

West Lothian

Strategic Service Statement

Older People

1 April 2009 – 31 March 2012

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1. INTRODUCTION

This Strategic Service Statement for Older Peoples services and support has been produced by West Lothian Council Social Policy – Adults and Older Peoples' Services and has been informed by partnership work undertaken with joint strategic working groups across older people's services from West Lothian Council and NHS Lothian. This Service Statement has also been informed by key partners and stakeholders across Lothian and in the voluntary sector and private sector

This Strategic Service Statement aims to address the current and potential needs of people aged over 65 years living in West Lothian. Older people currently represent a significant proportion of the population and this is set to rise substantially over the next 10 years

By 2018 West Lothian is forecast to experience the highest rise (+64 per cent) in any local authority in Scotland in people aged 75 and over, with the second highest increase in those aged 60-74 (+45 per cent). By 2014 one in three people in West Lothian will be over the age of 50.

Demographic factors are predicted to have a significant impact on future service needs, design and priorities. More older people will live longer and are likely to be working longer. Advancements in medicine will continue to enable people to be active into older age. Future provision of care services for older people will focus more on a community-based service rather than hospital or long-term residential settings. In addition the number of working age adults is likely to decrease and it is anticipated that this will have a significant impact on the number of people who will be able to undertake caring roles within their families and/or communities

This Service Statement is driven largely by the knowledge and anticipated impact of this substantial growth in the ageing population across Scotland. There are now efforts to anticipate, plan and put in place services that will be fit for purpose, accessible, adequate and cost effective. Whilst this Service Statement focuses on older people, it should be noted that older people may have a range of needs and that some of these may be covered in other Service Statements such as those for people with dementia, learning disability, physical disability or mental health.

National strategic documents create the context and direction for strategic local service planning. The Government has produced a number of research and policy papers in the last few years relating to age and ageing. In March 2007 the Scottish Executive published a national strategic document for older people entitled "All Our Futures: Planning for a Scotland with an Ageing Population" The Government identified six priority areas for strategic action.

These are outlined fully in Appendix 1.

The key priorities for this service statement are

- a) to improve the health and quality of life of older people,
- b) to improve care, support and protection for those older people who need it and
- c) to improve opportunities for older people -to create more chances for older people to participate and to be involved in their communities

In addition the 'personalisation of support services', 'service re-design', 're-enablement and self-management' and 'citizen leadership' are key themes of *Changing Lives*, the 21st century social work review and of the NHS *Kerr Report* and *Delivering for Health*. Joint Improvement, the development of Managed Clinical/Care Networks and the move towards self-directed support, are setting new structures and challenges for local service planning and delivery

In line with the key national and local policy drivers the following key areas underpin this service plan

- ❖ **Shifting the Balance of Care**
- ❖ Building Community Capacity
- ❖ Use of Assistive Technology - Telecare and Telehealth
- ❖ Support and Partnership with Carers
- ❖ Personalisation – personalising care and budgets

This service statement will outline the key national and local policy drivers and requirements, the shape of current service delivery, areas where there is a need to rethink future design and delivery of services, how our customers can and do participate in the development of services and consequently our commissioning intentions for the next three years.

2. APPROACH AND CONTEXT

a) Approach

Following the publication of “Better Health Better Care” and in light of the new Single Outcome Agreement there has been a drive by the government to create a framework that would lead to measurable improvements in outcomes for service users and carers. This is often referred to as “shifting the balance of care” i.e. efforts being made by health, social care and housing to rehabilitate, re enable, care and support individuals and their families / carers in their own homes and communities.

The Scottish Governments’ Joint Improvement Team identified eight “High Impact Changes” to assist with the measurement of progress in this shift in the balance of care. They are

1. Maximizing care at home with carer support
2. Better integrated health and social care for those in need and at risk
3. Reduce avoidable unscheduled admission to hospital
4. Improve capacity and flow for scheduled care
5. Better use of non medical skills and services outside acute hospitals
6. Improve access to remote and rural populations
7. Improve palliative and end of life care
8. Better joint use of resources

The approach taken in this plan is to attempt to relate current services to these high impact changes, to review services, both provided and commissioned by the council, to establish what needs to stay the same, what needs to change and how this is to be achieved.

The Older Peoples Service Statement draws heavily on the activities associated with “shifting the balance of care”. This has been the cornerstone of local planning and development activities for many years and is well demonstrated in West Lothian by

- the review of the Care at Home Service in 2002
- the introduction of a range of assistive technologies in 2001 and
- the review and redesign of residential and Nursing Home provision through 2000/2001 which led to a reconfiguration of services offering less Care Home places and introducing a range of options with the new Housing with Care complexes.

b) Context: Defining the Service User Group

“Scotland's population is changing. Lower birth rates mean that numbers of younger people will fall, while numbers of older people will rise. Ageing is a personal, biological and demographic fact, and mass ageing - people surviving into their seventies, eighties and nineties - is the result of huge and successful shifts in society.”

All Our Futures 2007

This service statement will focus on those individuals who are 65 years and over. This age is chosen not because it marks the start of "old age" or because we think all people over this age are somehow similar, but because for many it is a point at which life circumstances start to change in ways that have implications for the future. For example, many people retire from paid employment. People take on caring responsibilities perhaps for the first time, for example for elderly relatives. People also gradually become more likely to develop long-term health conditions, such as diabetes and arthritis, which they may have to live with for many years.

Developing a service plan for older people at this juncture gives us the opportunity to do two things 1) endeavour to have in place adequate services to meet the health and social care needs of people aged 65 and over and 2) to encourage the uptake of health promotion advice, preventive and anticipatory care, -in a sense to build the individuals capacity to keep as well as possible and to draw on their own personal, social and community resources for as long is possible or practicable. For example if an individual receives and becomes familiar with the core package of assistive technology whilst in their 60's or early 70's there is every chance that the technology can be enhanced as that individuals needs increase resulting in an ability and capacity to maintain their independence as long as possible. The impact is double fold – those who can look after themselves do so safely and confidently whilst the health and social care agencies are able to target their often limited resources on those who have complex health and social care needs

c) Context: Estimating the number of older people

Scottish perspective

“In 1900, the average Scottish life expectancy was 40; in 2004, it was just over 74 for males and just over 79 for females.

By 2031 the number of people aged 50+ is projected to rise by 28% and the number aged 75+ is projected to increase by 75%”

West Lothian perspective

Over the coming years the population of West Lothian, which was **165,700 in 2006**, is predicted to rise by 5% by 2011, by 10% in 2017 and by **22%** by 2031 when the projected population will be **202,114**.

Over these years there will also be a continuing rise in the population aged over 75, which, when compared to the 2006 population will have risen by 18% by 2011, 78% by 2021 and by 146% in 2031 (**a rise from 8,300 in 2006 to 20,300 in 2031**).

By 2031 38% of people in West Lothian will be over 50.

Demographic factors are predicted to have a large impact on future service needs, level and priorities. Older people will live longer and are likely to be working longer. Advancements in medicine will continue to enable people to be active into older age. Future provision of care services for older people will focus more on a community-based service rather than hospital or long-term residential settings.

Projected Demographic Changes

Year	All ages	65+	%
2006	165,700	20,797	13%
2011	174,178	24,173	14%
2018	184,366	30,310	16%
2031	202,114	42,554	21%

All Persons	2006	2011	2018	2031
65-74	12,544	14,451	17,327	22,211
75-84	6,396	7,578	9,980	14,056
85+	1,857	2,144	3,003	6,287
All ages	20,797	24,173	30,310	42,554

All Persons	2006	2011	2018	2031
65-74	60%	60%	57%	52%
75-84	31%	31%	33%	33%
85+	9%	9%	10%	15%
All ages	100%	100%	100%	100%

(General Register Office for Scotland)

Projected changes will of course also result in a reduction in those of working age paying tax as well as a reduction in those able to take on a caring role.

3. STRATEGIC CONTENT

There has been a significant amount of legislation introduced in recent years both at a national Scottish level coming from the Scottish Parliament as well as coming from the UK Government.

The Government outlines the key policy directives in the following policy papers

- All our futures – Planning for a Scotland with an Ageing Population (2008)
- Adding life to Years – (2002)
- Partnership for Care – (2003)
- Better Outcomes for Older People – (2005)
- Building a Better Health Service Fit for the Future
- Joint Futures Unit Policies – Scottish Executive (2002 – 2006)
- Changing Lives (2005)
- Care 21 – the Future of Unpaid Care in Scotland (2006)
- Coordinated, Integrated and Fit for Purpose (2007)
- Adult Support and Protection (Scotland) Act (2007)

A number of common themes thread through these documents. Partnership working and a 'joined-up' approach to service planning have been promoted as part of the shifting the balance of care agenda which aims to support more people with long term conditions in their own communities. Multi-agency and multi-disciplinary team working is seen as an integral part of developing local services, care and support. There is a greater recognition of the essential role played by unpaid carers and of the need to engage with service users and carers as key partners. There is also an increasing emphasis on the personalisation of services with service users being more involved and having more control over their own care and support.

The range of national and local policy drivers outlined above indicates a high level of activity that recognises the current and future pace of change. There is a desire to focus on anticipating, planning and delivering services that are informed by service user and carer consultation and that will be accessible, fit for purpose and able to demonstrate best value.

Whilst the national and local policy drivers have come from a variety of sources and agencies, a number of common themes have emerged. These are:

- A focus on shifting the balance of care more towards community and home-based care
- A greater emphasis on personalised or individualised services and a move to increased service user/carer responsibility and control over their care and support provision
- A focus on the management of long-term conditions within local communities – this would include offering anticipatory care, support for self-management and a robust risk management and enablement framework

- A focus on rehabilitation and re-enablement to be delivered as locally as possible
- The maximisation of independence and capacity – including improving employment and social opportunities and reducing attitudinal and environmental barriers
- A greater emphasis on service user engagement and choice
- A recognition of carers as partners in care – including the need for carer training and support
- A greater emphasis on strategic planning and commissioning, joint and partnership working, integrated service delivery and robust performance monitoring, management and reporting
- A move towards outcomes focussed approaches and frameworks in service commissioning and delivery

Please refer to Appendix 2 for a full list of national and local policy drivers

4. KEY PRINCIPLES AND VALUES

West Lothian Community Health and Care Partnership believe the following principles are key to the planning, organisation and delivery of good outcomes for older people and people with physical disabilities. The following four principles resonate with the values and views of older people and people with physical disabilities.

- To be customer focused – organising services around the needs of service users and citizens.

West Lothian Outcome Agreement 2007.

“Older people and people with disabilities want to remain in their own homes whenever it is possible with customised support”

Better Outcomes for Older People 2006

- To provide more efficient and effective services – providing more streamlined services, which reduce bureaucracy.

West Lothian Outcome Agreement 2007.

