East Lothian Council

REPORT TO: East Lothian Council

MEETING DATE: 26 February 2013

BY: Executive Director (Services for People)

SUBJECT: Older Peoples Change Fund 2013/14

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1 PURPOSE

1.1 To update the Council on the use of East Lothian's Change Fund and to seek approval for the 2013/14 Change Plan template, and rolling three year joint commissioning plan for reshaping care for older people.

2 RECOMMENDATIONS

2.1 Members are asked to;

(i) Note the contents of this report

(ii) Approve the 2013/14 Change Plan template and rolling three year joint commissioning plan for reshaping care for older people.

3 BACKGROUND

3.1 Members will recall that the Scottish Government established a £70 million Change Fund across Scotland in 2011/12. The purpose of the fund is to enable health and social care partners to implement local plans for making better use of their combined resources for older people's services.

3.2 The Scottish Government extended the fund for a further three years up to 2014/15. From 2012/13 until 2013/14, the fund will increase to £80m nationally, before reducing to £70m in 2014/15. Based on East Lothian's share of the fund increased from £1.256m in 2011/12 , to £1.435m in 2012/13, and will remain at this level, before returning to £1.256m in 2014/15.

3.3 East Lothian's Change Fund is delivered through a four way partnership involving the Council, the NHS, the voluntary and independent sectors. Table 1 sets out the deployment of the fund since 2011.

Table 1: Summary of Projects: 2011/13 Budget allocation by Sector

Sector	**No of Projects ongoing from 2011/12**	**No of new projects 2012/13**	**Totals**	**Total Budget £**	**% Budget**
Council	10	6	16	507,201	35 %
Third	15	6	21	657,899	46 %
Independent	0	3	3	40,000	3 %
CHP	5	1	6	229,900	16 %
Totals	**30**	**16**	**46**	**1,435,000**	**100 %**

3.4 The Scottish Government has advised that priority should be given to providing support for informal carers, preventative services delivered collaboratively and/or through a co-production approach, and volunteering.

3.5 We allocated 46% of the 2012/13 fund to support 24 innovative third sector projects. This is one of the largest percentage allocations to the third sector across Scotland. The main elements are: greater support to informal carers; information, practical support and preventative services; increased capacity of small third and independent sector organisations to support older people with more complex needs; greater capacity and development of volunteers and volunteering in supporting older people and their carers, and greater capacity in local communities to work together to support older people.

3.6 The Scottish Government requires Partnerships to invest a minimum of 20% of the fund to projects offering direct or indirect support to carers. In East Lothian we committed 39% of the fund for 2012/13 to support informal carers (Table 2). The Scottish Government has maintained its commitment to this target in 2013/14.

Table 2 Supporting Carers

Investment on direct carer support	£318,050	22%
Investment on indirect carer support	£245,366	17%
Total overall investment on carer support	**£563,416**	**39%**

3.7 The Scottish Government issued updated Change Fund guidance for 2013/14 in late 2012 and this contained some important changes in requirements. In summary, partnerships are now required to;

- Prepare three year rolling joint commissioning plans highlighting the strategic outcomes they aim to achieve and the action they will take to do this
- Publish their plans locally
- Submit a detailed self evaluation template to the Scottish Government highlighting action taken so far and the impact of the Change Fund to date as well as future plans for improvement. This is required to be with the Scottish Government by 28 February 2013.

3.8 The East Lothian Partnership has prepared a three year Joint Commissioning Plan as required and this is attached at Appendix 1. It sets out the partners' high level ambitions and makes appropriate connections to the forthcoming integration of health and social care. An important addition to the plan is the inclusion of a Housing Contribution Statement.

3.9 Alongside the Joint Commissioning Plan we have set out a series of actions required to deliver the outcomes it contains between 2013 and 2016. Once approved by both the Council and East Lothian CHP Sub Committee, the Plan will be published on the Council, Community Planning Partnership and NHS Lothian websites.

3.10 The Change Fund Partnership has completed the self evaluation template and this is attached at Appendix 2.

4 POLICY IMPLICATIONS

4.1 The Change Fund provides a vehicle to support delivery of the Older Peoples Strategy

5 EQUALITIES IMPACT ASSESSMENT

5.1 This report is not applicable to the well being of equalities groups and an Equalities Impact Assessment is not required.

6 RESOURCE IMPLICATIONS

6.1 Financial – £1.435 million across the East Lothian Partnership in 2012/13.

6.2 Personnel - None

6.3 Other - None

7 BACKGROUND PAPERS

7.1 Report to East Lothian Council Cabinet, “Change Fund Change Plan”, 14 February 2012.

AUTHOR’S NAME	David Heaney
DESIGNATION	Senior Manager (Strategy & Policy)
CONTACT INFO	tel. 7551
DATE	1 February 2013

East Lothian

Joint Commissioning Plan For Older People

2012 – 2015

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1.0 Foreword

People are living longer than ever, and the trend is set to continue into the future. Increased life expectancy is something that we should all celebrate, but longevity means that we need to plan ahead both collectively and individually, to ensure that we can maximise the benefits and positive experiences of a long life.

The ageing process varies from person to person and older people are as diverse in their circumstances, interests, activities and abilities as the rest of the population. This plan recognises that the services we require in East Lothian to meet the needs of older people must be flexible and diverse whilst also delivering value for money for the public purse.

The vast majority of older people are living longer and require support and care much later in life. This can be attributed to the advances in modern medicine, better social care and housing. A relatively small number of older people who suffer from ill health or disability do, however, need care and the plan focuses on services that will support their continuing independence.

We are committed to involving the people who use our services in designing the outcomes they want. We will make sure that the strong and effective partnerships we have established across the care sectors continue to deliver these outcomes.

We have prepared this plan at a time of great change as we await the introduction of Health and Social Care Partnerships. To that extent therefore, the future is unknown, so we are mindful of the need to continuously review the commitments we have set out here as we move towards the next phase of health and social care delivery in Scotland

Change Fund Partnership Leads:

…….	……
David Small	Murray Leys
NHS Lothian	East Lothian Council
……..	…….
Eliot Stark	Maureen Allan
East Lothian Third Sector Interface	Scottish Care

2.0 Introduction

This plan has been developed jointly by the East Lothian Partnership, comprised of representatives from East Lothian Council, NHS Lothian, the third sector and independent sectors. It describes how the partnership will develop its strategic approach to commissioning services for older people in East Lothian.

The plan is being developed in response to national policy and the need to demonstrate clear, joined-up commissioning priorities locally across health and social care. The plan will be reviewed throughout its lifetime and will be updated to take account of the evolution of our Health and Social Care Partnership following forthcoming legislation.

3.0 What is Strategic Commissioning?

"Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links 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. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget." Joint Improvement Team: Joint Strategic Commissioning – 'A definition' June 2012.

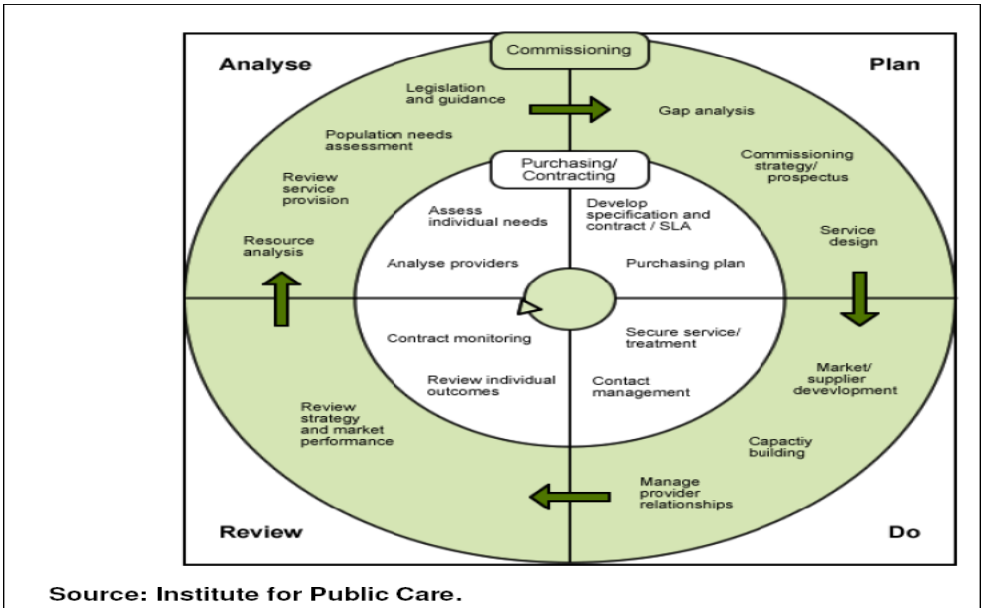


Figure 1: Commissioning Cycle, Institute of Public Care 2007

Figure 1 shows the commissioning process as a continuous cycle; this embeds a checking process to ensure that the services commissioned by both health and social care continue to meet local need, maintain excellent quality and are valued by the people who use them. All commissioning decisions have to be made within available resources.

To achieve effective joint commissioning, we must:

- Work collaboratively with our partners
- Have continuous and meaningful engagement with all stakeholders
- Undertake robust and regular outcome focused needs assessment
- Prioritise investment according to local needs
- Promote and specify continuous improvement in quality and outcomes;
- Ensure sustainable development and value for money.

4.0 Vision

The shared vision for older people in East Lothian is to enable all older people to live the lives they want, achieving their potential to live independently and exercising choice over the services they use.

Improving the health and wellbeing of individuals is central to this vision and will be embedded within our commissioning processes. For older people in our area, our services need to be delivered in a way that:

- Promotes mutual respect
- Values their contribution and their diversity
- Ensures their dignity is maintained at all times
- Takes account, when necessary, of their need for protection.

5.0 Scope of the Plan

The plan will inform service users, family carers, service providers, commissioning partners and the wider public of our commissioning intentions for services for older people for the period 2012 – 2015. These are set out within our Older People's Strategy.

The plan covers the area within East Lothian Council's boundaries, incorporates services for older people provided or commissioned by the Council, East Lothian Community Health Partnership, third and independent sector partners. It identifies priorities for joint working during the next three years, improving quality, enablement and strengthening joint commissioning arrangements.

