Joint Health & Social Care Strategy for Older People in Fife
2011 - 2026

Summary Version
Contents
Foreward...........................................................................................................................................i
Introduction.......................................................................................................................................2
Background.........................................................................................................................................2
Developing the Joint Health & Social Care Strategy for Older People in Fife, 2011 - 2026 .2
Strategic Context ..................................................................................................................................2
Principles Adopted Within the Strategy ...........................................................................................3
Areas of Strategic Intent .....................................................................................................................4
   Preventative/Anticipatory Care..........................................................................................................5
   Unplanned Care .............................................................................................................................6
   Hospital-based Care .......................................................................................................................7
   Home-based Care ..........................................................................................................................8
   Re-ablement, rehabilitation and Intermediate Care .......................................................................9
   Carers ...........................................................................................................................................10
   Communities ..................................................................................................................................11
   Housing .........................................................................................................................................12
   Integrated Care .............................................................................................................................13
Foreward

As Chair of Fife’s Health & Social Care Partnership, I am delighted to present the Joint Health & Social Care Strategy for Older People Services in Fife 2011-26.

The Strategy is a key piece of strategic partnership working between the health service, the local authority and the voluntary and independent sectors and sets out the pathway in Fife to promote health and wellbeing for older people and reshape care and services for those with more complex needs in the coming years.

The Strategy underpins Fife’s Health & Social Care Partnership’s commitment to providing services for older people in the future and is a significant step in preparing for the implementation of Health and Social Care Integration in response to the current Scottish Government consultation.

[Cllr Andrew Rodger’s signature]

Cllr Andrew Rodger
Chair, Fife Health & Social Care Partnership
Introduction

This summary version of the Joint Health and Social Care Strategy for Older People in Fife, 2011 – 2026 provides a clear direction for the future development of services to meet the health, housing and social care needs of older people living in Fife.

Background

It is projected that the number of people aged 65 and over in Fife will increase from 64,215 to 106,023 by 2035 and that the number of people aged 75 and over in Fife will increase from 29,179 to 56,031. This means that the demand for services will also grow.

It is important to acknowledge that older people are a great resource within our communities and, in terms of informal care, actually provide more services than they receive. However, some older people do have health and/or social care needs and need support to deal with these.

Older people say that they wish to be helped to be more independent, preferably in their own homes, with choice and control over how they manage their lives and have customised support. This is in line with Scottish Government policy, especially the Re-Shaping Care for Older People programme.

Taking all these points into account, this Joint Health & Social Care Strategy for Older People’s Services sets out how NHS Fife, Fife Council, the Voluntary Sector and the Independent Sector will work together to support those people who need support whilst helping to maintain and support independent living and quality of life.

Developing the Joint Health & Social Care Strategy for Older People in Fife, 2011 - 2026

To develop the strategy, information was collected on what services and resources already exist along with information about how Fife’s population will change and how this will affect services needed by older people. This involved a consultation to ask the general public, including older people's groups, and also organisations who work with or for older people what services they felt were needed for the future. The strategy was then developed to work towards achieving these goals.

Responses showed that the general public, older peoples groups and organisations agreed that health and social care services should have a primary aim of maintaining and supporting independent living and maintaining quality of life if they are to meet the needs of the older population now and in the coming years. The resources of local people and communities will be key to this.

Strategic Context

National policy around health and social care for older people and for carers emphasises the need to provide support and services that help keep people in their own homes where possible, the most recent policy being “Reshaping Care for Older People”. This is being

\(^1\) General Registrar Office Scotland, 2012, [www.gro-scotland.gov.uk](http://www.gro-scotland.gov.uk/)

taken forward in partnership with The Scottish Government, NHS Boards, Local Authorities, independent sector and third sector groups.

In Fife, previous work around services for older people, including the Fife Framework for Older People³, have all been taken into account when developing the strategy. In particular, the strategy takes forward the "Supported" and "Accommodated" outcomes from the Fife Framework for Older People which state that:

“Older people should have access to the highest attainable standards of relevant support services, especially health and social care, tailored to their individual circumstances. As these circumstances change, older people should be supported in their capacity to adapt to these changes and to make personal choices as far as practicable.”

and

“Older people should be supported to live as independently as possible and in accommodation suitable to their needs.”

