east lothian community planning partnership

Meeting of the Working Group

Date: 27 February 2012
Item: 6.3

SUBJECT: Quarterly Monitoring Report for SOA Outcome 5

1. Purpose

This is the Quarterly Monitoring Report for the SOA Outcome 5 *"In East Lothian we live healthier, more active and independent lives",* which is the responsibility of the Health and Social Care SOA Theme Group.

The remainder of this report focuses on proposed actions for the Working Group.

2. Actions proposed

The Working Group is asked to:

2.1 Note the actions underway;

- review and improve joint planning structures
- review mental health services
- deliver East Lothian's Change Plan
- launch East Lothian's Older Peoples Strategy
- develop a respite strategy
- health and social care data website
- draft guidance for ADPs
- gateway to recovery clinics

3. Background to actions

3.1 Work, previously approved by the Theme Group, is underway to review and improve East Lothian's community care planning structures and align them more closely with community planning structures

3.2 Work is underway to reconfigure adult and older people's mental health services across East and Midlothian

3.3 East Lothian's Change Fund Change Plan for 2012/13 has been submitted for approval to the Scottish Government (see Appendix 2). This followed approvals as follows;

• East Lothian Council Cabinet	14/02/12
• NHS Lothian Executive Management Team	14/02/12
• East Lothian CHP Sub Committee	By email
• East Lothian Community Planning Board	By Email

3.4 East Lothian's Older Peoples Strategy is being launched on 27th February 2012 at a public event in the Town House, Haddington.

3.5 A draft respite strategy has been developed and will be submitted for approval through a range of governance processes

3.6 A national website collating health and social care data has been launched

3.7 The Scottish Government has issued draft guidance on planning and reporting arrangements for Alcohol and Drugs Partnerships for 2012-15

3.8 A range of gateway to recovery clinics are being established across East Lothian.

4. Equalities Impact Assessment (in relation to actions)

4.1. This report is not applicable to the well being of equalities groups. An Equalities Impact Assessment is not required.

5. Resource Implications (in relation to actions)

The resource implications are:

5.1. Financial: An increase in the Change Fund in 2012/13 from £1.25m to £1.43m
5.2. Organisations: n/a
5.3. Personnel: n/a
5.4. Other: n/a

6. Community Consultation and Engagement (in relation to actions)

6.1. The following community consultation/engagement activity has taken place, or is planned:

- Community forums have been established in Dunbar and North Berwick focused on options for future service provision at Belhaven and Edington hospitals.
- A public launch of East Lothian's Older Peoples Strategy will take place on 27 February at the Town House in Haddington.

7. Background Papers / Appendices

7.1. Appendix 1: 13Quarterly update on the action plan for East Lothian Outcome 5
7.2. Appendix 2: East Lothian Change Fund Plan 2012/

Report from:	Health and Social Care SOA Theme Group Chair: Murray Leys Head of Adult Social Care, East Lothian Council Tel. 01620 827577 / mleys@eastlothian.gov.uk
Report written by:	David Heaney Senior Manager (Strategy and Policy) Adult Social Care, East Lothian Council Tel. 01620 827551 / dheaney@eastlothian.gov.uk
Date:	16 February 2012

Appendix 1

QUARTERLY UPDATE ON SOA ACTION PLANS (QUAP)

For the Health and Social Care SOA Theme Group - this report has not been discussed at a meeting and will be circulated to members

East Lothian Outcome: 5 In East Lothian we live healthier, more active and independent lives

Short Term Outcome(s):

- Increased positive mental health and wellbeing
- People live healthier, more active and independent lives in their own homes and communities for as long as possible
- Reduced and more responsible use of alcohol and drugs
- The gap in health inequalities is reduced.

1. **Are there any changes/additions to the initiatives in the Action Plan/Table?**
   - The review of community care planning processes reported to the last Working Group meeting is now underway. This involves engagement and discussion with each of the five planning groups currently responsible for Older People, Mental Health, Physical Disability, Learning Disability and Carers, and with key individuals with a role in the process including the Co-Chairs of the Theme Group. Recommendations for the future configuration of community care planning arrangements will be brought to the Theme Group on completion of the review
   - A national website has been launched to provide health and social data from a variety of sources at; http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/Data/CareData.
   - The Scottish Government has issued draft guidance to ADPs on planning and reporting arrangements for 2012-15. The guidance proposes an ADP delivery plan for 2012-15 submitted by March 2012 with annual updates submitted to the Scottish Government in March 2013 and March 2014 and an ADP annual report submitted by end of June 2012 then in June of 2013, 2014 and 2015. This is not in line with local planning cycles and will be reported to the Scottish Government
   - The guidance also provides a set of core outcomes for services linked where possible to a set of indicators. There is an assumption that each ADP will develop a set of local outcomes and indicators linked to their own delivery plan, and across the SOA.

