

2013-2023

Living Longer Living Better in Moray



A joint commissioning Strategy for older people, developed and agreed in partnership with Health, Social, Voluntary and Independent care sectors and older people themselves

Moray Community Health and
Social Care Partnership

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FOREWORD

In development to be written and agreed by all partners

NHS Grampian	The Moray Council
Third Sector	Independent Sector

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PART ONE: INTRODUCTION

1.0 Introduction

The demographic changes facing Scotland as a whole are well documented. Between 2008 and 2033, the number of people in Moray aged 75 and over is projected to rise by 103% and will then account for more than half (53%) of the pensionable age group. The next 20 years will see a continual growth in the over 65s, with a significant increase (140.5%) in the over 85 age group. This age group is predicted to have higher, more complex levels of support needs and is most likely to require specialist accommodation, care and support services.

Current service configurations for the care of older people are simply not sustainable given the demographic and financial pressure we face over the next 20 years. Moray spends a total of approximately £73 million on health and social care and support for older people annually.

Opportunity has arisen with the Scottish Government's introduction of the Change Fund as bridging finance. This provides a useful catalyst to accelerate the pace of change and development over the next four years in Moray.

Our previous strategy for older people "Living Longer Living Better" (2009-14) laid the foundations for the process of redesigning and reshaping our services for older people in Moray and good progress has been achieved in shifting the balance of care, increasing support delivered at home and developing new approaches such as reablement and prevention.

Building on what has already been achieved, this updated strategy has been developed and agreed by a commissioning group of key stakeholders in response to: national policy drivers; the need to demonstrate clear, joined-up commissioning priorities across all sectors of Health, Social Care, the Third and Independent sectors; and the local challenges of continuing to improve service delivery to an increasing older population - both now and in the future - in the way in which they want within a difficult financial climate.

A number of commissioning activities were carried out to inform this plan. These included a health needs analysis to determine the size and nature of the needs of

older people in Moray and explore the social, economic and environmental factors and behavioral determinants of their health and well being. A review of services across all agencies to determine what is currently available to older people, any trends, gaps in service, quality issues, highlighting particular pressures which required to be addressed. A review of national and local policy research was also completed and there was continual engagement and consultation with older people throughout the process. This joint commissioning plan is a culmination and a shared agreement of priority areas from these documents. Each section refers to the relevant appendix where further detail and background information can be found.

1.1 Purpose

The Moray Community Health and Social Care Partnership (MCHSCP) is committed to shifting the balance of care from acute to community settings and reshaping services for older people in their communities. A programme of work has been developed to achieve this shift as part of the Reshaping Care programme, with a stakeholder commissioning group agreeing the commissioning process to inform how health, social care, the Third sector and the Independent sector will work together in partnership to respond to the needs and expectations of Moray's older population within a whole systems approach.

The development of a joint approach to commissioning in Moray - working across all sectors - looks at the total spend of our resources in an environment where all partners who have responsibility for specifying, securing and monitoring services are able to contribute to future models of care for older people that achieve better outcomes for older people, created through shared ownership and co-production.

We aim to develop a credible joint commissioning strategy which reflects the shared priorities of key stakeholders and will inform service users, carers, the wider public, commissioners, service providers and other stakeholders of the commissioning intentions of the Moray partnership during the period 2013 to 2023.

1.2 Scope of the Strategy

In considering health, housing and social care services for older people, we have traditionally looked at the over 65 age group. However, we recognise that services require to focus on need rather than age, and the two are not necessarily linked. We

also recognise that people are living longer, remaining active for longer, and have increased and changing expectations. Alongside this, the oldest in our population often have complex needs and can require intensive support. This strategy therefore sets out our commissioning priorities across a range of needs, from preventative services for those at risk of developing care and support needs, to more intensive support for those in crisis and the complex health and care needs of the frail elderly.

It considers total resource implications across health, social care, and to a certain extent housing, using an integrated resource framework and will seek to ensure the right services and support are available and consider how we can involve people in the planning of personalised, good quality services that help older people to maintain their independence, and their mental and physical health and wellbeing within a housing environment that meets their changing needs as they grow older.

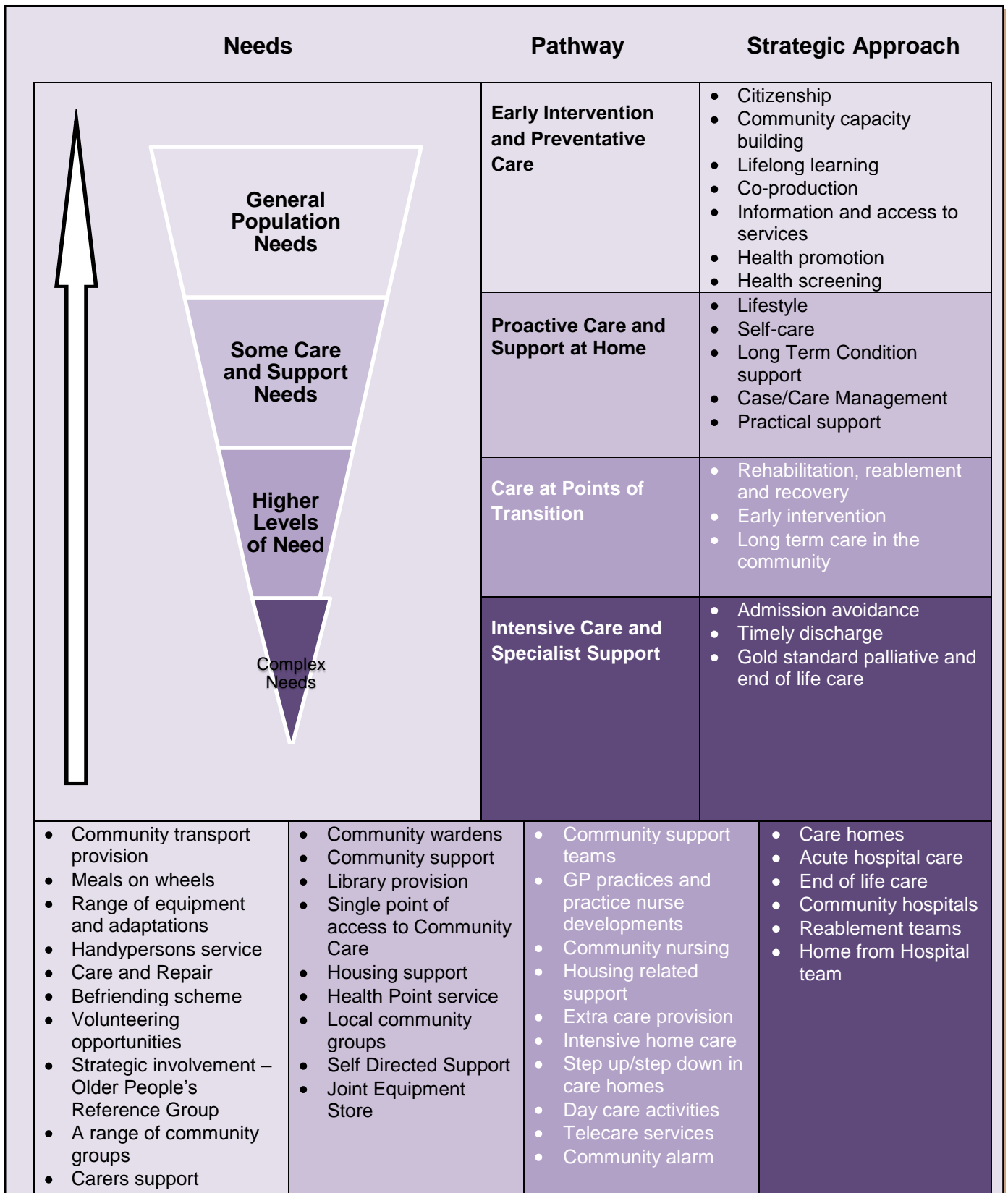
Moray is one of three community health and social care partnerships which cover the Grampian region in which NHS Grampian chiefly operates. Although the focus of this strategy is on services within Moray, we recognise that older people may be accessing services in Grampian as a whole, particularly in terms of out-of-hours services and acute hospital care. This also suggests opportunities for improving pathways for older people, improved integrated working and efficient use of resources across the Grampian region.

Dr Gray's Hospital in Elgin, Moray's only acute hospital, has this year changed from being led by the MCHSCP to being led by NHS Grampian. However, close links remain with the acute sector which has been engaged in the development of this strategy, and there is recognition of the benefits of a shared approach across all sectors.

There is a wide range of health and social services in Moray which support the community as a whole and which older people should be able to access, possibly with additional support, as well as some which meet the specific needs of older people. These services are operationally managed around the main geographical areas of Elgin/Lossiemouth, Forres, Keith and Speyside, Buckie and Cullen.

The following diagram (Figure 1) summarises the strategic approaches in scope across the reshaping care pathways. These reflect the services, or types of services, which will be considered for commissioning activity over the next 10 years.

Figure 1: Strategic approaches in scope across the reshaping care pathways



1.3 A Partnership Approach

Moray has a mature partnership between the local authority and NHS Grampian in the form of MCHSCP which has allowed a “whole systems” approach to planning. The Partnership acknowledges that supporting the health and wellbeing of older people needs to involve more than health and social care sectors: housing, transport, leisure, community support groups, and the independent and third sector all have a role to play.

The MCHSCP therefore invited a range of health and social care professionals, including GPs and housing, the third sector, independent sector, and older people themselves, to join a joint commissioning group. Working together, this group has developed this joint commissioning strategy for health and social care services for older people which reflects the shared priorities of key stakeholders and sets out the direction for future commissioning decisions and service development.

The Institute of Public Care, Oxford Brookes University (<http://ipc.brookes.ac.uk>) was commissioned by the Partnership to facilitate and support the development of cultural change and partnership working. They brought a wealth of experience in commissioning and in supporting the development of partnership working across health and social care.

1.4 Stakeholder Engagement and Communication

The new commissioning group worked actively with the older people of Moray to ensure their needs and expectations were being understood and responded to. We built on our existing engagement with older people, service users, patients, families and carers and the public in general, which was already embedded within the development of the reshaping care programme and now the joint commissioning process. This included:

- Using the Older People’s Reference Group as a two way communication mechanism
- Working with the wider older people’s networks of over 80 community groups
- Producing regular newsletters and holding wider consultation events

- Three members of the Group have actively participated in a series of workshops and commissioning activities.

We acknowledge that staff engagement at all levels is key to successfully implementing change and new approaches. The commissioning group includes a wide range of professionals from a number of agencies who were committed to updating and informing the services and professions they represent in the joint commissioning plan and Change Fund progress.

Further details on the partnership working which has taken place can be found in Appendix 1: A Partnership Approach

1.5 Equalities Impact Assessment and Housing Impact Assessment

An Equalities Impact Assessment will be undertaken on this strategy to ensure people are not affected negatively as an unintended consequence of our planned changes and actions.

A housing impact assessment will also be undertaken in the form of a housing contribution statement.

