Joint Health & Social Care Strategy for Older People in Fife
2011 - 2026
Foreward

As Chair of Fife’s Health & Social Care Partnership, I am delighted to present the Joint Health & Social Care Strategy for Older People Services in Fife 2011-26.

The Strategy is a key piece of strategic partnership working between the health service, the local authority and the voluntary and independent sectors and sets out the pathway in Fife to promote health and wellbeing for older people and reshape care and services for those with more complex needs in the coming years.

The Strategy underpins Fife’s Health & Social Care Partnership’s commitment to providing services for older people in the future and is a significant step in preparing for the implementation of Health and Social Care Integration in response to the current Scottish Government consultation.

Cllr Andrew Rodger

Chair, Fife Health & Social Care Partnership
1. Introduction

The World Health Organisation (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

The Fife Health & Wellbeing Plan, published in June 2011, builds on this and highlights that “a varied and complex range of individual, social, economic and environmental circumstances work together to affect our health and wellbeing.” Whilst acknowledging these other circumstances contribute to health and wellbeing, the health and social care services an older person receives play an essential role.

It should however be emphasised that older people are not a homogenous group and although some older people require health and social care, this is not necessarily age-related. Older people are a great resource within our communities and, in terms of informal care, actually provide more services than they receive.

Taking these points into account, this document focuses on strategic planning for health and social care services for those older people in Fife who require them, addressing their future shape and direction whilst understanding the wider context which impacts on and influences the health and wellbeing of older people. This paper also encompasses aspects of the Fife Housing Strategy relevant to older people.

The conclusions of the strategy will help determine the future direction of formal and informal health care and social care services and support for older people in Fife.

2. Background

The Strategy is set within the context of existing local strategies and national policy directions.

The most recent population projections published by the General Registrars Office for Scotland shows that, compared to 2008 figures, the number of people aged 65 and over in Fife will increase by 73% by 2033 (from 61,740 to 106,788) and that the number of people aged 75 and over in Fife will increase by over 97% (from 28,302 to 55,979).

Given the key health issues for older people, such as long term conditions, stroke, sensory impairment and dementia, if health and social care services

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1 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946
2 Dementia is defined by the Scottish Intercollegiate Guidelines Network (SIGN) as: “a generic term indicating a loss of intellectual functions including memory, significant deterioration in the ability to carry out day-to-day activities, and often, changes in social behaviour.”
continue to be arranged as at present, the increasing older population will result in a huge increase in demand for inpatient beds, houses suitable to their care and support needs, care home places and home care packages. Thus, the challenge exists to carefully review current practices and seek opportunities to redesign health service and care processes in order to meet the demands of changing demographics.

3. Purpose of the strategy

To meet the needs of the older population now and in the coming years, all Health and Social Care Services should have a primary aim of maintaining and supporting independent living and maintaining quality of life. The resources of local people and communities will be at the centre of social care provision.

The purpose of the strategy is, therefore, to provide a clear direction for future developments of the NHS Fife Services within hospitals (acute and community) and in the community, and Fife Council’s Services, acknowledging and building on the contribution of the Voluntary and Independent sectors.

The areas of future development identified in the strategy will enable Fife’s Health and Social Care Partnership to populate the Older Peoples Section of the Health and Social Care Service Delivery Plan with areas of work as noted in the Strategic Intent section. This in turn will enable these areas of work to be monitored through the joint performance monitoring mechanisms.

4. Scope of the strategy

What the strategy covers:

The strategy is a high level overview of strategic intent covering formal and informal services to meet health, housing and social care needs, related to ageing, of people living in Fife over the coming 15 years (2011 – 2026).

The strategy is therefore relevant to current services and future development of:
• Community Care services (including NHS and Local Authority as well as voluntary and independent sector arrangements).
• Community Infrastructure and resources from all relevant agencies and within Communities themselves.
• NHS Hospital services and the link between community and hospital services.

What the strategy does not cover:

The strategy does not provide detailed action plans which describe how areas of strategic intent will be taken forward. In particular, the strategy:
• Does not focus on the many individual conditions which may affect older people. There are other documents detailing such work and, where appropriate, the reader will be directed to these.
Does not provide detailed information such as financial plans, timescales or assign responsibility for areas of work to be taken forward. This level of detail will be provided in subsequent action plans. Instead, this high level strategy will provide a clear vision and direction to help to ensure an infrastructure will be in place in order to deliver the areas of work across the Fife Partnership.

Does not provide areas of strategic intent around other aspects that impact on health and wellbeing such as transport, advice and information, neighbourhood services or community safety. It is recognised that each of these areas, whilst playing a key role in an older person’s health and wellbeing, are dealt with in other strategic documents, such as the Fife Health and Wellbeing Plan (2011 – 2014). The strategy acknowledges the link to these other areas relevant to older people but does not include them in this document. Instead, the reader is guided to the appropriate document where further information can be obtained.

5. Strategic Context

National policy around health and social care for older people and for their carers\(^3\) emphasises the need to shift the balance to providing support and preventive services to keep people in their own homes. Appendix 1 lists the key policy documents and areas of work relevant to older people published or undertaken on a local and national level in the last five years.

