PERTH AND KINROSS COUNCIL

Housing and Health Committee – 13 March 2013

CONSULTATION DRAFT JOINT COMMISSIONING STRATEGY

Report by Executive Director (Housing and Community Care)

ABSTRACT
The purpose of this report is to seek approval for draft Perth and Kinross Joint Commissioning Strategy 2013/14 – 2015/16 prior to consultation.

1. RECOMMENDATIONS

It is recommended that Committee:

1.1 Approve the draft Perth and Kinross Joint Commissioning Strategy 2013/14 – 2015/16 prior to consultation (Appendix 1).

1.2 Instruct the Executive Director, Housing and Community Care to submit the final Perth and Kinross Joint Commissioning Strategy to a future Housing and Health Committee for consideration.

2. BACKGROUND

Reshaping Care for Older People Programme

2.1 'Reshaping Care for Older People Programme' is a 10 year programme which aims to optimise independence and wellbeing for older people at home or in a homely setting. It recognises that due to the challenges facing health and social care in relation to the increasing older people population and the financial constraints that maintaining the status quo will not suffice. There will need to be significant shifts to anticipatory and preventative approaches so as to achieve and sustain better outcomes for older people.

2.2 Services are delivered within a changing policy environment. This draft Joint Commissioning Strategy has been developed in response to a number of national policies, the increasing ageing population and acknowledgement of a difficult financial climate.

2.3 To address the broader aims of this Programme to deliver significant shifts in the balance of care from institutional to community settings, the Scottish Government established the 'Change Fund' in 2011/12 to enable health, social care, housing, independent and third sector partners to implement local plans for making better use of their combined resources to improve outcomes for older people. The Change Fund provides 'bridging' finance to facilitate shifts in the balance of care from institutional to primary and community settings and influence decisions taken with respect to the totality of Partnership spend on older people's care.

2.4 The draft Strategy is a joint statement by the Perth and Kinross Older People's Partnership which is represented by Perth and Kinross Council, Perth and Kinross Community Health Partnership, NHS Tayside, Perth and Kinross Association of Voluntary Services and Scottish Care. The document presents a ten year vision for older people's services but focuses on service development and commissioning priorities for the next three years.

2.5 Commissioning of services is an important function undertaken by the Partnership. Commissioning is at the heart of effective service delivery which can transform people's lives. It is not just about procedures and processes but it is a strategic activity investing for the long term. A significant proportion of Perth and Kinross Council's Housing and Community Care Services budget is spent on externally commissioned and purchased services.

2.6 This draft Strategy covers all adult health and social care services and support, whether delivered by public, voluntary or private sector providers, used by people aged 65 years and over. The draft Strategy's themes are based around the following reshaping care pathways of:

- Preventative and anticipatory care.
- Proactive care and support at home.
- Effective care at times of transition.
- Intensive care and specialist support.
- Enablers.

2.7 This draft Strategy incorporates many of the themes of 'Commission on Future of Public Services' and Scottish Government health and social care integration proposals.

2.8 The Partnership wishes to consult with a wide range of stakeholders to help share and clarify the aims of the Strategy and to assist in preparing the actions that shall support its objectives. It is anticipated that a three month consultation period will conclude in June 2013.

3. PROPOSALS

3.1 It is proposed that Committee approve the consultation draft Joint Perth and Kinross Commissioning Strategy 2013/14 – 2015/16.

3.2 The draft Strategy:

- Provides an overview of the health and social care system in Perth and Kinross.
- Provides the strategic framework for the future development of the local health and social care system, through which health and social care and other providers and investors can operate, so that needs and demands can be met more effectively with available resources.

- Establishes a shared understanding of the issues and priorities where particular forms of intervention are required.
- Sets out high level actions on how these issues and priorities will be addressed by the joint partners.
- Identifies how the Strategy contributes to the achievement of the national health and social care priorities and the wider social objectives as identified in the Perth and Kinross Community Plan and NHS Tayside Local Delivery Plan.

3.3 The draft Strategy sets out:

- The strategic planning and commissioning framework.
- Summarises the joint strategic needs assessment.
- Outlines the services that are currently commissioned.
- The present financial framework.
- How the Change Fund is helping to transform services.
- How the joint commissioning priorities will develop.

3.4 The draft Strategy identifies some of the significant challenges that the Partnership faces and these include:

- Recognising the challenges of demographic change.
- Addressing the increases in the number of people with dementia.
- Shifting the balance of care from institutional to community settings.
- Promoting healthy living.
- Supporting unpaid or informal carers.
- Promoting personalisation of services including self directed support.
- Providing a better range of housing options.
- Addressing welfare reform and financial constraint.

3.5 The following basic principles will inform our approach:

- Moving from a facility based approach to day care/day case services with people only being admitted to hospital or long term institutional care when there is absolute need to do so.
- Moving to an integrated health and social care community service which focuses on early identification, prevention, anticipatory care planning, self-directed support and self-management in hours and out of hours.
- Developing the current tests of change within the dementia model in Strathmore and Perth and Kinross to secure significant and sustainable improvements in the quality of support provided to service users and carers. These models will promote and support earlier diagnosis, independence, future planning and liaison/transitional care.
- Working with communities to support a more responsive approach towards the development of solutions to local problems, community ownership and long-term sustainability through local fora and service delivery structures.
- Extending the competencies of key groups of staff within and across services in order to move away from narrow specialisms and improve service responsiveness.

3.6 It is the intention to create a proportionate shift in services and resources from institutional settings to support people in their own homes through a partnership with communities which reduces the need for hospital or residential care. Over the three years of the draft Strategy we will change the way we organise and deliver services, including:

- Further shifting the balance of care to support an increasing older population with high level needs to be cared for at home rather than in hospital or care homes.
- Increasing the number of older people receiving support in the community, including homecare services, re-ablement, community nursing and other community based services.
- Changing the way care home places are used, reducing long stay care home places and increasing in the number of beds used for respite and step up/ step down care.
- Reducing the length of stay and delays people are delayed in hospital by increasing community based services and support.

3.6 The draft Strategy also illustrates some of the emerging areas where the Partnership wishes to promote to tackle the challenges and these are:

- Investing In ‘resilient’ communities.
- Co-production where public services are delivered in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.
- Locality planning.
- Self directed support.
- Supporting carers.
- Investing in suitable housing options.
- Prevention of falls and fractures.
- Anticipatory care.
- Providing high quality care in people’s homes.
- Supporting people with adaptations and equipment.
- Improving day opportunities.
- Supporting people with long term conditions.
- Telecare/Telehealth to help people to remain safely in their own home.
- Improving integrated case/care management.
- Developing effective care pathways.
- Supporting people with dementia and their carers.
- Providing good quality end of life care.
- Re-ablement and rehabilitation.
- Intensive care and specialist support.
- Workforce development.

3.6 It is further proposed that Committee note that a final Perth and Kinross Joint Commissioning Strategy shall be brought for consideration to a future Housing and Health Committee.

4. CONSULTATION

4.1 The Head of Legal Services, the Head of Democratic Services and the Head of Finance have all been consulted on the content of this report.

4.2 This draft Strategy has been developed through our work with people who use our services and local communities. Engaging with a range of stakeholders particularly people who use services and their unpaid carers is at the heart of our commissioning. In the preparation of this Strategy, we have considered consultation and engagement which has already been undertaken with the community to ensure we are meeting the needs, preferences and aspirations of current and future service users and carers.

4.3 Our consultation and engagement is based on the National Standards for Community Engagement with support from the 'VOiCE' (Visioning outcomes in Community Engagement) toolkit. Learning gained from engagement and communication activity is used to regularly review and update our approach. In addition to existing consultation processes a wide variety of mechanisms will be employed to maximise stakeholder input to the Strategy development process. Consultation on this Strategy will be ongoing and continuous. Appendix 9 provides an overview of the consultation arrangements to be undertaken.

5. RESOURCE IMPLICATIONS

The core activities and priorities identified in this report have been incorporated into the Service's revenue budget following approval at full Council on 14 February 2013 of the Council's Revenue Budget for 2013/14 (report 13/53).

6. COUNCIL CORPORATE PLAN OBJECTIVES 2009-2012

The Council's Corporate Plan 2009-2012 lays out five objectives which provide clear strategic direction, inform decisions at a corporate and service level and shape resources allocation. The following are relevant to this report:

(i) A Safe, Secure and Welcoming Environment.
(ii) Healthy, Caring Communities.
(iii) A Prosperous, Sustainable and Inclusive Economy.
(iv) Educated, Responsible and Informed Citizens.
(v) Confident, Active and Inclusive Communities

7. EQUALITIES IMPACT ASSESSMENT (EqIA)

7.1 An equality impact assessment needs to be carried out for functions, policies, procedures or strategies in relation to race, gender and disability and other relevant protected characteristics. This supports the Council's legal requirement to comply with the duty to assess and consult on relevant new and existing policies.

7.2 The function, policy, procedure or strategy presented in this report was considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcome:

- Assessed as relevant and the following positive outcomes expected following implementation: The services that are the focus of this report will have a positive impact on older people's wellbeing.

8. STRATEGIC ENVIRONMENTAL ASSESSMENT

8.1 Strategic Environmental Assessment (SEA) is a legal requirement under the Environmental Assessment (Scotland) Act 2005 that applies to all qualifying plans, programmes and strategies, including policies (PPS).

8.2 The matters presented in this report were considered under the Environmental Assessment (Scotland) Act 2005 and no further action is required as it does not qualify as a PPS as defined by the Act and is therefore exempt.

9. CONCLUSION

This report seeks approval for the consultation draft Joint Perth and Kinross Commissioning Strategy.

DAVID BURKE
Executive Director (Housing and Community Care)

Note: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information) were relied on to any material extent in preparing the above report.

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Date: 28 February 2013

If you or someone you know would like a copy of this document in another language or format, (on occasion only, a summary of the document will be provided in translation), this can be arranged by contacting Stephen Rankin

Council Text Phone Number 01738 442573

Consultation Draft
Joint Commissioning Strategy
Older People
2013/14 – 2015/16

February 2013

If you or someone you know would like a copy of this document in another language or format, (on occasion only a summary of the document will be provided in translation), this can be arranged by contacting Performance & Quality on 01738 476894

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Foreword

We are working on a draft Joint Commissioning Strategy for Older People 2013-2023 covering care and support services to older people over 65 years of age, which are delivered by the following partners:

- Perth and Kinross Council.
- NHS Tayside including Perth and Kinross Community Health Partnership (CHP).
- Voluntary sector providers.
- Independent sector providers.

This document outlines our plans for the first three years of the ten year period and explains how we intend to 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 outcomes 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.

We want to know what stakeholders think about this draft Joint Commissioning Strategy and we encourage you to respond. We look forward to working in partnership with you, in the future, as we work together, to implement the Joint Commissioning Strategy.

What is Our Vision?

"Our vision is to promote the independence and wellbeing of older people at home or in a homely setting.

We will work together and with communities as key partners in delivering the objectives of the Change Fund to achieve positive outcomes for Older People such as delivering or enabling personalised care and support, independence and a good quality of life. We shall support older people to be active citizens, enabling them to be included and valued within their community."

The Partnership will work with older people and the wider community to make sure they have the services they need."

The following basic principles will inform our approach:

- Moving from a facility based approach to day care/day case services with people only being admitted to hospital or long term institutional care when there is absolute need to do so.
- Moving to an integrated health and social care community service which focuses on early identification, prevention, anticipatory care planning, self-directed support and self-management in hours and out of hours.
- Developing the current tests of change within the dementia model in Strathmore and Perth and Kinross to secure significant and sustainable improvements in the quality of support provided to service users and carers. These models will promote and support earlier diagnosis, independence, future planning and liaison/transitional care.
- Working with communities to support a more responsive approach towards the development of solutions to local problems, community ownership and long-term sustainability through local for a and service delivery structures.
- Extending the competencies of key groups of staff within and across services in order to move away from narrow specialisms and improve service responsiveness.

Contents

The Strategy is a working document and is developed throughout its life. Feedback is sought on a continuous basis through consultation with stakeholders on a regular basis.

Is the Strategy available in other formats?

There is a shorter summary Strategy. It is available in Braille, large print, audio and in some community languages, upon request. Please use the contact details below for further information or copies.

How can you have your say on the Strategy?

You can write with your comments, using the response form at the rear of this document, to:

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1. Introduction

1.1 Overview

This is the Perth and Kinross Joint Commissioning Strategy. This Strategy:

- Provides an overview of the health and social care system in Perth and Kinross.
- Provides the strategic framework for the future development of the local health and social care system, through which health and social care and other providers and investors can operate, so that needs and demands can be met more effectively with available resources.
- Establishes a shared understanding of the issues and priorities where particular forms of intervention are required.
- Sets out high level actions on how these issues and priorities will be addressed by the joint partners.
- Sets objectives and targets and shows how progress will be monitored and impact evaluated.
- Identifies how the Strategy contributes to the achievement of the national health and social care priorities and the wider social objectives as identified in the Perth and Kinross Community Plan and NHS Tayside Local Delivery Plan.

This document presents a ten year vision for older people's services but focuses on service development and commissioning priorities for the next three years. It will continue to be reviewed annually 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.

This is a consultation draft Strategy. As such we wish to listen to as many stakeholders as possible so that when we prepare the final Strategy we know that we have encouraged as many contributions as possible. We shall be consulting for a 3 month period to 30 June 2013. The final strategy shall contain detailed action plans.