- Following a recent Kaizen event, Gateway to Recovery Clinics have been established. The idea is that service users benefit from a single point of entry, a standardised assessment and triage process for all alcohol and drug services. All services provided at the Gateway can be accessed through a drop-in at the following locations and times:
  - **Monday**: Roodlands Hospital Outpatients Dept', 1.00-4.00 pm
  - **Tuesday**: NEON Bus Musselburgh, 12 noon to 2.30 pm
  - **Thursday**: East Lothian Substance Misuse Service, Edenhall Hospital, 11.00 am- 4.00 pm
  - The Gateways opened for business on 6th February 2012.

2. Are there new opportunities in relation to achieving the outcome or initiatives in the action table or partnership working[1]?

- Arrangements are being put in place to set up meetings involving the Older Peoples and Mental Health planning groups across East and Midlothian as part of the commitment given in the proposal to review adult and older people's mental health services across East and Midlothian

3. Are there new risks/threats in relation to achieving the outcome or to specific initiatives in the action table or partnership working?

- Lack of alignment of timescales between proposed national planning and reporting by ADPs and existing local arrangements.

4. What community engagement activity or consultations are taking place or are planned[2]?

- Community forums, led by the CHP, have been established in Dunbar and North Berwick. The groups continue to meet.
- The launch of the Older People's Strategy on 27 February is a public event and is an opportunity for members of the public to offer views on plans for reshaping care for older people across East Lothian

5. Is there any other relevant information not covered above, including: links with other Theme Groups, Local Area Forums or partnership groups; changes in resources; changes in key indicators?

- No

[1] When looking at the opportunities / risks / threats / you may want to make use of the PESTELO model as checklist http://en.wikipedia.org/wiki/PEST_analysis

[2] Also include local community planning work with Local Area Forums.

6. What do we need to take up with others? What action is needed by?

- Working Group or Board: To note actions underway**.**

7. Please append the updated Action Plan/Table - not included as only appended for theme group meetings

QUAP from:	Murray Leys – co-chair, Health & Social Care Theme Group Head of Adult Social Care, East Lothian Council Tel. 01620 827577, mleys@eastlothian.gov.uk
QUAP *written by*:	David Heaney – key contact, Health & Social Care Theme Group Senior Manager (Strategy and Policy) East Lothian Council, Adult Social Care Tel. 01620 827551, dheaney@eastlothian.gov.uk
Date of report:	16 February 2012

Appendix 1
Change Plan Template

1. Name of Partnership

EAST LOTHIAN RESHAPING CARE PARTNERSHIP

2. Partner Organisations

2.1 Partners signed up to the Change Plan

East Lothian Council
East Lothian Community Health Partnership
Voluntary Action East Lothian
Carers of East Lothian
Housecall Care
Allan Ross
East Lothian Community Care Forum

2.2 Professional Engagement in the development of Plans

Two successful cross sector workshops were held in February and May 2011 to agree priorities for investment for year one of the fund in East Lothian. These were well attended with 50 delegates from 23 different organisations present at the May workshop including representation across the Council, the NHS, the voluntary and independent sectors and the Scottish Government.

The workshops resulted in agreement of our High Level Investment Plan. This confirmed that the Change Fund should be targeted in the first year at accelerating investment in the following areas;

- Intermediate care and tackling delayed discharges
- Building community capacity
- Housing and assistive technology
- Organisational development, community engagement and communication.

These investment areas closely relate to the four strategic outcomes identified in the Older People's Strategy, which it was agreed should guide our investment of the Fund.

Following the second workshop in May a cross sector Change Fund Delivery Group (CFDG) was established with representation across stakeholder groups including all of the partners. The function of the group is to drive the delivery of the fund, make decisions on areas of spend and act as a checkpoint to monitor progress. A project manager has been identified to co-ordinate the day to day management of the process and reporting on behalf of the delivery group.

The CFDG has identified 'Thematic Leads' for each of the four Investment areas. Leads are responsible for developing fund proposals in consultation with all relevant stakeholders within the allocated budget. A template was circulated to all stakeholders to develop outline project proposals and cross sector groups met

around the themes to consider proposals.

Agreements were reached on investments in relation to 33 Projects including two general funds to support project start-up and third sector support and innovations.

On 15th December 2011 a Cross Sector Joint Commissioning Workshop was held to take stock of the position of the change fund for Year 1 and identify the gaps in provision according to the Reshaping Care Pathway and priorities for Year 2.

A small cross sector writing group was identified to draft the change plan for wider circulation and comment.