1.6 Timescale and Review

The Joint Commissioning Strategy sets the strategic direction for services for older people over the next 10 years and will be subject to regular review and updating, consistent with local planning cycles, to ensure it continues to respond to emerging needs and expectations of older people, and reflects changes to the financial position, local and national policy, and emerging priorities such as the integration of health and social care.

The strategy incorporates a more detailed summary of our plans for what we want to achieve over the next three years. A one year investment plan provides detail on Moray's Change Fund investment intentions for 2013/14 and the accompanying evaluation process (Appendix 6: Moray Change Fund Plan 2013/14).

This document is owned by the wider stakeholders' partnership group which has undertaken a number of commissioning activities. The future joint commissioning department will be responsible for ensuring the completion of reviews.

PART TWO: BACKGROUND TO THE PLAN

2.0 Introduction

Demographic and financial pressures have combined to ensure that the provision of care and support for older people is a current political and policy priority.

This Joint Commissioning Strategy builds on our previous joint strategy “Living Longer Living better 2009-2014”. Much of the content remains relevant, but with many developments now implemented and significant changes developing within the wider policy and planning landscape, our new strategy provides an updated vision for the next 10 years.

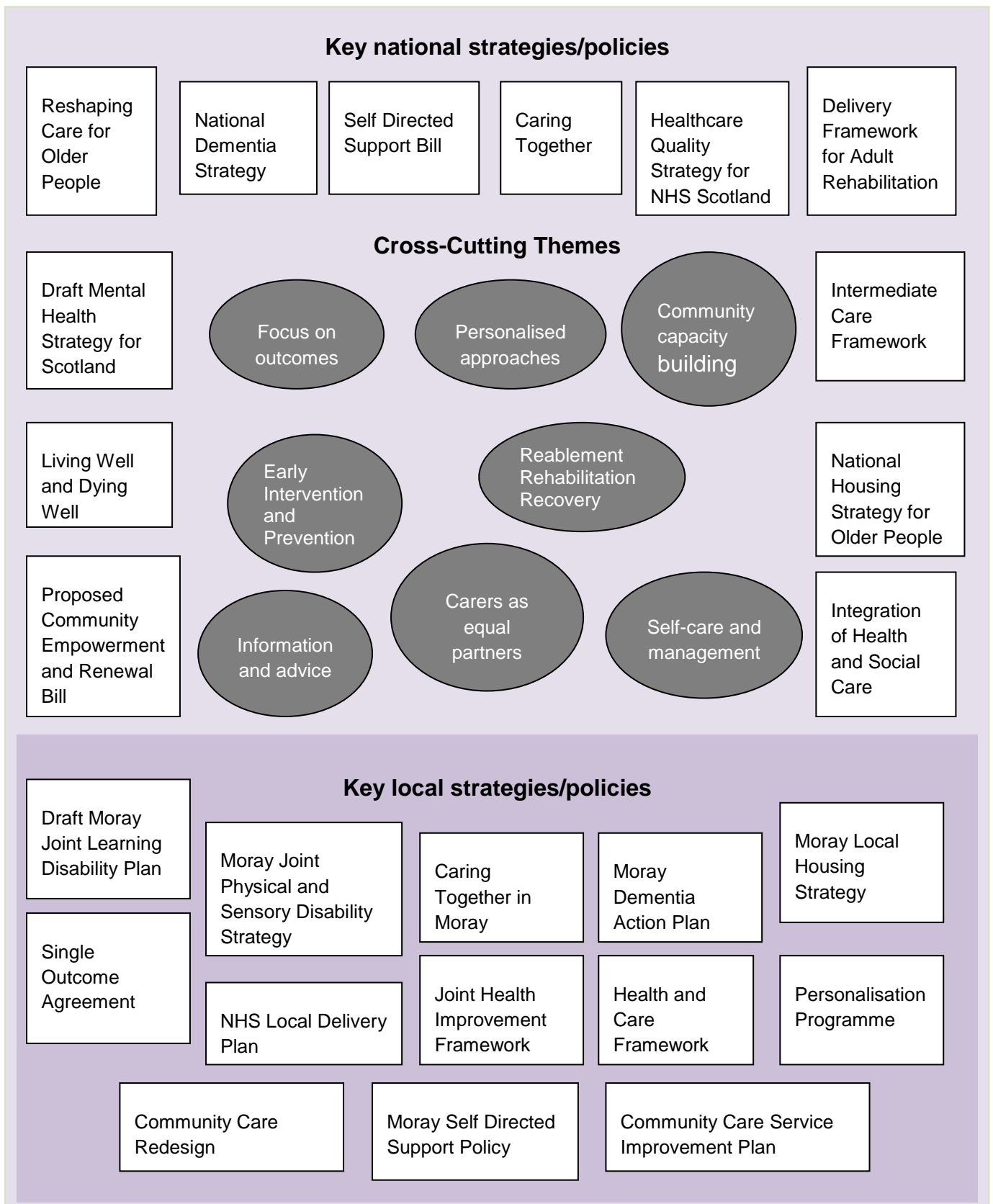
2.1 Policy Context

The Scottish Government’s Reshaping Care for Older People a Programme for Change 2011-2021 sets out the national framework within which local partnerships are developing joint strategies and commissioning plans and local change plans to access the Change Fund.

The framework sits alongside the ambitions of the NHS Quality Strategy and sits above and supports the delivery of other national strategies including the Dementia Strategyⁱ, Carers Strategyⁱⁱ, Self Directed Support Strategyⁱⁱⁱ and Living and Dying Well^{iv}. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

The most important national and local policies which influenced the development of this strategy are illustrated in the following Figure 2. Further detail of these strategies and how they impact on the work we are doing are outlined in more detail in Appendix 2: Local and National Policy Context.

Figure 2: Policy context



2.2 Changing demand

Demographic change

Currently, the population in Moray shows a higher proportion of older people compared to the Scottish average (Table 1), with particularly high proportions in the Buckie locality and the most rural locality of Speyside. In contrast, the Elgin locality has the largest population but a lower than the national average proportion of older people.

There are lower proportions of people of working age compared to the Scottish average, particularly in the Buckie/Cullen/Fochabers area. This will have an impact on the availability of the workforce within the health and social care sector to meet the increasing needs of older people.

The rural nature of some parts of Moray makes access to services more challenging.

Table 1: Current population per locality area (source: GP population data)

Area	Total population	% working age	% aged 75 and over
Scottish average		65.7%	7.7%
Moray	89,395	64.7%	8.5%
Speyside/Keith	15,894	64.1%	9.1%
Buckie/Cullen/Fochabers	18,631	63.1%	10.4%
Elgin/Lossiemouth	39,740	65.6%	7.5%
Forres	15,130	64.9%	8.3%

Projected population changes

The increase across the over 65 age group is variable, with a significant increase (140.5%) in the over 85s. This older age group is predicted to have higher, more complex levels of need and is most likely to require specialist accommodation and support services

Table 2: Moray population projections for 2020 and 2030, showing % change from 2011

Age	2011	2014	% change	2020	% change	2030	% change
50-64	18,380	18,720	1.8	19,776	7.6	16,147	-12
65-74	9,153	10,121	10.6	11,076	21	12,257	34
75-84	5,842	6,274	7.4	7,149	22.4	9,032	54.6
85+	1,613	1,818	12.7	2,442	51.4	3,880	140.5

The projected growth in the older population will create significant additional demand on health, care and support services, unpaid carers and available housing. This is particularly relevant in the over 85 age group which is most likely to have the highest level of need.

The change in the future working population will put pressure on the availability of a workforce within health and social care to meet the increasing needs of older people. It confirms that services in their current form are not sustainable for the future.

Long term Conditions

With increasing age there is also a rise in the number of people living with long term conditions who are likely to have increased care and support needs. This includes older people with functional psychiatric illness.

The prevalence of long term conditions will increase with the ageing population, and increase the burden on health and social care services in the community setting and the use of emergency beds if not managed well in the community.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health.

Frail Elderly

People are living longer but many are living with one or more long term conditions, and for a significant number, advancing age brings frailty. The cause of frailty is usually multi-factorial and correlates to disability, co-morbidity and self-related health and social care issues and these individuals are vulnerable to adverse outcomes.

They will require higher levels of complex care and support but also, and more importantly, skilled multi-factorial assessment in the form of a Comprehensive Geriatric Assessment (CGA) to achieve better outcomes for this vulnerable group

Unpaid Carers

Older people have a critical role to play in enabling other older people to remain in their home safely, independently and with dignity, and out of the formal care system. They provide far more care than they receive. It is estimated that there are between 2,734 and 4,651 older people living with an unpaid carer or receiving unpaid care in Moray.

As the older population continues to increase, so too will the numbers of older unpaid carers. Unpaid carers are a large provider of care and typically as they get older, they take on more caring responsibilities. It is much more likely that a cared-for person will be admitted to hospital as their carer's own health deteriorates. The interdependent caring role that an older couple can have must be acknowledged in care planning.

Support for carers is vital to achieving the outcomes of this strategy. It is essential there is help to support, sustain and grow this capacity as any loss of unpaid care provision will have an impact on health and social care. We have invested 20% of our Change Fund allocation this year to achieving this.

Dementia

Dementia is a key health issue facing Moray in the coming decades. As our population ages there is a projected 50% increase in the number of people with dementia. Dementia is a major cause of disability in people aged 60 and over. It contributes to 11.2% of all years lived with disability - more than stroke (9%),

musculoskeletal disorders (9.8%), cardiovascular disease (5%) and all forms of cancer (2.4%). It is estimated that only 40% of people in Moray with dementia have a diagnosis.

There were 504 people on the Quality and Outcomes Framework for general practices dementia register in 2010/11, representing a 10% increase from 2006/7. This compares with 21% and 33% in Aberdeen City and Aberdeenshire respectively. Moray aims to increase dementia diagnosis rates. It is acknowledged that specialist care and support for the individual and their carer, post diagnosis, will be required to enable people with dementia and their family carers to manage their symptoms and live well with their conditions for a period of time without the need for more costly intervention. As the symptoms of dementia progress, those living with moderate to severe dementia and their families require a more coordinated approach to the care and support that they receive.

Self Directed Support

Self Directed Support aims to empower people to direct their own care and support and to make informed choices on how their support is delivered. The key principles of choice and control are achieved through a process of co-production, with resource allocation in the form of a Direct Payment, Individual Service Fund or some combination of the two.

As Self Directed Support becomes the mainstream mechanism for the delivery of social care support, this will represent a major cultural shift and will have an impact on how services will be shaped in the future.

Housing Need

It is well evidenced that older people in Moray and nationally would prefer to remain in their own home with the support and care they need to live independently. As a greater proportion of older people will continue to live in general housing, rather than in care homes or hospital settings, as a result of our goal to shift the balance of care there will be increased demand for suitable housing and housing-related services as a result. There is now a body of evidence which demonstrates the contribution which housing and housing related services (such as adaptations and housing support)

play in supporting older people to live independently at home^v). Housing consequences are identified and incorporated in the Local Housing Strategy and Strategic Housing Investment Plan to reflect the needs of the growing older population.