6.0 Commissioning Themes

6.1 Working in Partnership

Our partnership has:

- A clear vision and a focus on key outcomes
- Clear, shared objectives, with a realistic plan and timetable for achieving these
- A clear and shared understanding of each partners' role and contribution
- A clear framework of responsibilities and accountability

6.2 Quality, dignity, respect and safety

The Partnership will ensure that quality, dignity, respect and safety are widely and routinely understood and achieved in all services delivered across the sectors. To achieve this, the Partnership will:

- Work with providers to ensure that older people can be confident of a consistently high standard of care/treatment across all services.
- Continue to develop user/carer involvement and quality assurance systems, and ensure advocacy services are available to support this
- Adhere to national care standards and codes of practice across all sectors.

The Partnership recognises that every person within our community has a right to live their lives free from violence and abuse. Adults at risk of abuse or neglect must have access to advice and support to enable everyone to live without fear and in safety. The protection of vulnerable adults is a shared responsibility and a high priority across our partnership.

6.3 Choice and Control

The Scottish Government and COSLA recently produced 'Self-Directed Support: A National Strategy for Scotland' which contains an aim of making SDS the "mainstream approach" for care and support in Scotland (Scottish Government and COSLA, 2010). The Social Care (Self-Directed Support) (Scotland) Bill was recently passed by the Scottish Parliament.

We are committed to:

- Putting service users at the heart of decision making about their care and the outcomes they want to achieve
- Developing the systems required to support the implementation of Self Directed Support and the wider personalisation agenda effectively.
- Providing better integration of home-based care and support services.
- Speeding up access to adaptations.
- Simplifying systems to support people's access to services.
- Identifying clear pathways through services for older people and their families

- Widening opportunities for self-assessment.
- Supporting care professionals to develop their skills in dementia care, end of life care, palliative care, dignity in care and a personalised approach to care including anticipatory care planning.

6.4 Supporting Carers

Caring Together - The Carers Strategy 2010 – 2015 states:

*"*We recognise carers as equal partners in the delivery of care in Scotland and fully acknowledge carers' expertise, knowledge and the quality of care they give. With appropriate support, especially support delivered early to prevent crisis, caring need not have an adverse impact on carers" The Carers Strategy 2010 – 2015.

Informal family carers are essential contributors to the social care workforce, and without them the services provided in East Lothian could not meet the needs of our population. The caring commitment ranges from a few hours a week to 24 hours a day, and many carers are older people with health and social care needs of their own.

We will work in partnership with carers to support them to sustain the best quality of life for themselves and the loved ones they care for, recognising them as full partners in their support and care. We have invested 39% of the Change Fund to date in projects aimed at supporting carers directly and indirectly.

Our commitment to carers in East Lothian is that they will:

- Have their own needs and aspirations recognised through an outcomes based and personalised assessment process.
- Be supported to stay well
- Be treated with dignity
- Be recognised as expert partners in care

6.5 Information and Access to Services

The Partnership will ensure that information is available to support older people to make choices about the support they need. We will ensure information is available in a variety of ways, and that when people need extra help to make decisions and follow up on information, the help is there. We are committed to:

- Ensuring that all practitioners in the community are aware of the services available across all sectors and that older people are provided with the right information at the right time.
- Developing the role of universal services such as libraries in providing information and helping people navigate through the system.
- Improving cross-sector working to increase access to services in hard to reach communities

7.0 Strategic Context

7.1 Reshaping Care for Older People

Scotland's older population is set to increase substantially in the next twenty years. Unplanned admissions to hospitals account for nearly one third of the combined resources that we currently spend on health and social care for older people in the country. To address these pressures, we need to change the way we plan and deliver care. That means planning and providing services in much more integrated ways between primary care, hospitals and community-based health, social care, housing, the voluntary and independent sectors and community organisations.

In order to adapt to the changing population we need to make changes to our public services in how they are funded, organised and delivered, but as importantly, the culture and values that underpin them need to change.

To support this process, the Scottish Government established a £70 million Change Fund across Scotland in 2011/12, running through until 2014. East Lothian's share of the fund in 2011/12 was £1.256m; this increased to £1.435m in 2012/13, and will return to £1.256m in 2014/15.

This reform programme is focused around four 'pillars':

- A decisive shift towards prevention;
- Greater integration of public services at a local level, driven by better partnership, collaboration and effective local delivery;
- Greater investment in the people who deliver services through enhanced workforce development and effective leadership; and
- A sharp focus on improving performance, through greater transparency, innovation and use of digital technology.

7.2 Local Strategic Context

The local context of the plan includes:

The Older People's Strategy 2010-2020 which identifies the following outcomes:

- Services will meet the needs of East Lothian's growing and ageing population
- Services will enable older people to live independently, with support whenever necessary
- Older people and their carers will be healthier and more active and feel included in their community
- We will raise standards of service to deliver effective and efficient services in a challenging financial climate

East Lothian's Single Outcome Agreement:

- In East Lothian we live healthier, more active and independent lives

- In East Lothian people in housing need have access to an appropriate type, tenure and standard of housing and are prevented from becoming homeless

NHS Lothian's Clinical Strategy The strategy sets out the overall service model and principles which will drive service re-design, based on safe, high quality evidence based patient pathways and identifies how we plan to deliver safer, more effective and person-centred health and healthcare for the people of Lothian.

Living and Dying Well*:* A national and local action plan for palliative and end of life care in Scotland. This sets out a framework to plan and develop services in the NHS which will embed a cohesive and equitable approach to the delivery of palliative and end of life care for patients and families living with and dying from any advanced, progressive or incurable condition across all care settings in Scotland.

Caring Together: The Carers Strategy 2010 – 2015
Caring Together acknowledges the vital contribution carers make to the health and social care system and commits to work with carers as equal partners in the planning and delivery of care and support.

A Sense of Belonging - A joint strategy for improving the mental health and wellbeing of Lothian's population 2011- 2016. This strategy sets out a clear vision, principles and approach for how people with experience of mental illness and/or mental health problems, people who use services, carers, the third sector, the four local authorities and NHS Lothian, will work together across Lothian to improve our mental health and wellbeing for people of all ages and ensure that the services delivered have an ethos of recovery embedded within them.

The East Lothian Local Housing Strategy 2012-17 aims to:

- Increase housing supply and improve access to appropriate housing including affordable housing;
- Improve the condition and energy efficiency and where appropriate the management, of existing stock;
- Ensure fewer people become homeless;
- Ensure people with particular needs are able to access and sustain their choice of housing including independent living, where appropriate; and
- Ensure fewer people live in fuel poverty.

8.0 Strategic Links to Housing

We are working closely with housing colleagues to ensure that older people have access to appropriate housing services. This includes accessible housing, repairs, adaptations, assistive technology and energy efficiency measures to help older people to remain in their own homes. It is acknowledged that one of the many reasons that people go into long term care is a lack of appropriate housing in the community.

The East Lothian Housing Strategy (LHS) 2012-17 was developed in a challenging financial climate, with evidence of an ageing population and more complex levels of need, prior to the publication of the national Strategy for Housing for Scotland's Older People 2012-21. Through the development of the LHS it was recognised that there was a need to improve the knowledge and understanding of the housing and housing support needs of older people to underpin a more effective strategic approach to the delivery of housing for older people. Research was commissioned in 2011 to assess the housing and housing support needs of older people and this will be published shortly. This report provides the evidence base for shared housing related outcomes.

The Housing Contribution Statement (See Appendix 1) identifies the strategic links between housing planning and health and social care joint strategic commissioning. The Statement ensures that the housing contribution to health and social care outcomes is acknowledged and maximised. Housing currently makes a significant contribution to health and social care outcomes for older people through a wide range of mechanisms.

It is envisaged that the integration of health and social care will bring opportunities to further align the connections between health, social care and housing to support improved housing outcomes for older people.

9.0 A Joint Approach for Older People

9.1 Integration – Health & Social Care Partnerships

In May 2012 the Scottish Government launched a consultation exercise on the integration of adult social care and health services in Scotland. The consultation paper noted,

"Where money comes from – health, or social care, or indeed housing – will no longer be of consequence to the patient or service user. What will matter instead will be the extent to which partnerships achieve the maximum possible benefit for service users and patients, together and against the backdrop of shared outcomes and an integrated budget". *(Scottish Government, 2012)*

The national policy is designed to make better use of resources and improve outcomes for service users and patients. In our response to the Scottish Government's consultation paper in September 2012, the Partnership noted; "*We support the overall drive to improve outcomes by integrating health and social care services which we believe can build upon the improvements we have already made through joint working with our partners, and integration should bring further benefits for service users, carers and communities."*

In East Lothian work is underway with partners across the sectors to develop plans for a Health and Social Care Partnership.

It is essential to recognise the challenging financial climate in which we are required to deliver this plan, and to integrate service delivery. The plan has been developed within the context of the dual pressures of increasing demand for services from a growing population, and reducing budgets for public services. This means that our approach to delivery has to be reformed, just as the services we deliver have to be reformed. Our new approach will therefore be characterised by;

- a focus on developing links to work in partnership to ensure the needs of older people are met
- the development of closer joint working to support seamless care pathways, and the more efficient use of existing services and resources
- creativity in how we can develop new services
- decommissioning or remodeling of services that are no longer strategically relevant or not cost effective and seeking to achieve better value for money in quality performance outcomes for the money invested
- Working closely with local communities to provide more cost-effective, creative solutions.

10.0 Future Demand

As people are living longer we face an ageing population profile that is particularly evident within East Lothian, where we have the third highest percentage of total population of over 75s in Scotland.[1]

In general, the health of the overall population in East Lothian is very good. Both male and female life expectancy is significantly higher than the Scottish average and has been rising steadily over time.[2] The working age population in East Lothian is significantly lower than the Scottish average, whilst the numbers of people aged 0-15 years and 65+ are significantly higher than the Scottish average.

