ABERDEENSHIRE COMMUNITY PLANNING BOARD – 10 JUNE 2015

SOA FOCUS: OLDER PEOPLE and OLDER PEOPLE'S CHARTER MONITORING APPROACH

1 Recommendations:

1.1 Discuss the progress made by the Aberdeenshire Older People's Strategic Outcomes Group in delivering the outcomes set out in the Single Outcome Agreement.

1.2 Support activity by demonstrating how each partner is contributing towards the "older people" priority.

1.3 Challenge performance as part of the partnership's governance role to be satisfied that we are collectively doing as much as we can to improve outcomes, plan preventatively and join up resources.

1.4 Discuss and agree the proposed approach to monitoring of the Older People's Charter

2 Background / Discussion

2.1 During the previous year the Community Planning Board has dedicated time on its agenda to scrutinising the priorities set in the Single Outcome Agreement. At its meeting in September 2014, the Board agreed a forward programme of "support and challenge" of its priorities stretching through to summer 2015.

2.2 The template in appendix 1 has been completed by members of the multi-agency Aberdeenshire Older People's Strategic Outcomes Group and is framed around the themes of prevention, resources, place and performance.

2.3 Board members are asked to show how their organisation is contributing towards the long-term outcome "*Older people will live independent, healthier lives for longer in a homely environment, in a community which respects and values them, with informal carers who receive support to continue to care"* as well as the specific themes highlighted in the template.

2.4 In light of Community Planning Partnerships being held responsible for improving outcomes for each of their priority areas, Board members are encouraged to challenge progress to date.

Older People's Charter

2.5 In March 2014, the Community Planning Board agreed an Older People's Charter for Aberdeenshire. This can be viewed at appendix 2. The Board agreed to monitor the Charter on an annual basis.

2.6 The multi-agency “Your Voice” steering group, which coordinates the older people’s forums in Aberdeenshire, have proposed an approach to monitoring of the Charter which can be viewed in appendix 3. Board members are asked to comment on the proposed approach. Work will be done to collate information over the summer period and a monitoring report will be tabled at the September 2015 Board meeting.

3 Implications for Local Community Planning Groups and/or Consultation with Local Community Planning Groups

3.1 Local Community Planning Groups now have the opportunity to contribute to the report to inform of any issues under this priority. This would be included under the “Place” heading within the SOA priority reporting template.

4 Equalities, Staffing and Resource Implications

4.1 The agreement on joint resourcing and community planning partnerships published as part of the Scottish budget for 2014/15 places further emphasis on partners demonstrating how they can pool their shared resources – budgets, staff, buildings, information – to deliver improvements for their shared priorities.

4.2 This report does not require an equalities impact assessment because its recommendations do not have a differential impact on people with protected characteristics.

Bill Stokoe, Strategic Development Officer; Ed Garrett, Mearns and Coastal Helathy Living Network; and Erin Wood, Strategic Development Officer (Community Planning)

19 May 2015

SOA PRIORITY:
Older People
LEAD PARTNERSHIP:
Aberdeenshire Health and Social Care Partnership – Older Peoples Strategic Outcomes Group
PREVENTION – How is the partnership shifting towards preventative planning? Are resources being shifted?
Prevention and early intervention is a key theme of the Partnership's Joint Commissioning Strategy. The Partnership has been fortunate in being able to utilise the additional resources from the Change Fund to invest in prevention and anticipatory care between 2011 and 2015. 48.2% of the total investment in older people's services under the Change Fund addressed preventative and anticipatory care in 2014-15; 46.3% in 2013-14; 41.9% in 2012-13; and 49.4% in 2011-12. As observed elsewhere, due to the nature of investment in prevention, the impact may not be completely evident for some years to come. However, as in previous years, key projects have been invested in that are expected to have significant impact in building community capacity to support older people and prevent reliance on statutory health and social care services. In 2014-15 these projects included Aberdeenshire Signposting, a Grampian Walking Strategy linking health walks to mainstream walking groups, Befriending, building community links and networks in Insch, Mens Sheds Development, Shopping Services, Falls Screening and Prevention, developing early diagnostic and treatment services in GP practices, training GPs in dementia diagnosis, and investing in self-management of long-term conditions. Through the Integrated Care Fund in 2015-16, further investment is planned in developing capacity in communities (£380k), self-care and self–management (£250k), and carers support (£150k).
RESOURCES – To what extent is the partnership and its members jointly resourcing the shared outcomes?
The Change Fund, which has provided the Partnership with £12M over the last 4 years has now ceased. About 80 projects were funded from this source. A new Integrated Care Fund of £3.7M has been provided for 2015/16, which will continue for a further two years, into 2016-17, and 2017-18. A small number of Change Fund projects will continue to be funded for this financial year from this new Fund. Monitoring of all projects funded by the Integrated Care Fund will be the responsibility of the new Integrated Health & Social Care Partnership.