Moray Housing Needs and Demand Assessment (2011) identified the following regarding older people and housing need in response to demographic change:

- The proportion of households headed by someone over 75 is projected to rise from 13.7% in 2008 to 19.9% in 2023, an increase of 208 households a year
- Number of single households over 65s will increase by 42% by 2023
- Number of single households over 75 will increase from 3,320 to 5,320 by 2023
- Moray has lower levels of extra care/sheltered/social housing designed for older people than other parts of Scotland
- If the current ratio of provision is sustained in the future, 95 units of amenity/extra care housing will be needed each year for the next ten years
- There is a gap in the provision of extra care housing in the Keith and Speyside area
- An estimated 12.8% of households are in extreme fuel poverty which is higher than the national average (Scotland 7.5%)
- 64% of households are owner occupiers.
- Between 53% and 67% of properties in Moray are in some degree of disrepair
- In Moray, 36.3% of older people with intensive care needs are cared for at home rather than in care homes or geriatric long-stay hospital beds (Scotland's average 31.7%)

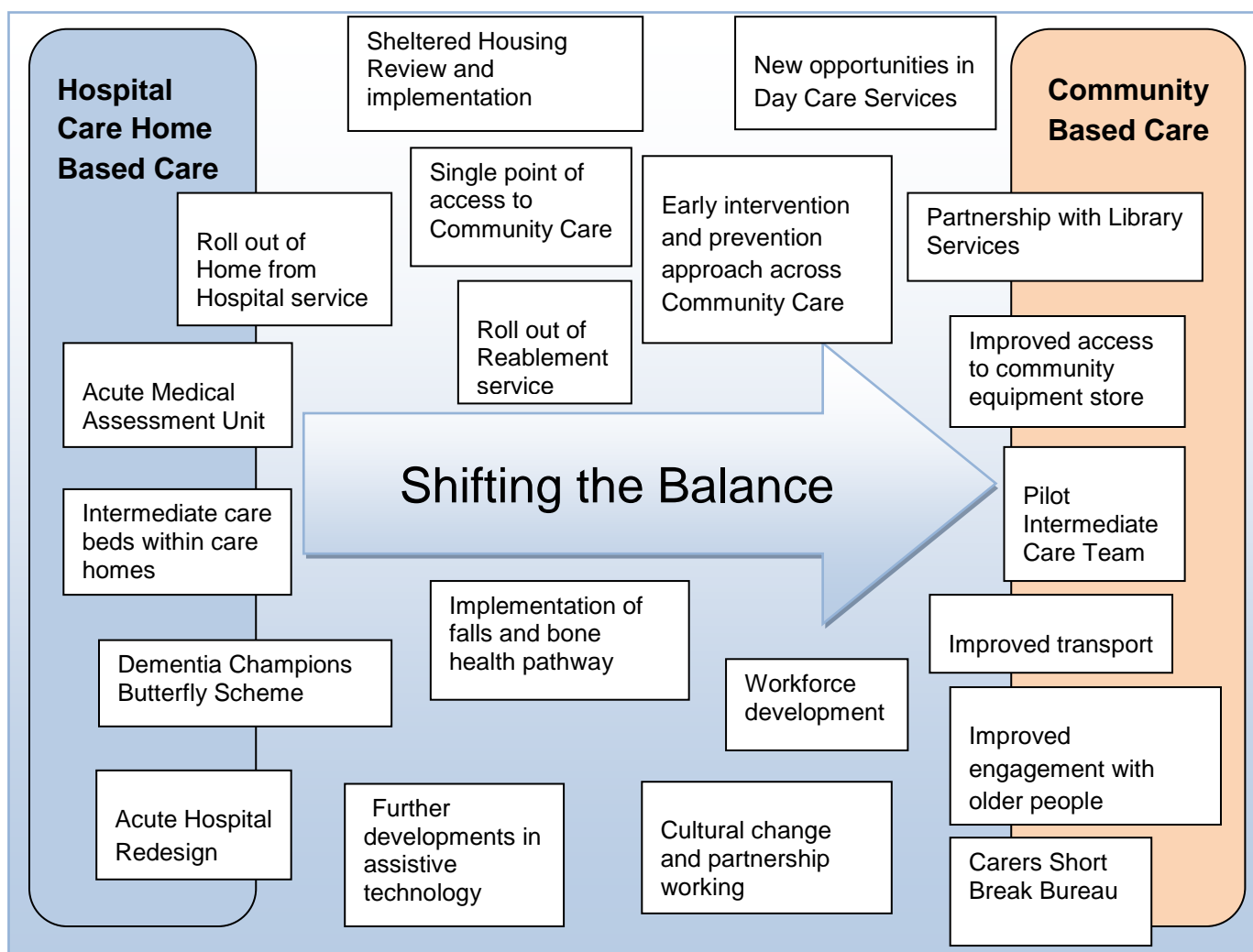
Further details around the above needs of the current population are provided in Appendix 3 Needs Analysis.

2.3 Current Services

Our previous strategy outlined new models of care for health and social care services to be developed from 2009. Significant progress in shifting the balance of

care has been made since then and initiatives are illustrated in Figure 3 below. Learning from these has informed our planning for future work outlined in this strategy. Investment made using the Change Fund is detailed in Appendix 4: Change Fund Investment.

Figure 3: Progress since our last Strategy



2.4 Key Service Developments

Review of sheltered housing - A number of priorities are currently being progressed: the development of extra care housing; access to housing support by all tenure types; linking commissioning of housing support and care in sheltered housing or combine with schemes designated as extra care; the potential use of

sheltered housing as a resource hub for other older people in the community, providing outreach to the wider older population.

Review of day care services - Working with service users and their families/carers to create meaningful opportunities which are outcome focused and rewarding for those who attend.

Moray Council Community Care Redesign Programme - Community Care are undergoing redesign to meet future demands. A single point of access to community care services has been established. The new service provides an early intervention and preventative approach to care with greater choice and control for older people over the support they need.

Reablement roll out – The Home Care Service has rolled out a reablement approach across Moray to support people to make the most of their own capacity and potential, thus maximising the opportunity for independence. An outcome based approach to the delivery of home care has also been developed.

Intermediate Care Team pilot – Learning from our Intermediate Care Team pilot included: Most referrals were already known to existing community teams but had not been responded to. A high proportion were referred for end of life/palliative care and support for carers

Acute hospital redesign – The acute hospital, Dr Gray's in Elgin, has redesigned the use of beds in an effort to reduce the amount of outliers. This included the introduction of an Acute Medical Assessment Unit, the review of the 23 hour bed area, improved structures for the medical wards and improved clinic areas. Health Point has a new facility within the foyer to promote information and advice.

Health and Care Framework – This framework led by NHS Grampian worked in partnership with local people in the Forres area and other agencies to agree what health and care services are required for the future needs of people in the area, including the community hospital resource. An option appraisal approach took them to an agreed way forward. This approach will move on to the Speyside area early 2013.

Building relationships with older people – Older people are now engaged at all levels. The Older People’s Reference Group has now been in place for four years and has followed the reshaping care programme in Moray. There are three representatives of the group who actively participate in the commissioning group. The wider older people’s network of over 80 groups has been kept informed of developments and been provided with opportunities to contribute through a number of local involvement events.

Workforce development – Work with IPC in developing this strategy has increased the skills of stakeholders to understand the commissioning process. Community nurses have received training in advanced clinical assessment skills, advanced prescribing and long term condition management. The home care service has been trained to take forward reablement. Health and social care staff have received dementia training. A joint workforce development post has been agreed to progress an integrated training plan across Moray.

Transport – Investment from the Change Fund in a Moray transport seminar in response to older people’s concerns has prompted a wider review of transport, the establishment of a service user forum and providers’ forum and funding to secure the sustainability of some community transport initiatives.

Use of technology/digital health – Moray is fast developing a reputation as a digital health hub. A life science centre is currently under construction in Elgin to progress digital technology in health provision. Moray was selected for inclusion in the three year ‘Dallas’ (delivering assisted living lifestyle at scale) programme. This involves two projects: Year Zero aims to enable people to actively manage their health information and includes a social networking and planning tool to connect family, friends, carers, health and care professionals; ‘Living It Up’ will use familiar technologies such as phones, TV and mobile devices to keep users connected to the people, communities and services that are important to them.

2.5 Current Use of Services

Figure 4 provides a summary of the volumes of key services provided to older people in Moray (based on most recent 2010/11 validated data). Further details around these services can be found in Appendix 5 service Mapping

Figure 4: Service volumes 2010/11

2010/11	Pathway	Service	Volume
	Early Intervention and prevention	Meals on wheels	286
		Sheltered housing	532
		Day Care	330
		Continance	344
		Befriending	34
		Community Alarm/Telecare	1,142
	Proactive Care and Support at Home	Extra care sheltered housing	56
		Home care	1032
		Intensive care needs(10hr+)	328
		Last six months at home	93%
		Direct Payments	70
		Social work referrals	1,785
		Respite packages	505
		Adaptations (%of total)	65%
	Items of equipment	7,248	
	Care at Points of Transition	Step up/down beds occupied	70%
Step up/down beds spot purchase		260days	
AHP referrals		3,182	
OOHrs calls (monthly/Grampian)		3,398	
A&E after a fall		916	
Av Length of stay Community Hospitals		24 days	
Av Occupancy level Community hosp	89%		
Intensive Care and Specialist Support	Care Homes	506	
	Care Home beds available	546	
	NHS Continuing Care	3	
	Planned admissions to DGH	3,592	
	Av Length of Stay	7 days	
	Unplanned admission to DGH	5,120	
	Two + emergency admissions	614	
	Attended A&E(51% out of hrs)	5,440	
	Fall related emergency admissions	632	

Early Intervention and Prevention – low level needs

There are relatively small numbers of people receiving low level services. We need to consider how to increase this type of service and ensure more people have

access to them and that professionals across health and social care are aware of them in order to refer or signpost.

Investment in prevention and early intervention has been proven to reduce the demand on specialist services in the longer term by addressing problems at the earliest opportunity before they are able to escalate.

We also acknowledge that there are many community groups, clubs and events for example the BALL groups which support older people within their own communities, enabling them to improve their health and wellbeing and reduce social isolation. Community Capacity building will be a key area for future investment alongside the contribution of the third sector.

Proactive Care and Support at Home - low to medium needs

The increasing volumes of home care, equipment and adaptation and respite packages for unpaid carers in the past few years reflects our shift to providing more care and support in the community in order to support more older people in their own homes.

A preventative, anticipatory approach to planning ahead with older people and their carers will be necessary to ensure people have the right equipment, adaptations and home care packages in order to maintain them at home and contribute to the prevention of any crisis e.g. falls.

We need to maximize the benefit of and access to these services, and the efficiency of them. A focus on increasing care and support in the home will reduce the pressure on emergency beds.

