks identified were that staff may not have an understanding of other cultures, that staff may not be trained to keep their prejudice attitudes under control and that people may be racist or homophobic without knowing it.

There was one comment that people should be treated with respectful loving care and not a ‘you are getting it free’ attitude. There was another comment on the need for workers to have patience.

*Equalities training is available to all staff and this promotes treating people fairly and working to ensure that services are accessible and welcoming to all. The inclusion of the needs of specific groups outlined above will be considered in the ongoing review and development of equalities training programmes.*

There was one comment that a respondent’s relative can be racist now they have dementia and that they hoped this condition would be taken into account if they said anything offensive to anyone involved in their care.

*Raising awareness about dementia, including how it can affect people’s behaviour and steps that can be taken to manage this effectively, is important, for care workers, unpaid carers and the general public. These issues are addressed through existing training (see section 7.1 of this report for further information about dementia training). Wider awareness-raising is a key theme within the Edinburgh Dementia Implementation Plan (see p55 of the Plan).*

8.4.2 Recruitment

There were two calls to recruit people with protected characteristics.

*The Council and NHS Lothian have policies in place to ensure equality and diversity in the recruitment and selection of employees and this is closely monitored. Monitoring information shows that the Health and Social Care*
(H&SC) workforce meets the target of reflecting the ethnic make-up of the city, for example 4.63% of H&SC employees are of Black Minority Ethnic (BME) origin against a general population of 4.2%. 1.88% of H&SC employees report that they have a disability, with a further 7.7% not providing this information.

There was one call for apprenticeships.

See section 7.1.2 of this report which describes some of the initiatives underway to promote care as a career choice for young people, including modern apprenticeships.

There was one comment that volunteer opportunities should include all sections of the community.

*Edinburgh’s volunteering strategy ‘Inspiring Edinburgh’s Volunteers – Building on Success 2012-2017’* notes how all sections of the community are engaged in volunteering opportunities: “Volunteering by its very nature is an inclusive activity. Volunteers represent the diversity of Edinburgh’s population with people of different ages, genders, ethnic backgrounds and employment status all being involved.” The Council, NHS and third sector organisations actively recruit volunteers from a range of backgrounds to best support the older people that they work with.

### 8.4.3 Staff Support

One group stated that the Council needs to consider how to support staff who can face discrimination from service users on the basis of race, ethnicity, gender and sexuality. They stated that staff can be very vulnerable going into people’s homes.

*Training is provided in relation to dealing with challenging behaviour and aggression and policies are in place to protect staff working in people’s homes. However, it is acknowledged that discrimination can take many forms and staff need to be supported in these circumstances. Staff facing discrimination from service users was identified as an issue at a recent equalities workshop with older people’s service managers. Managers are giving further consideration of actions to address this issue.*

### 8.5 Working in partnership

One group stated that the voluntary sector has a wealth on expertise on equality issues and commissioners should use this.

There were two calls on the need to work in partnership with other agencies, and to have good communication. It was stated that the Plan should be clear that equality duties apply to both the Council and NHS Lothian and that they should work together on this issue.
Equalities duties apply not only to the Council and NHS Lothian but also to voluntary and private sector organisations and this has been made clear in the Plan (p70). The expertise of voluntary sector partners is used, for example in the planning and development of services and the completion of Equality and Rights Impact Assessments.

8.6 Advocacy

Two responses noted the importance of advocacy services. Too often whether or not someone has a good experience of social care depends on their ability to argue their case.

The Council and NHS Lothian fund independent advocacy services for older people, further information is available at www.edinburgh.gov.uk/info/1350/asking_for_support/733/independent_advocacy/1

8.7 General/ other equalities issues

There were calls to make sure that services understand the needs of and do not discriminate against:

- gay people
- transgender people
- transsexual people
- disabled people
- people from different cultures
- people with drug dependency.

All service developments require ERIA to be undertaken to give consideration to the above.

A diverse range of comments were received on how to ensure good equality practice. These included:

- have a good whistle blowing policy that protects whistle blowers
- set procedures that apply to everyone
- monitoring
- make devising imaginative consultation methods part of the PRD process.

There was one statement that the 4 on and 4 off shift pattern does not allow people to avoid work on their sacred days, or allow parents to spend weekends with children.

These issues were raised as part of the Equalities Impact Assessment for this service development, which included actions to mitigate any issues identified. www.edinburgh.gov.uk/downloads/file/7583/home_care_phase_2_service_for_people_with_complex_needs_eqia_may_2012
There was one statement that workers have not spoken out against the four on and four off shift pattern for fear of losing their jobs and that independent research should be undertaken to deal with victimisation.

The Council and NHS Lothian have clear procedures in place for staff to raise issues, for example Grievance Procedure, Fair Treatment at Work Policy, and Public Interest Disclosure (Whistleblowing) Policy. Staff were fully consulted on the changes to shift patterns referred to above and opportunities have been provided for any issues raised by individual staff to be discussed and addressed.

There was one statement that standards should be set out for the whole sector so that people have a norm against which to check their own situation.

There was one call for parks and steps to be cleared during bad weather so the elderly are not housebound.

The Council has systems in place to deal with severe weather. This includes the prioritisation of clearing and gritting roads and pavements and support, information and advice for vulnerable people.

EQUALITIES SUMMARY
Most responses were about the need to improve services for particular groups. This included meeting communication needs, including spoken language needs and written communication needs (such as suitable formatting of material). One group spoke of the needs of LGBT people, including the need for specialised services until mainstream services are truly accessible.
There were also calls for improved understanding of the needs of particular groups, and to work in partnership to improve in this area.

Responses were divided between arguing for the needs of particular groups to be met and arguing that there is no need for specific services for particular equality groups, as everyone should be treated fairly. There were also calls for improved language skills of care workers.

14 of the responses stated that the plan did not pose risks to or discriminate against people from equalities groups. Concerns were raised that LGBT people may face discrimination from users of services and from staff, especially as many community services are provided by faith groups. There was a comment that the Plan may make isolation worse. There were also concerns about clients posing risks to staff who are from equality groups.
9 ANY OTHER COMMENTS

In this section there was often a repetition of themes which had been important to people throughout the questionnaire.

9.1 Partnership working

A detailed response outlined how the independent and the third sector need to be better involved in strategic decision making, so that it is a joint plan representing four sectors and not just two. They stated that the plan needs to be rewritten to take stronger account of comments from these sectors. Their response is copied below:

“We do however believe that our partnership approach could be further consolidated beyond the existing practice of inclusion and attendance at meetings. We believe that we should be more included in the governance and strategic decision making including how decisions are formulated, prioritised and developed. We believe that the current way of working still sees decision making predominantly remain with the two statutory partners and this should now include the Independent Sector (and Third Sector) in a more meaningful way.

Scottish Care has set out its position in the attached document (Positive Care Making it Happen: Developing a Strategic Commissioning Framework for Care Services: The Independent Sector Perspective) that is based on good practice advice from a number of national bodies and many of our comments seek to emphasise those made in the document which we anticipate will be subject to further discussion in the partnership.

The Scottish Care document sets out high level objectives in seeking a level playing field through national and local commitment to -

- involvement of independent sector representatives in the governance of partnership commissioning decision-making bodies;
- involvement of independent sector provider representatives in the planning, development and delivery of Joint Commissioning Strategies;
- a national framework that establishes a fair rate for both home care and care home provision, whilst reflecting local factors that affect quality, price and sustainability;
- a more consistent approach to procurement based on –
  - an awareness of the impact of price on maintaining an appropriately skilled and qualified, competent and confident workforce;
  - a rigorous Best Value options appraisal as part of all procurement decisions;
  - tendering that focuses on outcomes, is proportionate and fit for purpose;
  - the commitment of all partners to deliver better outcomes through sustainable, quality and cost effective services.

We propose that the Joint Commissioning Strategy could be clearer and stronger, should take account of our comments and should be written from the four partners perspective and not the statutory sector per se. We endorse, for example, the all
partners’ statements on pages 4 & 5.

We wish to express our clear support for:

- an outcomes based approach to change (page 13 & 14);
- shifting the balance to preventive services (pages 25 & 26);
- to the strategic approach to enhanced services for people with dementia and respite services (page 36);
- to step up / step down Care Home services, provided options are objectively appraised (page 44);
- to a partnership commitment and approach to ensure more consistent quality in personal care services (page 49) but developed in partnership, owned by all partners and not imposed without due process;
- of the range of comments we make, we see the references to Best Value, cost and quality of services through a commitment to create a competent, confident workforce across all sectors as pivotal. We also acknowledge that with partnership comes responsibilities for development and delivery of partnership priorities and Scottish Care is prepared to continue to lead this on behalf of the Independent Sector.