2.3 Public engagement in the development of Plans

The four Thematic investment areas were attended by representatives across the sectors at practice management level. These groups were responsible for considering and recommending proposals for agreement at the CFDG.

A similar process has been re-established for the Year 2 fund in line with the priorities identified by the Joint Commissioning Workshop. The Building Community Capacity theme group members will be particularly important in this process.

Regular meetings for project providers have been established to optimise communication, share practice, make appropriate links across the sectors and offer support with performance and finance reporting.

Cross sector working groups have been established to develop new models of service delivery and integration particularly between health and social care but also with partners in the third and independent sectors.

The Change Plan for years 1 and 2 of the Fund are closely associated with the East Lothian Older People's strategy. There was extensive public engagement in developing the strategy though media coverage, correspondence and public events. This process involved around 1,000 local people and generated around 300 written responses.

The development of this plan coincides with the launch of the strategy in East Lothian. A series of public information sharing mechanisms will be developed including a launch event and other public engagement events. These will publicise the older people's strategy and the contribution of the change fund plan to fulfilling its vision.

3. Finance

3.1 Resources available to Partnerships

The resource available to the Partnership for 2012/2013 is £1,435,000. In November 2011 a decision was taken by the Joint Programme Board, the high level group that directs delivery of the Older Peoples Strategy, that slippage for the fund in year 1 would be dealt with through a process of applications for one off capital or short term projects that linked to the original High Level Priorities. These were considered and agreed at the CFDG meeting held on 5th December.

It was recognised that due to the timing of funds transfer, most of the year 1 projects would be carrying forward to year 2 in order to offer a full year of service to be measured.

From	Amount £	Difference from 2011/12
Monies carried forward from 2011/12 allocation		N/A
Initial central allocation	1,435,000	179,000
Added by NHS Board		
Added by local authority		
Other		
TOTAL	1,435,000	179,000

3.2 Reasons for financial 'carry forward'

N/a

3.3 Change Fund allocation by pathway

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2011/12	240,969 19%	317,597 25%	283,638 23%	270,600 22%	143,196 11%
2012/13	344,400 24%	358,750 25%	344,400 24%	229,600 16%	157,850 11%
2013/14					
2014/15					

3.4 Total resource allocation by pathway

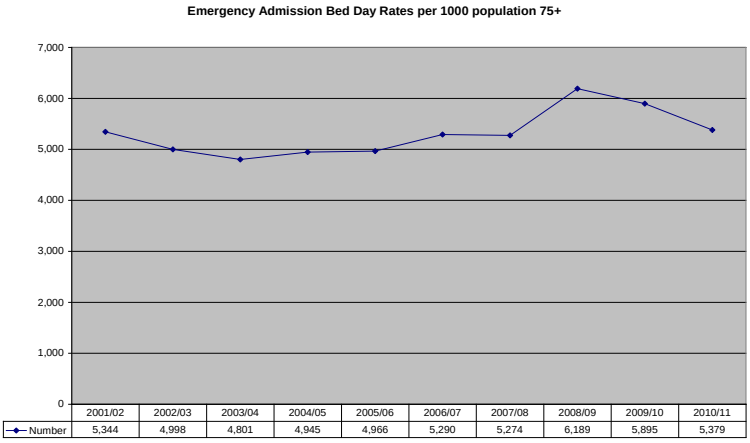
The total resource by pathway has not been calculated yet.

	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	Enablers
2011/12					
2012/13					
2013/14					
2014/15					

4. Self Assessment against 2011/12 Performance

4.1 Nationally available outcome measures and indicators

A1: Emergency admission bed day rates



Our focus on rapid access to care through the newly formed Emergency Care Service and Rapid Response teams will allow us to continue to improve on this performance. Specifically in 2012 – 14, development of rapid access to triage, supported by a proactive, anticipatory care approach will support a downward trajectory.

A2a: Delayed Discharge

At the January 2012 census, the East Lothian Partnership reported zero delays in each of the two national standards. The last reported delay in East Lothian was one short stay delay in June 2011, and prior to that no delays had been reported since March 2011. This level of performance improvement reflects the continuing efforts of partners to work together to tackle delays on a whole system basis supported by change fund investments to deliver and sustain it. This approach will be maintained in 2012/13.

A3: At August 2011, based on QOF registers held at East Lothian GP practices, there were 886 people with a documented diagnosis of dementia. East Lothian has one of the highest rates of dementia per head of population in Scotland. Dementia care has been agreed as one of 5 priority themes for our work in 2012-15 and we will continue to work closely with partners to develop evidence based, supporting services as well as learn from the lessons of the national demonstrator pilots. This will include the development of a specialist team to support behaviours that challenge (including carer mentor support) and a post-diagnosis support service.