There is low provision of extra care sheltered housing in Moray in comparison to traditional sheltered housing. Support received in traditional sheltered housing can now be delivered in the persons own home; this shift in the balance of care delivery will create a greater need for extra care sheltered housing as opposed to sheltered housing for the future.

Care at Points of Transition - medium to high needs

These services are often referred to as intermediate care services and delivered by a range of health and social care services in the community. The approach is one of rehabilitation, reablement and recovery post discharge from Hospital or after a period of ill health in the community or a social care crisis.

We need to ensure these services take an integrated approach to responding to the needs of older people, Clear pathways through services will be necessary to ensure a smooth, seamless journey of care and reduce the unnecessary use of emergency bed days in our hospitals.

The length of stays in our hospitals could be improved. This will require consideration of the role and function of our community hospitals which are presently not reflective of the population clusters in the locality areas alongside the capacity of care homes to include short stay beds

The step up/step down beds are a successful use of care home beds as a short stay beds and an alternative to hospital admission.

Acute Hospital and Care Homes - specialist, complex needs

We acknowledge that there will always be older people who require assessment, investigation and treatment in the acute hospital. However we need to focus on the increasing unplanned admissions, in particular the number of emergency bed days occupied by older people, which have increased from 45% of the total to 71% between 2010 and 2011. The number of older people with two or more emergency admissions has also increased from 592 to 614 between 2010 and 2011.

This requires better planning around the admission and discharge pathways, and the involvement of both primary and community care.

There will be a need for access to comprehensive geriatric assessment but at present geriatric provision in Moray is low. We must look at ways to overcome this gap in provision.

2.5 Current Performance

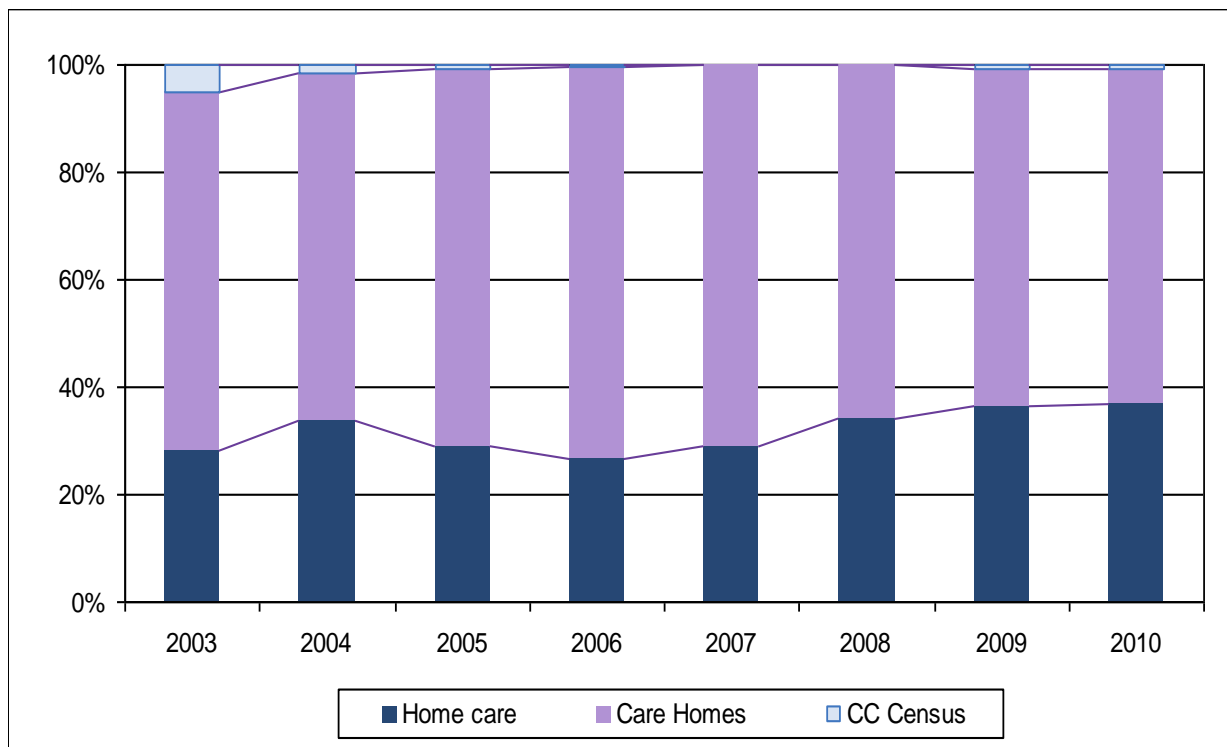
Measurement is an essential component of quality improvement. The following describes our current performance in key areas for tracking our progress in reshaping care for older people. This information has directed the focus of attention for our strategy. Further detailed information is provided in Appendix 5 Service Mapping.

We acknowledge that a more specific focus on the outcomes achieved for patients/clients, their families/carers is required. A joint performance manager for older people's services has been appointed to progress this change in approach to performance management.

Shifting the Balance of Care

Moray already performs strongly nationally in relation to supporting more people to live independently at home by shifting the focus from institutional settings. An increase of 1.7% between 2010 and 2011 of older people with intensive care needs supported at home saw Moray ranked 11th in Scotland.

Figure 5: Balance of Care: source: Scottish Government Quarterly Monitoring, Home Care census & ISD Continuing Care Census)



The percentage of over 65s receiving 10+ hours of care at home in 2011 was 38% compared to 32% nationally. This has been achieved through investment in community based services and changing the use of some care home beds to provide short stay.

Delayed discharges

Since January 2008, Moray has been one of only three community health and social care partnerships in Scotland to have had no patients waiting more than six weeks for discharge from hospital to an appropriate care setting, once treatment is complete.

This measure is reducing to four weeks from April 2013 and to two weeks from April 2015. Moray already has processes in place to achieve these targets. Potential delayed discharges are identified and monitored on a weekly basis at two weeks, four weeks and six weeks.

Investments have been made in intermediate care services, reablement service and home from hospital service to increase the number of people that can be supported when they leave hospital.

We cannot be complacent, however, and achieving the revised target will require continued integrated working across health and social care and a whole systems approach to assess the impact of new developments across the system. For example, a recent change to admissions policy to community hospitals in Moray increased the length of stay at the acute Dr Gray's Hospital.

Emergency bed days for over 75s

An emergency (unplanned) admission to hospital may be the right course of action for an older person who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However, for some older people an admission to hospital can be followed by complications such as a serious loss of confidence and confusion that prolongs their stay, compromising their independence and ability to return home quickly.

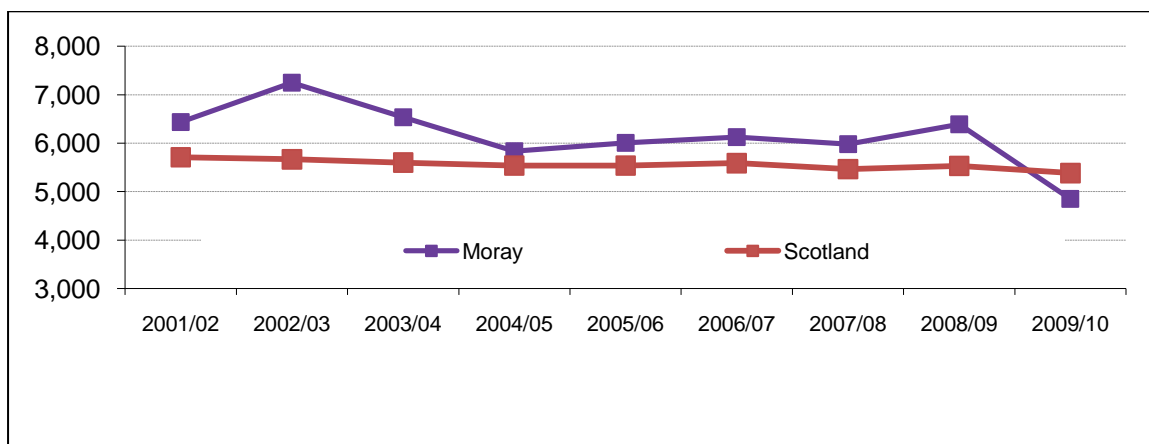
While rehabilitation can minimise this risk it is important to prevent avoidable emergency admissions wherever possible and to enable older people to return home as soon as is safe and practicable.

Moray has reduced the number of emergency hospital admissions (HEAT T12) from 3490 (October 2008) to 2913 (December 2010). However, there is scope to reduce these further as the number of older people who are supported at home increases.

It is acknowledged that a closer look at emergency bed days, rather than a focus on hospital admissions, may be a better indicator of the use of emergency beds.

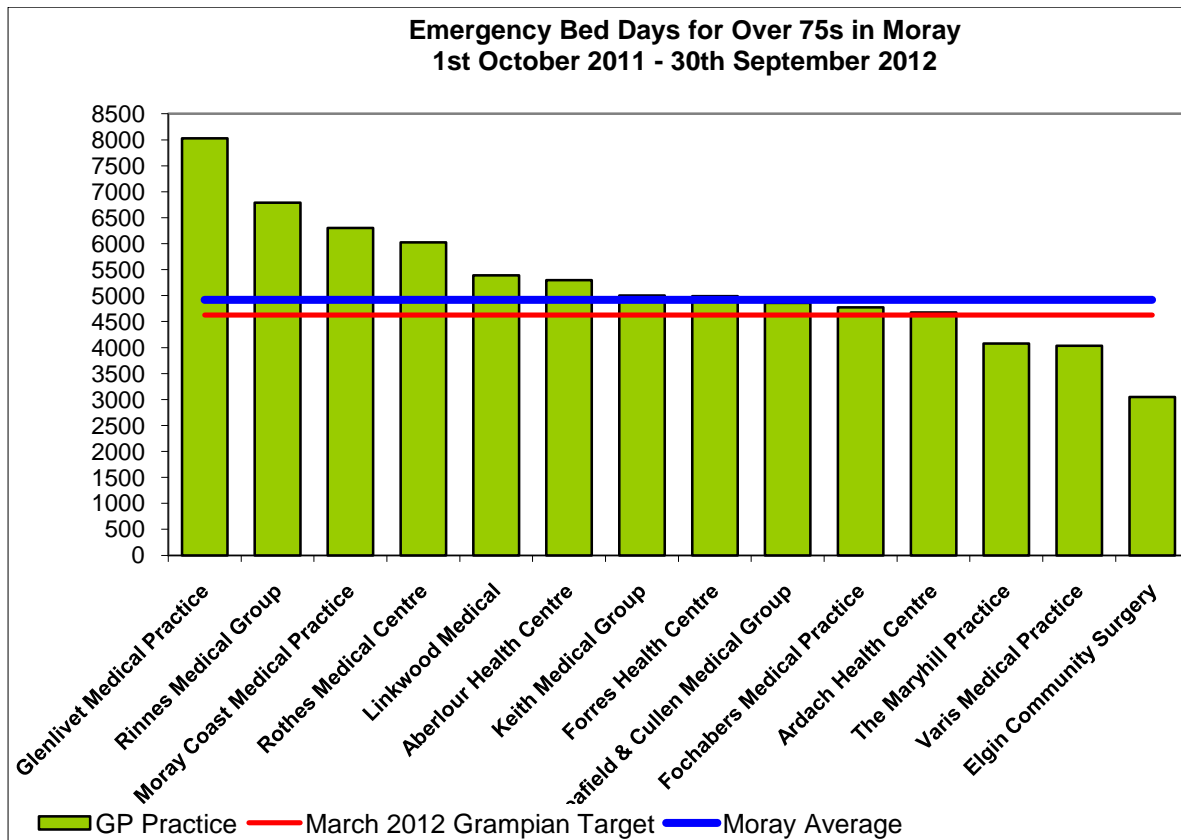
In 2009/10 Moray achieved a lower rate per 1,000 of emergency bed days than nationally.

