

Strategic Commissioning Plan Services for Older People & People Living with Dementia 2019-2023

*"Increasing wellbeing and reducing health inequalities across all
communities in West Lothian"*

Contents

| | |
|---|----|
| 1. Introduction | 3 |
| 2. Our Approach | 4 |
| 3. Previous Commissioning Plan Priorities and Key results | 8 |
| 4. West Lothian Context | 19 |
| 5. Developing the Strategic Commissioning Plan for 2019 -2023 | 21 |
| 6. Consultation and Engagement | 22 |
| 7. Our Strategic Priorities | 24 |
| 8. Finance | 29 |
| 9. Next Steps | 30 |
| 10. Monitoring and Review | 38 |
| Appendix 1 - Details | 39 |
| Appendix 2 - Older People Commissioning recommendations in 2015 | 40 |
| Appendix 3 - National Health and Wellbeing Outcomes | 42 |
| Appendix 4 - Links | 43 |

1. Introduction

In West Lothian we believe in providing support and services that allow our citizens to live well. The Older People and People Living with Dementia Commissioning Plan will act as a tool to allow us to work to this common goal across our organisation.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires arrangements to be put in place for the delivery of integrated health and social care. As a result of this we have published the [West Lothian Integration Joint Board Strategic Plan 2019-23](#) setting out both our aims and strategic priorities to achieve this ambitious goal. The vision of the plan is:

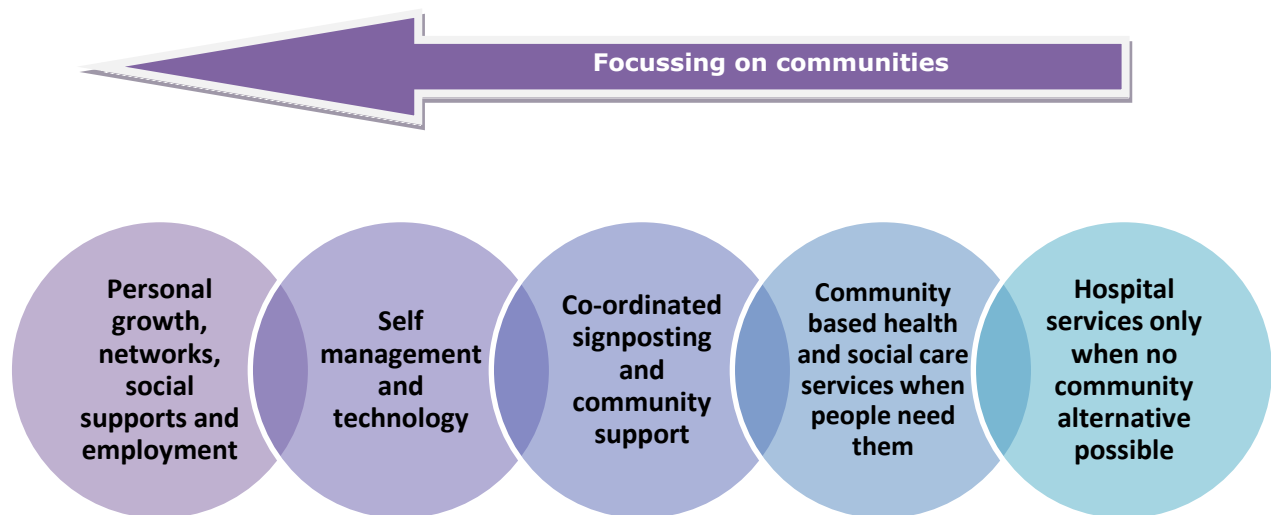
"To increase wellbeing and reduce health inequalities across all communities in West Lothian"

By working to the values of both West Lothian Council and NHS Lothian, The Integration Joint Board (IJB) has developed a set of values that will underpin the future commissioning of the services outlined in this plan.



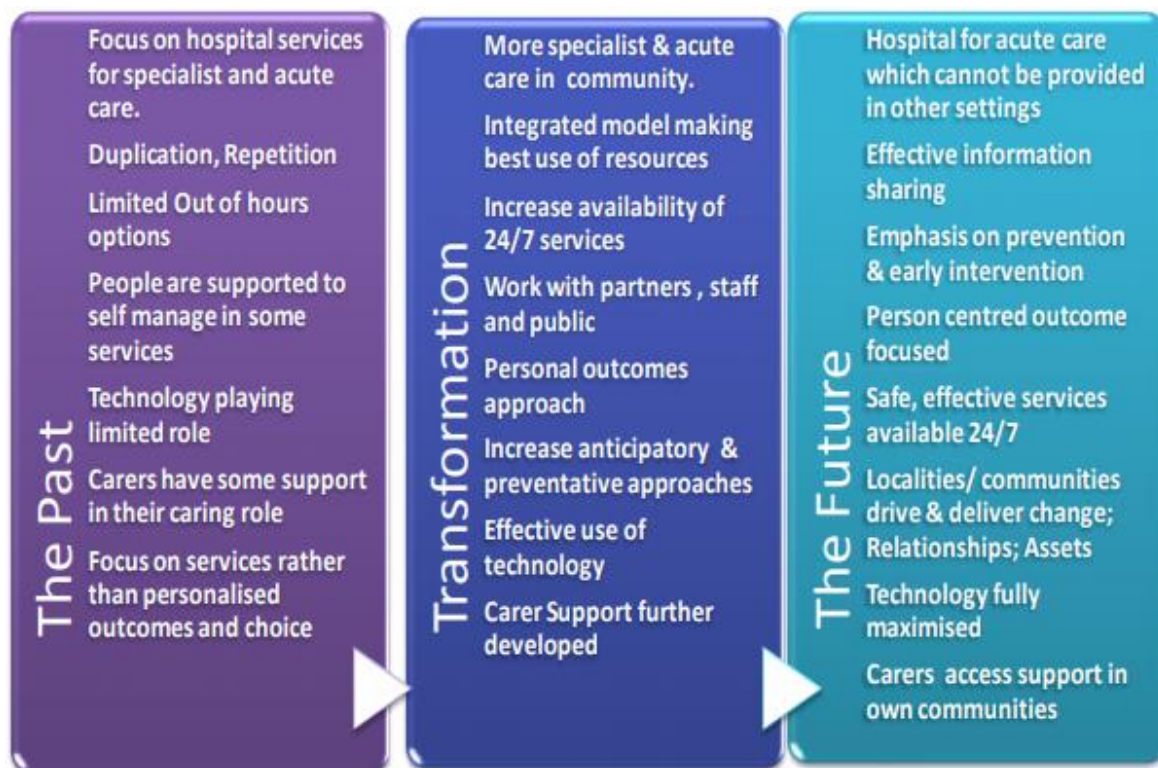
2. Our Approach

We have adopted a whole system approach to reviewing and developing older people and dementia commissioning in West Lothian. This means that we are thinking about how we invest our resources in hospital, community health and social care services in the future, recognising that in many instances services are delivered best when they are offered locally. We are working on the principle of offering health and care services in community settings unless there is a very good reason not to. We are focussing on how we shift the balance of care towards delivery of care and support at the right time in local communities.



Significant transformational change takes time and we recognise that it may take longer than the span of this plan to achieve all the changes we need. This plan, however, builds on previous work and provides a firm foundation for developing our older people and dementia services in West Lothian over the next three years. We need to think carefully about how we use our financial resources and develop our workforce to deliver new ways of working. It will be necessary to invest in some services and disinvest in others as our plans develop. We also need to build a sustainable workforce to address some of the workforce challenges we face, and to deliver the changes we need. We will ensure that we focus on maximising opportunities for integrated and partnership working.

The vision for transformational change in Health and Social Care in West Lothian is described in more detail below:



Development of this commissioning plan for older people and people living with dementia services has involved both targeted and open consultation processes with service users, carers, families, service providers from the third and independent sectors and staff from across the West Lothian Health and Social Care Partnership (WLHSCP) in the identification of our priorities. The consultation and engagement undertaken has allowed the WLHSCP to identify what matters most to those directly affected by the commissioning of existing and new services in West Lothian.

In March 2009, the Ministerial Strategic group for Health and Wellbeing (MSG) agreed to develop a strategy for reshaping care for older people to improve quality and outcomes of current models of care being mindful of projected demographic increases and financial pressures which impact resources. The Scottish Government published Reshaping Care for Older People programme 2011 to 2021 which contained the guiding ambition

The strategy focuses on improving:



- Prevention and early intervention

- Access to services to joined up services which enable older people to stay in their own home