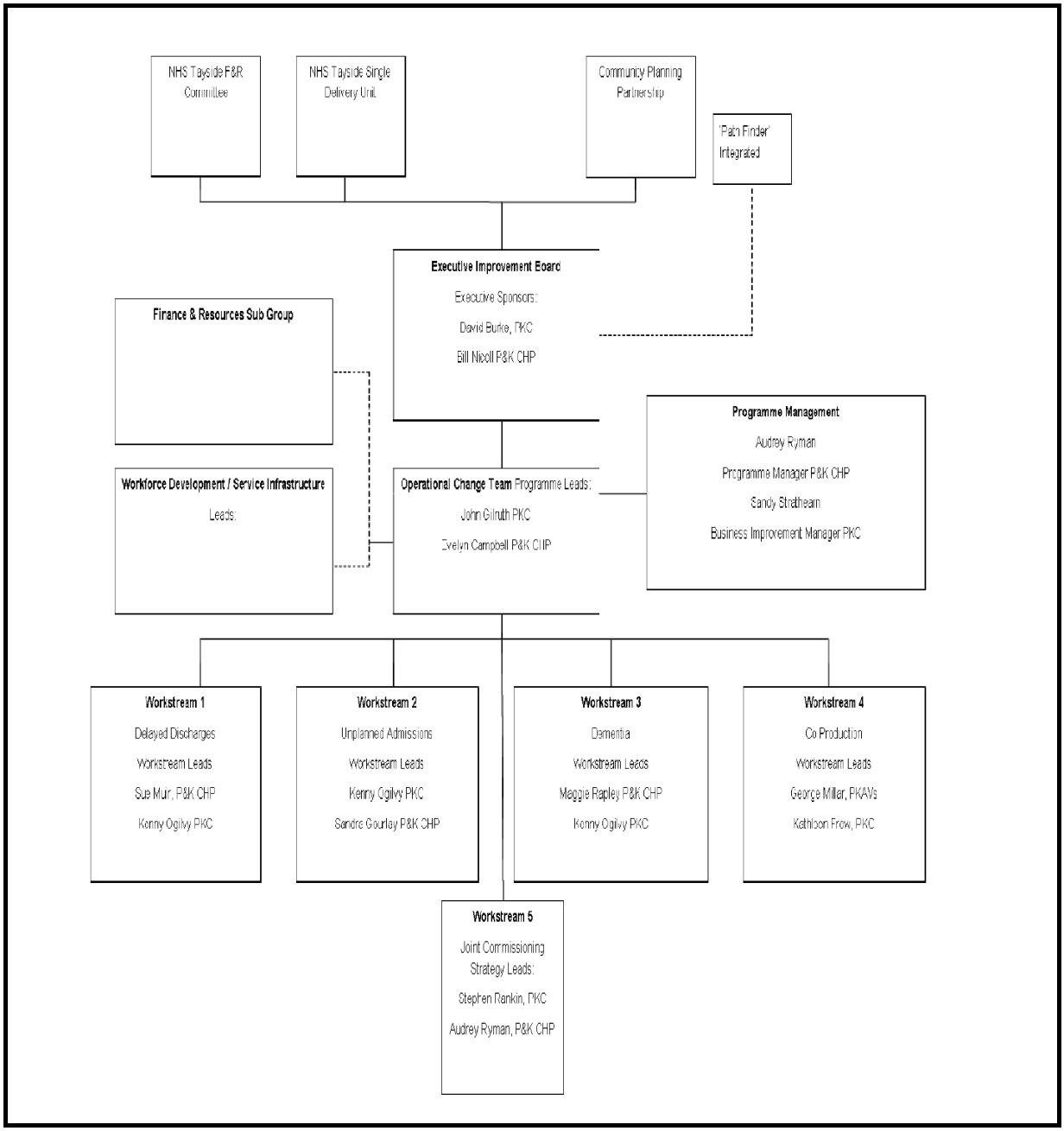
1.2 How Was The Strategy Produced?

This Strategy is a joint statement, the development of which has been overseen by the Perth and Kinross Older People's Partnership which is represented by Perth and Kinross Council, Perth and Kinross Community Health Partnership, NHS Tayside, Perth and Kinross Association of Voluntary Services and Scottish Care representing the independent sector.

The governance and management framework for the Joint Commissioning Strategy will continue to be directed through the Change Fund Executive Improvement Board with membership from local authority, health, independent and third sectors. The Board was established specifically to be responsible for the overall direction and management of the original Change Fund Programme. The Joint Executive Improvement Programme Board will remain accountable to NHS Tayside and Perth and Kinross Community Planning Strategic Health Partnership for the success of the

Change Fund Plans and Joint Commissioning Strategy until such times as the substantive Perth and Kinross Health and Social Care Integration Board is established in April 2014. Currently a 'Shadow Board' is being proposed whose role will be advisory in nature and will consider the basis for strategies in terms of integration and the Reshaping of Older Peoples' Services.

Figure 1.1: Joint Commissioning Planning Structure



The partners are very much committed to delivering on this Strategy and the joint working arrangements which underpins it. There are joint governance and accountability arrangements in place and these will be strengthened as legislation for further integration is implemented. These arrangements are to be further integrated over the life of this Strategy with the full commitment and engagement of all partners.

1.3 Consultation, Engagement, Involvement and Communication

We have developed this strategy through our work with people who use our services and local communities. Engaging with a range of stakeholders particularly people who use services and their unpaid carers is at the heart of our commissioning. In the preparation of this Strategy, we have considered consultation and engagement which has already been undertaken with the community to ensure we are meeting the needs, preferences and aspirations of current and future service users and carers.

Our consultation and engagement is based on the National Standards for Community Engagement with support from the VOiCE (Visioning outcomes in Community Engagement) toolkit. Learning gained from engagement and communication activity is used to regularly review and update our approach. In addition to existing consultation processes a wide variety of mechanisms will be employed to maximise stakeholder input to the Strategy development process. Consultation on this Strategy will be ongoing and continuous. For more on the consultation process, see Appendix 9. Once we have reviewed all the responses to this draft we'll publish a final Strategy that will incorporate, where feasible, the contributions we've received.

1.4 Equalities and Diversity

The planning and delivery of good quality health care, social care and housing as well as appropriate information, advice and support services in Perth and Kinross embraces the principle of equal opportunities, following the lead of the partners' Equalities Schemes. This means that the partners will strive to encourage equal opportunities and diversity, responding to the different needs and service requirements of people regardless of sex, race, colour, disability, age, creed, marital status, ethnic origin, sexual orientation or gender re-assignment.

1.5 What Are Our Joint Commissioning Principles?

Our joint commissioning principles are that we shall:

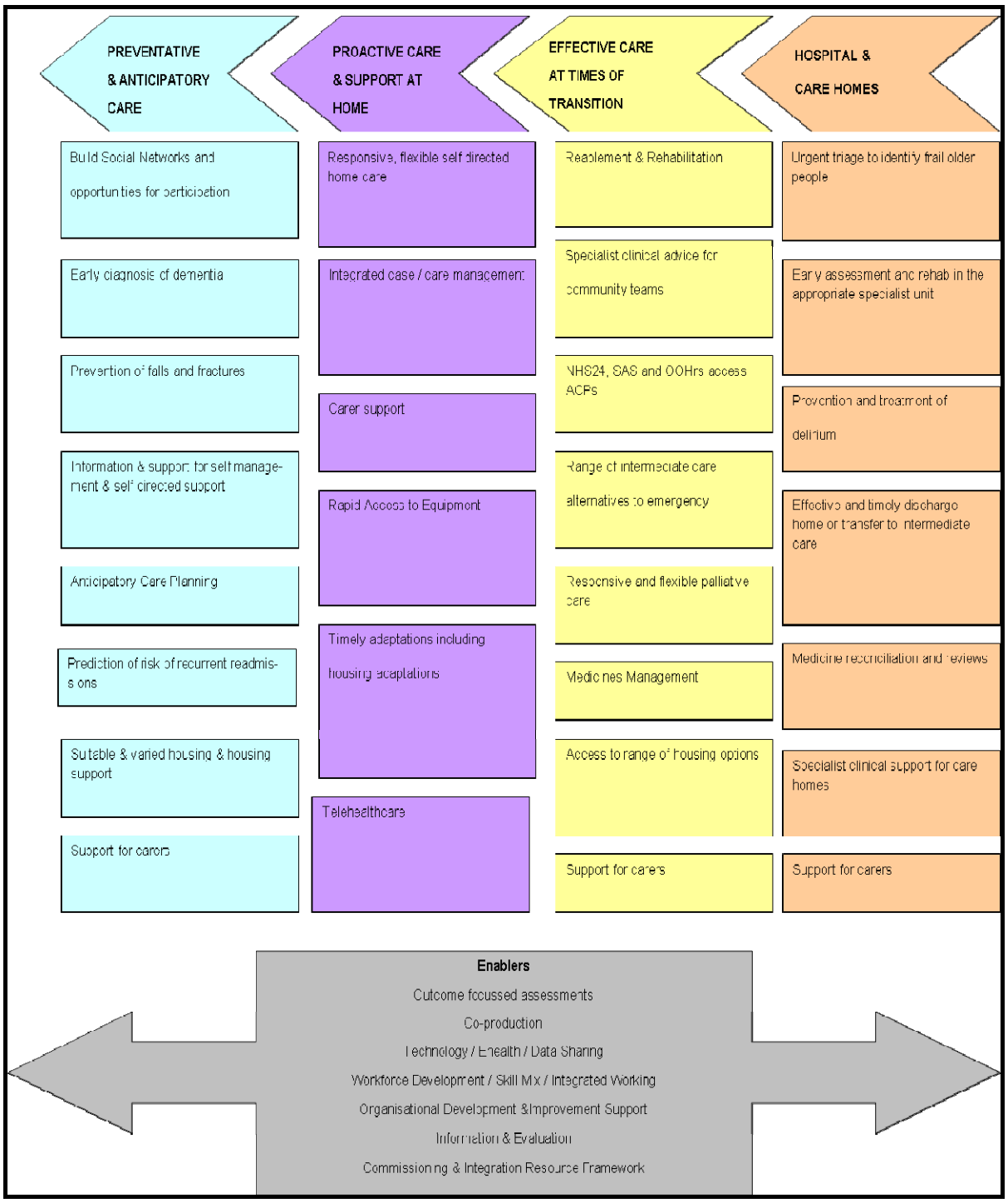
- Offer services that are personalised and enable choice.
- Promote self management, health and wellbeing and independence.
- Ensure that unpaid carers are equal partners in the planning and delivery of services.
- Communicate and engage routinely with stakeholders.
- Demonstrate that Best Value is being achieved.
- Support our providers to deliver the best possible services.
- Promote equalities and diversity.

1.6 Our Strategy's Scope

This Strategy covers all adult health and social care services and support, whether delivered by public, voluntary or private sector providers, used by people aged 65 years and over. Traditionally we have commissioned services based on a general

categorisation of client groups, such as older people (over 65 years), mental health and wellbeing, a learning disability, physical disability or substance misuse.

Figure 1.2: Perth and Kinross Reshaping Care Pathway for Older People



Based on the needs profile of our population our Strategy 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 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 services are as seamless as

possible. This Strategy's themes are based around the following reshaping care pathways of:

- Preventative and anticipatory care.
- Proactive care and support at home.
- Effective care at times of transition.
- Intensive care and specialist support.
- Enablers.

This pathway shows the types of approaches that we take to plan for and deliver the range of services that are required for older people.

We will employ an asset based approach to develop effective, efficient and sustainable models of care which focus on health and wellbeing and maximise the assets of both individuals and communities in order to promote resilience.

It is widely recognised that Reshaping Care for Older People will be highly complex and challenging. It may take several years to achieve; however, this process of change is not one which can be put off any longer because of the difficult financial position and the demographic change. Some of the differences between the 'old' and the 'new' models of care are illustrated in Table 1.1 below.

Table 1.1: Old Model Compared to New Models

Old Model	**New Model**
Reactive care only being given once you have become sick or have a crisis in your health	Proactive care helping people to stay healthy and plan for conditions.
Hospital Centred Care.	Community based in own homes if possible.
Disjointed care.	Integrated, continuous care.
Patients and carers as passive recipients.	Patients and carers fully involved in care.
Carers undervalued.	Carers supported as partners.
Self care infrequent.	Self care encouraged and facilitated.
Low tech.	High tech.
Episodic Care.	Planned care.
Geared towards acute conditions.	Geared towards long-term conditions.

As part of the change to new models of care outlined above, there will be increasing emphasis on making use of the 'assets' and community capacity that already exist within local communities. Assets are the collective resources that individuals and communities have which help protect against poor health and also support the development and maintenance of good health. Asset based approaches are ways of working that promote and strengthen existing assets within the community. Assets can be social, financial, physical and environmental and are more than just the things you can put a price on. Central to asset approaches is the idea of people in control of their lives through development of their capacities and capabilities.

The Partnership recognises and supports the value of an asset based approach to health and community care. This represents a radical departure from the 'deficit' approach that has been the main way health and social care has been approached in the past.