Figure 6: Rate per 1,000 of emergency bed days for patients aged 75+, 2001/02 to 2009/10 (source: Respite Care Statistical Release for 2011)

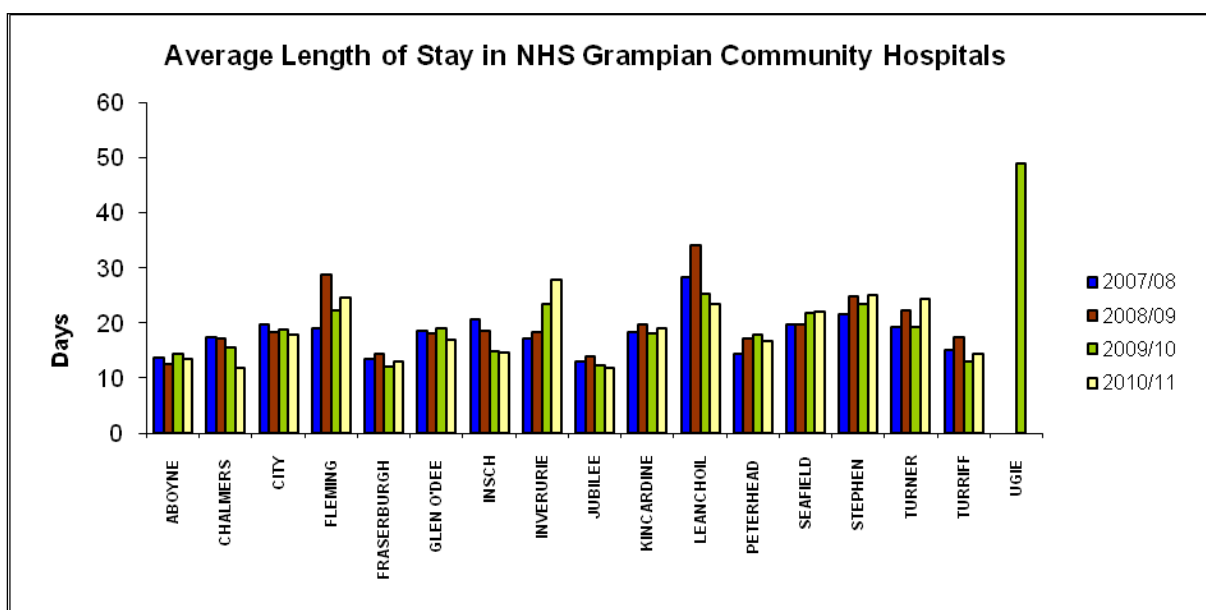


Our emergency bed days in Moray are now being reported on a month to month basis for ease of monitoring (Figure 7). This is further broken down by locality areas and GP practices, showing variation across the practices in order to address priority areas.

Figure 7: Emergency bed days per 1,000 population over 75 (source: Patient Administration Systems)



Length of stay in Community Hospitals



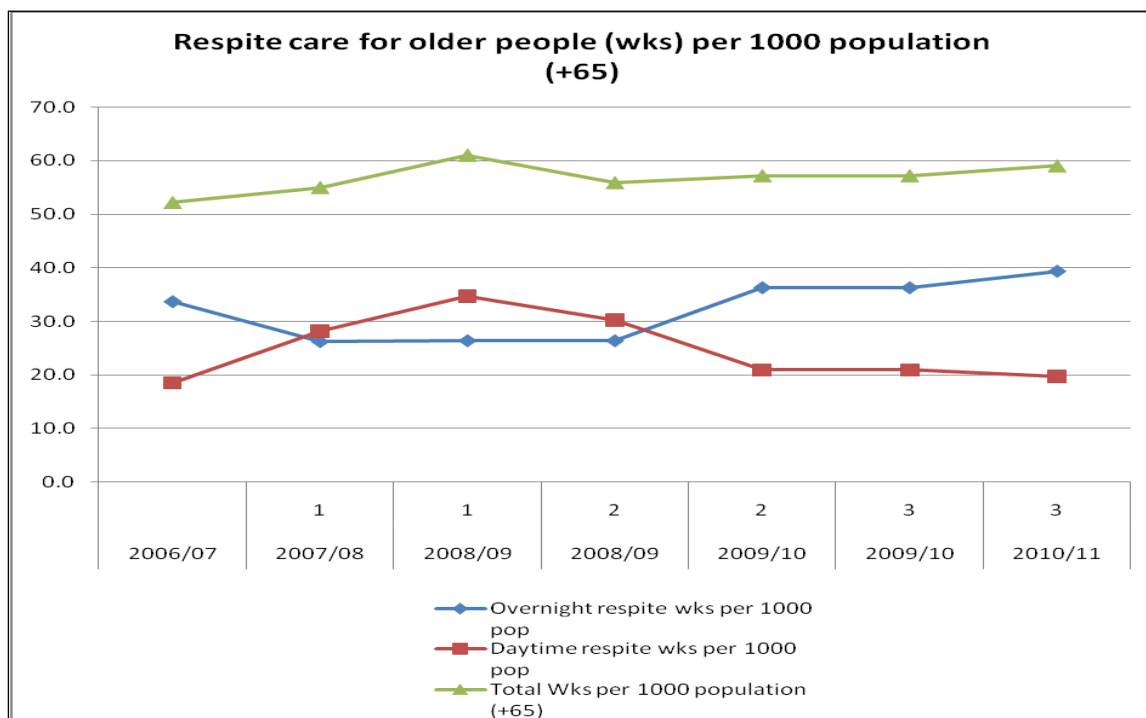
The length of stay in our community hospitals are the highest in Grampian and have been increasing over the last few years, this has increased the risk of delayed discharges in the community hospitals, whilst they operate under a virtual medical ward model. A recent change to the criteria for admission to community hospitals with a locality focus has made an impact on the length of stay and inadvertently reduced the bed occupancy. However this has basically shifted the problem to acute by increasing bed pressures in the acute hospital and the numbers of beds lost to delayed discharge.

Work needs to progress in this area to agree the function and role of community hospitals around rehabilitation and look at alternatives to hospital admission and the capacity of short stay beds in Moray.

Respite Care

For 2008/09, Moray was one of 19 local authorities to report an increase in total respite weeks (Figure 8). For 2009/10, Moray continued to meet its Concordat agreement with the Scottish Government by surpassing its 54 week target by 28 days. Provision has continued to increase in 2010/11.

Figure 8: Respite care for older people (weeks) per 1,000 population of 65+ (source: Respite Care Statistical Release for 2011)



Support for carers to continue in their caring role will be vital to meeting the outcomes of reshaping care for older people. It is estimated that there are between 2,734 and 4,651 older people living with an unpaid carer or receiving unpaid care in Moray. Many of these carers will themselves be elderly.

Work has progressed in this area with the creation of a short breaks bureau in year one of the change fund. This work will continue in year two to develop and progress the opportunities of interdependent breaks for couples where the separation of respite causes distress and outweighs any benefit from the respite itself.

2.6 Financial Framework

The resources to support the joint Commissioning Strategy are being mapped through the mechanism of the Integrated Resource Framework

Integrated Resource Framework (IRF)

The IRF seeks to take total health and social care expenditure for Grampian as a whole and allocate this down to CHP level and then to GP Practice level. It also seeks to allocate this expenditure by age group. The methodology for doing this has been agreed at national level and the figures are produced by the Information and Statistics Division of the Scottish Government Health Department. It should be noted that expenditure includes both direct costs (e.g. medical, nursing, drugs, medical supplies etc) and indirect costs (e.g. administration, management, energy, rates, depreciation etc) in the totals. Health costs are split between hospital services, community services and family health services. Moray council costs are split between Care Home, home care and other services which include befriending, Moray handyperson, care and repair, Moray lifeline and day care day care.

The estimated total expenditure from the IRF for Moray CHP in 2010/11 (the latest available information) was as follows :-

Mapped Health Expenditure for Aged 65 and above	£47.386 million	£2,843 per capita
Mapped Health Expenditure for Aged 75 and above	£27.984 million	£3,691 per capita
Gross Social Care Expenditure on Older Peoples Services	£23.201 million	£1,400 per capita

Existing IRF data from 2010/11 will be used to compare with 2011/12 when this information is made available. Currently the 2011/12 information is being collated and is expected to be available in March 2013. Usage of IRF data will assist in evidencing improvement measures and in particular the usage of resources.

Moray Community Health and Social Care Partnership MSCHP

For NHS Grampian this expenditure on the direct costs of community services for older people is estimated at £10.359 million. This includes the direct spend on services (i.e. no indirect costs have been allocated to the services) by community nursing, allied health professionals, mental health and public health. The expenditure on mixed patient groups where the component spent on older people is not readily identifiable as yet includes GP services and prescribing, dental services and acute services.

For Moray Council this expenditure on the direct costs of community services for older people is estimated as above at £23.201 million. This has risen to £26.839 in 2011/12.

Change Fund for older people

In order to support the implementation of Reshaping Care for Older People, the Change Fund was introduced by the Scottish Government to act as bridging finance. This has provided a useful catalyst to accelerate the pace of change and development of our services over the next four years in Moray. Moray was allocated £1.178 million in year one of the Change Fund 2010/11 and £1.353 million in year two 2011/12 to implement our change plans. (Appendix 4: Change Fund investment).