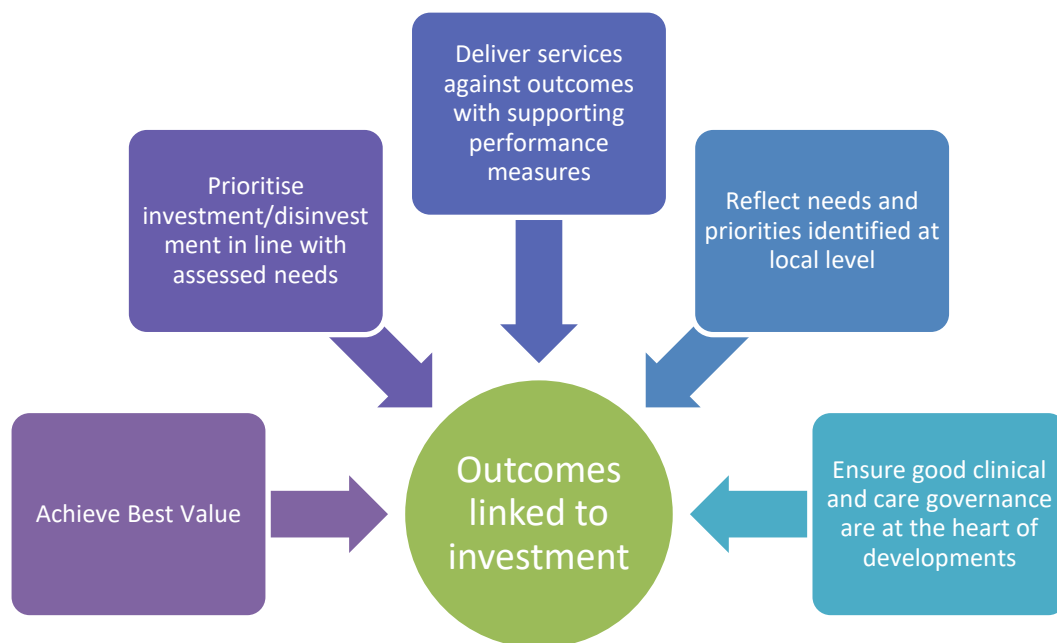
- Partnership working

- Rights, information and planning

The Scottish Government published Health and Social Care Standards: My Support, My Life in June 2017. The new Standards set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld. The development of our services will continue to be based on the following underpinning principles:



The development of the new West Lothian Commissioning Plan for Older People and People Living with Dementia has involved consultation with the Integration Joint Board's Strategic Planning Group, the Older People Commissioning Board, service providers and service users, and carers and aims to:



Climate Change

West Lothian Integration Joint Board acknowledges its position of responsibility in relation to tackling climate change in West Lothian.

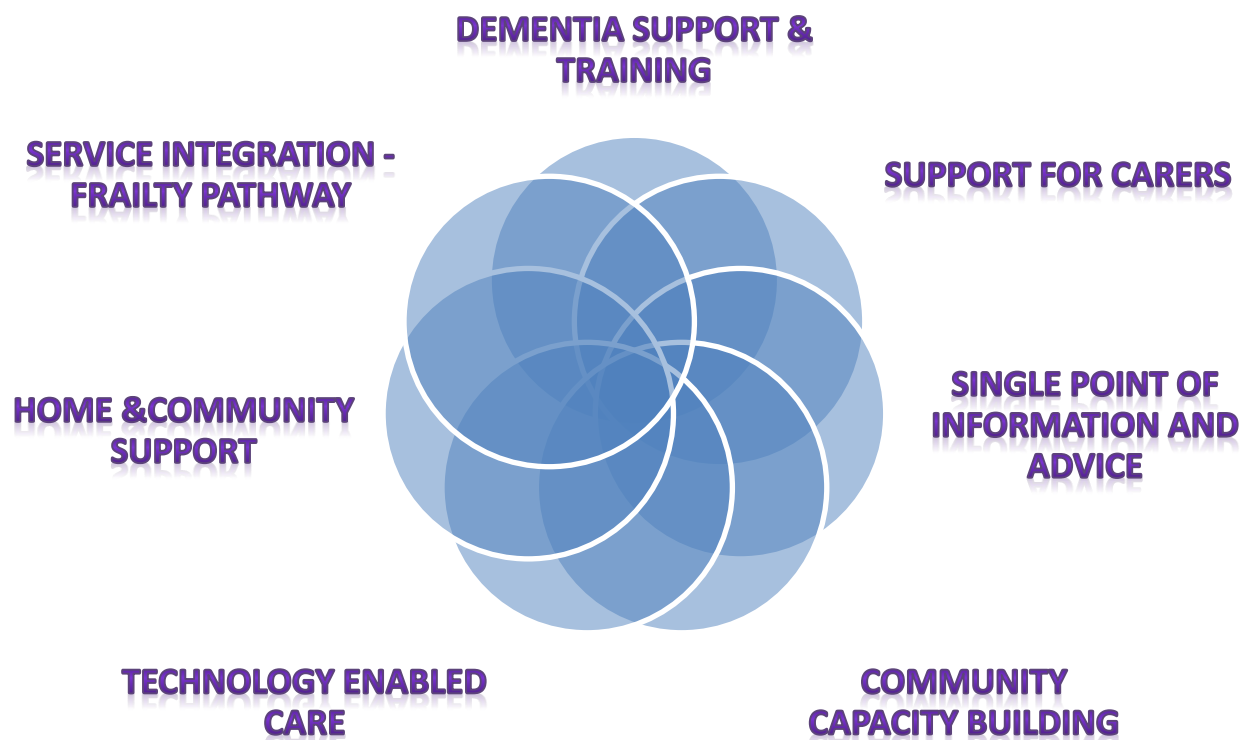
Organisations have a corporate responsibility to manage resources in a sustainable manner and in a way that minimises damage to the environment, for example through reducing the use of paper or emissions produced from vehicles and machinery, or simply disposing of waste materials in an environmentally conscious manner.

West Lothian IJB commits to influencing and encouraging an environmentally responsible approach to the provision of health and social care services in West Lothian wherever possible, through its strategic aims and decision-making processes.

3. Previous Commissioning Plan Priorities and Key results

In 2015, independent specialists in research were commissioned by the WLHSCP to develop a comprehensive [needs assessment - part 1](#) & [needs assessment - part 2](#) which was used as the basis for the 2016/17 to 2018/19 commissioning plan for older people services. The principles and key measures identified in that research continue to provide the foundation of our new commissioning plan, however, the priorities identified have been updated to take account of the current position in West Lothian and the themes emerging from recent consultation and engagement.

The main priorities for development identified in the previous plan were:



Service Integration- Frailty Pathway

Integrated Discharge Hub

During the course of the plan, significant problems were experienced with delays in discharging people from hospital. Many of the delays related to difficulties in securing sufficient supply of care at home services and care home places in the community. It was also recognised that we needed to identify patients to be discharged at an earlier opportunity and ensure there was a more integrated approach to planning their ongoing care and support in the community.

In response to rising levels of delayed discharge and in an effort to ensure that people received the right care and support at the right time, a multi-agency, integrated discharge planning hub was launched at St John's Hospital in December 2018. The purpose of this hub was to bring together health and social care teams and Carers of West Lothian based in the hospital to improve 'real time' discharge planning and improve the discharge experience and outcomes for patients and carers.

Discharge to Assess

For hospital discharges, we reviewed how assessments for ongoing care and support in the community were undertaken to allow multi-disciplinary assessment of ongoing need to take place at home rather than in hospital – known as 'discharge to assess'. Discharge to assess means that people with complex needs can now go home when they are medically 'fit to transfer' with assessment of ongoing care and support needs taking place in the more appropriate setting of home. The aim of the approach is to:

- reduce unnecessary delays in hospital
- maximise opportunities for people to return to the community as early as possible
- provide a period of rehabilitation and support to maximise independence
- assess ongoing care and support needs in the community

We strengthened the partnership between hospital, community health and social work staff within the integrated hub to deliver a more co-ordinated approach. We also invested additional resources in the internal Reablement Service to allow more people to receive rehabilitation and care at home.

The integrated discharge hub, has seen a positive impact on the average length of stay bed days on medical and rehabilitation wards:

10% reduction in the average length of stay to 6.5 days bed days

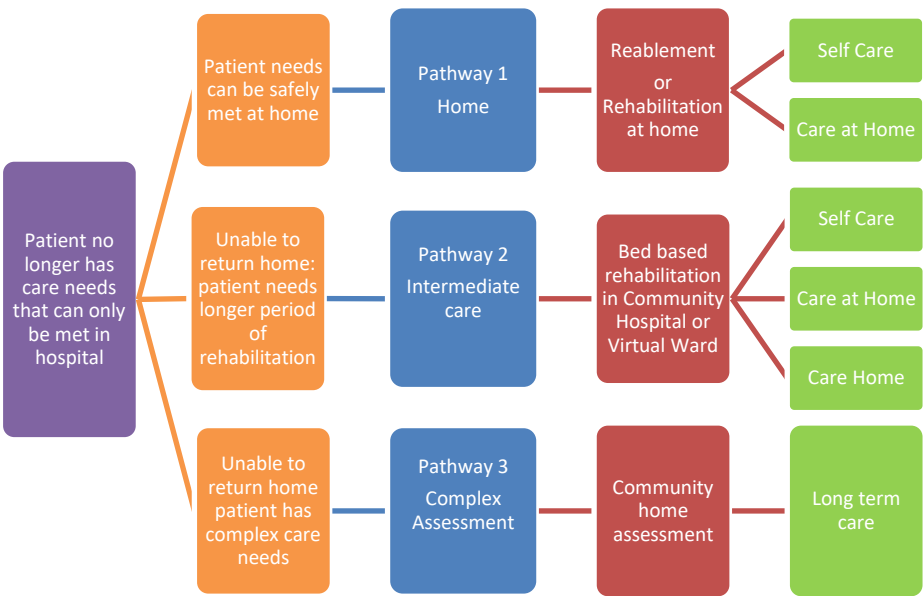
Investment in 'discharge to assess' has seen a further:

3% reduction in the average length of stay bed days

What we need to do going forward.....

Whilst the work we have done so far has had significant impact on how people are discharged from hospital, we still have further work to do to bring about more integrated and sustained improvement. For this reason, we will include further development of pathways to support hospital discharge in our new plan. Importantly, alongside that work, we will also consider how we can build capacity in the community to prevent people being admitted to hospital wherever possible to reduce pressure on hospital services.

