

12. OLDER PEOPLE PLANNING FRAMEWORK

(This framework should be read in conjunction with the Long Term Conditions, Cancer and Unpaid Care Frameworks as there is significant inter relation of these work programmes.)

12.1 Analysis of Local Position

- 12.1.1 Services for older people are planned jointly through the Older People's Joint Planning, Performance and Implementation Group (OPJPPIG). Membership includes representation across health, social work, voluntary organisations and public partnership forum to ensure an inclusive contribution to planning services to meet the needs of older people. There are established links to our Carers and Palliative Care JPPIGs to ensure these groups address the specific needs of older people.
- 12.1.2 The Rehabilitation and Enablement Managed Care Network has a lead role in taking forward the implementation of the '*Delivery Framework for Adult Rehabilitation in Scotland*' within Renfrewshire. Our Community Rehabilitation and Enablement Service will be implemented from May 2010. The Managed Care Network aims to support the existing health, social work, community based and hospital based outreach services to continue to develop and improve the services and outcomes for people in Renfrewshire. It will provide clear and effective direction to support the full implementation of the NHSGGC Community Rehabilitation and Enablement Framework.
- 12.1.3 'Single Point of Access' was implemented in July 2009, as phase one of the implementation process of the framework delivery. Future work will build on this and will deliver the rehabilitation and enablement service in an integrated and targeted way.
- 12.1.4 The Older People's Priority Group is a short life working group of the OPJPPIG which is currently considering the priorities for the next year and beyond and will make recommendations on the future planning of service priorities within available resources.
- 12.1.5 The Extended Professional Executive Group was set up with the partnership in order to oversee implementation and coordination of the Long Term Conditions, Community Rehabilitation & Enablement and the Primary Care Strategy frameworks (Ref: Long Term Conditions Planning Framework).
- 12.1.6 The Long Term Conditions Strategy is to improve the health and well being of people with long term conditions; to keep people as healthy as possible for as long as possible with the aim of reducing the incidence and impact of long term conditions. Through the extended PEG a scoping exercise is currently underway to identify the models of self managed care programmes in place within Renfrewshire. We will work in partnership with the NHS Greater Glasgow & Clyde Long Term Conditions Steering Group and the voluntary agencies to develop self management, expert patient models encouraging and increasing the opportunities for individuals to proactively manage their own conditions.
- 12.1.7 Talking Points is the personal outcomes approach which uses a tool to gather the views of users and carers about their lives and the outcomes they want, and captures this information to inform service design. A pilot is progressing within

Paisley Area Social Work Team which will be reported June 2010. In addition we are introducing this approach in our District Nursing Services with a view to roll out during 2010/11.

- 12.1.8 Shifting the Balance of Care has been a key driver in changing services locally and the main change in 2010 will be the closure of Johnstone Hospital and the associated community service development. District Nursing and AHP services play a significant role in supporting older people at home providing assessment and care management, patient education to support self care and promoting health improvement. A redesign of our District Nursing Service is underway with the aim of being fully progressed by 2013. There will be a readjustment of current teams and skill mix based on the analysis of caseload profiles and population health to ensure that we focus our efforts on effective management of long term conditions and rehabilitation and enablement.
- 12.1.9 Following a successful pilot we are in the process of rolling out the Liverpool Care Pathway (LCP) to all GP practices in Renfrewshire. This will facilitate improved palliative and end of life care at home and prevent avoidable hospital admission. Our plans to introduce the 'Just in Case Box' scheme to enable effective prescribing and symptom control in end of life care at home are well progressed with staff education programmes planned during 2010/11. In addition we are piloting the use of the Supportive and Palliative Action Register (SPAR) in 3 local authority care homes. This will be supported by learning and education programmes for care home staff and work to improve joint working between GPs, out of hours services and care homes.
- 12.1.10 Renfrewshire's performance against zero discharges over 6 weeks has declined since June 2009. Renfrewshire Council has forward placed a number of people against profiled placement activity and has transferred funding from community based placements to the hospital team. In addition an increased level of funding has been made available by NHS GG&C and the Council. An audit of people affected by delayed discharge has been completed to ensure that assessment practice is appropriate. Work is also underway to focus on achieving reduction in delayed discharges under six weeks. The partnership is working closely with the Joint Improvement Team to address ways in which to reduce the numbers of these delays and how this can be sustained in light of demographic change.
- 12.1.11 HEAT target to increase in % of long term care recipients > 65 years and receiving intensive care at home (10 hrs+) remains a target for 2010/11. Performance in Renfrewshire has decreased against target since the introduction of community meals service in 2008. As a result the home care hours allocated to meal preparation were no longer needed for the majority of cases. A Home Care Modernisation process is currently underway within Renfrewshire Council Social Work Services. The purpose is to improve integration with social work area teams and improve performance and outcomes for service users. The modernisation process will consider how these services contribute to the re-ablement approach, and alongside other developments to introduce a more flexible, personalised service.
- 12.1.12 Renfrewshire Council Social Work Services are in the process of implementing the recommendations from the Day Care Service Review. This will be monitored by the OPJPIIG.
- 12.1.13 Dementia : the CHP is connected to the Mental Health Collaborative approach via our Clinical Nurse Specialist EMI and the OP JPIIG. The CHP performance was

