Draft Joint Commissioning Strategy for Older People Summary
2013-2016
Draft Consultation Summary and Questionnaire

This is the consultation Draft Joint Commissioning Strategy Summary for older people in Perth and Kinross. The Strategy provides a 10 year vision from 2013 to 2023 for the future delivery of care and support services to older people aged 65 years and over, which are delivered by the following partners: Perth & Kinross Council, NHS Tayside including Perth & Kinross Community Health Partnership (CHP), Perth & Kinross Association of Voluntary Service (PKAVS), voluntary sector and independent sector providers.
Health and social care terminology can sometimes require explanation. There are jargon busters throughout the document to assist you with any language that may be unfamiliar to you.

The Draft Joint Commissioning Strategy outlines our plans for the first three years of the 10 year period and explains how we intend to improve outcomes for older people and the approaches we are taking.

**Jargon Buster**

Outcomes in a social care context are about the quality of life rather than levels of ability, health, employment or housing status. At a community level this can be about people feeling safer, people being healthier, communities being stronger. At an individual level this can be about the steps a person needs to take in order to improve their own safety and security.
About the Draft Joint Commissioning Strategy

This Draft Joint Commissioning Strategy outlines the needs of older people in Perth and Kinross and how we are planning to deliver good quality health and social care services to meet those needs. The Partnership will work with older people and the wider community to make sure they have the services required.

The Scottish Government Reshaping Care for Older People programme sets out what change is to take place to ensure the right services and supports are in place to meet the needs of older people. This means shifting the balance of care away from institutional based services to the community, increasing the need for:

• prevention so that people keep well and are helped to manage their conditions so that they do not require a hospital admission in the first place; and

• community-based services available, when people need more support in their own community.

Jargon Buster
Shifting the balance of care away from hospital settings and into local care, by providing the necessary support and treatment in or close to home.
Why do we need change?

There are approximately 149,500 people living in Perth and Kinross of which around 20 per cent are aged 65 years or over. The numbers of older people (over 65 years) are set to increase by around 40 per cent between 2011 and 2027. Figure 1 below highlights that the numbers of people aged 85 years and over are expected to increase the most by 80 per cent which is higher than the Scottish average. Similarly those aged between 75 and 84 years are expected to increase by 48 per cent compared with 40 per cent nationally. By comparison the numbers of people aged between 16 and 64 is expected to increase by only 14 per cent.

**Figure 1: Perth and Kinross Population Projections by Age Band, 2011-2027**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% Increase Perth and Kinross 2011-2027</th>
<th>% Increase Scotland 2011-2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15</td>
<td>-22.1</td>
<td>5.9</td>
</tr>
<tr>
<td>16-64</td>
<td>25.9</td>
<td>22.1</td>
</tr>
<tr>
<td>65-74</td>
<td>47.6</td>
<td>31.1</td>
</tr>
<tr>
<td>75-84</td>
<td>80.3</td>
<td>71.7</td>
</tr>
<tr>
<td>85+</td>
<td></td>
<td>71.7</td>
</tr>
</tbody>
</table>

Source: General Register Office (GRO) Scotland
The number of people living with dementia is also expected to increase in line with changes in population. It is estimated that there are currently over 2,700 people over the age of 65 years with dementia living in Perth and Kinross. In five years time the number is likely to rise by 18 per cent to over 3,200 people.

This draft Strategy’s themes are based around the following reshaping care pathways of:

- preventative and anticipatory care;
- proactive care and support at home;
- effective care at times of transition;
- intensive care and specialist support.

These pathways show the types of approaches that we take to plan for and deliver the range of services that older people need. It is widely recognised that Reshaping Care for Older People will be challenging. It may take several years to achieve; however, this process of change is not one which can be put off any longer because of the need to improve services and the expected changes in demographics.

**Jargon Buster**

**Anticipatory care** is a plan developed by the health care team together with the patient to ensure that health needs are met through planning and review of care for people with specific health conditions.

**Effective care at times of transition** - A set of actions designed to ensure co-ordination and continuity of care as patients transfer between different locations and different levels of care.
Some of the differences between the ‘old’ and the ‘new’ models of care are shown on Table 1 below.

**Table 1: Old Model compared to New Models**

<table>
<thead>
<tr>
<th>Old Model</th>
<th>New Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive care only being given once you have become sick or have a crisis in your health</td>
<td>Proactive care helping people to stay healthy and plan for conditions</td>
</tr>
<tr>
<td>Hospital-centred care</td>
<td>Community-based in own homes if possible</td>
</tr>
<tr>
<td>Care by different partners</td>
<td>Integrated, continuous care</td>
</tr>
<tr>
<td>Patients and carers as passive recipients</td>
<td>Patients and carers fully involved in care</td>
</tr>
<tr>
<td>Carers undervalued</td>
<td>Carers supported as partners</td>
</tr>
<tr>
<td>Self-care infrequent</td>
<td>Self-care encouraged and facilitated</td>
</tr>
<tr>
<td>Low-tech</td>
<td>High-tech</td>
</tr>
<tr>
<td>Unplanned care</td>
<td>Planned care</td>
</tr>
<tr>
<td>Geared towards acute conditions</td>
<td>Geared towards long-term conditions</td>
</tr>
</tbody>
</table>
Our Vision:

“Our vision is to promote the independence and wellbeing of older people at home or in a homely setting.