We also believe that our comments resonate with most of the recently published requirements of the Scottish Government’s Joint Improvement Team.

Scottish Care has responded below to the questionnaire as requested. In addition to the above, we suggest:

- more can be said about demographic impact, and more worked-up by all partners to deal with the consequences
- that more can be said about conclusions and the need for change (page 28)
- we see a need for further work following receipt of all comments, and in response to the newly published information requirements from JIT.

We would signal our willingness to engage on these comments and to develop a genuinely four-partner Joint Commissioning Strategy.”

A meeting has been held with Scottish Care to discuss their consultation response and to agree changes to be made to the final Joint Commissioning Plan for Older People. In addition to membership on a wide range of meetings and forums, further discussion will take place to agree action points as part of the ongoing development of the partnership, which includes Scottish Care as a key partner.

9.2 Concerns about the consultation document

A number of respondents used the ‘Other’ section to raise their concerns about the questionnaire.

Many people read and responded to the consultation document. This 14 page document aimed to summarise some of the key messages of the Joint Commissioning Plan for Older People. The full 60 page document was made available online and respondents could request a paper copy. Many of the issues raised by respondents relate to more detailed information contained
within the full Plan. This report gives the page numbers where further information can be found.

Linked to concerns about whether the plan could be funded, several respondents expressed concern that the consultation document did not give details of costing to support the proposals and that this was a lack in the consultation.

Further information about the financial framework is provided in the Plan (p32). Whole system financial planning is a continuous process, requiring to be adjusted to reflect the significant changes in demand, available resources and to incorporate new service models as they develop. Methods of modelling future demand, capacity and finances are well established in many areas of service and action is underway to further develop and join up this work to create an integrated financial plan.

One group stated that the key aims at the beginning of the plan and the supporting documents need to be more balanced as they are too positive at the moment.

See response at 6.1.5.

There was one comment that consultation with certain groups can lead to skewed responses.

The consultation was open to all and efforts were made to reach as many people as possible. This report aims to reflect the views contained within the responses received, whilst giving a balanced response. The consultation is of a qualitative nature, it does not claim to be statistically representative of the population and responses have not been weighted in any way.

There was one comment that this is an insulting document; a young person’s idea of older people.

There was one complaint that the document has used expensive paper and reflects the egos’ of the people involved.

The consultation document was designed with the input of members of the Checkpoint Group which includes older people and representatives from other interest groups (Appendix 2). Consideration was given to issues of accessibility, length of the document, content, language, format and design. Examples of similar consultation documents from elsewhere in the UK were also considered.

One group stated that the consultation is a waste of time and they could have spent the money better themselves on supporting people with cultural needs. They wanted someone to come and tell them what had been done about the information that they had given.
A group said that regular feedback to service users and providers about decision making will be key for the Plan to be supported.

The Council, NHS and partners are committed to ongoing consultation with stakeholders, including providers and service users. A Communication and Engagement Strategy is in place for the Reshaping Care for Older People programme, and related Personalisation and Integration of Health and Social Care programmes. Engagement takes place through a wide range of activity and forums using varied communication channels.

Following the publication of the final Joint Commissioning Plan for Older People, a summary document will be produced and key messages from the Plan will be communicated to a wide range of stakeholders. The Checkpoint Group will continue to be instrumental in this process, and will also assist with communicating the results of the consultation to those that took the time to respond.

The final Plan includes specific actions within Part Two and these are shown in an action plan in Appendix 3 of this report. The implementation of the action plan will be overseen by the Joint Older People’s Management Group. A bi-annual progress report will be produced and reported to the relevant Council and NHS committees.

Also section 3.10 of this report in relation to engagement in consultation.

9.3 Other

There was one comment that it is important to support charities like Pilmeny Development Project which the respondent had greatly benefited from.

The Council and NHS work closely with organisations such as Pilmeny Development Project. The contribution made by voluntary organisations in supporting older people is recognised in the Plan (p15, p43).

There was one comment that the community charge should be reassessed for older people who chose to live in the family home and remain a part of the community.
There were a number of key themes which recurred throughout responses to different questions. These included:

**Social integration.**
Respondents were keen to emphasise the importance of social integration. This was a theme which appeared strongly across questions in the consultation. Respondents both stressed how important it was to keep people connected to their communities and suggested potential gaps in current provision.

*Social isolation and the importance of supporting older people to be connected to their communities is a strong theme within the Plan. There is growing evidence of the significant risks to health and wellbeing posed by being lonely and isolated. The Plan supports the development of a preventative approach and this report includes details of relevant services and sources of information such as day services for older people, the Community Connecting service, the Get Up and Go publication and the range of voluntary and community based organisations that have an important role in reducing the isolation of older people (see sections 1.1.1 and 3.1).*

**Sheltered housing**
A group response from residents of a housing association sheltered housing scheme and a number of individuals expressed support for an ongoing role for wardens in sheltered housing.

*Warden services are highly valued in providing low level preventative support and access to social activities. However, these are only available to a small number of people in some sheltered housing. Demographic and financial pressures mean it is not possible to provide this for all older people. The Council is currently carrying out extensive consultation on proposed changes to Council managed Sheltered Housing as reported to Health, Wellbeing and Housing Committee on 23 April 2013. These consider whether there is potential to change the role of wardens in Council owned sheltered housing.*

**Housing**
Generally, respondents were supportive of the aims of the Plan, to support older people to live in their homes where possible and noted the services and supports that enable this to happen. Comments were raised on the availability of suitable housing for older people and housing support services, which were both felt to be important in supporting people to live independently in the community. Other feedback related to housing included points about aids, adaptations and telecare.

*See section 4 of this report for responses to these issues.*

**Advice and information provision**
The need for good quality and accessible information provision to underpin successful delivery of the aims in the consultation document were raised repeatedly.

Sections 1.2.2, 3.3, 4.8 and 5.11 of this report provide details of actions underway to improve the availability and accessibility of information, including a series of local information days for older people, improved engagement with and information for health professionals about the services available for older people within the community and the development of a comprehensive directory of services.

Joint working
This was raised across questions, both by organisations and by individuals. There were calls for improved joint working both in terms of better communication between agencies, improved location of services (particularly health services) in communities, better sharing of information and expertise and in terms of better strategic partnership working.

The Plan sets out a commitment to continue to build relationships and further develop the processes and supports required to continue to improve partnership working in Edinburgh. This includes working in partnership at all levels from strategic decision making to working in partnership with individuals in planning and arranging care. Forthcoming legislation for the Integration of Health and Social Care will further support joint working between the NHS, Council and partners. See sections 3.9, 5.6 and 7.3 of this report.

Finance
There was support for the plans but fears that sufficient funding is not available for them to be delivered.

See section 1.2.1 of this report which responds to the issues raised.

Monitoring
The need for careful monitoring and scrutiny of services as well as of decision making processes was raised by a small number of respondents throughout the questionnaire.

Ensuring good quality services is a priority within the Plan. See sections 6.1.4, 7.2.3 and 8.2 of this report for further detail.

Transport
The importance of accessible transport options that can help people to remain connected and reduce social isolation was raised through the consultation, in addition to the particular need for transport to hospital and medical appointments.

The Plan acknowledges that transport is vital in supporting older people to live in the community and in maintaining connections. In recognition of this important role, arrangements are being finalised to review Community and Accessible Transport across the city. The Review will consider many issues
including those identified through the Plan and raised through the consultation feedback. See section 3.5 of the Consultation Report for further detail.