“Services need to be shaped to meet those needs with in the context of flexibility and maximum choice, with out compromising quality or safety”

“Services should be realistic and sustainable in terms of resources and workability and should be jargon free and user- friendly”

Our Lives Our Way – Lothian Joint Physical and Complex disability Strategy

- To work with service users and ensure that people have the information and support to access services.

West Lothian Outcome Agreement 2007.

“As older people’s expectations for a better quality of life are increasing, individuals and their carers should be more involved more effectively in designing and commissioning joint services”

Better Outcomes for Older People 2006

- To provide local people with greater choice and influence over local decision making

West Lothian Outcome Agreement 2007.

“The voice of people who use services is included in planning”

Our Lives Our Way – Lothian Joint Physical and Complex disability Strategy

The previous chapter outlined the national and local policy framework and drivers for the future approach, design and delivery of outcomes for people in our communities. The key themes are

Active citizenship; all individuals have the same rights and responsibilities to contribute and participate in community life fully.

Social Inclusion; people with physical disability and older people should have the same rights and expectations of social inclusion. “Our Lives Our Way”- Lothians Joint Physical Disability and Complex Needs Strategy identifies that Inclusiveness should be a key corporate vision. It states that in order to achieve this services require to examine the attitudes of staff; the way agencies provide services, how agencies tell individuals about those services and how services can be made more accessible. Social inclusion is central to West Lothians CHCP’s vision.

Equity; services, facilities and opportunities should be available according to need on an equitable basis across West Lothian.

Equality/Diversity; services, facilities and opportunities should recognise and support differences from a person’s ethnic origin, disability, religion, gender or sexual orientation. Services should be sensitive to the needs of all individuals from minority ethnic groups.

Individuality and dignity; individuality and dignity should be fully respected wherever people need assistance in managing their lives. Individuals may make informed decisions about risks regarding their lives and circumstances, unless formal care and protection measures as defined in law are required.

Support for Carers; the needs of carers – in particular those providing high levels of care – should be fully recognised and supported.

Quality; services should be of good quality and have the full confidence and support of the people who use them.

Effective services; services should be soundly based on best current practices, be effective from the user’s perspective, and represent the best use of resources available.

Accountability and Transparency; services should be clearly accountable, operating within transparent policy and resource allocation.

Choices and Priorities; within the available resources, service choices and priorities should be based on the needs and preferences of older people, people with physical and complex needs and their carers.

5. SERVICE STATEMENT - TEN YEAR VISION

West Lothian Council has excelled in its approach to designing and delivering services with a difference for older people. However, in the context of a changing and challenging future, particularly in relation to the local demography, we recognise that there is no room for complacency.

We aim to ensure that Older People and their Carers

- Have the best possible quality of life
- Can remain living independently for as long as possible
- Have equality of access to universal services

These high level objectives cannot be achieved in isolation and West Lothian Council recognises that there will need to be a focus on communities and not simply on people with complex needs. Maintaining independence, promoting inclusion and well being and giving people more choice and control will all be central to improving outcomes for older people, bearing in mind that one of the overarching objectives is to shift the balance of care. A council wide focus therefore on;

- Improving Health
- Improving Quality of Life
- Making a Positive Contribution
- Having more Choice and Control
- Economic Well Being
- Personal Dignity

Will all prevent greater dependency on services and allow people to enjoy a better quality of life in ways that will be manageable given the financial and people resources, which will be available in future.

Achieving better outcomes for older people requires the further development of both universal and targeted services with the aim of reducing inequalities as a central objective in any strategic initiative.

The Council aims to do this in a number of ways but of key importance are;

- The Launch of a Council wide review of Older People's Services which aims to work in partnership with customers to agree and prioritise those universal services which will be of most value and achieve the optimum outcomes for the future
- A Commitment to the work of West Lothian Community Planning Partnership. Locality Planning is about making sure people and communities are genuinely engaged in the decisions made on public

services that affect them. This is linked to a commitment from public organisations to work together in providing better public services. It seeks to improve the connection between national priorities and those at regional local and neighbourhood levels. It focuses on disadvantaged and hard to reach citizens who tend to live in deprived areas by deploying multi-agency/partnership approach to identify need at a local level.

This plan sits within that wider context and aims to give clear messages to partners and stakeholders which will enable them to make good decisions about developing their services as well as indicating how we will be deploying resources over the next three years.

The three year plan aims to provide a strong foundation for the longer term vision for Older People in West Lothian. The key challenge is to make a significant contribution to changing the balance of care from group living either in hospitals or care homes to supporting a higher percentage of people at home. This will require different ways of thinking, innovation and close partnership working at all levels.

By definition, the services to which this plan refers are targeted to those who either temporarily or in the longer term have health and care needs. However, we will contribute significantly to the overall objectives by developing and delivering services, which promote independence and where both prevention and re-enablement have a higher profile

We will promote Direct Payments and Personal Direct Funding to offer Older People and their carers more choice and control but also re-design and develop services in such a way that choice and control are features regardless of who is directly purchasing the service.

Service developments over the next ten years will aim to

- Ensure that there is a focus on re-enablement
- Ensure that services have a preventive and anticipatory approach both in terms of promoting independence and in terms of more effective management of long term conditions
- Invest significantly in the development of creative alternatives to traditional services in a way that enhances quality of live and promotes independence
- Offer more choice and control for people who need services in the long term

In so doing, it is anticipated that we will contribute significantly to shifting the balance of care by;

- Reducing unscheduled admissions to both hospital and other care environments
- Increase the number of people as a proportion of the population who are living independently in their own homes
- Reduce the number of people who are dependent on case or care management
- Reduce the cultural and institutional barriers to Older People being fully involved and included in their communities.

6. THREE YEAR SERVICE PLAN

The commissioning intent for the next three years has been developed in the context of the 10-year vision described in the previous section and aims to provide a strong foundation for moving in that direction.

The Scottish Government has supported Local Authorities in achieving these objectives by the development of the Joint Improvement Team (JIT)

JIT is part of the Partnership Improvement and Outcomes Division within the Scottish Government's Health Directorates. The two key functions for the Division are performance measurement and management, and performance support and improvement

JIT aims to help partnerships across Scotland deliver the services that people want. They strongly believe that joint working between health, local authorities and the independent sector delivers better, faster, safer, closer services.

The JIT recently published as a result of their research to date, eight areas, which were identified as likely to result in high impact changes.

While West Lothian had already made significant progress in developing more innovative and community based services, this service statement focuses heavily on those change groupings, aligning developments and initiatives with a view to making transparent and measurable linkages with national strategies.

It is universally recognized that meaningful change needs to be based on a total system approach. This section is, on the whole, structured in terms of service areas, which enable us to offer resource information with more transparency. However, it is recognized that this is in some ways an artificial representation insofar as the services are inextricably linked. We will summarise our three year strategy in section seven but in this section will attempt to manage the tension between service outlines and themed activities by linking each service development or initiative to the eight areas of high impact change outlined in this section we will therefore outline all the services that can currently be accessed by older people in West Lothian.

Each category will describe service, how it is delivered and any initiatives and developments associated with the service

The categories are as follows

- **Assessment and Care Management** - this includes risk assessment and adult protection
- **Flexible Home Care and Carer Support**
- **Day Care and Short Breaks from Caring**
- **Self Directed Support and Direct Payments**
- **Occupational Therapy and Provision of Equipment / Adaptations**
- **Providing Telecare and Telehealth Support**
- **Mental Health**
- **Support for Carers**
- **Housing Options for Older People**
- **Residential Care Homes**

6.1 ASSESSMENT AND CARE MANAGEMENT

Service

Assessment, Care Planning, monitoring and review are central to the objectives of promoting independence and ensuring that services are responsive, targeted and appropriate

The Older Peoples Assessment and Care Management Teams are responsible for carrying out needs-led assessments for older people and for developing appropriate care and support plans as a response to identified need. The Team carries out the ongoing monitoring and review of care and support to older people providing a response to changing needs.

The Sensory Resource Centre (SRC), based at St. John's Hospital, provides a range of services and support for older people with sensory impairment. Services are both directly provided by the council and commissioned from specialist agencies. Assessments are completed for care, support, equipment and technical services.

A specialist palliative care social worker offers assessment and care management across all service user groups. This is a service for individuals, their carers and families who are in need of palliative and end of life care and support.

This worker liaises closely with other partners in the field of palliative and end of life care including the McMillan Centre in St John's Hospital, the Advice Shop and colleagues in Health.

Central to this process is the identification of carers needs collated either as an integral part of the service user assessment or as a *stand alone* assessment.

Effective care management requires a strong multidisciplinary approach and this has been observed to be a particular strength in West Lothian as evidenced by a range of independent reports and statutory inspections

Delivery.

The teams are located across three locations with one dedicated team in St. John's hospital. However, the nature of the service group combined with West Lothian's semi rural geography is such that most service is delivered almost exclusively on a visiting basis.

Referrals can be made by any member of the public or any other profession and we strive to ensure that there is equality of access by taking referrals via a number of different mediums.

In response to increasing demand, the Older People's team reviewed the skill mix in the assessment and care management team to ensure that the scarce skills of highly qualified professionals could be targeted to those complex interventions requiring that level of skill. The introduction of staff with a range of qualifications has enabled the older people's team to increase the number of staff and keep pace with demand. Recognising that staff with different care qualifications had a significant contribution to Assessment and Care Management processes and building on the recommendations of the 21st century review, we were able to introduce what the review would recognise as a 'para professional' role. This has contributed significantly not only to maintaining responsiveness but also to workforce development and planning.

These teams work in a complex environment where promoting independence will require an empowering approach to taking risks. The balance between taking risks and keeping people safe/protected from harm can be difficult to achieve but it will not be possible to encourage more

people to remain at home if there is a 'risk averse' approach in the organisational culture.

The UK agenda that is moving both health and social care services towards "Personalisation" emphasises an individuals' right of choice and independence. Across all services robust risk assessment and management practices must underpin these rights if vulnerable adults are to be helped to stay safe and be protected from harm.

While proportionate risk management is central to all care management processes, it's most complex level applies to statutory duties associated with Adult Support and Protection. West Lothian council along with its multiagency partners in Lothian and Borders Police Public Protection Unit in Bathgate and NHS Lothian comply with the Edinburgh Lothians and Borders Interagency Guidelines "Protecting Vulnerable Adults – ensuring rights and preventing abuse" (2003). In addition West Lothian council implemented an "Enhanced Adult Protection Guidance and Procedure" for social work practitioners and managers in 2006.

The Adult Support and Protection (Scotland) Act 2007 (ASPA) was introduced in October 2008 and in addition to creating a legislative framework for adult support and protection practice and procedures it has also introduced a requirement for each council to establish a multiagency Adult Protection Committee to overview and scrutinise strategy and performance in each local council partnership area.

Critical to the effective management of all the processes described above is an infrastructure, which allows the safe storage of information, which, with consent, can be shared across appropriate disciplines and agencies. West Lothian has developed and implemented a highly functional shared information system (e-care), which provides the capacity to build a whole person view for service users in West Lothian. This has and will continue to improve outcomes for older people in terms of reduction of duplication and supporting single shared assessment allowing faster access to services. It is worth noting that the JIT emphasise that local e-care support is central to placing an outcome focus at the centre of assessment and care management. (JIT – fourth bulletin on outcomes for community care, August 2008.)