“The Kerr Report, Building A Health Service Fit For The Future - A National Framework for Service Change in the NHS in Scotland” (May 2005)\(^4\), emphasised the need to provide health services effectively in community setting, nearer to the point of delivery, to promote self-care and to support carers. The report said:

“We believe that to meet the challenges and to deliver on the key requirements described above will require a shift in the way we deliver health care in Scotland. This will require new ways of working, new skills, new thinking and a new culture in the NHS - one of shared responsibility and engagement of front-line staff in service improvement”.

In responding to The Kerr Report, ‘Delivering for Health’\(^5\) set out a programme of action to shift the balance of care and “move towards a system which emphasises a wider effort on improving health and well-being, through preventive

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\(^3\) Caring Together: The Carers Strategy for Scotland 2010-2015 provides the following guidance on terminology to describe carers:

- “Carers provide care to family members, other relatives, partners, friends and neighbours of any age affected by physical or mental illness (often long-term), disability, frailty or substance misuse.”
- Other terms used to describe carers are “unpaid carer”, “family carer” and “informal carer.”
- “It is important that carers are not confused with paid workers, who are sometimes incorrectly called carers too: paid workers are care workers.”
medicine, through support for self care, and through greater targeting of resources on those at greatest risk, with a more proactive approach in the form of anticipatory care services.”

Similar themes were found in ‘Changing Lives: Report of the 21st Century Social Work Review’, where there is an emphasis on developing personalised services and enabling people to remain at home and in control of their own lives. The Implementation Plan says Changing Lives “will only be achieved by social work services working with their partners locally to re-design the delivery of services.”

“Better Health, Better Care” was released in 2007 with a strong degree of continuity with the previous policy document, “Delivering for Health” in that it re-emphasised the need to provide health services effectively in community settings, nearer to the point of delivery, to promote self-care and to support carers. It had specifically required NHS Boards to develop an action plan for the care of older people to ensure the following outcomes:

- Greater integration of health and social care provision;
- Use of new technology to support older people’s care at home;
- Enhanced community-based rehabilitation.

5.1 Fife Framework for Older People

On a local basis, a revised Fife Framework for Older People Services, endorsed by NHS Fife Board and Fife Council’s Health & Social Work Committee, was launched in March 2007. This revision introduced the concept of identifying outcomes for services for older people and the “Supported” and “Accommodated” outcomes relate to health, housing and social care for older people across Fife Partnership.

The “Supported” outcome states that:

“Older people should have access to the highest attainable standards of relevant support services, especially health and social care, tailored to their individual circumstances. As these circumstances change, older people should be supported in their capacity to adapt to these changes and to make personal choices as far as practicable.”

The “Accommodated” outcome states that:

“Older people should be supported to live as independently as possible and in accommodation suitable to their needs.”

The development of the Joint Health & Social Care Strategy for Older People can be seen as the action plan required to deliver the “Supported” outcome and the Fife Health & Social Care Partnership Delivery Plan 2012-15 also references this work.
5.2 Reshaping Care for Older People

The most recent programme of work around older people in Scotland is “Reshaping Care for Older People” which is being taken forward through a partnership between The Scottish Government, NHS Boards, Local Authorities, independent sector and third sector groups and aims to build a cohesive and comprehensive approach to meeting the care and support needs of older people. Work is currently underway to develop a ten year delivery plan.

The policy goal for “Reshaping Care for Older People” is to optimise independence and wellbeing for older people at home or in a homely setting with the desired outcomes as follows:

Older people and those who are close to them get the information, advice, support and services they need

- to help them stay well
- to live as they want, with choice and control
- to feel safe and
- to have meaningful activities and opportunities to meet and support each other.

In order to accomplish these outcomes, a series of Workstreams are being taken forward Nationally.

- Vision and engagement
- Future Funding of Long-Term Care: Demographic Pressures
- Care at Home
- Future Role of the Care Home Sector
- Wider Planning for an Ageing Population - Housing and Communities
- Healthy Life Expectancy - Healthy/Independent Ageing
- Workforce
- Care Pathways

“Reshaping Care for Older People” sits above and supports the delivery of more specific national strategies including the Dementia Strategy, Carers Strategy and Self-Directed Support Strategy whilst having a key role in supporting the three Quality Ambitions of the NHS Quality Strategy:

- Partnerships between the NHS and those seeking care;
- Safe and timely care and
- Appropriate care and treatment.

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4 Third Sector is a collective term which covers voluntary organisations, registered charities, community groups, social enterprises and development trusts. These organisations all have the following features in common: Governed by a voluntary Committee/Board; Non-profit distributing (may make profits but these are reinvested into the service/activity); Social aims
The National Programme on Reshaping Care for Older People has provided an opportunity for the Fife Partnership and wider stakeholders, including people who use services, carers, providers and the public, to take forward an engagement and delivery programme which builds on work already underway in Fife.