Figure 1 below provides an overview of the discharge to assess model and the pathways we are building.



Frailty at the Front Door

West Lothian Health and Social Care Partnership successfully participated in a national health improvement collaborative led by Healthcare Improvement Scotland 'Frailty at the front door'.

The aim of the collaborative was to improve the process of identification, screening, coordination of care, experiences and outcomes, for people living with frailty, who present to the local hospital. While this specific work focused on the front door of acute care, it is driven by an approach to recognise the importance of thinking about flow of patients across the whole health and social care system.

Intermediate Care

Intermediate care provides short-term interventions as a safe alternative to hospital admission when a person's health deteriorates, but can also provide short term rehabilitation support after a hospital stay.

We tested a bed based model of intermediate during the course of the previous plan and also developed ways to deliver more intermediate care through a rehabilitation and reablement approach in people's homes.

During financial year 2018-19 we made a significant investment into our Reablement services. This investment has seen an increase in community capacity to discharge people with complex needs from hospital back to the community for ongoing assessment and care.

In addition our community Rapid Elderly Assessment and Care Team (REACT) including hospital at home continue to make a significant contribution to delivering care, treatment and rehabilitation in the community. A rapid access clinic was a recent addition to REACT services and is providing urgent access for comprehensive geriatric assessments for our frail elderly population.

What we need to do going forward.....

We now need to build on previous work and agree a model of care for the future. Consideration of the approach to intermediate care needs to be undertaken alongside a review of beds across the health and social system including acute, community hospitals and care homes to develop a whole system approach.

Home and Community Supports

Care at Home Contract

Like most other areas of Scotland, securing sufficient supply of care at home services in the community remains a significant problem. Additional care at home providers were introduced to the area when things were most challenging and had a positive impact on unmet need. We also reviewed the administrative arrangements for matching care packages with providers which also had a positive effect.

A substantial piece of work was undertaken to review existing care at home provision to inform the development of a new care at home contract. A new contract was implemented towards the end of 2019 and commissioning officers are working with new providers in an effort to bring about sustained improvement in supply.

The care at home market in West Lothian, however, remains challenging with providers experiencing problems with the recruitment and retention of staff. Development of a sustainable model of community care is central to our commissioning approach and will therefore remain a key priority in the new plan.

Care Homes

Residents in nursing homes are frail with complex care needs, and unplanned hospital admissions are not always helpful. The GP lead for care homes in West Lothian worked with the Medicine of Elderly Team at St John's Hospital to develop an anticipatory care planning summary document to record residents' wishes around, for example, transfer to hospital during episodes of ill health or at the end of life. There has also been a focus on increasing the level of staff training and support within the care homes.

The REACT Care Home Team is continuing to work with care home staff to ensure there are good anticipatory care plans in place. The team is providing training for staff and developing a frailty passport to ensure patient care plans can travel with them and that their wishes are evident to everyone they meet on their journey. The team can support hospital avoidance and ensure medical treatment is provided at home where possible. We plan to continue this work and 2 Advanced Nurse

Practitioners have been appointed to support the needs of the nursing home population.

Availability of care home places in West Lothian was challenging over the past three years and contributed to rising levels of delayed hospital discharge. We reviewed arrangements for purchasing care home places to improve supply but need to think further about demand for care home places in the future and the models of care we need to develop for older people and people living with dementia.

What we need to do going forward.....

We recognise that a sustainable community care system is central to shifting the balance of care and central to many of the developments we propose. For that reason, we will maintain focus in the new plan on working with internal and commissioned care services to monitor performance and service delivery

Personalisation and Choice

We have worked on ensuring that a wide variety of options are available to allow people to have choice and control over how they live well and how they receive care and support when required. We developed a Market Facilitation Plan to support the IJB's new Strategic Plan which builds on previous joint commissioning work between our partners and stakeholders. It provides the basis for dialogue and collaborative working between the West Lothian Health and Social Care Partnership (WLHSCP), service providers, service users, carers and other community stakeholders to shape the way in which more personalised care and support are offered to the people of West Lothian in the future.

What we need to do going forward.....

We need to continue to develop how we support choice through Self-directed support with increasing recognition of the service user as the commissioner of future services rather than the NHS or the local authority.

Housing

Although most of those who use older people and dementia services will live independently with little or no special housing support needs, there are some people who, because of their complex health and social needs, will require more specialised accommodation and support.

During the planning cycle 2015-2018, key housing developments to support more older people to live independently included:

- West Main St, Broxburn, completed in January 2017. The homes are purpose-built amenity housing for older people and aimed at enabling individuals and couples to live as independently as possible in their own tenancy.
- Rosemount Gardens, Bathgate was completed in June 2016. This development offers 30 one-bedroom, two-person flats allowing for independent living. The communal facilities include a restaurant, a café, a hairdresser, a launderette, 2 multi-purpose rooms and 3 offices. Sixteen bedsits have also been refurbished at Rosemount Court and these are now self-contained, one-bedroomed flats.

What we need to do going forward.....

The strategic development of housing, care and support models for older people and people with dementia remains a key priority for the partnership. We will work alongside housing colleagues, to analyse future demand and ensure that we have plans in place to address the needs of the growing older people's population.

Community Capacity Building

Voluntary and 3rd Sector

The Voluntary Gateway and 3rd Sector organisations continue to play a pivotal role in helping people to remain active and engaged in their communities. Within West Lothian there is strong sense of purpose and commitment to developing communities through intergenerational activities, specialised supports for groups and individuals, and the volunteering opportunities. The Voluntary Sector Gateway began work on

the development of a locator tool which will help people to have greater oversight of voluntary sector resources in the community.

What we need to do going forward.....

The partnership has a long history of working with the voluntary sector but in the next planning cycle we will explore how those relationships can be further strengthened to enhance our approach to early intervention and prevention and integrated working. We also need to work with the Voluntary Sector Gateway to develop how we make information available to people in communities.

eFrailty

General Practitioners (GPs) identified meeting the needs of frail older people with mild to moderate frailty and those with longer term conditions as a key area for development. Discussions have been held and proposals are being considered with reference to the use of an e-frailty tool by GPs, to better understand levels of frailty within their practice populations. Once the data is available it will be important to have developed supporting community infrastructure to support onward referral and signposting.

What we need to do going forward.....

A key consideration of the new plan will be how community infrastructure can be developed to support people who are frail or may have long term conditions to improve or maintain their health and wellbeing.

Technology Enabled Care

During the last planning cycle we extended use of range of technologies which support self-management and encourage independence. For example, a 'myCOPD' app was used within general practice to support people with Chronic Obstructive Pulmonary Disease (COPD) to self manage their respiratory conditions. In addition we piloted a medication prompt service which reminds people by text message to take their medication and encourages independence. We continue to use 'just

checking' sensors to monitor service user activity, and to help in the assessment and evaluation of care.

What we need to do going forward.....

We will continue to focus on prevention, early intervention and promotion of independence by developing further our approach to technology enabled care. In addition, we will explore how we can better support our staff to use technology in their work to improve both staff and service user experience.

Support for Carers

The Carers (Scotland) Act 2016 was implemented on 1st April 2018. The Act is designed to help carers continue in their caring role whilst being supported to look after their own health and wellbeing. There is a requirement to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria. Where people are eligible for support, adult carer support plans and young carer statements are developed to identify carers' needs and personal outcomes. Arrangements have been put in place within West Lothian to meet the requirements of the Act.

Carers of West Lothian is the organisation in West Lothian which has been commissioned to provide support to carers across the Health and Social Care Partnership. Development continues to take place to ensure access to information, advice and support to help carers maintain their health and wellbeing and to have a life alongside their caring responsibilities.

What we need to do going forward.....

We recognise the importance of ensuring that we continue to support people in caring roles and the critical contribution carers make to the health and social system. For this reason, the ongoing support of carers will be a key area of development across all commissioning plans.

Single Point of Information and Advice

The Health and Social Care Partnership commissioned an advice and support contract from a 3rd sector organisation.

What we need to do going forward.....

The next phase of the plan will focus on reviewing that contract and considering opportunities for strengthening how people access advice and information within their local communities.

Dementia Training

The Health and Care partnership has continued to implement the dementia learning pathways through training to heighten awareness of dementia and enhance practice levels:

- Dementia Raising Awareness: - 4 courses have run from 2016 to 2019
- 3 cohorts of staff have completed Professional Development Awards in Promoting Excellence in Dementia Skilled Practice (PDA) between 2016 and 2018

The awareness raising course is generally delivered to new staff in the Support at Home service. As a Scottish Qualifications Authority (SQA) centre there are plans to explore delivery of a PDA module in Supervision next year.

Our West Lothian Psychological Approach Team (WeLPAT) has enhanced its service within care homes, by offering both training and interventions for individuals, living with dementia, who need support in managing stress and distressed behaviour. There has also been a focus on developing dementia champions within homes to provide a forum for shared learning and development.

The Health and Social Care Partnership recently embarked on a pioneering dementia venture, being the first partnership to induce a specialist advanced dementia nurse practitioner role into the care team. This role will be pivotal in taking forward delivery of a diagnosis (following clinical discussion with the medical team) within a person's home. This will ensure that support is provided immediately following diagnosis by someone with advanced skills.

What we need to do going forward.....