Deficit models focus on identifying problems and needs of populations which require professional resources to resolve them. This results in high levels of dependence on services which do not support the active involvement of individuals in their care. The asset-based approach has also been closely associated with co-production which means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. The differences in these approaches are shown in Table 1.2 below.

Table 1.2: Deficit Compared to Asset Based Approach

Deficit Approach	**Asset-based Approach**
Starts with deficiencies and needs of an individual or community.	Starts with assets / resources in an individual or community.
Responds / reacts to problems.	Proactively identifies opportunities and strengths.
Provides services to users.	Invests in people as active participants.
Emphasis on the role of services.	Emphasises the role of civil society
Focuses on individuals in isolation.	Focuses on individuals in communities / neighbourhoods and the common good.
Sees people as clients and consumers receiving services.	Sees people as participants and co-producers with something to contribute.
Treats people as passive and 'done-to'.	Helps people take control of their lives.
Tries to 'fix' people.	Supports people to develop their potential.
Implements programmes as the answer.	Sees people as the answer.

At the heart of our future plans is a shift in services and resources from institutional settings to support people in their own homes through a partnership with communities which reduces the need for hospital or residential care. Over the three years of the Strategy we will change the way we organise and deliver services, including:

- Further shifting the balance of care to support an increasing older population with high level needs to be cared for at home rather than in hospital or care homes.
- Increasing the number of older people receiving support in the community, including homecare services, re-ablement, community nursing and other community based services.
- Changing the way care home places are used, reducing long stay care home places and increasing the number of beds used for respite and step up/ step down care.
- Reducing the length of stay and delays people are delayed in hospital by increasing community based services and support.

1.7 The Perth and Kinross Area

Perth and Kinross covers an area of 5,286 square kilometres. Approximately one third of the population in the area lives in Perth and nearly 60% live either within Perth or within a 'commuter village' just outside Perth. Throughout the rural area there are a number of sizeable settlements with a historical status of being the former 'county towns'. To help plan services more effectively and equitably this Strategy provides information for 5 localities in Perth and Kinross. These are Kinross, North West/ Highland Perthshire, Perth City, Strathearn and Strathmore. These localities are shown in the map at the rear of this document. It should be noted that the localities may be subject to change and service delivery may reflect these changes.

2. The Strategic Planning and Commissioning Framework

2.1 Legal, Regulatory, National and Local Policy Frameworks

2.1.1 Introduction

The services that we commission are delivered within a changing policy environment that includes national legislation and strategies as well as local plans. This Strategy recognises the need to reflect this policy context. This Joint Commissioning Strategy has been developed in response to a number of national policies, the increasing ageing population and acknowledgement of a difficult financial climate.

'Reshaping Care for Older People Programme' is a 10 year programme which aims to optimise independence and wellbeing for older people at home or in a homely setting. It recognises that due to the challenges facing health and social care in relation to the increasing older people population and the financial constraints that maintaining the status quo will not suffice. There will need to be significant shifts to anticipatory and preventative approaches so as to achieve and sustain better outcomes for older people.

The Reshaping Care Programme is an important driver for implementing the 'NHS Quality Strategy' and the vision and aspirations set out in this plan are consistent with and give meaning to the 3 Quality Ambitions: Partnerships between the NHS and those seeking care and support; care that is reliably safe; and appropriate, timely and efficient care and treatment. The Reshaping Care Programme is equally a key driver for implementing existing policies within social care services. A number of the most relevant legislation and national policies are illustrated below.

- Scotland's National Dementia Strategy.
- Caring Together: The Carers Strategy for Scotland 2010 - 2015.
- Self-directed support: A National Strategy for Scotland.
- Living and Dying Well.
- Better Cancer Care – Detect Cancer Early Programme.
- Community Hospitals Strategy Refresh.
- Intermediate Care Framework.
- Integrated Resource Framework.
- Community Care Outcomes Framework.
- Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan.
- Rehabilitation Framework.
- Health Equity Strategy.
- Shifting the Balance of Care.
- Christie Commission.
- The Healthcare Quality Strategy for NHS Scotland.
- NHS Scotland Efficiency and Productivity: Framework for SR10.
- Re-shaping Care for Older People.
- National Performance Framework.
- Health Improvement, Efficiency, Access and Treatment (HEAT) Targets.

- Age, Home and Community: A Strategy For Housing For Scotland's Older People: 2012 – 2021.
- Better Health, Better Care: Action Plan (2007)
- Delivering Care, Enabling Health.
- Scottish Care Positive Care – Making it Happen – Developing a Strategic Commissioning Framework for Care Services.
- Mental Health Strategy for Scotland.
- The Same as You – A Review of Services for People with Learning Disabilities.
- Equality Act 2010.

2.1.2 Change Fund

To address the broader aims of this Programme to deliver significant shifts in the balance of care from institutional to community settings, the Scottish Government established the 'Change Fund' in 2011/12 to enable health, social care, housing, Independent and third sector partners to implement local plans for making better use of their combined resources to improve outcomes for older people. The Change Fund provides 'bridging' finance to facilitate shifts in the balance of care from institutional to primary and community settings and influence decisions taken with respect to the totality of Partnership spend on older people's care.

2.1.3 Health and Social Care Integration

The Scottish Government shall bring forward legislative proposals that shall promote the integration of health and social care. The objectives of this are to ensure that:

- Health and social care services are firmly integrated around the needs of individuals, their carers and other family members.
- They are characterised by strong and consistent clinical and care professional leadership.
- Commissioners and providers of services are held to account jointly and effectively for improved delivery.
- Services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

In Perth and Kinross this agenda is currently being pursued by an 'Integration Transition Board' which comprises of senior officers from the NHS Tayside and Perth and Kinross Council. From 1 April 2013, it is proposed that a 'shadow board' be established to ensure the development of effective governance arrangements for adult health and social care Integration. The rational behind these proposals is that the promotion of effective ways of working through inclusive trusting partnership relationships will be the key to increased integration which in turn will lead to better health outcomes. There are a number of important aspects to Perth and Kinross's approach to the Governance which will need to be addressed such as budget allocation, financial control, performance management, partnership scope, delegation of powers, clinical governance, risk management, human resources and democratic accountability.

2.1.4 Commission on Future of Public Services (Christie Commission)

The Christie Commission identified the need to improve service delivery and redesign to obtain better value for money. It highlighted that services must be redesigned as demographic change will mean there will not be enough people of working age to support current service provision, or the money available to pay for it. The main recommendations included:

- Need to empower individuals and communities by involving them in service design and delivery.
- All partners, including third and independent sectors need to work closely together to support people to have more years of healthy life.
- Expenditure on prevention of negative outcomes should be prioritised.
- Whole public service system, including the third and independent sector must become more efficient by reducing duplication and sharing services wherever possible.

In response to the Christie Commission's recommendations, the Government's public service reform agenda will be built on four pillars

- A decisive shift towards **prevention**.
- A greater focus on '**place**' to drive **better partnership**, collaboration and local delivery.
- Investing in **people** who deliver services through enhanced workforce development and effective leadership.
- A more transparent public service culture which improves standards of **performance**.

2.1.5 NHS Quality Strategy Outcomes and Ambitions

As with the Healthcare Quality Strategy for Scotland the Perth and Kinross Community Health Partnership's (CHP) will embrace the following statements to assist and guide its practice through the life of this Plan. These ambitions will be embedded in all approaches that are developed and implemented across the life of this Strategy with the desired effect of achieving the highlighted outcomes.

(i) The Quality Ambitions

- **Safe –** There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.
- **Effective –** The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.
- **Person-centred –** Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

(ii) The Healthcare Quality Outcomes

- Everyone gets the best start in life, and is able to live a longer, healthier life
  NHS Scotland works effectively in partnership with the public and other organisations to encourage healthier lifestyles and to enable self care, therefore preventing illness and improving quality of life.
- People are able to live well at home or in the community
  NHS Scotland plans proactively with patients and with other partners, working across primary, community and secondary care, so that the need for hospital admission is minimised.
- Healthcare is safe for every person, every time
  Healthcare services are safe for all users, across the whole system.
- Everyone has a positive experience of healthcare
  Patients and their carers have a positive experience of the health and care system every time, which leads them to have the best possible outcomes. This should be demonstrable across all equalities groups.
- Staff feel supported and engaged
  Staff throughout NHS Scotland, and by extension, their public and third sector partners, feel supported and engaged, enabling them to provide high quality care to all patients, and to improve and innovate.
- The best use is made of available resources
  NHS Scotland works efficiently and effectively, making the best possible use of available resources.

2.2 Local Policy Context

2.2.1 Introduction

The Perth and Kinross Reshaping Services for Older People Partnership's vision is to promote the independence and wellbeing of older people at home or in a homely setting; ensure that they will be involved in planning their own care and support, and be well informed about their options and choices; work in partnership with all sectors and older people to achieve positive outcomes, personalised support, independence, quality of life, supporting them to be active, included and valued. The Partnership will work with older people and the wider community to achieve this vision. This Strategy complements, and is consistent with, other Perth and Kinross plans and strategies such as the:

- NHS Tayside Local Delivery Plan.
- Perth and Kinross Community Planning Partnership Community Plan 2006 – 2020.
- Perth and Kinross Council's and Community Health Partnership's Equalities Action Plan.
- Perth and Kinross Local Housing Strategy 2011-2016.
- NHS Tayside Health Equity Strategy 2010.
- Perth and Kinross Joint Strategy for Adult Carers and Parent Carers 2011–2014.
- Perth and Kinross Homelessness Strategy 2009-2012.
- Perth and Kinross Joint Physical Disability Strategy 2010/11 – 2013/14.
- Perth and Kinross Joint Strategy for Learning Disability Services 2012 – 2015.

- Perth and Kinross Joint Mental Health and Wellbeing Strategy 2012-2015.
- Independent Advocacy Joint Strategic Plan for Tayside 2010-2015.
- Perth and Kinross Council Housing and Community Care Services Charging Statement, March 2013,
- Perth and Kinross Council Housing and Community Care Business Management and Improvement Plan 2011/12 - 2014/15.
- Perth and Kinross Council Alcohol and Drug Partnership (ADP) Strategy 2012-2015.
- Perth and Kinross Single Outcome Agreement 2009 – 2012.
- Perth and Kinross Council Corporate Plan 2009-2012.

2.2.2 Review of Community Planning and Single Outcome Agreements (SOAs) - Statement of Ambition (2012)

Effective community planning arrangements will be at the core of public service reform. These arrangements will drive the pace of service integration, increase the focus on prevention and secure continuous improvement in public service delivery, in order to achieve better outcomes for communities. The review of community planning identified the need to work through how community planning feeds into and supports wider aspects of the reform agenda, particularly the integration of adult health and social care services. Three core proposals were included:

- Strengthening duties on individual partners through a new statutory duty on all relevant partners, (whether acting nationally, regionally or locally), to work together to improve outcomes for local communities through participation in community planning partnerships and the provision of resources to deliver the SOA.
- Placing formal requirements on Community Planning Partnerships (CPPs) by augmenting the existing statutory framework to ensure that collaboration in the delivery of local priority outcomes via Community Planning and the SOA is not optional and is made as effective as possible.
- Establishment of a joint group at national level to provide strategic leadership and guidance to CPPs.

The Partnership is committed to monitoring the outcomes of this further work and will respond to these as required.

The ‘Concordat’ sets out the relationship between local authorities and the Scottish Government. Emanating from this is the SOA, for Perth and Kinross which outlines fifteen local outcomes, which contribute, to the national outcomes agreed through the concordat with the Scottish Government. In particular this Strategy contributes to the Single Outcome Agreement national outcome numbers 6, 7, 10 and 15 which are ‘We live longer, healthier lives’, ‘We have tackled the significant inequalities in Scottish society’, ‘We live in well-designed, sustainable places where we are able to access the amenities and services we need’ and that ‘Our public services are high quality, continually improving, efficient and responsive to local people’s needs’ respectively. A particular set of the local outcomes directly influences this Strategy. These are:

- (8) Our communities and people experiencing inequalities will have improved quality of life, life chances and health.
- (10) Our people will have improved health and well being.
- (12) Our communities will have access to the key services they need.
- (14) Our people will have access to appropriate and affordable housing of quality.
- (15) Our services shall be responsive, of high quality and continually improving.

In addition the Agreement stresses an 'overarching' priority for Perth and Kinross which directly influences this Strategy and is:

- Improving the health of all our population, ensuring that the quality of care provided to the elderly, disabled and vulnerable in our communities enables them to lead fulfilling and independent lives.

A full summary of the legislative and policy contexts is shown at appendices 1 and 2.

2.2.3 Commissioning Policies and Procedures

Commissioning of services is one of the most important functions undertaken by the Partnership. Commissioning is at the heart of effective service delivery which can transform people's lives. It is not just about procedures and processes but it is a strategic activity investing for the long term. Commissioning is the process by which local authorities decide how to spend their money to get the best possible services for local people. Our services may also work in partnership with a number of other agencies during commissioning.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.

Both Perth and Kinross Council and NHS Tayside have formal commissioning and procurement policies and contract rules which provide the framework for the practical aspects of the commissioning process.

This Strategy is part of broader commissioning arrangements for adult health and social care which set out how the Partnership's health and social care services for older people are currently provided and how these services will be commissioned and procured. Joint plans between Perth and Kinross CHP, Perth and Kinross Council, the third and independent sectors are also in place for care groups such as carers, mental health and well being, learning disability, physical disability, alcohol and drugs, sexual health and blood borne viruses. How our commissioning policies and procedures operate is outlined in Appendix 3.