[1] http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/2011/tables.html

[2] East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf) [1] GROS East Lothian Demographic Factsheet (http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/east-lothian-factsheet.pdf)[1] East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf)

Alongside this, East Lothian has a higher percentage of lone pensioner households. In recent years, there has been significant growth in the numbers of older people, defined as people aged 65 and over and this trend is set to continue. It is anticipated that between 2010 and 2035 the number of older people living in the county will increase by 77% (from 17,594 in 2010, to 31,093 in 2035) thereby significantly increasing demand for, and expectations of, services. [1, 2]

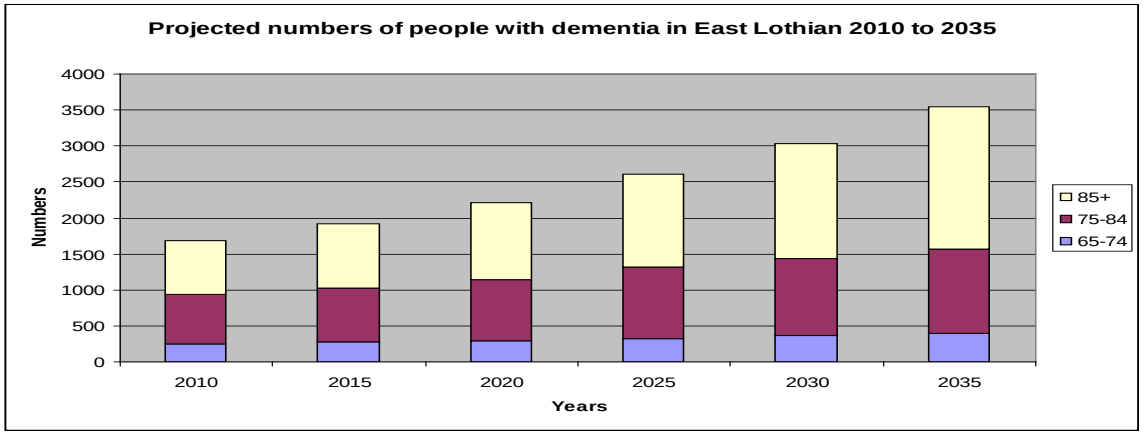
There will be a particularly large rise in the numbers of older people aged 85 and over (an increase of 161% from 2,121 in 2010 to 5,545 by 2035) – an important factor given that people over 85 years make the greatest use of health and social care services.

Managing admissions to acute hospital beds, residential and nursing homes is a key element of this plan. The population changes, we are experiencing will increase the pressure on acute and residential care services. In both health and social care there is a greater emphasis on providing care at home rather than in care homes. More choice is being given to individuals to say how, when and by whom services are provided, making them more flexible and responsive to need, and helping maintain dignity.

As our older people's population grows so will the need for increased specialist care for people with dementia. The figures below use 2010 population projections from the General Register Office for Scotland and then apply the European dementia prevalence rates taken from the EuroCoDe study as reported on the Alzheimers Scotland website. [3]

By 2020 the number of people with dementia can be estimated to increase by 1,855, (from 1,687 in 2010 to 3,542 in 2035) an increase of 110%. (Figure 1)

Figure 1



[1] http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/2011/tables.html
[2] East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf) [1] GROS East Lothian Demographic Factsheet (http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/east-lothian-factsheet.pdf)[1] East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf)
[3](Alzheimer Europe (2009) EuroCoDe: prevalence of dementia in Europe Alzheimer Europe – Consensual Prevalence Rates http://dementiascotland.org/news/statistics-number-of-people-with-dementia-in-scotland-2012)

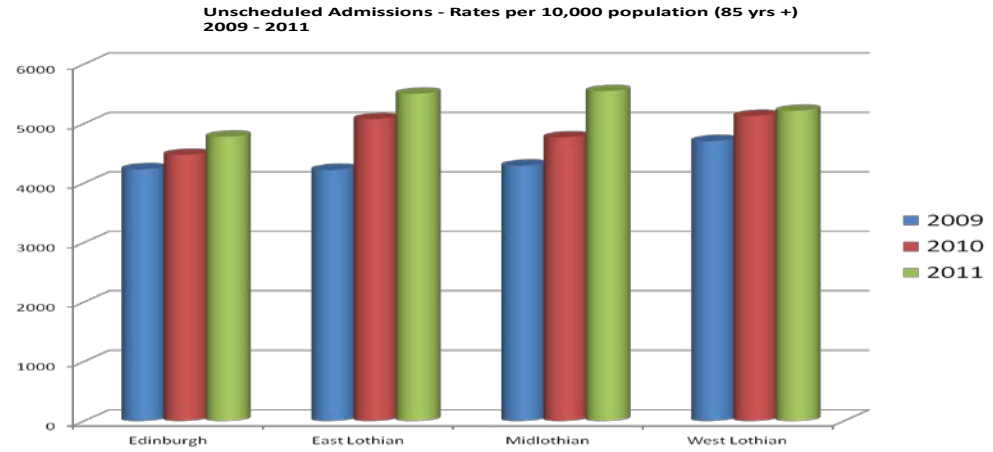
Health Profile: There are a number of long term conditions where the East Lothian population has a higher prevalence than the Scottish or Lothian average. In general terms this mirrors the profile of our older than average population and serves as an indicator of the required focus of preventative and health care services.

Figure 2

Conditions	Patients on QOF register	Raw prevalence rate (per 100 patients)		
		NHS Lothian	SCOTLAND	East Lothian
Hypertension	68,478	11.6	13.5	14.6
Obesity	32,036	5.4	7.7	4.9
Asthma	33,250	5.6	5.9	6.6
Hypothyroidism	16,657	2.8	3.6	3.5
CHD (Coronary Heart Disease)	20,013	3.4	4.4	4.4
Diabetes	21,627	3.7	4.3	3.9
CKD (Chronic Kidney Disease)	15,120	2.6	3.3	2.6
Depression 2 (of 2): new diagnosis of depression	59,565	10.1	9.0	11.4
Stroke & Transient Ischaemic Attack (TIA)	10,489	1.8	2.1	2.3
COPD (Chronic Obstructive Pulmonary Disease)	9,133	1.6	2.0	1.7
Atrial Fibrillation	7,023	1.2	1.4	1.6
Cancer	9,785	1.7	1.7	1.9
Dementia	3,951	0.7	0.7	1.0
Heart Failure	3,565	0.6	0.8	0.8
Mental Health	4,971	0.8	0.8	0.7
Epilepsy	3,614	0.6	0.7	0.6
LVD (Left Ventricular Dysfunction)	2,275	0.4	0.6	0.6

http://www.isdscotland.org/Health-Topics/General-Practice/Quality-and-Outcomes-Framework/2011-12/Register-and-prevalence-data.asp

Figure 3



As part of our ongoing work we constantly measure actual and relative rates of unscheduled hospital admissions. Figure 3 (below) highlights the particularly high relative rates of hospital admissions for our "oldest old" population, and therefore the need to focus our attention in understanding the reasons and patterns underlying this, developing services to address this and to keeping our older, vulnerable people safe and healthy at home. In the same way we will undertake to focus on those admissions with very short lengths of stay (< 48 hours) and readmissions to hospitals within 28 days.

1.0 Market Analysis

There are a wide range of services in East Lothian provided across the sectors that are able to support older people. The following describe the key areas of service provision:

Hospital Care	Accident & Emergency	Roodlands, Belhaven, Eddington and Herdmanflat Hospitals			Assessment (MoE)	Complex care	Rehabilitation	Surgery
Specialist services	Assessment, & rehabilitation	Duty & Response Team	End of life care	Day Hospital	Community Rehabilitation	Care & nursing homes	EMACS/ COPD	
Community services	Social Work	Assessment & care	Reablement service	Telecare	Emergency Care Service	Cross sector care at home	Adult protection	Supported discharge social worker
	Carers support	Respite and short breaks	Advocacy	Welfare benefits	Income maximization	Behaviour support service	Carer emergency plans	End of life training & respite
	General Practitioner's	Community nursing	Community pharmacy	psychology	Public health nursing	Practice nurses	Dental services	
	Physiotherapy	Occupational Therapy	Dietetics	Speech & language therapy	Podiatry	Equipment store	Falls services	Blue badge scheme
	Cross sector residential care	Housing/ housing with care	Day Centres	Housing support	Cross sector Transport services	Housing adaptations support	Home safety service	Garden share & aid
	Lunch Clubs	Frozen meals	Food bank	Volunteer services for OP	Good Neighbors service	Older People's Resource Centre	Volunteering & volunteer support	Befriending
	Dementia development worker	Dementia cafe	OP health & wellbeing project	OT Telecare – Dementia	Equipment store	Sporting Memories	U3A East Lothian	Ears East Lothian
	Supported leisure activities	Mobile library service	Ageing Well co-coordinator	Inter-generational work	Sports centres	Libraries	First Stop	

12.0 Future Commissioning Intentions

Our priorities are:

12.1 Managing long term conditions

Long-term conditions present a significant and growing problem for East Lothian and are a major contributor to health inequalities in the area. As people live longer, growing numbers have medical conditions that they will live with for the rest of their lives. These long-term illnesses are extremely common and the ability to respond well to the needs of these patients has become an important part of modern healthcare.

Our aims are to produce better health outcomes and quality of life, slow disease progression and reduce disability, resulting in reduced discomfort and stress and fewer preventable hospital admissions. In order to ensure that each person with a long-term condition has the opportunity to achieve the best health and level of independence that they can, we are committed to an approach to their care that:

- Is personal to them
- Addresses their clinical needs
- Offers informed choice
- Supports them to learn how to manage their condition effectively.

12.2 Developing preventative services and building capacity in our communities

Preventative services are a means of ensuring good health, well-being and independence in later life. The Scottish Government defines community capacity building as “a way of working with people to develop their ability to jointly influence what happens in their community. This can involve developing confidence, skills, structures and knowledge, to increase the opportunities communities have to make a real difference to the services, activities and changes that take place in their area” (Learning and Teaching Scotland, 2011)

We will promote the development of preventative services which are delivered using a partnership and co-production approach that:

- Are flexible in responding to individual requirements.
- Support older people to engage in a range of community social activities of their choice and contribute positively to the life of their communities.
- Support older people and their carers to remain physically active and healthy
- Treat older people with dignity respect and fairness so that they receive a service that respects them as an individual and equal member of the community

The Partnership will aim to ensure that older people can access a range of services, equipment, adaptations and improvements at home, making as much help as possible available where they live.