Developments and Initiatives

i. Single Shared Assessment (SSA)

The SSA framework and assessment tool used in West Lothian is currently undergoing a complete review. The format for assessment is

being redesigned in order to improve information gathering and to enable relevant electronic reporting from the e-Care system. The new format will also incorporate the information requirements from IoRN. The aim is to also increase the use of the SSA framework by partners in health and housing.

ii, Joint Care Management

The National Training Framework for Care Management underpins the move towards enabling health and housing staff to take on the role of care manager. Care planning and service monitoring and review has been largely undertaken by social work staff up until now.

Joint Care Management processes and protocols are to be further developed and implemented across the partners.

iii Expert Assessment Tool

We are currently working with key partners to develop a 'safe at home' electronic assessment tool, based on the 'expert system', such that non specialist staff in the health, housing and social care sectors can accurately identify people who would benefit from telecare, occupational therapy and falls prevention services or equipment.

iv. Adult Support and Protection

- The appointment of a multiagency post to support the activities of the APC and multiagency operational supports and developments. Funding from ASPA Local Authority allocation for implementation.

- The appointment of an additional .5 admin support funding from Adult Support and Protection (Scotland) Act 2007 Local Authority allocation for Implementation.

- Review and delivery of ASPA multi-agency training program.

- Consideration of how best to access expertise in relation to systems of support for people at risk of financial exploitation.

- Review of the Appropriate Adults Scheme.

- As part of a review of Advocacy Services consider how best to ensure availability of Advocacy to "Adults at Risk Performance Measures.

6.2 FLEXIBLE HOME CARE AND CARER SUPPORT

Service

The personal care at home service works closely with community health services to support people with care needs to remain living independently in their own homes. This service is targeted increasingly to people with complex health and care needs and a range of service developments *have resulted in a significant impact on changing the balance of care. For example:*

- *While the average number of care hours per person have increased by 20% since 2003, the number of service users has remained relatively static - a strong indicator that we are meeting the service aims in terms of supporting increasingly complex care (WLC Caremaster)*
- *The average length of time in a care home has decreased from 36 months to 12 months – again a strong indicator that people are being maintained at home for longer periods (WLC Commitment System)*
- *Consistently reducing the number of Delayed Discharges, ensuring that people are discharged safely but with a focus on maximising independence (ISD Scottish Gov.)*

A strong emphasis on both service re-design and partnership with valued independent providers has resulted in West Lothian enjoying one of the most efficient and responsive personal care services in Scotland. Services are delivered seven days a week between the hours of 7.30 a.m. and 10.00 p.m. and are therefore capable of offering customer choice in terms of time and pattern of delivery.

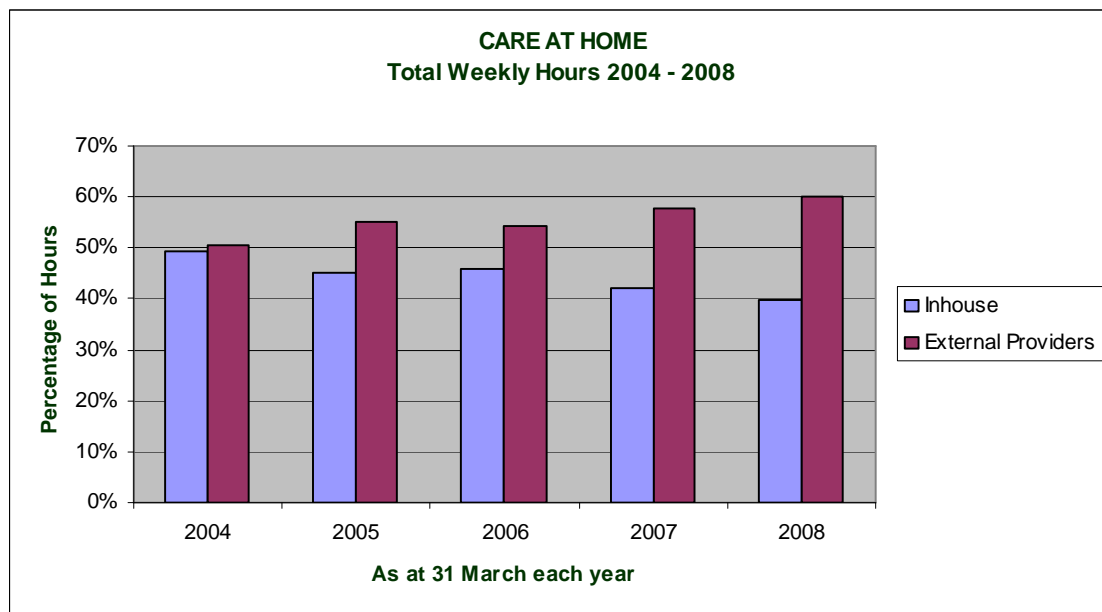
These service developments have required significant investment in training for personal care workers in all sectors and their skills are increasingly focussed on delivering complex personal care interventions. To support this focus, West Lothian has been committed to developing a range of creative and innovative services, which compliment the personal care service and maximise independence, e.g.

- Development of an alternative meals service
- Developing a home shopping service
- Care and Repair, equipment to assist activities of daily living and house adaptations
- Dedicated teams to support discharge and offer intensive re-enablement services promoting independence and reducing reliance on personal care interventions
- Developing innovative telecare solutions which complement personal care services

Delivery

West Lothian has developed a rich 'mixed economy' of provision with a purchasing strategy which has aimed to manage the sometimes difficult tensions around an 'open market' v continuity/quality of care and business stability. This has resulted in a range of contractual agreements, which balance the need to support existing providers to invest in service development and improvements while also leaving market capacity for new providers to build a business base in our community.

In recognition of the increasingly significant contribution of the independent sector, West Lothian council's purchasing strategy in the past five years has been almost exclusively targeted at growth of the independent sector. West Lothian Council's in house service now provides 40% of the total business with the other 60% being shared across a range of providers as below



Source; West Lothian Council, Caremaster

West Lothian Council is committed to retaining an in-house service but recognising the associated cost premium, the business plan has been increasingly to focus on specialist tasks such as:

- Crisis intervention
- Re-enablement
- Hospital Discharge
- Reaching remote geographical locations

In the next three years we will continue to develop and support in-house staff to develop these specialist skills and services but we will also transfer resources on an incremental basis to the independent sector that has a good track record of delivering robust mainstream services for people who have complex needs.

We will continue to support and promote Personal Direct Funding to maximise choice and independence. As demand requires, resources will be diverted from the purchase of more traditional services to support this.

Developments and Initiatives

West Lothian Council is committed to making a further significant impact on shifting the balance of care. We will do this in a number of ways but in terms of Care at Home, we want to improve services specifically in relation to:

- Support to Carers
- Crisis Response and Overnight Care
- Falls Prevention and Response
- Avoidance of Hospital Admission

Our three key developments and initiatives will therefore be:

1. The development of an Assisted Care and Technology Service (ACTS) in Partnership with Health, which will be expected to respond to emergencies over a 24-hour period and provide
 - Initial assessment of service user need for an emergency service (0-5 days)
 - Risk assessment including the use of a housing with care flat as a means of keeping people safe temporarily
 - Comprehensive multi-disciplinary assessment and fast track to appropriate specialist services including falls prevention, medical review, re-enablement and assistive technology
 - Respite service to designated key holders at times of holiday and illness
 - Check visits during the night

The team as a whole will comprise a diverse range of staff including a Falls Co-ordinator funded via the NHS Falls Prevention Programme.

2. We will work with Health to support the action plan for long term conditions, promoting self managed and anticipatory care with a view to improving quality of life and reducing emergency hospital admissions. The development of telecare and remote healthcare will be central to the service redesign process, which aims to maximise independence.
3. We will, over the next three years, continue to monitor and review contracts relating to care at home. This work will be supported by the Single Outcome agreement, which allows a more creative approach to developing the capacity of services previously constrained by ring fenced funding streams.

6.3 RESPITE AND SHORT BREAKS FROM CARING (INCLUDING DAY CARE)

Service

Short breaks from Caring are acknowledged as key pillars of integrated services which will support the shift in the balance of care from residential to community based services. Short breaks from caring are available in a variety of ways and can vary in length from a few hours at home to several weeks in a care home.

Delivery

- **Day Care**

Day Care as it is currently constituted is accessed through assessment for this particular provision and is to enable individuals to be supported in the community. There are a range of providers, by far the largest being the voluntary sector but with some provision delivered by West Lothian Council and a specialist dementia service via a Housing Association. All providers offer a service where trained staff provide comfortable and stimulating environments with healthy meal provision and transport to and from the centre.

- **Short breaks at Home;**

Short breaks from caring at home are currently commissioned almost exclusively via the voluntary sector who also fund raise to offer extended services. Trained carers visit the service user at home up to two times per week, offering support and social contact, leaving the carer free to get out of the house for a few hours

- **Residential Respite**

Contractual arrangements are in place offering a service to those with an assessed need, providing respite to informal carers. This is in circumstances where the cared for person is unable to remain at home alone for short periods or requires constant supervision at least during waking hours. Opportunities for short breaks away from the home are available in both housing with care and care homes. Again, there are a range of providers including the independent sector

Developments and Initiatives

- **Day Care**

Over the next three years we will be seeking to redesign day care services in line with national strategic direction, which will include an emphasis on individual and community capacity building. The themes in terms of service re-design will be:

- Community inclusion – working with colleagues in other service areas to promote additional opportunities for older people to engage in universal services delivered more locally
- Integration – diverting existing resources to work with individuals to promote independence and support them to find ways of re-integrating with communities from which they have become isolated
- Seeking to deliver services more locally
- Seeking opportunities to invest in additional specialist services for dementia
- Targeting centre based care on those with high levels of care needs
- Seeking agreement with all providers on a more streamlined, transparent and targeted access system
- Considering in partnership with Health what opportunities might exist to further integrate services

- **Short Breaks from Caring**

West Lothian Council recognises that the development of short breaks from Caring will be crucial in terms of supporting carers to continue in their role in a way, which does not impact adversely on their physical and mental health.

We have described in previous chapters a range of service developments, which aim both to keep people safe and also reduce the stress on informal carers. These can be summarised as:

- the development of a range of telecare options which will have an emphasis on prevention, remote monitoring and reducing social isolation
- the development of an assisted care and technology service which will offer crisis responses including enhanced overnight care on a visiting basis for short periods of time

The emphasis on preventive services as a strategy for reducing stress on informal carers in the long terms cannot be overstated if in the context of demographic changes we are to enhance the services which are targeted on very complex needs and caring situations.

However, for those complex needs, the council recognises that there is an urgent need to find additional investment to re-design and expand services, which will offer short breaks from caring in ways which are more flexible, appropriate and responsive.