Principles adopted within the strategy

Consistent with the 2007 Framework for Older People Services, Fife Partnership agreed that services for older people in Fife will:

1. Recognise and value the diversity of older people as individuals who contribute to society and will not directly or indirectly discriminate against anyone.
2. Ensure the development of future models recognises the need to safeguard older people who are at risk of harm.
3. Respect and dignity for older people must be integral to all our work.
4. Consult with and involve older people, their carers and older peoples’ organisations
5. Take account of evidence of effectiveness and tailor our services and service delivery to suit the needs of the older population within available resources
6. Support older people who need support, providing safe and high quality services at all times
7. Ensure that all aspects of an older person’s health and wellbeing are considered including physical, sexual, emotional and spiritual needs.
8. Use plain language and communicate effectively with older people.
9. Strive for equality of opportunity and plan for the inclusion of older people.
10. Raise the priority and profile of older people issues.
11. Promote the rights of older people and encourage positive attitudes towards older people.
12. Work in partnership to ensure effective use of resources and to improve services and opportunities for older people.
13. Support older people to access and retain the type of care of their choice, in accordance with their needs.

JOINT HEALTH AND SOCIAL CARE STRATEGY FOR OLDER PEOPLE IN FIFE 2011-2026: AREAS OF STRATEGIC INTENT

The following pages outline the areas of strategic intent that Fife Partnership will work towards to meet the health, housing and social care needs of older people in Fife.

This has been organised to follow the different stages of the journey which an older person may experience - through health, social care services or both. The different stages of care are summarised in the table below and detail about the areas of strategic intent for each of these stages is given in the following pages.

Older people may need different services at different stages of the journey set out below, based on their own personal circumstances.

<table>
<thead>
<tr>
<th>STAGE OF JOURNEY</th>
<th>WHAT THIS MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative/Anticipatory Care</td>
<td>Staying well, anticipating care needs</td>
</tr>
<tr>
<td>Unplanned Care</td>
<td>Where an immediate response is needed</td>
</tr>
<tr>
<td>Hospital Based Care</td>
<td>Receiving care in a hospital setting</td>
</tr>
<tr>
<td>Home Based Care</td>
<td>Receiving care at home</td>
</tr>
<tr>
<td>Re-ablement, Rehabilitation and Intermediate Care</td>
<td>Support to help regain independence</td>
</tr>
</tbody>
</table>

Other things that are key to an older person’s journey of care

There are key aspects relating to the care of older people that form the foundation of each of the stages of a person’s journey: Carers, Communities and Fit for purpose housing. As these are so important, areas of strategic intent have been identified to make sure work in these areas continue.

It is also important that, when possible and appropriate, older people receive care that is integrated between the relevant agencies i.e. health, social care, housing, the third sector and the independent sector. Therefore, a separate area of strategic intent is in place to take this forward.
Preventative/Anticipatory Care

Staying well, anticipating needs and preventing the need for unplanned care and treatment wherever possible.

Aim

• We will identify and support, in a planned way, people with long term conditions and their carers enabling home based care to be provided wherever possible

Strategy Focus

• We will have proactive integrated case management which will include a shared risk prediction framework and anticipatory care planning.
• We will put in place rapid access to alternatives to admission.
• We will anticipate possible crisis and prevent the situation occurring wherever possible
• We will establish links to other areas of work relating to the wider aspects of health and wellbeing of older people in Fife.

Outcomes

• People and those who care for them will get targeted support to prevent crisis and ensure effective treatment.
• Responsibility for delivery of care and crisis response will be shared by the person, their family and care providers.
• People will be able to access information about their condition(s) and care at the level they feel comfortable with.
• We will understand the population needs and have better planning information at a point of crisis.
• People will have more control over services and healthcare they can receive in order to enable them to lead as independent a life as possible.
### Unplanned Care

Where a person experiences changes to their health status or social support that require immediate response - (in a hospital setting, a community setting or at home) older people, their families and/or carers should have quick access to a range of services and healthcare to meet their needs.