A4: Percentage of people 65+ receiving intensive care who live in housing rather than a care home or hospital

Over the previous three quarters this figure has been 40.23%; 40.92% and 40.93%. Over the period 2012 – 15 we will work to ensure the vision of the Scottish Housing Strategy will be recognised in our redesign work.

A5: Percentage of time in the last 6 months of life spent at home or in a community setting

We are currently working with our analytical partners to determine this figure.
In 2011 we have actively developed a body of work in care homes which supports

good end of life care in this setting and prevents unnecessary admission to hospitals. We will continue to monitor, evaluate and further develop this service in 2012-14.

A6: Experience measures and support for carers.

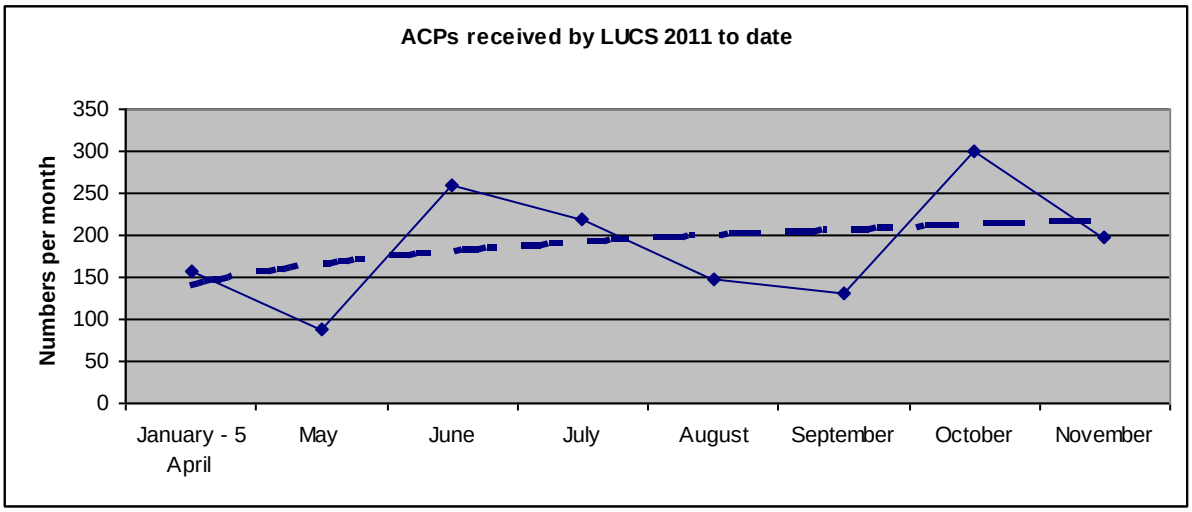
The most frequently used quantitative indicator of support for carers is the number of Carers' Assessments offered/carried out. In East Lothian the number of Carers' Assessments completed is recorded on ELC's Frameworki as an "episode", and is reported quarterly. However, work needs to be carried out to integrate the paper Carers' Assessment form with Frameworki, which will allow more detailed investigations of the benefits to carers of Carers' Assessments and ongoing support. This will also enable reporting on the National Outcomes for Community Care carer measures of: '% of carers satisfied with their involvement in the design of a care package' and '% of carers who feel able to continue in their caring role'.
The number of carers' assessments carried out - as reported on Frameworki in East Lothian - over the last 3 quarters is 52, 45, 50

A second challenge with using Carers' Assessments as an indicator is that it is a proxy for the actual benefit to carers of support they receive. *Carers of East Lothian* has introduced the use of the 'Carers Strain Index' as a rapid assessment tool of the pressure carers are under at any point in time. The CSI is a validated tool which asks carers to self-assess their situation across 13 factors such as finance, physical health, relationships, etc. Any score over 7 indicates significant strain and is a pointer to the need for a full Carers' Assessment and/or in-depth support. Of particular relevance here is that the tool can be used in a longitudinal way to track changes in carers' stress over time once they access increased support. *CoEL* has begun to use the tool in this way.

4.2 Local improvement measures

B1: ACPs shared with OOH

Currently data on Anticipatory Care Plans shared with out of hours services is only collected on a pan Lothian basis (see figures below). We will continue to work with colleagues to support data collection on a partnership basis. In addition, anticipatory care has been agreed as a priority workstream for the East Lothian partnership in 2012 – 15 and we will focus on integrating this approach into our hub system, whilst considering how to support effective, increased ACP use in primary and community care. Dedicated dialogue to further engage GPs in our plans will be central to this.