Needs of particular groups
The needs of the following groups were highlighted through the consultation and responses provided within the relevant sections of this report:

- LGBT people (see sections 1.1.6 and 8.1.3)
- older people with drug dependency (2.1.6 and 3.8)
- older homeless people (1.1.6)
- people with Parkinson’s disease (1.1.6)
- services for the hearing impaired (8.1.4)
- older people with mental health issues (3.8, 4.10 and 5.3).
Appendix 1

Joint Commissioning Plan for Older People

Consultation Summary

**General promotion** of the consultation included:
- 2000 flyers mailed to a random sample of social care service users
- Emails to a wide range of available networks (approx 500 people) including health and social care staff, service providers, Neighbourhood Partnerships, housing associations, unpaid carers groups and a range of groups and forums.
- Articles were featured in staff newsletters
- Press releases, social media (Twitter and Facebook) and the Council, NHS and partner websites have been used
- Materials were shared at a series of unpaid carer engagement events facilitated by Out of the Box
- Consultation materials were available at the Information Day at the Assembly Rooms on 27th November

Presentations were made and feedback recorded at a range of **management and team meetings**, including:
- Joint Older People’s Management Group
- Hospital Stakeholders Meeting
- Homecare Managers’ Meeting
- Citywide Sector Practice Managers’ Meeting
- Day Services Managers’ Meeting
- Assessment and Supported Housing Management Team
- Libraries and Information Services Management Team

Presentations/dischussions were held with a range of **external service providers**, including:
- Care Home Providers’ Meeting
- Care at Home Providers’ Meeting
- EVOC Older People’s Service Providers’ Forum
- Scottish Care

An offer was made to attend a wide range of **service user forums**. Groups which took up this offer included:
- A City for All Ages
- North East Edinburgh Care Action Group (NEECAG) Leith and Portobello
- Nari KallyanKallyan Shangho (NKS) (South Asian Women’s Group)
- MILAN Senior Welfare Organisation
- Deanaugh St, Trust Housing Association, sheltered housing residents meeting
- Lothian Centre for Inclusive Living (LCIL) hosted a coffee morning
- 3 consultation events were held with LGBT older people
## Consultation events

<table>
<thead>
<tr>
<th>Group</th>
<th>Date(s)</th>
<th>Number attending (approximate)</th>
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</thead>
<tbody>
<tr>
<td>Joint Older People’s Management Group</td>
<td>30 August 2012</td>
<td>16</td>
</tr>
<tr>
<td>Hospital Stakeholders Meeting</td>
<td>3 October 2012</td>
<td>10</td>
</tr>
<tr>
<td>Homecare Managers’ Meeting</td>
<td>6 November 2012</td>
<td>10</td>
</tr>
<tr>
<td>Citywide Sector Practice Managers’ Meeting</td>
<td>14 November 2012</td>
<td>12</td>
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<tr>
<td>Day Services Managers’ Meeting</td>
<td>29 November 2012</td>
<td>9</td>
</tr>
<tr>
<td>Assessment and Supported Housing Management Team</td>
<td>16 November 2012</td>
<td>8</td>
</tr>
<tr>
<td>Libraries and Information Services Management Team</td>
<td>10 December 2012</td>
<td>4</td>
</tr>
<tr>
<td>Care Home Providers’ Meeting</td>
<td>23 October 2012</td>
<td>20</td>
</tr>
<tr>
<td>Care at Home Providers’ Meeting</td>
<td>11 December 2012</td>
<td>20</td>
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<tr>
<td>EVOC Older People’s Service Providers’ Forum</td>
<td>7 November 2012</td>
<td>15</td>
</tr>
<tr>
<td>Scottish Care</td>
<td>13 July 2012</td>
<td>1</td>
</tr>
<tr>
<td>A City for All Ages</td>
<td>18 September 2012</td>
<td>15</td>
</tr>
<tr>
<td>North East Edinburgh Care Action Group (NEECAG) Leith and Portobello</td>
<td>7 and 27 November 2012</td>
<td>12</td>
</tr>
<tr>
<td>Nari KallyanKallyan Shangho (NKS) (South Asian Women’s Group)</td>
<td>14 December 2012</td>
<td>12</td>
</tr>
<tr>
<td>Deanhaugh St, Trust Housing Association, sheltered housing residents meeting</td>
<td>5 November 2012</td>
<td>8</td>
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<tr>
<td>Lothian Centre for Inclusive Living (LCIL) hosted a coffee morning</td>
<td>13 December 2012</td>
<td>9</td>
</tr>
<tr>
<td>Event Type</td>
<td>Date(s)</td>
<td>Count</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>LGBT older people events</td>
<td>21 September, 23 November, 25 November 2012</td>
<td>47</td>
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<tr>
<td>John Ker Court residents</td>
<td>November 2012</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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Appendix 2

Commissioning Plan for Older People - Checkpoint Group

Remit

- To agree an engagement and communications strategy, which will be employed for the consultation on the commissioning plan, reviewed and embedded within the final document as a model of best practice.
- To contribute to the vision for the plan
- To be aware of the key stages in the project plan and comment on them
- To advise on communication methods
- To contribute to the Equalities Impact Assessment
- To be a contact point for future independent evaluation of the commissioning plan
- To represent views to the commissioning plan Project Executive

This will be done by:

- Meetings of the Group at key stages in the project, built into the project plan
- Provision of short updates
- Seeking the views of representatives, which will be taken in to account to influence the shaping of the document
  - Some of this will be around the table viewpoints to ensure everyone’s voice is heard
  - Where appropriate, wider audiences will be informed and views sought (particularly for hard to reach groups).

Formation of the Group

The Project Executive will agree a framework for the membership of the Group.

Membership will include representation from service user and carer groups, advocacy groups, the voluntary, community, charity and private sector, equalities groups and Council and NHS staff.

The Group will have an independent chair.
List of Members:

Chair - Tim Puntis, volunteer with the Lesbian, Gay, Bisexual and Transgender (LGBT) Centre for Health and Wellbeing

Colin Murray/ Ian Brooke - Edinburgh Voluntary Organisations Council
Irene Garden – older person, member of NHS Public Partnership Forum and other NHS stakeholder groups, wheelchair user
John Moore – Lothian Community Transport Services
Joyce Armstrong – older person, member of A City for All Ages Advisory Group and other stakeholder groups
Lorna Wynn – Partners in Advocacy
Rohini Sharma Joshi – Trust Housing
Sandra Warburton/ Rene Rigby – Scottish Care
Wendy Laird – older carer, member of a range of stakeholder groups

Officers
Dorothy Hill – Communications and Engagement Manager, Health and Social Care, City of Edinburgh Council
Ewan Blain – Sector Manager, Health and Social Care, City of Edinburgh Council
Gillian Donohoe – Senior Project Manager, Housing Strategy and Investment, Services for Communities, City of Edinburgh Council
Jamie Hetherington - Change Fund Implementation Manager, NHS Lothian
Katie McWilliam - Strategic Programme Manager, Older People, NHS Lothian
Tricia Campbell – Senior Manager for Older People, Health and Social Care, City of Edinburgh Council
Caroline Clark – Planning and Commissioning Officer, Health and Social Care, City of Edinburgh Council
This is a consultation on a joint plan between NHS Lothian and the City of Edinburgh Council in partnership with Scottish Care and Edinburgh Voluntary Organisations Council (EVOC). The plan explains how we wish to improve services for older people over the next ten years.

The plan is still in draft until we hear the views of people who wish to participate in the consultation. The full document is on our website or you can contact us to request a copy.

We have produced this booklet to help you understand the plan and to encourage you to tell us what you think. The booklet contains some notes to explain a bit more about why we have produced the plan and why we want to hear people’s views. There is also a questionnaire.

The questionnaire can be completed by individuals on their own, by someone else helping a person to complete it, or by groups. All we ask is that you tell us how you are completing the questionnaire on page 5.

Social care and social work language can be complex and some terms may be unfamiliar to you. We have done our best to make the language in this document as straightforward and as accessible as possible.

We have marked phrases that might need further explanation in bold – you’ll find a more detailed explanation of these words at our glossary on page 14.
Our plans – what we are aiming for and how we will do it

- We recognise the value that older people bring to our communities and so we will focus on what they can offer, as well as on care and support for those that need it.

- We are committed to involving older people, their carers and representatives in producing our Joint Commissioning Plan and in ongoing development of care services.

- The Council, NHS, voluntary and private sectors will work as equal partners on the planning of services.

- We have formed an advisory group (Checkpoint Group) involving older people, their representatives and providers of service to oversee this plan.

- We will report the outcome of the consultation and proposals for the plan through the Council and NHS decision making arrangements.

- The plan, once approved, will be monitored by the Checkpoint Group and the multi-agency Older People’s Management Group.

Current services

Here is a list of some of the services available for people when they need care and support (there may be a cost for some services):

- lunch and day clubs
- befriending
- volunteering
- community transport
- support for carers
- information and advice
- planning care and support for the future
- promoting health and wellbeing
- care at home
- community alarms
- housing
- equipment and adaptations for the home
- community nursing
- help to get home from hospital, (including physiotherapy, occupational therapy)
- rehabilitation/reablement
- day care
- help with medication
- day hospitals
- care homes
- urgent hospital care
- general practitioners (GPs)
- social work assessment (hospital and community)
- end of life care

Finance – what we spend on services

A total of almost £217 million will be spent between 2012 and 2013 on services for older people. The largest part of this (just over £119 million) will be spent on the smallest number of people receiving intensive care and support in hospitals or care homes.

