Agenda Item

1

Shetland Islands Council

NHS Shetland

SHETLAND HEALTH AND SOCIAL CARE PARTNERSHIP

Social Services Committee and CHP Committee **30 September 2015**

External Audit Reports – Care Inspectorate	
Report No: CC-39-15-D1	
Report by: Executive Manager – Adult Social Work	**Community Health and Social Care Directorate**

1.0 Summary

1.1 On 11 June 2015 a new policy and procedure for Audit Scotland and other external audit body's reports as detailed in report IP-20-14-F was approved. (Min Ref: P&R 28/14)

1.2 All reports from Audit Scotland/external advisers will be directed to and considered by the relevant Committee and this will include reports where there are no specific issues relevant to the Council.

1.3 Community Health and Social Care Services receives reports regarding Mental Health Community Support provided at Annsbrae House from the Care Inspectorate.

1.4 The purpose of this report is to highlight one such recent report from the Care Inspectorate and address any actions to be taken as a result of the report.

2.0 Decisions Required

2.1 That the Social Services Committee consider the report on Annsbrae House (registered to provide housing support and support service for people with mental health issues) and note the requirements and recommendations that have been included, where appropriate, in the improvement plan.

3.0 Detail

Background

3.1 The following establishment was inspected:

- Annsbrae House, Lerwick: Announced Inspection, 11 June 2015

3.2 The grades that were awarded to Annsbrae in the reports are as follows:

Quality of Care and Support	Grade 6 – Excellent
Quality of Staffing	Grade 5 – Very Good
Quality of Management and Leadership	Grade 5 – Very Good

Grades from previous years' inspection are attached in Appendix 1.

3.3 Summary of Inspection findings;

<u>What the service does well:</u>

- The service provides a very high standard of support to service users
- Service user involvement and participation including quality assurance is promoted across the service
- The service provides consistency of care and works in partnership with all stakeholders and agencies
- The service promotes and encourages the independence of the people that use the service.

<u>What the service could do better:</u>

- Interview paperwork should be signed and dated by the staff who were part of the interview panel and make clear what questions have come from the service users

<u>What the service has done since the last inspection:</u>

- The service had developed a new quality assurance system since the previous inspection. This is progressing well and the manager will continue to use this system to assess the quality of the service being delivered

<u>Conclusion:</u>

- Overall the provider continues to offer an excellent level of support to the people who use it
- The service has a very committed and enthuiastic manager.
- The staff group work collectively to provide quality services throughout Shetland
- Some paperwork should be improved.

The service received no requirements.

The service received 1 recommendation as follows;

- The service recruitment procedure should be followed. National Care Standards, Housing Support Services, Standard 3, Management and Staffing Arrangements.

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities

Shetland Single Outcome Agreement 2013:

- We have supported people to achieve their full potential at all life stages – from birth and early years through working lives to old age.

Community Health and Social Care Directorate Plan has the following relevant priorities:

- Developing person-centred services, with personalisation driving the shape of all public services and a strong focus on developing a person centred approach to care and care planning.
- Implementing changes to services and our workforce to support the delivery of safe, efficient, sustainable services.

4.2 Community /Stakeholder Issues

These reports are available to the general public through the Care Inspectorate website and customers and family members are made aware of this. Paper copies can also be provided on request.

4.3 Policy And/Or Delegated Authority

The Council's Scheme of Administration and Delegations provides in its terms of reference for Functional Committees (2.3.1 (2)) that they monitor and review achievement of key outcomes within their functional areas by ensuring – (a) appropriate performance measures are in place, and to monitor the relevant Planning and Performance Management Framework; and (b) best value in the use of resources to achieve these key outcomes is met within a performance culture of continuous improvement and customer focus.

The CHP Committee ceased to be a formal sub-committee of Shetland NHS Board on 1 April 2015. It has been agreed that the CHP Committee would continue to meet in an informal advisory capacity until such time as the IJB is established. The CHP Committee can therefore make recommendations to Shetland NHS Board.

4.4 Risk Management

The Council has a statutory duty to ensure that local authority services are registered and adhere to care standards. Failure to meet care standards could result in closure of establishments.

The testing of equipment and records of maintenance and monitoring conform to best practice guidance. The Council also has a number of Health and Safety policies and procedures in place to support the service where necessary.

4.5 Equalities, Health And Human Rights
None

4.6 Environmental
None

Resources

4.7 Financial
None

4.8 Legal
None

4.9 Human Resources
None

4.10 Assets And Property
None

5.0 Conclusions

5.1 The Care Inspectorate has found that Annsbrae House is a friendly and welcoming service which continues to deliver a good level of care for its service users. It is appreciated by those who use the service and who were spoken with on the Inspection. A Grade 6 – Excellent has been achieved in the quality of Care and Support and this is testament to staff at Annsbrae House hard work and commitment to continuous improvement in the provision of quality and person centred services.

The recommendation in the inspection report is being addressed by the service and progress will be monitored through follow up inspections.

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26 August 2015

List of Appendices

Appendix 1 – Annsbrae House Inspection and Grading History

Appendix 1
Annsbrae House - Inspection and Grading History

Date	Type	Grading	
24 Nov 2014	Announced (Short Notice)	Care and support	5 – Very Good
		Staffing	5 – Very Good
		Management and Leadership	4 – Good

Date	Type	Grading	
25 Mar 2014	Unannounced	Care and support	5 – Very Good
		Staffing	5 – Very Good
		Management and Leadership	5 – Very Good

Date	Type	Grading	
22 Aug 2012	Unannounced	Care and support	6 - Excellent
		Staffing	6 - Excellent
		Management and Leadership	6 - Excellent

Date	Type	Grading	
11 Nov 2010	Announced (Short Notice)	Care and support	6 - Excellent
		Staffing	Not Assessed
		Management and Leadership	Not Assessed

Date	Type	Grading	
22 Mar 2010	Announced (Short Notice)	Care and support	6 - Excellent
		Staffing	5 – Very Good
		Management and Leadership	6 - Excellent

Date	Type	Grading	
2 Oct 2008	Announced	Care and support	5 – Very Good
		Staffing	4 – Good

Appendix 1
Annsbrae House - Inspection and Grading History

		Management and Leadership	4 – Good

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

Agenda Item

2

Shetland Islands Council

NHS Shetland

SHETLAND HEALTH AND SOCIAL CARE PARTNERSHIP

Social Services Committee and CHP Committee **30 September 2015**

Older People's Health and Wellbeing Strategy for Shetland: Living Long, Living Well	
CC-40-15 F	
Elizabeth Robinson, Health Improvement Manager, NHS Shetland	**Public Health Department**

1.0 Summary

1.1 The purpose of this report is to present the progress made towards meeting the aims of the Older People's Health and Wellbeing Strategy for Shetland: Living Long, Living Well and to present the plans for the next steps to be taken in delivering change and improvement..

2.0 Decision Required

2.1 That the Social Services Committee RESOLVES to, and CHP Committee recommends that the Shetland NHS Board, adopt the Older People's Health and Wellbeing Strategy for Shetland, including the action plan which sets out the further work necessary to achieve the ambitions of the Strategy.

3.0 Detail

3.1 Older People's Services are at the core of the Government's Adult Health and Social Care Integration Agenda and the Public Bodies (Joint Working) (Scotland) Act 2014. The strategy aims to meet the national health and wellbeing outcomes for older people in Scotland.

3.2 The Older People's Health and Wellbeing Strategy for Shetland covers the 10 year vision, principles, policies and financial detail of needs and services for older people, and forms the basis of a strategic commissioning plan for older people's services. The strategy includes a substantial analysis of the health and care needs of older people in Shetland, and assesses the impact of demographic and economic

changes over the next twenty years. The strategy proposes a framework of strategic intent, outcomes and actions to guide the commissioning of Older People's Services in Shetland, while meeting the challenges that face us.

3.3 The challenges for older people's services in Shetland include:

- **Growing public expectations** that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- **Demographic change** with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- **Increasing prevalence of long term conditions** and increasing multiple morbidity;
- **Technological change** e.g. in how care can be delivered through technology enabled care, for example, and through changing public expectations in how services can be accessed through advances in internet and mobile technology;
- **Reductions in public funding** due to the recession and current ongoing difficult economic climate;
- **Persisting inequalities in health**;
- **The need to demonstrate outcomes** not just process; and
- **The need to consider the sustainability of services**.

3.4 Shetland is already making good progress in changing its ways of working, but we need to do more. This will consist of continuing to:

- Keep people well by preventing those conditions that can be prevented, and encouraging self management where conditions cannot be prevented
- Nurturing and developing communities to support and utilise older people as full participants within those communities
- With the agreement of those being cared for, keeping carers at the centre of care provision – working together as true partners, recognising the needs of carers and providing appropriate support
- Continuing to re-focus services to actively support people to live at home, while reducing reliance on care, and managing risk sensibly. This will involve having access to information, advice and appropriate/appropriately adapted accommodation

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities
The Older People's Health and Wellbeing Strategy for Shetland: Living Long, Living Well is being delivered in partnership and supports delivery of a number of SOA (Single Outcome Agreement) priorities.

4.2 Community /Stakeholder Issues
The strategy makes the case for more prevention of ill health where possible, and quicker, more person centred care, as close to home as

possible. This reflects the feedback from the people, professionals and communities which were engaged with through the development of the strategy.

4.3 Policy And/Or Delegated Authority

The Social Services Committee, as the managing body for strategic plans under Community Health and Care, has delegated authority to take decisions in relation to those functions within its remit, including community care and community health and wellbeing.

The CHP Committee ceased to be a formal sub-committee of Shetland NHS Board on 1 April 2015. It has been agreed that the CHP Committee would continue to meet in an informal advisory capacity until such time as the IJB is established.

4.4 Risk Management

The risk of not having a strategy and not delivering the strategy's intended outcomes is that the improvement agenda is not met, which is likely to lead to increased ill health in the future, increased inequalities in health, and increased costs associated with the care of older people.

4.5 Equalities, Health And Human Rights

The strategy promotes equality, diversity and respect for people as individuals. Older people are seen as an asset and as full participants in the life of their community.

4.6 Environmental

No major implications identified, other than a general requirement to maintain or increase opportunities for physical activity and socialising for older people and to work towards creating a Dementia Friendly community.

Resources

4.7 Financial

The strategy recognises the future reduction in resources for health and social care in Shetland and Scotland, and the need to do more with less and work differently. The strategy suggests some ways of achieving this.

4.8 Legal

There are no implications arising directly from this report.

4.9 Human Resources

The strategy describes the challenges facing the workforce, including recruitment and retention, and underlines the importance of reducing reliance on local authority and health service staff by supporting people to take responsibility for their own health and wellbeing where possible.

4.10 Assets And Property

The strategy recognises that the current rural care centre model as it currently stands is unsustainable. Work is underway to understand the right mix of accommodation to meet the needs of older people in

Shetland. This is likely to involve a mix of residential care, housing with support, and adaptation of people's existing homes where possible.

5.0 Conclusions

5.1 Older People's Services are at the core of the Government's Adult Health and Social Care Integration Agenda and the Public Bodies (Joint Working) (Scotland) Act 2014. The strategy aims to meet the national health and wellbeing outcomes for older people in Scotland. The Strategy will drive improvements and the redesign needed to ensure that services continue to be sustainable and of high quality.

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13 August 2015

List of Appendices
Appendix 1 - Older People's Health & Wellbeing Strategy for Shetland – Living Long, Living Well.

END

NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

Name of document	Older People's Health & Wellbeing Strategy for Shetland – Living Long, Living Well	
Registration Reference Number		**New ☐ Review**
Author	Elizabeth Robinson	

Proposed groups to present document to:	

Date	**Version**	**Group**	**Reason**	**Outcome**
9th March 2015	1	PPF	(C/S)	PRO
	1.2	Community Nursing	(C/S, PI, PO)	PRO
	1.2	Area Clinical Forum	(C/S, PI, PO)	PRO
26th May 2015	2	Strategy and Redesign Committee	(C/S, PI, PO)	PRO
9th June 2015	3	Health & Social Care Joint Strategic Group	(C/S, PI, PO)	Meeting postponed
30th July 2015	3	Integrated Joint Board and Shetland NHS Board members	(C/S, PI, PO)	PRO

Executive Lead	Simon Bokor Ingram

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)

DATE	CHANGES MADE TO DOCUMENT
1/06/2015	Updating language to further integrate assets based, person-centred approaches e.g. from ‘clients’ and ‘patients’ to ‘individuals’
1/06/2015	Updated section on contribution of Pharmacy Services to keeping people well for longer, in their own homes etc.
28/07/2015	Updated figures on housing needs from Housing Department. Insertion of reference to "A look into the rear-view mirror" report from RCOP

Older People's Health and Wellbeing Strategy - Living Long, living well

1. Introducing the strategy

1.1 Background

Shetland produced an Older People's Strategy in 2003, which had an implementation action plan that was reviewed and updated up until 2008. At that time the business dealt with through the Older People's Strategic Planning Group became mainstream business for the Community Health Partnership (CHP) and the specification of services for Older People became a part of the Community Health and Care Partnership (CHCP) Agreement, with specific operational groups dealing with issues such as Discharge Planning. The Strategy Group therefore ceased to meet.

