MORAY COMMUNITY HEALTH AND SOCIAL CARE PARTNERSHIP

Living Longer
Living Better

An Older Peoples Strategy for Moray

SUMMARY VERSION

2009-2014

A framework for Older Peoples Services in Moray to enable them to live longer and live better

(A title chosen by older people in Moray)

Foreword

This plan is a shared vision across Health services, Social services and Housing Services within Moray and all the departments and agencies which support them.

We have created this plan after listening to what older people in Moray said would improve their lives and planning with professionals what redesign and development would be required to achieve this.

The challenge for all of us is to make this vision a reality in response to an ageing population, health trends, changing public expectations and workforce availability.

Five years down the line older people will be enjoying a better quality of life, with robust community rehabilitation & support services responsive to their needs, providing high quality services and support which enable them to live as independently as possible in their own home when suitable and safe

Delivering our plans will be overseen by an older peoples strategy implementation group – made up of NHS Grampian, Moray Council, Housing, voluntary organisations, carers and people who use services.

Introduction

This strategy will lay out the foundations for redesigning and shaping our services for older people in Moray over the next five years and in the future.

It focuses mainly on the health and social needs of people over 65 years of age

When planning this strategy, the partnership has put the needs of people who use services and their carers at the core of their thinking.

Older people in Moray are clear they want to get the support they need to stay at home for as long as possible as an alternative to going into a care home.

The strategy will build on this by designing new and better ways of working between health and social services, voluntary and private providers.

We want to ensure that more people with higher care needs can stay at home safely. There will still be some people for whom support at home is not safe or appropriate when their circumstances are complex.

The strategy underlines our commitment to work collaboratively to ensure that care in care homes are provided to a high standard, delivering person centred care for people whose needs cannot be met in any other setting

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Chapter One Setting the Scene

Planning for a Different Future

The population of Scotland is changing and it is projected that in the coming decades there will be increasing numbers of older people and diminishing numbers of working age adults in Moray.

The main impact of the age profile will be on the type of demands in services we face. The majority of older people are fit and well and independently living in their communities with no support.

However some older people are frail and have more complex health and social care needs including multiple long term conditions.

It will be vital that we provide opportunities for older people to maintain their physical, psychological and social health and wellbeing and anticipate any decline before it becomes acute.

The redesign of services across the whole system underpinned by a sustainable workforce and the available pool of unpaid carers

National Policy and Local Strategy

A number of significant national policy documents have been produced in the last few years highlighting the need to respond to an ageing population.

They provide direction for change in the services provided by Primary Care, Community Nursing, Social Work and Allied Health Professionals and Housing.

The focus in health, social care and housing services in Britain is moving towards an ‘outcome-based’ approach. The Scottish Government have embraced ‘outcomes’ as a more meaningful way of securing effective public services, and of delivering best value and continuous improvement.

The former Scottish Executive and the current Scottish Government have established an increasingly clear policy and performance framework for health and social care services, largely based on outcomes. The removal of ring-fenced funding and the development of

Single Outcome Agreements are the latest developments in this shift. A national outcomes framework for community care services is being developed and will focus our work locally on meeting new national objectives and targets for:

- Improving health
- Improving well-being
- Improving independence
- Improving inclusion

The national targets for older people's services are found in *The National Outcomes for Community Care*,and in other national policy frameworks – *Better Outcomes for Older People, Delivering for Health,* and others. This focus on outcomes, and the objectives and targets which describe how these high level aims will be delivered, and have been central to much of the work we have undertaken to develop our Joint Older People's Strategy.

Shifting the balance and focus of care

Building a Health Service Fit for the Future, developed from *the Kerr Report, Delivering for Health*, reinforces the Scottish Government's commitment to support the shift from reactive hospital-based care, to community-based preventive and rehabilitative models.