**Aim**
- We will reduce levels of unplanned care episodes, but where these occur, ensure return to community setting as soon as possible and that life changing decisions are not made at the point of crisis

**Strategy**

**Focus**
- We will provide rapid access to geriatric assessment, including old age psychiatry and acute medicine, in all settings.
- We will provide a comprehensive assessment of medicine administration.
- There will be a focus on recovery, rehabilitation and re-ablement, where this is in the best interest of the person, through a range of intermediate care services that emphasise physical and mental wellbeing.
- We will provide rapid access to a range of equipment and adaptations
- We will ensure that information systems can provide a function to alert community staff to admission, discharge and any resulting changes to care plans.

**Outcome**
- There will be no needless delays for assessment, care and support or equipment.
- Unpaid carers will feel supported and able to continue in their role.
- People will experience fewer adverse health (including medication) events.
Where an older person experiences changes to their health that requires admission to hospital they, their families and/or carers should have quick access to a range of services and healthcare to meet their needs

Aim

• Hospital-based care will provide specialist diagnostic and treatment services that cannot be provided within the community

Strategy Focus

• We will embed methods of comprehensive assessment of older people that routinely encompass their physical, mental, functional and social needs throughout the healthcare system.
• We will develop inpatient care pathways within acute care to support comprehensive assessment, treatment, care needs and early supported discharge.
• We will develop day care pathways to support access to comprehensive assessment and treatment that encompasses the effective use of community hospitals
• We will develop systems across primary care, community care and acute care to review and manage people with complex health needs.
• We will ensure that shared decision making is clearly visible at the centre of all patient pathways.
• We will strengthen compassionate care and communication at the end of life.

Outcome

• Hospitals will focus on providing safe and effective care according to individuals’ needs.
• Psychological difficulties will be detected and managed appropriately which, in turn, enhances independence, participation and wellbeing.
• Families and carers will be more able to adjust to the death of loved ones.
• Patients experience better end of life care in hospital.
• People feel comforted, comfortable, safe and cared for.
Where an older person experiences changes to their health status or social support they, their families and/or carers should have quick access to a range of services and healthcare to meet their needs.

**Aim**
- We will refocus services to actively support people to feel safe while living at home whilst reducing reliance on care where this is in line with the needs of the person

**Strategy Focus**
- We will provide enabling/re-abling care at home.
- We will establish consultant-led community geriatric medical services to develop a range of community based interventions.
- We will provide a comprehensive assessment of medicine administration.
- We will identify areas where funding can be realigned from care home/hospital settings to increase opportunities for people to be cared for at home.
- We will provide rapid access to equipment and adaptations.
- We will work in partnership to actively develop a wider range of care models through the voluntary and independent sectors and social enterprises.
- We will strengthen care and communication with people, and those close to them, at the end of life.
- Where it is the person’s wish, all possible effort will be made for older people to die at home through integrated work of health and social care staff with families and carers.

**Outcome**
- Dependency will be reduced and personal responsibility and capability emphasised.
- The proportion of people receiving long term care in a care home or hospital setting will reduce.
- People will have greater choice and flexibility of service provision and more individualised care.
- People will experience better end of life care in the community.
Where an older person experiences changes to their health status or social support they, their families and/or carers should have quick access to a range of services, including re-ablement, rehabilitation and intermediate care, to meet their needs.

Aim

- Everyone will have the opportunity to remain independent in their daily lives and, when indicated, be actively supported to regain quality of life as defined by them

Strategy Focus

- We will develop a full range of re-ablement focused intermediate care opportunities to support full recovery and rehabilitation where this is realistic and to the benefit of the person.
- We will use an outcome approach across all partnerships in order to inform care planning and care management.