Though progress has been made across many areas of the strategy and action plan, and many of the themes remain relevant today, there have been a range of policy and service changes and developments since then in Older People's health and care, and in other relevant fields, that suggest it is now time to refresh and re-write the Older People's Strategy for Shetland.

1.2 National context

There are a range of policies and strategies which affect older people's health and wellbeing in Scotland. An overview of these is helpfully provided in **Health and Social Care of Older People in Scotland Policy Landscape,** published in 2013 by the Scottish Public Health Network.

The key themes of Scottish Government Policy at the moment are:

- **Developing person-centred services,** with personalisation driving the shape of all public services and a strong focus on developing a person centred approach to care and care planning;
- **Delivering quicker, more personal care, closer to home**;
- A shift of care from hospital to community;
- **A shift towards prevention**, with preventative care or anticipatory care rather than reactive management. The desire is to prevent problems before they occur and resolve problems effectively at an early stage when they do occur. By addressing the causes and not the symptoms of problems, for example, it is hoped to tackle rising demand and reduce inequalities;
- **Targeting action in deprived areas** (using anticipatory care approaches, for example) to prevent future ill health and reduce health inequalities;
- **Developing a systematic approach to managing long term conditions**;
- **Increased use of Telecare, Telemedicine and Telehealth solutions** to support local care delivery and diagnosis;
- **Supporting older people to lead more independent lives**, have more personal control over their lifestyles, care and environment and to live at home for as long as they want to;
- **Valuing older people** as an asset;
- Improving support for carers;
- **Greater involvement of patients and carers** in the design of services and greater involvement of communities in developing sustainable local solutions;
- **Developing an asset-based approach to health and social care** (which involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits), thus empowering individuals, enabling them to rely less on public services;
- Encouraging people to take greater control over their own health;

- **Promoting 'co-production'** (which involves delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours);
- **Agencies working together more effectively**, with an increasingly stronger focus on not just joint working but on the **integration of services**; and
- **Using an outcome based approach** to improve outcomes that are relevant to patients and their carers, with an increasing focus now on **shared outcomes**. [i]

There are a number of issues and challenges which underlie the themes listed above. These include:

- **Growing public expectations** that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- **Demographic change** with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- **Increasing prevalence of long term conditions** and increasing multiple morbidity;
- **Technological change** e.g. in how care can be delivered through telecare, for example, and through changing public expectations in how services can be accessed through advances in internet and mobile technology;
- **Reductions in public funding** due to the recession and current ongoing difficult economic climate;
- **Persisting inequalities in health**;
- **The need to demonstrate outcomes** not just process; and
- **The need to consider the sustainability of services**. [ii]

Of the billions of pounds of public funding spent in Scotland on health and social care for people over 65, over half is spent on care in hospitals and care homes, often towards the end of life, yet 89.5% of older people use universal services and are 'outside' the formal care system.[iii]

The Scottish Government's ***Reshaping Care for Older People****: A Programme for Change 2011 – 2021* (known as the Change Fund) was designed to produce an ambitious shift towards care at home and in community settings:

- co-produced with political, organisational and community interests
- shift towards care at home and in community settings
- greater investment in preventative and coordinated care and support
- use of technology to empower greater choice and control

In March 2010, *Reshaping Care for Older People: A Programme for Change 2011-2021* set out the Scottish Government's vision and immediate actions for reshaping the care and support of older people in Scotland.

The programme provided a framework, built on consensus across all sectors and interests, to address the challenges of supporting and caring for Scotland's growing older population into the next decade and beyond. It aimed to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

The framework was based on the vision that: "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting." Within the Programme there are three core themes (Care Settings, Complex Care and Community Capacity) with two supporting themes (Workforce and Finance and Analysis).

Local partnerships have been expected to develop joint strategies, commissioning plans and Local Change Plans to access funding from the Scottish Government's *Change Fund*. Shetland has benefited from the fund, and a number of innovations have been initiated. The

fund ceased at the end of March 2015. The Integrated Care Fund has been established as a national initiative, with funding to address all adult age groups, and similarly to the Reshaping Care for Older People fund is to be used to pump prime initiatives that include services for older people.

1.2.1 Integration and Requirements for Joint Commissioning for Older People[iv]:

- A **Joint Strategic Commissioning Plan for Older People** which should be of a **10 year time-frame,** reviewed and refreshed regularly, consistent with related local planning cycles
- A detailed **3 year Implementation Plan** relating to the Strategic Commissioning Plan for Older People; which should be a rolling three year planning document refreshed on an annual basis
- **One year investment plans** which provides the detail of investments and delivery arrangements for the short term change agenda, building on the impetus of the Change Fund which ended in March 2015, and has been replaced with an Integrated Care Fund that extends to all adult age groups.

For Shetland the Joint Commissioning Strategy is the high level commissioning framework, previously known as the Shetland Community Health and Care Partnership (CHCP) Agreement. Individual care group strategies and plans sit below this framework.

This Strategy for Older People will cover the 10 year vision, principles, policies and financial detail of needs and services for older people, and form the future Joint Strategic Commissioning Plan for Older People.

1.2.2 Transformational change – post-Christie

Renewing Scotland's Public Services: Priorities for reform is the Scottish Government's response to the Christie Commission Report. It outlines the Government's approach to and priorities for public service reform, which are built on 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.

Priorities for Reform describes a need for fundamental reform in public services, rather than incremental improvements, in order to respond to the challenging financial context and demographic trends. It maintains the Scottish Government's emphasis on improving outcomes for people and communities across Scotland, and on improving value for money[v].

1.2.3 Self-Directed Support: A National Strategy for Scotland (2010)

Self-Directed Support (SDS) gives people the opportunity to manage their own support funding. Self-directed support (SDS) allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the **individual budget** spent on their support.

The idea is that people in need of support work with professional staff to agree what support they need and how it should be provided.

The Government wants self-directed support to become the main approach to provision of support in Scotland.[vi]

There are a number of other terms which are used to describe this new approach to care, and it is worth describing them here:

'As a graduate of the Zsa Zsa Gabor School of Creative mathematics, I honestly do not know how old I am.' Erma Bombeck

- Co-production: where support is designed and delivered in equal partnership between people and professionals.
- Personalisation: this is about doing things to suit an individual rather than expecting individuals to fit into a one-size fits all service. It's about enabling individuals to achieve choice and control.
- Enablement: is about helping people to become more independent and improve their quality of life; it might involve learning or re-learning how to do everyday tasks rather than having these done for you.
- Assets-based: means using an individual's skills, knowledge, personal relationships, and other resources; resilience, commitment to learning, self-esteem, sense of purpose; it means using the positives of a situation rather than focusing on the negatives.
- Engagement: is about involving local people in planning and organizing service, for example, analyzing what is needed , planning and designing services, delivering them and monitoring and reviewing them.

NHS Shetland 2020 Vision and the **Scottish Government's 2020 Vision and Route Map**, describe the 'triple aim of Quality of Care, Health of the Population and Value and Financial Sustainability, and priorities that include Person Centred Care, Integrated Care, Care for Multiple and Chronic illnesses, Unscheduled and Emergency Care, and Health Inequalities';

Primary Care Strategy: Primary care is seen as being at the heart of the 2020 vision, keeping people healthy in the community for as long as possible. There is a need to develop a new local strategy that delivers on government priorities that include the 2020 Vision of expanded primary care, and new models of 'place-based' primary care. Working with communities, there is an opportunity to do things differently, teaching self-sufficiency and empowerment, and utilising the whole multi-disciplinary clinical team. The Primary Care Strategy will be developed during 2015/16.

Prescription for Excellence (PfE): provides a vehicle to deliver pharmaceutical care of NHS patients with an emphasis on the medicine needs and issues of older people. Pharmacists will endeavour to bring services closer to people. The pharmacist's role in encouraging and supporting the individual to manage their own condition(s) which is central to the concept of *co-production* is a key component within this approach.[vii]

'How old would you be if you didn't know how old you was?' Satchel Paige (1906-1982)

1.3 Definitions

We have not used any fixed definition of 'older person' in this strategy. Life expectancy varies quite considerably across Scotland, from 72.6 years for men in Glasgow to 80.1 for men in East Dunbartonshire and from 78.5 for women in Glasgow City to 83.4 years for women in East Dunbartonshire.

In terms of preventing poor outcomes later in life, it is clear that action needs to start much earlier, so in preventative terms, we should be thinking about

older people as those aged 50 and over. In addition, for more socially and economically deprived groups, the process of aging can start much earlier.

Older age means different things in different communities. At the moment, many people undergo a major transition in their lives between the ages of 60 and 65, when they retire from full-time work. The age at which this transition occurs will increase in the coming years, as the State Pension age rises to reach 66 for both men and women in 2020 and then to 68 in the mid 2030s.

1.4 Values and principles

This strategy will support us in moving to a new model of care, based on the principle that older people should be seen as a positive source of time and energy, life experience, special and sometimes forgotten talents and skills, accumulated wisdom and a unique perspective.

'To know how to grow old is the master-work of wisdom, and one of the most difficult chapters in the great art of living'
Henri Amiel

We aim to move away from the idea that older people use up valuable resources and think about the opportunities of later life. The Government's Active and Healthy Ageing Plan for Scotland states:

'Older people as empowered consumers and active participants of society and labour markets bring value to the economy and prosperity to local communities'.[viii]

That said, we have some way to go to unlearn the behaviours of the last few decades, where we have consistently disempowered people by delivering 'one size fits all' services. What this means in practice is that, for the last twenty years or so, the 'normal' route for older people has been from home to hospital, to care home, and sometimes to a hospice for the last part of their lives. We have seen older people as becoming a burden to society.

By their very nature, older people are the biggest single consumers of NHS resources, but they have also contributed huge amounts as active tax payers and members of communities. The biggest challenge for the foreseeable future will be to maintain the level and quality of care the people of Shetland have come to expect, whilst recognising that we will have less money to do this with.

Our goal is to prevent or delay entry into the formal care system (care homes, hospital) and to move away from a reliance on institutional care settings. The evidence suggests that this will help more people to remain active, independent and healthy for longer.

The central differences between the old and new models of care are highlighted in the table below:

Old Care Model	New Care Model
o Geared towards acute conditions o Hospital centred o Episodic care (Different people caring for patients at different times) o Disjointed care o Reactive care o Patient as passive recipient o Self care infrequent o Carers undervalued	o Geared towards long-term conditions o Based in, and part of local communities o Team based o Integrated, continuous care o Thinking ahead and anticipating problems and issues o Patient as partner o Older people are encouraged and helped to look after themselves.

o Low tech o Service led	o Carers are respected and supported as partners o Using technology to support people in their own homes, or to reduce the need for travel. o Outcome Focused

Ref: Reshaping Older People's Care, COSLA 2009

1.5 Aims and objectives

1.5.1 Local policy aims are consistent with national policy:

- To enable people to grow old in good health where possible
- To enable more older people to remain at home.
- To increase levels of independence, self-care and self managed care.
- To reduce unplanned, emergency and inappropriate admissions to hospital.
- To facilitate early discharge from hospital.

1.5.2 Overarching objectives, from the Shetland Community Planning Partnership's Single Outcome Agreement

We live longer healthier lives –

- Reducing health inequalities and increasing physical activity

People are supported to be active and independent throughout adulthood and in older age

- Developing Locality based resource allocation and management.
- Addressing our housing needs.
- Developing Self Directed Support Strategy
- Developing Third Sector

2. Developing the strategy

The strategy has been developed through a process of consultation and engagement with a wide range of people and agencies, and reference to national and international best practice.

We have structured the information gathered to support the strategy as a needs assessment with three main components: epidemiology, demography and formal data available about the health and care needs of older people; the corporate assessment which is the official policy view on where the strategy should take us, and the consultative / participatory needs assessment which is the feedback obtained from the engagement with staff, older people and communities themselves about what is needed for older people in Shetland.

3. Needs Assessment

A huge local needs assessment has been undertaken, based on the national document *Health and social care needs of older people in Scotland: an epidemiological assessment* published by Scottish Public Health Network (ScotPHN) in 2013.[ix] The data and information used to inform the epidemiology have been drawn from a number of sources including local information systems; the ScotPHN Needs assessment as above; the Scottish Public Health Observatory (ScotPHO) online profiles tool for older people; the Information and Services

Division (ISD) website; the Scottish 2011 census; the Scottish Health and Household Surveys and other national surveys. ScotPHN has also published a separate Health Needs Assessment specifically for dementia.

Wherever possible Shetland specific data has been used. However, for some topics there is no local data available, or survey sample numbers are so small that it is not useful. In these instances, if it is a reasonable assumption that the Shetland population of older people are similar to the Scottish population then Scottish data has been used and applied to the Shetland population. Where the Scottish data or information source is not specifically stated, then it has come from the ScotPHN Needs Assessment.

