ARGYLL AND BUTE COUNCIL **COMMUNITY SERVICES COMMITEE**

COMMUNITY SERVICES **8 MAY 2014**

JOINT STRATEGIC PLAN FOR OLDER PEOPLE

1 SUMMARY

1.1 In March 2014 the Health and Social Care Partnership considered and approved a report on the Joint Strategic Plan for Older People. This report updates on the progress made to date with a particular emphasis on the proposals for engagement and consultation with stakeholders including staff within the wider context of the developing agenda around Integration.

1.2 The Argyll and Bute Partnership has developed a draft Joint Strategic Plan for Older People in line with Scottish Government direction. This document has been co-produced by Argyll and Bute Council, NHS Highland including the Argyll and Bute Community Health Partnership and Third and Independent sector providers. It has built upon a level of engagement across Argyll and Bute primarily on Re-shaping Care for Older People. It outlines our plans at a high level alongside specific areas for action covering a ten year period but necessarily focussing on the earlier years and sets out how we intend to improve outcomes for older people. The plan is a working document which will be continually updated and further developed both by the Partnership but also through listening to our stakeholders.

1.3 The Partnership is now progressing the development of a coherent programme of engagement and consultation on this draft plan. This will further ensure that we are best informed on what stakeholders think of the plan so far and what changes should take place to it, to better align it to the views, wishes, direction and experience of our service users, their families and carers and our local communities. The plan is necessarily lengthy and detailed. However, in undertaking this this engagement and consultation; we will look to develop more appropriate and easy read versions of this draft plan. This will be available in May 2014.

1.4 As stated above, in drawing up this programme of engagement and consultation, we are mindful of the developing agenda on health and social care integration and the requirement to similarly engage with our local communities and stakeholders. Further, the Public Bodies (Joint Working (Scotland) Bill and other guidance, calls upon Partnerships to consult widely with stakeholders prior to the implementation of the integration of health and social care and also migrate from the Joint Strategic Plan for Older People to Strategic Plans for all adult care groups and to Strategic Plans for all integrated resources (including incorporating

a Financial Plan) from now through to 2015/16. This together requires a co-ordinated and thoughtful approach to engagement and consultation with our stakeholders. To this end, we will ensure that we look to bring together this range of important and inter-related initiatives into one programme of engagement and consultation, adopting a building block approach, to be delivered on from May 2014 onwards.

1.5 The timescale for consultation and engagement will reflect the complexity and diversity of the issues. The responsibility for developing the overall Communication and Involvement Strategy will be led by the Integration Project Team through an Integration and Communication and Involvement Group drawn from both organisations. The Communication and Involvement Group will ensure that communication and engagement programmes in each locality are co-ordinated and take into account Reshaping Care for Older people and the Strategic Plan for Older People as well as Integration. The details of the programme and methods to be adopted are currently being worked up. This broad programme of engagement and consultation, as stated above will commence in May 2014 and will continue through to the implementation of the adopted model of integrated services in April 2015. Details of this plan for communication and involvement will be issued over the next month but will ensure we focus on the following, although not exhaustive, list of stakeholders:

- Members of the public in Argyll and Bute
- NHS Highland Board
- Elected members in Argyll and Bute Council
- Argyll and Bute Council staff and managers across all service groups and locations
- NHS Highland staff and managers across all service groups and locations
- General Practitioners
- Third party service providers
- Media – press/ local broadcasters
- Professional organisations and trade unions

1.6 The **Strategic Plan for Older People** in line with direction of Reshaping Care for Older People has an emphasis on prevention, early intervention and anticipatory support. Its purpose is to set out its approach to future commissioning of services for older people against a backcloth of the current financial situation, demographic change and the changing wishes, needs and aspirations of older people and their families and carers. The challenge is to ensure that within the available resource, outcomes are achieved for older people in line with what they both want and need. At its core is the challenge to deliver significant shifts from institutional to community based settings. The Change Fund allocation to the Partnership for 2011-15 has been a lever in looking to develop more effective engagement through the Partnership but also provide a greater focus on transformational change through innovative and preventative

approaches. The Change Fund allocation over the last few years has been the catalyst for the Partnership to examine current service patterns, activity and spend across their combined resources to improve outcomes for older people.