A particular need is identified for those people whose needs cannot easily be met by scheduled services and this will include people with dementia.

The future role of respite in care homes will be kept under review in the context both of demand and of the impact of service developments that support people in their own homes.

6.4 SELF-DIRECTED SUPPORT AND DIRECT PAYMENTS

Service

Since the Community Care (Direct Payment) Act (1996), local authorities have been allowed to make payments directly people eligible for a community care service to employ their own personal assistants or buy care directly from an independent provider and in 1997, West Lothian Council was one of the first Scottish Councils to set up a Direct Payments Scheme. The range of people eligible to receive direct payments has grown since then and the West Lothian Scheme has been reviewed and amended to reflect these changes.

Recipients can use a direct payment to buy support for personal care, daytime activities, respite care and temporary adaptations and equipment. The only community care service that cannot be funded by a direct payment is permanent residential care.

Service users and carers are given the opportunity to consider whether they would wish to receive a direct payment instead of direct service provision at the point of assessment and developing the care and support plan.

Delivery

The Social Policy Older People's Assessment and Care Management Teams carry out assessments and arrange and monitor direct payments for older people.

West Lothian Council has recognised that becoming an employer can be a daunting prospect for people even if they are keen to have the flexibility and control over their own care delivery that direct payments can offer. Therefore, West Lothian Council commissions and funds training and support services from the Lothian Centre for Independent Living which include preparing and supporting people as they take on the role of an employer; supporting people as they recruit and hire personal assistants; a training programme for recipients of direct payments and ongoing information, advice and support in managing a direct payment.

There has been ongoing promotion of the availability of Direct Payments and a range of information leaflets have been produced and distributed to inform potential service users and carers of this service option.

Developments and Initiatives

The national policy agenda of shifting the balance of care and the management of long-term conditions within local communities will clearly

require the increased personalisation of services and the recent Scottish Government revised guidance on self directed support endorses this.

Despite the availability of Direct Payments as an alternative to direct service provision, the take up in West Lothian has been limited. It is anticipated that this situation will change and that there will be a growing demand for Direct Payments and personalised care. There are no extra resources attached to the introduction of the new guidance with the government expecting that the move to a greater level of self-directed support will be funded from service re-design. However, many service users and carers are likely to opt for direct service provision and the challenge will be for the Council and key partners to manage these competing demands and the transition into alternative forms of service delivery.

Service users and carers who choose Direct Payments will require a range of supports to manage these including training on becoming an employer, recruitment issues, financial management etc. The Council has commissioned additional services from a local support organisation in the voluntary sector to provide these services and we will continue to work with this organisation as we develop our self-directed support opportunities. This is in line with the new Guidance and government policy.

Service pressures and developments in the area of self-directed support include:

- Revision of the West Lothian Direct Payments policy, guidance and procedures in line with the new national guidance for Self-Directed Support published in 2007. (Funded by Social Policy)
- Staff training on the revised guidance and procedures
- Strategies for freeing up resources from within existing services
- Provision of service user and carer training and support to manage a Direct Payment
- Commissioning of services to deliver the training and support to service users and carers
- Information and promotion of self directed support services

6.5. OCCUPATIONAL THERAPY, EQUIPMENT AND ADAPTATIONS SERVICES

6.5.1 Community Occupational Therapy (OT)

Central to the multidisciplinary care teams, Occupational Therapists offer specialist input to promoting independence by:

- Assessment of everyday tasks and the environment through activity analyses to find the most suitable means of maintaining that person in the community.
- Offering advice and professional guidance on how to carry out particular tasks differently
- The provision of equipment to improve independence with day to day tasks
- Recommending alternations to make facilities more accessible
- Practice to promote confidence, ability and independence
- Getting support and advice from other agencies

OT Services are offered by both community and hospital based staff and are delivered to people who have a temporary or permanent physical, mental or learning difficulty and there is an established commitment from both health and council staff working in partnership to deliver OT and rehabilitation services. This has successfully seen a reduction in duplicated work, with processes in place allowing Council and NHS staff access to Community equipment store disability equipment. A recent survey evidences a streamlined approach with appropriate use of each areas specialist skills This multi-agency approach to service delivery is underpinned by the more recent development of joint service objectives and by joint staff training and development

Work with Housing Partners, WLC Grants Section and Care and Repair forms a significant part of community OT service delivery, supporting people by making their home more accessible.

Delivery

Occupational Therapists provide a generic service and are based across two West Lothian Social Work offices. Key areas of priority for older people would be:

- Facilitating hospital discharge and contributing to zero delayed discharges
- Helping to prevent hospitalisation
- Supporting people with long term conditions to remain at home
- Reducing the risk of falls

For further information visit:

http://www.westlothian.gov.uk/media/downloadoc/1799563/ot_services

We aim to offer a seamless and responsive service and provide:

- a range of small equipment and adaptations without the need for an assessment (the Occupational Therapy Self Selection service). The service can be accessed directly by the public or by other professionals working with a service user. This simple, successful scheme has been in operation since 2000 and contributes significantly to reducing risk at home with everyday tasks. In a recent survey to users of this Service (December 2008), 24% of respondents requested a handrail following a fall and 66% requested a handrail to help prevent a fall.
- Occupational Therapists offer specialist professional advice on a range of equipment which without that specialist professional assessment might generate a risk either to the service user or to their carer. Examples would be equipment for getting in and out of bed and specialist shower chairs.
- Large equipment and adaptations can be recommended following assessment, such as showers, stair lifts or ramps. The Occupational Therapist can arrange the provision with the housing provider or with the house owner using Home Improvement Grant funding.

6.5.2 Community Equipment Store (CES)

The CES is a joint service provided by NHS Lothian and West Lothian Council Social Policy. The CES provides a wide range of equipment and specialist items which are issued, usually on loan for as long as they are required, to service users following an assessment of their needs and/or the needs of their carers. Equipment ranges from simple items such as dressing aids to specialist beds, seating and hoists. The aim of the equipment service is to enable people to remain living within their own home as independently as possible for as long as possible.

The CES also arranges the scheduled delivery of continence products across West Lothian and has a highly sophisticated and effective cleaning and refurbishment facility

Staff at the CES provide advice by telephone and at the point of installation for equipment users.

Delivery

Based centrally in St John's Hospital the store is ideally suited to delivering services across West Lothian and is an early example of single shared assessment in practice where a range of equipment can be accessed across service boundaries. Some equipment will still require the specialist input of a particular profession but this is well documented in joint agreements with NHS and Council staff.

Shared staffing and premises allow both the Council and Health to deliver services more cost effectively. For example, in addition to servicing the Self Selection Service for equipment delivery, the CES arranges the scheduled delivery of continence products across West Lothian. We will also soon localise the delivery of continence and urology products to care homes in the independent sector ensuring that local partners can enjoy the same high standard of service delivery.

Committed to efficiency and responsiveness the CES has a strong record of continuous improvement in relation to:

- Delivery and response times (82% of deliveries within 5 days)
- Cleaning and repair service allowing a higher percentage of reissue
- Using IT to ensure the best use of skilled people resources

6.5.3 Developments and Initiatives

Occupational Therapy and Community Equipment Store

- Equipment and Adaptations Guidance, draft published by Scottish Government, 3 December 2008, recommends standards for how best to deliver the occupational therapy service and equipment provision. Areas not already of the required standard in West Lothian will be improved with partners in social policy, housing and NHS and implemented by staff.
- The Housing Scotland Act 2007, with Scheme of Assistance is to be introduced April 2009 and will replace the existing Home Improvement Grant scheme. Occupational therapy will work with partners in Housing to develop West Lothian guidance to assist with the provision of disability adaptations for owner-occupier households

- We will work with Housing Allocations to make best use of adapted Council housing stock and in assisting with allocating suitable housing to disabled applicants.
- Improved stock control and re-cycling of equipment will help to meet increased demand. The range of occupational therapy equipment and eligibility is regularly reviewed, in consultation with service users – this has allowed us to continue to target those in greatest need without any increase in budgetary provision over the last four years
- Localising the supply and delivery of continence and urology products to independent care homes in West Lothian, ensures all partners benefit from the same high standard of service delivery.
- Recent completion of GPRS hand held devices project allows equipment delivery drivers in the field to update requisitioners on progress of deliveries. Updates will be made direct to requisitioners' PCs
- There has been a recent review of the equipment range provided for hearing impaired service users, in consultation with Deaf Action ensuring best value for service users.

6.6 PROVIDING TELECARE AND TELEHEALTH SUPPORT

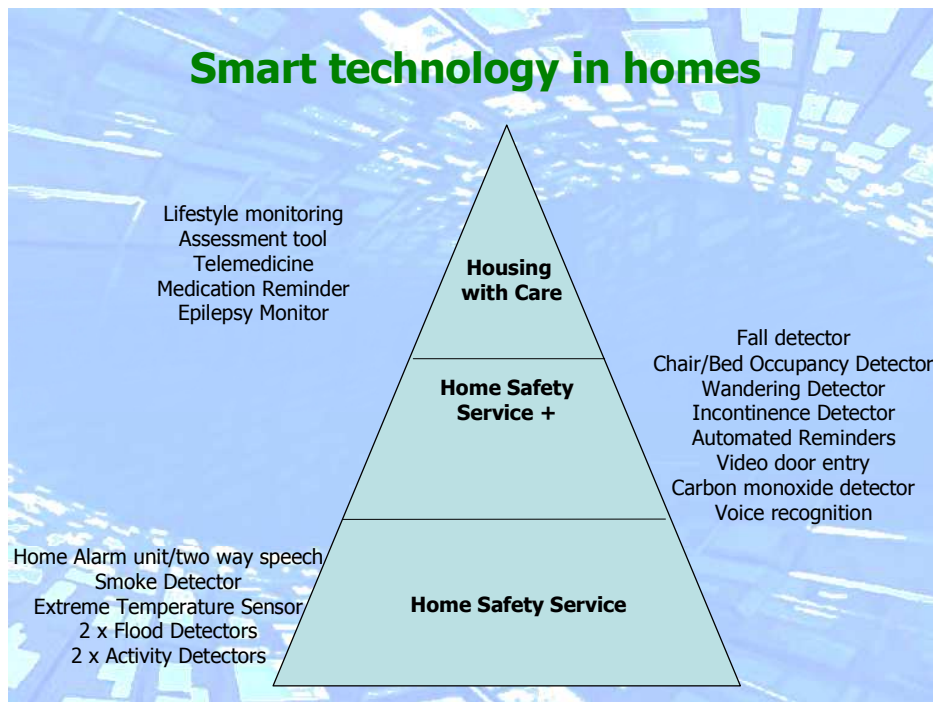
The Service

Ensuring that people feel safe, promoting independence and improving health and wellbeing are central to Older People's service aims. Achieving this requires innovative and creative thinking, which will enable us to focus on prevention, ultimately reducing the need for more extensive services as well as improving quality of life.