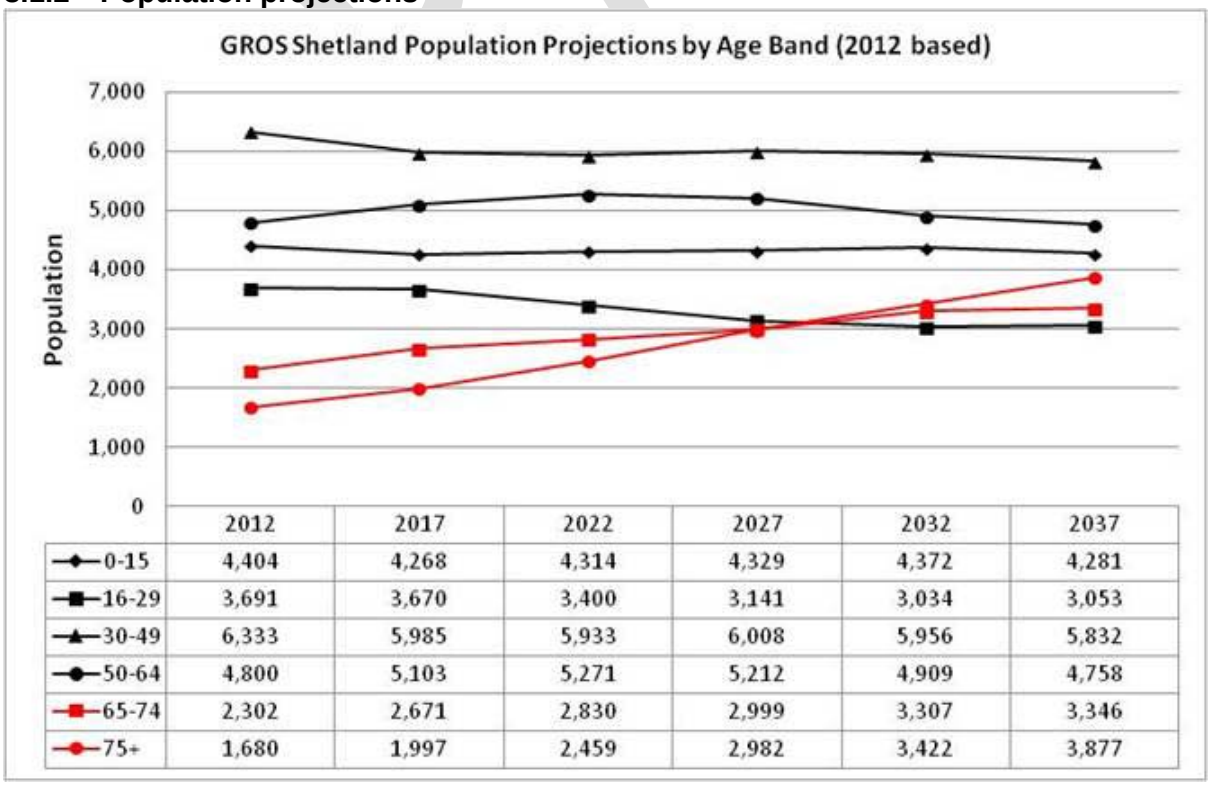
The full piece of work is presented in an annex to this strategy. However, the key points are set out below:

3.1.1 Age structure

	'Pre-school'	'School age'	'Young people'	'Working age adults'		'Older people'		
	0-4	**5-14**	**15-24**	**25-44**	**45-64**	**65-74**	**75-84**	**85+**
2011 Census	1389	2776	2746	5859	6620	2143	1178	456
(% of total population)	(6%)	(12%)	(12%)	(25%)	(29%)	(9%)	(5%)	(2%)
2014 GP registrations	1303	2592	2615	5659	6533	2454	1256	474
(% of total population)	(6%)	(11%)	(11%)	(25%)	(29%)	(11%)	(5%)	(2%)

Sources: *Scotland's Census 2011 website (www.scotlandscensus.gov.uk/r1-downloadable-files). Local GP data*

3.1.2 Population projections



	2012	2017	2022	2027	2032	2037
0-15	4,404	4,268	4,314	4,329	4,372	4,281
16-29	3,691	3,670	3,400	3,141	3,034	3,053
30-49	6,333	5,985	5,933	6,008	5,956	5,832
50-64	4,800	5,103	5,271	5,212	4,909	4,758
65-74	2,302	2,671	2,830	2,999	3,307	3,346
75+	1,680	1,997	2,459	2,982	3,422	3,877

As well as increasing in numbers, older people will also make up a bigger percentage of the Shetland population. The percentage of older people in Shetland compared to the rest of Scotland will also increase.

3.1.3 Gender

The number of men and women aged 65 to 74 is similar, but there are more women than men across the older age groups, which is the same pattern across Scotland. However, it is predicted that over the next 20 years, the number of older men (aged 70+) is projected to increase more rapidly than the number of older women, especially among the very oldest groups.

The difference in the number of men and women is significant because they may have different health needs (for example breast and gynaecological cancers which affect women and become more common with age). Also their care and support needs may be different: for example a preference for same sex care workers.

Gender breakdown of the older age groups in Shetland

	65 - 74	75-84	85 -94	95 and over
Male	1051	508	139	7
Female	1092	670	181	29

Source: *Scotland's Census 2011 website www.scotlandscensus.gov.uk*

3.1.4 Geographical variation in population ageing

There are differences in the age profile of different communities across Shetland. Four practices, including the largest in Lerwick, have an over 65 population of around 18%. Brae and Scalloway have younger populations; there are known to be more younger families and a larger working age population in these areas. The three island practices of Unst, Yell and Whalsay along with Walls on the Westside have the highest percentage populations of older people: around a quarter, and nearly 30% in Unst.

3.2 Life circumstances - physical and social environment

In Shetland there is a very high proportion of older people living specifically in the most access deprived areas. 2010 data showed that 2575 (67.9%) of people aged 65 and over lived in the 15% most access deprived areas. The national average is 15%. For people aged 85 and over 72.4% (354) lived in the 15% most access deprived areas, with the Scottish average also being 15%. Within Shetland, this means a huge reliance on transport. Although some people may live close to local amenities such as the GP surgery, local shop and post office, many people are not within a reasonable walking distance. As people age, they are less likely to be able to drive and/ or have access to a private car due to a number of issues including specific health problems such as dementia, loss of confidence, sensory impairment and disability related to aging; and financial constraints. This leaves a reliance on public transport and community transport and help from carers and neighbours.

In the 2011 Census, around a quarter of those aged 65-74 described themselves as economically active. In 2012 there were 140 adults aged 60+ claiming incapacity/severe disability allowance. Minimum income standard research suggests that pensioners claiming Pension Credit are guaranteed incomes close to their minimum requirement.

Information from the local Shetland Housing service notes that:

- The average household size is projected to decrease from 2.28 persons per home (2012) to 2.05 persons per home in 2037
- By 2037, 73% of homes in Shetland are projected to be occupied by just one or two adults.

- Projections show that by 2037, the number of households headed by someone aged 75+ is predicted to increase by 125% compared to 2012 figures. At March 2015, 4% of applicants on the housing register stated that they were registered disabled. A significant proportion of these will be older people.
- At July 2015, there were 240 housing applications who had been awarded medical points. Of these, 72 (30%) had been assessed as requiring the bedroom/bathroom on the same floor, and 59 (25%) required a level access property. This underlines the need for future-proofing and adapting properties.
- Almost half of applicants with the maximum award of medical points (46%) remain on the joint SIC and Hjaltland Housing Association (HHA) housing register a year later. This is a strong indication of the lack of accommodation available to meet the household's medical condition needs Medical points are awarded based on current and not future anticipated need; this is more of an indication of the general pressure and demand for housing. Future-proofing the housing stock and anticipating adaptations as a preventative measure could help to meet medical condition needs without the need for a house move.
- There were 49 applicants who had been assessed as requiring sheltered or very sheltered housing at July 2015. Of these, 16 (33%) require the highest priority of sheltered or very sheltered housing (support 24 hours a day). The remaining 67% required less support in the home but still had a requirement for some level of assistance. It is important to stress that although sheltered housing is traditionally associated with older households this is a housing option available to households of all ages that require support.
- There are specific issues for older people with learning disabilities, including with accommodation. Currently 53% of people attending Eric Gray Resource Centre services (i.e. with Learning Disabilities) live in the parental home, with the age of parents ranging from early 40s to late 70s. 43% live in a Supported Accommodation tenancy and 4% have their own independent tenancy

3.3 Health related behaviours

In general, older people are less likely to smoke and drink alcohol, but more likely to have a poorer diet and take less physical activity compared to younger adults. We have some local data on smoking and alcohol, but currently little data on nutrition and physical activity.

Whilst the rate of current smoking is lower in the over 65 age group compared to younger adults, the rate of ex-smokers is high, and there will continue to be a burden of smoking related diseases within this group. Although smoking can cause premature mortality, it also causes long term debilitating conditions which cause significant morbidity and disability, and associated use of health and social care services

Alcohol related admissions and deaths in 2011 (most recent figures on ScotPHO health profile)

	All aged 65 and over	Aged 75 and over	Aged 85 and over
Alcohol related admissions – number	94	18	<5
Alcohol related deaths	5	<5	N/A

The Scottish Health Survey 2011 shows that fruit and vegetable consumption falls with age (this is one of the key indicators of a 'healthy' diet). Although 23% of men and women aged

65 and over eat 5 portions or more of fruit and vegetables a day, which is more than the percentage for people aged 16 -64 (22% overall), within the older age group there is a decreasing trend, down to 18% amongst the over 85s.

3.4 Health status

3.4.1 Life expectancy

Life expectancy in Shetland as in Scotland as a whole, has increased over time. People in Scotland currently aged 65 might expect to live, on average, another 15-20 years, and those currently aged 75 another 10-12 years.

Children born in 2010 can expect to live to 76.1 years for men, and 80.6 years for women. This will further increase and children born in 2035 are expected to live to just over 80 years, and women to 85 years. However, although life expectancy is rising overall, there are inequalities between different populations.

Life expectancy is not the same as 'healthy' life expectancy; and how healthy the population is as it lives longer is a key issue for health and social care provision.

Both men and women in Shetland have a longer life expectancy than those in nearly every other Health Board area other than Orkney. In Shetland, the same as in all other Boards, women have a longer life expectancy. The tables below also show the difference between life expectancy and 'healthy' life expectancy: i.e. how many years people can be expected to live with ill health: this is significant in terms of burden of ill health and need for health and social care services.

Life expectancy (LE) and healthy life expectancy (HLE) at birth in years, in Shetland: 5-year period 1999-2003

	Life expectancy: upper and lower 95% confidence levels			Healthy life expectancy: upper and lower 95% confidence levels			Expected number of years in 'not healthy' life
Male	**75.4**	**74.2**	**76.5**	**70.4**	**70.0**	**70.7**	**5.0**
Female	81.0	79.9	82.0	74.5	74.1	75.0	6.4

3.4.2 Self-reported health status

The proportion of adults rating their health as 'good' or 'very good' reduces with increasing age. The reporting of poor, or very poor, health amongst those aged 65 and over is associated with deprivation, smoking status and alcohol consumption.

2011 Census data shows that overall, in Shetland, 86% of people self report their health as good or very good; and 3% as bad or very bad. Amongst the oldest age group, 85 and older, only 36% report their health as good or very good; and 17% report their health as bad or very bad.

3.4.3 Limiting long term conditions

Two thirds of men and women aged 65 years and over in the Scottish Health Survey reported a long term health condition, and the prevalence increases with age. 1 in 3 adults aged 65 and over self reported musculoskeletal problems; 25% heart and circulatory problems and 10% respiratory problems. (see below for further detail).

3.4.4 Mental wellbeing

Mental wellbeing, as measured on a population level using the Warwick –Edinburgh mental Wellbeing Scale (Scottish Health Survey), is higher amongst people aged 65 and over in Scotland compared to those aged 16-64; but it then decreases with age amongst older adults.

Among adults aged 65 and over the likelihood of having poorer mental wellbeing was increased in men who are single, divorced or separated; and men and women who were widowed, compared with those married or living together. Presence of a long term condition and low levels of physical activity also decreased mental wellbeing.

3.4.5 Disability

The prevalence of 'disability' is difficult to measure because it is difficult to define and subject to interpretation.

Data from the 2011 census shows how many people in Shetland self reported how much their daily activity was limited: the table below shows that there is a significant increase in the proportion who are limited a lot in their day to day activities between the 'younger' older age group and the oldest group, from 12% to 58%.