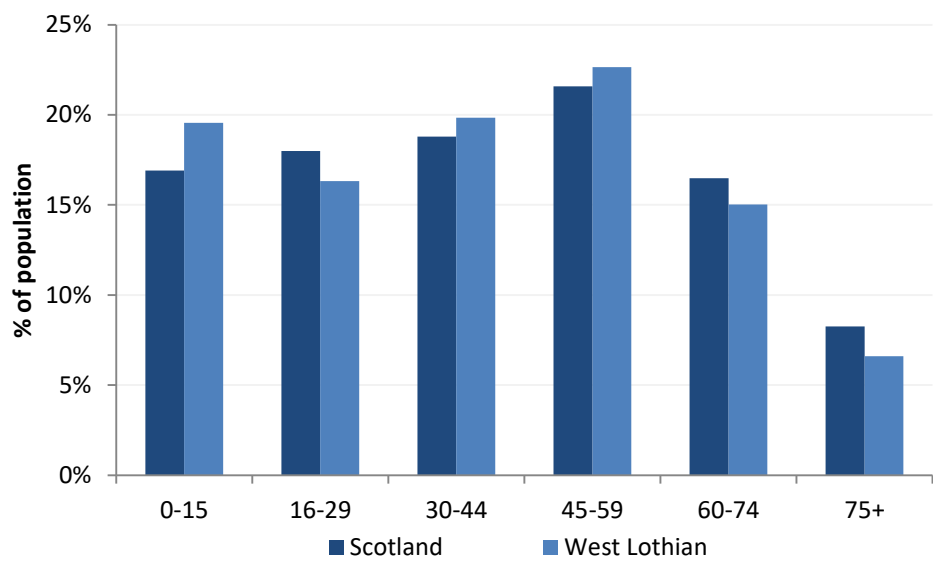
We need to review our current practice against the National Dementia Strategy for Scotland and prepare a development plan to support the 8 pillars approach.



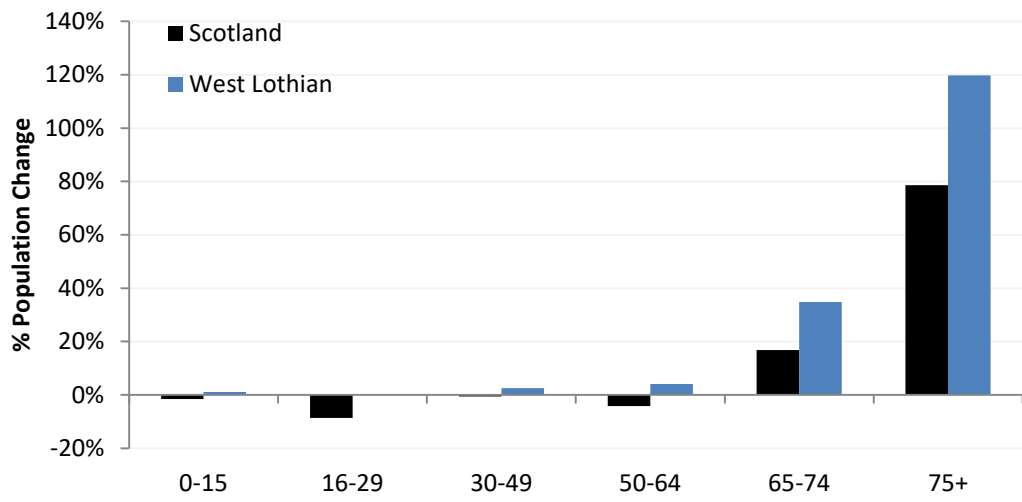
4. West Lothian Context

According to National Records of Scotland, the 2017 population for West Lothian was 181,310; this is a 3.5% increase of the population figures reported in 2011 Census (175,118). In relation to the comparison areas, mid-year estimates for 2017 show West Lothian has a higher population than Falkirk (160,130) and Renfrewshire (176,830), and lower than South Lanarkshire (318,170). Scotland’s overall population is also shown (5,424,800).

In terms of age, the West Lothian population is broken down below.



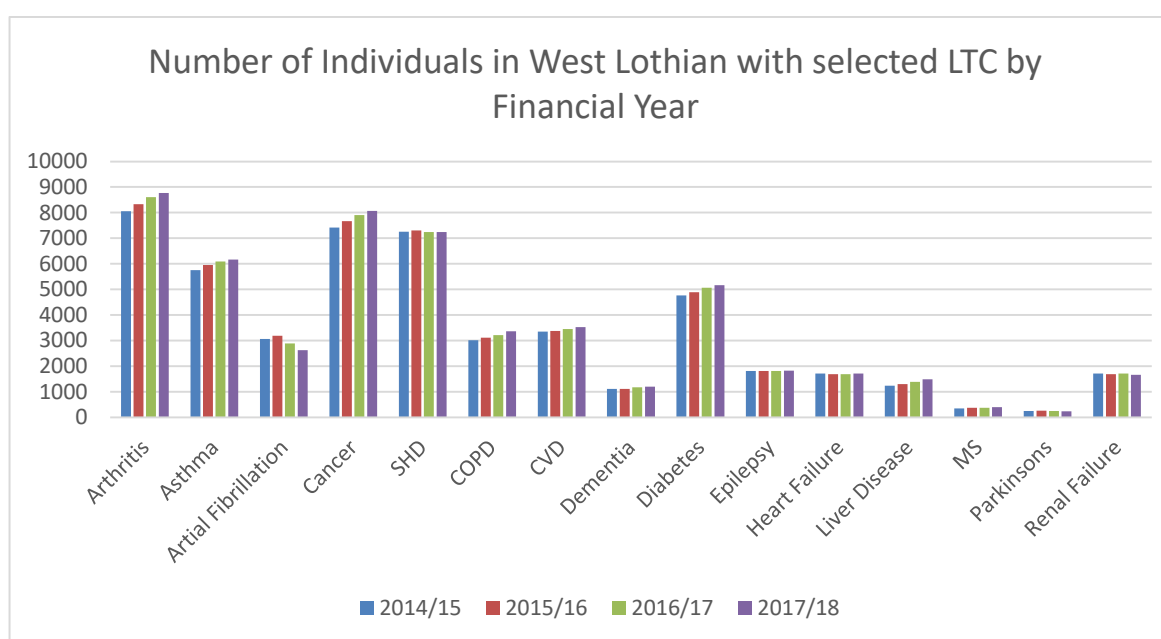
West Lothian is facing an aging population profile that represents a significant challenge. Compared to other local authorities West Lothian will see significantly higher level of growth (2016 to 2041) in number of over 75s and 85s, who will typically have increasing social care needs.



Over the period 2016 to 2041 West Lothian's population of over 75s will have increased by 46% compared to the national average of 27%

Long term Conditions

With people living longer, it is inevitable that community services will see more people living with one or more chronic illness. The graph below shows growth in longer term conditions and a rise of 6.32% between 2014/15 and 2017/18. Planning future services will need to focus on the preventative and proactive management of these conditions to prevent further deterioration.



Dementia prevalence

According to Alzheimer's Scotland, over 93,000 people had dementia in Scotland in 2017, around 3,200 of these people are under the age of 65 (3.4%). The following table shows the number of people with dementia in Scotland and West Lothian in 2017.

| Area | Female | Male | Total |
|--------------|--------|--------|--------|
| West Lothian | 888 | 1532 | 2,421 |
| SCOTLAND | 32,326 | 60,956 | 93,282 |

Source: <https://www.alzscot.org/campaigning/statistics>

5. Developing the Strategic Commissioning Plan for 2019 -2023

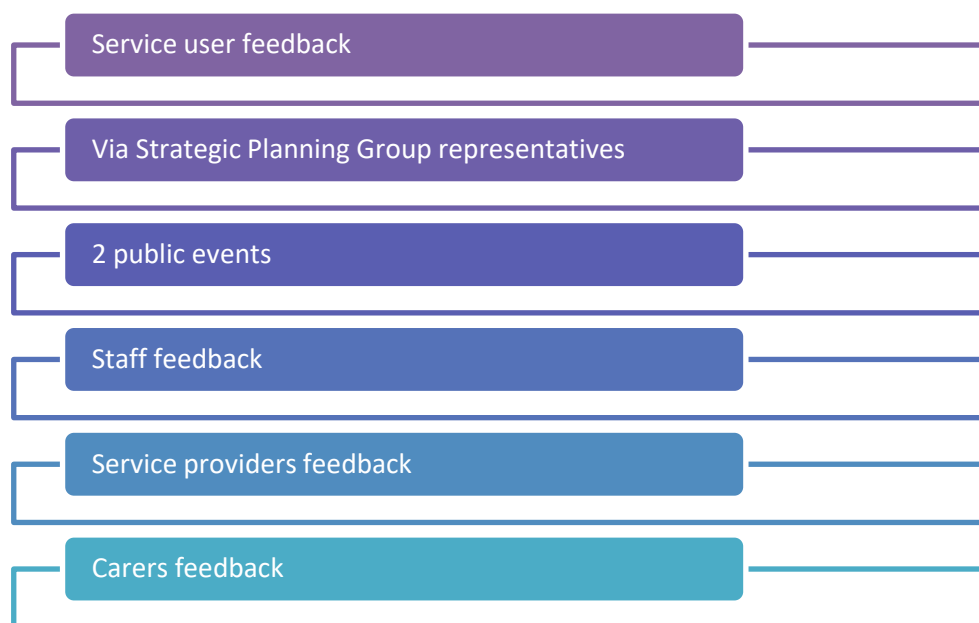
Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Commissioning is commonly described as a cycle of strategic activities similar to that shown below:



In this model, based on that developed by the Institute of Public Care (IPC), the Commissioning cycle (the outer circle) drives purchasing and contracting activities (the inner circle), and these in turn inform the ongoing development of Strategic Commissioning. We have used this model in the development of our plans.