The Joint Improvement team describe telecare as; the remote or enhanced delivery of services to people in their own home by means of telecommunications and computerised systems. It offers the prospect of preventative care services that maintain vulnerable people in the community with increased independence and at lower overall service cost.

West Lothian Council has invested heavily both in the development and provision of innovative telecare solutions which will achieve these aims at three different levels:

- Promoting and sustaining independence for those people with low levels of need
- Complimenting personal care services by offering more effective personal and home safety monitoring mechanisms, including improved response to emergencies such as falls
- Improved care management for those with chronic long terms condition



The above diagram depicts how technology can be targeted and adjusted over time as necessary to meet changing levels of need enabling the individual to maintain their independence. The home safety services being appropriate for the lower levels of need, with progression to housing with care if needs become greater.

An independent evaluation of the service concluded;

- The overwhelming user response to the technology has been positive, with users reporting an increased sense of personal safety and security
- Informal Carers report increased peace of mind
- Weekly costs of telecare based care service provision were around £145 - £185 less per week than a West Lothian Care Home Provision

[Bowes, A and Mc Colgan, G (2006) Smart Technology and community care for older people; Innovation in West Lothian, Scotland, Edinburgh, Age Concern Scotland]

Delivery

To date West Lothian Council currently has installed 3,200 households (serving 4,500 people) in the community with the Home Safety Service. Both the core and the enhanced services are customised to accommodate individual lifestyles with variable parameters depending on identified need. The service is supported by a dedicated call centre and response service with links either to informal carers or formal services to ensure a robust response system.

The telecare strategy has contributed to all of the following

- Maintenance of zero delayed discharges
- Reducing average length of stay in a care home
- Delivering an average response time to falls of 22 minutes (for those who have Careline) against a Scottish average of 4 hours

Telecare also supports the capacity building philosophy underpinning the Housing with Care model where people with complex needs can live in an independent tenancy in a supported housing complex with a dedicated call service and support team.

West Lothian Council will commit significant financial resources to continue to expand the service user base to benefit from Home Safety Initiatives. We have already included in the financial forecast a commitment of 480 new service users for each year over the next three years.

Developments and Initiatives

It is important to emphasise that technology is used to support personal care services and not replace them. Delivering better outcomes requires efficient and effective mechanisms for collating and communicating key information. Our key objectives in this respect can be summarised as:

- Improving service experience at the points of contact, assessment and service delivery
- Maximising needs within available resources
- Equipping the staff people come in contact with, with the best information and backup that we can provide
- Making the end result for people as quick and as comprehensive as we can make it

We are confident that the following developments will deliver on some or all of these objectives within the next three years.

- the development of a 24 hour crisis response service one of the key features being to fast track installation of Home Safety Service for people at risk of falls followed by a comprehensive multi-disciplinary assessment and care plan aimed at preventing further falls and related injuries
- working in partnership with health to pilot telehealth with a view to improving the management of long term conditions
- Investing in the development of a new assessment tool based on an 'expert system' approach, such that non specialist staff in the health housing and social care sectors can accurately identify people who would benefit from telecare, occupational therapy/equipment and falls prevention services
- identify a core package of telecare monitoring equipment for older people with dementia (see also dementia service statement)

Other initiatives may not be deliverable within a three year time frame but we will continue to be committed to investing our time and expertise in working with key partners to harness different technologies to work together to add greater value to the experience of the service users. Examples would be:

- whether there is a technological solution which will allow people with dementia to have maximum freedom of movement within safe parameters but also alerting carers to potential risks
- whether a range of technologies could be channelled through a 'set top box' to offer a more streamlined, customised and holistic service to promote independence

6.7 MENTAL HEALTH

In relation to mental health it is often only dementia that is associated with older people, but older people, as with any age group, can have mental disorders and / or be affected by a whole range of mental health problems.

Current research and development highlight three key areas

1. The prevalence and impact of depression and anxiety in older years
2. A shift towards focusing on the promotion, prevention and support as outlined in 'Towards a Mentally Flourishing Scotland'

3. Social Inclusion – the recognition that being actively involved with your family / neighbourhood / community can have a positive impact on an individuals mental health and wellbeing (See Appendix 3)

Depression in Older People is of particular concern – it affects approximately 10 to 15% of people over 65 years of age with severe depression affecting approximately 3 to 5% of older adults. Older people have the highest suicide risk across all age groups with older men most at risk of suicide.

There is an increased likelihood of depression in older people through the loss of a good support network, death of a spouse, poor physical health, loss of independence and financial difficulties.

Age Concern is due to publish a national strategy to raise awareness about depression in older people

Service and Delivery

The mental health of older people affects every service and improvements in the preventative agenda will require effective linkages both within Social Policy and across a range of wider Council Services. Influences on mental health and well being in later life include:

- Discrimination
- Participation in meaningful activity
- Relationships
- Physical Health
- Poverty

There are a range of known protective factors for good mental health and well being and the Scottish Development Centre for Mental Health suggests that it can be useful to consider three levels; Life and Coping Skills, Social Support, Access to resources and services (including access to mainstream services).

Specific social policy activities, which have and will support this agenda include:

- A robust income maximization process for all service users subject to financial assessment
- A programme of awareness training for staff in West Lothian Residential Care homes, 2008
- A range of Healthy living activities being developed and promoted by the Health Improvement team – these range from healthy eating to promoting and supporting physical activity
- West Lothian Care Home network – supporting and promoting increased physical activities in care homes

- The implementation of participation strategies across significant service areas

In addition to promoting more preventive approaches to maintaining positive mental health, West Lothian Council provides a specialist Care Home for people with severe and enduring mental health problems. Currently 20 placements are dedicated to this service user group although the demand will be kept under review.

Sadly, the degree and severity of mental health problems will for some people result in either temporary or permanent incapacity to make major life decisions and a range of support is required. The service aim will always continue to be to maximize independence and to minimize, where possible, any compulsory interventions. Where compulsory intervention is required, this must be the least intrusive and there must be demonstrable benefit to the service user. These decisions are complex and must always be underpinned with an understanding of basic human rights. West Lothian Council has a well-established specialist Mental Health team who support these complex decisions and ensure that the Council is appropriately executing the range of duties and responsibilities outlined in a range of legislation relating to adults with incapacity, but primarily the Adults with Incapacity (Scotland) Act, 2000.

Fundamental to ensuring that the rights and wishes of people are respected, even where they lack capacity, is the availability of independent advocacy services. This council commissions this service with a voluntary organization the priority group being people in hospital assessed as needing a care home placement.

Service Developments and Initiatives

The contribution of this service area to the promotion of good mental health needs to be seen in the context of wider council initiatives. This will include

- The corporate review of older peoples services
- Contribution to and maximizing the services available via social policy's Health Improvement team.
- The outcomes associated with the life stage planning model to reduce health inequalities

Partnership working across service areas will be key to achieving the aims of building individual and community capacity and the older peoples service in social policy will be fully engaged in this process. Of particular importance will be

the review of day care services and how we link with other service areas to develop and promote access to universal services.

Developments specific to this service area are:

- Review of advocacy services
- Over the next three years, there will be further moves with partners to shift the balance of care to the community. Lothian NHS Board is proposing to relocate hospital-based services into the community, and reinforce rehabilitation supports.
- A clearer targeting of housing and personal care services on adults with medium and high level needs, combined with a wider corporate approach on the “Inclusion in Mind” agenda, to enable widespread access and participation of adults with a mental disorder in mainstream services will help to ensure best use of limited resources in the medium to long term.
- Ensuring that staff are appropriately trained to recognise and respond to signs and symptoms of depression

6.8 SUPPORTS FOR CARERS

Service and Delivery

Unpaid carers make up the largest group of care providers in Scotland, making an enormous contribution to society, and there is an ever increasing recognition of the role unpaid carers play and its economic implications. Supporting carers is central to the health and social care agenda.

The Future of Unpaid Care in Scotland Report made 22 recommendations creating a ten-year agenda for valuing and supporting carers. The Scottish (Executive) Government response, whilst accepting the recommendations as a whole, identified four priority areas for public service providers and their partners to focus on. These priorities are better support for young carers, improved provision of respite services and short breaks from caring, safeguarding the health of carers and carer training to develop the knowledge and skills to support them in their caring role.

Based on the 2001 census, there are 15,147 carers in West Lothian (9.5% of the population) with 3,794 carers providing 50 or more hours a week of unpaid care. It is clear that the development and delivery of services and support for carers will not only benefit those they are caring for by enabling them to remain living at home for longer but will also benefit service providers who would otherwise be attempting to meet people’s care needs in their entirety.

Ensuring that unpaid carers are identified and supported to enable them to continue in their caring role for as long as they would wish to do so has been a key challenge. The growing awareness of the impact of caring on carers' health along with a recognition of the essential role unpaid carers play in reducing dependence on formal service provision and preventing admission to long term care has led to developments in carer services and support.

In West Lothian, carers are now seen as key partners in the planning and delivery of care and there have been a range of initiatives developed to support unpaid carers and to work collaboratively with them to develop and deliver the services and supports available to those they care for. In addition, work has been done with local medical practices to encourage the earlier identification and referral of patients who also have a caring role. The aim is to promote carers' health by enabling earlier intervention and support and thereby reducing or preventing situations reaching crisis point before support is accessed.

Services and support for carers includes:

Carers' Assessments

A Carers' Assessment Framework and assessment tool has been developed and implemented along with practice guidance for staff. Staff and carer monitoring and evaluation forms have been introduced to ensure that staff are offering carers' assessments to carers and feedback is regularly analysed.

There has been an active promotional campaign to highlight entitlement to carers' assessments with almost 200,000 leaflets being developed and distributed across West Lothian in partnership with health and the independent sector.

There has been a steady increase in the numbers of assessments being completed and the aim is to show continued progress in this area.

Carers of West Lothian

The independent sector organisation, Carers of West Lothian, has been integrated into the CHCP Centre at Strathbrock. West Lothian Council is a key funder of the organisation and remains committed to continuing to be so. There is an established relationship of co-operation and collaboration between the agencies that has created an ethos of partnership working when addressing carer issues and there

is an ongoing commitment to continued joint working to support carers and take the carer agenda forward.

The range of services and support offered by Carers of West Lothian has expanded and includes:

- Information and advice
- Carer Support Groups
- Carer Training Programmes on a range of needs and topics
- Carer Support Workers
- Young Carer Support Worker
- Hospital Discharge Carer Support Worker
- Support to establish 'Carers' Voice', a carers' forum
- Access to advocacy for carers
- Access to counselling for carers

NHS Lothian Carer Information Strategy

The requirement to develop NHS Carer Information Strategies was introduced in response to recommendation 6 of the Future of Unpaid Care in Scotland Report (2006) and these were required to be developed in partnership with local authority partners and the independent sector. West Lothian Council has been involved in the development of the NHS Lothian Carer Information Strategy

Initiatives and Developments

The essential role of unpaid carers in implementing national policy initiatives such as shifting the balance of care has been increasingly recognised as has the need to support carers in their caring role and to ensure that their health is not put at risk as a result of their caring responsibilities. Discussion with key partners including the local carers' organisation, Carers of West Lothian, has identified that local priorities are broadly in line with the four early priorities identified by the Scottish Executive in their response to the Future of Unpaid Care in Scotland Report which were:

- Respite
- Carers' health
- Carer Training
- Young carers

A fifth priority was identified locally, carer access to appropriate support.