Current work involves developing a Local Plan for Fife in order to actively direct, support and stimulate a coordinated local change programme effectively utilizing the available bridging finance through the Change Fund to support a whole system approach to shifting older people’s health and social care to non-institutional, community based settings and promoting independent and fulfilled lives.

The Strategy and the Strategic Intent detailed later, draws on the findings of the national Reshaping Care for Older People Programme and sets the context and direction of the Fife Change Plan.

6. Health & Social Care Performance Outcomes Specifically Relevant to Older People

Fife Council and NHS Fife have adopted the Community Care Outcomes Framework (CCOF) and report on this through the Health & Social Care Partnership which is the joint performance reporting structure in Fife.

The landscape for performance monitoring is changing rapidly as the CCOF is currently under review by the Scottish Community Care Benchmarking Network (SCCBN) on behalf of Scottish Government.

The CCOF allows local authorities and their NHS partners to understand their performance locally, at a strategic level, in improving outcomes for people who use community care services or support, and their carers. It also allows partnerships to share this information with other partnerships in Scotland and mutually compare performance directly on the basis of consistent, clear information.

The performance measures and targets within the CCOF are a combination of outcome, output, input and process measures and focus on the themes of Satisfaction, Faster Access, Support for Carers, Quality of Assessment and Care Planning, Identifying Those at Risk and Moving Services Closer to Users/Patients.

The CCOF underpins the national performance framework and there is also a considerable overlap with the Scottish Government’s National Indicators, Single Outcome Agreement menu of local indicators and NHS HEAT. The individual measures and targets are detailed in Table 1.
Table 1: Community Care Outcome Framework Measures and Targets

<table>
<thead>
<tr>
<th>Themes</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Satisfaction</td>
<td>• % of community care service users feeling safe.</td>
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<tr>
<td></td>
<td>• % of users and carers satisfied with their involvement in the design of care package.</td>
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<tr>
<td></td>
<td>• % of users satisfied with opportunities for social interaction.</td>
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<tr>
<td>Faster Access</td>
<td>• No. of patients waiting in short stay settings, or for more than 6 weeks elsewhere for discharge to appropriate setting.</td>
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<td></td>
<td>• No. of people waiting longer than target for assessment, per 000 population.</td>
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<tr>
<td></td>
<td>• No. of people waiting longer than target time for service, per 000 population.</td>
</tr>
<tr>
<td>Support for carers</td>
<td>• % of carers who feel supported and capable to continue in their role as a carer.</td>
</tr>
<tr>
<td>Quality of assessment and care planning</td>
<td>• % of user assessments completed to national standard.</td>
</tr>
<tr>
<td></td>
<td>• % of carers’ assessments completed to national standard.</td>
</tr>
<tr>
<td></td>
<td>• % of care plans reviewed within agreed timescale.</td>
</tr>
<tr>
<td>Identifying those at risk</td>
<td>• No. of emergency bed days in acute specialties for people 65+, per 100,000 pop.</td>
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<tr>
<td></td>
<td>• No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000 pop.</td>
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<tr>
<td></td>
<td>• Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment.</td>
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<tr>
<td>Moving services closer to users/patients</td>
<td>• Shift in balance of care from institutional to 'home based' care.</td>
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<tr>
<td></td>
<td>• % of people 65+ with intensive needs receiving care at home, in a care home or in an NHS long-stay geriatric bed</td>
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<tr>
<td></td>
<td>• % of home care clients aged 65+ receiving personal care</td>
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</table>

In addition to the CCOF targets, Fife Council Social Work Service has a comprehensive balanced scorecard which includes a range of measures and targets for older people’s services. These include:

- Increase in the number of people supported at home by Telecare/ assistive technology
- Indicators looking at respite provided to over 65s, overnight at weekends and during the day.

NHS Boards have Local Delivery Plans which form the performance management contract with The Scottish Government and details the work being taken forward to achieve HEAT Targets. The most recent guidance on Local Delivery Plans for 2011/12 highlights older people as one of the Scottish Government’s key priorities:
In terms of delivering the national targets contained within the Local Delivery Plan, NHS Fife used the Balanced Scorecard approach. The Balanced Scorecard is a corporate performance plan, supported at Delivery Unit level by detailed Action Plans, which is monitored and reported on through a range of performance management tools.

In terms of older people, the national targets contained in the NHS Fife Balanced Scorecard (as of 1st June 2011) are:

- Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed day rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

- To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.

In addition to these, there are two HEAT Standards with particular relevance to older people that the Scottish Government will continue to monitor:

- Delayed discharges: By April 2013, no people will wait more than 28 days to be discharged from hospital into a more appropriate care setting and by April 2015, no people will wait more than 14 days.

- Dementia: Maintain the number of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.

Other Fife strategies and plans such as the Joint Health Improvement Plan (now known as the Health & Wellbeing Plan) and the Community Plan are currently being updated and consultation is underway regarding areas of priority including older people.