6. Consultation and Engagement

The engagement process for the Older People Commissioning Plan comprised a range of methods as follows:



West Lothian Health and Social Care Partnership initiated the wide range of engagement activities from August through to mid-November 19 to ask service users, carers and families, staff, and service providers to identify what was currently working well, and to suggest areas for development to inform the Commissioning plan.

The engagement activity was tailored within each care group to the needs of stakeholders. This involved attending existing network groups, setting up face-to-face meetings and workshops with 3rd and Voluntary sector and their service users and carers, using a variety of feedback forms.

Engagement with staff groups across health and social care services also took place. Feedback forms were completed by adult community health and social care rehabilitation teams, district nurses, older people social work teams, GP practices and inpatient hospital teams.

Two public engagements events were held covering the commissioning plans which included older people, people living with dementia, people living with a learning disability, people living with physical disabilities and people living with mental health problems. Information about these events was circulated widely, posted on West Lothian Council's social media and

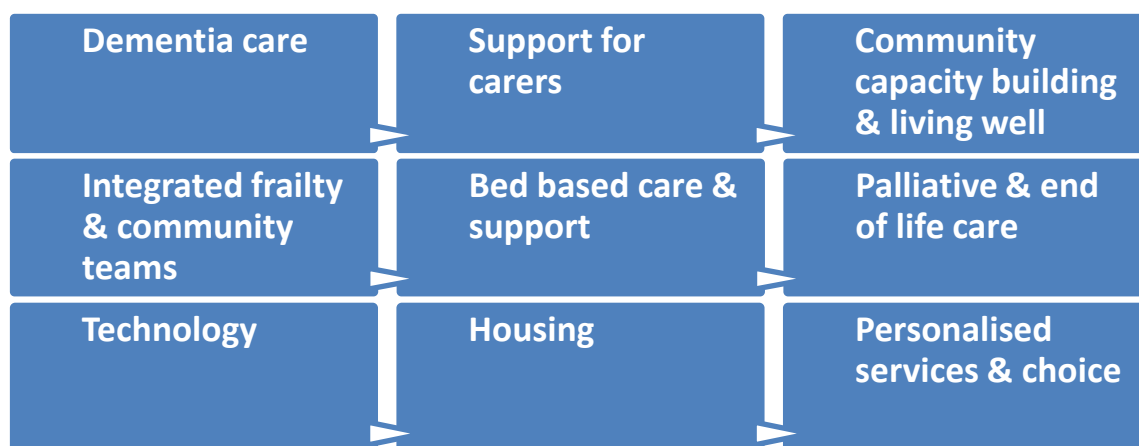
shared with older people providers, community centres, contacts and projects throughout West Lothian. The events were held on the afternoon of 8 October in Howden Park Centre and in the evening of 10 October in Bathgate Academy, with a total of 44 people attending.

Specific service user, carers, families, Black and minority ethnic carer group, advocacy and volunteers' feedback was gathered through facilitated workshops, meetings and one to one discussions by 3rd sector leads and commissioners. Feedback pro-formas were completed for those groups also.

Two dedicated Dementia engagement events were also held on 11 and 12 Nov 19 in partnership with Alzheimer Scotland, to offer a supported structure for groups of 10 service users and their families to have their collective voices and views heard. Specific focus was given to understanding the needs of both early onset dementia affecting people under 65 yrs and over 65 yrs.

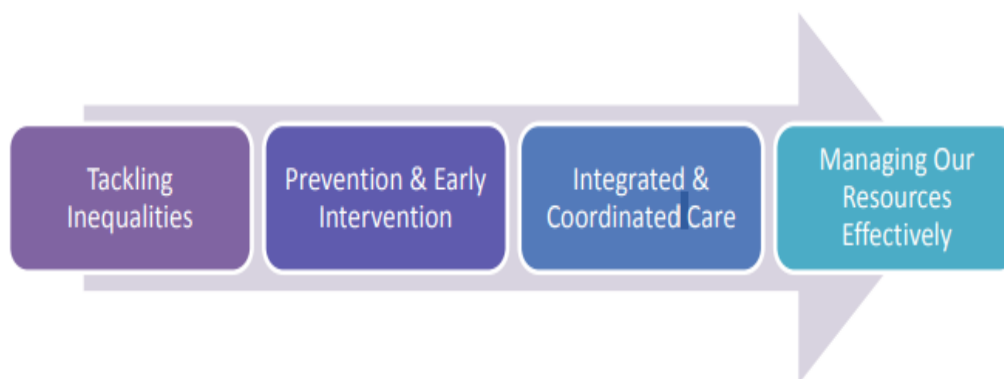
Completed pro-formas and feedback was discussed at meetings of the Older People Planning and Commissioning Board, where ideas were compared across all engagement groups to identify common emerging themes.

A copy of the full feedback summary can be accessed [here](#). The feedback from the engagement process is one part of the information gathering to inform the commissioning plan along with data and expert opinion from clinicians/service providers. The engagement feedback has provided a clearer idea of the emerging priorities that we will focus on going forward as follows:



7. Our Strategic Priorities

Achieving sustainable health and social care systems and improving health and wellbeing outcomes in West Lothain requires transformational change over time. The Integration Joint Board's Strategic Plan 2019 to 2023 identifies four strategic priorities for service development:



Tackling Inequalities

We recognise that addressing both health and social inequalities within our communities must be at the heart of our commissioning plans. Social circumstances such as those outlined below can impact our health and wellbeing:

| | | | |
|----------------------|------------|--------------------|---------------------------|
| Childhood Experience | Housing | Education | Social Support |
| Family Income | Employment | Sense of Community | Access to Health Services |

Deprivation plays a significant part in how well we live. People living in some communities are more likely to be living in poorer health and to die younger with higher rates of cancer, stroke, diabetes and heart disease. People with disabilities are more likely to have lower educational achievements, higher rates of poverty and poorer health outcomes. Unpaid or family carers are more likely to have poorer health than the general population which can impact people achieving their own personal outcomes and goals.

We will work with our partners to reduce the impacts of social circumstances on health through:

- ❖ Ensuring services are accessible to all based on need, and barriers to care are addressed
- ❖ Prioritising prevention, primary and community services to maximise benefit to the most disadvantaged groups
- ❖ Supporting services and initiatives to reduce the impacts of inequalities on health and well being
- ❖ Working with community planning partners to address underlying social inequalities that result in health inequalities
- ❖ Offering income maximisation assistance to families and access to specialist benefits and money advice

Prevention and Early Intervention

West Lothian's population is changing. Based on projected demographics we know that we must deliver our services in different ways and must focus on early intervention and prevention. We will continue to develop community supports and housing models to support those at greatest risk ensuring that people are able to live independently in local communities for as long as possible. Further development of community care teams will transform how day-to-day health and social care is provided by the right skilled person at the right time.

We know that we need to continue the development of an integrated approach to the delivery of health and social care within communities. We want to explore opportunities to develop locally based, integrated services which allow people to self-manage where possible and access agencies and community supports when they need them. A key priority will be to consider how we strengthen our partnership with the third and independent sectors to deliver our strategic intentions around early intervention and prevention.

A priority will be to strengthen the existing resources and pathways across health and social care for people with complex health needs through a combination of medical, nursing, pharmaceutical, social care supports based in the community.

We aim to develop sustainable community health and care services which support hospital admission only when there is clinical need for this and only when a community alternative is not appropriate.

Integrated and Coordinated Care

Health and Social Care Scotland issued a statement of intent in September 2019 which outlined the key elements involved in building a stronger community care system and is summarised in the diagram below. We will use this model in our approach to commissioning services for older people in partnership with stakeholders in West Lothian.



During the span of the commissioning plan, we will continue to explore opportunities to shift the balance of care closer to community settings to deliver the Scottish Government's vision for:

- integrated health and social care
- focus on prevention, anticipation and supported self-management
- hospital treatment when required, and cannot be provided in the community, day case treatment will be the norm
- care will be provided to the highest standards of quality and safety with the person being at the centre of decisions irrespective of the setting
- focus on ensuring that people get back into their home environment as soon as appropriate, with minimal risk of readmission.

Models of Care and Support

To progress our vision of shifting the balance of care, we intend to review existing bed based provision across the entire health and social care estate and agree a model which maximises opportunities for community based support, wherever possible. This will mean looking at hospital beds, beds in community hospitals and care homes across West Lothian and considering the best way to invest our resources going forward.

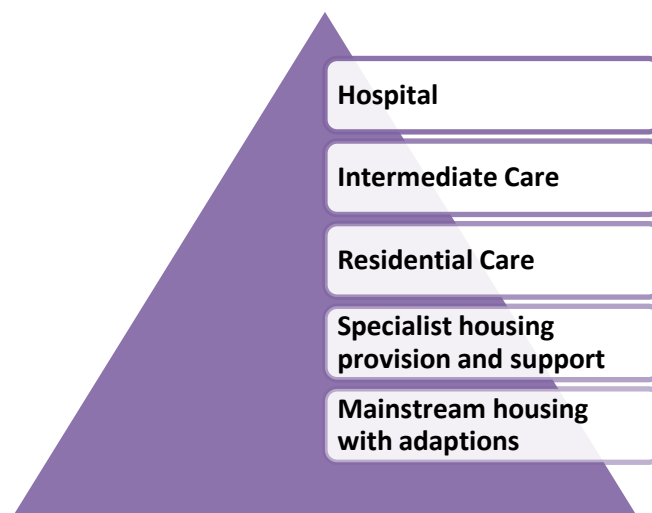
Community Integrated Teams

There is a need to explore how we further strengthen and integrate existing community services, working closely with West Lothian's primary care practices. We want to make sure that we have responsive community based teams which can deliver the right care at the right time. We will explore opportunities to integrate health and social care teams in the community further and opportunities to align with primary care services. We will consider the development of information points and geographically placed, integrated community hubs in close partnership with the third and voluntary sectors.