PLACE – To what extent is the partnership focussing on place? This will include reference to any issues raised by Local Community Planning Groups

In 2014-15 Aberdeenshire's Health and Social Care services started the integration process required by the Public Bodies (Joint Working) Scotland Act 2014. A public consultation was completed to facilitate the development of the Aberdeenshire Health and Social Care Partnership Integration Scheme, and local health and social care reference groups for each Aberdeenshire administrative area have commenced the process of joint planning to establish integrated health and social care teams for adults to improve the relationship and efficiency between health service and local authority social care services. The local reference groups include representation from local health and social care services, and the third sector, and link to community planning through the area managers and community planning officers.

In addition local community planning partnerships have started considering the impact of the recently published 'Community Empowerment bill' and enabling communities to participate in the process.

None the less "Ageing Well In Aberdeenshire", our joint commissioning strategy for older people 2013-2023, continues to set out how local care and health services will identify, prioritise and address the health and social care needs of our older population in the context of reshaping care towards greater self care and self management, and access to appropriate support in a rural environment. Older people have consistently told us of the importance of access within their local community. Future service re-design will have a strong locality focus where practicable and feasible. We will work closely with community planning partners to create a cohesive public sector network beyond our specific health and care aims, in matters such as transport, housing, regeneration, community support networks etc.

OPSOG, through the Co-Production Steering Group, continued in 2014-15 to use Change Fund money to support community groups and voluntary organisations to start up, extend or reshape activities that support older people to remain involved, and independent within resilient communities. Around 30 projects with a clear focus on early intervention and prevention, rehabilitation, enablement and improving choice in long term care settings have been supported. The most successful ones have extended funding to enable sustainability (Kincardine Befriending) or further roll out across the Shire (Men's Shed, Signposting project). The benefits and sustainability of these continue to be evaluated where possible. However, the nature of a co-producing approach means evidence of direct correlation between improvement and activity will require to be captured beyond the timeframe of the Change Fund, and key projects to build community capacity are being supported through the Integrated Care Fund in 2015-16.

PERFORMANCE – How is the partnership performing in delivering the outcomes set out in the Single Outcome Agreement?

	Indicator	Performance					Target			Comments
		2010/11	2011/12	2012/13	2013/14	2014/15 To end Q3	2013/14	2015/16	2022/23	
OP1	Number of bed days lost to delayed discharge *(JCS Joint Performance Framework)*	19,702	19,854	15,156	23,602	30,329	15,000	10,000	0	The increase in days lost is indicative of the problems associated with recruitment and retention of home care staff as well as increase in complexity of social circumstances of patients. A number of care homes have not been allowed to accept new clients due to embargo by Inspectors or the local authority

										(quality issues). Once embargo has lifted can only accept limited numbers each month resulting in more delays in hospital. Much work is ongoing to reduce the number of delayed discharges.
OP2	A measure of the balance of care split between spend on institutional and community based care *(SG National Change Fund Outcome Measure) (available for social care only)*	65%/35 %	63%/37%							
OP3	Percentage of time in the last 6 months of life spent at home or in a community setting *(SG National Change Fund Outcome Measure)*	94.6%	95.9%	94.7%	Not yet available	Not yet available				Data for 2013-14 not published until August 2015. It should be noted that Aberdeenshire consistently until 2013/14 has achieved the highest % of all Scottish Partnerships.

OP4	Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting *(SG National Change Fund Outcome Measure)*	97.1%	97.2%	97.2%	96.9%	96.8%		98%		Slight decline reflects increasing demographic and increase in care home placements.
OP5	Proportion of home care clients over 65 receiving 10 hrs+ of home care per week *(JCS Joint Performance Framework)*	18.7%	20.9%	23.7%	28.5%	29.4%	30%			Improving picture in spite of challenges in availability of care at home.
OP6	Proportion of home care clients over 65 receiving evening/overnight/weekend care *(JCS Joint Performance Framework)*	E/O 41.3% W 73%	58.3% 78.2%	61.8% 79.4%	63.9% 80.5%	E/O Not available Weekends = 80.3%		65% 83%		Evening and overnight data not available due to change in recording systems.
OP7	Number of people aged 75+ with a telecare package *(SG National Change Fund Outcome Measure)*	70	125	191	187	233		278		Staff awareness raising presentations are delivered regularly to ensure staff know of the potential for telecare and when to refer.
OP8	Number of very sheltered housing units *(JCS Joint Performance Framework)*	95	138	173	173	233				Development of new units underway
OP9	Rate of over 65s with two or more emergency admissions to acute	40.5	41.7	39.5	38.1	41.7		39.5		Over the last 2 years the target of 39.5 was achieved.