We are committed to:

- Simplifying and encouraging take up of simple technology for all older people e.g. community alarms, small equipment
- Developing access to opportunities for physical activity within the community to help people stay fit and strong and help prevent falls
- Ensuring that older people can access a range of supports close to home, e.g. s social activity, befriending and peer support, practical help, volunteering opportunities.
- Supporting people with dementia and their carers to have early access to a diagnosis and supporting them to access the services and information they need following diagnosis.
- Developing services for older people with functional mental health problems such as depression and linking community mental health services to practices to ensure people get the right support at the right time.

12.3 Managing dementia

Dementia is a progressive and eventually terminal condition, but with early intervention and the right support, people with dementia can achieve a good quality of life for many years. Dementia challenges the person in all aspects of their daily life. It is imperative that we develop support services that will help them take control of their condition and help them remain active and independent for as long as possible.

Scotland's National Dementia Strategy 2010 makes the following commitment to developing services for individuals with dementia and their families:
'*People who have dementia and those who care for them are entitled to dignity and respect and should be able to access services that provide support, care and treatment in a way that meets their personal needs'.(*Scotland's National Dementia Strategy (2010))

We will continue to work in partnership with Alzheimer Scotland to develop a centre of excellence for dementia services in East Lothian. We will develop a fully integrated care pathway for people with dementia, learning from the national Dementia Demonstrator sites.

We are committed to developing a range of responsive dementia services in East Lothian that:

- Meet individual needs through a personalised approach
- Support older people's independence and ability to remain in their own homes and with their families for as long as possible, without the need for unnecessary admissions and attendances at hospital..
- Ensure that people with dementia are cared for and receive support in an environment that supports inclusion, wellbeing and quality of everyday living.
- Are able to offer early support, diagnosis and treatment.
- Have a confident, competent trained workforce
- Treat people with dignity, respect and fairness.

12.4 Building a workforce fit for the future

In order to meet the challenges of the future, we will need to attract a diverse workforce. Traditional patterns of recruitment, structures and working practices will all have to change and the system will need to deliver flexible responses. The skills required by care workers will move towards enablement, empowerment and facilitation. The role will be about supporting people to be active citizens and to help them achieve a high quality and fulfilling lifestyle.

We are committed to developing our 'workforce' across the sectors in relation to all caring roles, including professional staff and managers, paid and unpaid carers, and the increasing number of individuals contributing through a volunteering role. Specifically we will:

- Implement a programme of workforce development to provide learning and development opportunities across these roles and sectors to ensure that we have a confident and competent health and social care workforce, operating to high standards.
- Develop and implement a Workforce Development Plan, drawing on the Joint Strategic Commissioning Learning Development Framework to support all individuals in the workforce to contribute effectively to the Joint Strategic Commissioning processes.
- Work in partnership with the Job Centre to create opportunities that attract new people into then caring workforce locally and make this an attractive career option.

12.5 Managing admissions to hospital & residential care

Our strategic objective is to rely less upon providing care in institutional settings and rely more on providing care within people's homes and communities. Our aim is to promote health and well-being, and work with all partners to ensure older people do not become isolated, enabling them to stay active and engaged in their communities.

It is recognised that most older people want to remain living in their own homes for as long as possible. Social care provision is increasingly focused on helping people to achieve this through the expansion of rehabilitation and preventative care services designed to improve outcomes that prevent older people being admitted into acute beds or residential and nursing homes.

We are committed to reducing the amount of time spent by older people in our hospitals and care homes by:

- Reducing inappropriate A&E attendance rates
- Developing comprehensive care at home services which focus on reducing hospital admissions and meeting mental health needs
- Delivering more telecare and tele-healthcare
- Increasing the availability of rehabilitation and preventative care services.

- Developing an integrated falls care pathway which links with the rapid response and assessment service and with primary care
- Developing extra care housing models as an alternative to residential care
- Working in partnership with local communities to increase local capacity to support older people to live in their own homes for longer
- Negotiating a shift in resources to invest in community alternatives to acute NHS care

13.0 Monitoring Arrangements

Delivery of the plan will be monitored and reviewed by the Change Fund Delivery Group which is made of equal representation from the statutory, voluntary and independent sectors as well as the Joint Improvement Team. The group will ensure the plan remains on course and will revise the action plan following the first full year of implementation.

The performance framework will be based on mutually agreed performance targets and outcomes. This arrangement will be maintained in the short term, recognising that the transition to an integrated Health and Social Care Partnership will bring its own governance and accountability arrangements when established, and that the HSCP will take oversight of the plan at that point.

Joint Strategic Commissioning Plan for Older People

Housing Contribution Statement

Introduction

This new addition to the planning process is expected to identify and clearly articulate the links between housing planning on the one hand and health and social care joint strategic commissioning (JSC) on the other. This document is intended to fill a perceived gap in ensuring that the housing contribution to improving health and social care outcomes is both acknowledged and maximised, together with potential investment in housing related preventative expenditure.

The housing sector already makes a very significant contribution to national outcomes on health and social well-being by:

- providing information and advice on housing options
- facilitating, or directly providing 'fit for purpose' housing that gives people choice and a suitable home environment
- providing low level, preventative services which can obviate the need for more expensive interventions at a later stage
- building capacity in local communities
- undertaking effective strategic housing planning

The proposed integration of adult health and social care is recognised as bringing opportunities to strengthen the connections between housing and health and social care, to improve alignment of strategic planning, to support the shift to prevention, and to incorporate (and if necessary review) current arrangements for housing support and homelessness services.

The HCS represents a first step along the way to putting practical local measures in place to maximise these opportunities. It is intended that the process of integration and synergy between housing, health and social care, and the HCS itself, will be developed and refined over the next year and beyond. For this round of SCPs for Older People a template has been devised setting out a series of series of basic but important questions around housing's contribution, and this is set out below .

HOUSING CONTRIBUTION TEMPLATE

This template should be completed jointly between appropriate lead officers from local authority housing and the health and social care partnership.

It should be signed off as part of the overall Joint Strategic Commissioning Plan for Older People by the signatories to that overall plan **and the Chief Housing Officer**.

Theme	Detail
Outcomes relevant to the housing contribution (*Note1)*	**National Measures and Outcomes** The housing contribution seeks to reflect the outcomes identified in the *Wider Planning for an Ageing Population report.* This sets out five outcomes which should be achieved for housing for older people. These outcomes are reiterated in more detail and underpinned by an action plan in *Age, Home and Community: A Strategy for Housing for Scotland's Older People 2012-2021.* **Local Measures and Outcomes** The East Lothian JSC Plan is set within the wider context of the *East Lothian Older People's Strategy 2010-20* which identifies the following outcomes, all of which are relevant to the housing contribution: • Services will meet the needs of East Lothian's growing and ageing population • Services will enable older people to live independently, with support whenever necessary • Older people and their carers will be healthier and more active and feel included in their community • We will raise standards of service to deliver effective and efficient services in a challenging financial climate *The East Lothian Joint Strategic Commissioning Plan for Older People 2012-15* sets out future commissioning intentions as follows: • Managing long term conditions • Developing preventative services and building capacity in our communities • Managing dementia • Building a workforce fit for the future • Managing admissions to hospital and residential care The following intentions and associated aims are considered most likely to be impacted by the Housing Contribution: • Developing preventative services and building capacity in our communities - An aim underpinning

	this is to 'ensure that older people can access a range of services, equipment, adaptations and improvements at home'. • Managing dementia - Underpinning this is the aim 'support older people's independence and ability to remain in their own homes and with their families for as long as possible, without the need for unnecessary admissions and attendances at hospital'. • Managing admissions to hospital and residential care - This is underpinned by two aims relating to housing; 'Developing extra care housing models as an alternative to residential care' and 'Working in partnership with local communities to increase local capacity to support older people to live in their own homes for longer'. The *East Lothian Local Housing Strategy (LHS) 2012-17* sets out five outcomes including 'People with particular needs are able to access and sustain their choice of housing including independent living, where appropriate'. This is underpinned by six actions: 1. Establish systems to enable ongoing analysis of data in relation to particular needs groups and undertake annual analysis 2. Develop initiatives to address the current and future housing and housing support needs of particular needs groups using the findings from the Housing and Housing Support Needs Assessment 3. Review the provision of new build affordable housing for particular needs groups and set a supply target for the provision of future stock 4. Improve joint working to ensure housing is integrated into the strategic planning for particular needs groups 5. Work in partnership with East Lothian Council Adult Wellbeing and others to develop housing support services with a focus on preventative support 6. Explore and develop social enterprise initiatives to provide assistance with moving home, decorating etc The LHS also identifies older people as being particularly vulnerable to fuel poverty. Underpinning the outcome 'Fewer people live in fuel poverty' is an action to 'target energy efficiency advice at households most at risk of fuel poverty'.
Strategic direction of travel and proposed investment changes within the draft SCP for older people *(Note 2)*	The population of East Lothian is changing, people are living longer and this will increase the pressure on acute services and residential care placements. The strategic objective of the Joint commissioning Plan is to rely less upon providing care in institutional settings and rely more on providing care within people's homes and communities.

