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## **HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL**

### **STRATEGIC COMMISSIONING PLAN FOR OLDER PEOPLE AND PEOPLE LIVING WITH DEMENTIA**

#### **REPORT BY DEPUTE CHIEF EXECUTIVE**

##### **A. PURPOSE OF REPORT**

The purpose of the report is to inform the Health and Care PDSP of the revised strategic commissioning plan for services of older people and people living with dementia.

##### **B. RECOMMENDATION**

It is recommended that the Panel note the contents of the strategic commissioning plan for services for older people and people living with dementia as detailed in appendix 1 of this report.

##### **C. SUMMARY OF IMPLICATIONS**

<b>I Council Values</b>	Focusing on our customers' needs
	Being honest, open and accountable
	Working in partnership.
<b>II Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)</b>	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance
<b>III Implications for Scheme of Delegations to Officers</b>	None.
<b>IV Impact on performance and performance Indicators</b>	The commissioning plan is aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
<b>V Relevance to Single Outcome Agreement</b>	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes as they relate to health and social care.
<b>VI Resources - (Financial, Staffing and Property)</b>	Financial resources as detailed in the IJB's Strategic Plan 2019 to 2023. Implementation of the commissioning plan will require to take account of available resources.
<b>VII Consideration at PDSP</b>	None

## **VIII Other consultations**

None required.

### **D. TERMS OF REPORT**

- D1** The Integration Joint Board approved a revised Strategic Plan for the period 2019 - 2023 at its meeting on 23rd April 2019. The plan detailed how high level outcomes were to be achieved through a process of strategic commissioning and included a commitment to developing a series of care group commissioning plans. Plans have already been approved by the IJB for mental health, learning disability, physical disability and addictions services.

### **D2 Commissioning Plan for Older People**

The IJB considered a first draft of the strategic commissioning plan for older people and people living with dementia in January 2020 when it was acknowledged that there was further work to be done to develop the action plan associated with it.

- D3** Much has happened since the first version of the commission plan was presented. Different areas of the partnership have had to adapt to different ways of working in the face of rapidly changing circumstances associated with the Covid-19 pandemic.
- D4** New ways of working have been introduced over recent months, some services have stopped and others have been stepped up, all of which have had significant impact on service users, carers and staff. The pandemic has, however, also allowed tests of change to be undertaken in a range of areas more quickly than might otherwise have been possible and the learning from this is important

The experience of developing services in recent months in the Integrated Discharge Hub at St John's Hospital, for example, has raised questions about how community services should be organised in the future to support a more preventative, community based approach. The third and independent sectors have also played a critical role in supporting people in communities during the pandemic and further exploration of how partnership working can be enhanced will be an important area of development in future plans.

Implementation of technological solutions has been a key feature over the past 7 months and is an area that the partnership would wish to develop further. The use of 'Near Me' has allowed GPs and mental health services, for example, to carry out consultations via video conferencing, and work now needs to be done to explore in more detail how greater use of technology can enhance future provision. Development of a digital strategy will allow the partnership to set out plans for developing its use of technology to support service development and delivery over the next 3 to 5 years.

- D5** The Strategic Planning Group held a development session in July 2020 to allow members an opportunity to reflect on their own experience during recent times. The findings of that session were collated and have been used alongside the outcomes of previous engagement activity to determine the priorities outlined in the revised strategic commissioning plan for older people and people living with dementia.

It is now proposed that the commissioning plan for older people is divided into three distinct programmes:

- Programme 1- Prevention and Early Intervention
- Programme 2 – Integrated Community Services
- Programme 3 – Acute Specialist Care

- D6** Given the scale of the transformation proposed and the wide range of services that support the older population of West Lothian and those living with dementia, consideration is being given to how the programmes are to be resourced. It must also be borne in mind, however, that the partnership continues to operate under difficult and uncertain circumstances which may impact progress as resources are used to respond to operational priorities.
- D7** Work is underway to develop performance measures to underpin all the strategic commissioning plans. This will be an evolving process given the level of transformation proposed in the plan for older people.
- D8** The Older People Planning and Commissioning Boards meets at least six times per year and reports in to the IJB's Strategic Planning Group. Implementation and progress of the commissioning plan will be monitored by the Strategic Planning Group with formal updates to the IJB every 6 months.

## **E. CONCLUSION**

In conclusion, the report presents to the Health and Care PDSP, a revised commissioning plan for older people and people living with dementia which takes account of priorities developed through stakeholder engagement and learning from the COVID-19 pandemic response.

## **F. BACKGROUND REFERENCES**

Integrated Joint Board Meeting 23rd April 2019.

Appendices/Attachments:	Appendix 1 Strategic Commissioning plan for Older people and People Living With Dementia Appendix 2 Strategic Direction
Contact Person:	Yvonne Lawton, <a href="mailto:Yvonne.lawton@nhslothian.scot.nhs.uk">Yvonne.lawton@nhslothian.scot.nhs.uk</a> , 01506 283949
CMT Member:	Allister Short, Depute Chief Executive
Date:	18 <sup>th</sup> February 2021

# Strategic Commissioning Plan Services for Older People & People Living with Dementia 2020-2023

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

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## 1. Introduction

In West Lothian we believe in providing support and services that allow our citizens to live well. The commissioning plan for older people and people living with dementia will act as a tool to allow us to work to this common goal across our communities.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires arrangements to be put in place for the delivery of integrated health and social care services. 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:

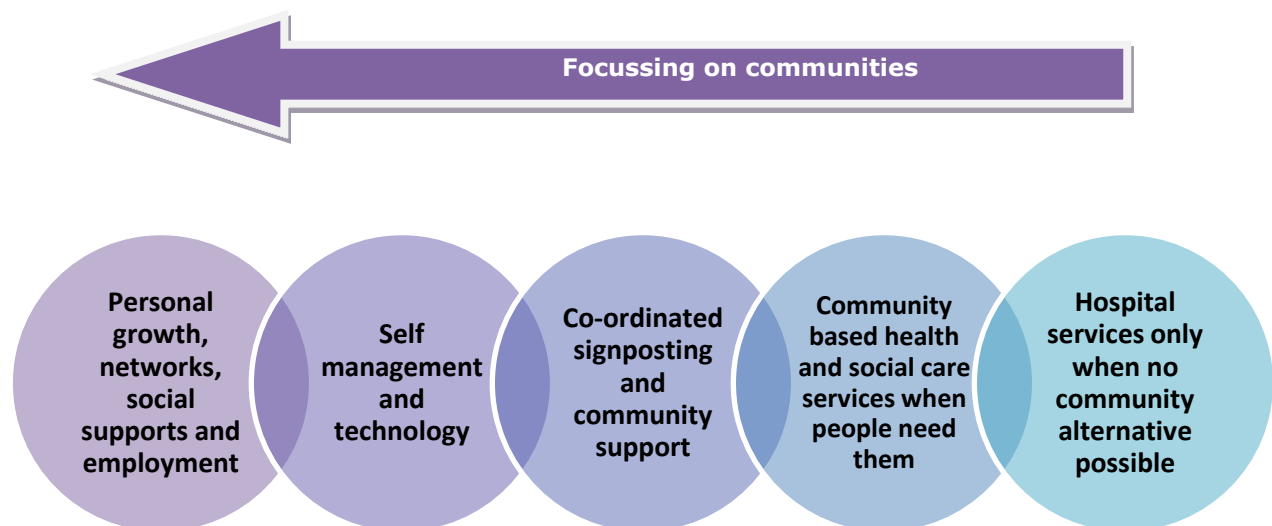
***"To increase wellbeing and reduce health inequalities across all communities in West Lothian"***

The Integration Joint Board (IJB) has developed a set of values that underpin the commissioning of the services which are outlined in this plan.



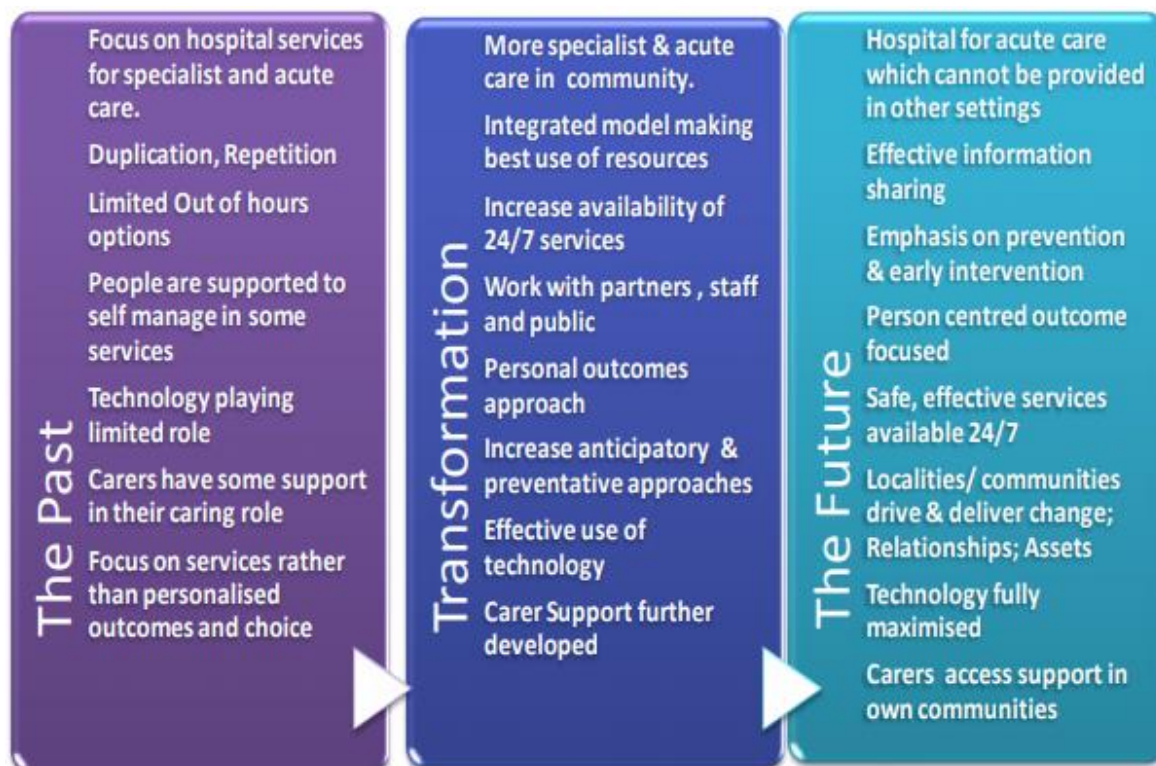
## 2. Our Approach

We have adopted a whole system approach to reviewing and developing 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 best when they are delivered 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 services for older people and those living with dementia 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 deliver the changes we need to make. We will ensure that we focus on maximising opportunities for integrated working across the West Lothian Health and Social Care Partnership (WLHSCP).