7. Integrated Resource Framework

The Integrated Resource Framework\(^5\) is being developed by the Scottish Government, NHS Scotland and COSLA, through the National Shifting the

http://www.scotland.gov.uk/Topics/Health/care/JointFuture/CHPs
Balance of Care Delivery Group. More effective integration can improve people’s experience of services, and enable better models of care to be provided without necessarily incurring additional cost.

Fife Health & Social Care Partnership Finance Group is in the process of developing an Integrated Resource Framework in terms of Older Peoples Services in Fife.

8. Developing the Strategy

Consultation Process

A first draft based on work previously undertaken through the Joint Health & Social Care Strategy for Older People in Fife was prepared by a small working group and circulated to members of the OPSIG in January 2011 prior to a wider consultation being taken forward in February 2011.

As part of the consultation process, a data collection questionnaire in (Appendix 2) was designed to gather views on the draft Strategy. The questionnaire was then sent to groups with a specific interest in older peoples issues in Fife to ensure they had an opportunity to comment. This included groups within NHS Fife and Fife Council Social Work Services.

In addition, the e-mail was sent to all NHS Fife staff, all Fife Council staff, all GP practices throughout Fife and all Voluntary Sector groups listed with Fife Council as providing support to older people. Finally, Fife’s Peoples Panel⁶ were asked to participate in the consultation process. The consultation ran from 14th February to 16th March 2011.

A total of 282 responses were received and all feedback was collated and summarised in order to update the document. The working group met to discuss the feedback and the document was updated prior to being circulated to OPSIG members for discussion and comment at its meeting on 8th June 2011. It was agreed at this meeting that final approval by OPSIG members would take place via e-mail before the Strategy was submitted to the relevant NHS and Local Authority committees for endorsement.

9. Definitions used within the strategy

As stated earlier, older people are not a homogenous group. Although some older people require health and social care, this is not necessarily age-related. Older people overall are a great resource within our communities and, in terms of informal care, actually provide more services than they receive.⁷

⁶ Fife’s Peoples Panel is a group of people used by members of the Fife Partnership to consult with on a variety of public issues. It has around 3000 members who will reflect the Fife adult (over 16) population in terms of age, gender, working status and geographical location.
This Joint Health and Social Care Strategy takes the same approach as the Fife Partnership Report “Framework of Older People Services 2007” which did not define older people in age terms.

Rather the strategy is concerned with meeting the health, housing and social care needs of adults that are associated with older age more generally. For some that may be after the age of 60, for others it may be from the age of 80 or 90 or there may be very few such needs in some cases.

10. Principles adopted within the strategy

Consistent with the 2007 Framework for Older People Services, Fife Partnership agreed that, in Fife, in the work we do in relation to older people, we will:

1. Recognise and value the diversity of older people as individuals who contribute to society and will not directly or indirectly discriminate against anyone because of Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex, Sexual Orientation or Marriage & Civil Partnership.\(^7\)

2. Ensure the development of future models recognises the need to safeguard older people who are at risk of harm because they are affected by disability, mental disorder, illness or physical or mental infirmity.

3. Respect and dignity for older people must be integral to all our work.

4. Consult with and involve older people, their carers and older peoples’ organisations in order to ensure the perspectives and rights of older people are central to the future development of services.

5. Take account of evidence of effectiveness and tailor our services and service delivery to suit the needs of the older population within available resources.

6. Support older people who need support, providing safe and high quality services at all times.

7. Ensure that all aspects of an older person’s health and wellbeing are considered including physical, sexual, emotional and spiritual needs.

8. Use plain language and communicate effectively with older people.

9. Strive for equality of opportunity and plan for the inclusion of older people.

10. Raise the priority and profile of older people issues.

\(^7\) These are “protected characteristics” relating to older people as detailed within the Equality Act 2010, In order to assure these characteristics remain protected, future implementation plans relating to the areas of strategic intent detailed in the strategy document will include impact assessments.
11. Promote the rights of older people and encourage positive attitudes towards older people.

12. Work in partnership to ensure effective use of resources and to improve services and opportunities for older people.

13. Support older people to access and retain the type of care of their choice, in accordance with their needs.

11. **Key Strategic Priorities**

A local strategy for older people’s services needs to address several key priorities through a holistic approach, including:

1. Ensuring that agencies have a clear understanding about the needs of the older population to ensure services are fit for purpose now and in the future to meet those needs, alongside clarity about the desired outcomes. In order to prepare the workforce to deliver evolving models of care, the need for a joint Organisational Development plan will be considered.

2. Ensuring there is an appropriate balance between the different levels of care, as represented in the Intervals of Care Pyramid (Figure 1), and between the different elements in the pyramid.

3. Ensuring services take account of the implications of medium/long term demographic change.

4. Agreeing the models of care and quality standards to apply in care settings and when supporting people in their own homes.

5. Maximising service user and carer influence and control in resource planning and service delivery.

6. Ensuring appropriate support services for carers.

7. Ensuring that older people have appropriate advice and support to access a range of housing options suitable for their needs.
Health and Care services should not be provided in this pyramid any higher than is needed by the population. Systems should be configured to enable people to move between levels of the care pyramid to meet their changing needs, focussed whenever possible on maintaining their usual place of residence.