	More choice is being given to individuals to say how and when services are provided, making them more flexible and responsive to need. The focus of the plan is on promoting health and well-being, and working with partners to ensure older people do not become isolated, enabling them to stay active and engaged in their communities. It is recognised that older people want to remain living in their own homes. Social care provision will increasingly focus on helping people to achieve this through the expansion of rehabilitation and preventative care services, to prevent older people being admitted into acute beds or residential and nursing homes. The Plan details the following strategic commissioning intentions: 12.1 Managing long term conditions 12.2 Developing preventative services/ building capacity in our communities 12.3 Managing dementia 12.4 Building a workforce fit for the future 12.5 Managing admissions to hospital & residential care: • Exploring extra care housing models as an alternative to residential care • Working in partnership with local communities to increase local capacity to support older people to live in their own homes for longer • Negotiating a shift in resources to invest in community alternatives to acute NHS care
The housing contribution – investment already planned on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock) (*Note 3)*	**Introduction** For the East Lothian LHS 2012-17, an ageing population is considered to be a key challenge with regard to investment in housing and service delivery. This is likely to result in increased demand for housing and housing related services, with more accessible homes required across all tenures. An efficient and effective redesign of existing services will be necessary to try and achieve 'more' with 'less'. **<u>Capital Investment</u>** **Affordable Housing** Over the past decade in the region of 9% of all new build affordable housing completions have been properties to address specific needs, which is just below the target set by the Council's previous LHS of 10%. All new build social housing is built to the Housing for Varying Needs standard and a priority is to increase the availability of affordable housing including housing for varying needs across East Lothian. This includes wheelchair standard housing in each new Council development. In addition, Housing Occupational Therapists currently input into the design of new build

	Council stock for particular needs. The current LHS will continue to ensure that a proportion of housing completions are for particular needs groups, including older people. During the LHS consultation a number of comments were raised about the availability of housing for particular needs groups as well as the importance of property type and location. The LHS states that the provision of affordable housing for particular needs groups will be reviewed and a supply target set for the provision of future stock. However, recent research into the housing needs of particular needs groups recommends that a target is not set as this is not considered effective and a decision on this will require to be reached during 2013/14. Investment of approximately £30m is planned between 2012 and 2015 for new build Council housing. In addition, Council and RSL funding streams have recently been brought together into one budget and from this, councils received a combined 3 year resource planning assumption from 2012/13 to March 2014/15. East Lothian was awarded £3.29m of new monies in May 2012 and allocated a further £0.649m in December 2012. The LHS 2012-17 does not specifically identify investment for housing for older people and was developed prior to the commencement of the integration of health and social care agenda and associated requirement for JSC Plans and Housing Contribution Statement. The development of a National Strategy for Housing for Older people was underway however and it was apparent that major changes were likely to arise in relation to integrating housing, health and social care. Give this and the lack of data available at that time in East Lothian on housing and older people, a study was commissioned into the Housing and Housing Support Needs of Particular Needs Groups, with a specific focus on older people and people with dementia. The focus of the LHS to date has been to ensure comprehensive and accurate information is available to inform the wider integration agenda, including investment decisions. Once the study has been agreed and the housing needs of older people are fully understood, the LHS sets out an action to 'Review the provision of new build affordable housing for particular needs groups'. Alongside this, there is also a need to consider the role of sheltered housing and extra care housing in meeting needs in the context of changing and growing needs amongst older people. The LHS also undertakes to develop initiatives to address the current and future housing and housing support needs of particular needs groups using the findings from the

	study; to develop housing support services with a focus on preventative support and explore and develop social enterprise initiatives to provide assistance with moving home, decorating etc. **Open Market Acquisitions** With an ageing population, there is increased demand for smaller properties and East Lothian Council has progressed with nearly 200 open market acquisitions to increase the supply of affordable housing, with a particular focus on smaller units. Some properties have also been adapted to meet specific needs. **Adaptations** East Lothian Council's Private Sector Housing Team administers grants for major adaptations to private sector stock, with dedicated support provided to clients by Care and Repair East Lothian. Typically around 50 adaptations to private sector stock are carried out each year, depending on assessed need although the number of approved adaptations was considerably higher in 2011/12, requiring an increased capital resource input and it is a trend which is likely to continue. East Lothian Council have a dedicated team who co-ordinate adaptations in Council properties. Around 90 adaptations are carried out in Council stock each year depending on assessed needs. Capital investment of around £800k per annum is budgeted for major adaptations. The Council has recently developed an 'Equipment and Adaptations Partnership Agreement' and revised its approval processes to deliver efficient working practices and improve service delivery. This work has been highlighted in the Final Report of the Scottish Government's Adaptation Working Group as an example of partnership working. **Standard of Housing** The Council is investing £10m per annum in ensuring that its stock meets the Scottish Housing Quality Standard by 2015. This includes meeting standards set out to address safety, security and energy. **Revenue Funding** **Housing Support** The Council is the largest provider of housing support services in East Lothian providing support to older people in their own homes. Housing support is also provided to

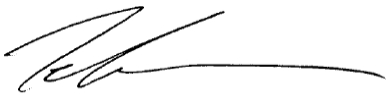
	older people in specialist housing, mainly in the form of very sheltered and sheltered housing. This type of housing is provided by a range of social landlords and private companies and is available in both the social rented and owner occupied tenures. In order to adapt to the changing population and economic climate, the way in which housing support is provided, organised and delivered will require to be reviewed. **Private Sector Repairs / Condition** The East Lothian Council Scheme of Assistance 2010-12 sets out assistance available for older people who own their own homes or are renting privately to maintain and repair their property. The Scheme covers information and advice and Care and Repair East Lothian deliver practical assistance to owners to carry out repair and improvement works to their properties. This includes a Small Repairs Service. Revenue funding of £285k was provided to Care and Repair East Lothian in 2012/13 to provide these services. **Fuel Poverty** East Lothian Council works with a range of partners to reduce fuel poverty and a number of projects and initiatives are in place to provide support and assistance. Older people are considered to be more vulnerable to fuel poverty and services which provide in-depth targeted support to vulnerable households are available. As the energy efficiency of a property is a key contributing factor to the incidence of fuel poverty, the majority of initiatives have a dual role to improve energy efficiency and reduce fuel poverty. Funding of £57k was provided to the East Lothian Energy Advice Centre in 2012/13 to provide fuel advice services. **Existing Social Rented Stock** A growing number of older people are currently under occupying family sized housing, which generally contributes to an overall shortage of affordable housing. The Council offers an incentive scheme for Council tenants who are downsizing to a smaller Council or RSL property either through a mutual exchange or transfer. Between April 2009 and March 2011, 232 tenants received a downsizing incentive, a significant proportion of which were older people. The Council also operates a mutual exchange register which helps tenants to identify potential exchanges which can again be useful for older people seeking more appropriate accommodation.

Likely future impact of plan upon housing resources (*Note 4)*	**Current Position** It is unclear at present what impact the plan is likely to have upon housing resources, going forward. Broadly, a requirement for increased numbers of older people to remain at home with support and a focus on preventative / support services is likely to require additional resources. This could include capital investment in housing and / or additional revenue funding for housing support. Given the current economic climate however, much of the focus is and will continue to be on reviewing existing services to ensure they are operating efficiently and effectively and are targeting groups appropriately. **Impact Assessment** A comprehensive assessment will require to be completed to fully consider the likely implications of the JSC Plan and wider integration agenda in relation to housing services and the corresponding financial impact that the Plan is likely to have on housing resources. It is likely that this will include the following: • Increase in capital funding for adaptations • Clearer targeting of capital funding towards housing for older people, either for remodelling existing stock or new build • Increase revenue / Reinvestment of revenue in support services • Targeted housing information and advice services
Process for integrating the housing contribution to the SCP for Older People in future*(Note 5)*	**Introduction** This Housing Contribution Statement has been developed by Housing in conjunction with Health and Social Care on an informal basis and it is recognised that a more formal process for integrating the housing contribution with JSC processes must be put in place and agreed. This will ensure that the housing contribution is clearly articulated and enable a stronger housing perspective to be incorporated in future. **Review of Existing Structure for Processes and Planning** Planning and processes relating to health and community care services in East Lothian are delivered by a range of Joint Planning Groups (JPGs) which include representatives from the Council, East Lothian Community Health Partnership, the voluntary sector, service users and carers. There are currently five JPGs which include the Older People's JPG, the Physical Disability JPG, the Learning Disability JPG, the Mental Health JPG and the Carers JPG. In addition the Mid and East Lothian Drug and Alcohol Partnership (MELDAP) is a multi-agency partnership working together to lead and co-ordinate the prevention and reduction of problems associated with drugs and alcohol. The Change Fund Delivery Group is separate from the JPG structure. All groups sit within the East Lothian Community Planning Framework which has

	recently been reviewed. Changes will be required to strategic planning groups including the JPG structure and while the detail of the revised structure is unclear, it is recognised by East Lothian Council that formal links between housing, health and social care should be strengthened. **Review of LHS** The LHS 2012-17 will be reviewed at the end of year one (April 2013) and revised to take account of the changing national and local context. A key aspect of the review will be to focus on the requirement to incorporate a stronger housing perspective into JSC processes and plans and how this can most effectively be realised in practice, taking into account new group structures for Community Planning and JPG's.
Outline and understanding of shared data sources , and gaps to be addressed *(Note 6)*	**Outline of Shared Data Sources** East Lothian Council commissioned Craigforth consultants in 2011 to undertake detailed research into the housing and housing support needs of particular needs groups. The report (to be published shortly) provides a shared data source which will inform both revisions to the LHS 2012-17 and the JCS Plan for Older People. The study focuses primarily on the scale and profile of housing and housing support needs of older people and also includes people with dementia and people with a physical disability as specific groups. The study recognises the complex inter-relationships between needs groups although provides an estimate of the extent of overlap between groups where appropriate. The study uses triangulation and corroboration to bring together a wide range of relevant data and intelligence, including population projections; household projections; housing list data; Scottish House Condition Survey (SHCS); EURODEM and EuroCoDe; Balance of Care / Continuing Care Census; Care Home Census and Social Housing Statistics. Where available, the study uses local datasets from East Lothian Council's Housing and Adult Wellbeing departments to refine and add depth to prevalence based estimates. Local socio-economic and demographic drivers are also taken into account such as income, deprivation, poverty and health. While this study is the key document underpinning both the LHS and JCS Plan for Older People, the following documents are also relevant: • Joint Strategic Needs Assessment (2009) • East Lothian Council Local Housing System Analysis Report (2011) • Private Sector House Condition Survey 2010/11 (2012)

	Gaps to be Addressed The key gap in data relates to Housing Need and Demand Assessments (HoNDA's). HoNDA Guidance (2008) sets out an approach to assessing housing need and demand to provide evidence to inform the development of LHS's. While the Guidance recognises the importance of providing housing for older people, in practice, this prescriptive Guidance does not provide a methodology for an assessment of the housing needs of older people. A new analytical and planning tool is currently being developed by the Centre for Housing Market Analysis (CHMA) to assist with the assessment of housing need and demand, setting out a revised approach to conducting HoNDAs. This tool will be critical for undertaking effective strategic housing planning and ensuring alignment of the LHS and JSC Plan for Older people. However, it is clear from the draft toolkit that the proposed new approach has limited provision for assessing the housing needs of older people. This is likely to result in a key gap in data for both the LHS and JCS Plan for Older People.
Key challenges going forward *(Note 7)*	**Key Challenges** The LHS identifies a significant ageing population in East Lothian alongside a lack of affordable housing and more specifically one bed units, combined with high house prices. This provides a challenging context for housing to maximise its contribution to deliver health and social care outcomes. The current economic climate and requirement to make efficiency savings will pose an issue for the contribution of housing to JSC and new innovative ways of working must be identified to ensure 'more for less' alongside a focus on prevention activity. Related to this, it is likely that the Welfare Reform agenda will be a key challenge going forward. The total annual loss in East Lothian through Welfare Reform is significant and estimated at £8,040,000 to £9,497,000. This will require to be closely monitored, as will the introduction of Self Directed Support, necessitating a major cultural change and increasingly person centred approach. A further key challenge identified in response to note 6 is to ensure a shared approach to assessing the housing needs of older people to support the alignment of shared strategic priorities. Taking this one step further, to ensure a fully joined up approach, it is considered that the incorporation of housing into the wider integration of health and social care cannot be achieved without links to the modernised development planning process.