Age group	Total no.	Day to day activities limited a lot	Day to day activities limited a little	Day to day activities not limited
65-74	2143	266 (12%)	505 (24%)	1372 (64%)
75-84	1178	337 (29%)	398 (34%)	443 (38%)
85 and older	456	265 (58%)	123 (27%)	68 (15%)

Source 2011 Census

When looking a primary care prevalence data, hypertension appears as the commonest condition, followed by heart disease and stroke. It is likely that many of the people with multimorbidities will have a combination of these because hypertension is a risk factor for the other conditions, along with diabetes.

3.4.6 Multiple Morbidity

While estimates of disease prevalence traditionally tend to focus on single conditions, in practice many patients have multiple, long-term conditions, requiring continuity and coordination of care. Managing multiple, long-term conditions is one of the biggest challenges facing the health care system.

The prevalence of multimorbidity increases substantially with age, as shown by the table above. Onset of multimorbidity occurs 10-15 years earlier in people living in the most deprived areas compared with the most affluent.

3.5 Use of health and care services

Shetland and the other island boards have a relatively lower percentage of older people attending for outpatient appointments compared to other Boards. Fractured neck of femur is one of the most frequent reasons for emergency admissions of older people to hospital. Fractured neck of femur is associated with older people and is usually the result of a fall; there may therefore be scope to reduce the number of fractures through falls prevention work. Bone fragility (e.g. due to osteoporosis, especially in women) is also a factor in the risk of fractures following a fall, and improved bone health may reduce the risk of fracture.

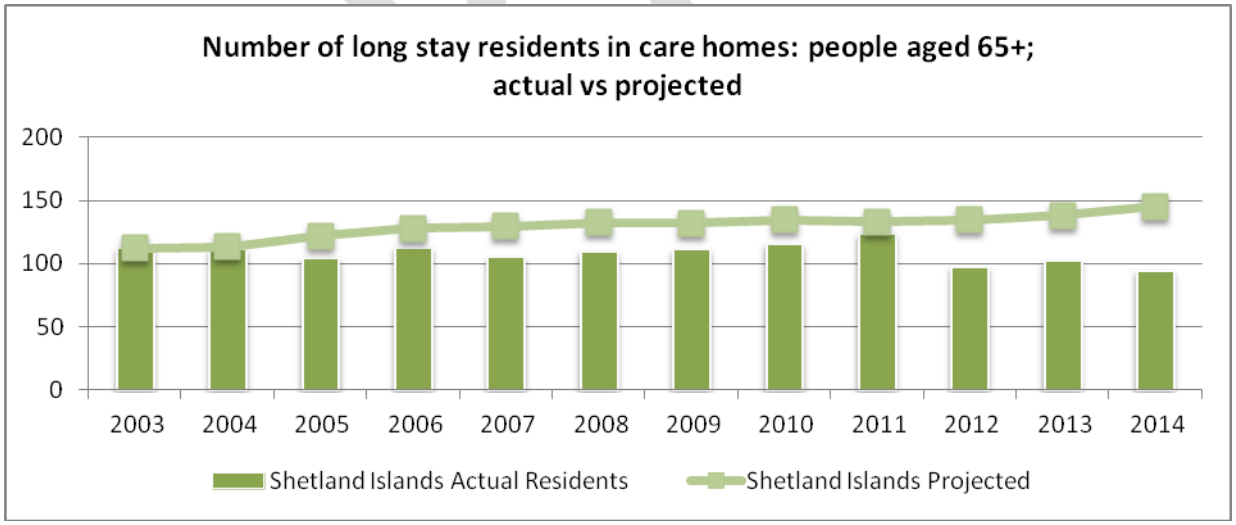
3.5.1 Hospital Length of Stay

Length of stay	65-74	75-84	85+
1 day	528	432	144
2-7 days	967	887	592
8 – 28 days	355	478	334
Up to 26 weeks	75	121	138
Over 26 weeks	4	9	6

The above table shows the range in the length of stays for older people admitted to hospital. This shows that the majority of patients are in hospital for 2-7 days, with a very small number in for over 6 months. There is a continuing trend to reduce the length of stay in hospital with people only being admitted and kept in if absolutely necessary. However, this is reliant on the appropriate social and health care being available in the community, and often the confidence of the patient, family, carers and / or staff in supporting the patient in the community.

3.5.2 Long stay residents in care homes

The following table is taken from a Reshaping Care for Older People report: A look in the Rear view mirror[x]. It shows that the numbers of long stay residents in care homes has not increased in Shetland at the rate that had been predicted. Other information shows that Shetland is reasonably below the Scottish average in terms of the numbers of people aged 65+ staying long term in care homes.



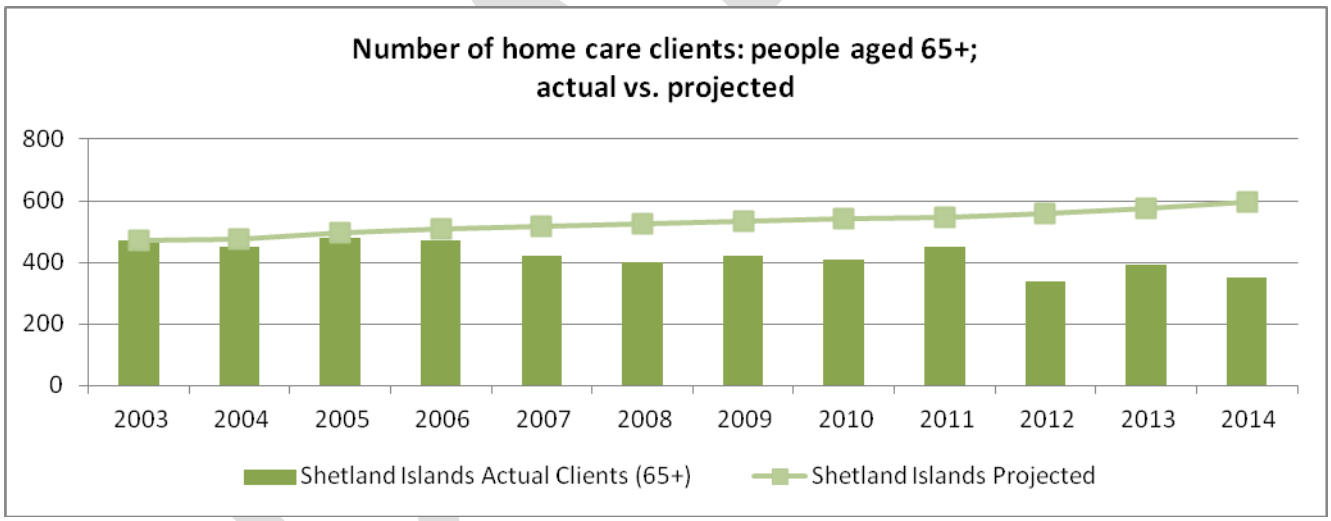
3.5.3 Care provided at home

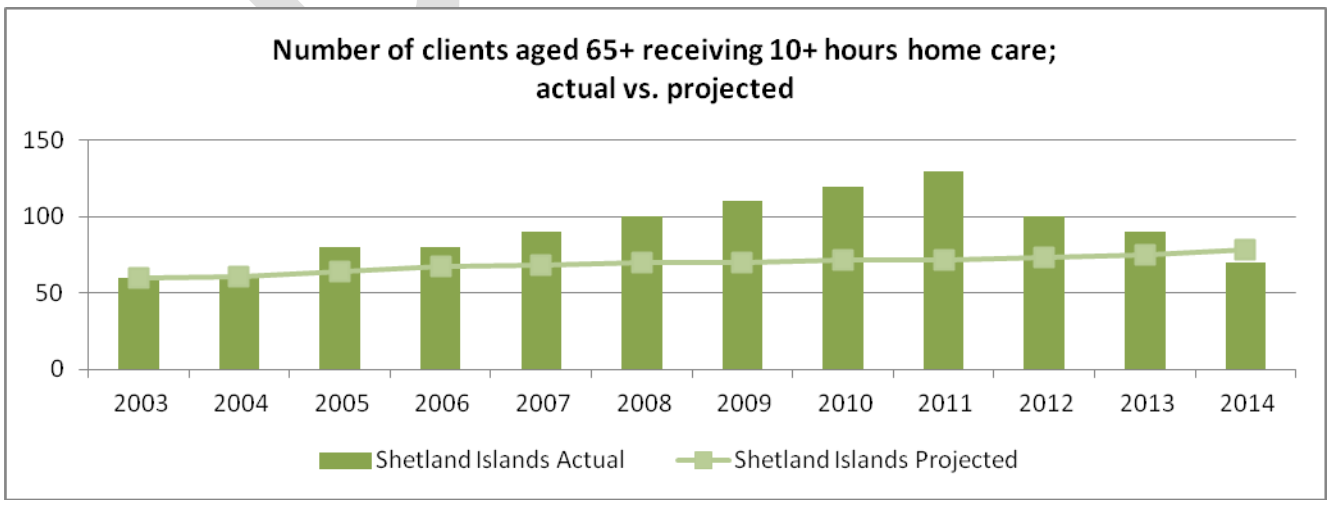
In recent years, the provision of free personal care to people in their own homes has moved away from providing tasks such as cleaning or shopping and moved more towards a preventative model of home care, characterised by short term targeted interventions based on enablement and rehabilitative models. This has led to a reduction in the use of home care. Access to care at home is controlled by specific eligibility criteria which are designed to ensure that care is provided to those in need. Despite this, Shetland provides care at home to more people aged 65+ (rate per 1000 population) than the national average and have done so consistently other than in 2009 and 2010.

Number of individuals in Shetland aged 65+ receiving free personal care services at home 2003/04 to 2010/11

	2003-4	2004-5	2005-6	2006-7	2007-8	2008-9	2009-10	2010-11
Shetland	190	190	170	180	210	220	240	230

The following two charts[xi] show that the number of home care clients aged over 65 has reduced over recent years, and not risen as predicted. The numbers in Shetland are proportionately smaller than elsewhere in Scotland.





3.5.4 Adult Support and Protection

The first interagency review of social work files has shown that there were 206 adults referred on adult support and protection grounds between April 2013-March 2014. Of these, 28 were over the age of 65. The majority of grounds for referral were financial (10 cases) and psychological (11 cases). Physical, self harm and neglect were the other grounds for referral. Three cases went on to be investigated, while the remainder either didn't meet the three point test (explain) or led to a review of existing care plans.

3.6 Carers

According to the 2011 Census, between 8% and 9% of people in Shetland were unpaid carers.

Of that number:

- **38.6%** are 50-64 years old
- **17.4%** are 60+ years old
- **42%** of carers have one or more long term condition.

Of the 42 who have one of more long term condition:

- **23.5%** have deafness or partial hearing loss
- **6.9%** have blindness or partial sight loss
- **0.1%** have a learning disability
- **6.8%** have a learning difficulty
- **1.2%** have a developmental disorder
- **18.8%** have a physical disability
- **12.3%** have a mental health condition
- **73.5%** have an additional or other condition

4. Corporate Assessment

Much of this section is taken from NHS Health Scotland's work on developing a Strategic Outcomes Model for Optimising Older People's Quality of Life, which supports the Scottish Government's aim of encouraging health and social care services to move towards a preventative approach that increases the number of people who remain active, healthy and independent for longer, as well as having potential cost-saving benefits. From a joint commissioning perspective, it is important to understand what a full range of effective preventative services might look like.

Research indicates that although older people are not a uniform group, their values in terms of quality of later life are consistent:

- Self-determination and involvement in decision making
- Personal relationships
- Social interaction
- A good physical and home environment
- Getting out and about
- Accessible information
- Financial security.

In addition, for those with higher support needs, having good support from and good relationships with carers.[xii]

4.1 Long term outcomes:

4.1.1 Quality of life

The main elements of quality of life in later life are: psychological (independence, an optimistic outlook on life); health (good health and mobility, physical functioning); social (social participation and support) and neighbourhood social capital (local facilities and sense of security). These factors appear to contribute more to older people's perceived quality of life than material and socio-economic circumstances, such as income level, educational level and home ownership.8

We can think about wellbeing as being generated at an individual level; but we can also understand it in terms of social engagement and interrelationships between people as well as social capital - the educational, social, and cultural advantages that a person might have.

Physical health & function

Maintaining good physical health and function is an important factor in older people's quality of life, although it is possible to have poor physical health alongside a sense of wellbeing. Ill health and managing long-term health conditions impact on relationships and experiences of loss, and can cause instability and uncertainty. Deteriorating physical health and disabilities can limit older people's capacity to engage in social life and maintain relationships, particularly if this includes loss of hearing, sight and speech.

Mental wellbeing

Being mentally well in later life is associated with adaptability and resilience and the ability to cope with loss and decline. There can be different types of loss: loss of physical capacity; loss of valued activities; loss of relationships with people who have been important to you; and coming to terms with not always 'being the person you used to be'. The experience of loss and decline may also come with deteriorating physical ill health which has emotional and psychological impacts. These include a loss of confidence and self-control and anxiety, related to, for example, going out alone, crossing roads, and negotiating public space and

places. Managing the psychological aspects of ageing and ill health, such as fear, anxiety and vulnerability, is more difficult if combined with increasing social isolation.