In addition, it is important to ensure there will be a strong foundation of local community resources for the future as an emphasis on community well-being and utilising universal services is fundamental to addressing the ‘demand’ within the health/social care system.

This approach will be founded upon community development and asset based principles and will involve investment in community capacity building, supporting volunteering, developing a range of lower ‘tier’ community services, supporting the third sector/community infrastructure, providing information and support and supporting carers.

12. Implementation

The Strategy will form the workplan of the Older People Strategy Implementation Group and the appropriate operational group e.g Local Management Groups will be asked to incorporate the areas of ‘strategic intent’ within their action plans.
RESHAPING CARE FOR OLDER PEOPLE IN FIFE: AREAS OF STRATEGIC INTENT

The following pages outline how the strategic intent will meet health, housing and social care needs to improve outcomes for older people and their carers in Fife. This has been organised to follow the different stages of the journey which may be experienced by an older person and their carer. This may be through health, social care services or both.

It should be stressed that older people may need different services at different stages of the journey set out below, based on their own personal circumstances.

**Preventative/Anticipatory Care:**

Staying well, anticipating needs and preventing the need for unplanned care and treatment wherever possible.

| Strategic Intent: | We will identify and support, in a planned way, people with long term conditions and their carers enabling home based care to be provided wherever possible and taking account of the wishes of the person and their carer. |
| Areas of work | Outcomes |
| • We will have proactive integrated case management\(^8\) which will include a shared risk prediction framework and anticipatory care planning. | • People and those who care for them will get targeted health and social care support to prevent crisis and ensure effective treatment where indicated. |
| • We will put in place rapid access to alternatives to admission that will enable as much care as possible to be provided safely at home. | • Responsibility for delivery of care and crisis response will be shared by the person, their family and health and social care are providers. |
| • We will anticipate possible crisis and prevent the situation occurring wherever possible. | • People will be able to access information about their condition(s) and care at the level they feel comfortable with. |

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\(^8\) Case Management Society UK defines case management as: a collaborative process which: assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individuals health, social care, educational and employment needs, using communication and available resources to promote quality cost effective outcomes.
We will establish links to other areas of work relating to the wider aspects of health and wellbeing of older people in Fife including areas of health promotion, primary prevention and health improvement

We will understand the population needs and have better planning information at a point of crisis.

People will have more control over services and healthcare they can receive in order to enable them to lead as independent a life as possible.

Accessing Care Appropriate to Needs

Older people, their families and/or carers should have quick access to a range of services and healthcare to meet their needs. In order to achieve this, various areas of work need to be progressed including providing direct access to all assessors to access a range of health, housing and social care services, improving opportunities for people to self assess and directly access services and extending direct payment and self directed support.

The overall desired outcomes from such work would be to promote better partnership working between all involved thus facilitating a faster response and enabling older people to be in a position where they will take a much more active part in planning their care in the community.

In relation to the types of care older people access, these can be categorised into either planned care or unplanned care where a person experiences changes to their health status or social support that require immediate response. Both planned and unplanned care could take place in a hospital setting, a community setting or at home.

Unplanned Care

Strategic Intent:

We will reduce level of unplanned care episodes, but where these occur, ensure return to their usual place of residence as soon as possible and ensure that life changing decisions are not made at the point of crisis.

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will provide rapid access to geriatric assessment, including old age psychiatry, psychology and acute medicine, in all settings.</td>
<td>• No needless delays for assessment, care and support or equipment.</td>
</tr>
<tr>
<td></td>
<td>• Unpaid carers feel supported and able to continue in their role.</td>
</tr>
</tbody>
</table>
• We will provide a comprehensive assessment of medicine administration.

• There will be a focus on recovery, rehabilitation and re-ablement, where this is in the best interest of the person, through a range of intermediate care services that emphasise physical and mental wellbeing.

• We will provide rapid access to a range of equipment and adaptations.

• We will ensure that information systems can provide a function to alert community staff to admission, discharge and any resulting changes to care plans.

• We will continue to improve software communication systems across all services

• People experience fewer adverse health (including medication) events.

**Hospital-based Care**

**Strategic Intent:**

*Hospital-based care will provide specialist diagnostic and treatment services that cannot be provided within the community*

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>• We will embed methods of comprehensive assessment of older people that routinely encompass their physical, mental, functional and social needs throughout all parts of the healthcare system.</td>
<td>• Hospitals will focus on providing safe and effective care according to individuals needs.</td>
</tr>
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9 Delirium is defined by The Royal College of Psychiatrists as “a state of mental confusion that can happen if you become medically unwell. It is also known as an ‘acute confusional state’. Medical problems, surgery and medications can all cause delirium. It often starts suddenly, but usually lifts when the condition causing it gets better. It can be frightening – not only for the person who is unwell, but also for those around him or her.”

10 Living and Dying Well: A National Plan for Palliative and End of Life Care in Scotland, published by The Scottish Government in 2008 describes palliative and end of life care as “integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition.”
• We will develop inpatient care pathways within acute care and community hospitals to support comprehensive assessment, treatment, care needs and early supported discharge.