Another £54 million will be spent on assisting people who need a bit more care and support at home. Just over £4 million will
be spent on helping people at an early stage to stay at home and in their community.

Reasons for change

In 2007, we consulted on our plan ‘Live Well in Later Life’ for older people’s services. Many improvements have been made since then. However, more needs to be done to respond to the changing needs of older people in our population and their carers.

Challenges can also present opportunities: for example, the growing number of older people in the population, most of whom do not need care services, make a great contribution to society. Many are carers themselves and many communities depend on the voluntary work of older people.

In line with the Scottish Government’s policy, ‘Reshaping Care for Older People’, we want to continue to do all we can together to increase the independence and wellbeing of older people at home or in a homely setting. For people who need it, we will also continue to develop the service provided by care homes.

A lot of progress has been made, but we need to respond to:

- the estimated increase in demand from the growing number of older people
- increasing number of people living with dementia and other complex health problems
- the need to build on the existing support for unpaid carers
- people living longer with long term health conditions
- the need for our services to be increasingly responsive while ensuring good quality
- the need for services to be inclusive of minority groups
- the need to expand housing options
- the need to continually improve the quality of services
- the number of people delayed in hospital
- the number of people over 75 admitted to hospital following an emergency
- any impact of new legislation to give people a different way of obtaining the care they need. (The Social Care [Self Directed Support] Scotland Bill).

What we propose

Through our plan for the future, we aim to support people to maximise their independence and quality of life. This means we will:

- take account much more of long term conditions
- build on support for unpaid carers
- focus more on preventative care
- support self management, choice and control.
- work with communities to reduce social isolation.
the QUESTIONNAIRE
Question 1: our vision

Here is our proposed vision for older people living in Edinburgh:

Edinburgh is a city which values older people and respects 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 their communities
- have choice and control to access quality care and support.

Do you have any comments or suggestions on our proposed vision?


Question 2: financial implications

Clearly, the money available for older people’s services is not unlimited. The diagram opposite illustrates how our combined budgets are currently allocated. We want to use the money available to achieve the best outcomes for older people.

By investing more in preventative and community based services for people, we can reduce costly emergency admissions to hospital. This will allow money to be released from hospital budgets and invested in community services.

Tell us what you think of these plans. How do you think the money available for older people’s services should be invested to achieve the best outcomes for older people?
Question 3: promoting health and wellbeing

To support people with lower levels of need at an early stage to stay at home and in the community, we will:

• invest in communities to reduce social isolation
• improve support for carers
• provide information and advice
• ensure the interests of equality groups are heard.

We will invest in:

• locally based projects that support volunteers
• services that connect socially isolated people
• accessible community transport options
• lunch clubs and day services
• projects that help build resilient communities
• increasing the awareness of community-based services and support, including community learning and activities
• preventative services that promote health and prevent negative outcomes
• support for carers when those they care for leave hospital
• support people with dementia and their carers, by developing existing services and employing carers as mentors
• support for carers (including information/advice and respite)

• information on activities and opportunities for older people
• a community-based electronic service directory
• promotion of information about specific health conditions
• encouraging people to plan for the future
• housing options advice.

We will also:

• assess the impact of all proposed changes on equalities groups
• encourage older people and their carers to get involved in planning services
• engage with carers in reviewing the Edinburgh Carers’ Plan
• continue to focus on reducing health inequalities.

Tell us what you think of these plans to promote health and wellbeing. Have we covered everything? Please add anything you think we have missed.

3
Question 4: care and support at home

When people need more care and support to help them stay at home, we will:

- provide high quality care in people’s homes
- invest in a range of housing options
- support people with adaptations and equipment
- develop day services and day hospitals
- provide support for people with long term conditions
- use technology to help people stay safe in their homes.

We will invest in:

- the ongoing modernisation to our home care and care at home service
- out of hours health and social care services
- the home care overnight service (expanding it from three to five teams)
- the development of a range of services to support and encourage people to direct their own support.

We will also:

- provide a housing support service
- support health care in the community through community

nursing, GPs, occupational therapists, physiotherapists, dentists, ophthalmologists and podiatrists

- review the current sheltered housing stock and the services offered by sheltered housing providers
- increase the number of people supported with equipment
- develop a community connecting approach in all day services
- work with partners to improve local resources for older people
- continue specialist day services
- extend services to help people who need support to manage long term health conditions
- increase the number of people with complex needs and dementia benefiting from telecare
- pilot the use of new telehealth technology.

Tell us what you think of these plans to provide care and support at home. Have we covered everything? Please add anything you think we have missed.
Question 5: support at times of change

When people need specific care and support, for example, following a stay in hospital, we will:

• develop a range of reablement and intermediate care services
• improve the links between different types of care
• support people with dementia and their carers
• support people through day hospitals and rehabilitation centres
• provide good quality end of life care.

We will invest in:

• community-based services such as reablement, physiotherapy, speech and language services, dietetic services and community pharmacy services for reviewing medication
• the early diagnosis of dementia
• a range of services to support carers of people with dementia, including specialist respite services.

We will also:

• improve care for older people through closer working between medical specialists, GPs and other community-based services
• adapt our care services to ensure people with dementia get the service most appropriate to them

• support people with dementia in familiar homely environments for as long as possible
• increase the availability of medical assessments within day hospitals as an alternative to and to prevent hospital admission
• use day hospitals as part of care and support after a hospital stay

• improve palliative care, including good symptom control, holistic assessment involving family and carers’ needs, choices around treatment options, place of care and preferred place of death.

Tell us what you think of these plans to provide extra support when people need it. Have we covered everything? Please add anything you think we have missed.

5
Question 6: hospital and residential care

For people who need to be cared for in hospital and in care homes, we will invest in good quality hospital and residential care.

We will do this by:

• improving care for people in hospital wards who have dementia, are suffering from confusion, or who are agitated and restless due to illness

• continuing the refurbishment and new build programme for Council care homes, including opening a new care home at Drumbrae in 2013

• improving quality assurance for all care homes

• supporting care homes in caring for increasingly frail residents

• ensuring better planned care to reduce the number of emergency admissions to hospital

• continuing to invest in activities both within care homes and for care at home residents in the community

• developing opportunities for care homes to offer step-up or step-down care after hospital

• improving the design of care homes to make it easier for people with dementia to settle.

Tell us what you think of these plans for hospital and residential care. Have we covered everything? Please add anything you think we have missed.

Question 7: our workforce

Our services will need a skilled workforce. We aim to:

• develop our understanding of the existing health and social care workforce in the city to inform how we plan to meet future demands

• work jointly with all partners to raise the profile of care as a career choice

• continue to develop joint learning and development opportunities to ensure that Edinburgh has a confident and competent workforce.

Tell us what you think of our plans for our workforce.
Question 8: equalities standards

Under the Equality Act 2010, councils have a duty to assess and review the impact of their policies and practices on equality groups.

Equality groups comprise of individuals with ‘protected characteristics’. The Equality Act defines these as including age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation.

What do you think we should do to ensure that our services positively contribute to promoting equality and good relations?

Are there any issues we need to consider in relation to individuals with protected characteristics?

Question 9: equalities needs

What services should be in place to meet the specific needs of people in equality groups and why?

Question 10: equalities risks

Please tell us if you think the plan might:

• pose any risk to people's rights – and why you think this.

• discriminate against any person or group, cause people to be harassed or victimised and why.

Joint Commissioning Plan for Older People Questionaire • 11
Question 11: other comments

Please add below anything you feel you’ve not had a chance to say so far in the questionnaire.

You may include here what you think are the most positive proposals and any fears you have about the outcome of any part of the plan.

Thank you for completing the questionnaire.

Question 12: about you

Please tell us if you are responding as:

☐ an individual.

☐ a group or organisation.

If you are responding as a group, please tell us the name of your group:

[Box for group name]

We will not make your response available to the public, but may list your group or organisation’s name when we publish a response to this consultation.

Are you happy for the name of your group or organisation to be listed?

☐ Yes.

☐ No.

We may wish to contact your group or organisation about your response. Are you happy to be contacted?

☐ Yes.

☐ No.
Glossary of terms

Health and social care terms can be quite complex. Here is a list of key terms that have been used throughout this document.

**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.

**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.

**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.

**Dietetic services**
Specialist advice on diet and nutrition.

**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.
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.

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
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.

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:
- 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
- promotes and improve people’s quality of life, independence, engagement with the community, learning, or which create healthy and supportive environments
- prevents inappropriate use of more intensive services where needs could be met by lower cost services or interventions

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.
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.

Reablement
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.