2 RECOMMENDATIONS

2.1 It is recommended that the Community Services Committee:

a) note the update on progress on producing a joint strategic commissioning plan for older persons services;

b) note the work being taken forward by officers to ensure engagement and communication activity relating to the joint strategic commissioning plan for Older People is incorporated into the wider integration agenda, thereby ensuring we co-ordinate our engagement with stakeholders and our communities to meet the statutory requirements of the Public Bodies (Joint Working) (Scotland) Bill.

c) Endorse the approach to the development of the joint strategic commissioning plan for Older People and agree that more appropriate and easy read versions of this be produced to aid communication, consultation and engagement.

3 DETAIL OF THE STRATEGIC PLAN FOR OLDER PEOPLE

3.1 The overall aim being to enhance the quality of the lives of the people with whom we work in order to achieve our **vision**. Our services are being aligned to focus on four common goals of:

- maintaining Independence;
- recognising and preventing difficulties;
- regaining skills and confidence; and
- delivering care that is dignified, respectful and person centred.

Together this will result in a new model of care, more suitable to current and future needs, more in line with current and future aspirations of our local communities.

As “good health adds life to years” (WHO, 2012), promotion of good health, prevention and health improvement need to be the core of how we work in the future.

3.2 Central to the draft Plan’s success, is that we adequately address and fund a number of key and related areas including, prevention (which is tightly inter-linked to the rest), community capacity building and responding to social isolation and loneliness, carers, housing, intermediate care, dementia, end of life care ,telecare and telehealth care, and modernising community services.

3.3 **Prevention** - prevention needs to be a primary focus of the Partnership’s

future work. The objective of preventative work is to help people maintain independence and stop people needing institutional care in both health and social care settings. Within this there are a number of levels and types of prevention covering primary prevention, secondary prevention and tertiary prevention. Primary prevention aims to reduce the likelihood of older people having problems or becoming dependent. Here, primary prevention will include reducing the risk of falls, healthy eating, exercise and housing based schemes (such as low intensity support, handyperson and design features such as step free paths) .Secondary prevention covers areas such as re-ablement, support for carers, and smart technology. Tertiary prevention looks to provide a balance between maintaining an independent capacity balance with care for those areas of life in which the person is dependent. Examples here would cover rehabilitation and recall work with people with dementia. In overall terms it is vital to the success of the draft plan that preventative strategies become a major area for future investment.

Community Capacity Building- building the capacity within local communities to take responsibility for their own health, support and care needs

Carers- ensuring unpaid carers are supported to continue their caring role

Housing-ensuring suitable housing supports individuals to live more independently at home for longer. The development of extra care housing is a central thrust of the draft strategic plan.

Intermediate Care-this describes a wide range of services which focus on admission, rehabilitation, re-ablement and recovery. They assist in preventing unnecessary admission to hospital and care homes and ensure a timely discharge following hospital stay.

Dementia-making sure that our services are configured to meet the growing numbers of people with dementia

Telecare and Telehealth Care-ensuring that we maximise the contribution of new technology in supporting older people at home especially in rural and very rural areas.

Modernising Community Services- making provision at home or in the community as a real alternative to institutional care. This is the biggest test for the Partnership-the extent to which it can develop real community based provision that reduces the need for admission to hospital and supports early discharge.

The above together, in essence, defines our new Model of Care-one which provides a higher focus on prevention, looks to reduce usage of institutional care by having in place that range of services in the community that prevents unnecessary admissions, supports timely discharge and makes provision at home a real and realistic alternative.