above the HEAT target for both March 2009 and October 2009. Our Clinical Governance Lead GP has written to all practices sharing the anonymised data and sharing good practice. In the period 01/01/09 to 11/12/09, 372 patients were offered first appointments at the memory clinic for assessment. The assessments and pathway at the memory clinic are based on the Dementia ICP. The CHP is part of a pilot involving Renfrewshire, East Renfrewshire and Alzheimer Scotland focusing on structured intervention, support and information following diagnosis.

12.2 Numeric Analysis

- 12.2.1 Renfrewshire has a GP practice registered population of 176,000, 65% are young and middle-aged adults and 16% are older people. In total there has been a drop of around 7,000 over the same period. Renfrewshire has seen an increase in the actual numbers and proportion of people over 65 years. This has been more marked in the 75 age group. Using current population projections, it is expected that between 2002 and 2013 the number of people over 65 years in Renfrewshire will rise by approximately 5000; an increase of 15%. The number of people aged over 75 years is due to rise by 23%. There will be a notable rise in the number of older people with long term conditions and dementia. There is also likely to be a reduction both in unpaid carers and the workforce that currently provides paid care.

The projected rise in older people in Scotland and Renfrewshire between 2006 and 2020 is significant. The over 65 population in Renfrewshire is set to rise by 28% and over 85's by 50% in this time period (against similar rises for the whole of Scotland).

- 12.2.2 Over 27,000 older adults in Renfrewshire live in circumstances of relative multiple deprivation. The Scottish Index of Multiple Deprivation charts the numbers living in areas of high relative deprivation.
- 12.2.3 As at March 2008 Renfrewshire had 7445 emergency hospital admissions of older people aged 65+. This is 9.54% (652 admissions totalling 8150 bed days or 28 beds based on an 80% occupancy rate) above the Scottish average based on pro rated population. As at August 2007 ISD reported a rate of 9.2% above the Scottish average, so this is a slightly less good performance than in August 2007.

The average length of stay of each of these 652 emergency admissions is 12.5 days which is below the Scotland Average of just over 13 days.

- 12.2.4 Renfrewshire's performance against zero discharges over 6 weeks has declined since June 2009. Renfrewshire Council has forward placed a number of people against profiled placement activity and has transferred funding from community base placements to the hospital team. At census date February 2010 there were 8 delayed discharges none of which related to funding.
- 12.2.5 The Scottish Intercollegiate Guidance Network (SIGN) 86 clinical recommendations and the national HEAT target to increase diagnosis and treat dementia has shown an increase in Renfrewshire. Register target is set at 60% of predicted prevalence (set nationally) and Renfrewshire has achieved this with a rate of 68%.
- 12.2.6 Reaching Older Adults in Renfrewshire (ROAR) is a public social partnership working together to design and deliver low level of care and befriending services for older people The CHP contributes to the funding of this initiative. Social

networks deteriorate as people get older and it becomes harder to make new friends. Social isolation can lead to depression, loneliness and anxiety, this in turn stops people from interacting with their local communities and ability to access services they need.

Organisation	Activity	Service users	Volunteers	
WRVS	Befriending and outings	67	30	
	Telephone information service	17/day		
	Transport to appointments	7	11	
	ROAR Clubs	Johnstone Linwood Houston	47 25 27	14 7 14
Alzheimer Scotland	Specialised befriending service	7	5	
Renfrewshire Seniors	ROAR Clubs	Lochwinnoch	35	12
RCHI	Proposed health and well being programme delivered to ROAR clubs and seniors forums			
Renfrewshire Citizen Advice Bureau	New development - service users made use of advice service			

12.3 Health Gap and Key Issues

12.3.1 Health inequalities is a major issue for older people. Identification of these and plans to address them will take place through Equality Impact Assessments. A number of these have been identified as priority for our Rehabilitation and Enablement Service. These are:

- Single Point of Access
- Service information for the public
- Service specification for our community Rehabilitation and Enablement Service
- Exit strategy from service to support self care

12.3.2 There is correlation between deprivation and the health and social well being of older people – in particular the impact of poverty. 19% of older people live below the official poverty line (Help the Aged). People living for long periods following retirement on limited pension are an increasing concern.