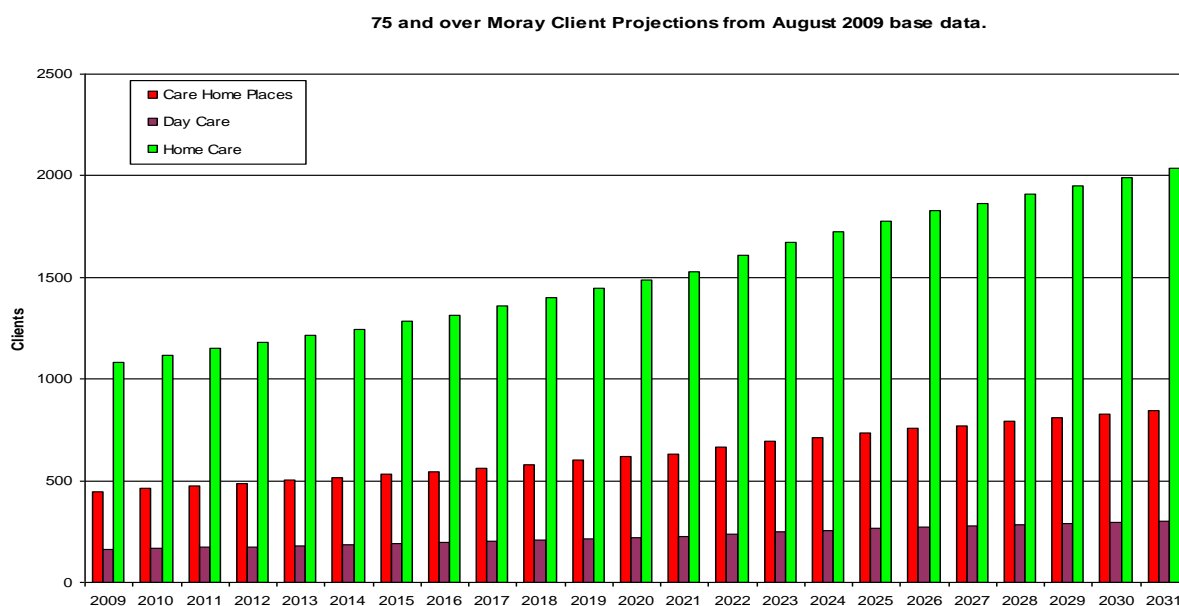
Table 2: Moray's Change Fund allocation

Year	National Change Fund	Moray's Allocation
2011-12	£70m	£1.178m
2012-13	£80m	£1.353m
2013-14	£80m	£1.353m
2014-15	£70m	£1.178m

2.7 Estimating future demand on resources

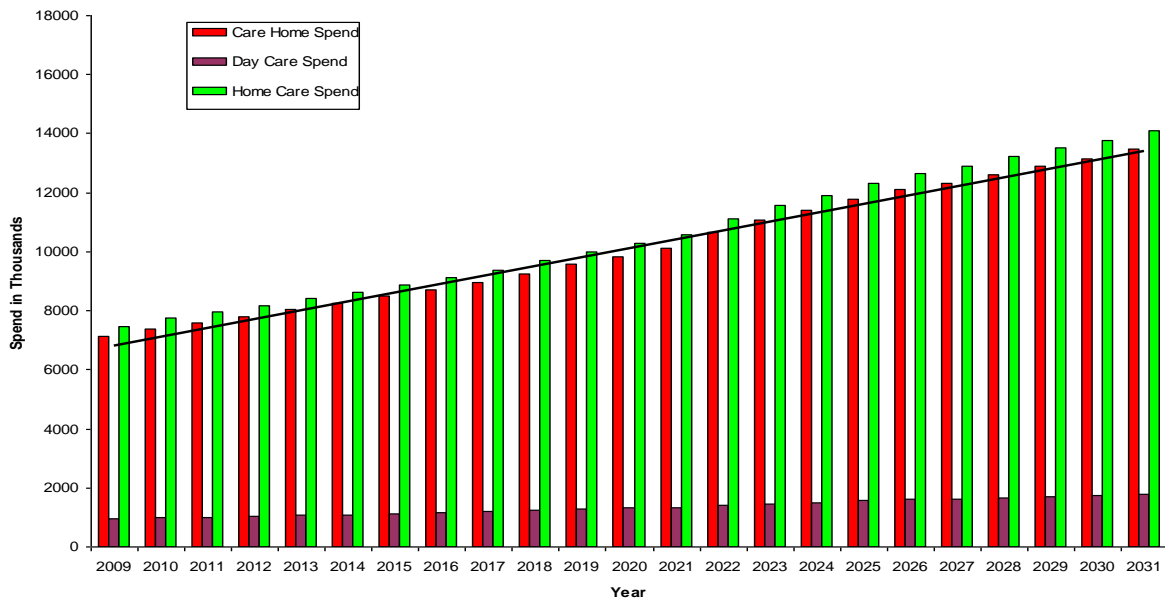
When the projections of the older population are applied to current service levels it provides an estimate of the projected need in Moray if our current practice does not change (Fig 9)

Figure 9: 75 and over Moray client projections (source: Moray Council Community Care Change Programme detailed business case 2011)



When client projections are applied to the current financial position, it confirms that current ways of working are not sustainable

75 and over Moray Fiscal Projections from August 2009 base data.



The partnership agrees that the increasing demand on health and care services will have financial implications if services continue in their current form. It is committed to ensuring the fullest use of all available resources in order to meet the objectives of our strategy. There is a need for efficiencies and smart solutions in the current financial climate and effective use of the Change Fund.

2.8 Conclusion

This section has outlined some of the significant pressures we are facing in Moray. Our analysis shows that the demand for and pressures on services will continue to grow with the older population over the life of this strategy and beyond.

They can be summarised as follows:

Policy drivers:

- A shift from institutional care to community based care
- Community capacity building and co-production
- The need to support informal carers effectively
- Self directed support and individual responsibility
- Early intervention and prevention

- Rehabilitation, re-ablement and recovery
- Outcomes focused care and support planned with people and their family/carers
- Proactive, responsive care which plan ahead for eventualities and maximises independence

Demography:

- High proportion of older people, particularly over 85's
- Reducing younger population
- Local variation in Moray
- Increasing age of unpaid carers
- Increasing demand for suitable housing, adaptations and housing-related support services

Health and wellbeing in Moray

- Increasing numbers with long term conditions and/or deteriorating conditions living at home
- Rapid increase in dementia
- Loneliness/social isolation is common
- High prevalence of chronic disease
- High mortality rates for cancer, heart disease and stroke

Services in Moray

- Increasing numbers of people receiving intensive packages of care at home.
- Increasing need for equipment and adaptations
- NHS provision is Aberdeen centric
- Increasing emergency bed days
- Need to develop self directed support agenda
- High length of stay in community hospitals
- Increasing provision of respite care

Resources

- Current pattern of expenditure is not sustainable in the longer term.
- Efficiency savings expected across health and social care
- Challenge(cost and logistical) of rural/remote provision of services
- Increasing expenditure in primary care and community care services
- Need to reduce expenditure on hospital based services in line with reductions in emergency admissions
- Efficient use of change fund

PART THREE: OUR STRATEGY

3.0 Introduction

The current pattern of service delivery is simply unsustainable. It will not deliver what future service users demand and will place even greater number of older people at risk of prematurely moving to a care home. It is also unrealistic in terms of workforce capacity and affordability in the current financial climate.

Planning for the longer term requires us to consider how combined resources can best be used to sustain the shift in the balance of care in line with what older people say they want. We need to continuously improve the outcomes we deliver and the quality, responsiveness and cost effectiveness of our services. A whole system approach by all partners i.e. the Third Sector, social care, primary and secondary care, community health care, housing, the Independent Care Sector and older people themselves, is required to ensure agreed decisions are taken within an environment which is aware of the impacts that changes can have on other parts of the system and which makes best use of resources.

This strategy sets out our shared vision and the strategic outcomes we wish to deliver for the older population of Moray. It describes the approach we will take to delivering the vision through focusing on specific issues and taking a whole system approach.

3.1 Our Shared Vision

Our vision for care and support services for older people is:

“We will promote a culture of choice, independence and quality with older people in Moray; where they are supported to share responsibility for leading healthy, fulfilling lives in active communities that value and respect them.”

The vision has been endorsed by the Older People's Reference Group and affirmed at an Older People's Get Together consultation and engagements event, held in partnership with Age Scotland.

It reflects how we value and respect older people and what they have to offer in their communities and how we are committed to including services in the community that increase the resilience of individuals and communities, maximizing independence by focusing on what older people can do rather than what they cannot (enablement) and deliver personalised care and support based on an individual's abilities and needs. Our services will be designed to be flexible and deliver the outcomes individuals have identified rather than being one size fits all.

3.2 Our Strategic Outcomes

The eight strategic outcomes we want to deliver for older people in Moray have been developed and agreed on the basis of the personal outcomes that older people in Moray have told us is important to them.

Older people will:

- Live more independently as long as possible in their own homes
- Be more able to make the most of their health and wellbeing
- Have more opportunities to be more involved in local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have a range of housing options available
- Have unpaid carers/ families who are supported to continue in their caring role

3.3 Our Commissioning Framework

Our joint commissioning process across all sectors was equitable and transparent and open to influence from all stakeholders via ongoing dialogue with service users, carers and providers. A shared understanding of the commissioning process was agreed and some common benefits emerged; agencies share common customers, services are usually interdependent, quality and cost-effectiveness of services can be improved when agencies work together therefore improving outcomes for older people. Appendix One details the commissioning activities carried out.

3.4 Our Priorities

A number of key priorities have been identified in Moray, which will be taken forward through the joint commissioning process.

- **Community Capacity Building** – building the capacity of the community to take responsibility for their own health
- **Carers** – ensuring unpaid carers (who are often older themselves) are supported to continue in their caring role
- **Housing** – ensuring suitable housing is accessible and meets the needs of older people will be vital in supporting them to live more independently at home for longer including the development of extra care housing
- **Dementia** – tackling the gap in diagnosis in Moray and providing post diagnostic support
- **Frail Elderly** – embedding specialist elderly services in Moray ensuring access to specialist assessment in the acute hospital and in the community. Supporting older people to manage their multiple long term conditions
- **Modernising Community Services** – focusing on recovery, rehabilitation and reablement approaches within services in the community to maintain older people at home.
- **Assistive Technology/24hr care** – Providing access to 24 hr health and social care across Moray. Develop our use of a range

Finance is a key priority which runs through the whole process and work will continue at all stages and in all areas of work to explore how we can use our total resources more efficiently and shift resources from acute services to community based services.

3.5 Commissioning Intentions

Our future commissioning intentions are outlined in the following pages in seven themes. These detail our 10 year commitment and the activities that are planned over the next three years. They emerged from our needs analysis, service mapping, consultation with older people and the work of the wider stakeholder group. This coupled with policy and evidence based research supported us to agree the priorities to be addressed in order to realise our vision in Moray over the next ten years.

Commissioning theme 1: Community Capacity Building

Commissioning theme 2: Informal Carers

Commissioning theme 3: Housing

Commissioning theme 4: Dementia

Commissioning theme 5: Frail Elderly

Commissioning theme 6: Modernising Community Services

Commissioning theme 7: Embracing Technology

Commissioning theme 1 : Community Capacity Building

Strategic outcomes - older people will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have unpaid carers/families who are supported to continue in their caring role

Long term commitment (10 years)

Moray has a clear intention to build community capacity in order, amongst other things, to facilitate earlier intervention and a preventative approach and to achieve a real shift in the balance of care. Building community resilience is key to working in partnership with older people within their communities.

Co-production and community capacity building will involve working with older people, their carers and the Third Sector to build an approach to providing care, based on co-production principles, develop new community driven models of care provision, and to help older people maintain their independence wherever possible.