We will work together and with communities as key partners in delivering the objectives of the Joint Commissioning Strategy to achieve positive outcomes for older people such as delivering or enabling personalised care and support, independence and a good quality of life. We shall support older people to be active citizens, enabling them to be included and valued within their community.”

The following principles will inform our approach. We will:

• offer services that are personalised and enable choice;

• promote self-management, health and wellbeing and independence;

• ensure that unpaid carers are equal partners in the planning and delivery of services;

• communicate and engage routinely with stakeholders (eg service provider and/or service user that will be affected by the results of an action);
• demonstrate that best value is being achieved;
• support our providers to deliver the best possible services; and
• promote equalities and diversity.

Jargon Buster

Best value is a legal requirement of all local authorities to make sure that they deliver value for money across their services. Best value balances quality and cost considerations in improving the performance of public service organisations. Achieving best value requires the Council to make arrangements to secure continuous improvement in performance (while maintaining an appropriate balance between quality and cost) and in doing so to have regard to economy, efficiency, effectiveness, equal opportunities requirements and to the achievement of sustainable development. Contracting authorities subject to the duty of best value are required to secure continuous improvement in their services, having regard to value for money and taking account of equalities and sustainability.
These principles will result in:

- further shifting the balance of care to support an increasing older population with high level needs to be cared for at home rather than in hospital or care homes;
- increasing the number of older people receiving support in the community, including homecare services, reablement, community nursing and other community based services;
- changing the way care home places are used by reducing long stay care home places;
- increasing the number of care home beds used for respite and step up/step down care;
- reducing the length of stay and time people are delayed in hospital by increasing community-based services and support.

**Jargon Buster**

Respite Care services are designed to provide relief for the carer as well as the service user by taking on the caring task for short periods of time.

**Jargon Buster**

Step Up/Step Down Care is a facility that provides less intensive care than a hospital. A Step Up service provides increased support without which a person would likely be admitted to hospital. A Step Down service is for a person who no longer requires hospital-based medical care but is not ready or able to return straight home. These services are short-term and can be provided in a range of settings.
Although a lot of progress has been made we want to continue to reshape care by changing the way resources are used. In the past services have been provided where both investment and focus has in the first instance been on specialist services. In the future we want to make sure that our investment and focus is on maximising the independence and choice of all older people. We plan to do this by implementing our following key statements of intent by:

- **supporting unpaid and other informal carers;**
- **working together with representatives from statutory, private and voluntary organisations together with local people;**
- **creating locality networks comprising of key service providers;**
- **promote personalisation and self-directed support where individuals have more choice and control on their care and support;**
- **investing in suitable housing options for older people;**

**Jargon Buster**

**Personalisation** is an approach to social care which gives people greater choice, control and flexibility over the kind of care they want. Choices may include having a direct payment managed by a third party, directing an individual budget, support from the local authority or from another provider. The choice can also be for a combination of these.

**Self-Directed Support (SDS)** is a term that describes the ways in which individuals and families can have an informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments.
• preventing falls and fractures;
• anticipatory care giving patients, carers and families information, knowledge and support to stay as well as possible and enhance their quality of life;
• reablement and rehabilitation focusing upon enabling the service user to regain a range of abilities in relation to personal support and personal care;
• providing high-quality care in people’s homes;
• supporting people with dementia and their carers;

**Jargon Buster**

**Reablement** is a concept that encourages people to learn or re-learn the skills necessary for daily living.
• supporting people to live in their own home with more adaptations and equipment;
• supporting people with long term conditions;
• using new technology to help people to remain safely in their own home. Examples include personal alarms, smoke sensors, etc;
• developing effective care pathways by improving links between services;
• providing good quality end of life care;
• providing Intermediate Care through a range of supported day clinics and prevention of admission schemes;

**Jargon Buster**

*Intermediate Care* is an umbrella term describing services that provide a ‘bridge’ at key points of transition in a person’s life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence.
• community hospitals that are effective and match the needs and expectations of the communities they serve;

• ensuring good quality hospital, nursing and residential care is available for those who need it;

• workforce development to maintain staff with appropriate skills.
Thank you for reading this Perth and Kinross consultation Draft Joint Commissioning Strategy Summary. We wish to listen to as many stakeholders as possible and encourage you to tell us what you think about the strategy. There is a questionnaire to fill in to give your opinion on the document. The responses will be influential in shaping and prioritising the way we deliver health and social care services over the next three years. We will be consulting to 30 June 2013. The final strategy shall contain detailed action plans.

You can respond to the consultation in a variety of ways:

- by completing the attached questionnaire and returning it to the address below;
- by completing it online at the following websites:
  - www.pkc.gov.uk/JCS
  - www.nhstayside.scot.nhs.uk/services/ChangeFund/index.shtml
  - www.pkavs.org.uk
  - www.scottishcare.org
- you can write with your comments to:

  Joint Commissioning Strategy  
  Housing & Community Care  
  Perth & Kinross Council  
  5 Whitefriars Crescent  
  PERTH  
  PH2 0PA  

  Email hccinfo@pkc.gov.uk
If you or someone you know would like a copy of this document in another language or format, (on occasion, only a summary of the document will be provided in translation), this can be arranged by contacting the Customer Service Centre on 01738 475000.

Council Textphone Number 01738 442573

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(PKC Design Team - 2013025)