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



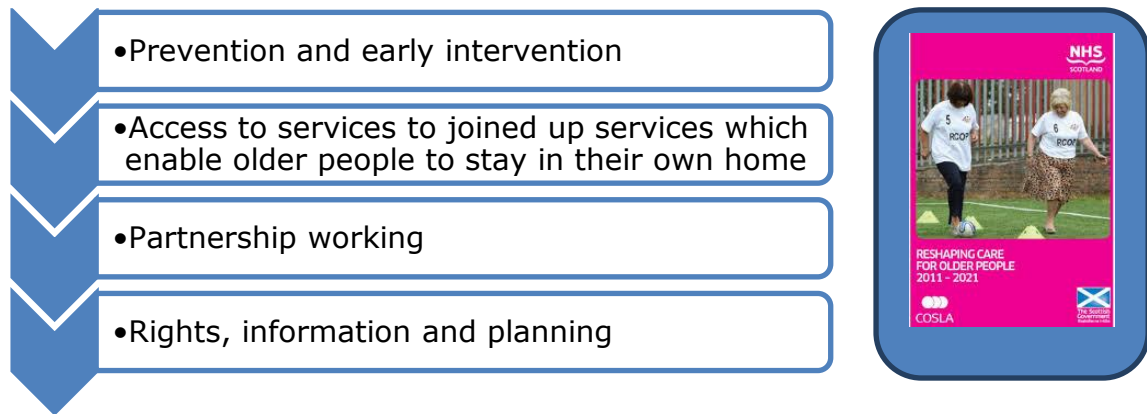
Development of this commissioning plan has involved both targeted and open consultation with service users, carers, families, service providers, representatives from the third and independent sectors and staff from across the partnership. The IJB's Strategic Planning Group has also played an important role in shaping the direction set out in this plan.

Consultation and engagement has allowed the WLHSCP to identify what matters most to those using existing services and to identify areas that we need to develop over the next three years.

The Scottish Government's strategy, 'Reshaping Care for Older People', 2011 to 2021 contains the guiding principles for the development of this plan.

The strategy focuses on improving:

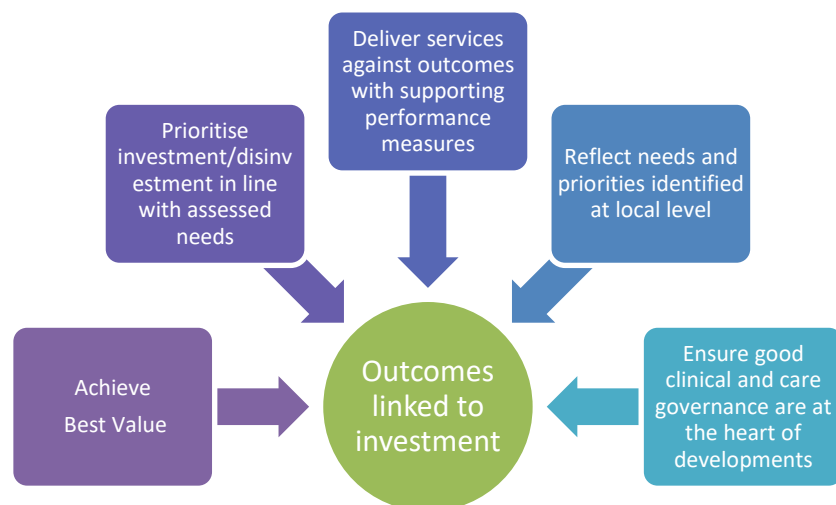




The Scottish Government published Health and Social Care Standards: My Support, My Life in June 2017. The new Standards set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone, to ensure that individuals are treated 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:



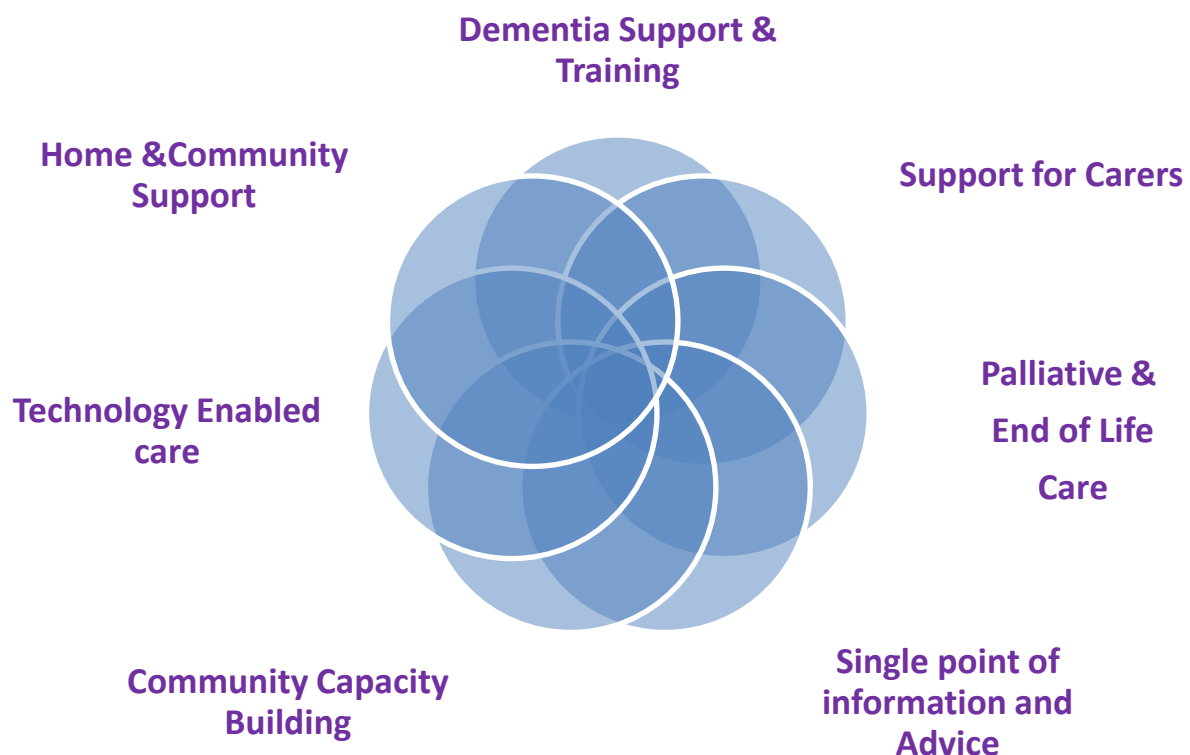
This commissioning plan also aims to:



### 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 which was published in two parts ([part 1](#) & [part 2](#)) which was used as the basis for the 2016/17 to 2018/19 commissioning plan for services for older people. 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 in the previous plan were:



Those priorities were built into the following programmes of work:

## Service Integration- Frailty Pathway

### Integrated Discharge Hub

During the course of the previous 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 representatives from Carers of West Lothian in the hospital to improve discharge planning and enhance 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 completed to allow multi-disciplinary assessment of ongoing need to take place at home rather than in hospital – known as 'discharge to assess'. The discharge to assess approach means that people with complex care needs can go home when they are medically fit to do so. Assessment of ongoing care and support needs can then be done at home which is a much more appropriate setting for identifying goals for rehabilitation and personal outcomes. 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 to discharge. We also invested additional resources in the

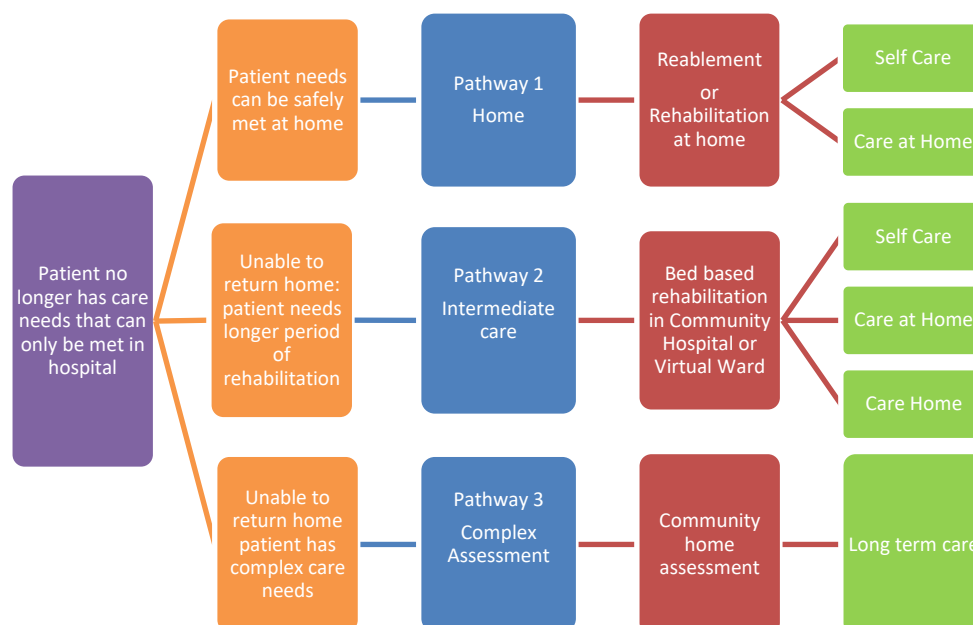
internal Reablement Service to allow more people to receive rehabilitation and care at home.

The integrated discharge hub and the discharge to assess approach have resulted in positive impact on the average length of stay on medical and rehabilitation wards.

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 timely hospital discharge in our new plan. Importantly, alongside that work, we will also consider how we can build capacity in the community under a single point of access (SPA) to prevent people being admitted to hospital unnecessarily wherever possible.

**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 participated in a national health improvement collaborative led by Healthcare Improvement Scotland, 'Frailty at the Front Door'. The collaborative was successful in improving the identification and coordination of care for people living with frailty who presented to the local hospital.

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

We need to ensure that the identification of frailty is done from the point of presentation at all acute front door areas to facilitate specialist frailty input. High quality frailty care needs to be embedded within the design and culture of all acute care areas.

### 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 care 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.

We also made significant investment in our reablement services. This investment has seen an increase in community capacity to discharge people with complex care needs from hospital back to the community for ongoing assessment and care.

In addition, our community Rapid Elderly Assessment and Care Team (REACT), including the Hospital at Home service, continued to make a significant contribution to the delivery of care, treatment and rehabilitation in the community. A rapid access clinic was added to REACT services and is providing urgent access to 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 remained 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 to 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.

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 care homes.

### REACT Care Home Team

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 two 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 identify future requirements based on a clear understanding of anticipated growth in our population of older people and changing models of care.

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

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

- West Main St, Broxburn opened 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 increasing number of older people.

## Community Capacity Building

### Voluntary and 3<sup>rd</sup> Sector

The Voluntary Sector Gateway and third 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 commitment to developing ways in which volunteers can support older people to remain



connected to their community. 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.

*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.

*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 considered with reference to the use of an e-frailty tool by GPs, to better understand levels of frailty within their practice populations.

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

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

*Technology Enabled Care*

During the last planning cycle we extended use of a 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 1<sup>st</sup> 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. West Lothian's Strategy for Carers was published in 2020.

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 work continues to support carers to maintain their health and wellbeing and to enable people 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 3<sup>rd</sup> sector organisation to ensure that people had access to timely information and advice.

### 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 Social Care partnership has continued to implement dementia learning pathways through training to improve awareness of dementia and enhance practitioners' skills. Dementia awareness raising courses ran from 2016 to 2019 and 3 cohorts of staff completed Professional Development Awards in Promoting Excellence in Dementia Skilled Practice (PDA) between 2016 and 2018.

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

The Health and Social Care Partnership embarked on a pioneering dementia venture, being the first partnership to introduce a specialist advanced dementia nurse practitioner into the care team. This role will allow support to be provided at an early stage by a practitioner 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.