• We will develop day care pathways to support access to comprehensive assessment and treatment that encompasses the effective use of community hospitals.

• We will develop systems across primary care, community care and acute care to review and manage people with complex health needs.

• In line with the Fife Dementia Strategy: 2010 – 2020\textsuperscript{12} we will develop care pathways to deliver effective management of frailty, dementia and delirium\textsuperscript{9} across all care settings.

• We will develop care pathways across primary care, community care and acute care to deliver effective recognition and management of psychological difficulties.

• We will ensure that shared decision making is clearly visible at the centre of all patient pathways.

• We will strengthen care and communication with people, and those close to them, at the end of life\textsuperscript{10}.

• There will be increased confidence and clearer pathways linking primary care and acute medicine.

• Delirium will be detected and managed earlier which, in turn, enhances independence, participation and wellbeing.

• Psychological difficulties will be detected and managed appropriately which, in turn, enhances independence, participation and wellbeing.

• Families and carers are more able to adjust to the death of loved ones.

• Patients experience better end of life care in hospital.

• People feel comforted, comfortable, safe and cared for.
## Home-based Care

### Strategic Intent:

We will refocus services to actively support people to feel safe while living at home whilst reducing reliance on care, where this is in accordance with the person’s needs and wishes. The important role of the carer will be recognised in this and appropriate support provided.

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>• We will commit to providing enabling/re-abling care at home, resulting in proportionally more older people being able to remain at home safely, where this is in line with the needs of the person.</td>
<td>• Care at home will be re-focused in order to reduce dependency and place emphasis on personal responsibility and capability, where this is in the person’s best interests.</td>
</tr>
<tr>
<td>• In line with the Fife Dementia Strategy: 2010 – 2020 we will develop care pathways to deliver effective management of frailty, dementia and delirium across all care settings.</td>
<td>• The proportion of people receiving long term care in a care home or hospital setting will reduce.</td>
</tr>
<tr>
<td>• We will develop care pathways to deliver effective recognition and management of psychological difficulties across all care settings.</td>
<td>• Delirium will be detected and managed earlier which, in turn, enhances independence, participation and wellbeing.</td>
</tr>
<tr>
<td>• We will establish consultant-led community geriatric medical services to develop a range of community based interventions. These will work in collaboration with other relevant services such as community psycho-geriatric services, to prevent admission while providing specialist care required.</td>
<td>• Psychological difficulties will be detected and managed appropriately which, in turn, enhances independence, participation and wellbeing.</td>
</tr>
<tr>
<td>• We will provide a comprehensive assessment of medicine administration.</td>
<td>• People experience fewer adverse health (including medication) events.</td>
</tr>
</tbody>
</table>
Home-based Care ctd

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will identify areas where funding can be realigned from care home/hospital settings in order to increase opportunities for people to be cared for at home, where this is in line with the needs of the person.</td>
<td>• We will provide greater choice and flexibility of service provision.</td>
</tr>
<tr>
<td>• We will provide rapid access to a range of equipment and adaptations to help the older person’s needs.</td>
<td>• We will provide more opportunity for individualised care.</td>
</tr>
<tr>
<td>• We will work in partnership to actively develop a wider range of care models through the voluntary and independent sectors and social enterprises.(^\text{11})</td>
<td>• Reduced delays for assessment, care and support or equipment.</td>
</tr>
<tr>
<td>• We will strengthen care and communication with people, and those close to them, at the end of life.</td>
<td>• People will experience better end of life care in the community.</td>
</tr>
<tr>
<td>• Where it is the person’s wish, all possible effort will be made for older people to die at home through integrated work of health and social care staff with families and carers.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{11}\)The Social Enterprise Coalition defines “Social Enterprise” as “businesses trading for social and environmental purposes...distinctive because their social and/or environmental purpose is absolutely central to what they do - their profits are reinvested to sustain and further their mission for positive change.”
Recovery and Rehabilitation

**Strategic Intent:**

Everyone will have the opportunity to remain independent in their daily lives, and when indicated be actively supported to regain quality of life as defined by them.

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will develop a full range of rehabilitative focused intermediate care opportunities to support full recovery and rehabilitation where this is realistic and to the benefit of the person.</td>
<td>• People will have the opportunity to define their own goals and have support to achieve them.</td>
</tr>
<tr>
<td>• We will use an outcome approach across all partnerships in order to inform care planning and care management.</td>
<td>• People will be supported and empowered to do as much as they are able to and therefore be more independent of services and have greater opportunities to participate in society as they choose.</td>
</tr>
</tbody>
</table>
Common themes throughout an older person’s journey of care

There are key aspects relating to the care of older people that form the foundation of each of the stages of a person’s journey as detailed above. These are as follows:

1. The Role of Carers
2. The Role of Communities
3. Fit for Purpose Housing
4. Integrated Care

Carers

As highlighted in Caring Together: The Carers Strategy for Scotland 2010-2015, “Carers play a crucial role in the delivery of the health and social care system in Scotland. This role will become more important as a result of demographic and social changes. Carers need to be at the heart of a reformed health and social care system with a shift from residential, institutional and crisis care to community care, early intervention and preventative care.”