Better integrated services

Visible, Accessible and Integrated Care, a review of Nursing in the Community in Scotland proposes a new service model in which the disciplines of district nursing, public health nursing and family health nursing are absorbed into a new single community health nursing discipline to support much of this shift in emphasis.
The community health nurse will be the visible access point for people and will provide care through a team of community staff nurses, health care support workers and administrative support. The team will have strong interfaces with key services such as primary care teams, mental health services and local authority teams.

Personalisation: choice and independence

Changing Lives, the report of the 21st Century Social Work Review recognises the need to plan, commission and deliver public sector services differently. It states that current ways of working do not make the best use of the skills of Social Workers and others who work in social work services.

The report acknowledges the complexity involved in changing how services are commissioned and delivered, and recognises that organisations need to build capacity to enable them to deliver services in a more personalised way. As a consequence, there are significant implications for the workforce in terms of roles, skills and the way services are organised.

In common with other reports, *Changing Lives* emphasises that Social Work services alone do not have all the answers, and that collaborative, team-based approaches will increasingly be the norm. The report is explicit in stating that users and carers must be involved in the plans needed to transform services and to deliver sustainable change.

A focus on rehabilitation

Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland (Scottish Executive 2007) recognises the challenges and opportunities inherent in the aim to shift the balance of care. It promotes rehabilitation as being central to the redesign of services that will improve the health and well-being of the population in general and older people in particular.

This will have an impact on the way everyone employed in health and social care in a community setting works, but is particularly relevant to the work of allied health professionals – physiotherapists, occupational therapists, podiatrists, speech and language therapists, dietitians, psychologists and art and music therapists.

The management of long term conditions: anticipatory and preventive models of care

The improved management of long-term conditions has been identified as fundamental to improving the health of the population in general and older people in particular. There is evidence that there is considerable potential to work with people to improve their situation. A common theme in long-term conditions work is targeting of people at risk of adverse outcomes and enabling them to have more control of their condition through knowledge, skills and access to services. The development of better anticipatory care and of services which have a greater focus on rehabilitation are core themes in this strategy and are key to the improved management of long term conditions.

Our strategy also links clearly with other local plans and strategies within Moray e.g. Moray Carers Strategy

Developing the strategy

In November 2007 an initial scoping visit from the Joint Improvement Team began the process of developing the strategy. A number of mapping workshops followed with a range of stakeholders working together to identify the issues important in relation to the future delivery of older people's services in Moray.

A further workshop provided clarity between current reality and the vision for older people in Moray

Four main themes emerged which required development:

- Older Peoples pathway through services
- Anticipatory Care and prevention
- Rehabilitation and Intermediate care
- Telehealthcare

Underpinned by a focus on:

- Users and carers
- Communication
- Workforce development

Work streams were established as sub groups of the multi-professional Older Peoples Strategy Steering Group and led by professional leads. Each work stream identified gaps/issues and areas for improvement and developed action plans

Our vision and strategic aims were agreed after consultation with our users and their carers and older people in Moray. A title for our strategy was included in the consultation process and "Living Longer Living Better" was chosen by older people in Moray.

Our Vision and Strategic Aims

Our vision is that in the future:

By adopting a partnership approach that promotes the quality of life of older people we will further shift the balance of care from acute to community based care; ensuring that services in the community are responsive to the needs of older people by the provision of high quality services and support which will enable older people to live as independently as possible in a suitable and safe environment with choice and control over their future needs. Older people will enjoy a better quality of life and feel part of the community.

We will achieve this by delivering the following strategic priorities:

- Promote active ageing by providing access to recreational activities and healthy living advice
- Manage long term conditions to ensure optimum independence
- Expand Preventative and Anticipatory services
- Improve 24 hour responsive services
- Develop Intermediate care services within the home and close to home
- Improve support to carers
- Improve integrated health and social care services in the Community
- Develop the workforce to deliver better outcomes for older people
- Ensure a seamless journey through high quality hospitals
- Expand the range of housing and care options for older people
- Improve information and advice about services and facilities for both staff and users/carers

Chapter Two Older People in Moray and our challenges ahead

Demographics

Population projections for Moray reveal some significant growth in the numbers of older people defined as people age 65 and over and the trend is set to continue

Between 2008 and 2030 the number of older people living in Moray (just over 16,000) will increase from 18% at present to nearly 40% of the population.