Name: Richard Jennings, Head of Housing and Environment, East Lothian Council

Signed: 

…….

Note 1: This should reflect those health and social care measures, including outcomes that are considered most likely to be impacted by the housing contribution. They should include national and local measures, as detailed in the JSC Plan for Older People

Note 2: This should describe the proposed overall shift in the balance of care and outline the key service re-design proposals in the JSC Plan for Older People that are intended to deliver this shift

Note 3*:* This should detail those aspects of the current LHS that contribute to delivery of the JSC Plan for Older People focusing on change in service delivery to support health and social care outcomes, and should also reference the local authority's investment plans for its own stock where appropriate.

Note 4*:* This should outline the potential impact that the plan is likely to have on housing resources – both services and bricks and mortar, going forward

Note 5*:* This should explain local proposals for ensuring that the housing contribution is clearly articulated and how a stronger housing perspective will be incorporated into future JSC processes and plans

Note 6*:* This should describe the data sources that have been used by both health and social care and housing in compiling the LHS and the JSC Plan for Older People and identify any currently apparent gaps in data that would better support joint working between the sectors

Note 7: This should highlight any particular issues regarding housings contribution that have emerged from discussions relating to the completion of this HCS and/or any other related processes

Appendix 2

East Lothian Joint Commissioning Plan for Older People - Action Plan

Intended outcomes	Actions required	Timescale
COMMISSIONING THEMES		
Working in Partnership		
We have a shared understanding of the needs of the population in East Lothian and share information appropriately between agencies	Development and agreement of shared Joint Strategic Commissioning principles across the partnership Information sharing protocols developed and agreed across the partnership.	2013 -2015
All partners contribute to decision making	Develop an agreed governance structure that all partners have contributed to and agree to, are clear about their role and contribution with written terms of reference.	2013/14
Older people and their carers are actively involved, and have influence in the Joint Commissioning process.	Information and engagement strategy developed and widely disseminated. Systems in place for routinely involvng older people and their carers in the joint commisioning processes.	2013 2013/14
Quality, dignity, respect and safety		
Older people lead healthy active lives and are at decreased risk of falls.	Easily accessible opportunities for older people to engage in physical activity within the community.	2013/14
Older people, carers and their families will experience quality, dignity, respect and safety standards seamlessly across sectors	Develop quality assurance procedures in consultation with older people and their carers	2013/14
Older people's views help to determine the quality of standards of all health and social care provision in East Lothian	Develop a communication and engagement strategy	2013

Older people are able to have their say	Support plans highlight where advocacy services may be required to enable views to be expressed where they cannot be communicated easily. Information about advocacy services is widely publicised across services and easily available to older people	2014 2013
Everybody know where and when to raise concerns about safeguarding issues	All services have whistle blowing policies in place Written information about how to raise a concern is widely available and provided by all services.	2013 2013
Choice and Control		
Services deliver the outcomes older peole have specified	Implementation of Self Directed Support and the wider personalisation agenda.	2013 - 2015
Older people are well informed about services and how to use them	Good public information is available in a range of formats	2013/14
It is easy for older people to access services	Complete transport review Develop and implement revised transport strategy and policy.	2013/14 2014/15
Services are delivered in an integrated way	Continued development of co-located integrated teams	2013 – 2015
Supporting Carers		
Carers and families are well supported	Development and implementation of Carer Star	2013/14
Carers have their own needs and aspirations recognised alongside their caring role, and be recognised as expert partners in the support of their loved ones.	Implementation of outcomes based, personalised carer assessments	2014
Carers are supported to stay mentally and physically well	Carers support services are in place	2013 - 2015

Information and Access to Services		
Older people who pay for their own care and services have better access to improved information and assistance, make good care decisions and put their money to best effect	Develop a network of advice and information that meets the diverse needs of all residents in our community	2013/14
Comprehensive information is available	Improve cross-sector working to increase access to services in hard to reach communities Develop the role of primary care, in working with the third, independent and community sectors to provide the right information at the right time.	2013/14 2013 - 2015
Older people have appropriately adapted houses	Development of Housing Adaptation Support service	2013
Older people are aware of services available and know where to go for help in a crisis.	Developing the role of universal services such as libraries in providing information and helping people navigate through the system.	2013 - 2015
COMMISSIONING INTENTIONS		
Managing Long Term Conditions		
Older people who experience long –term illness maintain independence and control of their daily lives.	Develop pathways of care that work across health and social care boundaries Review current service provision in disease specific areas to identify where services can be remodeled and delivered in the most appropriate setting	2013 – 2015 2013/14
Older people live independent lives in their own homes	Develop a Self Management Programme Further develop Telehealth and Telecare systems	2013/14 2013 - 2015
People at risk of developing a long-term condition have access to a range of preventive programmes to promote health and well-being.	Focus on developing integrated health and social care services at a community level	2015
Developing Preventative services/ building capacity in our communities		

Older people across East Lothian are healthy, active, independent, and able to contribute to the life of their community.	Develop service directory for wide distribution	2013
	Develop a range of community based services that promote social opportunities and befriending.	2013 - 2015
	Develop closer cross sector working with partners delivering physical activity opportunities	2013/14
Older people with dementia live healthy lives in their own homes	Adopt a case management approach promoting independence	2013/14
The right services are in place to support older people with dementia	Map and review current service provision Work with third sector partners to develop a Centre of Excellence in East Lothian	2013 2013/14
Fewer older people with dementia need to be admitted or treated in hospital	Develop a dementia action group to take forward the actions set out in this commissioning plan Commission respite/ intermediate care and short-term intensive management supports in the community	2013 2013 – 2015
People with a diagnosis of dementia receive high quality post diagnostic support	Establish an implementation plan to ensure the objectives within the National Dementia Strategy are met.	2013/14
Our staff are better equipped and trained to support people with dementia .	Establish an action plan for reducing prescribing of anti-psychotic medication Commission work to support excellent dementia care in nursing and care homes to help manage behaviour and reduce inappropriate attendances at A&E.	2013 2013
Building a workforce fit for the future		
We have a confident and competent health and social care workforce, operating to high standards	Implement a programme of investment in workforce development to provide learning and development opportunities across these roles and sectors.	2013/14
We have sufficient capacity in the workforce to deliver the range of care services required.	Actively promote the career opportunities available in social care, working closely with careers services and job centres and using all existing networks.	2013/14

We involve staff in developing our plans	Develop and implement a Joint Commissioning Workforce Development Plan	2013/14
People with dementia are treated with dignity and respect in all care settings	Deliver a programme of dementia awareness training and skill development for the health and social care workforce including the independent sector.	2013/14
Managing admissions to hospital & residential care		
Older people live independent lives in their own homes.	Develop a joint strategy for reducing inappropriate A&E attendance rates (unscheduled care), managed through a joint governance board Develop a joint assistive technology strategy Explore extra care housing models as an alternative to residential care	2013/14 2013/14 2013/14
Our services can respond to people's needs	Develop a care home liaison/support service which focuses on reducing hospital Admissions.	2013/14
Older people's skills and talents are maximised and utliised.	Increase the availability of enabling and preventative services. Develop an integrated falls care pathway which links with the rapid response and assessment service and with primary care	2013 2013
Older people Spend less time in hospital and more time at home.	Progress the further development of the Community Re-ablement Service Negotiate a shift in resources to invest in community alternatives to acute NHS care Progress plans to ensure effective integrated communications, particularly IT systems, to ensure data sharing	2013 2013/14

Annex A

Joint Strategic Commissioning Plan Self Evaluation Template

PARTNERSHIP DETAILS

Partnership name:	East Lothian Partnership
Contact name(s): See note 1	David Heaney
Contact telephone	01620 827551
Email:	dheaney@eastlothian.gov.uk
Date of Completion:	4 February 2013
Date published on website(s)	28.2.13

The content of this template has been agreed as accurate by:

……	……
David Small for the NHS Board	Murray Leys for the Council
……..	…….
Eliot Stark for the Third sector	Maureen Allan for the Independent sector

When completed and signed, please return to:
Brian Slater,
2 ER, St Andrew's House,
Regent Road,
EDINBURGH, EH1 3Dg
Brian.slater@scotland.gsi.gov.uk

Whole System Key Indicators

	Indicator See note 2	Detail	Comments
1	The value of the **total resource envelope** that has been used as the basis for your JSC Plan for OP	Not yet available	Work is currently underway to establish the total resource envelope as part of our preparations for the integration of health and social care.
2	The nature and value of the **different services** that comprise the total resource envelope See note 4	The total resource envelope in East Lothian will comprise the following: * ELC - Adult Wellbeing – OP services * CHP services – OP services * Housing ELC, IS & TS – OP services * Third Sector Services to older people, * Contribution to OP services through volunteering * Independent Sector care at home and care home services * Contribution from unpaid carers * Local NHS Lothian hospital services * GP services	As above. Work will be undertaken during 2013/14 to quantify the value of these services.
3	The nature and value of any **disinvestments** that have taken place or are anticipated to occur within the lifetime of your plan	East Lothian Older Peoples Strategy describes proposed redesign of local authority residential care and NHS continuing care so that "The changing needs of the population can be met more flexibly and disruption to their care is minimised".	Modelling work on this continues and on its conclusion, formal agreements will be struck between East Lothian Council and the CHP setting out how the new model of care will operate, the level of resources that will be needed to deliver it, and the amounts of funding that can be shifted into community care services

	See note 5	Change Fund – Disinvestments totalling £350,000 were made through a 3 stage review process of 2011 – 2013 projects. Reasons included: specific piece of redesign complete; temporary scoping or other work complete; project not demonstrating expected outcomes and unsuccessful start-up of project.	These resources were re-invested in new services

Joint Strategic Commissioning Plans – criteria

Red: No action underway/**Amber**: Action underway but not complete/**Green**: Action is complete

	Theme	R A G See note 6	Comments See note 7
	ANALYSE		
4	**An outcomes based Joint Performance Framework is in place that reflects the national outcomes focus** See note 8	A	**Joint Performance Framework** This is being developed by bringing together key performance measures from the Council's Adult Wellbeing service and the NHS. The framework is used to track performance on a regular basis and identify areas of common interest. The areas covered by the framework are: Contacts; Assessments and Reviews; Carers Assessments; Delayed Discharge; Intermediate Care; SDS/Direct Payments; Long Stay Placements (aged 65+); Long stay Placements (adult - 18 to 64); Health Residential Services; Respite; Adult Protection; Aids and Equipment; Criminal Justice; Unmet Need; Balance of Care; Staff Management Discussions are ongoing about the how the framework will be developed to support integration.