Carers want flexible and responsive services with transparent eligibility criteria.

Local service pressures and areas for development include:

- Forward and contingency planning to be available to carers as part of the overall assessment and care management processes, linked to anticipatory care and the management of long term conditions
- Develop our ability to respond to overnight crises and to create the capacity to provide interventions to support people while they are ill
- Carer Training Programmes, for example, in understanding long-term conditions, financial issues including Guardianship, safer moving and handling and so on
- Accessible and comprehensive information for carers and the implementation of the Carers Information Strategy in partnership with health – there should be an emphasis on promoting and sustaining carers' health
- Promotion of carers' assessments and working in partnership with GP's and other agencies and colleagues to facilitate the take up of these assessments. An updated Carers Assessment Tool is being developed as part of the review of SSA processes and protocols.
- Partnership working with other Council services and agencies to identify young carers and offer appropriate support and services
- Availability of day support and care at home services to enable carers to maintain employment if requested – services should be flexible, responsive and available
- Carer engagement and consultation should be a routine part of service planning and development

6.9 Housing and Housing Support Options

Central to the success of 'shifting the balance of care' is the need to ensure that a range of housing options for older people are in place within West Lothian.

In West Lothian there has been a significant shift in the balance of care for older people from more costly care home provision to new forms of care and housing support that are more appropriate to client need and choice. This shift originated through the Opening Doors for Older People Partnership, which was the catalyst for mainstreaming housing with care developments and the use of telecare technology to assist older people to continue living at home where they choose to do so. The weekly costs of the Opening Doors new build housing with care model are around £185 per week lower than care homes. (Smart Technology and Community Care for Older People; University of Stirling 2006).

Critical to the success of the model has been ensuring that individual capacity building is firmly embedded in care practices with a move from an ‘hands on’ approach to assisting and supporting older people.

In April 2007, along with a number of service areas, the ring fencing for housing support was removed under the Concordat signed between COSLA and Scottish Ministers. This agreement will provide opportunities in developing services, which are more flexible and holistic in terms of meeting the needs of service users as well as considering the possibility of streamlining contracts, which have been previously separated.

Service Delivery

The council currently contracts with 7 providers (6 voluntary sector and WLC) to provide 46 housing support services across West Lothian. Table 1 below outlines the current housing support provision in West Lothian and breaks this down into provision by the voluntary sector, including Registered Social Landlords (RSLs), and WLC as of end October 2008.

Table 1: Housing Support Provision in West Lothian

Type of Provision	No of Units	No of Hours	Voluntary Sector	WLC
Amenity	44	n/a	100%	0%
Sheltered Housing	754	n/a	90%	10%
Very Sheltered	30	n/a	100%	0%
Housing with Care	176	n/a	18%	82%
Extra Care	26	n/a	100%	0%

Table 1 illustrates that the voluntary sector mainly through registered social landlords is the main sector for the provision of sheltered housing, amenity housing and very sheltered housing. However, the Council is responsible in the main for the provision of housing with care. This position is partly due to historic development and staffing of supported accommodation for older people through RSLs while in more recent years the Council has taken forward in partnership with RSLs and others new models of care such as housing with care.

Overall the void levels in supported accommodation for older people is low. Some providers are experiencing problems with the design of accommodation (e.g. bed sits are less popular) and have put strategies in place to address this.

The overall aim in West Lothian is to develop an ever-increasing range of housing options with the right level of surrounding support. Central to this

will be the overall Housing Strategy and we will work in partnership with housing services to inform that process. The need identified in the context of the Older People's Review (see 10 Year vision) is for accessible housing in town centres close to local amenities and services.

Sections 6.1 – 6.6 of this chapter outlined the range of enhanced and developing services designed to support people in their own home, regardless of tenure. The initiatives and developments in this section focus on the development of specialised housing options with dedicated support, which may be provided on site or remotely. While many more people can be supported in their own homes, the availability of alternative housing support options is critical for people where their existing home does not lend itself to maximising independence

Developments and Initiatives

We intend to build on our strong foundation and further extend and enhance the options for accommodation with support for older people in West Lothian and will do this in the following ways:

- By working in partnership with existing supported housing providers to consider how recent care developments such as technology might offer an opportunity to redesign services in a way that achieves a better outcome for older people in West Lothian.
- Propose to undertake in partnership a review of Sheltered/very Sheltered Housing provision in West Lothian
- We will consider what opportunities are generated by the single outcome agreement to streamline and refocus services who's development may have been constrained by ring fenced funding
- We will seek to increase the number of housing with care tenancies. We are confident that the three year budget profile will accommodate the development of 50 Housing with Care tenancies, some of which will be in existing sheltered housing complexes. We will continue to seek to identify additional funding opportunities to support this programme.
- We are interested in testing the market in terms of owner occupied housing with care and will consider the viability of this in future developments.
- Capital funding is available within the next five years to further develop Housing with Care with an emphasis on dementia. Over the next three years we will be developing the concept with a view to further pushing the boundaries in relation to supporting people with more severe dementia.

6.9 RESIDENTIAL CARE HOMES

Care Homes continue to provide a crucial element in the range of care that is available to people in West Lothian. There are 17 Care Homes in West Lothian, four of which are run by West Lothian Council. The market in West Lothian is robust with demand and supply being well matched. The Council enjoys a positive working relationship with providers and contractual arrangements are based on the National Care Home Contract finalised in 2007.

All care home services are required by statute to register with the Care Commission and are subject to inspection twice yearly. These inspections apply the requirements of the Regulation of Care Act and the National Care Standards.

Delivery

Like many care services, access to care homes is arranged on the basis of an assessment of need. West Lothian Council has a well-established policy on choice, the provisions of which ensure that there is a fair and equitable allocation of placements while also providing for interim arrangements until the placement of 1st choice becomes available.

Providers in every sector have consistently applied the principles of the policy on choice and have worked in partnership with West Lothian to develop and implement a single placement allocation system. The support of the independent providers in maintaining this transparent allocation process has been invaluable in terms of maintaining our excellent performance in relation to delayed discharge.

Developments in community based services have resulted in people staying at home longer with the average length of stay in care homes, decreasing to approximately 12 months. It is anticipated that this trend will continue and that with a further shift in the balance of care there will be a net reduction in care home purchasing. In the West Lothian context and given local demographic trends, it is anticipated that this will result in a continuation of current purchasing levels i.e. that the *proportion* of the older population who live in care homes will decrease, whilst the proportion of the older population supported in the community will increase.

Developments and Initiatives

The key aims of promoting healthy living, choice and independence are as central to the service objectives in residential care as they are in community based services. Always fundamental to the inspection process, the new graded inspection framework has an added emphasis on evidencing choice and participation.

Care Home developments over the next few years will focus on further promoting healthy living and preventing the lifestyle disruption associated with unscheduled admissions to hospitals. Care Homes have been implementing a range of new best practice guidance to progress this agenda:

- A focus on Nutritional Health supported by a new screening tool. The *Malnutrition Universal Screening Tool* (MUST) has been introduced in care homes in collaboration with Health Service colleagues. An initiative to implement this tool commenced in late 2008 and further consultation and development is being undertaken in 2009 for implementation in care homes this year and beyond.
- Related to Nutritional Health is a recognition of the difficulties associated with oral hygiene in residents of long term care facilities. Lothian Health has recently launched the Lifesmile project to improve team working and the effectiveness of oral healthcare delivery. The pilot has involved four care homes in West Lothian and the initial evaluation is very positive.
- Care Homes are being encouraged build on existing good practice in relation to palliative care and are further implementing the recommendations of 'Making good care better' and 'Living and Dying Well'
- There will be an emphasis on improving care planning in relation to falls prevention and this will be supported by the recently appointed falls co-ordinator
- We will actively promote the benefit of physical activity as a means of reducing the impact of long term conditions on both physical and mental health. 2008 saw the development of West Lothian's Care Home Network, co-ordinated by the council's Health improvement team. The network aims to raise awareness of the risks of inactivity and allows the care homes to come together, engage with one another and share knowledge, experience and resources.
- We will encourage all providers to work in partnership with primary health care teams to implement anticipatory care plans to improve the management of long term conditions
- There will be a focus on more a more systematic approach to falls prevention will be encouraged and this will be supported by the

Lothian NHS falls prevention programme with a local co-ordinator having been appointed.

- Similarly, we will seek to raise the profile of the importance of positive mental health for residents in care homes and seek to consider the recommendations of Lothian Care Homes Mental Health Improvement programme.

7. CONSULTATION

West Lothian Council aims to develop local services which suites the needs of our local communities.

It recognises that in order to do so it requires to engage and consult with a wide cross section of the community as well as partnership agencies, this approach being entirely in keeping with the expectations and guidance issued by the Scottish Government.

As a mechanism for translating this requirement into reality it currently engages and consults at a variety of levels. Within the Community Health and Care Partnership the approach has been to create a Public Partnership Forum, which comprises of individual members of the public, patients, carers and well as existing community voluntary groups. It is via this Forum local people are informed, consulted and enabled to raise issues, which in turn feed into the planning and decision making process with regards to the identification of future health and social care needs and subsequent provision.

Underlying this activity is the actual service-planning phase itself, where detailed service statements are developed with input from a wide range of internal and external stakeholders as well as agencies working within the statutory, voluntary and independent sectors, this one relating to the provision and development of older peoples services.

It is only by harnessing and utilising this collective input at a range of levels that we have been able to set out within this document our clear vision for the future of older peoples services within West Lothian.

8. SUMMARY

West Lothian has a reputation for designing and delivering innovative services for older people. In 2007 the Social Work Inspection Agency awarded the service an excellent grade for the category “Impact on the Community” In the same year West Lothian Council was the first Scottish council to attain a corporate Chartermark status for customer service. However times move on and West Lothian faces many challenges in sustaining these accolades and in continuing to respond to changes in both national and local policy direction and political imperatives.