B2: Waiting times for housing adaptations, assessment of need and delivery.

At present this information is generically held as waiting time for an OT assessment. Following assessment the case is allocated and if an adaption is recommended it will be progressed.. The time between assessment and adaptation will depend however upon the detail, tenure and complexity of the adaptation, and any statutory processes involved. A project is currently underway to develop a partnership agreement between all tenures for major adaptations. This will streamline the provision of a major adaptation from the point of assessment to the conclusion of provision. Outcome and performance measures will also be agreed,

B3: Proportion of people 75+ with a telecare package

The number of people in receipt of Telecare in ELC over 75yrs = 2,180.

Note: This includes service users connected to the alarm receiving centre through their scheme/sheltered housing, service users with a "dispersed" alarm *and* those in receipt of "stand-alone" Telecare. The Total projected population over 75 is estimated at 8,414, giving an estimated 26% of the population over 75 receiving Telecare.

B4: Reduction in hours of support required after reablement service

In Quarter 2 106 clients started reablement and 52, some of whom had started the previous quarter, completed a reablement programme

Total hours at start of reablement 321
Total hours at end of reablement 148
Reduction by 173 hours (46% reduction in care at home required after reablement)

B5: Respite care for older people per 1000 population

The most accessible source of data on respite is the information collected by the Scottish Government in its annual audit of respite weeks provided or purchased by each local authority. This breaks respite down by age group and overnight/daytime. The information is converted into respite weeks to allow presentation of an estimate of the total number of respite weeks provided each year across Scotland. In order to calculate this, seven respite nights equal one respite week and 52.5 hours equal one respite week. The data for East Lothian is noted below:

2007-8	18-64	65+	Total
Overnight	450	640	1,090
Daytime	20	70	90
Total	470	710	1,180

2008-9	18-64	65+	Total
Overnight	420	720	1,140
Daytime	20	80	100
Total	440	800	1,240

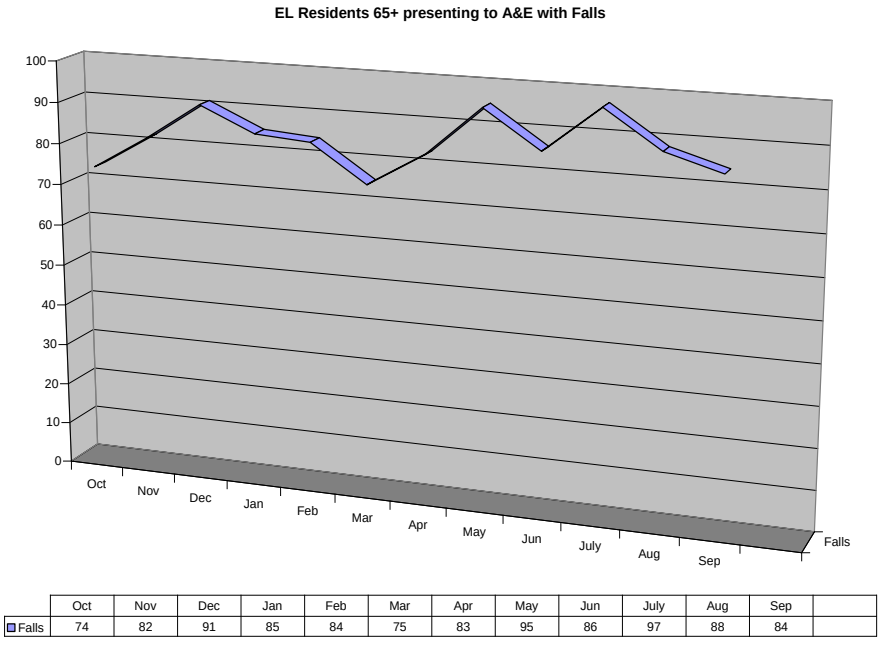
2009-10	18-64	65+	Total
Overnight	390	620	1,010
Daytime	20	90	110
Total	410	710	1,120

2010-11	18-64	65+	Total
Overnight	390	740	1,130
Daytime	10	90	100
Total	400	830	1,230

It should be noted this excludes respite funded by Direct Payments, which shows an increasing trend over the years.

Again the challenge with using this data as an indicator is that it is a proxy for the benefit to carers of the short break they have. *Carers of East Lothian* is piloting a Short Breaks Service for East Lothian, initially funded by the Scottish Government Short Breaks Fund and now funded by the Change Fund to support personalised short breaks for older people and their carers. As part of this work, qualitative evaluation tools have been developed to capture the impact on carers of their short break.