	specialities (per 1000 over 65)) *(HEAT target)*									There has been an increase in multiple admissions during 2014/15. This is being carefully monitored.
OP10	Emergency inpatient bed days rate for people over 75 (*SG National Change Fund Outcome Measure)*	5245	4834	4853	4500	4536		4628		The trend during 2014/15 is upwards and the target set has not been met. This is being carefully monitored. It should be acknowledged that there has been a substantial increase in the over 75 population.
OP11	Number of people aged 75+ living at home with anticipatory care plan shared *(SG National Change Fund Outcome Measure)*	155	290	500	2,194	1,500		1000		This continues to be part of the GP contract. Although the number of ACPs has increased substantially from the baseline of

										155, there are issues about the quality and the level of engagement with patients, families and carers since this was included in the GP contract. This is being pursued.
OP12	Proportion of older people discharged from re-ablement service to lower level of care *(SG National change Fund Outcome Measure*)	--	40%	60%	Not available	Not available		70%		Pilots ceased in Jan 2014. A new pathway is in development.
OP13	Number of people 65+ in receipt of self-directed support *(JCS Joint Performance Framework)*	43	45	55	135	169		10% yr increase		Implementation of Self Directed Support Act 2013 from April 2014 means this option is now offered to all service users
OP14	Rate of care home placements per 1000 population 75+ *(JCS Joint Performance Framework)*	58.1	66.3	65.7	66.3	69.5		2.5 reduction/yr		Increase reflecting demographic pressure. People continue to be placed at the right time, as

										lengths of stay decrease and average age on admission increases.
OP15	Rate of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall *(SG National change Fund Outcome Measure)*	19.5	25.0	24.4	24.1	41.1		20 per 1000		The Ambulance Service has changed the way falls are recorded several times so base line of 19.5 may not be accurate. It has not been possible to ascertain how many patients were admitted to a hospital bed or checked over in A & E and returned home.The early screener posts have stopped as funding from the Change Fund is no longer available.
OP16	Number of over 65's identified as at risk of falls *(JCS Joint Performance Framework)*	-	65	359	662	427		30% increase		The number of people identified as at risk of falls

										continues to increase in spite of the early screener posts having stopped
OP17	Number of short break weeks provided for carers of people 65+ with dementia *(JCS Joint Performance Framework)*	-	781.19weeks	961.84 weeks	1000 weeks	429.6				Under-reporting in 2014-15 due to changes in recording practices following implementation of SDS
OP18	Number of people 65+ using self directed support for respite *(JCS Joint Performance Framework)*	9	24	19	8	Not available		48		
OP19	Respite care (weeks) for older people per 1000 population *(SG National Change Fund Outcome Measure)*	96.3	96.8	94.6	101	57.8		104		Under-reporting in 2014-15 due to changes in recording practices following implementation of SDS
OP20	Number of people with dementia supported at home with telecare *(JCS Joint Performance Framework)*	51	55	74	71	86		118		
OP21	Prevalence rates for diagnosis of dementia (QOF)	73%	74.7%	74%	74%	Not available		75%		This is raw prevalence data per 100 patients (**all**

	(SG National Change Fund Outcome Measure)									**ages)** in GP practices.The rate for 2014/15 will not be available until end of August 2015.
OP22	Eligible home care and care home staff trained in dementia care	-	17.8%	39.4%	77%	Not available		75%		Training continues using Stirling University Best Practice in Dementia Care packs.
OP23	Waiting time between request for a housing adaptation, assessment of need and delivery of any required adaptation *(SG National Change Fund Outcome Measure)*			Referral to assessment 37 days Assessment to completion 196 days	Referral to assessment 49 days Assessment to completion 192 days	Referral to assessment 54 days Assessment to completion 227 days				Processes for Housing adaptations under review to streamline and harmonise processes

PERFORMANCE – How is the partnership performing in delivering the action plan set out in the Single Outcome Agreement?

See indicators above.

APPENDIX 2

Older People's Charter in Aberdeenshire

Introduction

Old age should be celebrated.

Older people must be respected for their experience, wisdom and values.

Older people should expect to be treated with dignity as individuals within the health and social care systems.

These are the beliefs at the heart of Aberdeenshire's 10 year Strategy for Older People, "Ageing Well in Aberdeenshire".