Independence

The value placed on maintaining independence is central to older people's sense of wellbeing. When asked, older people value independence in terms of having choice and control over where and how they live their lives and being able to contribute to the life of the community, and for that contribution to be valued and recognised. Becoming dependent and accepting help can be difficult. Older people may be reluctant to ask for help because of not wanting to be a burden or fearing a loss of independence and control. Asking for help can also be difficult because of a fear of rebuff or rejection.

Quality of end of life (not addressed in detail as part of this strategy as the Shetland Palliative Care and End of Life Care Strategy is already in place.)

The experience of death and bereavement is a central feature of later life and optimising the quality of the end of life is important for older people. This is addressed within the Shetland Palliative and End of Life Care Strategy which was updated in 2013.

In summary, the main principles of Palliative Care and End of Life Care Strategy are to:

- Identify people who would benefit from palliative care, and to develop care plans with people that include establishing preferred place of care and preferred place of death;
- Maximise the time spent in peoples preferred place of care (e.g. home or community setting);
- Minimise emergency admissions where these could be avoided through good anticipatory care planning;
- Support realistic choice of place of death (taking into account a holistic assessment of patient, family and carer needs). Responders to the consultation have made it clear to us that whilst more people would to prefer to die where they live, rather than in an acute hospital setting, choices must be considered against a realistic assessment of circumstances, support, individual needs, and therefore feasibility of delivery.

There are a number of actions that remain to be completed which are detailed in the Action Plan attached to the Palliative Care Strategy.

4.2 Medium term outcomes

There are a number of medium term outcomes that influence the longer term outcomes:

These include:

- Keeping/more healthy and active
- Physical and social environments are more age-friendly
- Keeping more socially connected
- Keeping/more financially and materially secure
- Systems work better for older people
- Personalised care and choice?

Who should we be targeting and how?

One way of working out who we should be targeting and how, is to think of older people in terms of the following categories:

a. Older people who are healthy, active and independent, including carers
b. Older people who are at risk/in transition, including carers
c. Older people who have high support needs, including carers

Older people who are healthy, active and independent, including carers

Active ageing allows people to realise their potential for physical, social and mental well-being throughout the life course and to participate in society, while providing them with [the] adequate protection, security and care they need. It involves continuing to participate in social, economic, cultural, spiritual and civic affairs...active ageing aims to extend healthy life expectancy and quality of life for all people as they age.'[xiii]

Evidence appears to tell us that, among older people, self-reported health and wellbeing does not seem to worsen at the same rate as the prevalence of disability and long-term conditions. This may suggest that people can still live well in spite of or with health conditions.

One of the ways of measuring the proportions of the older population who are ageing well, is through healthy life expectancy (HLE). This is the length of time an individual can expect to live free of chronic or debilitating disease. We should also be supporting people who are caring for themselves or receiving informal support to be healthy, active and independent.

Older people who are at risk/in transition, including carers

Some older people may be experiencing limitations due to long-term physical or mental health problems such as diabetes, musculoskeletal conditions, heart and circulatory system conditions, respiratory conditions, hypertension, poor mental wellbeing or dementia. It also includes people who may be at risk of developing long-term conditions owing to, for example, obesity, smoking, drinking above recommended levels of alcohol, poor diet or being physically inactive. People in this group may experience multimorbidity (the presence of two or more chronic conditions). The prevalence of multimorbidity increases with age and also occurs 10–15 years earlier in people living in more deprived areas.

This group may already be making greater use of statutory health and social care services as well as receiving informal care. They may also be at greater risk of unplanned or emergency hospital admissions.

Delivering for Health (2005) outlined a model with three levels of care for people with LTCs

Level 1 Supported self care (also known as self management) covers the majority of people with LTCs (70-80 per cent). Most of these people are thought to be able to manage their own conditions with appropriate advice and support.

Level 2 Shared care relates to around 15-20 per cent of people with LTCs who require additional care and support to manage their conditions.

Level 3 Intensive professional care is a more coordinated and proactive approach known as intensive care management or case management. This approach is required for a small proportion of the population with complex needs, who often have more than one condition (up to 3-5 per cent).

Older people who have high support needs, including carers

The Joseph Rowntree Foundation's (JRF) five-year programme A Better Life: Valuing our later years, defines older people with high support needs as: 'Older people of any age who need a lot of support due to physical frailty, chronic conditions and/or multiple impairments (including dementia). Most will be over 85 years old, though some will be younger. Many will be affected by other factors including poverty, disadvantage, nationality, ethnicity, lifestyle etc. Some of the very oldest people may never come into this category.' This group includes people in nursing homes or residential care or receiving high levels of health and social care in the community. It may also include those receiving end of life care.

We also need to be supporting and developing professionals and service providers – Services have a critical role in improved outcomes for older people, including generic and specialist professionals in primary, secondary and tertiary health and social care as well as a range of independent and third-sector providers, including providers of home care, day care and residential and nursing home care. In itself, this suggests the broad scope for effecting change, but also the complexity of achieving this given the range of carers, other supports within the community, and different professional and provider groups.

We know that preparation for health and wellbeing in later life needs to start in the early years and continue throughout life. It is vital that any intervention has a sound evidence base.

Evidence Based Interventions:

Interventions should be based on an appropriate and proportionate joint assessment of the target group, where they are located and the outcomes which are to be met: careful planning is the cornerstone of success.

Work with other organisations and the community itself to decide on and develop initiatives.

Build on the skills and knowledge that already exists in the community, for example, by encouraging networks of people who can support each other.

Take account of – and resolve – problems that prevent people changing their behaviour (for example, the costs involved in taking part in exercise programmes or buying fresh fruit and vegetables, or lack of knowledge about how to make changes).

Base all interventions on evidence of what works and evaluate all interventions.

Train staff to help people change their behaviour. [xiv]

'We've put more effort into helping folks reach old age than into helping them enjoy it.' ~Frank A. Clark

Keeping more healthy and active

The main socio-economic determinants of healthy and active ageing include poverty, which has a negative effect on health, life expectancy, disease and disability, and financial stress, which has a detrimental effect on the ageing process. The lifestyles adopted across the life course also influence, and are influenced by, physical health and function. Lifestyles include a wide range of health-related behaviours, such as smoking, diet, exercise and alcohol consumption, which are in turn influenced by socio-economic position. Smoking and excessive alcohol consumption is less common in older people than younger age groups, although approximately a quarter of people aged 65–74 years still smoke. Eating the recommended levels of fruit and vegetables is poor generally in Scotland and tends to get worse with increasing age. Likewise, physical activity levels are relatively low and worsen with increasing age.

Diet and Nutrition:

Good nutrition plays a vital part in the health and wellbeing of older people, and in delaying and reducing the risk of contracting disease.

In general, healthy eating advice is the same for older people as for the rest of the population, with a few exceptions. Whereas for the general population the emphasis is placed on good diet to prevent obesity, it is generally agreed that the risk of under-nutrition, rather than obesity, is the main focus of concern for those aged over 75. An increase or decrease in body mass is a risk factor associated with functional decline in older people. An

excessive reduction of lean body mass is, for example, one of the seven indicators of frailty described by Ferrucci et al.

Falls Prevention

One in 3 people aged over 65 falls every year. Many of these falls can be prevented with the right advice and interventions

A Falls Policy is in place in Shetland. It aims to:

> *'Those who think they have no time for bodily exercise will sooner or later have to find time for illness.' Edward Stanley (1826-1893)*

- reduce the total number of falls occurring in the community by providing a user-centred approach to reducing the risks of harm and promote safety
- heighten awareness and knowledge of users and carers on the prevention and causes of slips, trips and falls
- provide guidance for the actions to be taken when a user has fallen.
- provide guidance on assessing for future risk of falls and fractures

Best practice is to identify cases where there is a high risk of falling at the earliest possible opportunity, then undertake a multifactorial risk assessment, with consideration of the following:

1. identification of falls history
2. assessment of gait, balance and mobility, and muscle weakness
3. assessment of osteoporosis risk
4. assessment of the older person's perceived functional ability and fear relating to falling
5. assessment of visual impairment
6. assessment of cognitive impairment and neurological examination
7. assessment of urinary incontinence
8. assessment of home hazards
9. cardiovascular examination and medication review**.**

There are a range of interventions which are recognised as being effective in reducing the risk of falling, usually including:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal.

Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function. [xv]

Physical Activity

Participation in physical activity across the life course is highly likely to impact positively on all the long-term outcomes. The Swedish National Institute of Public Health (2007) concluded that exercise is 'the best preventative medicine for old age and significantly reduces the risk of dependency in old age.'

A preventative approach to improving the quality of later life should have a strong emphasis on encouraging and promoting physical activity among older adults. The Toronto Charter for

Physical Activity sets out a call for action to create sustainable opportunities for physical activity lifestyles for all. For older people the benefits can include independence, less risk of falls and fractures and protection from age-related diseases.

Some examples of effective interventions:

Exercise and physical activity

Exercise programmes and interventions to increase physical activity are the most commonly recommended interventions for optimising physical health and function in older people. A number of reviews have assessed the benefits of physical activity and exercise on the health and wellbeing of older people.

Barriers to older people initiating and adhering to exercise programmes include lack of confidence to exercise and a belief that exercise is likely to do more harm than good.

Mental Health & Wellbeing

Maintaining positive mental health & wellbeing throughout life and in older people

The living environment of home and neighbourhood makes an important contribution to optimising older people's quality of life. This may be through opportunities for social interaction or aspects of the physical environment such as housing, streets and contact with nature. Being able to get out and about independently is reliant on local access to affordable transport, mobility equipment and having money to pay for taxis.

For older people with high support needs living in supported housing, there is qualitative evidence that they value their safety and security (actual and perceived physical safety), their living environment, financial security, emotional security and continuity of care.78 Positive attributes of sheltered housing include fostering self-determination, a sense of safety/security, privacy for personal relationships (especially for couples) and opportunities for wider social interaction. Aspects of the housing and social environment that contribute to quality of life include:

- the extent of regular contact with family
- ongoing involvement in the community
- the impact of longer-term disabilities versus those acquired later in life
- accommodation, such as space standards, location, security
- on-site service provision, for example scheme manager/support model, quality of staff
- availability of additional care/support, including specialist support for residents with specific needs.

There are strong associations between the long-term outcome of positive mental health and wellbeing and levels of social connectedness, including levels of community trust, social support, positive social relationships and networks.

'He who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition, youth and age are equally a burden.'

Plato (427-346 B.C.)

The Optimising Older People's Quality of Life Outcomes Framework provides information on the importance of building social connectedness and community engagement, and evidence of effectiveness of interventions to achieve well being in older people.

Examples of effective interventions: befriending, Crossroads-type visits that encourage social

interaction; home visits by nurses and other healthcare professionals

Older people living independently in their own homes have potentially a lot to gain from home visits by nurses and other healthcare professionals. The aim is to improve health and physical function and help to avoid unnecessary admission to a hospital or nursing home. A review of preventative primary care outreach interventions concluded that home visits were associated with a 17% reduction in mortality and a 23% increased likelihood of continuing to live in the community.

Technology Enabled Care

Technology Enabled Care refers to the provision of health and care-related technology services, home health and care monitoring, and patient education at a distance using telecommunication technologies. Telephone-based care services can combine telemonitoring with health messages. Telemonitoring refers to telecommunication devices that enable automated transmission of a patient's health and/or care status and, from a distance, to the respective health and/or care setting.

In the frail older group, most of the benefits of technology enabled care are shown for 'information and support services' where case management by telephone has been found to improve clinical outcomes and improve adherence to treatment.

The potential benefits of technology enabled care interventions reported by the University of Leeds include:

- delayed entry of people with dementia and other comorbidities to institutional care
- enabling more people to be discharged early from hospital
- cutting unnecessary costs from health and social service care, such as home visits and overnight sleeping services
- reducing risks such as fire, smoke, gas and falls in the homes of older people
- assisting in the management of specific conditions, e.g. monitoring vital signs
- enabling frail older people to summon assistance rapidly when needed
- providing support and reassurance for carers.

Technology enabled care may be particularly useful for people living in remote areas of Scotland and, although it may not directly prevent unplanned hospital admissions, it seems plausible that it may lead to optimising physical health.