B6: Rates of 65+ to A&E with principal diagnosis of a fall



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	
Falls	74	82	91	85	84	75	83	95	86	97	88	84	

The East Lothian Emergency Care Service was initially developed to support telecare users who fall. Through our Change Plan developments, we are progressing work to further integrate this service with our response, rehabilitation, primary care and day hospital services in order to maximise the impact of the service, but also to ensure a highly effective preventative approach is built into our systems. Our initial planning assumptions were that we would receive around 20 calls per month when the service was set up in January 2011. By January 2012, the service received 232 referrals in one month.

B7: Access to CGA

Whilst we currently do not have ready access to this data, the importance of comprehensive geriatric assessments in frail elderly people is well recognised. As part of our ongoing work in 2012-14 with development of a "hub" based team with rapid access triage and outreach support, we will continue to support and develop use of this tool. In addition, we will work closely with colleagues in the acute sector to ensure adoption of this approach.

B8: Use of long term residential care – rate and proportion admitted from home, hospital, IC or respite.

We do not currently gather "admitted from" data. We will work with analytical colleagues to develop this dataset for future use.

4.3 Partnership resources

C1: Per capita weighted cost of accumulated bed days lost to delayed discharge

C2: Cost of emergency inpatient bed days per 75+ (per 1000 population 75+)

C3: Measure of the balance of care

Our budgets are not currently divided across pathway headings. We are currently working with colleagues to determine these analyses.

Currently in East Lothian, 41% of people aged 65+ with intensive needs are receiving care at home.

4.4 Successes and lessons learnt

There have been some significant successes in the process of developing and delivering the Change Fund thus far, including the degree of participation across the sectors and the level of co-located and collaboratively produced services that are in the process of development, e.g. the Response and Rehabilitation service that is co-located with a view to developing in a more integrated way. The Garden share project and carer training projects are good examples of such services within the third sector. The development of intermediate care beds is an exciting new development as a collaborative venture across social care and the independent sector

The development of Theme Groups and the Building Community Capacity Theme in particular has facilitated an active engagement of third and independent sector organisations in the process. The positive benefits of this have included a much
greater understanding of services across sectors, the development of collaborative projects

between third sector organisations and across the sectors. The process has enabled a greater understanding of where linkages across projects have been able to be made and some creative elements added to proposals e.g. the carer mentor element of the Challenging Behaviour service.

The development of the Emergency Care service over the past year has been a good example of where joint financing of the service is leading to positive outcomes across health and social care. The change fund has enabled the service to develop from an initial Telecare response and falls service to a more comprehensive admission prevention service with links and pathway through NHS 24, Emergency services 999, GP practices and cross sector care at home providers.

Another positive outcome of the process has been the degree of professional engagement in the process across the sectors. The development of theme groups in addition to representation at the delivery group and Joint Programme Board level has required a significant commitment for all agencies. The willingness for all parties to maintain this input and join the providers meetings has facilitated the development of positive relationships, creativity in projects and new innovations, all of which support the degree of transformational change that will be required to deliver the desired outcomes.

We have continued to build on the involvement of the independent sector as a key member of East Lothian's Reshaping Care Partnership over the past year. We will continue to develop this approach with our contribution to the cost of an associate post through Scottish Care. The post is currently partly funded through our Change Fund as a demonstration of commitment to working positively with the independent sector and developing its role within the Reshaping Care Partnership. A proposal for a full year of funding for 2012/13 has been submitted to continue this work.

Another lesson we have learnt is the time that is required for an effective cross sector process to take place e.g. in relation to presenting and considering project proposals. The cost of delivering on the tight timescales required for each part of the process has at times been to the full integrity of the process, with compromises requiring to be made e.g. in short circuiting decision making. Whilst this has been done transparently and with agreement across partners, it nonetheless has taught us the importance of planning effectively and leaving adequate time for due process at each stage.

As a relatively small partnership we have at times found it difficult to muster the right mix of partners to actively participate in the full range of JIT workshops underway on the Change Fund especially when these have taken place in the run up to deadlines for approval and submission of plans. We do however endeavour to participate as fully as possible.

We have found the support of our local JIT partner to be extremely helpful and constructive and he participates fully in both the delivery group and the Joint Programme Board as well as supporting and advising outwith the formal meetings at our request.

It has become clear that the scale and complexity of our change fund programme requires full-time, dedicated management. As part of the 2012/13 change plan we are proposing to invest in a full time programme manager to take forward delivery of the whole programme and in capacity to support the finance and performance management elements of the programme.

Overall we believe that the East Lothian Partnership has achieved a very positive start to our Reshaping Care process and we are in a strong position to move this agenda forward through our Change Plan.