12.3.3 Population ageing means that we are faced with unprecedented numbers of people who have many things wrong all at once. These people are frail and they challenge how health care is delivered (*Professor K Rockwood*).

Addressing these needs requires multi agency and multi disciplinary approaches. Therefore, we need to address our above average rate of emergency admissions for people age 65 years and delayed discharges over 6 weeks over in Renfrewshire by providing services that particularly are focussed on reducing readmission.

- 12.3.4 A steady growth in the incidence of dementia in older people in Renfrewshire is predicted over the next 25 years. In 2010 it is suggested that there are approximately 1800 people with dementia. This is expected to rise to 1984 in 2014 and 2544 in 2024, an increase of 39%. This increase will require early diagnosis, provision of suitable day care, support to carers and in particular older carers, and suitably skilled staff to deliver care in the most appropriate care setting within available resources. Although we are meeting current demand within in community services, the predicated increases will be challenging. We require to continue to improve public and staff awareness, provide clear referral routes, timely diagnostic assessments and improved early management and support.
- 12.3.5 The local system continues to fail in delivering zero delayed discharges. We need to deliver a reduction in delayed discharges that is sustainable. Our work to date on intermediate care services provides a solid foundation for the emerging community rehabilitation and enablement services which will link closely to our redesign of District Nursing Services and other mainstream community services.
- 12.3.6 We continue to improve our involvement of older people and their carers in planning and reviewing our services. There is a need to continue to improve in this area and also to ensure more meaningful involve people in defining their goals and outcomes. Our early work on the use of the 'Talking Points' tool will inform future work.
- 12.3.7 By 2013, we anticipate we will need to support at least 230 additional older people per year who require the level of care that a care home currently provides. Our current services are and will continue to be under pressure to meet the needs of our population within available resources. Redesign work will be key to meeting and supporting this demand and will be a priority for the OPJPPIG.

12.4 Outcomes Table

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>The health and care system of GGC optimises outcomes for older people, use of resources and continues to be sustainable in face of mounting pressures.</p>	<ul style="list-style-type: none"> - NHS Greater Glasgow & Clyde Board to develop a strategy to reflect the emerging work from 'Reshaping Services for Older People'. <p>We will contribute to this process and ensure our local planning takes account of this via OP JPPIG. Already working with JIT on work emerging re Frailty Pathway.</p>	<p>Strategy which meets the needs of the population of Renfrewshire.</p> <p>Development of local implementation plan to deliver required outcomes/benefits.</p>
<p>People remain active in later life, continue to have meaningful things to do and are part of their local communities. People are enabled to stay healthy. People can access a range of employment and volunteering opportunities. People maintain their social and family networks. People are well informed about the choices available to them. People enjoy a range of leisure services & social activities. People can access transport. People can access health, care and support services when required.</p>	<ul style="list-style-type: none"> - Further develop the Guide to Health and Well Being in Later Life in Renfrewshire. This forms part of the activities being developed for older people to maintain an active ageing/lifestyle. - The carer's service are working with the carers JPPIG to determine the shape, direction and level of short break provision. - Implement the recommendations arising from the Social Work review of day care services. - Explore models (eg local area coordination) to help people access leisure activities and social opportunities. - Support care homes to maintain people's links with their local community. - Work with council and community planning partners to improve access via sustainable modes of transport. 	<p>Monitor via OP and Carers JPPIGs. Production and implementation of revised guide.</p> <p>Monitor demand and provision of respite and identify any gaps.</p> <p>Identify models for RCHP and monitor uptake.</p> <p>Test initially in the 3 Council homes.</p> <p>Numbers using hospital evening visitor transport scheme Support for ROAR (Reaching Older Adults in Renfrewshire) in exploring other community</p>