3. Joint Strategic Needs Assessment

3.1 What Are the Main Challenges and Why Do We Need to Change Our Approaches?

In preparing this Strategy the Partnership has undertaken a Joint Strategic Needs Assessment (JSNA). This assessment shows the many health and wellbeing drivers that can impact on an individuals' demand for health and social care. Such a relationship is a complex one but examining certain estimates such a life expectancy, smoking rates, diet and obesity can give an indication to the likely need for health and social care. It also shows the current level of services that are being delivered.

The full detailed JSNA is available at Appendix 4 and it provides the basis, alongside the policy drivers set out in section 2, for this Strategy's approach that for many of the services that we currently commission we cannot maintain our current ways of working into the future. Instead we need to 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. The assessment shows that there are significant issues that require to be addressed and these are shown below.

Overall, in relation to the other Partnership areas in Scotland, Perth and Kinross is above average in many of the health and wellbeing indicators, that is on average health and well being is better than that of other places in Scotland. However this does not mean we can become complacent in our approach to delivering services but instead recognise where challenges still remain, for example areas that do experience deprivation within Perth and Kinross. Another challenge within the geography is access to services, several areas are remote and rural in Perth and Kinross.

3.2 Recognising the Challenges of Demographic Change

The General Register Office (GRO) for Scotland indicates that the 2011 mid year estimate population in Perth and Kinross is approximately 149,500 of which around 20% are aged 65 years or over. Perth and Kinross has the highest projected growth rate in Scotland with significant growth predicted in the number of older people, (over 65 years), by around 40% between 2011 and 2027. Over the next 15 years, large increases are forecast in the number of people in each of the three older persons' age groups: 65-74 (26%). 75-84 (48%). and 85 plus (80%). By comparison, the traditional working age population is projected to increase by 14%

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 the vast majority of older people over 65 years are not in the care system. Indeed, the analysis we have been able to undertake with our patient level health and social care data show that in Perth and Kinross a vast number of people over the age of 65 years are not using health and social care services. Therefore in some localities we will need to focus on access to services for the 80 years plus age groups.

Table 3.1: Perth and Kinross Population Projections by Age Band, 2011-2027

Age Group	2011	2017	% Increase 2011-2017	2022	% Increase 2011-2022	2027	% Increase 2011-2027
0-15	24984	26036	**4.2**	28370	**13.6**	30513	**22.1**
16-64	94680	100508	**6.2**	104388	**10.2**	108035	**14.1**
65-74	15743	18416	**17.0**	18860	**19.8**	19813	**25.9**
75-84	10132	11291	**11.4**	13244	**30.7**	14957	**47.6**
85+	3981	4951	**24.4**	5945	**49.3**	7178	**80.3**
Total	149520	161202	**7.8**	170807	**14.2**	180496	**20.7**

Overall, 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 65 years, and many community assets and activities depend on the voluntary contributions of this age group. We value older people as assets by supporting them in their caring roles and in the development of volunteering opportunities.

3.3 Addressing the Increases in the Number of People with Dementia

The number of people living with dementia is projected to increase in line with demographic change. It is estimated that there are currently over 2,700 people over the age of 65 with dementia living in Perth and Kinross. In 5 years, time the number is likely to rise by 18% to over 3,200 people. Dementia is a progressive illness with the incidence of severe dementia increases with age.

It is imperative that we see significant improvements in the care pathway to ensure that people living with dementia and functional illness, their families and carers are seen by the right person, at the right time and in the right place.

To do this, we have been testing models of care which supports early identification, improves support in the community and homely environment and provides training and education to all staff involved in provision of care. We are doing this through the National Dementia Demonstrator Site (Strathmore) and Change Fund initiatives (Perth City). The challenge will be when we start to spread the learning from these models across Perth and Kinross and the additional resources that will be required to do this.

As part of the evaluation model for dementia it is our intention to use the Integrated Resource Framework which will enable us to be clearer about the cost and quality implications of the new pathway and in turn support the decision making process to support shifts in clinical / care activity within and across health and social care services.

3.4 Recognising the Challenges in Shifting the Balance of Care

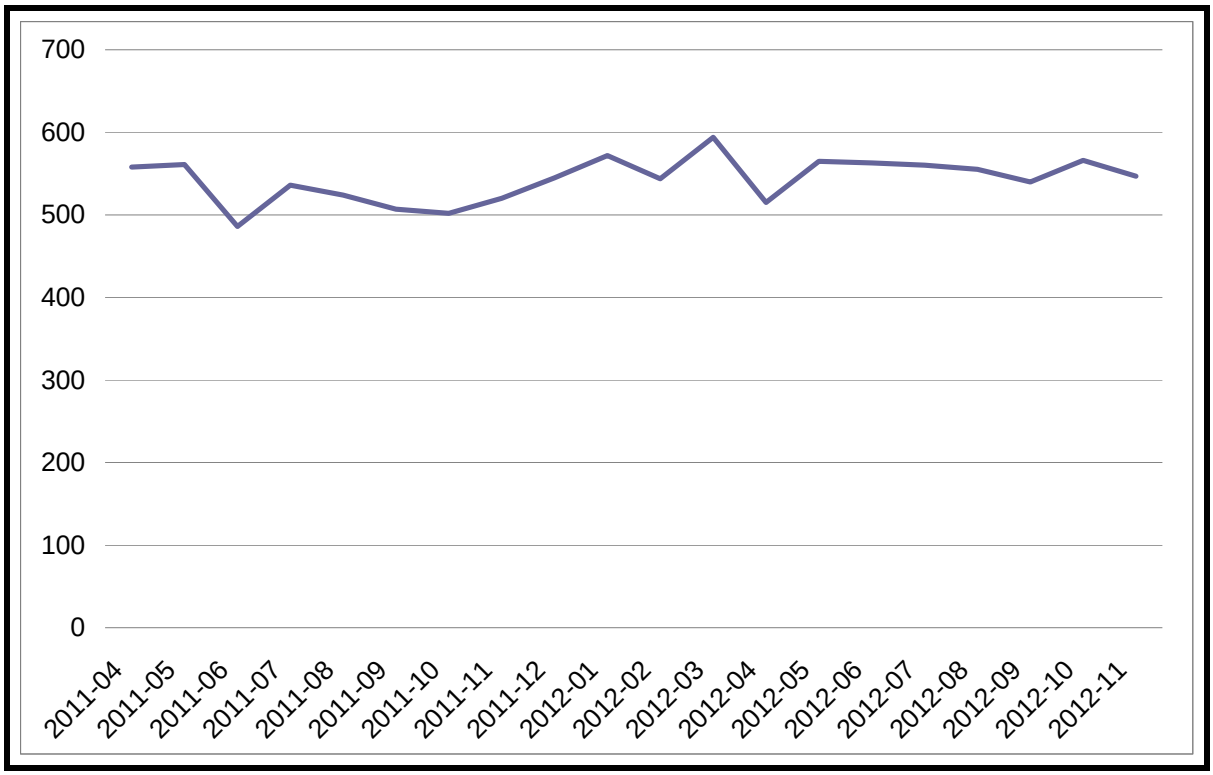
The NHS offers excellent responsive services when people are at a point of crisis or suffer injury which cannot be dealt with elsewhere.

We know that many of the people who come to hospitals as emergencies could have been offered better support or services earlier on, which would have prevented the need for them to come to hospital, or may have involved a planned visit to hospital.

Emergency admission to hospital is inevitably unplanned and can be a time of stress and anxiety to both the patient and to relatives and friends. Some admissions cannot be avoided. But the more comprehensive our approach to improving health and wellbeing, and the co-ordinated provision of alternatives to hospital care, the less likely we make the need for hospital admissions.

Older people admitted regularly to hospital as an emergency are more likely to be delayed there once their treatment is complete. This, in turn, is particularly bad for their health and independence.

Figure 3.2: Unplanned Admissions for 65+ per Month Apr 2011 to Nov 2012



There are a range of factors that will impact on admission numbers, some personal and some systems related. It is therefore imperative to ensure that earlier intervention models are available for complex / long term conditions to provide the personal outcomes for the individual's health needs such as promotion of self management and specialist community services. It is also important to ensure that alternative options are open to GPs in referring patients directly to hospital such as short term rapid response services.

In order to prevent admissions that could be supported in the community, it will be essential to continue to develop rapid access to geriatrician assessment and diagnosis in a day setting environment. This will also be supported by a 'Hospital at Home' model which will allow people to be cared for at home for as long as possible.

Figure 3.3: Delayed Discharge Days per month for 65 and over: Apr 2011 to Dec 2012

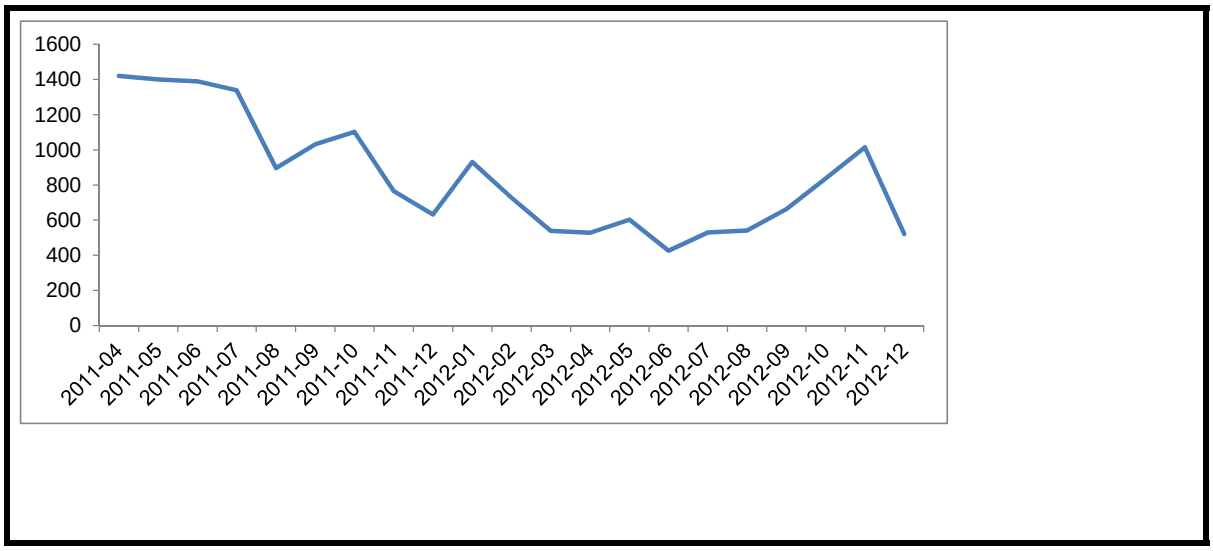


Figure 3.4 shows the reduction in bed days lost due to delayed discharges over the Change Fund period 2011 to 2012. The Change fund has successfully implemented strategies from the 2nd quarter of 2011/12 to reduce the bed days lost due to delays in discharge and although this graph has an increased spike of delay in November the overall reduction in days is on target.

3.5 Recognising the Challenges in Promoting Healthy Living

Demographic changes will result in significant increases in the number of older people over the next decades. At the same time mental health is becoming an increasingly important issue. Depression is the most common mental health problem in later life resulting in poor physical health, and increasing social isolation.

National and local health and social care provision are also challenged by significant increases in the frequency of long term conditions, obesity and sedentary lifestyle. Physical inactivity is a major contributor to these problems.

Many of the people suffering the greatest negative health effects relating to mental health, obesity and long term disease are those experiencing poverty and social disadvantages. Addressing the needs and contributions of all citizens in different settings of everyday life is a pre requisite for ensuring equality and comprehensiveness in efforts to promote mental health and wellbeing.

Physical activity is beneficial to health at all ages and active ageing can make a dramatic difference to the well being of older people. Active living contributes to

individual physical and mental health but also to social cohesion and community wellbeing.

To make the most of the resources available and tackle inequalities, policies need to target those with most need. It is never too early and never too late to improve lifestyle behaviours as this can make a real difference to health. Keeping people well across the life course will therefore be imperative.

3.6 Supporting Unpaid or Informal Carers

The vast majority of older people do not use formal health and social care services on a regular basis and 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. It is estimated that there are nearly 18,000 carers across Perth and Kinross with over 4,000 aged over 65 years with around 30 percent caring for more than 20 hours per week.

3.7 Promoting Personalisation and Self Directed Support

Personalisation is an approach which means that every person who receives support has choice and control over the shape of that support in all care settings. It entails services being tailored to the requirements of the individual rather than a 'one size fits all' fashion.

It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities.

A key element of personalisation is '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.

It is difficult to fully predict the impact that the self-directed support is likely to have on the take up of direct payments. There is no 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.

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 service fund agreements 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 individualised support.

3.8 Providing a Better Range of Housing Options

There will be an increasing and substantial demand for housing across all tenures which is built specifically or can be adapted to suit the needs of people with particular needs who are aged over 65 years. This could include the development of additional housing for older people with or without housing support and/or social care.

3.9 Welfare Reform

The Welfare Reform Act 2012 shall bring about the biggest change to the welfare system for many years. The benefits system will be simplified with changes to the assessment process and entitlements. 'Universal Credit' shall replace most existing benefits. The changes shall affect thousands of older people households and may result in a reduction in older person household income. Financial insecurity undermines health and well being and as such could result increased demand for health and social care services.