As such, carers should be treated as true partners in discussions about the person they care for.

NB: It is also important to recognise that carers have the right to choose not to be a carer – this choice should be respected.

Strategic Intent:

With the agreement of the person being cared for, we will keep carers at the centre of care provision – working together as true partners

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will further identify the partnership with carers groups in Fife in order to identify the support that carers need to continue in their caring roles.</td>
<td>• Carers will be involved as true partners in the care and support plan.</td>
</tr>
<tr>
<td>• We will launch a revised Fife Carers Strategy in line with Caring Together: The Carers Strategy for Scotland 2010 – 2015.</td>
<td>• Care plans will routinely reflect the needs of carers and their ability to continue in their caring role.</td>
</tr>
<tr>
<td>• There will be an emphasis on the provision of carer assessment in order to inform the response to those needs.</td>
<td>• Carers will be confident to continue their role with the knowledge that they are being listened to and supported as required.</td>
</tr>
<tr>
<td></td>
<td>• We will have increased knowledge as to what support carers require to enable them to continue the crucial role they play.</td>
</tr>
</tbody>
</table>
Community

As highlighted in Reshaping Care for Older People and the new Health and Wellbeing Plan for Fife, communities can play a key role in supporting older people as full participants in community life. Additionally, an emphasis on community well-being and utilising universal services is fundamental to addressing the ‘demand’ within the health/social care system.

<table>
<thead>
<tr>
<th>Strategic Intent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will actively nurture and develop communities to support and utilise older people as full participants within those communities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will engage with and support communities and the third sector to develop a range of services and activities to promote health and wellbeing of older people.</td>
<td>• The community will play a bigger role in preventing loneliness and isolation of older people.</td>
</tr>
<tr>
<td>• We will work with communities to build confidence in relation to providing care through supporting the development of social enterprises.</td>
<td>• The skills and knowledge of older people will be better utilised in designing services and activities that promote and maintain health and wellbeing.</td>
</tr>
<tr>
<td>• We will improve joint working across all agencies e.g. community education and activities for older people.</td>
<td>• Greater wellbeing and independence within our older population.</td>
</tr>
<tr>
<td>• We will facilitate older people being more involved and their contribution more valued within our communities.</td>
<td>• More local people will want to become more involved in providing a range of support for older people living in our communities.</td>
</tr>
<tr>
<td>• We will build on local peoples’ roles in caring and supporting older people in our communities through improved working with volunteers and the third sector.</td>
<td>• We will seek opportunities to work across the generations.</td>
</tr>
</tbody>
</table>
**Housing**

The Fife Housing Partnership / Health and Social Care Partnerships’ approach to specific needs housing targets support to sustain living arrangements; promote individual choices for independent and sustainable living; plan resources and services; promote partnership working; and provide equality of opportunity. In responding to the changing demographics in Fife, the needs of older people in particular are being addressed through the Specific Needs Housing Approach.

### Strategic Intent:

**We will actively ensure older people have access to information, advice and housing support services to enable independent living of their choice.**

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advice and information on housing options will be available in a range of formats and locations.</td>
<td>• Older people are provided with quality assured housing advice and information.</td>
</tr>
<tr>
<td>• Housing Support Services will be designed and targeted according to demand and need.</td>
<td>• Older people are offered appropriate housing support services to sustain their choice of living arrangements and facilitate independent living.</td>
</tr>
<tr>
<td>• We will ensure rapid access to appropriate adaptations to properties.</td>
<td>• Older people can access housing adaptations which will allow for retention of both their dignity and independence.</td>
</tr>
</tbody>
</table>
Integrated Care

Wherever possible and appropriate, care should be integrated between the relevant agencies i.e. health, social care, housing, the third sector and the independent sector.

Strategic Intent:

Integrated care provision should be put in place to support improved outcomes

<table>
<thead>
<tr>
<th>Areas of work</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We will extend the range and scope of multi-agency community teams.</td>
<td>• Joint working and integration will be intentionally designed to meet the outcomes as expressed by people who use services.</td>
</tr>
<tr>
<td>• We will achieve integration of out of hours services.</td>
<td>• We will make the best use of staff skills and avoid duplication of effort.</td>
</tr>
<tr>
<td>• We will prioritise the delivery of a joint information and data collection and dissemination system that is effective and supports effective practitioner working and person centred outcomes.</td>
<td>• People who use the services will experience a more straightforward care model which is easier to understand and access.</td>
</tr>
<tr>
<td>• We will further develop the infrastructure around integrated planning, governance and leadership.</td>
<td>• There will be a good flow of information and improved data recording to reduce the recording burden for staff and repetition for service users and their carers.</td>
</tr>
<tr>
<td></td>
<td>• Staff will have greater satisfaction in their roles.</td>
</tr>
<tr>
<td></td>
<td>• People who use the services will have high levels of satisfaction and confidence about effective joint working.</td>
</tr>
<tr>
<td></td>
<td>• People will feel confident and listened to and be reassured that there is a safety net.</td>
</tr>
<tr>
<td></td>
<td>• Staff will have more time to spend with people.</td>
</tr>
</tbody>
</table>
### Appendix 1: Key policy documents/areas of work relevant to older people used to inform the Strategy