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	<ul style="list-style-type: none"> - Work to maintain or improve access performance and develop primary care capacity. - Work across partners to reduce isolation and strengthen support for older people. - Challenge the widespread ageism which leads people to believe that mental health problems are an inevitable part of growing older, and therefore that nothing can be done. - Focus on preventing depression and anxiety and promoting positive mental health. 	<p>transport initiatives</p> <p>Monitor via SPOA and R&E Services</p> <p>Activity reports re ROAR.</p> <p>Plan awareness raising via launch of Dementia Strategy June 2010. Monitor via SSA.</p> <p>Care Management approach.</p> <p>Doing well.</p>
<p>People with care and support needs have a say in finding solutions personalised to their needs and aspirations.</p> <p>Peoples' capabilities and aspirations are recognised.</p> <p>People are supported to identify their priorities.</p> <p>People have a say how their support is personalised to their circumstances.</p> <p>People receiving care and support experience positive outcomes from our work with them (safety, dignity and respect)</p> <p>Carer's contributions are recognised and they are supported to continue in their caring role.</p>	<p>We will progress communication and engagement with older people to inform service development linking with the Public Partnership Forum. Particular areas to focus will be hard to reach groups, those who are housebound and those people with a diagnosis of dementia.</p> <ul style="list-style-type: none"> - Talking Points pilot commenced in Paisley Area Social Work Team. - Carers self assessment now in use for all carers identified. This is forwarded to social work where these are recorded and monitored. Needs identified and will 	<p>Monitor via OP and Carers JPPIGs.</p> <p>Evaluation of pilot and subsequent roll out.</p> <p>Report on numbers and needs arising from assessment ensuring these are addressed.</p>

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	<p>action a full carers assessment if required.</p> <ul style="list-style-type: none"> - All people who have been identified with complex needs will have a risk assessment carried out as part of their assessment process. - The introduction of the Rehabilitation and Enablement service will deliver rehabilitation to people across a number of settings in Renfrewshire. 	<p>Monitor via SSA and Care Management approach.</p> <p>Monitor against High Impact Changes in R&E Framework.</p>
<p>People live as independently and safely as possible.</p> <p>More people and people with a disability are living in housing appropriate to their needs.</p> <p>People are able to make realistic lifestyle choices.</p> <p>People are supported to plan and prepare for the future.</p> <p>People's independence is maximised and they are supported to recover from injury or illness.</p> <p>People are well informed about the choices available to them.</p> <p>People feel safe in their communities and are protected from harm.</p>	<p>We will support older people to encourage independence and facilitate a more pro active approach to self manage their condition where possible. Our staff will be supported with targeted learning and education programmes to meet future service needs and ensure evidence based practice.</p> <ul style="list-style-type: none"> - Renfrewshire continue to develop the Telecare services. Progress to developing a specialist training environment is underway. - A pilot has commenced within a few identified GP practices to work with district nurses and GP to support those patients in the practice identified through SPARRA and also using other risk identifiers. - The extended Professional Executive Group is progressing work to scope out current models of self care for those 	<ul style="list-style-type: none"> - HEAT T8: To increase the level of older people with complex care needs receiving care at home. Consider with review of home care as part of Renfrewshire Council Transforming Social Work. - Monitor via OP and Carers JPPIGs. - Report number of staff trained. - Report provision of telecare and impact on maintaining people at home. - Evaluate and report on pilot. - Monitor via ePEG work plan. - Implement Directory of Services - Evaluate usage and impact on service

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<p>people in Renfrewshire with long term conditions. This will be incorporated within the directory of service in order for people to be sign posted to the appropriate</p> <p>Progress the development of Reaching Older Adults in Renfrewshire (ROAR) model within the partnership.</p>	<p>users and carers</p> <ul style="list-style-type: none"> - ROAR reports regularly on performance measures to OPJPPIG.
<p>Older people are able to maximise opportunities for recovery and re-ablement. People take control of their own health. People have access to the resources to keep as fit and as healthy as possible. People are supported to manage long term health conditions. People experience timely, coordinated and effective responses when they contact services. Fewer people are admitted to hospital unnecessarily. Where people are admitted to hospital they receive timely assessment and support to facilitate their discharge. The number of people admitted to permanent residential or nursing home care is reduced.</p>	<ul style="list-style-type: none"> - A re-enablement pilot has been progressing through social work, this will be reported to the OPJPPIG and recommendations will be made with an action plan detailed to take this forward. - Phase one of the rehabilitation and enablement service has implemented a single point of access. This provides rapid access to services for all referrals from professionals. - Phase two will see all referrals for 	<ul style="list-style-type: none"> - HEAT T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11. - HEAT T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E - HEAT T12: By 2010/11, to reduce emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05. - Monitor via OP and Carers JPPIGs. - Evaluation report (now available). - Phase 2 – implement July/August 2010