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/telehealth
Equipment and services that support people’s safety and independence in their own home. Examples include personal alarms, smoke sensors, etc.
You can get this document in Braille, tape, large print and various computer formats if you ask us. Please contact the Interpretation and Translation Service (ITS) on 0131 242 8181 and quote reference number 12-0490.

ITS can also give information on community language translations.
‘Live Well in Later Life’

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

<table>
<thead>
<tr>
<th>Strategic Vision</th>
<th>Draft Edinburgh Health and Social Care Partnership Strategic Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pledge</td>
<td>Health and wellbeing are improved in Edinburgh and there is a high quality of care and protection for those who need it</td>
</tr>
<tr>
<td>Strategic Vision</td>
<td>Working together for a caring, healthier, safer Edinburgh</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Outcomes</th>
<th>Strategic Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Need and dependency on formal services are reduced</td>
<td>A Developing preventative services and anticipatory care</td>
</tr>
<tr>
<td>2 Care and support is personalised and person-centred</td>
<td>B Developing effective personalised services and person-centred pathways of care</td>
</tr>
<tr>
<td>3 Edinburgh’s carers are supported to continue in their caring role</td>
<td>C Improving and increasing support for carers</td>
</tr>
<tr>
<td>4 People are supported and cared for at home or in the most appropriate setting</td>
<td>D Helping people improve and maintain their independence</td>
</tr>
<tr>
<td>5 Communities are inclusive and supportive</td>
<td>E Developing the capacity and investment of communities</td>
</tr>
<tr>
<td>6 People and communities are safe and protected</td>
<td>F Integrating and improving our approaches to public protection</td>
</tr>
</tbody>
</table>

**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:

- G Improving quality through the delivery of care and support services that are safe, effective and sustainable
- H Reducing poverty, inequalities and unequal health outcomes
- I Engaging with all our stakeholders to improve people’s experience of health and care services
- J Engaging, supporting and developing all staff across sectors

Taken from the “Draft Health and Social Care Strategic Work Plan” 2013.
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 (p63).

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 focusing 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:

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

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.
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](image)

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.

![Care home places in Edinburgh by sector. Source: Scottish Government](image)

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.

**New Models of Care – Key Developments**

![Diagram](image)

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.

REDUCING DELAYED HOSPITAL DISCHARGE
Number of patients ready for discharge: Edinburgh
April 2004 - April 2012

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 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):

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\(^1\) HEAT – T12: Emergency Bedday rate of persons 75+

\(^2\) CEL, 2008 (6) NHS Continuing Healthcare – February 2008
<table>
<thead>
<tr>
<th>Proportion of residents whose stay was less than two years</th>
<th>2007</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51%</td>
<td>56%</td>
</tr>
<tr>
<td>Proportion of residents whose stay was five years or more</td>
<td>18%</td>
<td>15%</td>
</tr>
</tbody>
</table>

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, 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% 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. 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.

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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 background.

\(^5\) 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.
In 2010/11 Edinburgh spent £10.7 million 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 choose 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>National Change Fund</th>
<th>Edinburgh’s allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>£70m</td>
<td>£6.013m</td>
</tr>
<tr>
<td>2012-13</td>
<td>£80m</td>
<td>£6.872m</td>
</tr>
<tr>
<td>2013-14</td>
<td>£80m</td>
<td>£6.872m</td>
</tr>
<tr>
<td>2014-15</td>
<td>£70m</td>
<td>£6.013m</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of people 2012</th>
<th>Estimated number of people 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative services</td>
<td>17,250</td>
<td>20,900</td>
</tr>
<tr>
<td>Proactive care and support at homes</td>
<td>33,000</td>
<td>39,900</td>
</tr>
<tr>
<td>Effective care at times of transition</td>
<td>5,800</td>
<td>7,050</td>
</tr>
<tr>
<td>Intensive care and specialist support</td>
<td>4,700</td>
<td>5,750</td>
</tr>
</tbody>
</table>

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.

![Diagram showing financial resource allocation](image)

**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.

![Pie chart showing financial resource allocation](image)

**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.

**Shifting the balance of investment**

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:

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

\(^6\) Source: Commissioning Strategy for Care and Support 2011-16
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

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.
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](image)

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
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.

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.

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)
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:
  o 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
  o 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.
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

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.
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.

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**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 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.

<table>
<thead>
<tr>
<th>In the short to medium term (1-3 years) we will:</th>
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<tbody>
<tr>
<td>• continue to develop the adaptations process</td>
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<tr>
<td>• further develop our flexible approach to adaptations and expand the range of adaptations available</td>
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<tr>
<td>• increase the provision of equipment to support more people to live safely and independently in the community</td>
</tr>
<tr>
<td>• increase the number of bathing and toileting assessments undertaken by the equipment and adaptations service</td>
</tr>
<tr>
<td>• review capital investment requirements, to consider, amongst other things, the needs of the growing population of older people.</td>
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</table>

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.
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.

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**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.

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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.
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.

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.

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

2) Effective care pathways are developed
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

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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.

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**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.
• 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:
  o Still Caring – developing a range of support services for carers of people with dementia
  o Canalside Connections – flexible support service to people with dementia who are living at home
  o Senior Saheliya – support earlier diagnosis and interventions for people with dementia amongst black and ethnic minority women in Edinburgh
  o 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.
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.
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
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.
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”.

Service Movements by 2022

Anticipated number of people with high levels of need in 2022 is 5,760
Long stay beds include care homes and NHS inpatient complex care

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.

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

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.

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11 Baseline</td>
<td>Projection including enhanced community rehabilitation/support functions</td>
<td>Projection including impact of initiatives to reduce the length of stay in acute hospital beds</td>
<td>Projection including demographic impact to 2020</td>
</tr>
<tr>
<td>Total beds required</td>
<td>688</td>
<td>582</td>
<td>526</td>
</tr>
</tbody>
</table>

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 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 coordinating 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:
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)


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


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 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 is 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:

<table>
<thead>
<tr>
<th>Scottish Population 2010</th>
<th>% of Males with disability</th>
<th>% of Females with disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group 60 - 69</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Age Group 70+</td>
<td>48</td>
<td>52</td>
</tr>
</tbody>
</table>

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](http://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.

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

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Date opened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marionville</td>
<td>2007</td>
</tr>
<tr>
<td>Castlegreen</td>
<td>2007</td>
</tr>
<tr>
<td>North Merchiston</td>
<td>2009</td>
</tr>
<tr>
<td>Inchview</td>
<td>2010</td>
</tr>
<tr>
<td>Drumbrae</td>
<td>2012</td>
</tr>
</tbody>
</table>

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 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 safeguard 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 COMPrehensive ASSessment 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

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

<table>
<thead>
<tr>
<th>LOS Grouping</th>
<th>Local Authority</th>
<th>Private</th>
<th>Voluntary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>less than 3 months</td>
<td>18</td>
<td>5</td>
<td>117</td>
<td>10</td>
</tr>
<tr>
<td>3-&lt;6months</td>
<td>24</td>
<td>7</td>
<td>81</td>
<td>7</td>
</tr>
<tr>
<td>6 months - &lt;1 year</td>
<td>47</td>
<td>14</td>
<td>187</td>
<td>17</td>
</tr>
<tr>
<td>1 year - &lt; 2 years</td>
<td>105</td>
<td>30</td>
<td>246</td>
<td>22</td>
</tr>
<tr>
<td>2 years - &lt;3 years</td>
<td>59</td>
<td>17</td>
<td>166</td>
<td>15</td>
</tr>
<tr>
<td>3 years - &lt;4 years</td>
<td>44</td>
<td>13</td>
<td>98</td>
<td>9</td>
</tr>
<tr>
<td>4 years - &lt;5 years</td>
<td>13</td>
<td>4</td>
<td>62</td>
<td>6</td>
</tr>
<tr>
<td>5 years plus</td>
<td>38</td>
<td>11</td>
<td>161</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>348</td>
<td>1118</td>
<td>396</td>
<td>1862</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>LOS Grouping</th>
<th>Local Authority</th>
<th>Private</th>
<th>Voluntary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>less than 3 months</td>
<td>55</td>
<td>9</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>3-&lt;6months</td>
<td>32</td>
<td>6</td>
<td>73</td>
<td>6</td>
</tr>
<tr>
<td>6 months - &lt;1 year</td>
<td>82</td>
<td>14</td>
<td>144</td>
<td>13</td>
</tr>
<tr>
<td>1 year - &lt; 2 years</td>
<td>133</td>
<td>23</td>
<td>235</td>
<td>21</td>
</tr>
<tr>
<td>2 years - &lt;3 years</td>
<td>82</td>
<td>14</td>
<td>145</td>
<td>13</td>
</tr>
<tr>
<td>3 years - &lt;4 years</td>
<td>50</td>
<td>9</td>
<td>140</td>
<td>12</td>
</tr>
<tr>
<td>4 years - &lt;5 years</td>
<td>46</td>
<td>8</td>
<td>84</td>
<td>7</td>
</tr>
<tr>
<td>5 years plus</td>
<td>101</td>
<td>17</td>
<td>207</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>581</td>
<td>1128</td>
<td>482</td>
<td>2191</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>less than 3 months</th>
<th>3 - &lt;6 months</th>
<th>6 months - &lt; 1 year</th>
<th>1 year - &lt; 2 years</th>
<th>2 years - &lt; 3 years</th>
<th>3 years - &lt; 4 years</th>
<th>4 years - &lt; 5 years</th>
<th>5 years and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>12%</td>
<td>7%</td>
<td>13%</td>
<td>17%</td>
<td>14%</td>
<td>10%</td>
<td>8%</td>
<td>19%</td>
</tr>
<tr>
<td>2009</td>
<td>10%</td>
<td>8%</td>
<td>12%</td>
<td>19%</td>
<td>15%</td>
<td>10%</td>
<td>8%</td>
<td>17%</td>
</tr>
<tr>
<td>2010</td>
<td>12%</td>
<td>8%</td>
<td>11%</td>
<td>19%</td>
<td>15%</td>
<td>10%</td>
<td>8%</td>
<td>17%</td>
</tr>
<tr>
<td>2011</td>
<td>15%</td>
<td>9%</td>
<td>12%</td>
<td>18%</td>
<td>14%</td>
<td>10%</td>
<td>8%</td>
<td>15%</td>
</tr>
</tbody>
</table>