We also acknowledge that whilst the development of services for people living with dementia sits within the plan for older people, there is significant overlap with the mental health commissioning plan. As developments progress, lead officers will ensure that there is discussion across all planning and commissioning boards to ensure that services of the future reflect the needs of the entire adult population.

## Palliative and End Of Life Care

Within West Lothian there is a strong partnership with Marie Curie & McMillan in providing coordinated, person-centred palliative and end of life nursing care, advice and support. The partnership expanded the team by introducing advanced nurse practitioners within community hospitals who are working on the development of enhanced community services.

Community teams have focused on anticipatory care both at home and in care home settings, and have also had the opportunity to shadow the Marie Curie team to develop the range of supports on offer. The community nursing team continues to play a critical role in assessing and delivering palliative and end of life care, both in and out of routine hours.

The health and social care partnership meets regularly with partners to identify opportunities for continuous improvement and has undertaken engagement work with service users, carers and families to inform the priorities detailed below:

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

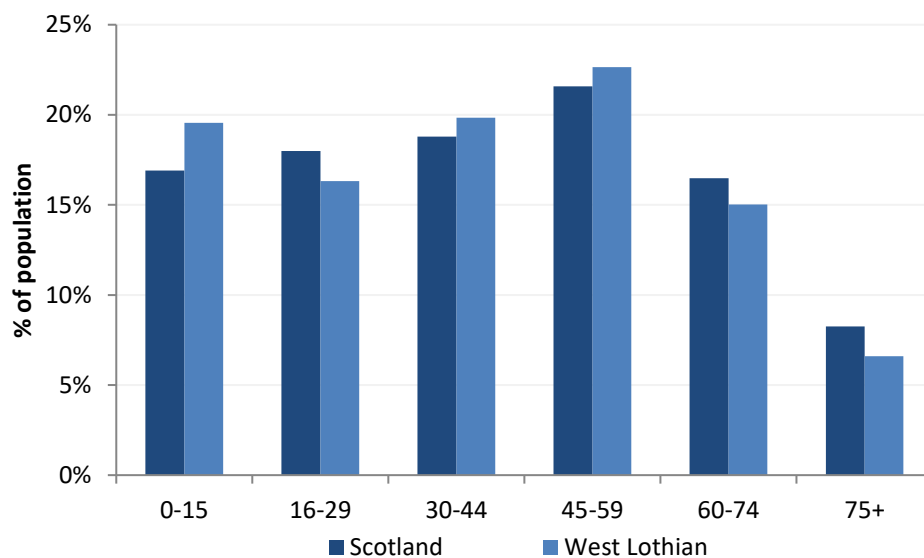
Key considerations of the new plan will be to improve:

- the early identification of palliative and end of life needs
- accessible inpatient end of life care locally
- care pathways
- education and training

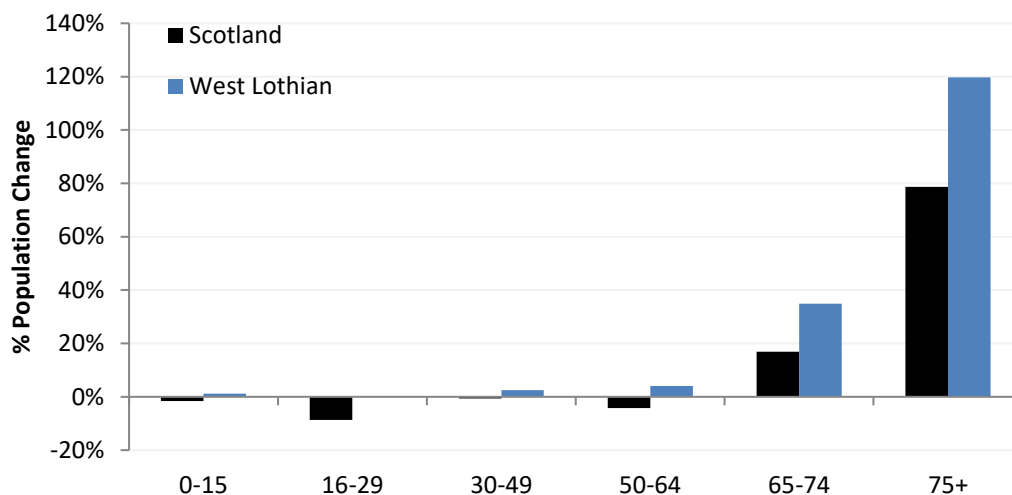
## 4. West Lothian Context

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.



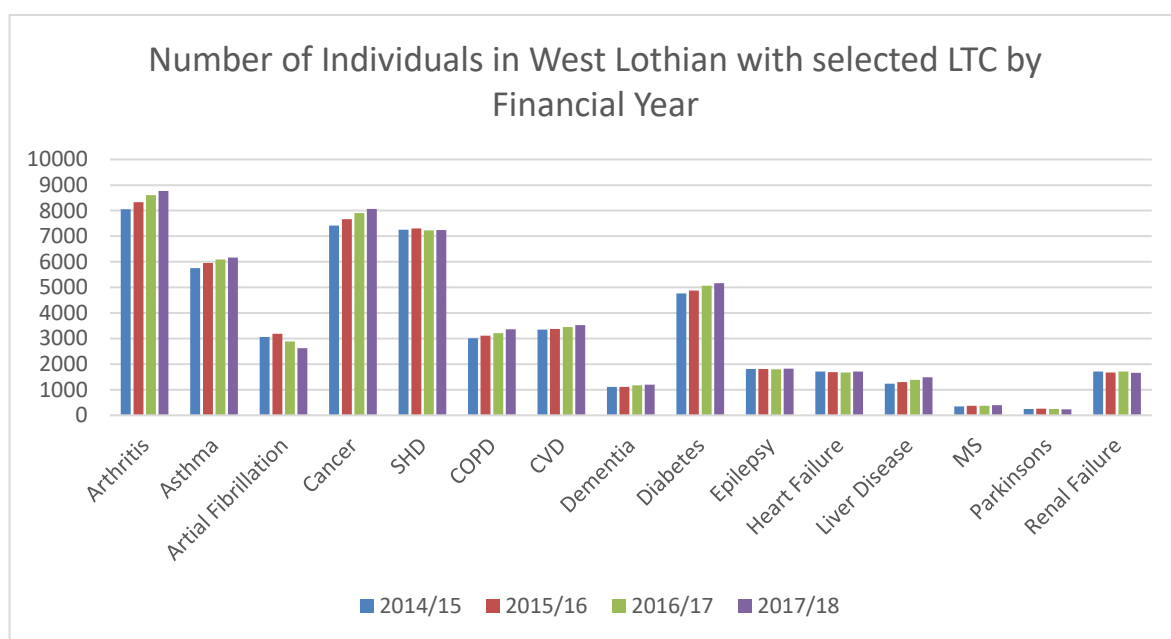
West Lothian is facing an aging population profile that represents a significant challenge. Compared to other local authorities West Lothian will see significantly higher level of growth (2016 to 2041) in number of over 75s and 85s, who will typically have increasing social care needs.



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

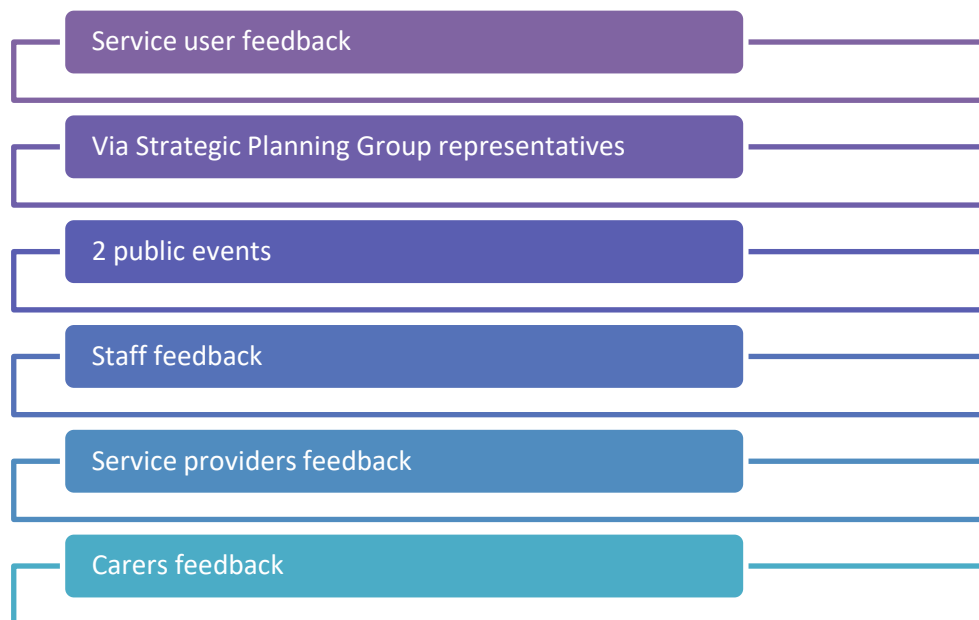
Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Commissioning is 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 a 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 provide an opportunity for people 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 the third and voluntary sectors, and direct engagement with 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 a learning disability, people living with physical disabilities and people living with mental health



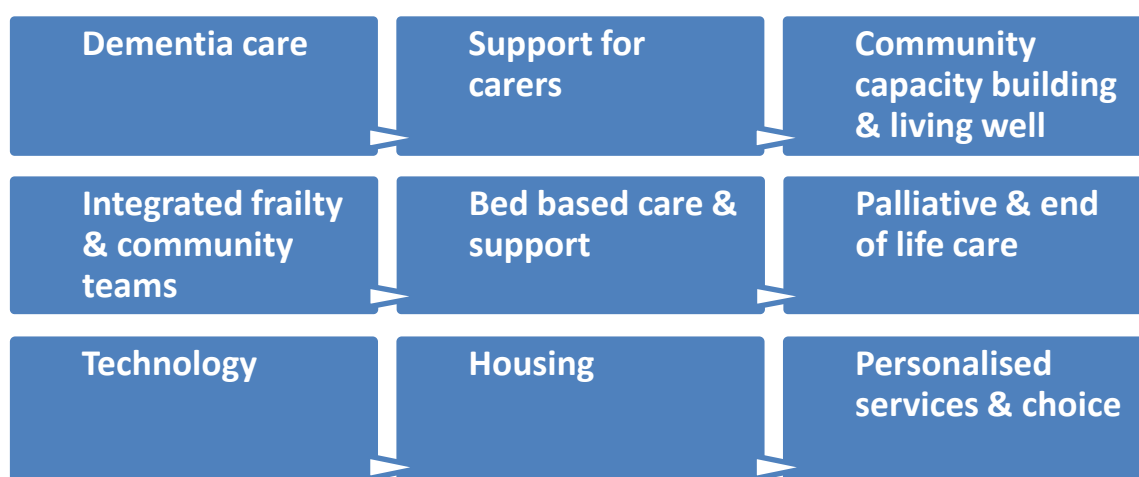
problems. Information about the events was circulated widely, posted on West Lothian Council's social media pages and shared with providers, community centres, contacts and projects throughout West Lothian.

Specific feedback from service user, carers, families, Black and minority ethnic carer group, advocacy and volunteers' was gathered through facilitated workshops, meetings and one to one discussions by 3<sup>rd</sup> 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 people aged under 65 with early onset dementia as well as the needs of those aged over 65.