5. Governance

5.1 Describe your Partnership governance framework and financial framework to enable Partnership decisions if they have changed since 2011/12

Our governance process remains the same as with the 2011/ 2012 plan with the addition of the Change Fund Delivery Group reporting to the Joint Programme Board, which in turn reports to individual Agency Board/Committee processes and to the Community Planning Board via the Health and Social Care Theme Group.

We have begun the process of developing our Joint Commissioning Strategy, and also to consider the Reshaping Care Partnership in light of the future development of a Health and Social Care Partnership. Both of these processes may require changes to the current governance structure, and we will maintain our focus on this during 2012/13.

The overall financial framework also remains the same for 2012/2013, with the Change Fund providing the joint resource and each organisation developing and contributing resource on a project by project basis outwith the Fund. This is in line with our shared direction of travel, agreed in relation to funding for the Older People's Strategy, agreed in order that progress could be made towards a more integrated approach in the interim.

6. Carers

6.1 Describe the range of services that improve outcomes for carers

The following projects offering direct support to carers were identified in year 1 change plan, accounting for 23% of Change Fund overall spend. It is envisaged that most of these projects will continue into year 2 subject to review, and the Partnership is committed to sustaining or increasing the proportion of spend allocated to supporting informal carers. At least 20% of the 2012/13 will be dedicated to this area.

<u>Carer Support</u>

Carer Emergency Response – Carers of East Lothian (CoEL)
The aim of this project will be to prevent situations when families experience an emergency in their caring role turning into a crisis. This will be done by identifying replacement care arrangements as an alternative to hospital/care home admission and then putting them in place when the need arises. The project will adapt 'CERT' model developed in Sefton. The project will employ a part-time (18hpw) Carer Support Worker to work with carers to develop emergency plans as part of Carers Assessments and co-ordinate systems to implement these plans when emergencies arise. The project will be developed by *Carers of East Lothian* and will link in with the development of the Emergency Care Service.

Responsive and Rapid Respite Support - Crossroads
To provide crucial support to the carer when it is most needed after the cared for person has left hospital with the aim of tapering off that support once people's needs change and recuperation has lessened.

As part of the discharge plan Crossroads can provide extra support to the carer in the form of additional and regular breaks. The length and intensity of the breaks would be increased during a specified short period (for example 6 weeks) either before or after a person is admitted into hospital. The care to be provided would be assessed in conjunction with the other agencies involved. This additional support would be reviewed after a specified period and a decision made as to whether to continue with the same level of support, decrease the amount or in some cases (and it is hoped most cases) to cease the support altogether as the crucial, vulnerable period of recuperation will be over and no further support will be needed.

Short Breaks (Respite) Development - CoEL
We are proposing to extend our successful Short Breaks Project (currently funded by the Scottish Government Short Breaks Fund to develop respite opportunities for people with physical disabilities and people with learning disabilities) to develop short breaks opportunities for a pilot groups of 30 older people and carers who:

- Are referred to Social Work 'duty team' for arranging respite
- Use East Fortune House for respite
- Use East Lothian Council and NHS Lothian services

The project employs a full-time Short Breaks Development Worker to use person-centred planning to help service users and carers access flexible and personalised respite, and build a business case for a local Short Breaks Bureau.

Respite for carers - Palliative and End of Life Care - Crossroads
To provide respite to carers caring for people who have a terminal illness and are living at home. By providing 2 – 6 hours of support for the cared for person each week the carer will be enabled to take a break from the caring role. This will support the carer in maintaining their wellbeing as well as providing outside stimulation for the cared for person.

Training for care - CoEL
We are proposing a transformational increase in the amount and range of Expert Training available to informal carers, staff of all 10 Older Peoples Day Centres and volunteers in a range of settings working with older people. This will be achieved by the employment of Training Co-ordinator (18hpw) and the creation of a comprehensive programme of Expert Training courses. For example;
Moving and Handling Safely, Looking After an Older Person at Home, Coping with Changed Relationships, What is Dementia?, Medications, Behaviour and Communication, Accessing Services and Support, Money, Benefits and Legal Matters, MIDAS, First Aid, Food Hygiene

Challenging Behaviour Service – CHP
The service would assist formal and informal carers in domestic settings and staff in Care Homes, in managing behaviours, exhibited by people with dementia, which are found challenging and which often result in admission to hospital. The project would assist, through training carers/staff, consultancy and support with individual patients, to enable carers and staff to manage the person within their current living environment. The service would also offer input to the wards in Herdmanflat Hospital, to support their work and help manage the patient's transition into a suitable living environment. This funding would be used to develop a team consisting of clinical psychology and nursing, with admin support.