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+:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LLTI [2001 Census]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPCS Mod+Reg [3-8]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People aged 65+</td>
<td>18,633</td>
<td>19,426</td>
<td>20,128</td>
<td>21,213</td>
<td>23,183</td>
<td>26,097</td>
<td>29,746</td>
<td>33,752</td>
</tr>
<tr>
<td>HSE Personal care disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People aged 65+</td>
<td>11,887</td>
<td>12,389</td>
<td>12,893</td>
<td>13,661</td>
<td>14,976</td>
<td>16,321</td>
<td>19,142</td>
<td>21,768</td>
</tr>
<tr>
<td>OPCS Continuous care needs [9-10]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People aged 65+</td>
<td>4,091</td>
<td>4,482</td>
<td>4,683</td>
<td>4,965</td>
<td>5,476</td>
<td>6,173</td>
<td>7,043</td>
<td>8,262</td>
</tr>
<tr>
<td>People aged 85+</td>
<td>1,840</td>
<td>2,206</td>
<td>2,345</td>
<td>2,535</td>
<td>2,920</td>
<td>3,304</td>
<td>3,689</td>
<td>4,674</td>
</tr>
</tbody>
</table>

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.

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

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 chart 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).

**Projections for current services – based on current models**

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.
## 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Care Home Nights 65+</th>
<th>Domiciliary Care Hours 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>~1,060,000</td>
<td>~1,790,000</td>
</tr>
<tr>
<td>2012</td>
<td>~1,110,000</td>
<td>~1,850,000</td>
</tr>
<tr>
<td>2013</td>
<td>~1,160,000</td>
<td>~1,910,000</td>
</tr>
<tr>
<td>2014</td>
<td>~1,210,000</td>
<td>~1,970,000</td>
</tr>
<tr>
<td>2015</td>
<td>~1,260,000</td>
<td>~2,030,000</td>
</tr>
<tr>
<td>2016</td>
<td>~1,310,000</td>
<td>~2,090,000</td>
</tr>
<tr>
<td>2017</td>
<td>~1,360,000</td>
<td>~2,150,000</td>
</tr>
<tr>
<td>2018</td>
<td>~1,410,000</td>
<td>~2,210,000</td>
</tr>
<tr>
<td>2019</td>
<td>~1,460,000</td>
<td>~2,270,000</td>
</tr>
<tr>
<td>2020</td>
<td>~1,510,000</td>
<td>~2,330,000</td>
</tr>
<tr>
<td>2021</td>
<td>~1,560,000</td>
<td>~2,390,000</td>
</tr>
<tr>
<td>2022</td>
<td>~1,610,000</td>
<td>~2,450,000</td>
</tr>
</tbody>
</table>

### 2022 Volumes:
- ~1,330,000 care home nights
- ~2,218,000 domiciliary care hours

### 2011 Volumes:
- ~1,060,000 care home nights
- ~1,790,000 domiciliary care hours
## Appendix 5: Edinburgh Change Fund Plan 2013/14

### Care pathways (including intermediate and short term care)

<table>
<thead>
<tr>
<th>Work stream</th>
<th>2013/14 Investment</th>
<th>Summary</th>
<th>Key outcomes/ outputs</th>
</tr>
</thead>
</table>
| Re-ablement                  | £1,145,060         | 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 |
| Lead: Andy Shanks            |                    | + staff transport provision (upto £100,000 allocated for community based staff)                                                                                                                        |                                                                                                                                                      |
| Community Therapy Services   | £1,122,871         | 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. |
| Lead: Fiona Stratton/ Mark Smith/ Linda Gibson/ Michelle Brogan/ Fiona Huffer | + staff transport provision |                                                                                                                                                                                                       |                                                                                                                                                      |
| Day Services                 | £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                                                                                                                                 |
| Lead: Doreen Copeland        |                    |                                                                                                                                                                                                       |                                                                                                                                                      |
| Community Nursing            | £187,917           | Increase capacity of the IMPACT nursing team and to                                                                                                                                                   | • Increase balance of care                                                                                                                                                                                      |
| Case finding, identification and management of patients | 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 | 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 | £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 |
| Lead: Ruth Burns |  |  |  |

| Telecare | £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 |
| Lead: Heather Laing |  |  |  |
|enerative 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. | • Number of call outs per month  
• Improved response times  
• 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 group |

*115*
<table>
<thead>
<tr>
<th>Lead: Linda Bertram</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-production and community capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community connecting</td>
</tr>
<tr>
<td>Lead: Caroline Clark</td>
</tr>
<tr>
<td>£400,000</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>• Reduce social isolation</td>
</tr>
<tr>
<td>• Reduce rates of emergency bed days for the 75+ age group per 1,000 pop</td>
</tr>
<tr>
<td>• Reduce number of delayed discharges</td>
</tr>
<tr>
<td>• Improved mental health &amp; wellbeing</td>
</tr>
<tr>
<td>• Improved support for carers</td>
</tr>
</tbody>
</table>

| 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   |

<p>| 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 &amp; wellbeing   |
| • Building community capacity          |
| • Increasing social capital            |
| • Reduction in delayed discharges      |
| • Reduction in hospital admissions     |
| • Increased care &amp; resilience          |</p>
<table>
<thead>
<tr>
<th>Training, communication and culture change</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transformation Station</strong></td>
<td><strong>£135,000</strong></td>
</tr>
<tr>
<td>Lead: Jacqueline Whitehead</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Communication, engagement, organisational development support and evaluation</strong></td>
<td><strong>£150,000</strong></td>
</tr>
<tr>
<td>Lead: Dorothy Hill/ Evaluation Group</td>
<td>Communications and engagement work including a two year Communications Officer post to lead the life Planning Campaign. Organisational development and support costs.</td>
</tr>
<tr>
<td><strong>Project infrastructure and support</strong></td>
<td><strong>£247,659</strong></td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

**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. |  |

- Increased flexibility in support provision
- Intergenerational work
<table>
<thead>
<tr>
<th>Service</th>
<th>Funding</th>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Nursing Liaison Service</td>
<td>£122,000</td>
<td>Proposal yet to be confirmed but agreed in principle and funding ear marked for concept testing in 2013/14.</td>
<td></td>
</tr>
<tr>
<td>One off funding for 2013/14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Dementia Link Workers                         | £530,636| 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 |
| Lead: Ewan Blain                              |         |                                                                                                                                                                                                            |                                                                                                                                                                                                     |
| 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 |

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<table>
<thead>
<tr>
<th>Project Description</th>
<th>Funding (£)</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| reminiscence software                                                              |             | • Trial within care homes and day services for older people.  
• 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    | • 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     | • See COMPASS objectives above                                                                                                                                                                          |
| iPads for volunteers in care homes                                                  | £5,600      | • 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     | • 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 substance misuse for Older People.  
• Encourage greater understanding of dementia among care home staff and older people attending care homes.                                                                                                                                 |
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 |
Community Connecting for inpatients in Royal Victoria Building | £100,000 | **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  
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.
## Joint Commissioning Plan for Older People 2012-22
### Draft Action Plan 2012-2015