			Change Fund The Performance Framework and Logic Model developed for the Change Fund is based on: • The Reshaping Care Core Measures defined by Scottish Government • The Scottish Government Integration Outcomes • East Lothian Single Outcome Agreement Projects use outcome based templates to submit proposals to the Fund and to provide 6 monthly written reports relating directly to identified outcomes from the Logic Model.
5	**A Joint Strategic Needs Assessment has been undertaken that provides a clear, coherent assessment of need and it has been disseminated widely** See note 9	G	A Joint Strategic Needs Assessment was completed in 2009 for the development of the East Lothian Older People's Strategy. This included population demographics and projections, and focused on age, gender, prevalence of dementia and use of current health and social care services. Partners to the Strategy were: • East Lothian Council • East Lothian Community Health Partnership • NHS Lothian • Carers of East Lothian • East Lothian Community Care Providers Forum • East Lothian Community Care Forum, including East Lothian's Older People's Forum. Consultation on the strategy was widely advertised in local newspapers and East Lothian Council's Focus magazine as well as through posters in local shops, and public buildings. We also made extensive use of online methods and were extremely pleased with the levels of interest shown by stakeholders. We estimate that more than 1,000 people attended 31 meetings, and over 300 letters and emails commenting on the draft strategy were received.

			A number of consultation methods were used, including: • Public meetings held in the evenings • All day public meetings, enabling members of the public to drop in at a time convenient to them • Presentations to specific groups, such as carers, people who use services, community councillors and groups of staff. Specific consultations were also carried out with: • Older hospital patients and people who are housebound • People using day centres for older people These processes influenced the final contents the Older People's Strategy that was published in 2011 along with a detailed action plan. In 2012, Craigforth conducted research on Particular Housing and Housing Support Needs in East Lothian that covers all major care groups including older people. This has provided updated demographic information on particular needs groups including older people and people with dementia. This research has been helpful in having a particular focus on housing support needs, adding critical detail for the current planning of local service development and redesign. Data sources for the Joint Commissioning Plan include: • National Records of Scotland (NRS) – 2010 based principal population projections by sex and single year of age 2010 - 2035 • Registrar General for Scotland • NHS Lothian PH & HP • East Lothian Health and Wellbeing Profile 2010 (http://scotpho.org.uk/web/FILES/Profiles/2010/Rep_CHP_S03000031.pdf • GROS East Lothian Demographic Factsheet (http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/east-lothian-factsheet.pdf)

			• Alzheimer Europe (2009) *EuroCoDe: prevalence of dementia in Europe* Alzheimer Europe – Consensual Prevalence Rates • http://dementiascotland.org/news/statistics-number-of-people-with-dementia-in-scotland-2012 • Scottish Government Health and Community care – Datasets. • Audit Scotland SPI data 2006 – 2008, Scottish Government 2009 - & 2010 • 2001 Census • The Scottish Health Survey 2010
6	**Suitable data has been used to scope the programme budget (eg. IRF data) and a baseline position has been established regarding activity, costs and variation** See note 10	A	IRF data is being used to scope the programme budget and a baseline position has been established covering activity, costs and variation. The IRF data covers NHS and social care spend for the three years from 2008/09 to 2010/11. There has been an extensive data matching exercise to allow the full costs of service for an individual to be established across both the NHS and social care. This has involved drawing data on services provided to individual clients/patients from the information systems within NHS and the councils across Lothian. Where possible direct costs have been established but where this has not been possible data has been apportioned. This information will allow us to map out significant trends across the health and social care system and identify areas where there may be potential to reorganise services to avoid acute admissions, work more closely together and re-allocate resources to improve service efficiency.
7	**A coherent approach has been applied to selecting and prioritising investment and disinvestment options** See note 11	G	The high level priorities for Change Fund investment are aligned with those identified in the Older People's Strategy. At a more detailed level for the Change Fund, a robust cross sector process has been established to support prioritisation and investment/disinvestment decision making. This means; • All applicants use the same outcomes based template to apply for funding and to report on performance and spend. • Applications and performance reports are scrutinised by an evenly balanced

			cross sector group who also offer individual opportunities to meet with project leads where further information is required. This group make recommendations as to investment/disinvestment to the Change Fund Delivery Group (CFDG) – also structured to provide equality of representation across the sectors and from the JIT. CFDG make the final decisions in relation to spend. This is an effective process enabling a more holistic picture to be gleaned from intelligence across the sectors that can be used to identify priorities, gaps and capacity issues.

	PLAN		
8	**We have a shared vision and joint strategic objectives** See note 12	G	At this stage, the Joint Commissioning Strategy will only be applicable to older people. Our Older People's Strategy provides the strategic overview and direction of travel in relation to major redesign, investment and disinvestment options across health and social care in East Lothian. It identifies the following shared strategic Outcomes: ***Outcome 1 -*** Services will meet the needs of East Lothian's growing and ageing population. ***Outcome 2 -*** Services will enable older people to live independently, with support whenever necessary ***Outcome 3 -*** Older people and their carers will be healthier and more active and feel included in their community. ***Outcome 4 -*** We will raise standards of service to deliver effective and efficient services in a challenging financial climate.

9	**Our strategic commissioning work is clearly linked to Community Planning priorities and processes** See note 13	G	Our Older Peoples Strategy was developed by an Older Peoples Joint Planning Group made up of representatives of the four sectors, service users and carers' representatives. This is one of five joint planning groups in East Lothian. We recently reviewed our joint planning structures to ensure greater coherence and connection with our Community Planning process and established a strong link between both via the Health and Social Care Theme Group. East Lothian's Community Planning arrangements have also been reviewed recently and the revised model will ensure that the Health and Social Care Partnership will become an integral element of the Community Planning system once established.
10	**Mutually supportive 4 sector engagement in our JSC processes is in place** See note 14	G	The cross sector process in place for the Change Fund (described above) is being used to progress the Joint Commissioning process. There has been good representation by all sector leads throughout the Change Fund process and this has led to the development of positive and effective working relationships. Projects supported by the Fund have a clear focus on working across partnership sectors to achieve best outcomes. This approach addresses the concerns expressed by Scottish Care in their recent research "Reshaping Care for Older People: Engaging the Independent Sector – Baseline Survey Report", 2012. Evaluation Support Scotland are currently supporting East Lothian with outcomes reporting for preventative work undertaken by third sector organisations that we will apply across the sectors.
11	**Users and carers are embedded within the partnership commissioning processes** See note 15	G	Involvement of service users and carers in the Change Fund process is a central tenet of our approach and includes: • Representation on the CFDG, and Older People's Planning Group by local organisations that are funded to engage with service users and carers

			• All projects funded through the change Fund are required to provide service user feedback.
12	**GPs, clinicians and social care professionals are well represented and have opportunities to contribute at all stages of the planning work** See note 16	**G**	GPs and social care professionals are directly represented both on our Older Peoples Joint Planning Group and on the Change Fund Delivery Group and are active participants in the decision making processes. We intend to use The Joint Strategic Commissioning Learning Development Framework developed by the Institute of Public Care to prepare staff to contribute to the processes at the appropriate level for their role. As part of our planning for the introduction of a Health and Social Care Partnership we will bring forward detailed proposals for increased involvement of GPs and social care professionals working in partnership with service users and carers and local community organisations within locality planning groups.
13	**A JSC Communication Plan is in place** See note 17	A	Our Communication and Engagement Plan described will form part of a wider public and stakeholder communication and engagement process in relation to the Joint Commissioning Plan. **Our Aim** Service users, family carers, the public the workforce and other stakeholders have the information they need to understand and become involved in the development of the Joint Commissioning process. Supported by 4 objectives for public and stakeholder engagement and communications: • To provide opportunities for the public and stakeholders to better understand, comment on and influence Joint Commissioning Strategy, planning and decision making

			• To provide opportunities for the East Lothian Partnership to draw on the knowledge and experience of the public and the stakeholders to improve its planning and decision making • To build relationships between the Partnership the public and the stakeholders that lead to mutual support and confidence • To enable the Partnership to meet its legal and regulatory responsibilities Our guiding principles are that we will: • Give clear and easy to understand information to people about what we can and cannot do. • Help people to have as much choice and control as possible over their lives. • Work together across the partners to look at and resolve where possible any difficulties people have when using or accessing our services. • Listen to what people say and be open to new ideas and be there when people need us. • Listen to what carers say and find out what they need. If they are satisfied and feel confident it will help them in their role. • Deliver on our promises.
14	**A Housing Contribution Statement has been prepared** See note 18	G	The Housing Contribution Statement has been completed and is attached to the Joint Commissioning Plan.
15	**A person centred care/SDS focus has been incorporated into our approach to strategic commissioning** See note 19	G	East Lothian Council are early adopters of SDS. We have begun a phased implementation of SDS and outcomes focused assessments with older people, individuals who have a Learning Disability and individuals in transition between children's and adult services. We will be rolling this out over the next year to include all care groups and our staff are currently receiving the required training to enable this to happen. 'Choice and Control' is one of the main commissioning themes in our Joint Commissioning Plan, which states our commitment to progressing SDS and the

			wider personalisation agenda. We intend that this personalised approach will become core to all of our work across the sectors and care groups and integral to our Joint Commissioning process. Work will begin during 2013 to assess and progress these changes and potential implications for organisations and services. We are currently consulting with stakeholders including service users and carers representatives on our proposed assessment tools for SDS and will refine these to reflect feedback.
16	**All relevant statutory requirements regarding impact assessments have been addressed during the compilation of our JSC Plan** See note 20	G	All relevant assessments have been completed.