Another priority for community teams will be consideration of how they work with people frailty and on/long term conditions as early as possible to allow them to have care and treatment in a community setting. Development of this work will take place in conjunction with a review of how outpatient services are delivered.

Housing

West Lothian's population is changing and we recognise that. With projected increases in all age demographics in the coming years, we must aim to deliver housing models which meet the needs of our population.



Care should be delivered in an individual's home or community whenever possible. Clinical necessity will continue to be the procedure for admitting an individual to hospital or community bed.

End of Life Care

End of life care was identified as a priority for development during consultation. A palliative work stream has been developed to lead a review of existing arrangements and develop a commissioning plan for palliative care. The work is being led by the partnership's Chief Nurse.

Managing Our Resources Effectively

We know that growing pressure on our health and social care system means that the way in which we are currently delivering services is unsustainable. We will explore investment in approaches which focus on avoiding admission to hospital, supporting discharge from acute care without delay and supporting people to live as well as possible in their own homes.

We need to better understand existing demand and capacity across health and social care partners through more effective use of data and performance information to inform future developments.

We recognise there are substantive challenges in the recruitment of health and social care staff in Scotland. As a result of this, we aim to work closely with service providers to ensure that the right people are in the right roles to offer good quality support to those that need it. We recognise that our workforce needs to transform. This means attracting and securing future supply, up-skilling existing staff and exploring new roles and new ways of working.

Having a workforce with the right skill, at the right time and in the right place, provides the foundation for the delivery of effective health and social care services. Our transformational change programmes will be underpinned by this ambition and will link to the IJB's Workforce Development Strategy.

8. Finance

In line with the approach to IJB financial planning, budget plans have and continue to be developed across health and social care functions and officers supporting the IJB are at the forefront of ensuring overall health and social care considerations are taken into account in a collaborative approach to IJB and partner financial planning. This should importantly help ensure a consistent approach to service and financial planning for delegated health and social care functions across the IJB, Council and Health Board. Detailed below is an annual average of total planned spend in West Lothian during 2020/2021 on services for older people.



9. Next Steps

The Older People and Dementia Plan is designed to inform service development from 2019 to 2023. Decision on the investment and disinvestment of resources will require to be made as the actions outlined below are progressed.

The following action plan will support the development of services for older people and people living with dementia in West Lothian over the next three years and will incorporate the strategic priorities contained in the IJB's Strategic Plan. The Older People Commissioning Plan will be reviewed annually, and commissioning intentions developed each year in the form of an annual report which will summarise activity, progress and performance for the year.

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|-------------------------------------|---|---|--------------------------|----------------------|--------------------------------|-----------|--|
| 1. Dementia Care and Support | | | | | | | |
| 1.1 | Dementia care pre and post diagnostic support | - To map existing dementia services to outcomes under the 8 pillar national dementia strategy domains and identify opportunities for enhancing service user experience | 1,2,3,4,5,6, 7,8,9 | P&EI,TE, ICC,MRE | Map and agree aligned pathways | 2020 | Clinical Nurse Manager |
| 1.2 | Dementia Training | - To continue to deliver 'Promoting Excellence' training, knowledge and skills to staff, service users and families | 1,2,3,4,5,6, 7,8,9 | P&EI,TE, ICC,MRE | Training courses delivered | Annually | Clinical Nurse Manager/ Business Support Team Manager |
| 1.3 | Complex dementia needs | - Review need for specific dementia models, to meet long term complex dementia need, for both Care at home and Beds (Alzheimer Scotland - 'Transforming Specialist Dementia') | 1,2,3,4,5,6, 7,8,9 | P&EI,TE, ICC,MRE | Evidence of transition plans | 2020-2023 | Senior Manager Community Care |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|---|---|--|-----------------------|----------------------|-------------------------------------|-----------|--------------------------------|
| 2. Support for Carers | | | | | | | |
| 2.1 | There is a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria | - Review unpaid Carers Advocacy support in West Lothian | 1,2,3,4,5,6,7,8,9 | P&EI, TE, ICC, MRE | Review in line with Carers Strategy | 2020 | Team Manager Business Support |
| 2.2 | | - Complete review and publish revised carer's strategy in line with the Carers (Scotland) Act 2016. | 3,4,5,6,7,9 | TE, ICC | Strategy Published | 2020 | Team Manager Business Support |
| 2.3 | | - Support all carers to access information, support and services in line with the Council's Carers Eligibility Framework. | 1,2,3,4,5,6,7 | TE, ICC | Review of commissioned services | 2023 | Group Manager Business Support |
| 2.4 | Access to Information | - Ensure appropriate arrangements are in place for carers of older people including dementia have to access information and support. This should consider options to expand technology enabled care. | 1,2,3,4,5,6,7 | P&EI, TE, ICC | Service User forum feedback | 2020-2023 | Senior Manager Community Care |
| 3. Community Capacity Building and Living Well | | | | | | | |
| 3.1 | Community Capacity building | - Develop an approach to build community capacity/ social prescribing across partner organisations (i.e. inter-generational, increasing volunteers, mentors/ peer support etc) | 1,2,3,4,5,6,8,9 | P&EI, TE, ICC, | Approach Agreed | 2020-2023 | Head of Strategic Planning |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|----------|---|---|-----------------------|----------------------|--|-----------|--|
| 3.2 | Align voluntary and 3 rd Sector Activity | - Explore areas to further align capacity of voluntary/ 3 rd sector and community health and social care to continue to develop joint connected pathways and person centred plans | 1,2,3,4,5,6, 7,8 | P&EI,TE, ICC, MRE | Pathways, demand and capacity reviewed | 2021-2023 | Senior Manager Community Care |
| 4 | Integrated Frailty Community Teams & Access to Information | | | | | | |
| 4.1 | Access, community demand and capacity | - Develop a better understanding of community demand, activity and waiting times to establish a baseline for planning and evaluation of improvement work | 1,5,7,8,9 | TE,MRE | Agree a demand and capacity community baseline | 2020 | Heads of Health & Social Policy – Programme Manager |
| 4.2 | Integrated Community Teams & Access to information | - Scope the costs and benefits of integrated health and social care community teams with a single point of access, linked to GP Clusters and 3 rd sector alongside consideration of information points/hubs' across Wards in West Lothian for access to community preventive/ early interventions and advice and support across West Lothian | 1,2,3,4,5,6, 7,8,9 | P&EI,TE,I CC,MRE | Options Appraisal | 2020 | Heads of Health & Social Policy/ Clinical Director - Programme Manager |
| | | - Scope how community information hubs could support mild and moderate frail people/long term conditions/co-morbidities within general practice to prevent deterioration in health with the aim of reducing re-occurring GP appointments - linked to use of e-frailty tool | 1,2,3,4,5,6, 7,8,9 | P&EI,TE,I CC,MRE | Options Appraisal | 2021 | Clinical Director - Programme Manager |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|--|---|--|--------------------------|-------------------------|--|-----------|--|
| 5. Care Pathways and Service Delivery | | | | | | | |
| 5.1 | Proactive care and long term conditions | - Further develop care models and pathways for frailty and long term conditions/co-morbidities to manage proactively people in the community | 1,2,3,4,5,6,7,8,9 | P&EI,TE,ICC,MRE | Community models developed | 2020-2023 | General Manager Senior Manager Community Care Outpatient Manager Acute Hospital Medical Lead Associate Nurse Director – Acute |
| 5.1.1 | | - Continue to embed health and social care support to Care Homes in preventing unnecessary admissions | 1,2,3,4,5,6,7,8,9 | P&EI,TE,ICC,MRE | Reduction in hospital admissions from care homes | 2020 | General Manager Primary Care |
| 5.2 | Crisis/ Deterioration At risk of hospital admission | - Continue work to effectively stream and redirect of frail/ older people within the Community, Medical Assessment Unit, Primary Assessment Area and Accident & Emergency to offer connected pathways which optimise independence in the community and prevent unnecessary hospital admission. | 1,2,3,4,5,6,7,8,9 | ICC,MRE | Clearly defined alternative pathways with agreed access criteria Reduction inappropriate hospital admission | 2020-2023 | Medical Director - Acute Head of Health Senior Mgr Community Care General Manager Mental Health General Manager Medicine- Acute |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|-------------------------------|--|---|--------------------------|-------------------------|--|-------------------|--|
| | | - Review pathways to manage acute admissions for people with delirium and dementia. | 1,2,3,4,5,6,7,8,9 | P&EI,TE,ICC,MRE | Define model, pathways with agreed KPIs | 2020-2023 | General Manager Mental Health |
| 5.3 | Recovery Rehabilitation& Reablement | - Develop integrated functions and responsibilities across partner organisations to streamline hospital discharge planning pathways | 1,2,3,4,5,6,7 | TE,ICC | Agree functions and responsibilities of all discharge planning processes | 2020 | General Manager Primary Care/Senior Manager Community Care/General Manager Acute |
| | | - Monitor that care at home provision and supply to meet the needs of an individuals. | 1,2,3,4,5,6,7,8,9 | P&EI,TE,ICC,MRE | Reduction in delayed discharges | Ongoing reporting | Team Manager Business Support |
| | | - Scope opportunity to further strengthen the integrated delivery model for rehabilitation and reablement. | 1,2,3,4,5,6,7,8,9 | P&EI,TE,ICC,MRE | Integrated rehabilitation and reablement care model | 2020-2023 | Senior Manager Community Care/General Manager Primary Care |
| | | - Develop an agreed Guardianship pathway, with consideration of alternative care arrangements for patient awaiting Guardianship rather than hospital care | 3,4,5,6,7,9 | TE,ICC,MRE | Guardianship pathway mapped with associate processes and KPIs | 2020-2021 | Senior Manager Community Care |
| 6. Bed Based Care and Support | | | | | | | |
| 6.1 | Intermediate Care Beds - | - Review the current use of bed based assets across health and social care | 1,2,3,4,5,6, | P&EI,TE,I | Reduced admissions/ | 2020-2023 | Consultant Geriatrician/ |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|---|-----------------------------|--|-----------------------|----------------------|--|------------------|--|
| | link to 4.2 and 4.3 actions | including hospital beds, community hospitals and care homes | 7,8,9 | CC,MRE | delayed discharges | | Head of Health/Senior Manager |
| 7. Palliative Care & End of Life | | | | | | | |
| 7.1 | | - Priorities and actions to be identified and agreed within the WL Palliative Care Strategy Group | | | | 2020 | Chief Nurse |
| 8. Technology Enabled Care | | | | | | | |
| 8.1 | | - Continue to review, identify tech solutions and make recommendations on applications that support older people and carer to optimise care and minimise social isolation. | 1,2,3,4,5,6,7,8,9 | P&EI,TE,I CC,MRE | Develop plan for increasing technology enable care | 2020-2023 | Senior Manager Community Care |
| 8.2 | | - Optimise Telehealth and Telecare – consider technology enabled care options for use in assessment and evaluation of care | 1,2,3,4,5,6,7,8,9 | P&EI,TE,I CC,MRE | % of older and people with dementia accessing technology enabled care and remaining in the community | Annual reporting | Senior Manager Community Care |
| 8.3 | | - Develop technology solution to strength community teams integrated working within older people and dementia services | 1,2,3,4,5,6,7,8,9 | P&EI,TE,I CC,MRE | Develop a technology development plan | 2020-2023 | Senior Manager Community Care/General Manager |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|--|---|---|--------------------------|-------------------------|---|-------------------------|---|
| 9. Housing | | | | | | | |
| 9.1 | | - Through service user and stakeholder engagement, finalise a vision and model of care for current/future older people housing- to include community supports/ housing options to improve flow and pathways | 1,2,7,8,9 | P&EI,TE,ICC,MRE | Proportion of people cared for within West Lothian increased Reduction in delayed discharges | 2020-2023 | Senior Manager Housing Senior Community Care Manager |
| 9.2 | | - Develop a need and a demand assessment for older peoples housing | 1,2,7,8,9 | P&EI,TE,ICC,MRE | Map existing capacity and anticipate future need and gaps in housing provision | 2020-2023 | Senior Manager Housing |
| 10. Ensuring choice through Self-Directed Support | | | | | | | |
| 10.1 | Focus on market development to ensure people have access to opportunities which enable personal outcomes to | - Ensure practitioners and business support services and other stakeholders are involved in shaping market development teams and care managers are involved in shaping market development | ICC,MRE | TE,ICC,MRE | Market Facilitation plan update and published | Annual update 2020-2023 | Team Manager Business Support |
| 10.2 | | - Ensure service users and carers have a say in how future services should be developed. | 1,3,4,8,9 | P&EI,TI,MRE | Feedback provided via Forums | Annual update 2020-2023 | Team Manager Business Support |