### Preventative services

#### A1 Communities are more resilient and older people are less isolated

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Progressed through</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Invest in building community capacity with an emphasis on preventative services:</td>
<td>March 2015</td>
<td>Change Fund Core Group</td>
</tr>
<tr>
<td>• by allocating at least 20% of Edinburgh’s Change Fund to projects that build the capacity of communities and support volunteers</td>
<td></td>
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<tr>
<td>• by developing a community connecting service for all areas of the city</td>
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<tr>
<td>• 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. Evaluate these projects to inform future planning of older people’s services.</td>
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<td>• by supporting transport options that people can easily access</td>
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<tr>
<td>2 Continue to support and develop lunch and day clubs</td>
<td>Ongoing</td>
<td>CEC/ Joint Older People’s Management Group</td>
</tr>
<tr>
<td>3 Develop evidence-based action to build resilient communities</td>
<td>March 2015</td>
<td>Change Fund Core Group</td>
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<tr>
<td>• 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</td>
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<tr>
<td>4 Increase awareness of community based services and support</td>
<td>Ongoing</td>
<td>Change Fund Core Group</td>
</tr>
<tr>
<td>5 Continue to support and develop health promotion</td>
<td>Ongoing</td>
<td>NHS Lothian/ Joint Older People’s Management Group</td>
</tr>
<tr>
<td>6 Encourage older people to take advantage of community learning and activities</td>
<td>Ongoing</td>
<td>Community Learning and Development</td>
</tr>
</tbody>
</table>

#### A2 Older people and their carers can access the information they need, when they need it
<table>
<thead>
<tr>
<th>7</th>
<th>Continue to provide information on various activities and opportunities available for older people across the city</th>
<th>Ongoing</th>
<th>Libraries and Information Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>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</td>
<td>Ongoing</td>
<td>Reshaping Care for Older People (RCOP) Communications Strategy</td>
</tr>
<tr>
<td>9</td>
<td>Promote links to information sources about health conditions and how to better manage them</td>
<td>Ongoing</td>
<td>RCOP Communications Strategy</td>
</tr>
<tr>
<td>10</td>
<td>Encourage people to plan for the future including making wills and provision for power of attorney</td>
<td>March 2015</td>
<td>‘Life Planning Campaign’, RCOP Communications Strategy</td>
</tr>
<tr>
<td>11</td>
<td>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</td>
<td>Ongoing</td>
<td>City Housing Strategy</td>
</tr>
<tr>
<td>12</td>
<td>Enable choice by providing the balanced information that people need to make informed decisions about their care and support</td>
<td>2014</td>
<td>Personalisation Programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A3</th>
<th>Unpaid carers are supported to continue their caring role for as long as they wish</th>
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<tbody>
<tr>
<td>14</td>
<td>Improve support for carers within the hospital discharge process</td>
</tr>
<tr>
<td>15</td>
<td>Provide support for carers of people with dementia and employ people with lived experience of caring through the Edinburgh Behaviour Support Service</td>
</tr>
<tr>
<td>16</td>
<td>Invest at least 20% of Edinburgh’s Change Fund to supporting carers</td>
</tr>
<tr>
<td>17</td>
<td>Provide additional flexible respite/ short breaks for carers</td>
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<tr>
<td>18</td>
<td>Engage with carers of people with dementia to agree priorities for action</td>
</tr>
<tr>
<td>19</td>
<td>Continue to support carers with information, advice, training and support</td>
</tr>
<tr>
<td>20</td>
<td>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)</td>
</tr>
</tbody>
</table>

A4 Services are accessible to all older people

| 21 | Undertake equalities impact assessments to identify any impact that service changes may have on particular groups of older people and mitigate the effect | Ongoing | CEC/ NHSL/ All services |
| 22 | 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 | Ongoing | All agencies planning activity Day Services Change Fund Core Group |
| 23 | Continue to focus on reducing health inequalities | Ongoing | Health Inequalities Standing Group |

B Proactive care and support at home

B1 High quality care is provided within people’s homes

<p>| 24 | Continue to modernise our home care service (see Appendix 2) | Ongoing | Homecare Transformati |</p>
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<tbody>
<tr>
<td>25</td>
<td>Increase the capacity of the home care overnight service from 3 teams to 5</td>
<td>February 2012</td>
</tr>
<tr>
<td>26</td>
<td>Enhance the home care and care at home services to meet the demands of demography and shifting the balance of care</td>
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</tr>
<tr>
<td>27</td>
<td>Support the health care needs of people in the community through community nursing, allied health professionals, general practitioners, dentists, ophthalmologists and podiatrists</td>
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<tr>
<td>28</td>
<td>Enhance out of hours health and social care services</td>
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<tr>
<td>29</td>
<td>Develop services to support and encourage people to direct their own support</td>
<td>2014</td>
</tr>
<tr>
<td>30</td>
<td><strong>Appropriate housing options are available for older people</strong></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Deliver accessible and wheelchair accessible homes through the Strategic Housing Investment Plan (SHIP)</td>
<td>ongoing</td>
</tr>
<tr>
<td>32</td>
<td>Review provision of Council and partner sheltered housing to ensure most effective use</td>
<td>Consultation completed Aug 2013</td>
</tr>
<tr>
<td>33</td>
<td>Develop a system to monitor the number of older people who are receiving information and advice</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Ensure Change Fund projects are integrated into wider housing and support strategies</td>
<td>March 2015</td>
</tr>
<tr>
<td>35</td>
<td>Develop improved housing options advice covering all tenures</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Provide accurate and relevant information and advice to improve the quality of homes</td>
<td></td>
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<tr>
<td>37</td>
<td>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.</td>
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<tr>
<td>B3</td>
<td>People are supported to live safely and independently at home with adaptations and equipment</td>
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<tr>
<td>37</td>
<td>Continue to develop the adaptations process</td>
<td>ongoing</td>
</tr>
<tr>
<td>38</td>
<td>Further develop our flexible approach to adaptations and expand the range of adaptations available</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Increase the provision of equipment to support more people to live safely and independently in the community</td>
<td>March 2015</td>
</tr>
<tr>
<td>40</td>
<td>Increase the number of bathing and toileting assessments undertaken by the equipment and adaptations service</td>
<td>March 2015</td>
</tr>
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<table>
<thead>
<tr>
<th>B4</th>
<th>Day services support people to continue to live in the community</th>
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<tbody>
<tr>
<td>41</td>
<td>Implement the developments contained within the Commissioning Plan for Social Care Day Services for Older People 2012-17 which include:</td>
</tr>
<tr>
<td></td>
<td>o development of a community connecting approach in all day services for older people</td>
</tr>
<tr>
<td></td>
<td>o 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</td>
</tr>
<tr>
<td></td>
<td>o continuation of specialist day services, where appropriate, with supported integration into mainstream services as an alternative</td>
</tr>
<tr>
<td></td>
<td>o development of a re-ablement approach within registered day centre services through the appointment of two new occupational therapists.</td>
</tr>
<tr>
<td>March 2014</td>
<td></td>
</tr>
<tr>
<td>ongoing</td>
<td></td>
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<tr>
<td>End 2012</td>
<td></td>
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<thead>
<tr>
<th>B5</th>
<th>People with long term conditions are well supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>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</td>
</tr>
<tr>
<td>43</td>
<td>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</td>
</tr>
</tbody>
</table>
## B6 Technology is used to help people to stay safely in their own home

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<tbody>
<tr>
<td>44</td>
<td>Increase the number of complex telecare packages for people aged 75+ by 10% by 2015</td>
<td>March 2015</td>
</tr>
<tr>
<td>45</td>
<td>Pilot the use of many new telehealth care technologies as a means of supporting people at home for longer</td>
<td>March 2015</td>
</tr>
<tr>
<td>46</td>
<td>Use telehealth care to underpin changes to working practice so that services can concentrate on providing high quality support to people</td>
<td>Telehealth Service</td>
</tr>
<tr>
<td>47</td>
<td>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</td>
<td>Telehealth Service</td>
</tr>
</tbody>
</table>

## C Effective care at times of transition

### C1 Older people experience a seamless and effective range of intermediate care services

<p>| | | |</p>
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| 48 | 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. | March 2015 | Change Fund Core Group |
| 49 | Test the COMPASS (Comprehensive Assessment) model (below) in South East Edinburgh from April 2012, using evaluation of the trial to shape future services | March 2015 | Change Fund Core Group |
| 50 | Evaluate the ‘step down’ from hospital model within Elizabeth Maginnis Court to inform the development of ‘step up’/‘step down’ models within care homes | Change Fund Core Group |
| 51 | Establish in-reach arrangements for many community-based services to improve the transition from hospital to home that people experience | March 2015 | Change Fund Core Group |
| 52 | 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 | Health and Social Care Partnership |