Among these people, there will be large rises in the number of older people aged 75 and over, and age 85 and over

Projected percentage change in Moray

	2011	2016	2021	2026	2031
all ages	1	1	0	0	-2
65+	10	15	21	26	39
75+	15	32	53	83	104

Registrar General for Scotland 2008

The total number of older people 75 years of age and over in Moray is projected to increase by 104% by 2030 (from over 7,000 to around 14,000)

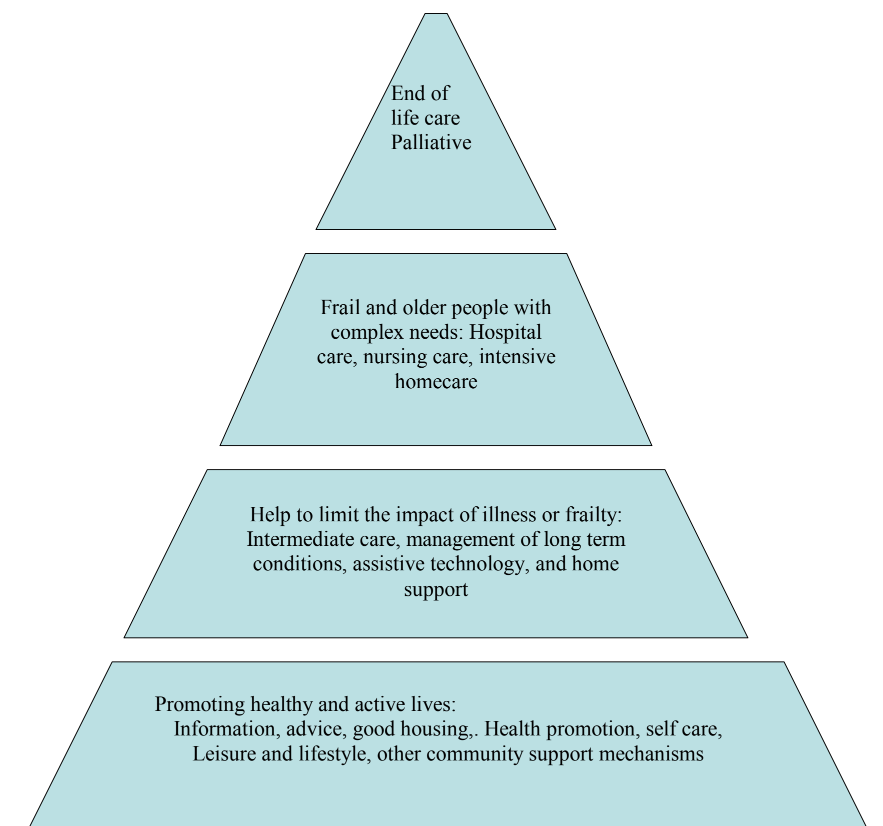
It is this group of people who are predicted to have higher, more complex levels of need that require to be met by the most appropriate support and services.

Service Use

A range of services are available across Moray, some in remote and rural areas which pose challenges of access and equity to services for older people. These include 462 care home beds, 51 residential units, 488 sheltered housing units and 56 very sheltered units.

Services provided in the home include 377 clients receiving meals on wheels and a total of around 8,000 hours of home care, 279 clients attend day care.

Pyramid of care
Care systems proposed in Moray can best be described as a pyramid of care.



Wider community support systems ensure that older people's needs are met within their local communities at the base of the pyramid. At the next level community services help to limit the impact of illness or frailty increasingly know as intermediate care. The next level provides care for older people with complex conditions, most often acute hospital care, care home or intensive home care, the top of the pyramid provides palliative and end of life care

Shifting the balance of care

The challenges ahead are that of continuing to shift the balance of care:

- Shifting the focus of care towards health promotion, prevention, a proactive and anticipatory approach and management of long term conditions
- Shifting the location of care towards more community based facilities
- Shifting the roles and responsibilities of clients and staff

In this way we will ensure the health of our ageing society and promote the capacity of communities to care for themselves by providing support from services that are built around the needs of our older people now and in the future with a workforce which has the capacity and skills to meet those needs.