4.3 Role of the Third Sector

The Third Sector contribution to care for older people logic model describes the ways in which the Third Sector can most usefully and effectively contribute to the Reshaping Care for Older people Agenda. This model is useful in that it works backwards from an outcome focus. The intermediate outcomes are:

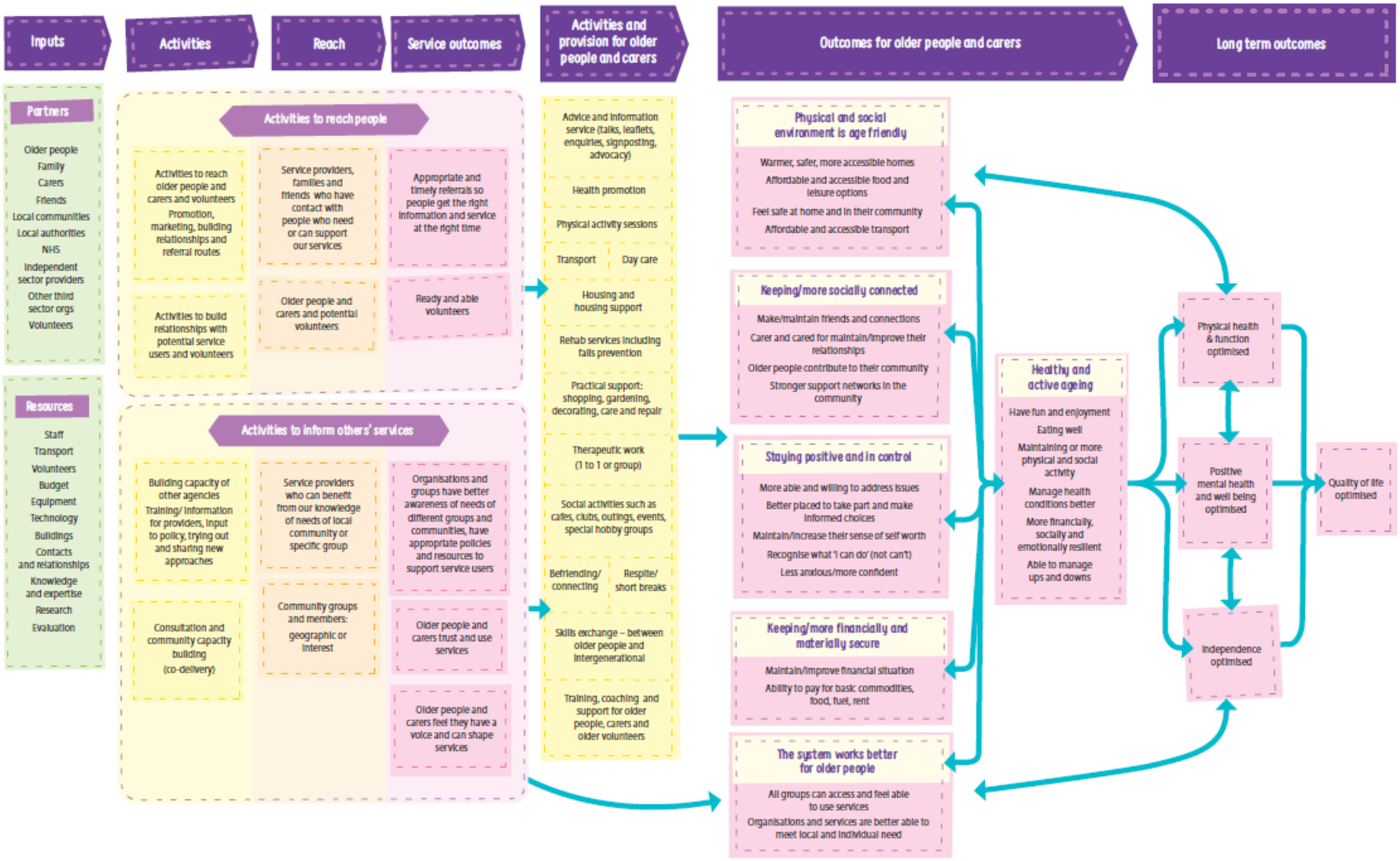
- Physical and social environment is age friendly
- Older people are staying or becoming more socially connected
- Older people are staying positive and in control
- Older people are keeping more financially and materially secure
- The system works better for older people

The activities that would lead to these outcomes are then described, with recommendations for who they should be targeted towards. These activities range from advice and information services to practical support, to rehabilitation services, to training, coaching and support for carers or older volunteers.

Evaluation Support Scotland have also developed a set of indicators - a 'Stitch in Time Indicator Bank' http://www.evaluationsupportscotland.org.uk/media/uploads/resources/final_ess_sit_indicator_bank_web.pdf which will help those involved in commissioning and delivering Third sector services in clarifying the work that they should be doing and how effectively it is being delivered.

The Third Sector contribution to care for older people logic model is depicted on the following page:

Third sector contribution to care for older people



5. Consultative / participatory needs assessment

This section is written from the information received from the engagement and consultation with groups and local communities working with, caring for and living with older people, and older people themselves. Feedback has been grouped into themes, for ease of reference.

5.1 Keeping people healthy and well

5.1.1 Living in communities

With our increasing older population, we need to value the contribution that older people make, and focus on getting older people involved and active in the community. Some people in Shetland feel isolated and lonely, and do not have the connections that they would like, and older people are one of the groups most at risk, as are carers, and people with health problems.

We know that poverty has an impact on how well older people connect, and so does access to computers and IT (often linked), and that more needs to be done to tackle both[xvi] . Older people and carers are two of the groups less likely to be online, who arguably could benefit most.

Many opportunities for participation by older people already exist and could be built on, enabling older people to connect, contribute and share skills through intergenerational activities, time bank, volunteering, evening classes and college community learning classes, through self-directed learning groups, lunch clubs, carers groups, befriending and University of the Third Age. There is scope to widen and to increase self-organising groups, and the Local Authority Community Development team and voluntary organisations such as Royal Voluntary Service have a role to play in helping to develop these and build on the informal supports that already exist in local communities.

5.1.2 Strengthening communities

In remote areas community initiatives have had significant successes, for instance increasing population, increasing economic and social activity, providing local shops and transport and addressing priority needs such as access to broadband and social housing. However some areas, particularly the outer isles and more remote areas are increasingly fragile. There is potential to provide focussed support for these areas to build their capacity to identify and address what they want to change, and older people have a significant role to play in this.

Strong and active communities rely on local people getting involved in decision making through co-production, and this is more difficult for some people including older people. They may be less confident about being involved or making their voice heard, they may have difficulty in accessing places and processes where decisions are being made, and may find it more difficult to express their ideas and opinions about what matters to them.

With an increasing older population we need older people to be engaged and involved, as a part of developing community capacity building and community support. In addition we know this will reduce the risks to individuals of isolation and loneliness, and will help develop neighbourly support and local social and care networks, to prevent the risk of admission to hospital or residential care.

5.1.3 Being active and staying healthy

Older people want to stay healthy and active for as long as possible, and we need to do more to prevent ill health in older people, and to help people keep themselves healthy while they can.

Some groups are less likely to be active that others, particularly older people. Although there are a large number of groups that support people to be physically active, there is scope to

widen participation by those who would not normally take part, and tailor opportunities for more physical activity suited to older people. We would want every older person to have access to appropriate activities in their local community.

5.2 Managed self-care and anticipatory care

Anticipatory Care is a more formal system of anticipating and preventing ill health in people with known chronic conditions. People themselves can take control of their own health through supported self management, and Community Nurses and community care workers have a key role to play – they notice when someone is deteriorating and can act, they can then deal with issues before they become problems. Some areas e.g. Brae felt they could do with more input into specific areas such as falls prevention.

5.3 Respite

People really value the role of respite care in care homes or in peoples own homes, particularly for carers to be able to 'recharge their batteries'. There is a small number of people on the waiting list for residential care. Some care home staff felt there was a large number of individuals requiring respite, with some difficulties in transfer of information about these individuals, for example, when someone registered with a GP in one area comes to live in a care centre in another area, and this causes difficulties.

5.4 Discharge from hospital

Delayed discharges continue in small numbers. As more people are supported at home, there is an increasing risk of delayed discharges due to timescales required to make adaptations to property.

There is a recognition that getting people discharged from hospital when they are ready to leave is an important part of getting them back on their feet or into their home community, but how it is planned and communication when it happens is really important. This is particularly true in remote areas when issues like medication supply (e.g. getting stocks of new drugs) can sometimes be difficult, and letters back to the GP in a timely way are important so that carers know how they need to look after the individual.

The Housing service is keen to be involved in discharge conversations as early as possible. They felt they had a critical role as a key partner in assisting with early interventions and preventative actions to ensure that people can live safely in a homely environment, in some cases avoiding the need for hospital admissions and the prospect of delayed discharges.

5.5 Reablement

As pressure increases on Care at Home services to support people with higher levels of need at home, there is a risk that less time can be given to reablement tasks which enable people regain the skills required to achieve independence.

Some care centre staff felt that they were more successful doing reablement two years ago than they are now because they had more staff to be able to support this. Reablement holds out the most hope for getting people back on their feet and able to look after themselves, but takes more time and needs regular reviews – a high level of input is required.

5.6 Accommodation

Brucehall terrace (Extra Care housing) is a model of housing with care and support that allows people to remain in their own homes. it is staffed for 24 hours but at a lower level than a care centre. This has worked well, as a community of people of different ages. Brucehall Terrace is an example of a flexible approach to meeting housing, care and support needs. The Housing Service, through its Local Housing Strategy want to continue to support this type of accommodation model. A further pilot project was carried out in the

North Isles to demonstrate that cost-effective conversions of existing sheltered housing stock was possible and is a model that can be replicated in other areas., However it is noted that due to demand for smaller sized accommodation and a mismatch in supply and demand, there is a need to manage expectations in how quickly this model can be replicated.

During our consultation, there was a strong call for more King Erik type (extra care) accommodation, where people have their own tenancies in units that are easier to manage as their own home on a day to day basis. Housing for life is a model of supported living that can happen in someone's own home, where that is suitable, or in adapted housing. It provides choice, is seen as being more 'normal', and doesn't necessarily involve communal living. The cost of keeping someone in their own home is 25% of the cost of placement in a care centre, which means that there is more funding available to support a greater number of people who need care.

What makes the difference is the support that is provided to make remaining in ones own home sustainable. What are the low level supports needed to keep folk in their houses? The role of housing support workers is felt to be undervalued – housing support needs to be available in appropriate places, and integrated as part of local communities.

One respondent felt that in twenty years time we will look back and think how cruel it was to put our old folk into care homes. There was a feeling that resources at the moment are tied up in supporting people who might have been supported differently, perhaps in their own home or an adapted tenancy.

The perception of staff at one Care Centre was that there is no supported accommodation in that area anymore, and no warden.

5.7 Workforce

Respondents described a significant amount of change recently in the workforce within the local authority and current challenges with recruitment. There is a pressure on staff to do things differently and sometimes this means doing more with less. Training budgets are smaller and at the same time staff are being required to work towards SVQ 2 or 3.

There were seen to be significant challenges in terms of recruiting care staff at the moment – the numbers go up and down, depending on the numbers of people needing care. There was a feeling that the reintroduction of ferry fares between Yell and Unst has been a disincentive to people travelling to work in Unst, especially for part time staff. There was a feeling that posts would be more likely to be recruited to if they were advertised as permanent rather than temporary contracts.

The outer isles felt disadvantaged in terms of access to some types of professional staff. Examples included Physiotherapy staff only coming to Yell and not to Unst; and the Health Visitor only visiting ½ a day per fortnight.

Some staff felt they had difficulty in providing the right quality of care because of limited resources and competing priorities, for instance, GPs responding urgently to Adult Support and Protection issues.

It is clear that there are some particular challenges in the care workforce, which include the age profile and gender balance of the current workforce and the desire to attract younger recruits and those looking to change careers into care; and the increasing qualification requirements from the Scottish Social Services Council. The geography of Shetland, demands for care in peak times, and the fluctuating nature of these demands all make it more challenging to deliver SVQ assessment to the workforce while recently the buoyant economy locally has meant that there are alternative employment opportunities. Different approaches are being trialled in order to attract more young people into care, for example through modern apprenticeships, and the Shetland Learning Partnership is providing work based placements in 5th and 6th year aimed at getting more young people to take up career

opportunities in care. Team Leaders are looking at rotas to make sure these are attractive to recruiting and maintaining good quality staff. Additionally, the service is looking at its recruitment practices and considering how it can best harness all ways of reaching applicants including social media, and awareness raising at local events.

5.8 Integration

The feeling among staff was that integration makes complete sense – if we can't do it in Shetland, we can't do it anywhere. It would be really useful to be co-located i.e. daily meetings between social care workers and community nurses. It would provide continuity of care, for example around discharge information. It might create the possibility of delegated responsibilities. Integration might remove some of the unintentional duplication which can happen; for example, two nurses turning up at someone's house because of manual handling needs, as the care staff are just leaving the house.

5.9 Palliative care

There was also a strong theme running through the feedback obtained in developing the palliative care strategy, which noted the importance of positive psychology, self management and raising public awareness regarding 'living a healthy life and having a good death'. There was an emphasis on how we need to work together to support people to have conversations about 'life and death' in a positive way, in an attempt to change the societal culture and taboos, which are associated with talking about death and dying. Providing appropriate psychological services, counselling and information for people who need additional support to manage their grief and loss following the death of a loved one, was also considered a key aim to be incorporated into this strategic plan.