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<ul style="list-style-type: none"> - rehabilitation from professionals - Phase three will progress direct referrals from the public through the single point of access - Progress the EQIA for the Rehabilitation and Enablement Service and monitor and evaluate this process on the services. - Local mapping in progress to identify structured education and support programmes offered by voluntary sector - Pathways of care through the rehabilitation and enablement service identified to improve the journey of care for people. This will be implemented when established. - The OPJPIG are progressing the balance of care for older people and EMI. - EMI day hospital under a review process at present, this is being progressed to complement the work already achieved within the delivery of the Rehabilitation Framework. - The discharge process for older people with complex needs will be progressed through the single point of access. - A new direct referrals process for homecare has been established to promote a rapid response for discharge. 	<ul style="list-style-type: none"> - EQIA completed. Action Plan developed and implemented. - Monitor use of pathways and patient experience. - Review recommendations will report September 2010. - Monitor and evaluate outcomes and patient experience. - Monitor and report performance against standard.
<p>People with dementia and their family carers receive the treatment, care and support following diagnosis that enables them to live as well as possible with dementia regardless</p>	<p>Work to improve liaison arrangements between GPs, psychiatrists, nurses, community pharmacy, care homes, and community services in prescribing and</p>	<ul style="list-style-type: none"> - HEAT T9: To achieve agreed improvements in the early diagnosis and management of patients with a dementia

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<p>of setting.</p> <p>People with dementia have access to a pathway of care that delivers early assessment, diagnosis, treatment, care and support following diagnosis.</p> <p>People with dementia and their carers can access an appropriate range of help and support in the community.</p> <p>People with dementia shape their own support and have their rights and dignity protected.</p> <p>Public and professional awareness and understanding of dementia is improved and the stigma associated with it addressed.</p>	<p>medicines management.</p> <ul style="list-style-type: none"> - Implement Part V of the Adults with Incapacity Act. - The Older Adults Mental Health Team will be integrated in to the Rehabilitation and Enablement Service. <p>Evaluate behaviour management approaches and implications for training and development.</p> <ul style="list-style-type: none"> - Support people with a recent diagnosis to plan for future support. - Develop good quality information on dementia and support from diagnosis onwards. - Develop and manage care pathways for people with dementia across the whole system, including community, care home, hospital and end of life care. - Develop the range and quality of support available in the community for people with dementia. - Develop transitions management in relation to admission, discharge and crisis response. - Develop understanding of approach to and evaluate the management of dementia in general hospital and non-specialist settings. - Develop the skills and knowledge of non-specialist workforce. - Improve the knowledge and understanding of service providers working with people with dementia. 	<p>by March 2011.</p> <p>Monitor via OP and Carers JPPIGs.</p> <p>Audit and report on ICP Dementia.</p> <p>Map current provision and uptake.</p> <p>Include in R&E service specification.</p> <p>Address via Dementia Strategy Implementation in partnership with Acute Services.</p> <p>Include in L&E plans.</p>

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
	<ul style="list-style-type: none"> - Review standards of service delivery for people with dementia with the aim of improving quality of care. - Review arrangements for protecting the rights of people with dementia. - Target health improvement activity on lifestyle changes which may reduce incidence or slow progress of dementia. Consider physical checks and interventions to improve quality of life. - Raise awareness and understanding of dementia and promote early identification and improved response. 	<p>Inpatient and community services – review and reuse service standards and audit same.</p> <p>As part of Adult Support and Protection plan.</p> <p>Include in Health Improvement plans.</p> <p>Consider links to NGMS contract.</p> <p>Address via Dementia Strategy launch and implementation.</p>

12.5 Finance and Workforce

- 12.5.1 The future community and rehabilitation and enablement service will, in the first phase, be developed from a redesign of existing services and teams into an integrated single service. In year one the main challenge will be ensuring effective implementation the NHSGGC HR process, and subsequent redesign whilst maintaining existing service provision. This will require to be supported by a targeted learning and education focussed on optimising improved outcomes for service users and carers and continuing our cultural change programme. In parallel we will continue to discuss feasibility of future integration of social work physical disability services within our service model and to review existing CHP adult community health service provision in line with Renfrewshire Council's Transforming Social Work Programme.
- 12.5.2 Resources for the Older People's Financial Framework are established and monitored through the Older People's JPPIG. In 2010/11, without adding any new commitments, the Older People's Financial Framework as a whole has significant financial pressures, and financial balance will be a major challenge.