We aim to have supportive local communities which have the capacity to provide care and support with and for older people. Growing community capacity that focuses on early intervention and a preventative approach will reduce isolation and loneliness, enable participation, improve independence and wellbeing and delay escalation of dependency and need for more complex care and support.

Development areas (next 1-3 years)

- Increase the capacity of the Third Sector interface to respond to the needs of older people
- Progress the development of social enterprise in Moray
- Further develop the successful volunteering service
- Support healthy ageing, with a focus on diet, exercise, falls prevention and tackling social isolation
- Continue working with Libraries to improve access to quality information regarding services and opportunities around healthy ageing
- Support the development of low level interventions as informed by older people such as

time banking, telephone befriending, foot care

- Supporting older people to live independently at home by developing a supported sustainable network of community groups
- Support Fuel Poverty and Benefits advice project led by REAP and partners

Commissioning theme 2 : Carers

Strategic outcomes - older people will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have unpaid carers/families who are supported to continue in their caring role

Long term commitment (10 years)

Supporting unpaid carers to continue in their caring role will be key to providing care and support to older people in Moray. We will work with carers as partners and encourage and support families to provide a caring role.

Development areas (next 1-3 years)

- Dementia training for carers
- Dementia specific peer support for carers
- Delivery of at home Digital Reminiscence Software pilot
- Pre and post training support for carers, specifically including carers of people with dementia
- Health screening for carers to be offered locally in a variety of health and non-health settings
- Carer health and wellbeing pilot course to support access to fitness opportunities for older people
- Carer training around foot care for older people
- Initial support to attend training, peer support or relevant events
- Development of interdependent carer assessment, support and respite provision
- Awareness and training for carers around reablement and other times of transition in their caring journey
- Involvement of carers as equal partners in care homes/hospitals.
- Access to short breaks/respite to support accessing any of the above initiatives

Commissioning theme 3: Housing

Strategic outcomes – older people will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have a range of housing options available to them
- Have reduced feelings of isolation

Long term commitment (10 years)

There are clear links between good health and wellbeing, the availability of social networking and care, and enabling housing and environments which allow older people to maintain their dignity and independence in later life. A lack of appropriate available housing for older people can lead to a premature move to long term care.

Providing access to a range of housing options for older people and tackling social isolation are two of our strategic outcomes for older people in Moray. Our commitment to shift the balance of care means supporting older people to remain at home independently for longer. Housing and housing related support have a key role to play in supporting this and reducing the use of institutional care.

We will continue to work with housing as partners to ensure that we have the right mix of housing and support services to meet the needs of older people. There will be an increase in extra care sheltered housing in preference to traditional sheltered housing, particularly the Speyside area where there is currently a lack of provision, with corresponding new builds of bungalows, preferably in cluster models, across Moray. Community Resource Hubs will provide access to preventative services to the wider ageing population within communal facilities in the community e.g. sheltered housing, releasing time in day services to focus on more dependent clients

Development areas (next 1-3 years)

- Invest in a handypersons service to provide low level preventative services
- Continue investment in early intervention and prevention work with sheltered housing i.e. confidence to cook, computer literacy, intergenerational working, outreach projects and the development of resource hubs

- Establish 30 new build extra care housing units at Linkwood, Elgin
- Establish 30 unit extra care housing units at Leask Road, Forres, as redevelopment of existing sheltered housing
- Carry out further research to quantify the demand for extra care housing in Speyside and identify land for extra care facility in Speyside locality area
- Housing adaptations services –focus on improving processes, systems and delivery arrangements across tenures providing streamlined and more effective alterations to people’s homes to increase or maintain their independence and reduce the risk of an accident
- Ensure clear links with Moray’s Local Housing Strategy and the future requirements for older people’s housing inclusive of fuel poverty actions
- Continue to invest in the Moray Community Health and Social Care joint equipment store to provide timely access to rising need for equipment
- Housing with care and support – extend the supply of housing which includes onsite support making better use of existing sheltered housing and any future new provision

Commissioning theme 4: Dementia

Strategic outcomes contribution - older people will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have a range of housing options available to them
- Have unpaid carers/families who are supported to continue in their caring role

Long term commitment (10 years)

We want to ensure that people with dementia and their family/carers have an improved quality of life with the care and support that meets their needs in a safe environment within the community.

We believe that this can be achieved by engaging with the population of Moray so that the profile of dementia can be raised. This will enable individuals with dementia, their families and carers to be informed and have choice and control about the services available to them. With increased understanding in the community there will be more confidence in the services that are available and a lessening in the uncertainty as to how to access the appropriate level of care for the individual or their carers. In the longer term this will lead to a system wide change in healthcare expectations and improve the efficiency of the care network.

This will enable an educated, motivated health and social care network to enhance the level of care given to people with dementia. This will allow patients and their carers to have increased confidence in knowing that their needs will be seamlessly met throughout their journey. That locus of care will increasingly be in their homes.

Development areas (next 1-3 years)

- Development of dementia strategy in Moray
- Publicity/Awareness profile raising across all sectors
- Continue to engage and involve carers and people with dementia
- Ensure all staff have the skills to recognise the potential for early diagnosis allowing identification of the needs of people with dementia across all sectors
- Continue to shift the diagnosis of dementia in Moray to primary care with a corresponding increase in post diagnostic support available in the community
- Ensure that people receiving a diagnosis of dementia are offered one year of

diagnostic support

- Consider the development of specialist dementia units in the independent sector
- Explore an integrated community model of care which considers the range of care and support required throughout the progression of the symptoms of dementia
- Development of smooth pathway of care across disciplines with clear communication structures
- Work with Alzheimer's Scotland to provide access to post diagnostic support via their hub
- Increase the number of dementia cafes across Moray
- Development of anticipatory care plans with links to out of hours to minimise the risk of a hospital admission
- Continue work in secondary care around improving standards of care for people with dementia, dementia champions, butterfly scheme
- Carers support (theme 2)

Commissioning theme 5: Frail elderly

Strategic outcomes contribution - Older People will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have unpaid carers/families who are supported to continue in their caring role

Long term commitment (10 years)

The impact of population ageing means that more people will live with multiple long term conditions. Along with a predicted doubling in prevalence of dementia, it is clear that multi-morbidity will become the norm, frequently compounded by functional and cognitive impairment and poor socio-economic circumstances. These changes will inevitably lead to a sharp increase in the number of frail older people with complex and frequently changing care and support needs.

Frail older people commonly present with falls, immobility and confusion. Well over half (60%) of those aged over 75 taken to or referred to Accident & Emergency are admitted to hospital. This may be entirely appropriate but in acute care they are susceptible to complications such as delirium prolonging their stay and resulting in high rates of mortality and institutional care. The human costs of complications such as healthcare-associated infections, delirium, pressure sores, malnutrition and dehydration can be high.

We aim to provide effective interventions delivered through pathways that span across acute and community services to effectively enhance the quality of care, reduce avoidable hospital admissions and support older people independently at home.

There is very little geriatric provision in Moray. We aim to build on this and increase our geriatric capacity and embed the specialism in the community.

Development areas (next 1-3 years)

- Provision of Access to comprehensive geriatric assessment (CGA) in hospital and the community
- Embedding geriatric specialism in the community including clinic based

assessment

- Identification of frail and vulnerable elderly using IT based tools and local knowledge of community health and social care teams and carers
- Development of anticipatory/advanced care plans for those at risk using a case/care management approach
- A workforce that has the awareness, environment, knowledge, skills, confidence and capability to enable people to live well with their conditions.
- Embed preventative and anticipatory care approach across workforce in all sectors
- Support care homes to enhance clinical skills including use of anticipatory care plans and specialism in palliative and terminal care
- Support Frail elderly and their carers within a culture which supports people with long term conditions to be the lead partners in decisions about their health and wellbeing.
- Health, housing, social services, community and voluntary partners to work together with people with long term conditions and their families.
- Explore regular review/ MOT/assessment need with older people

Commissioning theme 6: Modernising Community Services

Strategic outcomes contribution – older people will:

- Live more independently as long as possible in their own home
- Be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- Have unpaid carers/families who are supported to continue in their caring role

Long term commitment (10 years)

There needs to be a clear focus on recovery, rehabilitation and re-ablement approaches within services in the community to maintain older people at home or when older people are at points of transition (between healthy lifestyle and frailty). Older people will be supported to enable a quick recovery and successfully maintain independence and control over their daily lives after a short/long term illness.. We aim to provide alternative options to hospital admission for those that would benefit by building on our use of care home beds as short term beds. We also need to re-align the hospital beds available in the community hospitals more appropriately to the populations and review the function of the community hospitals to support their local communities with more of an outreach support and bringing day clinic/services closer to home. Community services will be key players in preventing admission to hospital and facilitating timely discharge.

Development areas (next 1-3 years)

- Progress the Health and Care framework in the Speyside area
- Build the capacity of community services to meet the needs of the older population with particular focus on:
 - Rehabilitation, Reablement and recovery
 - Health Promotion and self care approach
 - Management of long term conditions
 - Anticipatory Care – planning ahead for eventualities
 - Palliative and end of life care
- Have transparency/openness about shrinking public services
- Further develop integrated working arrangements that enable aligned teams of health and social care staff to access and arrange services taking an

integrated approach

- Develop intermediate care facilities within the home and close to home preventing unnecessary admissions to hospitals, facilitating early hospital discharge and preventing premature admission to residential and nursing care
- Develop clear pathways in and out of secondary care
- Develop adequate response times across disciplines to meet the needs of older people in the community

Commissioning theme 7: Embracing technology

Strategic Outcomes contribution – older people will:

- live more independently as long as possible in their own home
- be more able to make the most of their health and wellbeing
- Have opportunities to be more involved in their local communities
- Feel safe and secure
- Have more choice and control
- Have reduced feelings of isolation
- have a range of housing options available to them
- Have unpaid carers/families who are supported to continue in their caring role

Long term Commitment (10years)

Use of technology to support older people's health and wellbeing is now common place in Moray. Technology is ever changing and provides exciting opportunities for the future to continue to provide this kind of support. We aim to improve access to information, services and appointments for older people in Moray. We will also take full advantage of the opportunities through the *dallas* programme to develop strategies which support periods of wellness as well as illness.

There is a wide range of potential benefits of assistive technology in relation to health and wellbeing from community alarm, medication prompt, bed sensors and property exit sensors to video conferencing to a consultant clinic to reduce travelling time. WE are considering similar technology which will allow people to stay connected to friends and family and reduce social isolation.

Overall the *dallas* programme and its Scottish project *Living It Up* in particular is driving innovation to improve the way that products and services meet the needs of older people.

Development areas (next 1-3 years)

- Publish a further Telehealthcare strategy for Moray aligned with national *dallas* objectives
- Ensure telecare technology is considered in all care packages to support older people to live independently at home with a focus on over 75's
- Ensure staff, older people and the public are kept updated on the latest ever changing technology – Independent living centre
- Strengthen links with falls pathway and community alarm
- Enhancement of call centre arrangements to improve efficiency
- Investigate the potential of technology enriched housing in Moray
- Develop and implement localized aspects of Living it Up

PART FOUR: DELIVERING OUR STRATEGY

4.0 Introduction

The fulfillment of the vision of this strategy necessitates that older people themselves along with professionals from across a range of different public and voluntary services will need to come together to ensure that we deliver a future service that achieves the best outcomes we possible can for older people.