5.10 Dementia

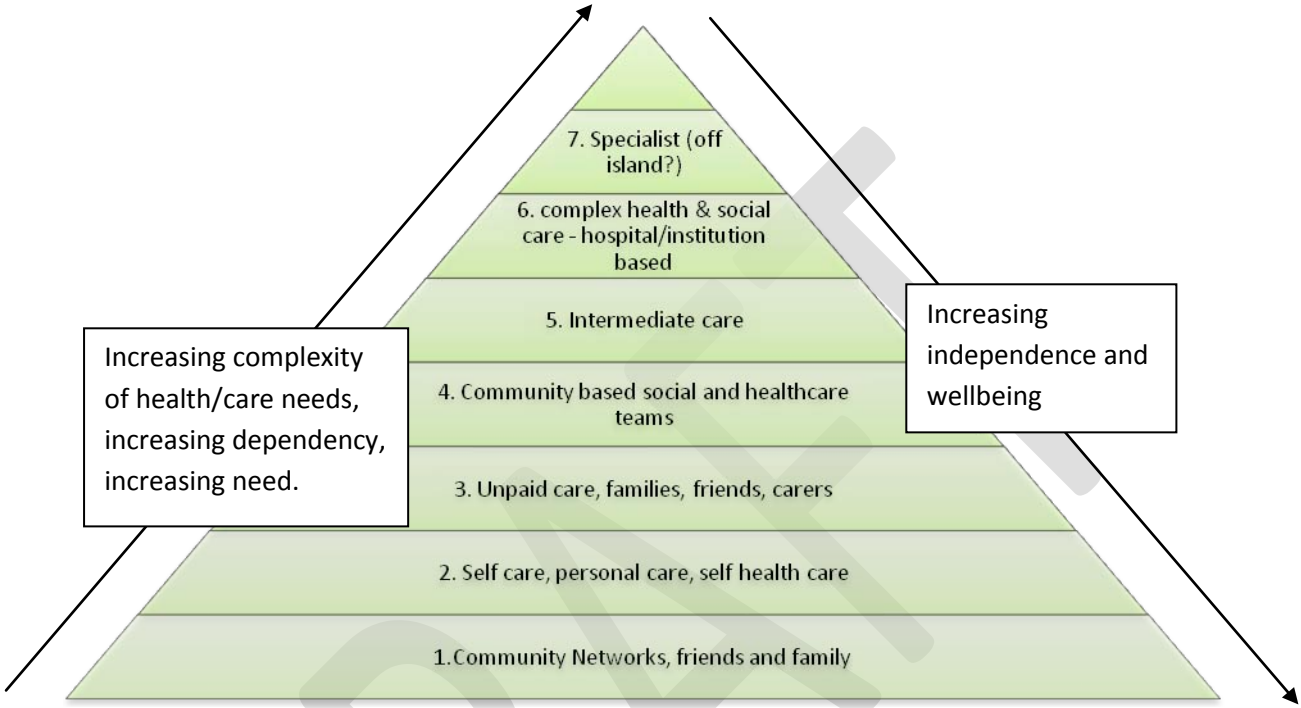
A level of anxiety exists in the wider community about interacting with people who have dementia. The development of the dementia strategy is being progressed which will describe the steps we need to take to describe a dementia friendly society.

5.11 Adult Support and Protection

The Adult Support and Protection (Scotland) Act 2007 made it a requirement that every local authority area established a inter agency Adult Protection Committee which introduced and oversees the local Adult Protection Procedures. Shetlands Adult Protection Committee is an active interagency forum that ensures interagency working to act against harm to any adult in Shetland. The aim is to offer adult protection training to all staff providing services to older people to ensure that physical, emotional, financial, psychological, sexual and discriminatory abuse and neglect are recognised and reported.

6. Current Service Provision

Current service provision is described in terms of the tiers of care triangle below, bearing in mind that people move up and down the triangle, and that our aims are always to support people either to remain at the lower tiers or to return to lower tiers as soon as possible.



6.1 Education, Community Learning, general involvement in community

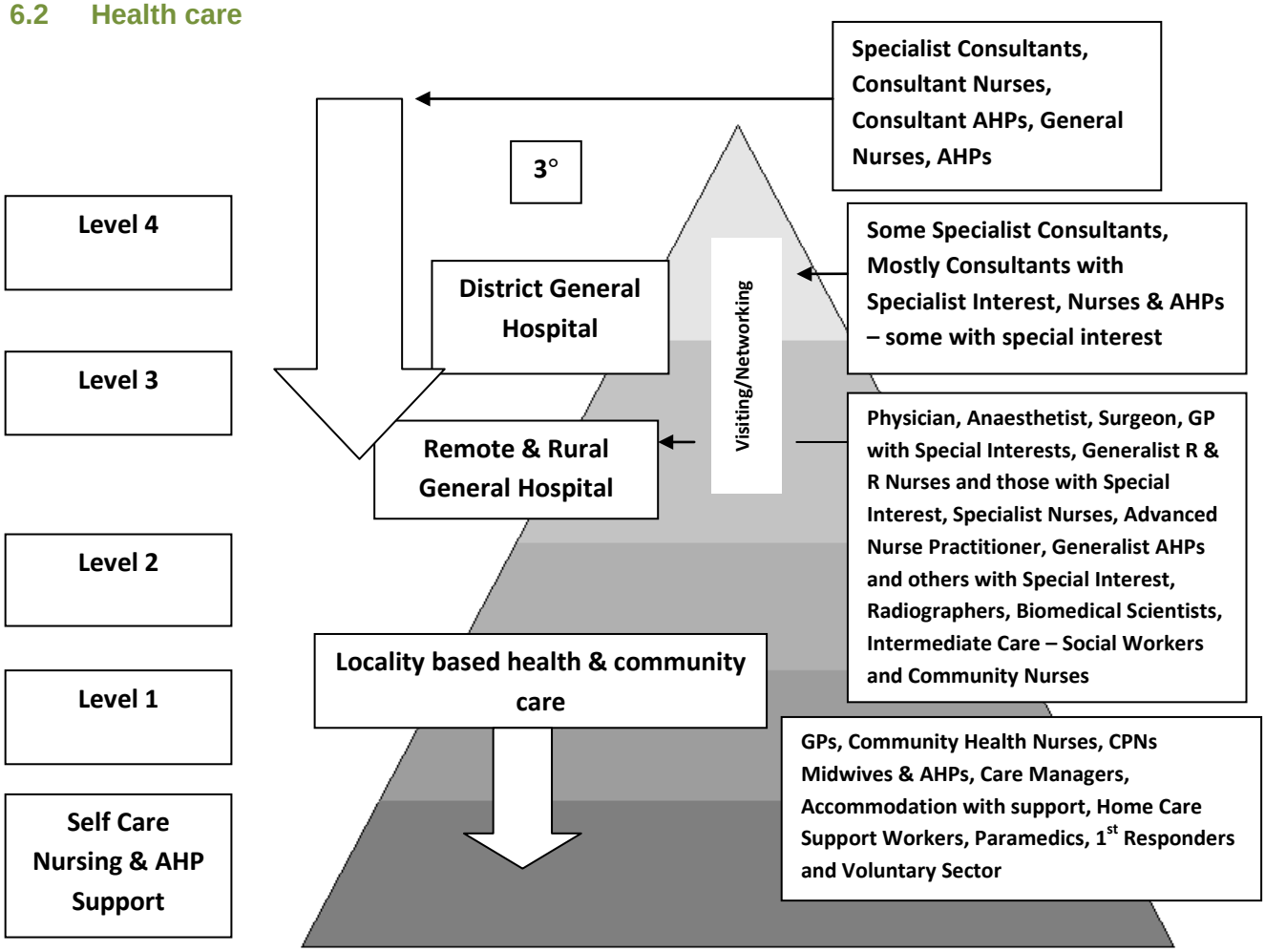
A recent analysis of community learning identified arrange of opportunities that are available to older people within the local community. These aren't necessarily aimed exclusively at older people, but certainly include them. The list includes evening class programmes, University of the Third Age (U3A), and groups such as with Scottish Rural Women's Institute (SWRI).

There are a number of activities which can be seen as being relevant to the general population, but play a vital role in keeping people well or potentially preventing conditions worsening or admission to hospital.

These include:

- Tai Chi – Arthritis Care deliver adapted programme for people with arthritis
- Chair Based Exercise – Awards for All have given us £10,000 to roll out across Shetland.
- Disease specific exercise programmes e.g. cardiac rehab, neurological groups – not just for older people
- Physical activity Pathway being rolled out
- Walking programmes

6.2 Health care



Level 1 Community Health & Care

At all levels of the health and care triangle, older people have access to the same range of generic health and care services as those provided to all people in Shetland.

Within these generic services there are some that have specific relevance to older people:

Services for people with Long Term Conditions and those supporting self-care and self-managed care

All primary care services have a role in supporting people with long term conditions. Long term conditions include health problems e.g. diabetes, asthma or disabilities and affect people of all ages. Services aim to support self-care and self-managed care and support from community networks and resources across all sectors.

Anticipatory care plans are put in place for people in the community who have long term conditions and / or are at risk of admission to hospital. Community nurses have a lead role in supporting anticipatory care and preventative work linking with GPs and other local service providers e.g. community care residential and care at home and housing support services.

Complex care at home and in community settings

In Shetland community nursing care is accessible to individuals within their own home, or a care home, 24 hours a day, seven days a week, 365 days a year.

Intermediate Care Team – this multi-disciplinary, partnership team provides additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

Shetland has in place a model of multi-agency, multi-disciplinary assessment and care management through single shared assessment, the "With You For You" process, which is for all adults with support needs but becomes increasingly important for older people with multiple morbidities (health problems and care needs).

Older people are more likely to be receiving multiple medications and be at risk from complications due to the incidence of side effects which can increase as with ageing. The pharmacy service provides medicines reviews and chronic medication services through primary care teams and working with care homes. These activities help to ensure that older people are not receiving medicines which are likely to do more harm than good, and helping people to develop an understanding of how the benefits of each medicine can be maximised.

Palliative and end of life Care
The aim of Palliative Care in Shetland is to provide appropriate, high quality palliative care in all care settings that is person- centred, safe and effective, and to provide a comprehensive rapid response service for palliative care.

People living at home or in residential care are supported by their GP, community nursing service, specialist nurses, and social care services. Specialist support and advice is available from the Macmillan nursing team and other specialist Long Term Conditions nurses e.g. cardiac, stroke, continence , dementia and MS nurses. Access to specialised services is through the remote and rural general hospital in Shetland and NHS Grampian. Most of the expenditure on palliative care and Long Term Conditions is included in budgets for services provided to other care groups and cannot be identified separately.

Previously palliative care focused on the needs of people with cancer; however, we need to ensure the needs of all people requiring palliative care are addressed. We have restated this in the updated Palliative and End of Life Care Strategy which was produced in 2014, particularly the need to look at ways in which we can develop models that support 'strengthens based approaches' to help people living with long term conditions to focus on 'ability', 'self management' and positive conversations about living with a life limiting or palliative condition.

Mental ill-health in old age including dementia
Local assessment, diagnosis and support services are in place for people with dementia, as is specialist care through health and social care supports. The local team is made up of specialist nurses with a visiting consultant in old age psychiatry.

Level 2/3 Hospital care

The majority of older people's acute health care at hospital level is dealt with through the Gilbert Bain Hospital working as the local Remote & Rural General Hospital.

Level 2 Acute Care

A transitional, rehabilitation unit is under development in order to provide end of life care, more appropriate and timely discharges, and continuing care needs.

The Ronas facility will focus on providing time limited rehabilitation to maximise patient's potential following an episode of acute illness or deterioration of an existing long term condition. The unit will have 6 inpatient beds and 6 ambulatory care beds for patients who do not require an overnight stay in hospital.

The introduction of a fast stream rehabilitation unit/pathway is part of a wider programme of redesign focussed on older people's care which includes:

Developing rapid response options for community based care (voluntary, health and social) to as alternatives to hospital admission and to support discharge; (currently have 5 or 6 people at any one time who are making the choice to wait in hospital until the care home of their choice becomes available.

- Intermediate pathways to support people to achieve maximal independence and recovery (e.g. time limited, slow stream rehabilitation) in the community;
- Specific pathways to support patients with palliative and end of life care needs (as per the current strategy);
- Redesign of dementia services in the community;
- Implementation of *Prescription for Excellence* to ensure the most effective use of medicines

The implementation of the other services/pathways is important to and interdependent with, the changes proposed for older peoples care in hospital. Core funding and investment (e.g. Change Fund) is being used to develop these new services.

Level 3 Long Stay Hospital

There are 6 inpatient and 6 ambulatory beds designated for 14/15 which provide a range of services for predominantly older people on Ronas Ward in the Gilbert Bain Hospital. Services include long-term health care, medical assessments, slow stream rehabilitation and some palliative care.