3.10 Locality Challenges

Developing locality networks comprising of leaders from the key service delivery agencies (whether public, voluntary or independent sector) in particular localities will be a significant challenge especially identifying resources and enabling investment/disinvestment decisions required to address the needs of a particular locality.

3.11 Workforce Challenges

We will be challenged by not only an ageing population with multiple long term conditions posing more complex care needs, but also by an ageing workforce. Opportunities for the workforce lie in retaining quality, knowledgeable, highly-skilled and motivated staff who are very able to deliver high-level services, but who can also further improve those services, develop their own personal knowledge and skill base, and allow for better succession planning

The implementation of the Strategy will be enabled by continually recognizing that staff members are the organisation's most valuable assets, and its most valuable resource. Health and social care commissioners will need to develop the infrastructure and strategies that provide for having the right people with the right skills and experience in the right places at the right times. This requires the implementation of strategies for recruiting people with the knowledge, skill base and values that are consistent with the new ways of working that our communities need.

The difficulties that are often encountered in accessing specialised professional skills, will mean that we must be concerned with ensuring the security of our workforce for the medium and long term. They must also be concerned with the retention of our workforce as it continues to age in the same way, and at similar rates as, the broader community.

4. What Services Do We Currently Commission?

There is a wide range of services commissioned by the Partnership delivered by a significant number of organisations including directly provided services by the commissioners, voluntary and private sector organisations. The balance between the different sectors in shown in section 5 below and a full service overview is available at appendix 6. The main services areas that we currently commission are shown below.

4.1. NHS Tayside Commissioned Services within Perth and Kinross

- Medicine for the elderly.
- Stroke care.
- Intermediate care.
- Falls prevention.
- Minor Injury and Illness Units.
- Psychiatry of Old Age (POA)/ Community Mental Health Teams for Older People
- Palliative care.
- GP Services.
- Community nursing.
- Community allied health professions.
- Acute hospital services.
- Community Hospitals.

4. 2. Perth and Kinross Council Commissioned Services

- Locality teams.
- Re-ablement.
- Occupational therapy.
- Care at home.
- Rapid response.
- Care homes.
- Respite.
- Day opportunities.
- Self-directed support including direct payments.
- Housing.
- Community alarm and telecare services.

5. How Much Are We Spending on Services?

5.1 Introduction

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 Strategy considers services across the entire pathway experienced by older people.

We intend to co-ordinate 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 resources that are needed and disinvesting in resources that will no longer be required. The approach is consistent with the Scottish Government's commitment to increased integration of health and social care services and providers.

Older people in Perth and Kinross, as well as the wider population, expect high quality services which meet their aspirations for quality of life. Our joint Strategy aims to meet this 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.

5.2 Rebalancing the Allocation of Financial Resources

Perth and Kinross Council and NHS Tayside between them spend around £90 million, including the Change Fund, on services for older people in Perth and Kinross which are either directly provided or procured externally from the independent or voluntary sectors. At present the vast majority of expenditure is undertaken through separate budgets. However there is an increasing focus on the joint strategic management of these budgets alongside preparation for the integration of decision making and administration of future joint budgets.

Table 5.1 Summary of Revenue Resources 2012/13

Funding Source	**£ (M)**
Scottish Government Change Fund	3.0
NHS Tayside	43.8
PKC - Social Work	40.7
PKC – Housing Revenue Account (HRA)	0.7
PKC –Non Housing Revenue Account (Non HRA)	1.8
Total	**90.0**

Note: Based on total resources for Older People. Excludes Leisure, independent sector, voluntary sector (except where funded by NHS/PKC).

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 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.

Table 5.2 below shows how the total resources for older people's services are allocated in 2012/13. It can be seen that a significant part of the Partnership investment is in care homes and NHS in-patient services. However the proportion of older people requiring access to these services is relatively small. This draft Strategy shows financial information on expenditure for the year 2012/13 to illustrate existing the spend profile. At the time of writing future years expenditure is not confirmed. However the final Strategy shall outline future purchasing intentions.

Table 5.2: Total Resources by Service Area (2012/13)

Agency	Service Area	£ (M)
CHP	Medicine for Elderly	3.0
	Psychiatry of Old Age (In Patients)	3.9
	Psychiatry of Old Age (Other/ Community)	2.3
	Community Hospitals (South)	1.7
	Community Hospitals (North)	2.4
	Intermediate Care and Management	0.9
	Palliative Care	1.2
	Community Nursing Services (Other/Community)	3.1
	Allied Health Professional Services	1.6
NHS Tayside	General Medical Services	6.9
	GP Prescribing	9.2
	Acute Services	7.7
	NHS Tayside Sub - Total	**43.8**
Perth and Kinross Council	Care Homes	21.3
	Care at Home	10.8
	Community Support Teams	3.0
	Occupational Therapy	2.2
	Direct Payments	1.6
	Day Opportunities	1.4
	Other	0.2
	Respite Care	0.2
	Housing (HRA)	0.7
	Housing (non-HRA)	1.8
	PKC Sub - Total	**43.2**
Partnership Total		**87.0**

Notes
1. Figures for GP Prescribing and General Medical Services are apportionments to over 65 age group of overall CHP resources. 2. Figures for Acute Service are a notional representation of direct costs. 3. Figures for other services are direct costs associated with service provision and include full costs of some services that largely, but not exclusively, deliver services to older people.

Intensive care and specialist support services are more expensive than preventative services as they include 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.

Perth and Kinross Council purchases the majority of its community care services for older people from independent or voluntary sector providers, while NHS Tayside directly provides all of its services for older people.

There is a mixed economy of care in community settings. The Partnership shall explore opportunities to enhance the delivery of services provided by a variety of providers by stimulating and supporting the market.

Table 5.3: Expenditure by Service Area and Sector in Perth and Kinross (2012/13)

Service Area	Sector		
	Public	Voluntary	Private
Community Support Teams	99.7%	0.3%	0.0%
Day Opportunities	80.6%	15.5%	3.9%
Respite	0.0%*	15.2%	84.8%
Direct Payments	3.6%	0.0%	96.4%
Care Homes	15.6%	10.0%	74.4%
Care at Home	52.8%	5.9%	41.3%
Occupational Therapy	100%	0.0%	0.0%
Other	0.0%	98.8%	1.2%
Housing	28.1%	71.9%	0%
NHS Tayside	100%	0%	0%

* PKC residential respite included in PKC care homes total.

The units and volumes purchased are shown in appendix 4.

The Partnership is 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:

- Improving the health and wellbeing of older people and their carers to prevent or delay the need for higher levels of care.
- Investing in community based and preventative services to allow more people to be supported in their home or a homely setting.
- Developing innovative solutions, evaluating 'what works' and using this information to design and plan future services.
- Redesigning hospital services and reducing the length of time people stay in hospital.

Year on year there shall be a plan to shift the proportionate balance of resources towards the pathways of Preventative and Anticipatory Care, Proactive Care and Support at Home and Effective Care at Times of Transition and away from Hospital and Care Homes. Initially this shift in proportionate investment is underpinned by the Scottish Governments four years of Change Fund Funding.

The Partnership takes a planned approach to delivering efficiencies. Whilst some of the efficiencies 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 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.

5.3 Capital Investment

As well as significant revenue expenditure Perth and Kinross shall deliver additional capital investment in buildings and infrastructure. Table 5.4 below outlines that the capital investment of £3.8M shall be concentrated in Council residential care homes, day opportunities and joint equipment and loans services. In addition the Council shall invest in very sheltered and sheltered housing with housing association partners.

Table 5.4: Capital Investment (£M) 2012/13 – 2016/17

	Agency/Year	2012/13	2013/14	2014/15	2015/16	2016/17	Total
PKC	Residential care homes	0.1	0.6	0.2	0	0	1.0
	Day opportunities	0.8	0	0	0	0	0.8
	Joint equipment/ loans	0	0.3	0	0	0	0.3
	Very/ sheltered housing	0	0.5	0.5	0.2	0.5	1.7
NHS Tayside		0	0.8	0	0	0	0.8
Total		0.9	2.2	0.7	0.2	0.5	4.6

NHS Tayside manages its capital investment on a pan-Tayside basis however each year, as part of the strategic financial planning process, a capital plan is approved which does allocate funding to various specific named projects. The last approved capital plan was agreed in March 2012. In that plan there was an allocation for 2013/14 for £750k for infrastructure investment in Blairgowrie. The capital plan will be revised in March 2013.

5.4 Integrated Resource Framework

Key elements of our Change Fund developments reflect findings from our initial Integrated Resource Framework (IRF) research which suggest local patterns of admission to care homes and hospitals that are not explained simply by geography or demography. This research also suggests a link between 'admissions' and the relative resilience of communities and individual service users.

The IRF helps our Partnership to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups.

By providing the Partnership with the information required to plan strategically and review services more effectively, and by developing financial relationships that integrate resources around populations instead of organisations, partners are able to realign their resources to support shifts in clinical/care activity within and across health and social care systems.

The Partnership has mapped the consumption of resources for all community care expenditure across the whole of Perth and Kinross. The patterns of expenditure have been calculated using the post code of the service users and attributing values to the hours of service consumed. The information begins to pose questions about the reasons for these consumption patterns. For example is it the existence of a facility or service in a particular area; is it a variation in behaviour of practice, or is it because of the variation in community resilience? Examples of how the Partnership is using the IRF to identify investment decisions is shown at appendix 5. In addition the Partnership is currently exploring with the Scottish Government a 'Programme Budgeting Marginal Analysis' approach on care pathways to better identify how areas of investment/disinvestment shall potentially affect service outcomes.

The IRF data will be used as a baseline to demonstrate current use of health and social care resources. This data will show resource use for older people across health and social care. This approach to examining resource use is different from the traditional budget view of the cost of providing a service. It examines the resource use of population specific groups (for example older people), and it does this by costing activity in hospital (cost of admission, length of stay, theatre time, delayed discharge and overheads) to provide a resource use for hospital based services.

The advantage of the IRF approach is it allows partnerships to demonstrate the resource use across health and social care for sections of their population rather than viewing use of services by single budget lines such as acute, community and social care for example; its objective is to show the detail of the resource use.

Perth and Kinross also benefits from detailed IRF data in the form of patient level health and social care data. This provides a powerful tool for examining health and social care resource use in more detail. For example smaller groups of the population use of health and social care can be examined, such as data zone, GP practice level, by care pathway. Perth and Kinross Partnership is already using this mapping to further understand how the population uses health and social care. It also provides an evidence base to provide more effective and efficient care. Examples include dementia, alcohol and drug, and delayed discharge.

IRF activity and costs are displayed in table and graph format and can be found in Appendix 5 of this document.

6. How Are We Promoting The Change Fund To Transform Services?

6.1 Introduction

The Scottish Government's Change Fund supports the transformation of older people's services, in line with the 'Reshaping Care' national strategy and is available to local Partnerships from 2011-15. The Perth and Kinross share of the fund is approximately £10m for the 4 year period and is (2011-12), £2.3M, (2012/13) £2.6M, (2013/14), £2.6M and (2014/15) £2.3M.

The Perth and Kinross Change Fund Plan was developed jointly by stakeholders from NHS Tayside, the local authority, and the voluntary and independent sectors. The governance arrangements for Change Fund Projects are rooted within existing structures, with reporting arrangements to the Perth and Kinross Community Planning Partnership and the Community Health Partnership Committees respectively. Operational oversight of the Change Fund team is conducted by the Change Fund Operational Group which, in turn, reports to the Change Fund Executive Improvement Board comprising senior officers and elected members and board members of Partnership agencies.

At the heart of our plans to reshape the care and support offered to older people is a shift in services and resources to support people in their own homes and communities. This will be achieved through partnership working at locality level bringing the partners together with communities in order to deliver shared solutions to people's health and care requirements which support a reduction in the incidence of unplanned admissions to hospital. The Perth and Kinross Change Fund approach has the following key objectives:

- Reduce the number of bed days lost through delayed discharges relating to people over 65 years of age.
- Reduce the numbers of unplanned (non-elective) admissions to hospital of people aged over 65.
- Shift the balance of care between long stay nursing home/residential care home and community provision.
- Improve the quality of care and treatment for people living with dementia and their families.
- Work with communities to increase their resilience and provide support to older people.
- Develop a joint performance dashboard.

The work of the Change Fund Operational Team is organised under 5 work streams which relate to the following key areas:

- (1) Discharge planning.
- (2) Unplanned admissions.
- (3) Dementia care.
- (4) Co-production / community consultation and engagement.
- (5) Joint Commissioning Strategy.

6.2 Financial Framework

Table 6.1 below shows that over the lifetime of the Change Fund the percentage of resource directed towards **Enablers and Hospital and Care Homes reduces** and is replaced by an increased percentage investment in the pathways for **Preventative and Anticipatory Care, Proactive Care and Support at Home and Effective Care at Times of Transition**. Much of the investment in Enablers is to facilitate the work on the implementation of the Strategy and consequently is time limited.