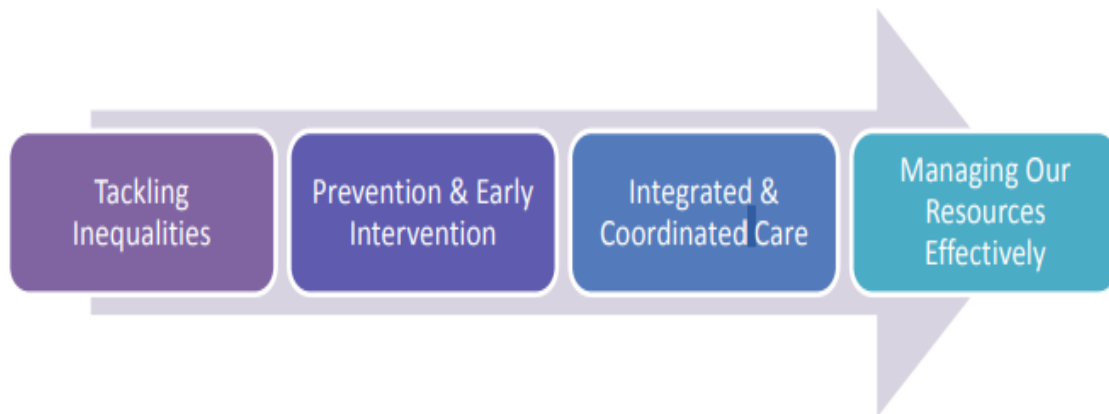
Completed pro-formas and feedback was discussed at meetings of the Older People Planning and Commissioning Board, where ideas were compared across all engagement groups to identify emerging themes.

A copy of the full feedback summary can be accessed [here](#). The feedback from the engagement process was used alongside a range of other information such as local and national 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:



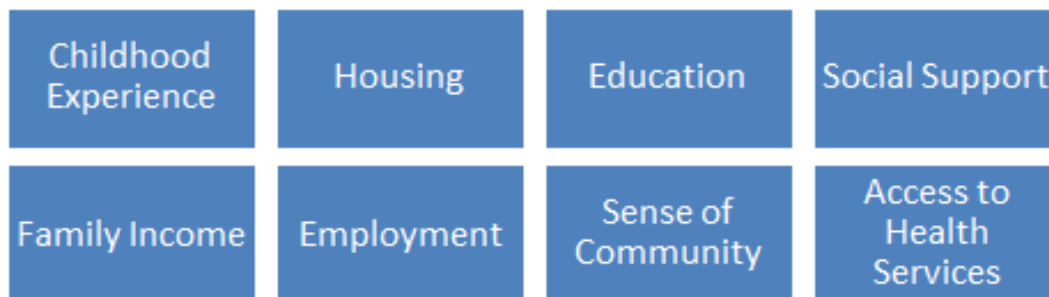
## 7. Our Strategic Priorities

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

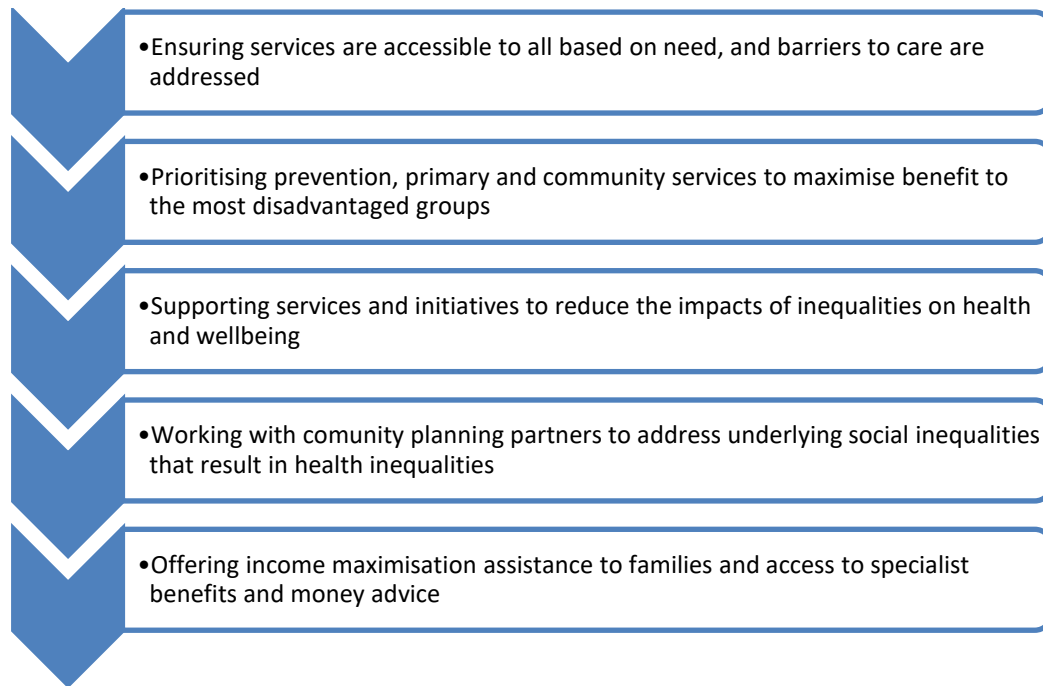
We recognise that addressing both health and social inequalities within our communities must be at the heart of our commissioning plans. Social circumstances such as those outlined below can impact our health and wellbeing:



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 also more likely to have poorer health than

the general population which can impact people achieving their own outcomes and goals.

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



## Loneliness

As society changes, there is increasing recognition of social isolation and loneliness as major public health issues that can have a significant impact on a person's physical and mental health.

Whilst greater access to information and technological resources has enabled people to feel more connected, many people are affected by digital exclusion which can further exacerbate loneliness.

In order to tackle social isolation more effectively, there must be greater focus in our plans on improving inclusion amongst vulnerable groups such as older people, people living with dementia, carers and homeless people.

## Person-centred approach to Prevention and Integrated Priorities

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 as summarised, below. This model has been used in the approach to commissioning services for older people in West Lothian.



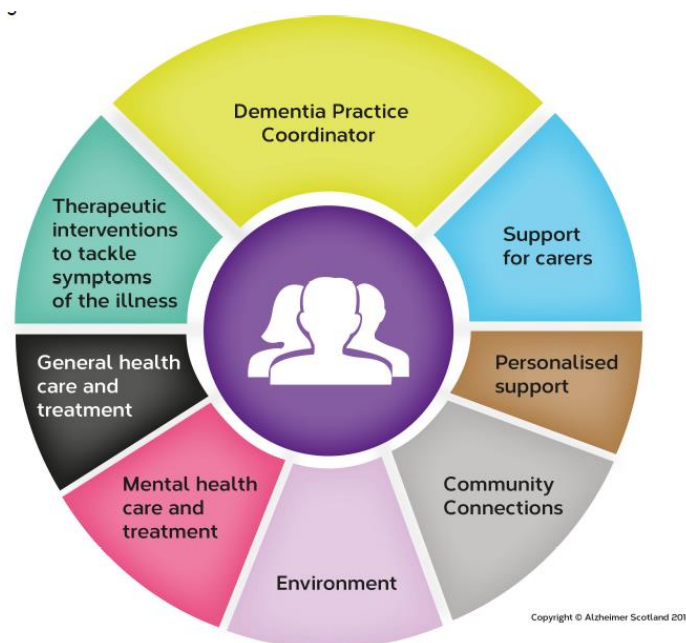
During the span of the commissioning plan, we will continue to explore opportunities to shift the balance of care closer to community settings, through integrated partnership working to deliver the Scottish Government's vision for:

- integrated health and social care
- focus on prevention, anticipation and supported self-management
- hospital treatment when required, and where this 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.

## Dementia Care from identification to post diagnostic support

In Scotland, improving care and support for people with dementia and those who care for them has been a major ambition of the government and partner organisations since 2007. Over the last decade dementia services have made significant progress in developing pathways and delivering comprehensive post diagnostic support that has strengthened integrated person centred care.

The National Dementia Strategy 2017-2020 challenged services to go further for people and families around earlier diagnosis, anticipating care needs, increasing support for carers and improving outcomes at each stage of the illness. It is acknowledged that individuals who are diagnosed early with dementia will continue to need care throughout their illness. Within West Lothian we will continue to support the national dementia 8 pillars approach as outlined below



Recent dementia stakeholder engagement workshops highlighted a need for further development of integrated partner pathways and access to targeted information to meet the needs of individuals.

A review carried out by Alzheimer Scotland' Transforming Specialist Dementia Hospital Care' identified that the majority of patients did not

have a clinical need to be in hospital and could be cared for in a community setting.

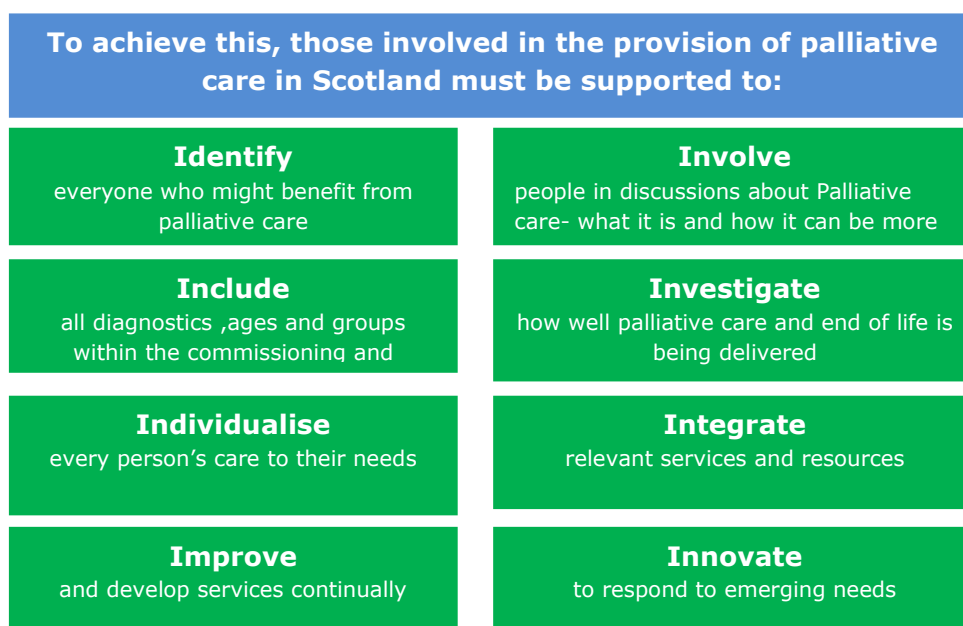
Part of the 8 pillar work will scope the right models of care and level of support required within a care home setting to manage longer-term complex care for people with dementia. The Integrated Joint Board will need to consider the level of capacity required for community resources to safely transition people to a community setting. There will be a need to invest in multi-disciplinary approaches to support care homes and people living at home, and for consideration to be given to the level of specialist acute beds required.

### Palliative and End of Life Care

It is widely accepted that palliative and end of life care is related to all people with a life limiting illness, not just those who are diagnosed with cancer. People are living longer with more illnesses and long-term conditions which will lead to increased demand on our services.

Within West Lothian we are committed to delivering the Scottish Government's ambitious framework for action on palliative and end of life care.

By 2021 there is an aim to ensure that everyone who needs palliative care will get hospice, palliative or end of life care. It also aims for people who would benefit from having a 'Key Information Summary' (where information on care needs, long-term conditions, care plans and end of life preferences are held) to have one.