Chapter Three Healthy Active Ageing

Health Needs

Health takes on a particular significance in later life. The proportion of people with a long term illness and a disability increases with age. However the majority of older people live at home the majority in good health. It is important that opportunities exist in the community for older people to maintain their physical, mental and social wellbeing

Some older people however can become frail and have complex needs. Frail older people are usually over 75 and often over 85 and have multiple conditions which may include dementia. They are the fastest growing group of the population and require the most support

Carers

The impact of caring can be significant, many older people are recipients of unpaid care or in fact carers themselves. We plan to strengthen the support to older carers or carers of older people to reduce the risk of frailty, depression and isolation by commissioning services which provide care and support to older people allowing them to feel valued, supported and key partners in care. Our revised contract reflects this.

The Respite service will be developed to ensure carers are supported to maintain their caring role and remain healthy both physically and mentally.

Health Promotion

Health promotion is everyone's business. Staff working in health, social care and housing services are contributing on a daily basis to the health and well being of the people they work with, but there are specific areas of health improvement which this strategy has the potential to address. These include:

- Supporting older people to self care and self manage
- Provide leisure and lifestyle opportunities for older people
- Be Active Life Long groups will be increased across Moray

Housing and Housing Support

Housing and housing support is important to the health and independence of older people. Housing solutions are integral to our plans to support the shift in the balance of care. We are presently reviewing sheltered housing within each locality for suitability to modernise the existing model to one that provides extra care.
At present housing support is only available to sheltered housing residents, we will look at ways that this could be available to all tenure types and enhance the valuable care and repair service. Provision of equipment in the home will be improved as we progress a joint Occupational Therapy store with access 24/7

Telehealthcare

There has been considerable advance in the use of technology to support older people and their carers. It can help vulnerable people to live at home, retaining their independence for as long as possible. It can provide reassurance and confidence, relieve stress on informal carers and improve clinical and care outcomes.

We presently have around 50 individuals with telehealthcare packages and over 300 supported by the Moray lifeline.

A wide range of alarms and sensors are available, designed to assist older people in managing the risks of living in their own home, such as falling over or fire hazards

We plan to develop this service making all staff and older people and their carers aware of the assistive technology available and the opportunities it gives to older people to live safely and independently at home. Some GP's signed up to the Healthy outlook COPD forecast alert service this year which helps identify when COPD patients are at most risk. We intend to look at ways to broaden access across Moray year.

Prevention and Early Intervention

This is a key component to healthy ageing in older people involving an anticipatory approach to care. We have focused on specific areas where we can prevent, manage and provide early intervention. These include:

- Development of a screening programme for older people in Moray
- An integrated falls and bone health service in Moray
- Improve the nutritional status of dependent older people
- Increase the provision of specialist dementia care
- Review and redesign Older Peoples Mental Health Service
- Improved detection and management of long term conditions

Chapter Four Building Services in the Community

In order to achieve our vision and shift the balance of care to the community we will ensure that a range of integrated community-based services are available which support older people to live safely in their communities for longer
This will require significant change to the way that we provide care and support services

Proactive anticipatory services

The model of service provision is moving away from reactive care and crisis management to an emphasis on planning ahead and providing information and support to maintain health and independence.

We need to ensure staff have the knowledge skills and resources to work differently and in a more integrated way to support this change in approach. Our developments include:

- Identification of older people at risk
- Development of anticipatory/advanced care plan for older people at risk
- A case management approach to complex cases
- Examine the role of day care in anticipatory care/prevention and ensure an outcomes based approach to the service

Personalisation
Extending personal choice is now part of mainstream health and social care policy to ensure that individuals get the care that is right for them. The strategy will provide opportunities for older people to direct their own support through direct payments as it is promoted and embed the concept of personalisation and enablement

Extended community Care Teams
Health and social care teams have been working jointly for some time now as community care teams. These teams include a range of professionals. We are proposing a model of extended community care teams where communities are facilitated to care for themselves using a variety of resources in the community including the voluntary sector. The national community nursing review will be part of this.