Table 6.1: Estimated Change Fund Care Pathway Spend (£1000's) (2011/12 – 2016/17)

Care Pathway/ Year		Preventative and anticipatory care	Proactive care and support at home	Effective care at times of transition	Hospital and care homes	Enablers	Total
2011/12	%	22.7%	16.4%	12.3%	22.0%	26.7%	100%
	£(1'000s)	235	170	127	228	277	1,037
2012/13	%	18.1%	20.1%	35.9%	14.1%	11.8%	100%
	£(1'000s)	536	598	1,066	417	351	2,969
2013/14	%	25.8%	20.9%	33.2%	7.1%	13.0%	100%
	£(1'000s)	951	773	1,225	262	480	3,691
2014/15	%	23.6%	26.9%	42.1%	3.6%	6.8%	100%
	£(1'000s)	702	713	1,254	108	203	2,980
2015/16	%	19.5%	26.9%	47.5%	1.8%	4.3%	100%
	£(1'000s)	526	724	1,277	48	116	2,691
2016/17	%	19.1%	27.1%	47.3%	1.9%	4.7%	100%
	£(1'000s)	476	675	1,179	48	117	2,495

6.3 What Have We Achieved and Proposed Actions for 2013/14

Perth and Kinross have invested the Change Fund monies to test models that start to shift resources from hospital / long term care institutions to more upstream provision in the community and prevention and early intervention models. Our progress so far under each of the pathways headings is as follows:

6.3.1 Prevention / Early Intervention

- Provided additional opportunities for participation and social networks through expanding the Healthy Communities Collaborative model, testing time banking in 2 areas of Perth and Kinross, invested in additional community engagement resources working with PKAVS, and invested in digital technology for communities such as texting bundles, voting pads and computers.
- Tested early diagnosis of dementia model in Strathmore National Dementia Demonstrator Site through the use of Open Access Memory Clinics in General Practices.
- Provided training and education to care homes on the prevention of falls and introduction of anticipatory and advanced care plans.
- Increased and promoted opportunities for self management classes for long term conditions through Disability Information Services in Perth and Kinross.

- Commenced testing the concept of Self Directed Support working with 100 individuals to identify what options work for them.
- Tested an integrated care model in Pitlochry to identify people at risk of readmission so as to provide the care and support required to remain at home.

6.3.1.1 One Year Action Plan

We will continue to invest in the above projects over the next year, embedding practice and rolling out into other areas and localities. We will further invest in the following services:

- Working with 'Live Active Leisure' by investing in Physical Activity Co-ordinators who will work with communities to put in place sustainable physical activity provision that is accessible and meets local needs.
- Invest in additional Community Geriatricians to support polypharmacy and community based prevention of admission services.
- Pilot 'Men's Sheds' in one locality to provide men, who might otherwise become isolated from important work, family and community networks, a place to gather, to participate in a variety of activities whilst supporting each other and reduce isolation.
- We will test opportunities to integrate locality services as appropriate with a primary focus on early intervention and prevention of admission.

6.3.2 Proactive Care and Support at Home

- Invested in Alzheimers Scotland Link Workers to improve community based dementia services for pre and post diagnostic support in the form of provision of information, advice and support to the cared-for person and the carer.
- Increased community based support for people living with dementia in the community, shifting resources from traditional bed based models.
- Increased spending on equipment and adaptations to homes to support more people at home.
- Developed telemed opportunities in the Highland Perthshire locality to improve communication between primary and secondary care.
- Commenced testing alternative options to admission for General Practitioners(GPs) and other professionals to ensure support and care is provided at the right time, by the right person and in the right place. This is in the form of rapid response services and step up.
- We are also working in partnership with 'Marie Curie Care' to support patients who are at end stage of life to stay at home if that is their preference. This work will provide support to carers of these individuals to meet the needs of their loved one.
- Invested in a COPD /CHD nursing and a physiotherapy specialist in the community to provide support, education and training and also rapid response to patient's with exacerbation of their illness using a case management approach and anticipatory care planning.

6.3.2.1 One Year Action Plan

We will consider through our Change Fund Improvement Executive Board the impact of integrating the total community resources for Reshaping Care for Older People within the appropriate work streams. This will allow for integrated planning at locality level across facilities and community resources.

New initiatives that are being proposed that support the approach of looking after more people at home will be the following:

- Scope the benefits around integrating health and social care services within a hub type arrangement incorporating community beds, rapid response services, community rehabilitation, evening and out of hours services, as appropriate to the locality needs.
- Overnight care at home for people who need support with personal care.
- Identifying and developing options for telehealthcare in community settings in hours and out of hours.
- Reviewing our out of hours provision of services to ensure that we work more effectively with our partners across health, social care, private and voluntary sectors.

6.3.3 Effective Care at Time of Transition

- In partnership with the private sector developed step down and interim placements in care home beds.
- Invested in additional private home care provision to provide increased support in the community.
- Provided additional capacity for discharge services in the form of an immediate discharge service incorporating re-ablement officers and health care assistants and improved the discharge process by providing direct access to social care services.
- Increasing social work capacity to provide faster access to social work assessments in the community and as an inpatient.

6.3.3.1 One Year Action Plan

- Improve Perth and Kinross wide dementia liaison service based around PRI. Community Hospitals and Care Homes.
- Develop integrated step down model supported by appropriate medical and clinical staff.
- Work with our acute colleagues to identify an improved care pathway for people admitted to acute care who have a cognitive impairment or diagnosis of dementia.
- Enhance the current liaison services to ensure Medicine for the Elderly input to dementia wards to address the more complex physical health care needs.

6.3.4 Hospital and Care Homes

- Enhanced psychiatry of old age liaison services to ensure patients with a cognitive impairment are provided with effective care and support to enable timely discharge and transitional care on discharge.
- Test the provision of Allied Health Professionals input into the Stroke Unit at Perth Royal Infirmary (PRI) in hours and at weekends to increase rehabilitation opportunities and ensure timelier discharge.
- Established a new discharge pathway which supports a reduction in length of stay within the hospital environmental.

6.3.4.1 One Year Action Plans

- We will continue to review business processes and systems to streamline to increase the capacity and flow within our hospital services.
- Work in partnership with acute colleagues to implement across the acute sector the discharge pathway.
- Work with our care come private sector providers to identify and develop alternative options for use of care home facilities for example day opportunities and step down.

6.3.5 Enablers

- Provided additional capacity in health, social care, private and voluntary sectors to support the development and implementation of Change Fund projects.
- Enhanced capacity for communication, consultation and engagement in localities to enable more people to become involved in the planning and development for future service provision.
- Developed and implemented training and education packages across all sectors to enhance their knowledge and skills and improve the quality and flexibility of services for example falls prevention, dementia training, anticipatory care Planning, palliative and end of life care.
- “Get ready for winter” sessions have been held with community organisations and local people in Aberfeldy and Pitlochry where organisations agree to undertake particular roles in the event of severe weather and where opportunities for future service development were identified. .Joint training around ‘Preparing for Winter’ in relation to admission avoidance in COPD has taken place in various locations.
- Created more opportunities for organisational development courses such as Action Learning Sets to engage with all frontline staff to improve understanding of each other’s roles and responsibilities and develop new ways of working.

6.4 Organisational Development

An organisational development programme of “action learning sets” has been commissioned from NHS Tayside and Scottish Social Services Council to engage health, social work and Independent sector front line staff with the following objectives:

- Developing further understanding of each other's roles and responsibilities.
- Developing new ways of working more closely together within specific communities.
- Sharing experiences and problems and assist Action Learning Sets (ALS) colleagues in finding achievable solutions.
- Increasing knowledge and understanding of concepts and current partnership projects.
- Providing a springboard to increase engagement and involvement of a wider, local stakeholder group.

These ALSs have been completed in Highland Perthshire and Strathmore, with a roll-out programme across Perth and Kinross. .Further development sessions will be held with health and social care staff to deliver integrated health/care plans for service users; an improved understanding of and response to risk; and a co-ordinated approach towards improving resilience of communities.

6.5 Carers

The Perth and Kinross Joint Strategy for Adult Carers and Young Carers highlights that we are currently spending £4.3 million per annum on services to support carers of adults. .Of this, £1.1m is Carers' Strategy funding and funding for respite for older people and people with learning disabilities. The strategy recognises that carers have rights, including the rights to be considered as equal partners. The main outcomes for carers are:

- Improved emotional and physical well-being.
- Increased confidence in managing their caring role.
- Ability to combine caring responsibilities with work, social, leisure and learning opportunities and retain a life outside of caring.
- Reduced disadvantage or discrimination, including financial hardship, as a result of caring.
- Involvement in planning and shaping the services they need.

The Change Fund, by its nature provides direct and indirect support for carers. Over the Change Fund's three year period we expect to allocate £1.72M funding to support carers representing around 23% of the total. Some examples of work to support carers are listed below and these are consistent with the carers' strategy. We have:

- Established a hospital link worker for carers.
- Developed the rapid response service (in-hours and out-of-hours) providing a single point of contact for professionals and carers who need additional support, information and advice.
- Worked with Alzheimers Scotland link workers providing pre- and post-diagnosis information, advice and support for the cared-for person and their carer.
- Established community capacity building in the form of time banking which ensures a network of community based support for the cared for person and carer.

- Provided a range of telecare products to support vulnerable adults to remain in their own community.
- Developed additional social work capacity to support discharge planning in a hospital environment, as well as assessment in the community for the cared for person and carer.
- Expanded a more comprehensive re-ablement service to support the cared for person to become more independent.
- Introduced self-management courses for long term conditions to enable the cared for person to become more independent.
- Set up consultation and engagement models with carers and cared for person to enable co-design and co-production of activities that improve the quality of life for older people.
- Ensured that carers are involved in a range of consultation and evaluation activities (e.g. conferences).

Identifying the particular needs of carers within Black and Minority Ethnic Communities is an area of specific attention which requires exploration. Development work is being progressed with the gypsy/traveller community, through the work of a local project, which is working to identify the needs of carers and to support people to access relevant services and support.

6.6 Future Intentions

On the basis of the information sharing which underpins our Change Fund approach and learning achieved during implementation, the following factors have been identified as essential to achievement of our proposed models of care:

- Developing integrated health and social care services which identify the risk of hospital admission earlier and respond promptly with appropriate short and long term integrated health/care community-based arrangements.
- Developing information sets that clearly identify both the level of usage of such arrangements and the continuing level of hospital admissions per GP area.
- Developing a network of community supports which build on existing provision, fill identified gaps and work closely with statutory services, independent providers and other voluntary organisations.
- Developing the competencies of the Health and Social Care workforce through training, education, work shadowing and other avenues.
- Expanding the total workforce committed to the 'Reshaping of Older People's Care' agenda through increasing involvement of volunteers and communities in the provision of important local supports.
- Targeting capital investment and improvements effectively towards the design of community facilities in order to meet future demand, improve quality of provision and achieve co-location where relevant and deliver efficiencies in the provision of health and social care services.
- Spreading the learning from Change Fund Projects into mainstream core culture, behaviour and practice.
- Exploring project budget and marginal analysis of key elements of the Reshaping Care Plan within the Change Fund in order to evidence the relative impact of contributions and the sustainability of key components.

- Redesigning mainstream budgets/services to ensure greater flexibility and responsiveness – in line with learning secured from Change Fund Projects and other related work.
- Extend the capacity for key personnel to engage effectively with GPs and secondary care consultants in order to secure efficiencies in the delivery of services.
- Creating a learning and development environment at locality level which encourages local leaders to drive change, consult with communities and contribute directly to the community.

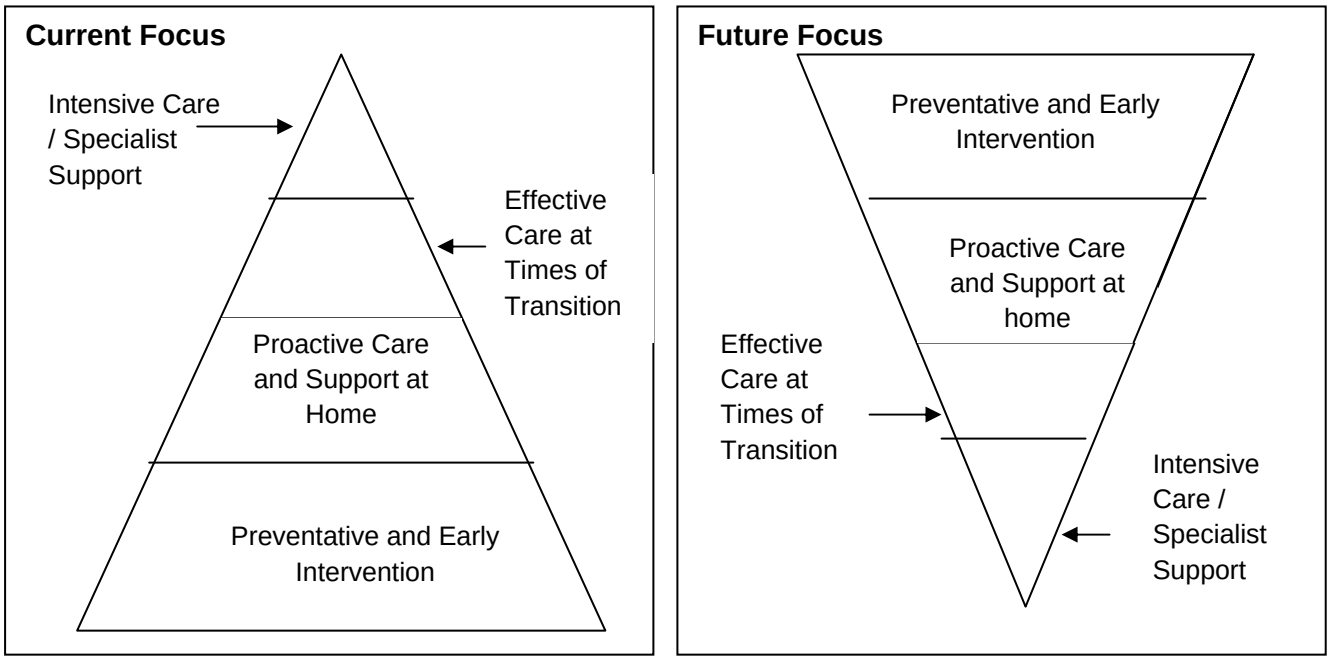
7. How Will Our Joint Commissioning Priorities Develop?