Nursing input would come from the existing complement of staff when staff are freed up from their existing posts in the next few months following the Mental Health Service Redesign underway in East Lothian. A unique part of the proposed service will be employing people with lived experience of caring as Carer Mentors

Emergency Care Service Extended Admission Prevention Role - ELC
The ECS has been established for a year now providing a response to Telecare alerts and falls. It now averages 200 call outs per month, and approximately 55% of these relate to falls. This service was always intended to have a wider admission prevention function, however and be easily accessible to support individuals and their carers to prevent unnecessary admissions to hospital or for emergency respite. We would intend that the service could offer emergency packages of care for up to 72 hours, a sitting service, including overnight sitting where this would prevent an admission, and be able to respond to a carer crisis by supporting the individual to be able to remain in their own home whilst the issue is resolved. We would also envisage the service to be able to support complex discharges.

6.2 Indicate the total amount of Partnership resource allocated to support carers to enable them to continue to care

In 2011/2112 £285,315 was allocated to supporting informal carers, accounting for 23% of the overall spend. The partnership is committed to an ongoing allocation of at least 20% of the Fund to carer support.

7. Support Mechanisms

7.1 What support has helped you so far? What didn't?

It has been extremely helpful to have a dedicated JIT representative as part of our process to offer advice and support and also to act as a sounding board for ideas as the process develops.

The Reshaping Care Pathway has been helpful in providing a framework to consider gaps in resource and a focus for priority setting. The information around the Core Measures has been useful to assist all partners in understanding the overall purpose of the Reshaping Care agenda and their potential role in the process, and also as a base for developing a performance framework.

The Scottish Government's on-line WebEx events have provided a good opportunity to hear from other Partnerships on particular issues. The timing of these, however has not always been in synch with our process reducing the ability to get the most from them.

The Joint Commissioning workshop in November was useful in beginning the process of working towards the development of the Joint Commissioning strategy.

The sheer volume of information and invitations to participate in the workshops and WebEx sessions has been challenging in relation to our capacity to attend across the sectors. We would urge that 2012/13 can be a year of consolidation of projects and can enable us to focus

on developing the Joint Commissioning Strategy that will take the partnership forward over the next few years.

7.2 What support, if any, could you offer other Partnerships?

Probably the area where we believe we have made most progress in the first year has been the effective engagement of partners across all of the sectors, but particularly the third sector. One of our third sector partners delivered a workshop on this process at the Building Community Capacity event on 26th January. We will continue to support partnerships in this area.

8. Joint Commissioning Strategy for Older People

In terms of your Joint Commissioning Strategy:
- what Partners will be involved in the preparation of the Strategy;
- what are the estimated total resources for the Strategy;
- what governance arrangements are you planning on implementing;
- what is the timeline involved;
- how will your Joint Commissioning Strategy link in with your Change Fund application?

The initial cross sector Joint Commissioning Workshop held in December will be followed up in 2012 with a programme of workshops and opportunities/events to engage more widely with individuals and organisations in developing the strategy. This process also coincides with public launch events relating to our Older People's Strategy and we will use both opportunities to garner information, comments and concerns that will inform the development of the Joint Commissioning Strategy.

Discussions are currently underway in relation to the implications for the Reshaping Care Partnership of the development of the Health and Social Care partnership. We will use IRF data to establish the Health and Social Care element of resources and discussions with partners in the third and independent sectors will be held in relation to identifying the wider element of financial and community resource available for the process.

The governance of the strategy will initially mirror that for the development of the Change Plan. A process is underway in East Lothian however, to better integrate the community care, health and community planning processes. As this work progresses there will be a much clearer integrated structure across the sectors that will include the governance for the Joint Commissioning Strategy. Representation across the sectors at all levels will be agreed within that process. A set of shared performance measures will be developed including all relevant reporting requirements and through this process, a more integrated approach to the ongoing development and delivery of the Single Outcome Agreement will be achieved.

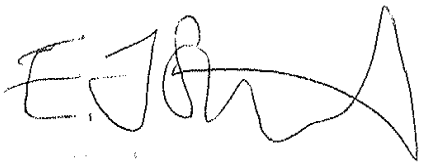
We aim to have completed these processes and developed the Joint Commissioning Strategy by the end of 2012.

This Change Fund Plan has been prepared and agreed by the NHS, Local Authority, Third Sector and Independent Sector interests.

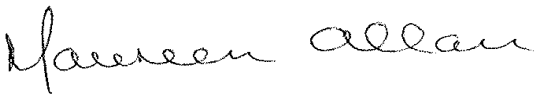
Signed:

Murray Leys
Head of Adult Social Care, East Lothian Council

David Small
General Manager, East & Midlothian Community Health Partnership



Eliot Stark
Voluntary Action East Lothian



Maureen Allan
Scottish Care Member