Community Care Services

Community Care have agreed a framework for service change which identifies two key outcomes

- A confident, competent workforce
- Capacity to deliver personalised services

This includes some changes to the home care service. The successful home from hospital team will be broadened to all areas and the service as a whole will become one of enablement and rehabilitation. Progress here includes:

- Development of a recruitment strategy for an increased demand For carers
- Increased induction programme

Other community developments include:

- Developing the meals on wheels service to provide a nutritional service linking with dietitians
- Enhancing the important role of pharmacy in medicine management of older people and pharmaceutical care

Enabling, Rehabilitative services

Community Health and Social care services must support the appropriate use of hospital services and help older people to live safely and independently. We will focus on rehabilitation and enable older people to access care and support in the most appropriate setting for their needs by building on our existing community therapy teams. The ethos of the rehabilitation model is about enabling the maximum potential of the individual and improving their quality of life

AHP teams have an important contribution to make to the rehabilitation agenda. We need to progress the development of accessible rehabilitation services in the community, promoting independence and self management

Mental Health

The current older adult mental health service is undergoing a review and redesign programme it aims to improve health services for the

elderly with a mental illness across Moray and to deliver patient centred care as close to home as possible supporting a preventive and anticipatory approach

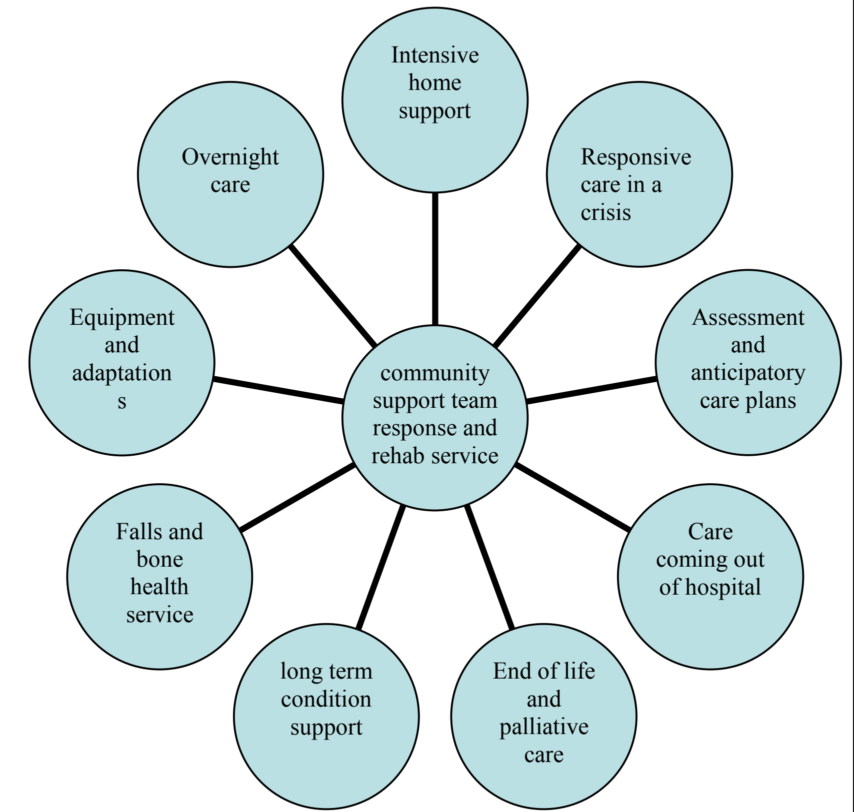
Intermediate Care

Intermediate care services have been developing in Moray over the past four years. They can be described as services which do not require the resources of a general hospital but are beyond the reach of primary care service. It can be provided at home, in a residential setting or hospital for people who need some form of rehabilitation, recuperation and re-enablement after a change in health/social status.