Scottish National data identifies that people with palliative care needs have greatest impact on hospital unplanned bed days.

Between 2004-2016, the proportion of home and care home deaths in Scotland increased: up to 23% at home and by 18% in care homes. If this trend continues, and the number of deaths at home and in care homes increase, this could mean that two-thirds of the population will die outside hospital by 2040.

In responding to this within West Lothian, our focus will remain on continuing to shift the balance of people enabled to die at home or in a homely setting, whilst improving outcomes and enabling a shift of resources across the health and care system. We aim to ensure a person's needs are met in the most appropriate and preferred setting.

For the Commissioning plan this will mean a focus on:

- Early identification of palliative and end of life needs
- Compassionate person centred conversations
- Access to the right support & care, at the right time, closer to home
- Education and up-skilling the health and social care workforce and wider community on matters of where a person is on their trajectory of illness, dying and death.

It has been agreed that the development of palliative and end of life care will be hosted and reported within this plan. However, it is acknowledged that people of all ages may require palliative or end of life care and there will be a requirement to ensure that the needs of the entire adult population are reflected in future developments.

### Technology Enabled Care

Over the next three years there will be an emphasis on exploring and testing new and emerging technology, to support and increase the number of people enabled to remain in their own homes for longer. We will continue to focus on prevention and early intervention in assessing and providing interventions to maximise a person's independence.

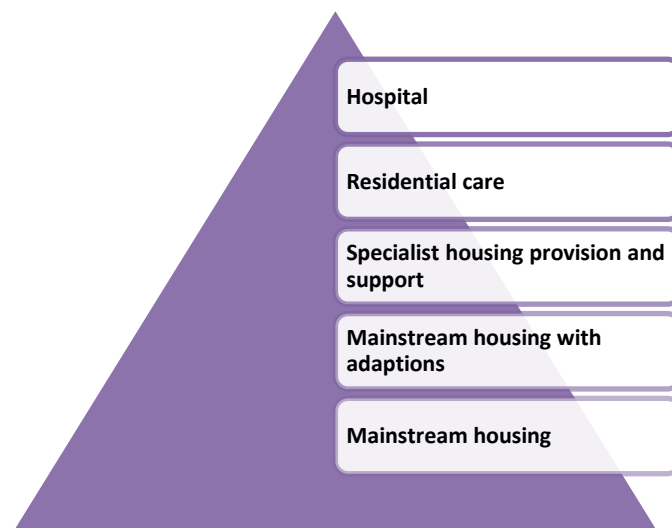
In addition, we will explore how we can better support our staff to use technology in their work, to improve both staff and service-user experience and outcomes.

## Support for Carers

A strategy for supporting carers ([insert link](#)) was approved by the Integration Joint Board in September 2020 and will provide the basis for developing appropriate supports for carers in West Lothian for the duration of this plan.

## Housing

West Lothian's population is changing. Given the projected increase in all age demographics in the coming years, there is a requirement to contribute to the development of a housing strategy which aims to ensure that population needs are met. We will continue to develop housing models to ensure that the needs of those facing barriers to independent living are addressed at the earliest possible stage.



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.



## Our Workforce

We recognise there are substantial 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 which will mean attracting a future supply, up-skilling existing staff and exploring new roles and new ways of working. Those requirements will be reflected in our workforce plans.

## Self Directed Support

The Social Care (Self-directed support) (Scotland Act 2013) requires public bodies to give people a greater voice in decisions about local services and greater involvement in designing and delivering them.

In West Lothian, the HSCP continues to work with stakeholders to realise this vision for self-directed support in effective and innovative ways. The fundamental principles of participation, dignity, involvement, informed choice and collaboration are central to our local practice.

## Learning From Covid-19

When we first embarked on the development of the commissioning plan for older people in 2019, we could not have imagined how dramatically the world would have changed just months later as a result of the COVID-19 pandemic.

The West Lothian community, like the rest of Scotland, has faced unprecedented circumstances and has needed to find new ways of living and working. The spirit of cooperation that has been evident between health and social care staff, service users, their families, carers, and the many commissioned services and other stakeholders that make up the West Lothian Health and Social Care Partnership, has been remarkable and we want to capture the positive work that has been evident over the past seven months in the development of our future services.

The IJB's Strategic Planning Group held a development session for key stakeholders in September 2019 to allow an opportunity for reflection on the pandemic response. A summary of the experiences described by

participants was published ([insert link here](#)) and has been used to inform the future programmes of work outlined in this plan.

There has been opportunity during the pandemic to progress change at a quicker pace than might otherwise have been possible and we want to ensure that we continue to build on the learning we have taken from that.

We know that technology will play an increasing part in the future delivery of health and social care and we will develop a digital strategy for the partnership to ensure that services maximise opportunities in that area too.

## 8. Our Future Programmes of Work

Taking account of all the priorities outlined in this report, we have identified three programmes of work to develop our future services for older people and for those living with dementia.

### 1. Prevention and Early Intervention

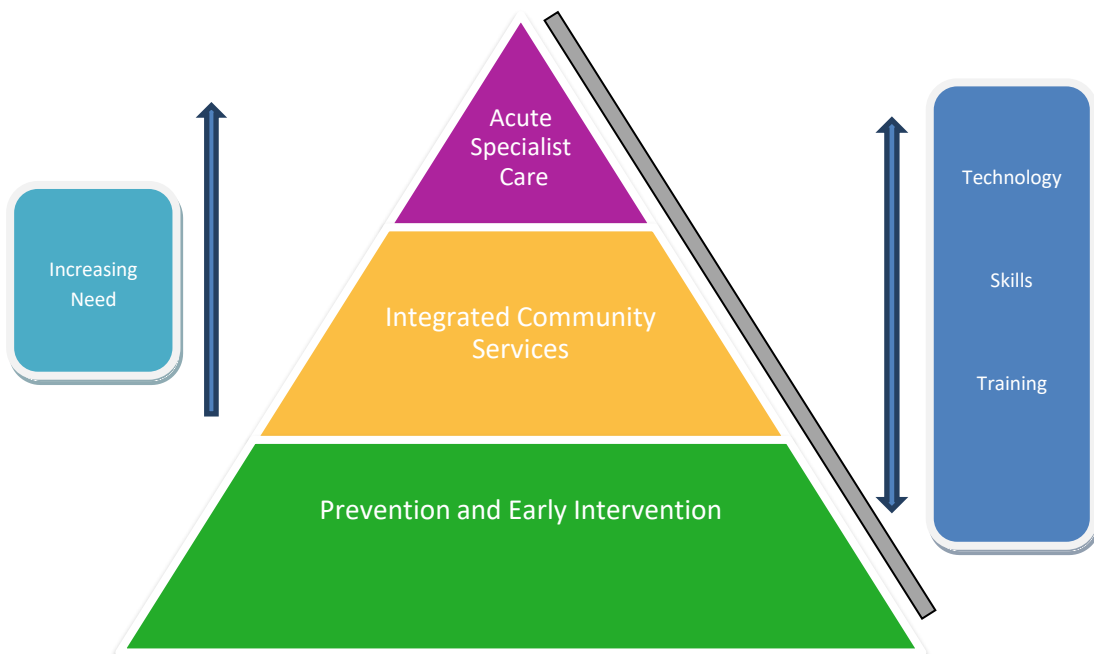
This programme will focus on helping people stay healthy and preventing deterioration in health and wellbeing.

### 2. Integrated Community Services

This programme will support individuals who are unwell and at risk of hospital admission, who are recovering from illness post hospital admission or who require support to maintain health & well being and independence within the community.

### 3. Acute Specialist Care

This programme will help those who need specialist care and treatment within the health and care system.



The triangle represents the total population of older people in West Lothian. People will transition between the tiers of the triangle as their

health and care needs change. The grey shared area on the triangle represents opportunities to join up statutory and voluntary sector resources to create new and ambitious models of care.

Each programme focuses on improving quality of care and on progression of more integrated approaches to health and social care delivery.

The three programmes of work will require decisions to be made on how services are resourced in the future, the configuration of our community hospitals and care homes, the use of acute hospital beds and development of more community based services for older people.

Broad Category	Broad health category	Broad service use	What needs to be developed (grey shaded area)	Examples interventions for people who need something different
<b>Prevention and early Intervention</b>	<b>Broadly well with lowest level of needs</b>  Most of population, reasonable levels of health & wellbeing for much of their life. Some health needs may start to arise	<b>Universal pathways sufficient</b>  Most services delivered in community but occasional use of specialist services or voluntary sector help	Improvements in access to community supports including third sector and other community resources	Improving access to early joined up support with the third sector
<b>Integrated community services</b>	<b>More complex needs</b>  Some people will have complex health and care needs such as long term conditions; multiple morbidity	<b>More complex needs</b>  Universal services will meet needs through short term intermediate care and or supported by specialist services	<b>More complex needs but universal services</b>  May need assessment and care management if at risk	Link workers, multi-disciplinary teams, e-frailty screening, medicine reviews, social prescribing, additional support
<b>Acute Specialist Care</b>	<b>High need</b>  Small numbers of people with acute or complex care needs	<b>Complex Pathways</b>  Often complex patient pathways to navigate	<b>High intensity/complex needs</b>  People at high risk of hospital admission	Joining up specialist community, out-patient and community interventions

## Programme 1

### Prevention and Early Intervention

Aims to continue to improve access to advice and support to enable people to live healthy lifestyles and remain independent for as long as possible making an active contribution to their communities.

Lowest need -  
whole  
population



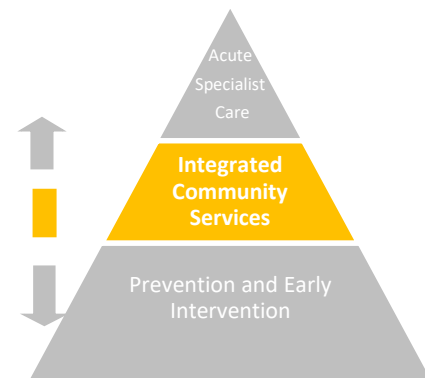
Key Priorities	Description	Outcomes/Impact Areas
<b>Building resilient communities &amp; promoting volunteering and social inclusion</b>	<p>Strengthening partnerships between health, social care, voluntary and third sectors aligned to an agreed strategy.</p> <p>Localised community pathways of care.</p> <p>Increasing volunteering opportunities and social inclusion using community asset based approach.</p> <p>People are in the main able to live independently.</p>	<ul style="list-style-type: none"> <li>Neighbourhood cohesion and belonging and safety</li> <li>Timely and effective hospital discharge, reduction in deterioration of health and increased community capacity</li> <li>Reduced isolation and inequalities of older people and people living with dementia</li> <li>Increased capacity in the health and care system from early supports from volunteers</li> </ul>
<b>Improving access to timely local advice, information and social prescribing to improve health and wellbeing</b>	<p>Local &amp; easy availability, via a single point of access, to advice, information, technology enabled care and support to reduce unnecessary use of healthcare and social care services. Solutions explored on social prescription/ signposting.</p> <p>Carers supported in line with priorities within West Lothian's Carers Strategy.</p>	<ul style="list-style-type: none"> <li>Reduced inequalities</li> <li>Improved access to timely advice, information and support</li> <li>Improved health and wellbeing and reduction in unnecessary use of health and social care services</li> <li>Reduction in unnecessary A&amp;E presentations</li> <li>Unpaid carers feel support and have access to breaks from caring</li> </ul>
<b>Health + Social care prevention and early intervention delivered locally</b>	<p>Integrated health and social care teams delivering care and support closer to home and strengthening links with GP clusters and partner organisations. Local teams empowering people with long term conditions to manage their own health and well being and to provide intermediate care and longer term interventions to maintain independence in the community.</p>	<ul style="list-style-type: none"> <li>Patient self manages</li> <li>Increase in personal support network</li> <li>Increased use of technology enabled care</li> </ul>

## Programme 2

### Integrated Community Services

Aims to continue to build a community model that strengthens local, person-centred, integrated care and support. It will include proactive, intermediate care, longer term and palliative care to meet the needs of older people and people living with dementia.