Two key challenges are themed throughout this Service Statement. Firstly, demography -the reality is that there is going to be a huge increase in the number of older people in West Lothian in the next 15 years. It is incumbent on Social Policy, its partners within the council and its partners and stakeholders external to the council to work collaboratively to anticipate, identify and meet the needs of those who are most vulnerable within our communities. It is unlikely that there will be additional budget allocations to meet these needs. It is therefore quite clear that we cannot just keep “doing more of the same”. It is also clear from customer feedback that older people their families and carers do not want “more of the same”. This service statement starts to outline **how** the council proposes to meet these challenges. It includes

Listening and involving our customers

Working collaboratively with other council partners, external statutory services – including the health and police service, and the independent sector

Building individual and community capacity – supporting individuals and communities to maintain their personal independence, but also their social connection to their own communities

The second theme emanates from the national and local policy directive to “shift the balance of care”. Essentially this means that health, social care and housing services should endeavour to rehabilitate, re enable, care and support individuals and their families / carers in their own homes and communities. West Lothian embraced this agenda about 10 years ago, best evidenced in the last 5 years by the consistently lowest delayed discharge figures nationally. The establishment of alternative housing with support options such as Housing with Care and the introduction of assistive technology have also made a great impact on this agenda. The emphasis here is moreso on **what** we do and intend to do to continue to shift the balance of care. It includes

Commissioning of services – an increase in commissioning services from the independent sector and a focus on designing and delivering more specialised services in house

Increasing and enhancing the use of Telehealth and Telecare services

Increasing support for carers

A redesign / streamline of out of hours services

A shift towards more specialised service provision in the areas of domiciliary care, day care and short breaks from caring

Establishing a specialist service for people with dementia and their families / carers

Our overall aim, in line with the Scottish Governments “ Outcomes for Community Care” is to achieve better health, improved social inclusion, improved well being and improved independence and responsibility. This Service Statement outlines the approach, priorities and methods to be employed in reaching these outcomes.

The content of the section to follow focuses on **new** developments and initiatives, summarising the content in this statement but grouped round the eight areas of high impact changes identified by the Joint Improvement Team.

9. ACTION PLAN - “SHIFTING THE BALANCE OF CARE”

Area of Priority	Themes	Action(s)	Lead	Timescale	
Maximising Care at Home with Carer Support	1.	Develop more flexible response to crisis and out of hours care	Develop Assisted Care and Technology Service (ACTS)	AB	2009
	2.	Short breaks from caring	- develop in partnership with carers, short breaks service for people with dementia	PM/VdS	20010
			- implement recommendations of day care review. Re-focus on re-enablement, respite for carers	PM/VdS	2010
	3.	Personalisation	- promote the use of Direct Payments and Personal Direct Funding, re-allocating funding from existing services	CS	Ongoing
- review the existing policy framework for DP's and PDF			JAD	2009	
4	Support to Carers	- increase by 5% the number of Carers assessments each year	CS	Ongoing	

Area of Priority	Themes		Action(s)	Lead	Timescale
	5.	Commissioning direction	<ul style="list-style-type: none"> - Work jointly with NHS to implement the Carers Information Strategy (including the rollout of the Carers Training Programme). <p>Support the growth of the independent sector by transferring resources via demographic growth and change opportunities in West Lothian Council Services.</p>	RB	2008-2011 Ongoing
	6.	Assistive technology	<ul style="list-style-type: none"> - Develop 'Expert' Assessment Tool - Develop Core telecare package for people with dementia. <p>Further develop the level and scope of assistive technology in people's own homes by:</p> <ul style="list-style-type: none"> • Increasing the number of core packages • Increasing the number of assessments for enhanced packages 	AB/AS AS AS	2010 2009 2009

Area of Priority	Themes		Action(s)	Lead	Timescale
Better Integrated Health and Social Care for those in need and at risk	1	Shared Information systems	<ul style="list-style-type: none"> - Conclude the review of single shared assessment and implement new 'refreshed' framework 	IQ/JMcD	2009
	2	Multi-agency strategic overview of adult support and protection	<ul style="list-style-type: none"> - Establishment of an Adult Protection Committee and sub committees - Establishment of a multi-agency post - Report to COG - Report to Scottish Government 	VdS VdS VdS VdS/SDO VdS/SDO	2009 2009 2009 2009 2010
	3	Risk Assessment	Implement risk assessment and management framework	CS	2009

Area of Priority	Themes		Action(s)	Lead	Timescale
	4.	Dementia Services	Re-structure assessment and care management team to build a specialist dementia team to further extend joint working with specialist health teams and promote SSA	CS	2010
	5.	Advocacy	Review of Advocacy Services	RB/VdS	2009

Area of Priority	Themes		Action(s)	Lead	Timescale
Extending and enhancing the options for accommodation with support	1.	Housing with Care (HWC)	Continue to increase the number of HWC tenancies by 50 over the next three years by redesign of existing resources	MR/SDO	2009-ongoing
	2.	Sheltered Housing	Review of Sheltered/Very Sheltered Housing	MR	2009-ongoing
	3.	Housing with Care/Dementia	Develop design concept for a specialist housing with care model for dementia	SDO/MR	2009-2011
	4.	Assistive Technology	Increase the level and range of assistive technology in both Care Homes and Housing with Care	AS/SDO/ACTS	2009-ongoing

Area of Priority	Themes		Action(s)	Lead	Timescale
<p>Reduce Avoidable unscheduled admissions to hospital</p>	1.	Crisis Care	<ul style="list-style-type: none"> - Develop (via ACTS) a falls prevention/confidence building service, which will include fast track assessment and installation of telecare for those at risk of falls. - Extend out of hours service (via ACTS) to provide capacity to support 144 clients annually that need short term overnight care. 	AB	2010/11
	2.	Anticipatory Care Planning	Work in partnership with health to further develop and integrate anticipatory care in the care management framework	CS/DE	2009 – 2011
	3.	Telehealth	Work in partnership with health to further develop telehealth potential once pilot is completed	AB	2009-ongoing

Area of Priority	Themes		Action(s)	Lead	Timescale
<p>Improve capacity and flow for scheduled care</p>	1.	Delayed Discharge	<p>-Maintain zero delayed discharge - develop further local target of reducing bed days lost by 15% over the next three years</p>	PM/CS	2011

Area of Priority	Themes		Action(s)	Lead	Timescale
Better use of non medical skills and services outside acute hospitals	1.	Falls prevention and overnight crisis care	Development of ACTs Team	AB	2010
	2.	Management of long term conditions	Consider and support the outcomes of the Lothian Telehealth pilot	AB/AS	2010
	3.	Active Healthy Living	To support the activities of the Health Improvement Team	all	

Area of Priority	Themes		Action(s)	Lead	Timescale
<p>Improve access to remote and rural populations</p>	1.	Social Inclusion	<p>To consider in the context of the day care review whether services could be improved by adopting a 'dispersed' model.</p> <p>To work with other service areas in the context of the Review of Older people's services to promote a more inclusive approach in universal services</p>		

Area of Priority	Themes		Action(s)	Lead	Timescale
<p>Improve Palliative and end of life care</p>	1.	Living and Dying Well	To support the implementation of anticipatory care planning in West Lothian.	DE	2010
	2.	Specialist Palliative Care Worker	To further support and consolidate this specialist post.		
	3.	NHS Palliative Care Strategy	To cooperate with the development and implementation of the NHS Palliative Care Strategy.	JMD	2009-Ongoing

Area of Priority	Themes		Action(s)	Lead	Timescale
Better use of joint resources	1.	Housing Options	<ul style="list-style-type: none"> - Review Housing Allocations – better use of adapted properties - Implementation of the Housing Scotland Act - Improved stock Control and re-cycling of equipment via joint equipment store 		

Key:

PM	Pamela Main
VdS	Val de Souza
CS	Charles Swan
RB	Ronnie Barnes
AB	Alan Bell
AS	Anne Sherriff
IQ	Ian Quigley
JMcD	Joyce McDermott
MR	Marion Reid
DE	Dan Easton
JAD	Jill Derby
JMD	Jillian Dougall
SDO	Service Development Officer
ACTS	Team

10. LEARNING AND DEVELOPMENT PLAN

OLDER PEOPLE'S SERVICES
Learning and Development Plan
2009-2012

Key:

Black type - Confirmed

Red type = To be updated (work in progress)

Blank = To be completed

OLDER PEOPLE'S SERVICES LEARNING AND DEVELOPMENT PLAN 2009 - 2012

High Priority

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
Induction *	✓				All staff	2009 /12	Team/Unit						
Risk Assessment and Management Process	✓				Managers (Unit, Group, Team) Depute Assistants Managers	2009/12	Operational Group Managers		As Available				
Disability Awareness	✓				Managers Depute/ Assistants OTs CCAs DCOs SCWs Clerical Workers SW's / SP's	2009/12	Individual	36	12	3	400	1200	
Mental Health (C & T) Level 1	✓				Managers, Depute/ Assistants Social Workers, OTs CCAs	2009 / 2012	Social Policy	107	50	3	SP		

* To include AWI, Appropriate Adult, SSA, FOI, Adult Protection

BS = Business Support SP = Social Policy

High Priority (Contd)

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
Food Hygiene	✓				Resource Managers Depute Assistants DCOs SWs Catering Staff	2009/ 12	Corporate	8	As Available		SP		
Infection Control	✓				Depute Assistants Managers DCOs SCWs Laundry Assistants Facilities Assistants	2009 / 12	Team	15	15	1	500		
CALM Training	✓				Depute Assistants DCOs Resource Managers	2009 / 12	Corporate	5	As Available		SP		
Safer People Handling	✓				Depute Assistants DCOs SCWs OT's	2009/12	Social Policy	9	As Available		SP		
Administration of Medication	✓				Resource Manager Depute Assistants	2009/12	Social Policy	2	As Available		SP		
Risk Assessment & Management Processes	✓				OTs SWs SP's	2009 /12	Group Managers	10					

Risk Assessment	✓				CCAs DCOs SCWs	2009 / 12	Group Managers	14	To be arranged		
Single Shared Assessment (SSA)	X				Managers Team Managers CCA's SW's SP's OT's	2009 / 12	Social Policy				
Support for Carers – Carers assessment	X				Managers Team Managers CCA's SW's SP's OT's	2009 / 2012	Social Policy				
Adult Protection	X				Managers Team Managers CCA's SW's SP's OT's	2009/ 2012	Social Policy				
Sensory Awareness Training	X				Managers Team Managers CCA's SW's SP's OT's	2009 / 2012	Social Policy				

Dementia Awareness Training	X				Managers Team Managers CCA's SW's SP's OT's	2009/2012	Social Policy				
Dementia Awareness Training	X				Managers Depute Assistants Social Worker CCAs DCOs SCWs	2009/ 2012	Social Policy				

Medium Priority

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
Customer Consultation		✓			Manager Depute Assistants	2009 /2012	Corporate	8	As Arranged		BS		
Awareness e.g. Autism/Epilepsy		✓			Managers Depute Assistants Social Worker CCAs DCOs SCWs	2009/12	Team/ Individual/ External	72	12	6	500	3000	
Direct Payments (SDS) Initial Training Refresher Courses New procedures		✓			Managers OTs SWs SP's CCAs	2009/2012	Social Policy	2	As Arranged		SP		Recommend move to high priority

Medium Priority (Contd)