3.4 In implementing the Strategic Plan we need as a priority, to :

- Recognise the progress already made across the Partnership area.
- Ensure that localities are the basis for future commissioning of services.
- Revisit current service arrangements to evaluate whether they are in accord with the Model of Care and whether they are consistent with achieving our vision.
- Ensure that all future investment plans are consistent with the Model of Care approach.
- Evaluate the impact of all Change Fund initiatives and whether we should look to find permanent funding across the Partnership for these.
- Revisit the current provision of institutional care across health and social care services with a few to settling on service redesign options appropriate to locality need.
- Continue to look to the development of and funding opportunities for extra care housing as a main platform for effecting change in the current balance of care including within remote areas.
- Develop a scale of anticipatory initiatives which will result in improved care pathways for older people.
- Continue to develop and fund community capacity and co-production through our locality arrangements.
- Develop more capacity in extended community care teams thereby supporting people for longer at home and preventing hospital admission.
- Develop a strong model of clinical case management in the community for those polder people at the highest risk of hospital admission.
- Review and evaluate falls prevention and fall management services
- Develop new models of day services.
- Improve our approach and support for end of life care in line with the Marie Curie Delivering Choice Programme.
- Develop an overall dementia strategy for Argyll and Bute which will include a review of the specialist dementia in patient resource in Lochgilphead.
- Realise the 12% reduction in emergency bed admissions in line with national targets.
- Encourage care at home providers to find joint solutions across localities.
- Be clear with the third and independent providers on the direction we are taking and what the reshaped care system will look like in the future.
- Undertake a year on year review on the changing form of the care system and set priorities for future years' investment/ disinvestment plans.

3.5 We have developed an Integrated Resource Framework to better understand the activity and resource across populations in Argyll and Bute. This needs further work to allow us to more meaningfully break down activity and finance across localities. Whilst data capture and budgets have been traditionally been broken down by locality in adult social care, the

Partnership as we move towards integration, will need to deliver the same across the whole of health and social care for all integrated services.

The information we have brought together so far tells us that the total resource envelope is £107.4m (2011/12 price base) (including the Third Sector contribution). The data sets out the spend on key areas including on hospital in- patient and out -patient services, NHS community services and GP services and GP prescribing, as well as care home and care at home budgets .The draft Plan begins to consider the potential for resource release through disinvestment and opportunities for investment. It also recognises that the Partnership needs to make key decisions on how we are going to realise the changes we want to put in place across the care system. This demands a level of joint decision making, risk management and corporate agreement on a scale not previously experienced across the Partnership. This will be assisted by the agreement to establish a Shadow Integration Board to ensure the effective development of governance arrangements for adult health and social care integration. An early priority as we move through to April 2015 will be the adoption of priority investment/ disinvestment plans across health and social care within an agreed joint financial framework.

3.6 In terms of tracking our performance we have developed a suite of core improvement measures. These will be important in looking at our progress in reshaping the care system and understanding the impact that our future decisions on investment and disinvestment are making and will make. The use of a balanced scorecard via the Pyramid performance management system will form the basis of reporting outcomes against both the Change Fund initiatives and future resource decisions. In relation to capturing real outcomes, the development of a new scorecard for Adult Services which focusses on the development of the “Talking Points Agenda” will be in place over 2014/15. The measures within the scorecard will be able to capture live commentary from the assessment documentation and begin to assess whether the commissioning of services is directly impacting on improved quality and outcomes for the service user.

3.6 The challenge faced in relation to an ageing population with growing health and social care needs comes about at a time when within Argyll and Bute, we are faced with a reducing population of working age. We need to look at what initiatives are possible to ensure that the integrated partnership is an attractive career choice for young people with clear opportunities for progression. We also need to ensure it is also similarly attractive to those who may wish to remain economically active beyond their retirement age. Our workforce planning and organisational development are pivotal to our success. Workforce planning needs to recognise that, what we will do is different from what we have done in the past. We need to find solutions that remove duplication, and maximise the competences of the workforce in line with the outcomes older people themselves wish for. The Partnership has commissioned an external consultancy to ensure that the workforce is skilled and equipped as leaders to deliver the agenda ahead of. We will develop a formal Organisational Development Strategy to continue and sustain this work.

4 CONCLUSION

4.1 The draft Joint Strategic Plan for Older People has been prepared by the Partnership. It will now be subject to wide and lengthy communication consultation and engagement alongside our proposal and plans for integration. The challenges facing the Partnership and its successor body are complex but require to be addressed if we are to make a reality of the vision set out in the Joint Strategic Plan.

5 IMPLICATIONS

Policy: Consistent with national policy direction

Financial: There are no direct financial consequences arising from this paper. Change Fund monies have been allocated for 2011-15 and future change will be dependent on a financial investment/disinvestment strategy

Personnel: Workforce planning and organisational development issues are being developed

Legal: Implications of Public Bodies (Joint Working) (Scotland) Bill once enacted

Equal Opportunities: Nil

Risk: There are significant financial, operational and reputational risks associated with the remodelling of adult health and social care services

Customer Services: The draft plan will be the subject of extensive consultation and engagement with service users.

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