We will focus on developing a menu of intermediate care services across Moray including palliative and terminal care

Responsive, integrated services

When crises occur, health and social care service must provide a co-ordinated robust response. This can provide an alternative to hospital admission and help older people to return home as quickly as possible. We already have the building blocks of a robust community rehabilitation and support service 24/7 in most areas. Further enhancement will provide us with the following support services in the community. This will provide medical and nursing advice to older people out of hours


Intensive home support
Overnight care
Responsive care in a crisis
Equipment and adaptation s
community support team response and rehab service
Assessment and anticipatory care plans
Falls and bone health service
Care coming out of hospital
long term condition support
End of life and palliative care

Chapter Five Improving the Quality of Care

As older people move through the health and social care system we must ensure a seamless pathway throughout which meets the standards of care for older people and enable them to return to maximum independence as close to home as possible

Acute Services

We provide a range of hospital services in Moray. Dr Grays hospital provides a range of services which older people have access to: general medicine, general surgery, orthopaedics, gynaecology, high dependency, day ward facilities and diagnostic facilities. The inpatient services can be planned or unplanned. However we do not presently have a geriatrician service in the acute service, Moray is currently covered by part hours of a community geriatrician. Improvements planned to ensure a seamless journey include:

- Review of the medical pathway for older people
- Development of a comprehensive Geriatric Service
- A pre assessment service for planned care of older people to anticipate any potential needs post discharge
- Progress the 18 week whole journey standard from GP referral to hospital treatment
- Improved multidisciplinary discharge planning
- Development of an acute medical assessment unit
- Progress toward meeting Quality Improvement standards of care for older people in acute service

Admissions to Hospital

Our statistics show that some admissions to hospital can be unnecessary and multiple for some older people and longer than expected .This impacts on the independence of older people and can be detrimental to a good recovery to their optimum independence. We plan to make the following improvements:

- Reduce the amount of unplanned admissions and multiple admissions by improving anticipatory care and 24 hour community support and a variety of intermediate care options

- Reduce the length of stay in hospital by improving the management of the older peoples pathway

Community Hospitals

There are five community hospitals in Moray. They provide a range of services to their local areas including intermediate care and rehabilitation, palliative care, assessment, treatment and a minor injuries service. However they are not aligned proportionately to the needs of the local areas

We are presently reviewing the role of our community hospitals with a focus on rehabilitation, supporting the local community and complementing the existing medical beds in Dr Grays.
Community Hospitals have also developed standards of care and are working towards meeting these

Care Homes

The provision of all care homes in Moray is by the independent sector. There are approximately 462 care home beds available. Places can be limited in some geographical areas. Through the provision of our improved and increased community based services we intend to limit the need for moving to a care home until absolutely necessary

We have good communication systems with the care home owners and are working in partnership with them to achieve:

- Appropriate access for older people to both primary and specialist health care services
- Increase the quality of care provided including the increased availability of single rooms and enhancing opportunities for social activities
- Standard of care which meet the national care standards

Chapter Six How We Will Do It?

This strategy sets out our commitments within Health, Social work and supported Housing to work together to improve the experience of older people who use services.
With an increased focus on support for most need, we need to use our resources to support people with the highest levels of need. There are some principles which will be integral to the successful delivery of this agenda

Partnership working

Integration and partnership is a key component to delivering this strategy. We recognise that where problems are complex, no one agency can tackle the problem or situation in isolation. An integrated service will ensure that older people can access this sort of service when they need it

Whole systems approach

The whole system approach puts older people at the centre of service delivery and planning. It considers services across organisational boundaries, and ensures clear assessment processes, access routes and pathways through different services. This approach will ensure that health, housing and social care work together in a single, integrated whole system