	Deliver		
17	**Leadership and implementation arrangements for the Joint Strategic Commissioning Plan are clearly set out and incorporated into relevant policies** See note 21	G	In relation to the Change Fund, all relevant leadership, reporting and operational arrangements are in place to support service delivery according to Change Fund principles and requirements. Governance for the Change Fund will be linked with the establishment of the Health and Social Care Partnership in the future and this in turn will be integrated within the Community Planning system as noted above. Partners have their own range of policies relevant to delivery of components of the Older Peoples strategy and Joint Commissioning Plan.
18	**Joint Financial and Workforce plans are in place** See note 22	A	As noted above, the joint financial framework is being developed as part of scoping for the introduction of a Health and Social Care Partnership, and IRF data is

			providing a helpful baseline for this work. As part of our preparation for integration we have established a series of workstreams and assigned lead officers to these. One workstream is focused on HR and Organisational Development and the lead will be asked to recommend actions in this area to our shadow governance arrangements which are currently being developed. Partner agencies currently operate their own individual workforce development plans and the Change Fund has created opportunities for cross sectoral training on for example, dementia awareness.
19	**Specific policies and procedures for securing health and social care services are in place** See note 23	**G**	The Council's Adult Wellbeing Service currently spends two thirds of its total budget on commissioning services from independent sector providers. These services are purchased within the context of procurement rules and legislation, and in line with the Council's policies. The Council manages this range of care contracts and works with providers and the Care Inspectorate to support improvements when service standards fall, and provides close monitoring and support to ensure performance improvements are sustained.
20	**Market analysis and facilitation for relevant services has been undertaken** See note 24	**G**	Our Partnership has a very constructive relationship with our external care providers both at strategic and operational levels. We work with providers through regular forum meetings where the focus of discussion includes; action to improve recruitment, training and retention of staff, efficient deployment of resources, joint working and delivering services in hard to reach areas.
	Review		
21	**Systematic recording of progress made, variance against plans and remedial actions is in place for**	G	The Change Fund Delivery Group is responsible for deciding the detail of Change Fund allocations. They are provided with information and recommendations arising from project reviews, which includes information on spend and performance against targets set.

	individual services and the whole system change agenda See note 25		Information is presented to the Delivery Group in the form of spreadsheets containing detailed spend by projects and summaries according to each sector and the Reshaping Care Pathway. All projects funded through the Change Fund use the same finance and reporting process and all are accountable to the Change Fund Delivery group on behalf of the partnership.
22	**Outcomes focussed contract monitoring arrangements are in place** See note 26	G	The Council has begun to move all contracts to an outcomes focused approach and the following are in place: • Our tender documentation is outcomes focused. For example our Invitations to Tender make reference to and ask questions about outcomes. • Contracts put in place are outcome focused and we have agreed key performance indicators to evidence if they are achieved. • We have a performance monitoring framework we measure provider performance against, and this includes outcomes.
23	**A schedule for service monitoring and review is in place** See note 27	**G**	All Change Fund projects are reviewed quarterly, with detailed information provided at six monthly intervals to inform investment/disinvestment decisions. As contract monitoring is widened to include all services it is likely that six monthly or annual monitoring would be a more realistic interval. The current cross sector review system involves project visits, a paper review followed by interviews/meetings with project leads, and recommendations to the Delivery Group who make the final decisions.
24	**Users and carers play a central role in evaluating the impact of services** See note 28	**G**	Change Fund project review reports include feedback from service users and carers. We are working with Evaluation Support Scotland to further develop our reporting framework and this will include the formalising of service user and carer

			views in a wider sense. We will include a requirement for projects to consult with users and carers in Service Level Agreements for Change Fund Projects ongoing in 2013/14 and include this in the development of our Joint Commissioning work plan. We are developing a core data set that will be gathered across projects which will include user and carer views.
25	**A systematic approach to capturing personal outcomes is in place (eg, Talking Points)** See note 29	**A**	The performance framework developed for the Change Fund projects uses an outcome based approach, and tracks the Reshaping Care, Integration and SOA outcomes. We are currently refining this with support from Evaluation Support Scotland. The use of the Older Persons star and the development of the carer star locally will also inform this process and support us to capture personal outcomes for individuals and their carers. The Council is developing its outcomes based assessment in line with the early adoption of Self Directed Support in East Lothian.
26	**Reporting arrangements which demonstrate the impact of services and aggregate data to inform service-level / strategic adjustments are in place** See note 30	**A**	Change Fund projects report formally on performance against targets and spend against budget on a six monthly basis as described above. Information from the reviews is collated to provide an overview of activity against the Reshaping Care Pathway and the Core Measures. Evaluation Support Scotland are assisting us to develop core data sets in relation to this and to use the Reshaping Care Pathway and Integration Outcomes more effectively to aggregate the data in a meaningful way. The following criteria for decision making are used to inform investment/disinvestment decision making from project reviews:

CRITERIA	DESCRIPTION	SCORING Y/N
STRATEGIC FIT **(SF)**	Does the project fit with the aims, objectives and values of the RCOP agenda and the Change Fund objectives? Reshaping Care Pathway/ Core Measures/OPS Priorities/	YES / NO
DELIVERY **(D)**	Is the project delivering according to expectations and targets set for activity? If not, are there reasons for this that are being addressed?	YES / NO
SUSTAINABLE **(SUS)**	Is the project financial plan on target and is the project within budget? If not are there clear reasons for this? Is there a plan for how the work of the project can be sustained in the longer term?	YES / NO
RISK **(R)**	Are risks being identified and managed effectively?	YES / NO
RETURN ON INVESTMENT **(ROI)**	Has the project been able to evidence clear added value and a proportionate return on investment for the indicated outcomes?	YES / NO
OPERATIONAL FIT **(OF)**	Is there evidence that other local services/processes and related change targets are being positively impacted by the project?	YES / NO
DUPLICATION **(DUP)**	Is the project as being delivered able to demonstrate its unique selling point, i.e. it is not duplicating other project or other current activity/practice?	YES / NO
PARTNERSHIP/ COLLABERATION **(P/C)**	Have appropriate links to other services/organisations and opportunities for partnership working/collaboration been maximised?	YES / NO

Annex B

1 YEAR CHANGE FUND INVESTMENT PLAN (2013/14)

Indicators of Progress

Question	Comments
Please describe the extent to which your Change Fund activity to-date has **changed the spend profile of the total resource envelope for Older People** in your area, and whether it has led to any **disinvestment**	The Change Fund has supported a substantial increase in preventative services delivered through the third sector. While the fund represents a relatively small proportion of the overall financial envelope, its impact on significant measures is beginning to be seen. For example, we have had a consistently good performance in delivering our six weeks delayed discharge standard, and our balance of care performance has exceeded 40% since the fund was established. As noted above, we have agreed Change Fund disinvestments of £350,000 to date.
Please describe your **approach to determining the long term sustainability** of your Change Fund investments. Please provide summary information on any investments for which clear evidence as to their sustainability is available	All applications to the fund are required to provide an exit strategy for the end of the Change Fund. These vary across the projects but the following reflect the main themes: 1. Project work will be sustained from training provided and/or adoption of new practice. 2. Redesign will be complete and service will be sustainable from existing resources. 3. Project will seek funding from another source or will cease to be able to deliver.
Please describe your **approach to determining the return on investment** of your Change Fund investments. Please provide summary information on any investments for which you consider clear evidence is available as to	We will continue to develop or joint performance framework to evidence cost effectiveness of services and performance against jointly agreed outcomes. We are currently assimilating the information currently gathered through project reporting templates and presenting this in

the return on investment that they are delivering	relation to the Core Measures, Reshaping Care Pathway and integration Outcomes.
Please describe the **value of your Change Fund investment in prevention** across the entire re-shaping care pathway. Please explain the rationale that you have used to identify relevant investments, in particular those that fall within the institutional spectrum	We have allocated £898,118 (63%) of the Fund on projects that are aimed at prevention in a broad sense. These include: • low level preventative services aimed at promoting health and wellbeing with the aim of delaying the need for assessed services; • services aimed at preventing crisis/unscheduled admissions to hospital or care homes, and • projects aimed at understanding and meeting the needs of carers to prevent deterioration of their wellbeing and ability to continue in a caring role. Only £69,000 (5%) of the Fund has been spent on the institutional spectrum. This relates to two projects one focussed on supporting discharge from hospital, and one supporting carers and care home staff to increase confidence and competence in managing dementia related behaviours that can lead to admissions to hospital. The majority of spend on prevention has been on projects delivered through or in partnership with third sector organisations. This part of our overall strategy to increase service delivery through collaborative and co-production approaches and make most effective use of the added value that these approaches bring. The element of the Fund supporting statutory services in this area is focussed around service redesigns and collaborative ventures supporting greater integration of services.

Change Fund 2013/14 – Financial Summary

ITEM	£
2012/13 Change Fund year end spend total	1,435,000
2012/13 Change Fund carryover	0
2013/14 Change Fund allocation	1,435,000
2013/14 local resources added to central Change Fund allocation (LA)	NK
2013/14 local resources added to central Change Fund allocation (NHS)	NK
2013/14 other local resources added to central Change Fund allocation (please state)	NK
Total 2013/14 Change Fund resources	**1,435,000**

Carers	£ Projected spend in £s	G % of total 2013/14 Change Fund allocation
Change Fund investment on direct carer support	245,212	17%
Change Fund investment on indirect carer support	272,384	19%
Total Change Fund investment on all carer support	**517,596**	**36%**