Outcome

- People will have the opportunity to define their own goals and have support to achieve them
- People will be supported and empowered to do as much as they are able to and therefore be more independent of services and have greater opportunities to participate in society as they choose.

* Re-ablement services focus on maintaining or developing a person’s skills
Carers should be treated as true partners in discussions about the person they care for

**Aim**
- To keep carers at the centre of care provision – working together as partners

**Strategy Focus**
- We will further identify the partnership with carers groups in Fife in order to identify the support that carers need to continue in their caring roles.
- We will implement a revised Fife Carers Strategy in line with Caring Together: The Carers Strategy for Scotland 2010 – 2015.
- There will be an emphasis on the provision of carer assessment in order to inform the response to those needs.

**Outcome**
- Carers will be involved as true partners in the care and support plan.
- Care plans will routinely reflect the needs of carers and their ability to continue in their caring role.
- Carers will be confident to continue their role with the knowledge that they are being listened to and supported as required.
- We will have increased knowledge as to what support carers require to enable them to continue the crucial role they play.

* Carers are people who look after a family member, neighbour or friend – they are distinct from people whose job it is to care for people (care workers)
Communities

Communities can play a key role in supporting older people as full participants in community life

Aim
• To actively nurture and develop communities to support older people as full participants within those communities, particularly through developing volunteering and building the collective voice of older people
• To actively support the development of innovative, community-based support options for older people who require more intensive care and support delivered by the voluntary and independent sectors (including social enterprises)

Strategy Focus
• We will strengthen community resilience in relation to care provision through supporting the development of social enterprises within care.
• We will improve joint working across all agencies We will build on local peoples’ roles in caring and supporting older people in our communities through improved working with volunteers and the third sector.

Outcome
• The community will play a bigger role in preventing loneliness and isolation of older people
• The skills and knowledge of older people will be better utilised in designing services and activities that promote and maintain health, wellbeing and independence.
• More local people will want to become more involved in providing a range of support for older people living in our communities.
Housing needs of older people will be addressed through the Specific Needs Housing Approach which targets support to sustain living arrangements; promote individual choices for independent and sustainable living and provide equality of opportunity.

Aim
- To actively ensure older people have access to information, advice and housing support services to enable independent living
- To develop new extra care sheltered housing and re-provision existing community sheltered housing complexes to deliver services

Strategy Focus
- The Local Housing Strategy and the Strategic Housing Investment Plan will deliver new housing units specifically designed for older people.
- The services associated with extra care sheltered housing, e.g. meals, social activities, etc., will be further developed.
- Advice and information on housing options will be available in a range of formats and locations.
- Housing Support Services will be designed and targeted according to demand and need.
- We will ensure rapid access to appropriate adaptations to properties.

Outcome
- Older people are provided with quality assured housing advice and information.
- Older people are offered appropriate housing support services to sustain their choice of living arrangements and facilitate independent living.
- Older people can access housing adaptations which will allow for retention of both their dignity and independence. Older people will be accommodated with integrated support, care, and health services
- Improved outcomes for older people at risk of tenancy failure
Wherever possible and appropriate, care should be integrated between the relevant agencies i.e. health, social care, housing, the third sector and the independent sector.

**Aim**
- To put in place integrated care provision to support improved outcomes.

**Strategy Focus**
- We will extend the range and scope of multi-agency community teams.
- We will achieve integration of out of hours services.
- We will prioritise the delivery of a joint information and data collection and dissemination system that is effective and supports practitioner working and person centred outcomes.
- We will further develop the infrastructure around integrated planning, governance and leadership.

**Outcomes**
- We will make the best use of staff skills and avoid duplication of effort.
- People who use the services will experience a more straightforward care model which is easier to understand and access.
- There will be a good flow of information and improved data recording to reduce the recording burden for staff and repetition for service users and their carers.
- Staff will have greater satisfaction in their roles.
- People who use the services will have high levels of satisfaction and confidence about effective joint working.
- People will feel confident and listened to and be reassured that there is a safety net.
- Staff will have more time to spend with people.