<table>
<thead>
<tr>
<th>Policy document/Area of work</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Outcomes for Older People</td>
<td>April 2005</td>
</tr>
<tr>
<td>Building a Health Service Fit for the Future (Kerr Report)</td>
<td>May 2005</td>
</tr>
<tr>
<td>Delivering for Health</td>
<td>November 2005</td>
</tr>
<tr>
<td>SPARRA: Scottish Patients at Risk of Readmission and Admission</td>
<td>August 2006</td>
</tr>
<tr>
<td>Visible, Accessible and Integrated Care: Review of Nursing in the Community in Scotland</td>
<td>November 2006</td>
</tr>
<tr>
<td>Developing Community Hospitals: A Strategy for Scotland</td>
<td>December 2006</td>
</tr>
<tr>
<td>Community Health Partnerships Long Term Conditions Toolkit</td>
<td>January 2007</td>
</tr>
<tr>
<td>Co-ordinated, Integrated and Fit for Purpose: A Delivery Framework for Adult Rehabilitation in Scotland</td>
<td>February 2007</td>
</tr>
<tr>
<td>All Our Futures: Planning for a Scotland with an Ageing Population</td>
<td>March 2007</td>
</tr>
<tr>
<td>Fife Framework for Older People Services</td>
<td>March 2007</td>
</tr>
<tr>
<td>Active for Later Life – Promoting Physical Activity with Older People</td>
<td>June 2007</td>
</tr>
<tr>
<td>Better Health, Better Care</td>
<td>August 2007</td>
</tr>
<tr>
<td>Let’s Make Fife More Active! - A Strategic Framework for Physical Activity in Fife</td>
<td>March 2008</td>
</tr>
<tr>
<td>Independent Review of Free Personal and Nursing Care in Scotland</td>
<td>April 2008</td>
</tr>
<tr>
<td>Living and Dying Well: A national action plan for palliative and end of life care in Scotland</td>
<td>September 2008</td>
</tr>
<tr>
<td>The Self Management Strategy for Long Term Conditions in Scotland</td>
<td>September 2008</td>
</tr>
<tr>
<td>Reshaping Care for Older People</td>
<td>May 2009</td>
</tr>
<tr>
<td>The Fife Dementia Strategy: 2010 - 2020</td>
<td>March 2010</td>
</tr>
<tr>
<td>Scotland’s National Dementia Strategy</td>
<td>June 2010</td>
</tr>
<tr>
<td>Self-directed support: A National Strategy for Scotland</td>
<td>October 2010</td>
</tr>
</tbody>
</table>
Appendix 2: Consultation Questionnaire

Please answer the following questions

Q1: In what capacity are you responding to this consultation (e.g. patient, client, older person, carer, health care professional, social care professional, other professional etc)?

Please note: you do not have to answer this question if you do not wish to. If you choose not to answer it, please move on to the next question.

..................................................................................................................................................
..................................................................................................................................................

Q2: Do you agree with the purpose of the strategy? (page 1)

(Please delete as appropriate)

Yes       No       Don’t Know

Please comment

Q3: Do you agree with the scope of the strategy? (page 2)

Yes       No       Don’t Know

Please comment

Q4: Do you agree with the principles of the strategy? (page 8)

Yes       No       Don’t Know

Please comment

Q5: Do you agree with the strategic priorities? (page 9)

Yes       No       Don’t Know

Please comment

Q6: Do you agree with the strategic intent for Preventative/Anticipatory Care? (page 11)

Yes       No       Don’t Know

Please comment

Q7: Do you agree with the strategic intent for Unplanned Care? (page 12)

Yes       No       Don’t Know

Please comment

Q8: Do you agree with the strategic intent for Hospital-based Care? (page 13)

Yes       No       Don’t Know

Please comment

Q9: Do you agree with the strategic intent for Home-based Care? (page 14)

Yes       No       Don’t Know
| Q10: Do you agree with the strategic intent for **Recovery and Rehabilitation**? (page 15) | Yes | No | Don’t Know
| Q11: Do you agree with the strategic intent for **Carers**? (page 16) | Yes | No | Don’t Know
| Q12: Do you agree with the strategic intent for **Community**? (page 17) | Yes | No | Don’t Know
| Q13: Do you agree with the strategic intent for **Integrated Care**? (page 17) | Yes | No | Don’t Know
| Q14: Do you feel the time period of 15 years to deliver the strategy is right? Should there be a review of the strategy at some point in this time period? | Yes | No | Don’t Know
| Q15: What do you feel should be the priorities for the next 12 months for taking the strategy forward? | | | |
| Q16: Do you have any other comments you would like to make about the DRAFT Joint Health & Social Strategy for Older People in Fife? | | | |
References