The Reshaping Care for Older People programme sets out what change is to take place to ensure the right services and support are in place to meet the needs of older people. Central to this agenda is the need to shift the balance of care away from hospital based services to the community. This increases the need for:

- Prevention so that people keep well and are helped to manage their conditions better so they do not require a hospital admission in the first place.
- Community based services available, when people do need more support, in their own community.

This requires a change in the way resources, both finance and staff, are deployed. This is illustrated by the model shown in Figure 7.1 below, which is the basis for this Strategy's vision and reflects the overall direction of travel adopted.

Figure 7.1: Reshaping Care Model



By illustrating levels of support and care in a triangle, we highlight the majority of older people who generally keep well, are most physically active and able to maintain their wellbeing. This is contrasted with the minority of older people who will require extensive support and care, many of whom will have more than one long term condition and may need more extensive care at the end of their life and who will require the majority of resources to support them.

Traditionally our model of service provision has been one where both investment and focus have primarily been on specialist services. By inverting the focus on specialist services and placing universal services at the top of the triangle, we will ensure that our investment and focus is primarily on maximising the independence and choice of all older people.

Our long term ten year vision will be supported by short to medium priorities (up to 3 years). Full and detailed action plans will be developed and monitored as part of our wider evaluation framework for the final Strategy. The Action Plans shall focus on the following areas as per the reshaping care model**.**

7.1 Preventative and Anticipatory Care

7.1.1 Investing In 'Resilient' Communities

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

These carers 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. Other factors important in preventing ill-health relevant to older people include good nutrition, physical activity and exercise, and strong engagement with the local community.

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. 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.

7.1.2 Co-production

We are working to improve capacity in communities. For example the delivery of tested self management classes through the voluntary sector in Highland Perthshire and the implementation of 'Time banks' in two communities in Highland Perthshire with a third due to come on stream in 2013. We shall expand the number of these projects. We will integrate and build upon our co-production/community capacity building to date by developing models of integrated service delivery and community planning at locality level informed by effective community engagement and involvement. We shall, for example, expand the work of the Healthy Communities Collaborative working collaboratively with representatives from statutory, private and voluntary organisations in conjunction with local people. These groups, led by local people recognise issues, develop ideas and will be supported to initiate and lead activities locally, ensuring communities are in control, helping people stay active and involved thus developing caring, resilient communities.

7.1.3 Locality Planning

As part of the wider community planning approach, the Partnership is moving towards creating locality networks comprising of leaders from the key service delivery agencies (whether public, voluntary or independent sector) operating in a particular locality. The networks shall have a key role in relation to identifying, prioritising and planning locality needs with a specific remit to:

- Populate and maintain a locality profile as a key source of baseline data and wider evidence about local needs, priorities alongside intelligence about existing resources deployed in the locality.
- Identify and prioritise local needs, based on the locality profile.
- Identify resources and investment/disinvestment decisions required to address those needs.
- Identify potential for further service integration/mainstream service redesign which may be required longer-term.
- Plan and commission service delivery by agencies, working either individually or jointly, to meet local needs.
- Ensure effective community engagement which informs delivery priorities and drives continuous improvement in service delivery. This may include community representation on the network itself.
- Communicate and agree delivery priorities with the Community Planning Partnership.
- Monitor performance against delivery and provide performance reports.

Providing information and advice for older people and their carers for self management.

Ensuring that older people and their carers can access information they need about opportunities and support available when they need it is essential to maximising health and well being. Older people need to be supported to plan their future finances, accommodation and care arrangements as early as possible. The Partnership will work closely with service providers to establish how investment in this area can be maximised and how services can be best integrated.

7.1.4 Personalisation and Self Directed Support (SDS)

The shift towards an outcomes focused approach and the introduction of a re-ablement service aligned to this approach commenced in July 2010. This has resulted in a significant restructuring in the care at home market place, as private and independent care at home agencies have been commissioned to deliver longer term care and support, after re-ablement. Care at home providers were consulted and involved in this strategic development through the Care at Home Providers Forum and will have to further adapt to meet the challenges of SDS in the future.

Re-ablement will continue to be our crucial first stage of the assessment/support process to ensure people are enabled to become as independent as possible, when failing health or a crisis affecting their self reliance has required them to seek help.

If longer term support is required and eligibility criteria are met, outcomes focused assessments will be undertaken, agreeing outcomes with the service users relating to an improvement in their health, wellbeing, social inclusion, independence and responsibility in line with the national framework for community care.

Under SDS, support planning with the person and their family will be undertaken to explore a range of options in pursuance of agreed outcomes. The 4 options for practical and financial management of support will be explained, giving families time to consider what will work best for them. Support planning will be carried out with the person and their family in line with the outcomes agreed during the assessment ensuring that risks identified are managed. Arrangements will then be made for the agreed support to be put in place in line with the option chosen. Ongoing monitoring and review will ensure that the achievement of outcomes is monitored and that the level of support is adjusted as required.

At present the first phase of SDS is being piloted in North West Perthshire for older people and across Perth and Kinross for people with learning disabilities and mental health issues. A formal evaluation will be conducted when 100 people have taken up the option of this new way of receiving support. An analysis of performance information will be used to inform adjustments to the model and to determine its future sustainability. A peer audit with another local authority will also be undertaken to inform the development of a best practice model based on customer feedback, tested systems, processes and financial management.

It is envisaged that the general introduction of SDS following commencement of the legislation in 2013-14 will continue to influence the shape of the social care market place and commissioning arrangements to deliver the choice and flexibility that older people will demand. There will also be geographical differences and for example older people in rural areas, where there has been a shortage of providers, may be more pre-disposed to direct payments for personal assistants.

Support to establish micro-providers to respond to the potential demand for personal assistants will be necessary and work is ongoing to identify support agencies which may be able to help prospective micro-providers develop their business plans. The Partnership is keen to expand these approaches and roll out them across Perth and Kinross.

For all existing providers, including care at home agencies, housing support providers, specialist supported living providers, day care providers and other providers SDS will mean changes in the way that services are purchased, shifting from block contracts to individual contract arrangements in response to the choices and demands of older people directing their on support.

7.1.5 Supporting Unpaid or Informal Carers

Unpaid carers support the overwhelming majority of people over 65 years that do not receive any formal care. This Strategy is based on a commitment to regard unpaid carers as equal partners and to work together 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 that carers are 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 Perth and Kinross Joint Strategy 2011-14 for Adult Carers and Parent Carers sets out a series of service development priorities which are informed and influenced by the Scottish Government's agenda and carer's views. The Carers Strategy's priorities are to improve:

- Respite service options.
- Carer's access to independent advocacy.
- Support services for individual carers.
- Carers support planning including enabling options for greater personalisation of services.
- Training for carers.
- Carer's health.
- Information and advice services to help the identification of carers.
- Communication between statutory and independent agencies which support carers.
- Services for young adult carers, which take account of their rights, as young adults, to further education and employment.
- Support for working carers.
- Maximising income for carers.

We are currently reshaping our carers' services in order to provide dedicated support within our major rural centres of population, linked to a larger carer's hub within the city of Perth. We will look to build on our existing respite service and carers vouchers scheme through this approach and through the work of the Change Fund in providing specialist support to carers of those with a diagnosis of dementia and those with long-term conditions.

7.1.6 Investing in Suitable Housing Options for Older People

There will be an increasing and substantial demand for housing across all tenures which are built specifically or can be adapted to suit the needs of people with particular needs who are aged over 65 years. Within the context of the overall increase in the older population, there is a need to explore opportunities for a range of housing options for frail older people. This could include the development of

additional amenity housing, very sheltered housing or intensive housing support and/or social care for those who wish to remain in their own homes.

As such the Council shall re-orientate existing sheltered and very sheltered housing towards meeting the housing, and care needs requirements of those in greatest need. This may involve upgrading or reconfiguring existing Council and RSL sheltered or very sheltered housing services.

There is a substantial and increasing demand, from people of all ages, for housing which is suited to the needs of people with a range of disabilities. As well as the provision of new build housing built to 'varying needs standards' there is a greater demand for adaptations to mainstream housing both in the social rented and private sectors.

The Partnership's approach to meeting the needs of people with particular needs focuses predominantly on a 'supported living' approach which seeks to enable individuals to live independently within their own homes integrated within existing communities. For future provision for particular needs it is envisaged that this need will be met mainly within housing for varying needs mainstream developments. The Partnership's approach is to enable integrated developments with appropriate support and management arrangements to assist individuals with community care needs to live independently rather than develop 'specialist' schemes.

7.1.7 Prevention of Falls and Fractures

Around 1 in 3 people over the age of 65 years and one in two of those aged over 80 years will fall every year. With an increasing ageing population, there will also be an increase in the number of people who fall. We are constantly seeking to improve the falls prevention initiatives already in place. This includes working with all our partner organisations and the private sector in heightening falls awareness/prevention and identifying fallers at an earlier opportunity with pathways for them to refer onto a falls assessment service. These agencies include the Scottish Ambulance Service, care at home services (private and Local Authority), sheltered housing wardens, Tayside Fire and Rescue, optometrists, community pharmacists, emergency departments, community health and community social work services.

With increased demand on our falls clinic services there is a need to consider more community based falls screening/assessment services similar to that currently provided by the Community Alarm Falls Screener with pathways onto other health and social care services if required and only those requiring a full specialised falls assessment being referred on to a falls clinic. There is a need to develop more community based exercise programmes and in particular exercises which improve strength and challenge balance and are evidence based to prevent falls .

7.1.8 Anticipatory Care

Anticipatory care involves a continuum which begins with self management where patients, family and carers can be given the information/knowledge an support to adapt their life style in order that they can stay as well as possible, minimise exacerbations of their condition(s), slow down the advancement of their condition(s)

and maximise their engagement in the community, what ever that may be, employment or employability, social activity etc.

Initiatives which are happening in the CHP include smoking cessation, immunisation, 'Keep Well', self management courses and development of a self care toolkit. Patients often have self management plans which support them to live as well as possible and to manage any expected deteriorations or crisis that arise (e.g. COPD management plan).

Disease management where the pathology of the condition has advanced is mainly supported through GP practices and through an anticipatory approach with patients, can prevent the development of exacerbation to the stage where hospital admission is required.

In time the needs of the patient may change and they require case management, which addresses the need to be proactive and co-ordinated in identifying the most complex and vulnerable people living with a long term condition and then co-ordinating and managing their care in partnership with the individual and their carers. Community nurses are using this approach to caring for people on their caseload in order to maximise their health and prevent unnecessary hospital admissions.

Anticipatory care planning is a process of discussion and reflection about goals, values and preferences for future treatment in the context of an anticipated deterioration in their condition with a loss of capacity to make decisions or communicate them to others. It involves planning what further support a patient would require from family and informal carers to stay as well as possible and what short term step up of health or care social care can be provided to prevent an avoidable admission. Where an admission is unavoidable, ensuring admission to the right place, (care home or hospital), with an agreed discharge plan already in place.

7.2 Proactive Care and Support at Home

7.2.1 Providing high quality care in 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. Where people have ongoing care needs which are assessed as being eligible for social care they will be offered the choice of having a direct payment or the Council arranging services for them. The local authority will offer a choice of self-directed support options. Work is underway to develop proposals to ensure that sufficient good quality support is available to enable people to direct their own support successfully.

7.2.2 Re-ablement and Rehabilitation

Our approach to rehabilitation and re-ablement will be one which continues to focus upon enabling the service user to regain a range of abilities in relation to personal support and personal care. Our rehabilitation services will integrate appropriately

with re-ablement to develop a joint approach towards the management and delivery of occupational therapy resources.

7.2.3 Supporting people with dementia and their carers

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. 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. Health, social work and the independent and voluntary sectors will work closely together to achieve this. There will be a continued emphasis on early diagnosis and post diagnostic support.

In keeping with our commitment to develop integrated care pathways, we will seek to develop a range of integrated supports/services for people with a diagnosis of dementia and their carers across the disease trajectory.

Building on the work from the 'Dementia Demonstrator Site' in Strathmore and the Change Fund 'early case co-ordination', work undertaken by Alzheimer Scotland – we will seek to develop pathways which:

- Offer opportunities for the early diagnosis of dementia.
- Provide helpful advice and information to people with the diagnosis and their families/carers.
- Support them in constructing simple support plans during early stages of the disease.
- Provide them with information about other local services which will be available to them should they require them at a later stage.
- Develop responsive Day Services in a range of localities which reflect the particular needs of those with Dementia and their families.
- Develop the concept of a single lead worker to co-ordinate and support the family in different stages in the disease.
- Reduce reliance upon hospital admission as the primary form of respite.
- Provide expert advice to staff in clinical hospitals on the support and management of patients with dementia.
- Review the balance of our in-hospital and community dementia provision.