Moderate or recurring health and social care needs



Key Priorities	Description	Outcomes/Impact Areas
Proactive / complex and scheduled care longer term care	<p>Coordinated, proactive care, targeted management from health and social care professionals and third sector supports for individuals with complex needs.</p> <p>Dementia services that deliver the 8 pillar national dementia strategy and meet demand.</p> <p>Delivery model for health teams and community and hospital social work teams to be developed to support all programmes of work with an integrated focus.</p> <p>Enhanced support and training in care homes to help them respond to urgent and routine health and well being needs and reduce A&amp;E attendances.</p>	<ul style="list-style-type: none"> <li>Seamless community care and support delivered to people by the right service at the right time</li> <li>Improve EQ-5D-5L (Quality of Life outcomes) for people with 1+ long term condition</li> <li>Increase number of people dying in their preferred place of care</li> <li>Reduction in unnecessary hospital admissions from care homes</li> </ul>
Urgent/ Intermediate Care – Home	<p>Same day access to appropriate health and social care professionals to avoid wherever possible further deterioration/crisis in health.</p> <p>Aligned out of hours and same day services.</p>	<ul style="list-style-type: none"> <li>Timely local intervention to prevent further deterioration of health &amp; unnecessary escalation and admission</li> <li>Strengthen resources aligned to GP practices releasing GP time to reinvest into complex proactive care</li> <li>Reduction in A&amp;E and attendances and unnecessary hospital admissions</li> </ul>
Rapid Access to Primary and Community Care	<p>24/7 services.</p> <p>New community models of care that identify what care can be delivered in the community to strengthen existing provision and offer consistent and effective primary care and community mental health services.</p>	<ul style="list-style-type: none"> <li>Acute hospital more able to focus on patients that require their specialist expertise</li> <li>Reduction in Scottish Ambulance Service conveyances to A&amp;E</li> <li>Delivery of high quality services consistently across the week</li> </ul>

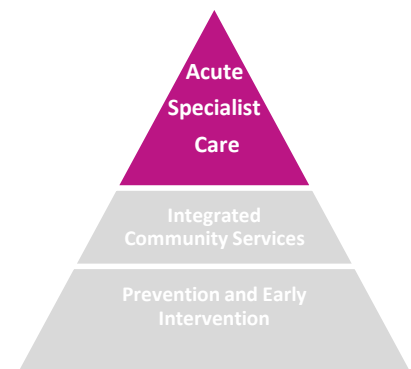
<p><b>Enhanced discharge support in the community</b></p>	<p>Single approach to assessing, coordinating and meeting discharge care needs in the community for older people and people living with dementia.</p> <p>Optimising technology enabled care to maintain people in their own homes.</p> <p>Single point of access for community care at home services.</p>	<ul style="list-style-type: none"> <li>Streamlined, timely, coordinated access to assessment treatment &amp; support, reducing duplication of resources</li> <li>Improved long term outcomes for individuals through integrated approach to rehabilitation and reablement</li> <li>Reduction in occupied hospital bed days &amp; readmissions</li> <li>Increased use of technology enabled care</li> <li>Increase in personal support networks, focus on health and wellbeing outcomes and improved carer support</li> </ul>
<p><b>Intermediate Care – Community Beds</b></p> <p><i>Community Hospitals and Care Homes</i></p>	<p>Effective bed based rehabilitation (step up/down) delivered via an agreed intermediate care model across West Lothian.</p> <p>Whole system partnership review of medical model across the rehabilitation beds in West Lothian.</p>	<ul style="list-style-type: none"> <li>Reduced unnecessary hospital admission and improved system flow</li> <li>Improved independence scores - avoiding or delaying need for longer term care</li> <li>Reduction in the average length of time spent in a care home</li> </ul>
<p><b>Longer term beds</b></p> <p><i>Care Homes</i></p>	<p>Longer term care should be diverse, focusing on the importance of home and community and providing environments for older people that are flexible and provide high quality care.</p> <p>Opportunities should be taken to explore new models of care within specialist housing and care homes, to meet the longer term needs of older people and people living with dementia.</p> <p>Current capacity and models of care within care homes reviewed to ensure account is taken of demographic changes and changing care needs.</p>	<ul style="list-style-type: none"> <li>Person centred, tailored support to meet individual needs</li> <li>Reduction in the median time people spend in a care home setting, optimising opportunities to remain at home wherever possible</li> <li>Care home provision across west Lothian that meets changing demand and demographic pressures</li> </ul>
<p><b>Palliative and End of Life Care</b></p>	<p>Person centred, palliative/end of life care to relieve suffering and improve quality of life for people with deteriorating health.</p> <p>Support for the person and their families and carers in their preferred setting.</p>	<ul style="list-style-type: none"> <li>Improved palliative care and end of life support that offers choice and control to people using services</li> <li>Increase in the number of people able to die in their preferred place of care</li> </ul>

## Programme 3

### Acute Specialist Services

Aims to deliver specialist acute care that provides access to specialist input to meet complex physical and mental health needs, minimising harm and ward moves. To join up specialist outpatient treatment with proactive case management work within the community.

Highest need



Key Priorities	Description	Outcome/Impact Areas
Front Door	<p>Effective hospital frailty model to avoid unnecessary admission and provide rapid advice from specialists to inform the inpatient care plan.</p> <p>Scottish Ambulance Service to increase their 'hear, see and treat' services and divert to community services to avoid the need for acute care.</p>	<ul style="list-style-type: none"> <li>Individuals to receive the right care, at the right time by the right skilled teams</li> <li>Reduction in Scottish Ambulance Service conveyances to Hospital</li> </ul>
Specialist Inpatient	<p>Acute bed capacity the right size for West Lothian.</p> <p>Hospital internal care optimises outcomes and efficiency.</p> <p>Comprehensive interdisciplinary assessment embedded within hospitals and informed by community team.</p> <p>Inpatients that require support on discharge will be tracked and case managed by a 'single point of access' with focus on maximising the number of people who are able to return home.</p>	<ul style="list-style-type: none"> <li>Only acutely ill patients are treated in the hospital setting</li> <li>Reduction in number of bed days lost due to delays in transfer of care.</li> <li>Reduction in older people losing independence whilst in hospital and impacting on their ability to continue to live within their own home</li> <li>Improved, timely, person centred discharge planning with patients and families</li> <li>Improved patient satisfaction and improved outcomes on discharge</li> <li>Reduction in readmission rates</li> </ul>
Outpatient	<p>Specialist outpatient staff to participate and share expertise with multi-disciplinary teams in the community to join up the pathways and outcomes for delivering proactive care to patients.</p>	<ul style="list-style-type: none"> <li>Reduced hospital admission for ambulatory care sensitive conditions</li> <li>Improve patient experience and outcomes</li> <li>Increased use of technology enabled care</li> </ul>



## 9. 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.



## 10. Next Steps

The Older commissioning 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. As such, the outcome measures determined in the action plan will need to be refined over the course of the commissioning cycle to ensure they remain relevant and reflect the decisions taken at each stage of the transformation journey.

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
<b>Programme 1 – Prevention and Early Intervention</b>							
1.1	Building community resilience, & promoting volunteering and social inclusion	- Develop an approach to build relationships with the third sector, and include the third sector as a pathway linked to social prescribing	1,2,3,4,5 6,8,9	P&EI TE, ICC MRE	Evidence of alignment of 3 <sup>rd</sup> sector pathways to HSCP and increased use of social prescribing  Surveys Reduction in number of people feeling isolated Increase in the number of people who feel supported.	March 2022	Head of Strategic Planning/ Programme Manager
1.2	Improving access to timely advice, information & social prescribing	- Establish community 'pop up' information hubs to improve access to timely information, advice and support from health, social care	1,2,3,4,5, 6,7,8,9	P&EI TE,	Impact on demand for health and social care community services	December 2021	Senior Manager Social Policy

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
		teams and wider community partners to prevent further deterioration and maximise health and wellbeing		ICC MRE	Increase in number of carers accessing support and feeling supported		
1.3	Delivery of preventative approaches to health and social care and early intervention in community locations	<ul style="list-style-type: none"> <li>Scope delivery options for integrated community health and social care/social work teams working within a community 'Single Point of Access' (to deliver programme 2 &amp; 3 aligned to clusters; directly linked to information 'pop up' hubs.</li> <li>Undertake demand and capacity modelling to identify a baseline for developing delivery models, pathways and processes.</li> </ul>	1,2,3,4,5,6,7,8,9	P&EI TE ICC MRE	Options Appraisal / Business case and agree demand/ capacity baseline.	September 2021	Heads of Health/Social Policy, Clinical Director
<b>Programme 2 – Integrated Community Care</b>							
2.1	Proactive and complex care – scheduled  (Linked to action 2.5,3.4)	<ul style="list-style-type: none"> <li>Map and strengthen existing proactive care pathways to case manage people at risk of hospital admission (e.g. integrated Frailty, Respiratory, Falls etc)</li> </ul>	1,2,3,4,5,6,7,8,9	P&EI TE ICC MRE	Reduction in unnecessary hospital admissions  Improvement to EQ-5D-5L tool to measure quality of life outcomes for people with 1+Long term conditions	December 2021	General Manager Community Care Outpatient Manager Acute Hospital Associate Nurse Director or Medical lead – Acute

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
2.2	E-Frailty	- Increase the use of the e-frailty tool, using the Livingwell approach and, MDT partnership working to manage and support people who are frail	1,2,3,4,5, 6,7,8,9	P&EI, TE ICC MRE	Reduction in the occupied acute bed days per GP practice that uses e-frailty tool and MDT care management approach	September 2021	Clinical Director
2.3	Day opportunities (Linked to 1.1 and 1.2)	- Work with all partners, to review models of support offered through day opportunities for older people ensuring links with revised models of care and support	1,2,3,4,5, 6,7,8,9	P&EI TE ICC, MRE	Number of eligible people accessing the right day opportunities  Carers feel supported to continue their caring duties.	Jul 2021	Senior Manager Social Policy
2..4	Care Homes and future models of delivery	- Review current care home support and scope future need, including opportunities to provide new models of care and support for both physical and mental health needs, to prevents unnecessary hospital admission.	3,4,5, 7,8,9	P&EI TE ICC,	Use of Scottish Health And Care Experience (HACE) survey  Reduction in median length of stay in WL care homes for longer term care  Reduction %/ Number of people admitted to hospital from a care home	July 2021	Primary Care General Manager/ MH Senior Manager/ Senior Manager Social Policy
2.5	Intermediate Care – Home Crisis/ Deterioration and Recovery  (Urgent care & short term ICT support)	- Strengthen community rapid response pathways with GPs focussing on hospital admission avoidance and supporting national scheduling of unscheduled care work.	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	Reduction in calls to 111  Reduction in number of patients that are diverted from SAS to community pathways  Reduction in A&E Attendances	March 2021	General Manager Community and Senior Manager Social Policy