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
ILF		✓			SWs / SP's CCAs	2009/12		4					
Safer People Handling (basic)		✓			CCAs	2009/12	Team	2	As Available		SP		
Administration of Medication		✓			DCOs	2009/12	Social Policy	5			SP		
Disability Awareness		✓			Catering Staff	05/06	Social Policy						
Infection Control		✓			Catering Staff	05/06	Social Policy						

Low Priority

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
Food Hygiene			✓		Resource Manager Depute Assistants DCOs SCWs Catering Staff	2009/12	Social Policy	8			SP		
CALM			✓		Depute / Assistants	2009/12		2	As Available		SP		

Low Priority (Contd)

DEVELOPMENT REQUIREMENT	M	N	R	O	TARGET GROUP	ESTIMATED TIMESCALE	ARRANGING PROVIDER	NUMBERS REQ. INPUT	NUMBERS PER SESSION	NUMBER OF SESSIONS	COST PER SESSION	TOTAL COST	COMMENTS
Safer people Handling			✓		Resource Manager Depute / Assistants DCOs SCWs	2009/12	Social Policy	10	As Available		SP		
Epilepsy Awareness			✓		Depute / Assistants	2009/12	Team	1	As Available		SP		
Rectal Diazepam			✓		Depute / Assistants	2009/12	Team		As Available		SP		
Food Hygiene Awareness			✓			2009/12		6	As Available		SP		
Moving and Handling			✓		Clerical Workers Catering Staff Laundry Assistants Facilities Assistants	2009/12		1	As Available		SP		

M = MANDATORY N = NECESSARY

R = REFRESHER O = OPTIONAL

11. Performance Indicators 2009 / 2010

WEST LoTHIAN COUNCIL

SERVICE: CHCP AND SOCIAL POLICY

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Assessment and Care Management	To provide assessment and care management services to older people, their families and carers	Improving The Health And Wellbeing Of Communities	<p>All assessments/ reviews to be completed within 13 weeks of referral</p> <p>% of care plans reviewed within agreed service timescale</p> <p>% of user assessments completed to national standards</p> <p>% of users and carers satisfied with their involvement in the design of care packages</p> <p>% of community care service users feeling safe</p> <p>% service users satisfied with opportunities for social interaction</p> <p>Number of people waiting longer than target for assessment per 1,000 population</p> <p>% of people 65+ admitted twice or more as an emergency who have not had an assessment</p> <p>Number of patients waiting in short stay setting, or more than 6 weeks elsewhere, for discharge to appropriate setting</p>	Number of assessments/ reviews completed

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Assessment and Care Management (continued)	To offer support to informal carers	Improving The Health And Wellbeing Of Communities	<p>All assessments/ reviews to be completed within 13 weeks of referral</p> <p>% of carer assessments completed to national standard</p> <p>% of carers who feel supported and capable to continue in their caring role</p>	Number of assessments completed
	Adult Protection	Improving The Health And Wellbeing Of Communities	All referrals to be allocated within 24 hours of receipt	Number of Adult protection referrals investigated
Purchased Care Home Placement	Purchase Care Home placements	Improving The Health And Wellbeing Of Communities	<p>Care home placements secured as required</p> <p>% of care staff who have appropriate qualification for post held</p> <p>a) private</p> <p>b) voluntary</p> <p>% of occupied places for older people that are single rooms</p> <p>% of occupied places for older people that have en suite facilities</p> <p>Average open placements per month</p>	Number of purchased placements
Provision Care Home Placement	Provision of Care Home placements	Improving The Health And Wellbeing Of Communities	<p>Care home placements secured as required</p> <p>% of care staff who have an appropriate qualification for post held</p> <p>% of occupied council places for older people that are single rooms</p> <p>% of occupied council places for older people that have en suite facilities</p> <p>Average open placements per month</p>	Number of placements provided

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Interim Care Home Placement	Provision of Interim Care Home Placement	Improving The Health And Wellbeing Of Communities	a) maintain zero delayed discharge b) provided responses to emergencies % occupancy levels % of care staff who have an appropriate qualification for post held % of occupied council places for older people that are single rooms % of occupied council places for older people that are en suite	Number of placements made in Craigmair
Short Breaks from Caring	Purchase of short breaks from caring in registered accommodation	Improving The Health And Wellbeing Of Communities	2,184 nights of respite available to carers	Number of bed days purchased
Short Breaks from Caring	Provision of short breaks from caring in registered accommodation	Improving The Health And Wellbeing Of Communities	2,184 nights of respite available to carers	Number of bed days purchased
Short Breaks from Caring	Purchase of short breaks from caring services at home	Improving The Health And Wellbeing Of Communities	Number of hours purchased per month: 1,050	No. of Short breaks provided
Day Care Support Services	Provision/Purchase of Day Support and activities outwith the home which promotes independent living and supports carers	Improving The Health And Wellbeing Of Communities	Service is available when required	Number of days supported provided annually
Direct Payments	To provide personal direct payments to older people	Improving The Health And Wellbeing Of Communities	To increase the number of people in receipt of personal direct payments	Number of service users

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Advocacy	To purchase an independent advocacy service to people in a care home or hospital	Improving The Health And Welling Of Communities	Responding to requests for service within seven days	Number of people who have been provided with an advocacy service

Domiciliary Care

Performance Indicators 2009 / 2010

WEST LoTHIAN COUNCIL

SERVICE: CHCP AND SOCIAL POLICY

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Support at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	<p>Service is available as required</p> <p>% of people 65+ receiving personal care at home a) provided b) purchased</p> <p>% or people 65+ with intensive needs receiving care at home (10+ hours pw) a) provided b) purchased</p> <p>no of people waiting longer than the target time for service per 1,000 of the population</p> <p>% of homecare clients receiving personal care</p> <p>% of homecare clients receiving a service at weekends</p> <p>Total number of homecare hours provided as a rate per 1,000 of population aged 65+</p>	Number of care at home hours purchased per week

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10
Rapid Response and Re-enablement Team	Avoid unnecessary admissions to hospital and enable early supported discharge from hospital including the provision of a re-enabling service	Improving The Health And Wellbeing Of Communities	Number of people receiving a service per annum Number of hospital admissions avoided	Number of service users per week

The measures highlighted in green are those additional measures to be gathered in future as part of outcome focussed reporting.

Appendix 1

All Our Futures: Planning for a Scotland with an Ageing Population”

The Government identified six priority areas for strategic action. It has developed these based on what our consultation and engagement told them needs to be addressed now, informed by a clear view of the challenges and opportunities for the future

1. We will act to continue to improve opportunities for older people - to remove barriers and to create more chances for older people to participate and to be involved in their communities - as volunteers; through paid work; in learning, leisure, culture and sport.
2. We will act to forge better links between the generations
3. We will continue to act to improve the health and quality of life of older people
4. We will continue to improve care, support and protection for those older people who need it.
5. We will ensure that the right infrastructure is in place for a Scotland with an ageing population with housing, transport and planning progressively meeting the needs of all ages.
6. We will offer learning opportunities throughout life.

Appendix 2

National and Local Policy Drivers - Common Themes

Policy/Drivers Source	Theme	Activity
National Adding Life to Years 2002	Whole system approach	Strategic Planning and Service Design
National Partnership for Care 2003	Whole system approach	Partnership working
National Better Outcomes for Older People 2005	Joint Future	Development of Integrated Services
National Building a Health Service Fit for the Future	Change Management	Joint approach to service redesign
National Joint Future Unit Policies	Joint Future	Joint Performance
National Changing Lives 2005	Review of Social Work Services	Focus on personalisation, outcomes focus, joined up services and accountability
National Care 21 2006	The Future of Unpaid Care	Carer support and involvement
National All our Futures 2008	A response to a Scotland with an ageing population	<ul style="list-style-type: none"> • Active Ageing • Promotion of health and wellbeing agenda, work leisure and educational opportunities • Removal of environmental barriers.
National Coordinated Integrated and Fit for Purpose 2007	Adult rehabilitation	<ul style="list-style-type: none"> • Access to services • Local service provision • Self managed care • Flexible workforce and capacity

National Adult Support and Protection Act 2007	Protection of "Adults at Risk"	<ul style="list-style-type: none"> • Personal and community safety • Risk assessment management and enablement • Joint working and accountability
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Local West Lothian Capacity Plan 2005	Capacity Plan for Older People 2006-2015	<ul style="list-style-type: none"> • Demographic changes • Health expectancy • Supply of unpaid care • Patterns of individual choice • Service costs
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Local West Lothian Workforce Planning Report 2005	Workforce planning	<ul style="list-style-type: none"> • Partnership approach • Flexibility across sectors • Development of competent qualified staff
---	--------------------	--

Policy/Drivers Source	Theme	Activity
Local West Lothian Strategic Day Services Review 2007	Day Services Review	<ul style="list-style-type: none"> • Establish a strategic approach to commissioning • Develop services capacity to cater for Individuals with high dependency needs
Local Improving Care Investing in Change 2006	Strategic planning model and capacity plan	<ul style="list-style-type: none"> • Community based rehabilitation • Management of long term conditions • Role of medical day hospital • NHS Continuing Care

Appendix 3

Health and Wellbeing in Later Life

There is growing evidence of the importance of physical activity for the older person, including the immediate and long- term physiological, psychological and social benefits. However, many older adults do not sufficiently value physical activity in their lives and it has a very low priority. As a result, the majority of men and women over 60 do not undertake sufficient daily physical activity to benefit their health and well-being. The table below illustrates this very clearly:

Inactivity Levels

	Men (%)	Women (%)
65 years	68	80
75 years	82	86
85 years +	92	96

These levels of inactivity are made worse because many older adults also sit for longer periods. The combination of inactivity and increased sedentary behaviour accelerates the age-related decline in strength and muscle mass post 35, so this can be going on for a long time. The result is that an inactivity impairment arises that can have major consequences for maintaining independence, mobility and the ability to undertake daily tasks and freedom to get around and meet with friends.

Regular physical activity is important for all body systems, the brain and the mind. It has the power to energise and enrich lives. It enables people to widen their views about what they can do in their lives so that they can extend their capabilities and enhance well-being and health. For the majority of older adults, this is a realistic expectation if they view daily physical activity as an essential part of feeling well.

In our communities and local neighbourhoods we can use physical activity to address two agendas:

- Prevention, and
- Treatment.

In the prevention agenda we can use physical activity to:

- Reduce the risk of developing health problems.
- Ensure that people do not gain excessive weight.
- Delay functional decline and onset of dependency.

- Reduce the risk of developing the complications of immobility.

However, physical activity can play a very important role in either reducing the risk, delaying or slowing down the progress of Dementia, Parkinson's and Alzheimer's.

Physical activity can be used also in therapy and treatment for:

- Chronic conditions - it has a beneficial effect on many chronic diseases or disorders.
- Depression
- Obese and overweight adults
- Falls
- Restoring physical capacity and maintaining independence

In addition physical activity can be used as a social tool to combat loneliness and isolation.

All of these factors mean that physical activity is a resource that we need to cherish because it energises daily living, enhances the quality of living and improves our well-being.