7.2.4 Supporting people 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 provision of adaptations is needs-based following an assessment by an occupational therapist. This ensures the 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.

7.2.5 Joint equipment loan store (JELS)

Our joint equipment loan store enables our health and social care occupational therapy staff to access a wide range of equipment efficiently. This store also has the facility for equipment to be cleaned and re-used, reducing expenditure on new equipment. It is our hope to further develop the JELS store into an assessment centre where service users can test out equipment within the centre and avoid the potential delivery of equipment of the wrong size. The service has joint revenue funding between community care and health. The installation of aids or equipment can support older people to leave hospital earlier and to maintain or regain confidence.

7.2.6 Improving day opportunities

Day opportunities 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 services for older people and 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 relevant. We are reviewing our day services and shall move away from traditional centre based activities to more flexible outreach non-centre opportunities.

7.2.7 Supporting people with long term conditions

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.

7.2.8 Telecare/Telehealth to help people to remain safely in their own home

There is a range 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 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 and include items such as personal alarms, smoke sensors, and cooker isolators. Telehealth equipment and services allow people with health conditions to better manage these in the community include examples such as blood pressure or blood glucose monitoring, medication reminders.

7.2.9 Integrated case/care management

In order to drive forward the integration of services within key localities in pursuit of the Governments Reform Agenda, we will broaden the competencies of staff and further develop the concept of a 'single lead worker' in line with the principles of 'Getting It Right For Every Child' (GIRFEC).

We will seek to improve the sharing of recorded information and introduce a system of joint care planning. Key staff from relevant agencies will receive training in the development and delivery of an integrated care plan.

An outcome focussed approach to assessment based on 'Talking Points' was introduced to community care services in July 2010. The change in language and culture required to truly embed this approach is on-going as staff aspire to a more positive and aspirational way of thinking for some households. The outcome focussed assessment and review processes for individuals who require support, as well as their carers are compliant with national standards and allow for recording of the achievement of outcomes at Review. This links directly to the national community care outcomes and evidences the impact of intervention and support. As part of the assessment and case management process the delivery of successful outcomes, are reviewed and recorded. This approach will be expanded and enhanced. For delivery performance see appendix 7.

7.3 Effective Care at Times of Transition

7.3.1 Developing effective care pathways

As more care is provided for people in their own homes services provided for people will need to work differently with one another to deliver more co-ordinated and effective care. Services provided at points of transition, particularly between hospital and home will change the way services link so that people experience is as smooth as possible. 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. The connections between services are central to provide a smooth journey, where the care required is delivered when the person needs it. Adopting an outcome focussed approach should help ensure people receive appropriate support when they need it. Care pathways will be developed which will affect the different care and treatment journeys of service users with specific needs/health conditions.

7.3.2 Providing good quality end of life care

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. There is a dedicated Perth and Kinross Palliative Care strategy which aims to ensure patients have choice and access to appropriate palliative services according to the individual patient and family's needs.

7.3.3 Intermediate Care

Intermediate care service provides a range of transitional care models and prevention of admission schemes. The service provides geriatrician supported day clinics to rapidly review elderly patients failing at home, early intervention through rehabilitation support, discharge facilitation and review at home, functional rehabilitation and in-reach ward intervention by allied health professionals.

The service also provides screening of potential admissions on arrival at PRI, to support those patients to leave hospital and receive rehabilitation and support at home, step down rehabilitation in care homes and prevention of admission interventions to support people to stay at home. The community rehabilitation teams also support the delivery and review of re-ablement services, identifying when resources require to be reviewed or reduced as a person becomes more independent in daily activities.

We intend to widen the scope of the day clinic to develop a hospital at home model supported by the nursing team. We are also seeking to commission a 'home from hospital' service in partnership with the voluntary sector, to provide support on discharge from hospital.

7.3.4 Community Hospitals

Community hospitals are well placed to support patients on their journeys of care through health and care systems. With the integration of health and social care this will have a significant impact on the way that community hospitals are managed and delivered. It will be necessary to ensure that community hospitals are effective and match the needs and expectations of the communities they serve.

We will work with the wider community to review how community hospitals fully link and align themselves with local care and support services such as care homes and home care support and how we can improve the pathways to improve outcomes for patients.

7.4 Intensive Care and Specialist support

7.4.1 Hospital, Nursing and Residential Care

Ensuring good quality hospital, nursing and residential care is available for those who need it. Care homes continue to have an important role for people with more intensive and complex care needs and many people will continue to need high quality medical 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.

Health, social care and external providers are continually working to provide the best quality of care possible in care homes and there are well established partnership working arrangements to focus on this sector, under the oversight of a Care Home Liaison Group involving representation from Perth and Kinross council, NHS and independent care home providers.

The group co-ordinates the Care Home Forum, which is held three times per year and associated sub groups. Four further sub groups meet regularly and these are the:

- Communications Sub Group.
- Care Home Activity Network (CHAN) Sub Group.
- Workforce Sub Group.
- Training Sub Group.

A Joint Care Home Support Statement was agreed in July 2012 and this recognises the essential importance of the care home sector which provides services for older people who are vulnerable and have complex medical conditions. Partnership working groups will be fully utilised to ensure care homes continue to deliver quality care focused on individual outcomes for older people, integrated into a whole system approach.

In addition to the above partnership working arrangements a Care Home Review Group comprising the statutory partners, Housing and Community Care and NHS Tayside, meets quarterly to discuss individual Care Home monitoring reports, care home market intelligence and homes of concern ensuring a consistent approach is undertaken.

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 Accident and Emergency 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.

7.5 Enablers

There are a number of 'enabling' services, processes and support structures that need to be in place to deliver the aims of this Strategy. 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.

7.6 Workforce Development

Workforce development is fundamental to ensuring that we maintain the workforce capacity and capabilities to meet the future care and support requirements of older

people. Many of the priorities identified and issues faced are relevant across the care sector.

We need to work together to create the workforce that we will need to deliver the outcomes of this Strategy. While recognising that the commissioning process and price impact on the ability of partners to maintain appropriately skilled and trained staff. We are working towards a joint approach to developing our future workforce involving the Perth and Kinross Council, NHS Tayside, voluntary and independent sector partners. Some of the key areas of work underway are summarised below. Our workforce plan will extend to cover the broader challenges of the health and social care integration agenda. At this juncture, our focus is upon:

- Working across traditional boundaries.
- Extending the skills and competencies of key staff.
- Self-directed support.
- Developing co-productive solutions with communities.
- Bed-light models of care.
- Overnight needs for care.
- End of Life care.
- Disease management advice and monitoring from specialists involving telehealth care.
- Hospital at home models.
- Roll out of re-ablement.
- Early disease detection and intervention.
- Joint commissioning.

Staff recruitment and retention is predicated on a realistic organisational development plan that will support our workforce through major changes in ways of working whilst maintaining the continuum of care. It will support and challenge our staff to work out-with traditional boundaries, will require them to develop new skills and will introduce them to new partners.

8. Monitoring and Evaluating the Strategy

The monitoring and reviewing of the Strategy will be linked to the ongoing evaluation of existing and planning of new services. A detailed monitoring framework linked to detailed action plans will be developed. In addition the monitoring and evaluation of related planning processes such as Joint care group strategies and the Local Housing Strategy will also complement the monitoring process. Progress on implementation of the Strategy will be reported to the respective joint governance bodies.

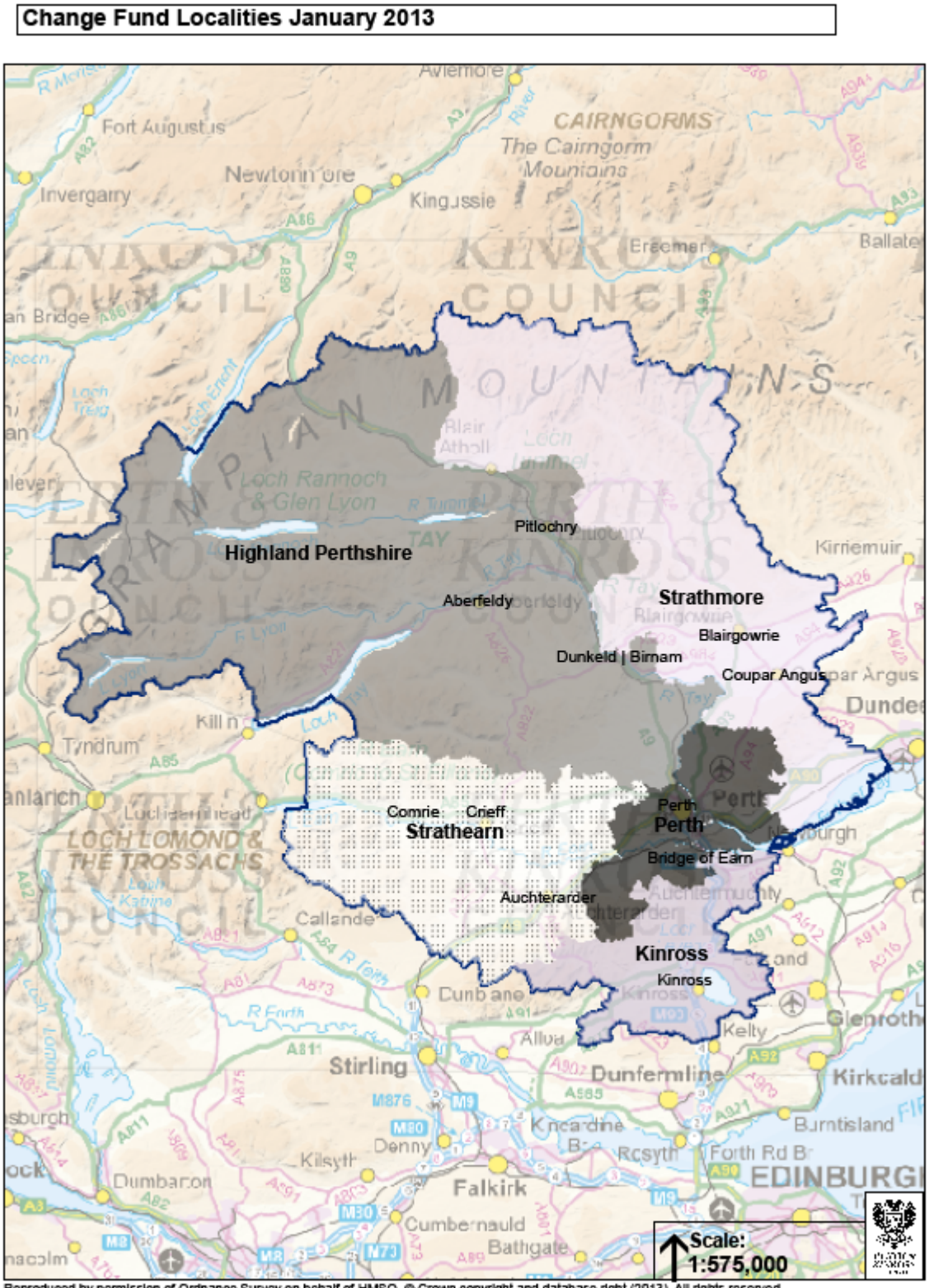
Wherever possible, progress delivered through the Strategy will be evidenced on what has been proven to be effective. We also want to ensure new ways of working are developed to meet all the needs of older people now and in the future. So, when there is no evidence available, we will try our best to gather it so we can be sure the commissioning plan is achieving its aims.

Our evaluation shall recognise what service users and their carers 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.

We will use information from a range of sources for our evaluation. This will include existing information systems within NHS Tayside and the Perth and Kinross Council and those of our partner organisations in the voluntary and independent sectors. Additionally, information that is gathered from service users and their carers about their views and experiences is of crucial importance. So, our evaluation will pull together a range of information to allow for the most comprehensive understanding to be achieved.

A comprehensive performance framework has been developed and is set out in Appendix 7. This will show how good the Strategy's impact has been with the measurement of key outcomes. To provide information and encourage accountability, the Partnership shall produce an Annual Review Report that will outline progress in the implementation of Strategy and an update of the key issues and investment priorities.

Perth and Kinross Localities



9. Response Form

Thank you for reading the Perth and Kinross consultation draft Joint Commissioning strategy. You can write with your comments to the address provided at the end of this form (overleaf). If you wish to receive an acknowledgement of your comments, please give your name and address in the space below.

1 Your name and address

Name: _____

Address: _____
_____
_____
_____
_____

Town: _____

Post Code: _____

Email: _____

You can write with your comments to:

Stephen Rankin
Planning and Commissioning Manager
Housing and Community Care
Perth and Kinross Council
5 Whitefriars Crescent
PERTH
PH2 0PA

Tel: 01738 476174
Email: stephenrankin@pkc.gov.uk

2 In the space provided below, feel free to comment about the proposals set out in this Strategy.

Comments
Is the Strategy well presented and easy to understand? **Are our priorities correct?** **Are there any potential issues missing?** **Is there anything else missing from the Strategy?** **Please use this space to add any other views you have**