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
2.6	Home First	<ul style="list-style-type: none"> <li>- Further implement the Home First, Early Supported Hospital Discharge community model, joining up services to maximise Home-First capacity:</li> <li>- Develop joint health and social care community pathways and assessment models focussing on the following: <ul style="list-style-type: none"> <li>- Discharge to Assess/Reablement – care at home pathway</li> <li>- Rehabilitation AHP only</li> <li>- Palliative care/End of Life</li> <li>- Guardianship pathway</li> <li>- Complex care</li> </ul> </li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	<p>Increase number of days older people who remain independent at home following discharge (Baseline 163days)</p> <p>% Readmission rates</p> <p>Reduction in delayed occupied bed days</p> <p>Evidence of increased use in home technology</p>	June 2022	General Manager Primary Care and Senior Manager Social Policy
2.7	Externally Commissioned Care at Home Services	<ul style="list-style-type: none"> <li>- Ensure future care at home services are aligned to changing models of care and that contractual arrangements for care at home reflect the need for joint working and the timely delivery of support to those who are eligible.</li> <li>- Care at home contract to be reviewed in accordance with required timescales ensuring it aligns with commissioning priorities.</li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	<p>Measure improvements in health and well being outcomes for people receiving care at home support</p> <p>Reduction in delayed discharges and delayed occupied bed days</p> <p>Reduction in rates of hospital admission from the community</p>	Ongoing reporting	Senior Manager Community care
2.8	Intermediate Care Bed based provision	<ul style="list-style-type: none"> <li>- Review learning from a test of change during winter 2020-21 on intermediate care model comprising 8 beds in a community</li> </ul>	1,2,3,4,5, 6,7, 8, 9	P&EI TE,	Evaluate the impact of the intermediate care palliative	June 2021	Primary Care General Manager and Senior

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
		hospital to help to inform future planning of intermediate care provision		ICC MRE	model Reduction in occupied bed days linked to cohort's frequency of hospital presentations to hospital		Manager Social care
2.8.1		- Develop an intermediate care bed-based (step up/down) operational delivery model using the learning from the test of change having regard to existing and projected demand	1,2,3,4,5, 7, 8, 9	P&EI TE, ICC MRE		March 2022	Consultant Geriatrician/ Head of Health/Senior Manager Community Care
2.8.2		- Undertake modelling of bed based provision for frail elderly and older people living with dementia to ensure WL commissions and realigns resources to enable people to be cared for in the right bed, closer to home  - Review above to include community hospitals, LA care homes, housing with care, commissioned care homes and unscheduled acute beds for frail/older people	1,2,3,4,5, 6,7, 8, 9	P&EI TE, ICC MRE	Evidence of plan to align bed to community interventions and resources.  (no patient to be in an acute bed that doesn't require acute care i.e. have a 'reason to reside')	March 2023	Head of Health/Head of Social/Hospital Director/ Lead MOE Consultant/ Lead Nurse

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
<b>Programme 3 – Specialist Acute Care</b>							
3.1	<b>Front Door</b>  (Linked to action 2.2)	- Identification of frailty from presentation at all acute front door areas to facilitate specialist frailty input. High quality frailty care to be embedded within design and culture of all acute care areas (linked to future community Single point of Access)	1,2,3,4,5,6,7,8,9	P&EI TE ICC MRE	Percentage of frail patients identified on admission and receive specialist frailty input	November 2020	Head of Health/ General Manager Acute Programme Manager
3.2	<b>Inpatient</b>  (Linked to actions 2.1,2.5,2.6 )	- Delivery of assessment and interventions for frailty syndromes to be carried out in tandem with addressing acute medical issues.  - Joint multidisciplinary care from relevant specialists (e.g. MOE, Psychiatric, Palliative care) in best environment	1,2,3,4,5,6,7,8,9	P&EI TE ICC MRE	Define model, pathways with agreed KPIs	March 2022	General Manager Community/ Mental Health/ Senior Manager Social Policy/MOE Consultant
3.3	<b>Hospital Discharge Planning</b>  (linked to action 2.6)	- Proactive discharge planning from the earliest point in acute pathway focusing on patient centred goals  - To include reviewing all hospital discharge processes including housing	1,2,3,4,5,6,7	TE ICC	Agreed functions and responsibilities of all discharge planning staff roles & processes  Reduction in unnecessary occupied bed days associated with awaiting for emergency housing	July 2021	General Manager Primary Care/Senior Manager /General Manager Acute  Housing Officer

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
3.3.2	Rehabilitation pathway  Linked to actions 1.3,2.6)	- Single point of access for rehabilitation to facilitate the right pathway for each patient based on individual circumstances, needs and goals, aiming to deliver rehabilitation at home or as close to home as possible	1,2,3,4,5, 7,9	TE ICC MRE	% of people achieving their rehab goals  % of patients receiving the right rehab from the right team in the right care environment  straight home from Edinburgh or out of areas without transfer to SJH for rehabilitation	March 2021	OT/ Physio Acute Lead/React Manager
3.4	Specialist input in the community	Prompt access to the right specialist input from the community Planned multidisciplinary proactive frailty management to reduce risk of unscheduled crisis admissions	1,2,3,4,5, 6,7,8,9		% of people having access to specialist input in the community	March 2022	MOE Consultants/ Clinical Director HSCP
<b>The following priorities cut across all aspects of Programmes 1 to 3</b>							
<b>Dementia Care and Support</b>							
4.1	Early Onset Dementia  Programme 1&2	- Review existing model/processes that identify and support people referred with a diagnosis of early onset dementia & establish a user group to shape interventions that improve experience, outcomes and reduce inequalities	1,2,3,4,5, 6,7,8,9	ICC MRE P&EI TE	Survey – improved older people experience- establish a baseline  % of people accessing post diagnostic within 12 months of diagnosis	September 2021	General Manager MH/ Senior Manager Social Policy



	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
4.2	Complex dementia needs  (Links to actions 2.1, 2.6, 2.8, 3.2 and 5.1)	<ul style="list-style-type: none"> <li>- Review need for specific dementia models to meet long-term complex dementia needs, (care at home and bed based care aligned to intermediate care model) with reference to Alzheimer Scotland - 'Transforming Specialist Dementia'</li> <li>- Provide high quality dementia care during acute inpatient admission and deliver support in community for managing advanced dementia, including anticipatory care discussions and end of life care.</li> </ul>	1,2,3,4,5, 6,7,8,9	ICC MRE P&EI TE	Evidence of transition plans and modelling and pathways for complex dementia care needs	March 2023	General Manager MH/Senior Manager Social Policy
4.3	Dementia Training	<ul style="list-style-type: none"> <li>- To continue to deliver 'Promoting Excellence' training, knowledge and skills to staff, service users and families</li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	Number of Training courses delivered per year  Annually report the number of people trained	Ongoing	Clinical Nurse Manager MH
4.4	Technology enabled care for dementia	<ul style="list-style-type: none"> <li>- Explore and test home digital reminiscence therapy software to be used at home. .Full review to be completed of available technology to promote independence and maintain people in their own homes for as long as possible.</li> </ul>	1,2,3,4,5, 6,7,8,9	ICC MRE P&EI TE,	% increase in patient experience	September 2022	General Manager MH/Senior Manager Social Policy
	Integrated Care pathways Home Team and WeLPAT	<ul style="list-style-type: none"> <li>- Explore opportunities for more integrated working and pathways between the care home team and the West Lothian Psychological Approaches team).</li> </ul>	1,2,3,4,5, 6,7,8,9	ICC	To be agreed	To be agreed	General Managers MH/Primary Care

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
<b>Palliative and End of Life Care (EOL)</b>							
5.1	Early Identification of palliative/EOL needs	Clinical teams in all settings to increase the number of people being identified earlier with Palliative or EOL needs and ensure each person has access to anticipatory care plans co-created with the person, carer & family with appropriate support.	1,2,3,4,5, 6,7,9	TE ICC MRE	Pathways developed that support early identification.	December 2021	GP/ Palliative care team
5.2	Accessible in-patient end of life care locally  (Linked to actions 2.8.1, 2.8.2)	- To deliver local provision for inpatient end of life care in West Lothian (linked to Intermediate Care) following a review of existing provision and modelling	1,2,3,4,5, 6,7,9	TE ICC MRE	Increase % of the number of people dying in their preferred setting	March 2022	General Manager Community/ Senior Manager Social Policy
5.2.1		- Assess the increasing demand and ability deliver end of life care in the community for people dying in WL	1,2,3,4,5, 6,7,9		Monitor waiting times from identification to support / care being put in place	Ongoing	General Manager Community/ Senior Manager Social Policy
5.3	Education and Training	- To develop health and care staff through training to support palliative and end of life care, enabling earlier patient conversations on disease management	1,2,3,4,5, 6,7,9	TE ICC MRE	Information on number of people trained	Ongoing	General Manager Community/ Senior Manager Social Policy
5.4	Pathways of Care	- To improve the experience of patients and carers in accessing appropriate and timely palliative & end of life care and support  -	1,2,3,4,5, 6,7,9	TE ICC MRE	Reduction in face contacts where appropriate	Ongoing	General Manager Community, Senior Mgr Social Policy

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
<b>Technology Enabled Care</b>							
6.1	Linked to Programmes 1, 2,	<ul style="list-style-type: none"> <li>- Scale up and optimise existing Telehealth and Telecare provision – consider new technology for use in assessment and evaluation of care.</li> <li>- Enable more people to self-manage and provide alternatives to tradition forms of service delivery i.e. using ‘near me’ and ‘just checking’.</li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	Annual reporting/ increased numbers of people self managing their health and well being via telecare	March 2022	Senior Manager Community Care
6.2		<ul style="list-style-type: none"> <li>- Develop digital technology solution to strengthen community teams and integrated working within older people and dementia services.</li> <li>- Consider the introduction of an electronic scheduling tool into REACT Care and consider whether this is used for D2A modelling to support capacity building.</li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE ICC MRE	Develop a technology development plan	2020-2023	Senior Manager Community Care/General Manager
<b>Support for Carers</b>							
7.1	There is a duty for local authorities to provide support to carers, based on the carer's identified needs,	<ul style="list-style-type: none"> <li>- Review access to unpaid Carers Advocacy support in West Lothian in line with Carers Strategy and existing contractual arrangements.</li> </ul>	1,2,3,4,5, 6,7,8,9	P&EI TE, ICC MRE	% increase in carers being supported	December 2020	Team Manager Business support

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
7.3	which meet the local eligibility criteria	- 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	Health and Social care experience survey – carers	2023	Business Support
7.4	Access to information Linked to programme 1+2	- Ensure appropriate arrangements are in place for carers to access information, support and 'short breaks from caring.	1,2,3,4,5,6,7	P&EI TE ICC	Service User forum feedback	July 2021	Senior Manager Community Care
<b>Housing</b>							
8.1		- 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	2020-2023	Senior Manager Housing Senior Community Care Manager
8.2		- Develop a need and a demand assessment for older peoples' housing and explore opportunities for people requiring specialist housing for long term conditions.	1,2,7,8,9	P&EI TE ICC	Map existing capacity and anticipate future need and gaps in housing provision	2020-2023	Senior Manager Hosing
<b>Ensuring choice through Self-Directed Support</b>							
9.1	Market development to ensure people have access to opportunities which enable personal	- Ensure practitioners and business support services and other stakeholders are involved in shaping market development.	ICC,MRE	TE ICC MRE	Market Facilitation plan update and published	Annual update 2020-2023	Group Manager
9.2		- 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	Group Manager