A joint commissioning approach therefore challenges how the public sector has delivered services in the past and recognises that the commissioning process needs to be jointly managed.

This part of the strategy outlines an approach to governance in terms of how this can be achieved over the 10 year timeframe of this document.

4.1 Governance

The governance structure in Figure 10 outlines how decisions relating to this strategy will be made and how progress will be monitored across all sectors and work streams.

At the heart of the governance arrangements is a Change Fund Governance /Commissioning Strategy Steering Group which has been established with key stakeholders from across the four sectors. The group had a dual role of leading the development of the joint commissioning strategy and allocating the change fund spend, ensuring there were clear links.

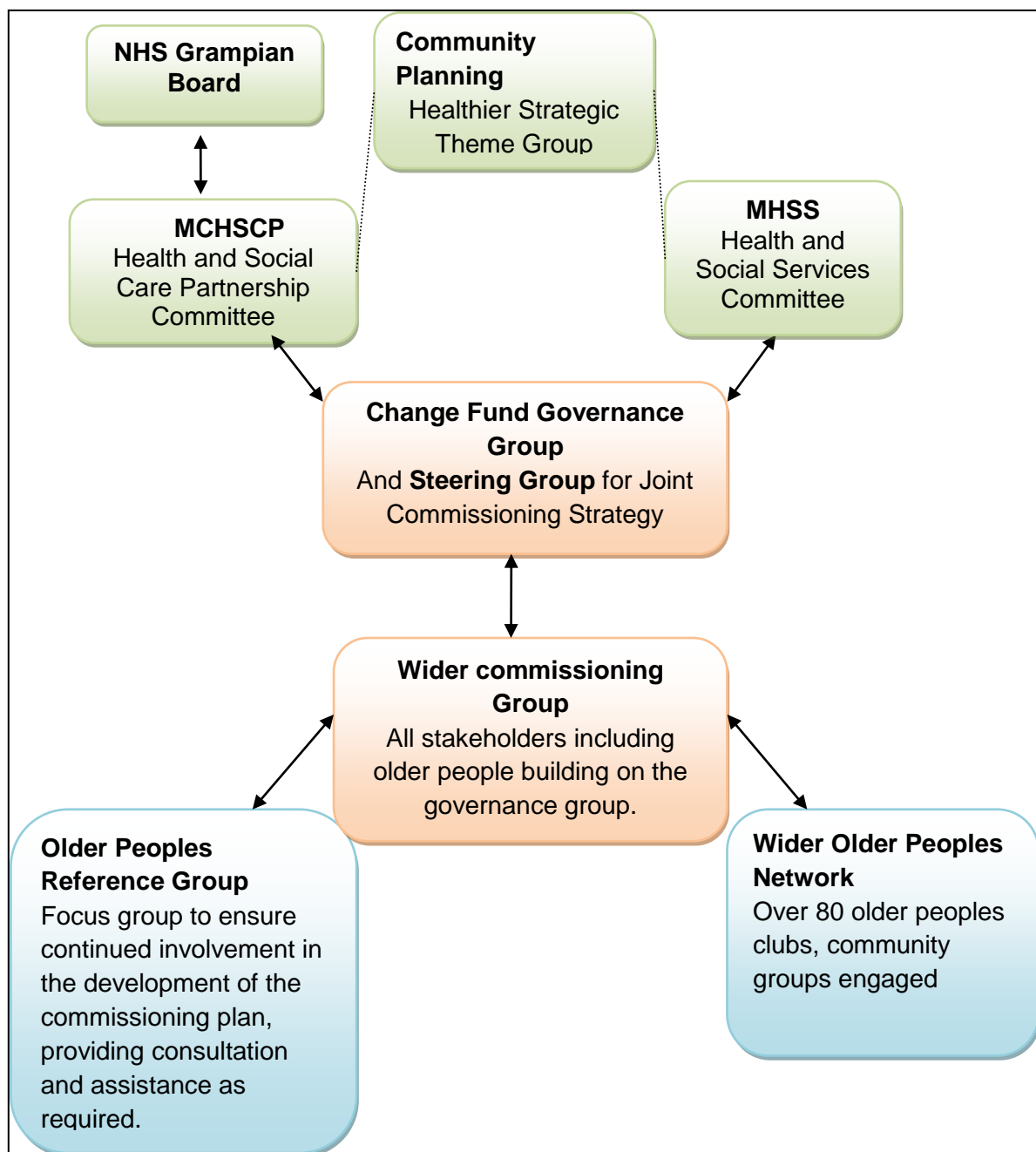
The NHS Grampian Board is accountable for Change Fund monies. The Moray Community Health and Social Care Partnership Board performs the statutory function of the health service and joint health/care services. The partnership is responsible for the use of the change fund via the change fund governance group. A separate healthier strategic group fulfils the community planning function.

Moray Council and the NHS are accountable for resources/contracts/human resources/ management of agency services aligned with all budgets for all activities

with the exception of prescribing and corporate functions. The existing Older Peoples Reference Group supports the function of engagement and consultation.

Through these governance arrangements the impact of this strategy will continue to be reviewed. This joint accountability will be strengthened as legislation and arrangements for further integration for health and social care in Moray is implemented.

Figure 10 : Moray Governance Structure



4.2 Performance Management and Monitoring

Performance monitoring and evaluation is a key component of the commissioning cycle, it drives improvement and the future development of services. Monitoring the impact of services and analysing the extent to which they have achieved the purpose intended will be key in achieving our objectives in Moray

We have made good progress in Moray using the suite of core measures distributed by the Scottish Government. This basket of measures contributes to the Quality Measurement Framework, links to the Community Care Outcomes Framework and aligns with the National Performance Framework. They fall into three categories:

- Nationally available outcome measures and indicators which use data already collected at local level and compiled nationally
- A set of improvement measures to inform and support local change
- Measures of shift in Partnership resource and in Change Fund use over time.

Using these measures and the underpinning indicators will prompt local actions to test changes in order to improve experience and outcomes. Timely feedback of data from local improvement measures connects practitioners and teams with the changes they are making and assists them to reflect on how to continually improve aspects of care and support.

The information which is collected locally to monitor each improvement measure will build a picture of trends over time, allowing teams to incrementally determine the impact of the changes they have been testing and implementing.

Developments progressed in this area

The following progress has been made in this area and will continue to develop over the course of this plan:

- Establishment of a joint Performance Management Group (JPMG) which are progressing the development of agreed measures across the partnership to monitor our progress in delivering this plan.

- The development of a joint Performance Plan for the partnership and systems to bring together relevant data on finance, activity and outcomes
- Development of agreed performance baselines, indicators and potential targets
- Recruitment of a joint performance and monitoring officer for older people
- Recruitment of a joint commissioning officer for older people
- The development of a joint outcomes based training programme including the Sliding Doors initiative (pilot sponsored by SSSC and NHS Education).

4.3 Workforce

Moray, like many areas, faces major challenges in recruiting and retaining staff and there is a continuing need to train and develop skills as the nature and demands of jobs change. In community care and healthcare, as elsewhere, staff are our most valuable resource, without staff, at all levels, the changes required across healthcare and community care will not happen. Supporting informal carers and volunteers and ensuring a flexible, well-trained, motivated and highly-valued workforce will be pivotal in the delivery of this strategy.

From a national level workforce development issues are being taken forward in a joined up way by the Scottish Social Services Council (SSSC) and NHS Education Scotland (NES) working together with all interested parties to consider current and future workforce requirements.

Our last strategy summarised our long term goal based on an action set by the action team report for older people in Scotland:

“A health and social care workforce that reflects demography and need, increasingly community-based and less focused than at present on acute and unscheduled care: with changes delivered via training, education and career paths: knowledge, skills

and attitudes: with more people working in teams and away from hospitals: and making maximum use of emergent IT and other technology for example Telecare.^{vi}

This long term goal still stands however within our new plan success has as much to do with shifting our attitudes, expectations and aspirations in the community of Moray as it has about shifting resources, care institutions, providers and workforce. Achieving these aims will require all of us to work together, to resolve our differences and transcend traditional boundaries; to recognise our shared aspirations and responsibilities; to share our skills, talents and resources; and to familiarise ourselves with an exciting new dynamic where we are all both contributors and beneficiaries alike.^{vii}

We are working towards a joint approach to developing our future workforce and will continue to invest in IPC to support cultural change in Moray, with organisational development activities to support the transformation of the whole system within our partnership organisations.

Education and training needs have been identified within the work of our multi agency work streams. Key areas for development are:

- **Leadership** - we need to invest in leadership development for staff at all levels so that they can lead and contribute to the cultural change required
- **Commissioning** - we need to continue to develop commissioning skills and competencies so that we can carry through the redesign of services
- **Dementia care** – ensuring that dementia is everyone’s business, awareness training across all services to ensure that staffs across all sectors understand the needs of people with dementia and have the skills and information to deliver high quality care and support.
- **Intermediate care** - promoting a greater focus on rehabilitation, reablement and recovery in the community
- **Complex Care for the frail elderly** – ensuring that the workforce are aware of the needs of the frail elderly and have the skills and information to deliver high quality care
- **Carers** – ensuring carers are partners and are equipped with the skills and information required to continue in their caring role.

- **Capacity building in the third sector interface** – development of the third sector interface in representing all voluntary agencies in Moray. Working together to build the capacity of the third sector to meet the future needs of older people in Moray, focusing on building resilience in the community geared towards prevention and support for low level needs
- **Palliative and end of life care** – ensuring older people are supported appropriately at the end their life to remain comfortably at home if they choose, with the dignity and respect they deserve.

A joint workforce development officer will be recruited to progress this work. The current integration agenda will provide a comfortable environment to progress an integrated workforce development plan identified in our last strategy.

APPENDICES

- Appendix 1: A Partnership approach**
- Appendix 2: Local and National Policy Context**
- Appendix 3: Needs Analysis**
- Appendix 4: Change Fund Investment**
- Appendix 5: Service Mapping**
- Appendix 6: Future Change Fund Investment**
- Appendix 7: Glossary**

ⁱ <http://www.scotland.gov.uk/Publications/2010/09/10151751>

ⁱⁱ <http://www.scotland.gov.uk/Publications/2010/07/23153304/0>

ⁱⁱⁱ <http://www.selfdirectedsupportscotland.org.uk/>

^{iv} <http://www.scotland.gov.uk/Publications/2008/10/01091608/8>

^v In relation to housing adaptations, see in particular *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations*, University of Bristol (2008) <http://odi.dwp.gov.uk/docs/res/il/better-outcomes-report.pdf>

^{vi} Scottish Executive (2005) “**Care of Older People**” Action team report as part of the national framework “fit for the Future” Edinburgh: Scottish Executive

^{vii} Programme for change, Scottish Government