| | Area of Development | Actions | Outcomes (appendix 3) | Strategic Priorities | Measures | Timescale | Lead Officers |
|------|---------------------|---|-----------------------|----------------------|---------------------------------|-----------|--------------------------------|
| 10.3 | be met | - Ensure those receiving SDS have information and advice to allow to support them to achieve their personal outcomes. | 1,3,4,9 | P&EI,TI | Review of Commissioned Services | 2021 | Group Manager Business Support |

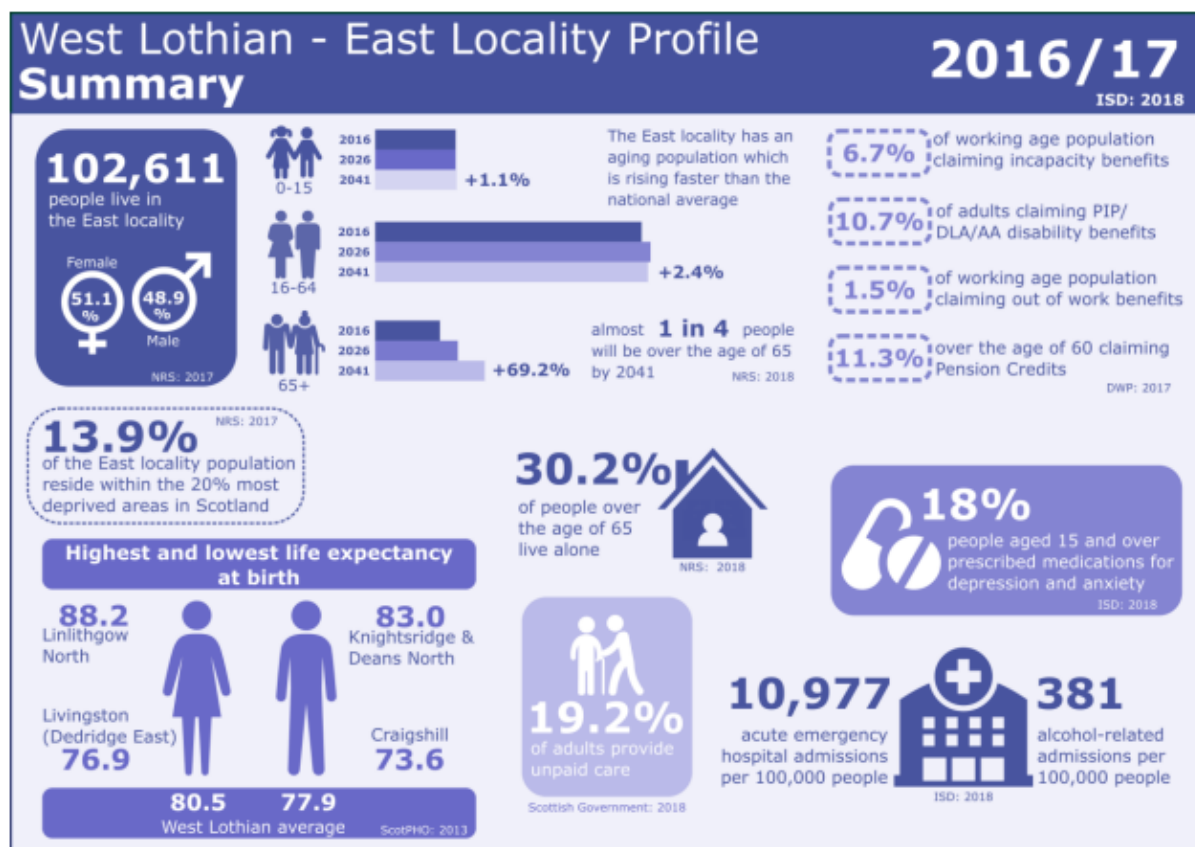
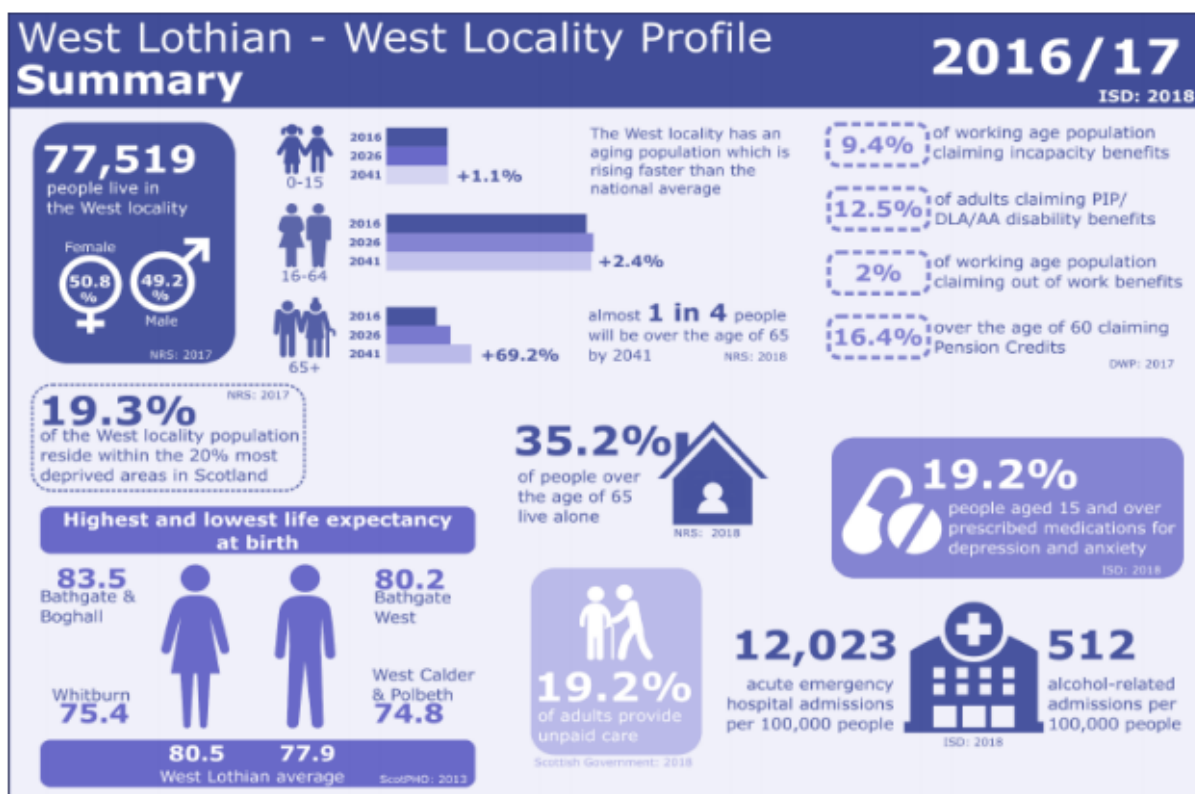
10. Monitoring and Review

A performance management framework will be developed to underpin the strategic commissioning plan. The performance framework will provide a mechanism for measuring progress and impact in relation to each of the priorities outlined in the plan.