The vision of "Ageing Well in Aberdeenshire" is to optimise the independence and well-being of every older person in Aberdeenshire.

This Charter has come out of extensive engagement with older people. It outlines the principles and aims that will help us achieve our vision and put our beliefs into practice. It recognises the positive contributions made by older people in their communities as volunteers and leaders.

We, Aberdeenshire Council, NHS Grampian, voluntary organisations, local communities, and older people support this Charter. It contains a series of aspirations that can only be achieved by us all working together.

1. Having A Voice

Older people already have their say on issues which affect them. We will work together to ensure that older people have:

- Access to groups to represent their views
- Support with advocacy to get their voices heard
- Information about where to go to raise an issue

2. Information and advice

We recognise the importance of information and advice for older people and will work together to ensure this is as clear and accessible as possible:

- Information and advice about housing, health and care services, benefits and community activities
- Quick and accessible support with filling in forms
- Advice with arranging funerals
- Information about reliable tradespeople

3. Transport

Transport is crucial in accessing a range of services and activities. We will work together to support sustainable transport solutions for older people:

- Where possible help with transport to all medical appointments
- Available community transport to access services and activities, particularly during the evening and at night
- A range of options to access affordable transport, eg taxicard
- Services to be delivered as locally as possible to cut down on need for transport
- Better information about what transport is available

4. Residential accommodation

Older people are concerned about the cost of residential accommodation and the level of care they might receive. We will work together to ensure that:

- All care home staff have access to training
- Terms and conditions for staff are improved where possible
- There is good, available information about care homes
- There is improved interaction between care homes and the community, eg open days
- All care home staff to be able to communicate effectively with residents
- There is good food and appropriate activities

5. Day care

Day care is an important part of the lives of less able older people. We will work together to develop modern day services which meet the changing needs of today:

- Day care that is free or affordable
- Greater availability and greater frequency of day care
- More flexible day care

6. Living at home

We will work together to develop sustainable community solutions to enable older people to remain living at home for as long as possible:

- Affordable and reliable help with shopping, transport, cleaning, gardening, and small jobs around the house
- Affordable and accessible home care
- Home carers have adequate time to do their job properly
- Greater support with housing adaptations
- More support for older carers
- Opportunities for respite schemes
- Enhance support for residents of sheltered housing, with sheltered housing officers working with residents to build on existing support
- Opportunities for social contact, eg befriending schemes
- Affordable housing options in their own communities
- Morning check-up call service
- Emergency response from someone near at hand
- Clear information about sheltered housing
- Preparation for life transitions such as retirement

7. Communities

Many older people are active in their communities. We will work together to ensure communities provide a range of activities and services for older people, whilst recognising that volunteers have limits to what they can give:

- Safe communities to live in

- Community groups are able to plan ahead without worries over funding
- Access to support and advice for community groups when needed
- Help to recruit and support volunteers
- Support for community groups to develop
- Good information about sources of support for development
- Greater intergenerational involvement

8. Health

We will work together to ensure that older people have access to the highest levels of health care delivered as locally as possible:

- Easy, prompt access to health professional of choice
- Regular health screening
- Choice as to who to share information with about their health condition
- Treated with respect by all health staff and not to be patronised
- Listened to with empathy and understanding
- Easy access to chiropody / physiotherapy appointments
- Cleanliness and hygiene in hospital
- Good food in hospital
- Support with eating and drinking in hospital

Further information

If you want to find out more about national standards and the rights of older people, please visit www.nationalcarestandards.org

Appendix 3

Older People's Charter in Aberdeenshire

Plan for monitoring 2014/15

The Your Voice project developed and produced an Older People's Charter as part of its work with older people's forums in Aberdeenshire. The Charter was signed off by the Chair of the Aberdeenshire Community Planning Board in April 2014. The Board committed to responsibility for monitoring the Charter on an annual basis.

Partners involved on the Your Voice project will lead on the monitoring and feed back to the Community Planning Board at their meeting in September. There will be four parts to the monitoring process:

1. Feedback from older people's forums and other groups about their views on progress towards aspirations in the Charter. Views will be gathered from all ten Your Voice forums in Aberdeenshire. The Charter will also be discussed at the Age Scotland network event in June.

2. Details of actions that the older people's forums are taking in relation to the aspirations in the Charter

3. Feedback from other stakeholders on the Charter and progress towards its aspirations. The Charter will be taken to the Older People's Strategic Outcomes Group (OPSOG) for feedback.

4. Details of how the Charter relates to progress regarding other action plans, in particular the Older People's Action Plan