Involvement of older people and their carers

Communication with people who use services and their carers – and how they communicate with colleagues is a crucial part of services working well. Improving communication will be central to everything we do.
Patient focus public involvement mechanisms are already in place in Moray we will build on this by:

- Progressing our older peoples communication strategy
- Setting up an older peoples forum to oversee the implementation of the strategy

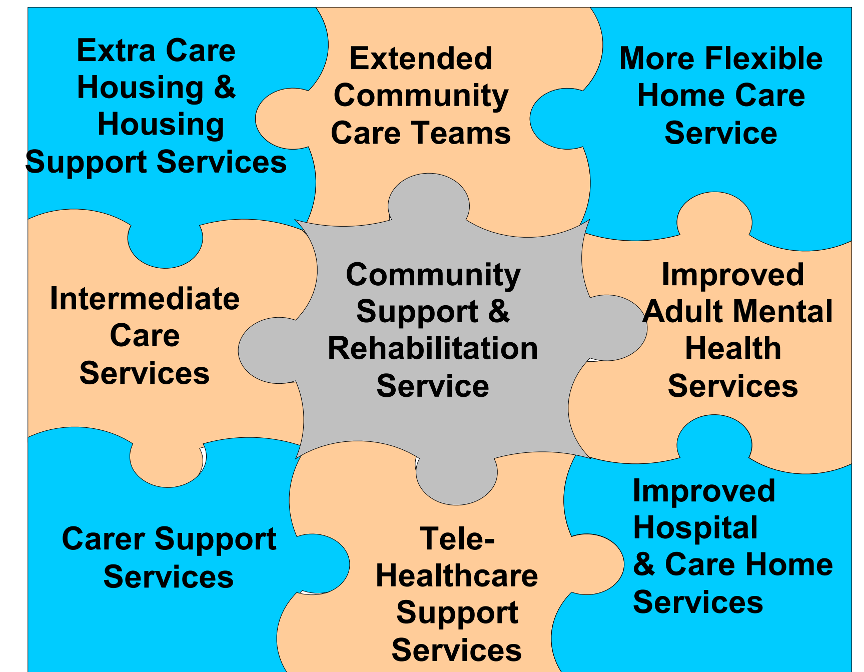
Communication

We recognise the need to provide improved information, advice and signposting to ensure easier access to service for older and their carers. This will be a priority as we look at how we organise our services differently.

Workforce Development

This strategy requires many changes in the way we work for staff. Moray also faces major challenges in recruiting and retaining staff and there is a continuing need to train and develop skills. Across health and social care, staff are our most valuable resource and without them the changes required will not happen, Supporting informal carers and volunteer and ensuring a flexible, well trained, motivated and highly valued workforce will be pivotal in the delivery of this strategy.
We aim to develop a workforce where there is no ageism and staff have the skills that meet the needs of older people and foster an enabling and rehabilitative approach. Our integrated workforce development plan will progress this.

Each theme introduced in this strategy is part of a jigsaw which when complete will result in a seamless, joined up service for older people in Moray which supports independence.



There will be an ongoing monitoring and evaluation process developed to ensure better services are provided and better outcomes delivered. Throughout the five year life of the strategy, we will be seeking the views of older people to ensure our actions meet the aspirations of older people in Moray to "Live Longer Living Better"

Your Chance to respond

What do you think about the Older Peoples Strategy?

Different published versions of Living Longer Living Better are available on Moray Council website and NHS website:

- Living Longer Living Better full document
- Living Longer Living Better summary document
- Living Longer Living Better implementation plan

These documents are also available in large print if required and can be translated

If you want to comment on any of the points in the strategy, you can respond in the following ways:

Write to Head of Community Care, MCHSCP, Spynie Hospital, Elgin, IV30 5PW

or

Telephone Sandra Gracie, Older People Strategy Project Officer 01343 567184

You can also:

Get involved in developing, improving and reviewing services during the implementation of the strategy by contacting

- Ann Griffin, Public Involvement Officer 01343 567140
- Sandra Gracie, Older Peoples Strategy project officer