The Older People Planning and Commissioning Board which meets at least 6 times per year will oversee the implementation of the Older People Commissioning Plan.

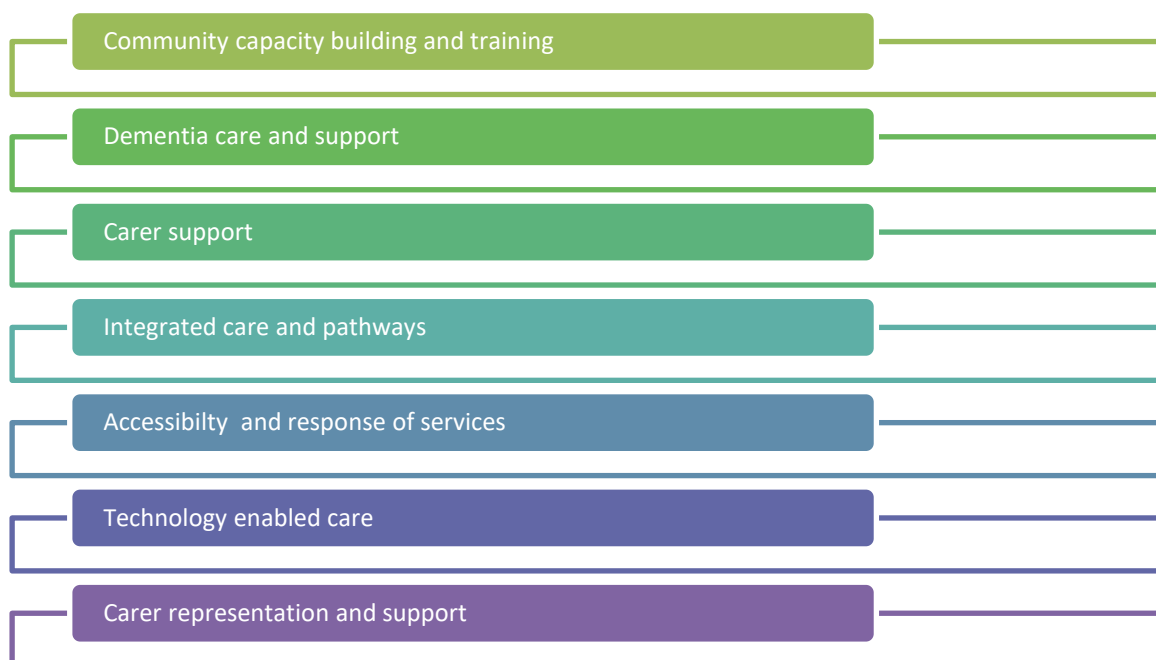
Formal updates on progress in relation to the commissioning plan will be submitted to the Integration Joint Board every 6 months.

Appendix 1 - Details



Appendix 2 - Older People Commissioning recommendations in 2015

The following 14 recommendations were identified under 7 key themes:



Recommendation 1: In future development of Joint Strategic Priorities should be needs – led, with key focus on early prevention and early intervention.

Recommendation 2: Dementia care in general requires higher prioritising and particular attention needs to be given to improving post diagnostic support.

Recommendation 3: Interfaces with the 3rd sector should be strengthened and the review of 3rd sector involvement should include pathway planning.

Recommendation 4: Consideration needs to be given to including support for carers in future priorities.

Recommendation 5: In order to provide the best conditions for sector sustainability and growth, commissioning practices need to avoid short term funding cycles. (e.g. year on year funding arrangements)

Recommendation 6: Current performance monitoring arrangements should be reviewed to develop an appropriate and proportionate (long term) monitoring framework to audit performance against outputs and

outcomes, as well as to provide equity of compliance across all statutory and commissioned provision.

Recommendation 7: Consideration should be given to establishing a single point of information for Older People Services and supports which provides written information in addition to online availability. This is especially important for those with dementia who tend not to use the internet.

Recommendation 8: The challenges created by a culture of 'silo working' by services was consistently highlighted throughout the needs assessment. Opportunities to move away from the practice of 'silo working' should be sought during all developments of integrated health and social care.

Recommendation 9: Consideration needs to be given to realising the significant opportunities for community capacity building.

Recommendation 10: Where future emphasis is placed on community capacity building there will need to be a need to provide training and learning opportunities for a much wider 'workforce' (including family carers, volunteers etc)

Recommendation 11: Strategic planning for older people's services needs to take account of the challenges created by the issue of recruitment and retention of care staff.

Recommendation 12: The West Lothian Older People's Forum should be reviewed to ensure it is representative of the demographic it represents.

Recommendation 13: Specialist Mental Health provision stops at the age of 65, and with the life expectancy of people with severe and enduring mental health increasing there is a gap in how specialist services should be planned and budgeted for.

Recommendation 14: Current priorities to increase technology assisted care could be having an adverse effect on social isolation for older people, however, technology enabled care could provide significant opportunities for helping to connect older people with a wider range of help and support (e.g. peer support, connection through social media and online virtual activities).

Appendix 3 - National Health and Wellbeing Outcomes

The 9 Scottish Government Health and Wellbeing outcomes:

| | |
|----------|--|
| 1 | People are able to look after and improve their own health and wellbeing and live in good health for longer. |
| 2 | People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. |
| 3 | People who use health and social care services have positive experiences of those services, and have their dignity respected. |
| 4 | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. |
| 5 | Health and social care services contribute to reducing health inequalities. |
| 6 | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. |
| 7 | People who use health and social care services are safe from harm. |
| 8 | People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. |
| 9 | Resources are used effectively and efficiently in the provision of health and social care services. |

Appendix 4 - Links

Below are several strategies and strategic plans that complement the development of the Commissioning plans:

[West Lothian IJB Strategic Plan 2019-23](#)

[West Lothian IJB Participation and Engagement Strategy 2016-26](#)

[West Lothian Autism Strategy 2015/25](#)

[Active Travel Plan for West Lothian 2016-2021: Making Active Connections](#)

[West Lothian Children's Services Plan 2017-20](#)

[West Lothian Local Housing Strategy 2017-22](#)

[West Lothian People Strategy 2018/19-2022/23](#)

[West Lothian Anti-poverty Strategy 2018/19-2022/23](#)

[digital transformation strategy west lothian - Google Search](#)

Legislative context

[Community Empowerment \(Scotland\) Act 2015](#)

[Adults with Incapacity \(Scotland\) Act 2000](#)

[Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#)

[Mental Health \(Scotland\) Act 2015](#)

[Public Health etc. \(Scotland\) Act 2008](#)

[Community Care and Health \(Scotland\) Act 2002](#)

[Social Work \(Scotland\) Act 1968](#)

[The Equality Act 2010](#)

[The Equality Act 2010 \(Specific Duties\) \(Scotland\) Regulations 2012](#)

[Transport \(Scotland\) Act 2005](#)

National Strategies

[A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger social connections - gov.scot](#)

<https://www.ageing-better.org.uk/sites/default/files/2017-12/Inequalities%20insight%20report.pdf>

[Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study - The Lancet](#)

[Transforming Specialist Dementia Hospital Care | Alzheimer Scotland](#)

[Scotland's National Dementia Strategy-2017-2020](#)

[A Fairer Scotland for Older People: framework for action - gov.scot](#)

[Care of older people in hospital standards](#)

[Living Well in Communities | ihub | Health and social care improvement in Scotland - Living Well in Communities](#)

[Frailty at the Front Door | Acute Care | ihub - Frailty at the front door](#)

<https://hub.careinspectorate.com/media/1323/reshaping-care-for-older-people-a-programme-for-change-2011-2021.pdf>

http://www.parliament.scot/S4_PublicAuditCommittee/Reports/pauR-14-06w.pdf

[Age, Home and Community: next phase - gov.scot](#)

[Age, home and community: a strategy for housing for Scotland's older people 2012-2021 - gov.scot](#)

<https://hub.careinspectorate.com/media/1182/full-report-on-the-future-of-residential-care-for-older-people-in-scotland.pdf>

<https://www.alzscot.org/sites/default/files/2019-07/Transforming%20specialist%20dementia%20hospital%20care.pdf>

[Health and Social Care Integration Partnerships: reporting guidance - gov.scot](#)

[Transforming social care: Scotland's progress towards implementing self-directed support 2011-2018 - gov.scot](#)