### C2 Effective care pathways are developed

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<tbody>
<tr>
<td>53</td>
<td>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</td>
<td>Intermediate Care Services</td>
</tr>
<tr>
<td>54</td>
<td>Embed the Falls Emergency Pathway into practice and evaluate the results</td>
<td>Intermediate Care</td>
</tr>
<tr>
<td></td>
<td>Services</td>
<td></td>
</tr>
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<tr>
<td>55</td>
<td>Make enhancements to some condition-specific pathways such as stroke care, through the investment in the Edinburgh Community Stroke Service</td>
<td>March 2015 Change Fund Core Group</td>
</tr>
<tr>
<td>56</td>
<td>Review the ways our services work with one another, so that people receive care that is comprehensive and well managed</td>
<td>Health and Social Care Partnership</td>
</tr>
<tr>
<td>57</td>
<td>Continue to redesign hospital pathways to ensure effective capacity and flow.</td>
<td>Unscheduled Care Group</td>
</tr>
</tbody>
</table>

**C3 People with dementia and their carers are well supported**

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<tbody>
<tr>
<td>58</td>
<td>Increase the effective early diagnosis of dementia</td>
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<tr>
<td>59</td>
<td>Develop and implement the Edinburgh Dementia Implementation Plan</td>
</tr>
<tr>
<td>60</td>
<td>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</td>
</tr>
</tbody>
</table>
| 61 | 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. | March 2015 Change Fund Core Group |
| 62 | Continue to support our staff in raising awareness of dementia | 2012-2015 Edinburgh Dementia Delivery Group |
| 63 | Adapt our care services to provide the most appropriate interventions for people with dementia | 2012-2015 Edinburgh Dementia Delivery Group |
| 64 | Improve the management of people’s dementia by keeping them in familiar, homely environments for as long | 2012-2015 Edinburgh |
as is appropriate through a range of enhanced community-based care and support services

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<tr>
<td>65</td>
<td>Develop specialist respite services which meet the needs of people living with dementia</td>
<td>2012-2015</td>
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<tr>
<td></td>
<td>Edinburgh Dementia Delivery Group</td>
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<tr>
<td>66</td>
<td>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</td>
<td>Community Alarm Service</td>
</tr>
<tr>
<td>67</td>
<td>Encourage people to plan for the future at as early a stage as possible.</td>
<td>2013-14</td>
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<tr>
<td></td>
<td>‘Life Planning Campaign’/ Edinburgh Dementia Delivery Group</td>
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</table>

**C4** Day hospitals/ assessment and rehabilitation centres are available for those that need them

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<tbody>
<tr>
<td>68</td>
<td>Enhance the availability of assessments within day hospital for older people who are at risk of a hospital admission</td>
<td>COMPASS Steering Group</td>
</tr>
<tr>
<td>69</td>
<td>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</td>
<td>Unscheduled Care Group</td>
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</tbody>
</table>

**C5** People experience good quality end of life care in their chosen setting

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<tr>
<td>70</td>
<td>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:</td>
<td>Lothian Palliative Care Service Redesign Programme</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
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<td></td>
<td>• maximise the time spent in people’s preferred place of care (home, care home, and community hospital)</td>
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<td></td>
<td>• minimise emergency admissions where these could be avoided by good anticipatory care planning</td>
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<td></td>
<td>• support realistic choice of place of death (taking into account a holistic assessment of patient, family and carer needs).</td>
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<tr>
<td>71</td>
<td>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</td>
<td>Lothian Palliative</td>
</tr>
</tbody>
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<tr>
<th></th>
<th>Continue to support our staff in raising awareness of living and dying well and end of life care</th>
<th>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</th>
<th>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.</th>
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<tr>
<td>74</td>
<td>Encourage older people to make plans for old age, including end of life, advanced directives, guardianships and wills</td>
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<tr>
<td>D</td>
<td>Intensive care and specialist support</td>
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<td>Intensive care and specialist support</td>
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<tr>
<td>D1</td>
<td>Good quality residential care is available for those who need it</td>
<td>Good quality residential care is available for those who need it</td>
<td>Good quality residential care is available for those who need it</td>
</tr>
<tr>
<td>76</td>
<td>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</td>
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<tr>
<td>77</td>
<td>Improve quality assurance for all Edinburgh care homes</td>
<td>Improve quality assurance for all Edinburgh care homes</td>
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</tr>
<tr>
<td>78</td>
<td>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,</td>
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<tr>
<th></th>
<th>2013</th>
<th>2013</th>
<th>March 2015</th>
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<tbody>
<tr>
<td>Care Service Redesign Programme</td>
<td>Lothian Palliative Care Service Redesign Programme</td>
<td>Lothian Palliative Care Service Redesign Programme</td>
<td>Change Fund Core Group</td>
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</tbody>
</table>

**D** Intensive care and specialist support

**D1** Good quality residential care is available for those who need it
<table>
<thead>
<tr>
<th></th>
<th>Activity</th>
<th>Implementation Plan</th>
<th>Department</th>
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</thead>
<tbody>
<tr>
<td>79</td>
<td>Develop care home respite by concentrating provision in self-contained units with separate staffing arrangements</td>
<td>Care Homes Accommodation Strategy</td>
<td></td>
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<tr>
<td>80</td>
<td>Commission additional specialist dementia respite within the independent sector</td>
<td>Care Homes Accommodation Strategy</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Work closely with independent sector providers to develop intermediate care (step up/ step down) beds in care homes</td>
<td>Oct 2013 Joint Older People’s Management Group</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Apply dementia friendly standards to building design</td>
<td>Care Homes Accommodation Strategy</td>
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</tr>
<tr>
<td>83</td>
<td>Review NHS inpatient complex care requirements and projections for the future</td>
<td>Capacity Planning Group</td>
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</tr>
<tr>
<td>84</td>
<td>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</td>
<td>Apr 2013 Change Fund Core Group</td>
<td></td>
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<tr>
<td>85</td>
<td>Implement the ‘My Home Life’ programme in 30 care homes in Edinburgh</td>
<td>Apr 2013 Change Fund Core Group</td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Provide funding and co-ordination for a programme of dementia training in all care homes (Council and independent sector) in Edinburgh</td>
<td>2013 Change Fund Core Group</td>
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<tr>
<td></td>
<td><strong>D2</strong> <strong>Good quality hospital care is available for those who need it</strong></td>
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<tr>
<td>87</td>
<td>Reduce the number of emergency admissions to hospital while increasing the number of planned admissions for older people</td>
<td>Unscheduled Care Group</td>
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<tr>
<td>88</td>
<td>Develop services that focus on the personalised care needs of individuals, enabling patients to have choice and control wherever possible</td>
<td>Personalisation Programme</td>
<td></td>
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<tr>
<td>89</td>
<td>Improve care for people with dementia and delirium in acute hospital ward settings</td>
<td>Dementia Delivery Group</td>
<td></td>
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<tr>
<td>90</td>
<td>Implement acute care standards for mental health and older people’s services.</td>
<td>Mental Health</td>
<td></td>
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<td>Enablers</td>
<td>Services</td>
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<tr>
<td>91</td>
<td>Continue to develop Social Care Direct as a single point of contact for all social care referrals</td>
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<tr>
<td>92</td>
<td>Ensure that professionals across the city are aware of the range of services available and how to signpost or refer people to them</td>
<td>RCOP Communications Strategy</td>
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<tr>
<td>93</td>
<td>Increase the number of social care reviews carried out</td>
<td></td>
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<tr>
<td>94</td>
<td>Continue to develop an outcomes approach to assessments, reviews and service delivery</td>
<td>2014 Personalisation Programme</td>
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<tr>
<td>F</td>
<td>Workforce</td>
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<tr>
<td>95</td>
<td>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</td>
<td>Workforce Planning and Development</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>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</td>
<td>Workforce Planning and Development</td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>Ensure dementia training is incorporated into workforce development plans</td>
<td></td>
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<tr>
<td>98</td>
<td>Deliver a programme of organisational development activities to support the transformation of Health and Social Care</td>
<td>Workforce Planning and Development</td>
<td></td>
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<tr>
<td>99</td>
<td>Develop and implement a sustainable health and social care worker recruitment strategy.</td>
<td>Workforce Planning and Development</td>
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