	Area of Development	Actions	Outcomes Appendix 3	Strategic Priorities	Measures	Timescale	Lead Officers
9.3	outcomes to be met	- Ensure those receiving SDS have information and advice to support them in achieving their personal outcomes.	1,3,4,9	P&EI TI	Review of Commissioned Services	March 2021	Group Manager Business Support

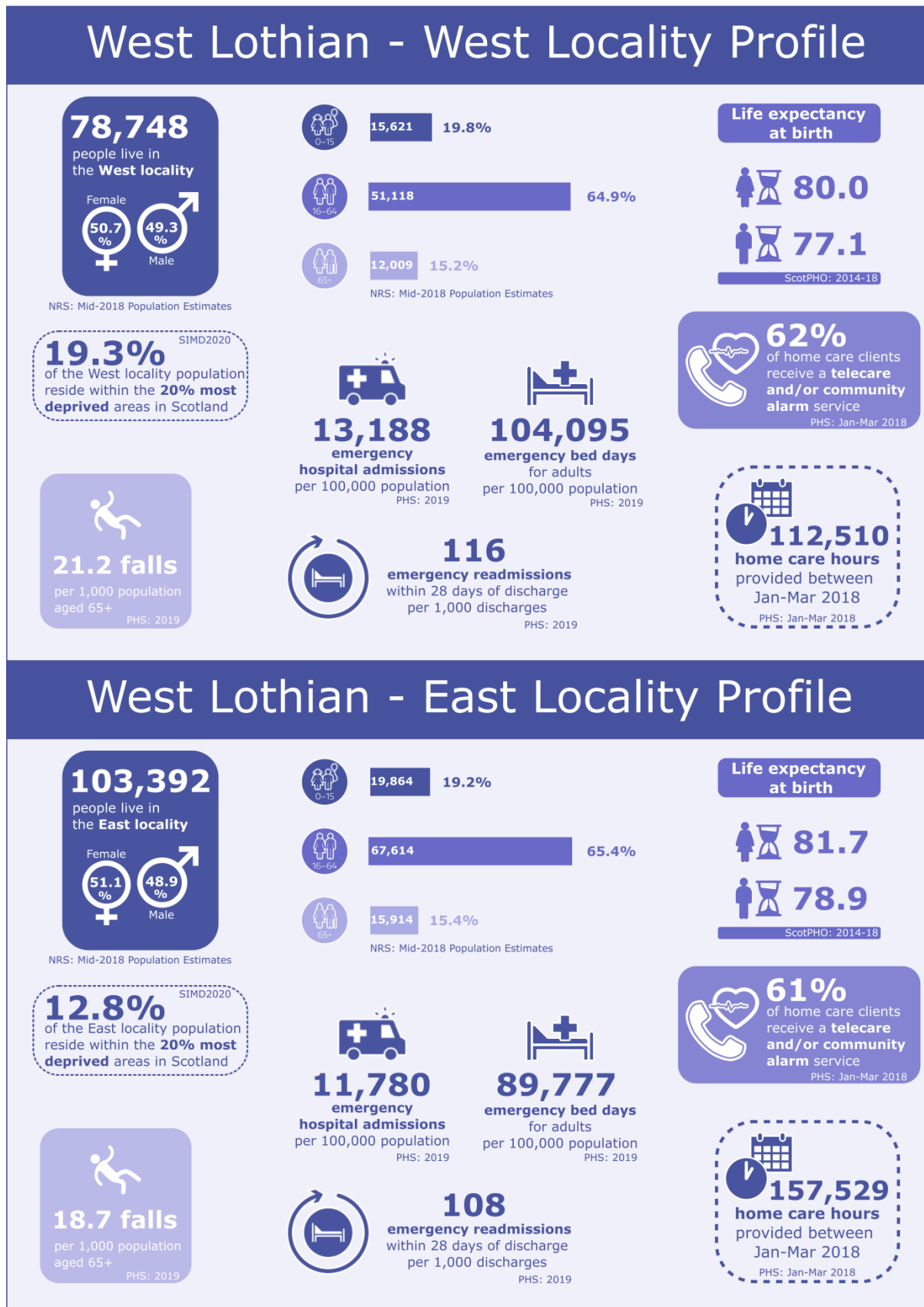
## **11. Monitoring and Review**

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.

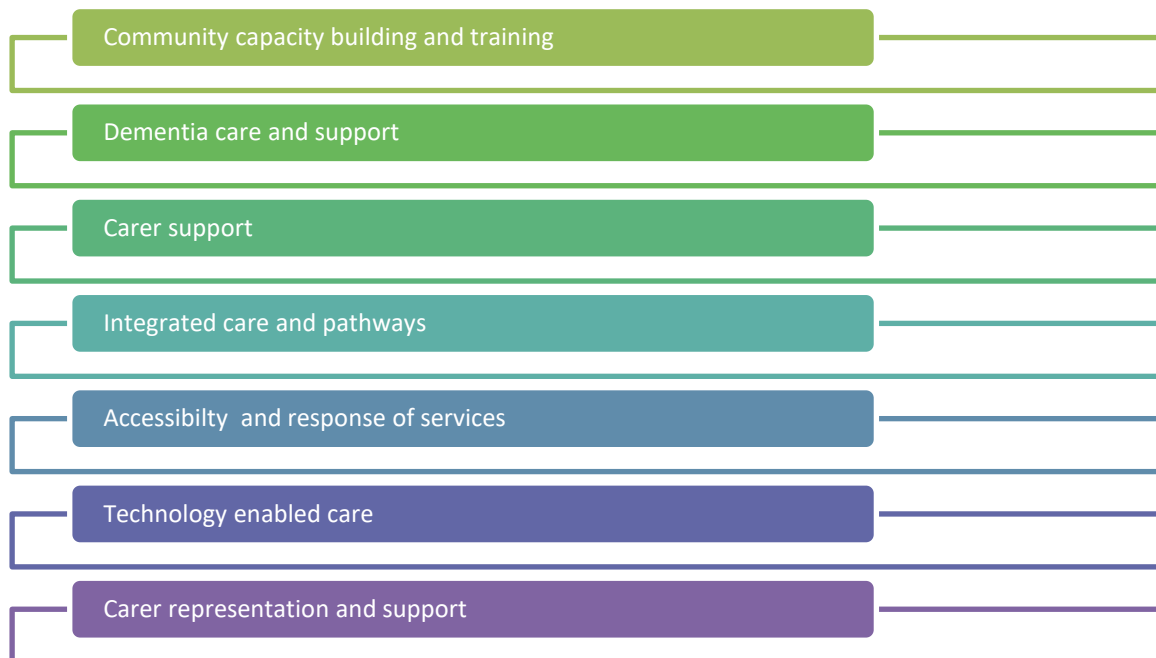
Formal updates on progress in relation to the commissioning plan will be submitted to the Integration Joint Board every 6 months.

## Appendix 1 - Locality Profiles



## Appendix 2 - Older People Commissioning Recommendations 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 3<sup>rd</sup> sector should be strengthened and the review of 3<sup>rd</sup> 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 - The Scottish Government Health and Well Being Outcomes

The 9 Scottish Government Health and Wellbeing outcomes:

<b>1</b>	<b>People are able to look after and improve their own health and wellbeing and live in good health for longer.</b>
<b>2</b>	<b>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.</b>
<b>3</b>	<b>People who use health and social care services have positive experiences of those services, and have their dignity respected.</b>
<b>4</b>	<b>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</b>
<b>5</b>	<b>Health and social care services contribute to reducing health inequalities.</b>
<b>6</b>	<b>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.</b>
<b>7</b>	<b>People who use health and social care services are safe from harm.</b>
<b>8</b>	<b>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.</b>
<b>9</b>	<b>Resources are used effectively and efficiently in the provision of health and social care services.</b>

## 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](#)

[Carers \(Scotland\) Act 2016](#)

## 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](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](#)

## West Lothian Integration Joint Board

### Direction – WLIJB8

1.	Implementation date	10 Novevember 2020
2.	Reference number	WJIJB8
3.	Integration Joint Board (IJB) authorisation date	10 November 2020
4.	Direction to	NHS Lothian and West Lothian Council
5.	Purpose and strategic intent	<p><b>Older People, Care Homes and Housing with Care</b></p> <p>In order to shift the balance of care, there is a need to develop community based services for older people which offer different types of provision which reflect the needs and preferences of people and deliver the capacity required both now and in the future.</p>
6.	Does it supersede or amend or cancel a previous Direction?	Yes- WLIJB8 – 23 April 2019
7.	Type of function	Integrated function
8.	Function(s) concerned	<p>Social Work (Scotland) Act 1968</p> <p>Social Care (Self-directed Support) (Scotland) Act 2013</p> <p>Intermediate Care</p>
9.	Required Actions/Directions	<p>NHS Lothian and West Lothian Council are directed to implement the Strategic Commissioning Plan for Older People 2019 to 2023 which sets out commissioning intentions in relation to delivery of services for older people in the community and people living with dementia. NHS Lothian and West Lothian Council should progress the actions to develop community resources which support people living independently in communities as long as possible and services and support which prevent unnecessary admissions to hospital.</p>

		<p>Focus should be on the following priority areas of development:</p> <ul style="list-style-type: none"> <li>• Dementia care</li> <li>• Support for carers</li> <li>• Community capacity building and living well</li> <li>• Integrated frailty and community teams</li> <li>• Review of bed based models of care and support</li> <li>• Technology enabled care</li> <li>• Housing for older people</li> <li>• Personalised services and choice.</li> </ul>
10.	Budget 2019/20	<p>See summary of budgets for Strategic Directions.</p> <p>Budget availability will be determined based on agreed IJB annual budgets for relevant functions. The IJB Chief Finance Officer should be consulted on financial implications associated with developing community based services.</p>
11.	Principles	<p>Are integrated from the point of view of service-users</p> <p>Takes account of the particular needs of different service users</p> <p>Takes account of the particular characteristics and circumstances of different service-users</p> <p>Improves the quality of service</p> <p>Are planned and led locally in a way which is engaged with the community(including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)</p> <p>Best anticipates needs and prevents them arising</p> <p>Makes the best use of the available facilities, people and other resources</p>
12.	Aligned National Health and Wellbeing Outcomes	<p>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</p> <p>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services</p> <p>Resources are used effectively and efficiently in the provision of health and social care services</p>

		<p>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services</p> <p>People who provide unpaid care are supported to look after their own health and wellbeing including reducing any negative impact of their caring role on their own health and wellbeing</p>
13.	Aligned priorities, strategies, outcomes	<p>Integrated and co-ordinated care</p> <p>Prevention and early intervention</p> <p>Managing our resources effectively</p>
14.	Compliance and performance reporting	<p>Compliance with the Direction will be monitored through the Directions Tracker</p> <p>Performance reporting will be managed via the Older People's Planning and Commissioning Board and the Frailty Programme Board.</p>
15.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	<p>Any changes in services will need to be planned to ensure stability during transition phases.</p>