Pharmaceutical Care

Medication is by far the most common form of healthcare intervention. Four out of five people in Shetland aged over 75 years take a prescription medicine and 36 percent are taking four or more. Local and national evidence would suggest that up to 50 per cent of drugs are not taken as prescribed and many drugs in common use can cause problems. Adverse reactions to medicines are implicated in 5 - 17 percent of hospital admissions. Pharmacists and pharmacy technicians are needed to support patients in taking their medicines. Most patients are taking or receiving their medicines in their own homes, and work is being piloted to support this, particularly in the Lerwick area where there has been an impact both in the patients experience and benefits from medicine and in reducing wastage.

The Managed Pharmacy Service covers the following areas in relation to older people:

- Supporting General Practices, both dispensing and non dispensing, in demonstrating safe and effective prescribing

- Working within Care Homes and meeting patients in their own homes to help to ensure patients are receiving medicines safely and appropriately and that waste is avoided
- Providing prescribing clinics, run by pharmacists, such as polypharmacy reviews to minimise the harm and maximise the effect of medicine regimes.
- Developing patient safety programmes, supporting people in managing their own health through the Public Health Service Minor Ailments can be allow some medicines to be supplied free of charge by a pharmacist, supporting people to take responsibility for their own health. And when older people need a little bit more help in ordering and managing their longer term medicines, the Chronic Medication Service is available.
- A named pharmacist will be identified for patients requiring medicine on a regular basis, this pharmacist will follow the patients medicine and pharmaceutical care needs when they are in hospital at home or in living in a care setting.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

Unscheduled care

The areas we need to work on here are:

- Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and discharge planning models need to be revised.
- Developing a strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community assessment and support options.
- Focus on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so.
- Reducing the number of people who are delayed in hospital.
- Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable.
- Developing ambulatory care and day care models as a safe alternative to inpatient care.
- Developing monitoring and evaluation systems and procedures based on personal outcomes, which span across services.

6.3 Housing and Accommodation

The Housing Needs and Demand Assessment is the evidence base for the Local Housing Strategy.

At present, the following extra care housing is available:

- King Erik House, Lerwick, 17 flats
- Brucehall Terrace, Uyeasound Unst, 8 bungalows
- Annsbrae House, 9 flats

Sheltered Housing consists of 33 schemes, across Shetland. These properties are available in the first instance to any adult eligible to be on the housing waiting list and who is assessed as requiring housing support services.

The Housing Service has developed a flexible model of housing support provision across locality areas. The redesigned service is now a fully community based service and is no longer restricted to traditional sheltered housing model. The Service has adapted properties to meet dementia-friendly standards already in place – with relatively cost effective measures.

The Housing Service has a clear commitment through the priorities of the Local Housing Strategy to work with a range of partners to provide housing support to vulnerable members of our communities, focusing on the importance of support at home to maintain residence in the community.

6.4 Social care

Residential, day services and care@home are available for older people, some of whom may have dementia; and for adults with learning disabilities. The establishments providing these services in Shetland are listed below. Residential care places may be used for long term care or short breaks (respite.)

The social care service enables older people to remain at home by increasing levels of independence, self-care and self-managed care. The service aims to reduce unplanned, emergency and inappropriate admissions to hospital and facilitate appropriate discharge from hospital wherever possible, through the use of Care at Home and Care Centre resources.

The service has the following elements, delivered from a number of hubs around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

In a week, the services deliver approximately 2200 hours of personal and domestic care in people's own homes to approximately 350 individuals.

Services are offered to meet assessed needs in the following circumstances:

- to enable people to maintain their independence and remain at home;
- to prevent admission to hospital or residential care;
- to facilitate discharge from hospital;
- to provide support to someone who is at risk of neglect or abuse.

Social Care services available to support older people in their own homes include:-

- Care at Home Services providing high levels of personal care and help with domestic tasks
- Dementia Services Partnership – Care at home support specialising in dementia care
- Crossroads Care Attendant Scheme providing short breaks at home
- Meals on Wheels
- Occupational Therapy
- Aids and adaptations
- Lunch Clubs
- Community Alarm
- Telecare

These services are available to people in all community care groups depending on an assessment of individual needs.

Care at home services and meals on wheels are managed locally from care centres.

Voluntary/Third Sector

There are a number of voluntary organisations, which provide support to older people. These include:-

- Advocacy Shetland
- Age Concern – based on Age UK, provide advice for anyone in difficulty; used to provide a Good Companions Club, but social work do a lot of these types of thing now.
- Alzheimer Scotland
- Red Cross
- Senior Citizens Clubs
- WRVS
- Crossroads
- Citizens Advice Direct Payments Advisor

There is a range of different clubs/support groups e.g. Islesburgh 60 Plus Club, Nesting & Lunnasting Golden Circle Club, Sandsting and Aithsting over 65s

More information on voluntary services available can be obtained via Voluntary Action Shetland's home page http://www.shetland-communities.org.uk/vas/

Community Alarms

The community alarm system in Shetland is widely used with currently 567 units being monitored by Hanover Telecare; this monitoring covers a wide variety of environmental and personal alarms.

Technology Enabled Care

Additional equipment such as GPS monitoring and "Just Checking" systems for activity assessments are examples of technology now in use. These are used in both the community and Care Centres. Within Care Centres a variety of sensors such as bed occupancy sensors and door alarms are used to keep residents safe.

Older People with Learning Disabilities, Autistic Spectrum Disorders and Complex Needs.

Day care for older people with learning disabilities and autistic spectrum disorders is currently provided for by the Growing Old with Learning Disabilities (GOLD) group which runs 3 days per week at Newcraigielea, using staff there. The GOLD Group will eventually integrate with day services provided by Eric Gray Resource Centre. This will have an additional benefit of releasing staffing resources at Newcraigielea to meet the increasing demand for short break and respite provision under current eligibility criteria.

6.5 Carers

"A carer is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live without the carer's help due to frailty, illness, disability or addiction.

The support a carer provides may include moving and assisting (manual handling); help with feeding, personal hygiene and administering medication; as well as providing emotional support, acting as an advocate or guardian for the cared-for person and enabling the person with support needs to access leisure and recreation." [xvii]

The legal definition of a carer is 'Someone who provides substantial amounts of care on a regular basis to either an adult or a child, where that adult or child receives, or is eligible to receive, support services under the Social Work (Scotland) Act 1968 (section 12AA) or the Children's (Scotland) Act 1995 (Section 24)' (p.4)National Minimum Information Standards for Carers Assessment and Support

Consequently the need for unpaid and family carers is going to grow for the foreseeable future. Carers are key partners in care provision alongside the statutory agencies and organisations in the voluntary and independent sector.

Carer's rights include

- the right to a carer's assessment and equal rights for young carers (carers aged under 16)
- the right for carers to be informed by local authorities and the NHS of their entitlement to an assessment
- the right for carers to have their views and their contribution to the care provided taken into account in decisions made about the services to be provided for the cared-for person [xviii].

Services Available

- Carers assessments
- Carer support groups
- Meeting support
- Signposting to support services
- Virtual Carers Centre – one stop to information for carers and new support and learning project.
- Carer identified training
- Short break `Me Time` carer grants and travel assistance
- Carer trips
- Online support
- Facebook information page
- Focus groups
- Carers Cruise

Services specifically designed to meet the needs of carers include:-

- advice and information including a range of materials from the Stirling Dementia Centre
- training opportunities
- independent advocacy
- peer support, including a range of carers support groups, the Carers Link Group, Outreach project to Unst.

There are a range of short breaks available including

- residential short breaks for older people; older people with dementia; adults and children with learning disabilities and adults with mental health problems
- day services for older people; older people with dementia and children and adults with learning disabilities

- short breaks at home – Crossroads Care Attendant Scheme
- Short breaks and respite can also be arranged in a personalised manner through Self-Directed Support

The Scottish Government has set national targets for increasing the amount of short breaks available. In Shetland the level of short breaks is high and increasing year on year.

The Carers Strategy identifies the following unmet needs or issues

- There is increasing demand for all existing service provision and this trend is expected to continue for the foreseeable future.
- Lack of affordable transport, particularly in the more remote parts of Shetland, limits access to some services.
- Home-based care in an emergency is generally not available e.g. where the main carer at home becomes ill and cannot provide essential care. Residential short breaks are usually offered in this type of situation.
- There are limited training opportunities for unpaid carers and low take up of training that is on offer. Carers have said that they do not want to spend time out from caring on training courses that are often half or full day events.
- Volunteer services to support vulnerable people to do things like going shopping or undertaking other activities in the community would provide respite for carers and improve the quality of life for the cared-for person.

6.6 Recreation and leisure

Shetland Recreational Trust provide a number of different classes and opportunities for older people, including active afternoon, a senior leisure club and Fitness Vive (60 is the new 40).

Shetland has an active voluntary sector which provides a range of local clubs which support older people and more often than not are provided, organised and staffed by older people e.g. :

Gulberwick Senior Citizen's Club

Northmavine Happy Hour Club

Sandsting & Aithsting over 65s

Unst Senior Leisure Club

Walls & Sandness Senior Citizen's Club

Whiteness & Weisdale Good Companions

During 13-14, Shetland Charitable Trust provided £12,260 towards running costs of these, out of project costs of £28,805.

Many of these groups provide outings, lunch-clubs, and companionship.

6.7 Adult Support and Protection

All Social Workers in the Community Care Team are Council Officers in the terms of the Adult Support and Protection (Scotland) Act 2007 and undertake adult protection investigations. Quality assurance work carried out in 2013 and 2014 indicates that adult protection referrals are responded to quickly and appropriately and older people who may be subject to harm are safeguarded. Since May 2014 there has been a fortnightly interagency meeting that discusses any non- urgent adult protection referrals. This has proved to be a

valuable way of sharing information and planning - many referrals do not meet the three point test, but people may need responses under other legislation e.g. Mental Health Care and Treatment Act or Adults with Incapacity Act or may require their care needs to be assessed or reassessed.

6.8 Housing and accommodation

The model of delivery of housing support continues to develop, with national and local emphasis focusing on the importance of providing support to people in their own homes and within their own communities, where possible.

Advances in Telecare and other health technologies are effective enablers to support people continuing to live in their own homes and communities. It is also the most cost-effective way of supporting vulnerable householders who are able to remain in their own home to do so, whilst providing additional services both remotely and in person.

As at 2014, the following accommodation is available within Shetland to older people with care needs:

Rural		**Permanent**	**Respite**
Care home	Fernlea	8	2
	North Haven	11	4
	Wastview	13	2
	Overtonlea	12	3
	Isleshavn	6	4
	Nordalea	6	1
Extra care housing:	Brucehall Terrace, Unst	8 bungalows	-
Lerwick		**Permanent**	**Respite**
Care home	ET and Taing House	38	3
	Walter & Joan Gray (Church of Scotland)	14	2
	Montfield Support Services	10 (2 permanent, 8 interim placement)*	5 (Emergency respite)
Extra care housing:	King Erik House	17 flats	-
Total		**143 permanent**	**26 respite**

*Another 3 beds will become available at ET and Taing Support Services during 2015.

We also need appropriate housing and accommodation, as described in the Local Housing Strategy. Where the opportunities arise, we should be creating/developing housing for life. The Scottish Government's Residential Care Task Force[xix] has recommended an evolution and expansion of the extra-care housing sector. While the housing and occupational therapy services will try to adapt people's existing homes where possible, in circumstances where that is not achievable then appropriate alternative accommodation with care and support should be considered as the next option. This can be achieved through a number of different models. Where possible this should be done through making best use of existing assets. New build provision should be carefully considered to ensure that the homes for life

model is applied, and that future needs are taken into account, with the understanding that new build provision takes time and does not provide an immediate solution. The development of the Primary Care strategy will take into account the role that health would play in delivering this.

The Task Force also recommends a growth in the residential sector focused on rehabilitation and prevention (step down/step up care) and a smaller more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs. In any case, we need to audit the physical infrastructure of the care home estate to provide a sense of what type of future investment might be required. It is likely that the Shetland Charitable Trust funding of the rural care centre model as it stands is unsustainable, so there is a pressing need now to determine the desired mix of accommodation to meet the needs of Shetland.

The decision making process will need to include comparison of the ranges of need and costs in order to better understand the comparative costs of residential care and housing with support. In Shetland we should undertake this work using the localities model of service planning and involving/engaging communities to understand and eliminate inefficiencies where possible, and also build on the capacity of a community to look after its own people. We also need to address issues around lone or under- occupancy of private houses which will increasingly become a problem in terms of fuel poverty, isolation and property condition. We need to start thinking imaginatively about other models e.g. multigenerational housing, which may have knock on positive effects on availability of housing for young people.

In fact, the "A look into the rear-view mirror" report from Reshaping Care for Older People shows us that the number of people over the age of 65 requiring long term residential care or care at home has reduced rather than increased in line with projections, and reduced faster than in the rest of Scotland. This suggests that we are already working in ways that maintain older people's independence at home as far as possible.

However, the following table shows the number of care home beds we will need to provide in the future, the number of carers, etc, based on the projected increase in the population of older people, and assuming that we maintain our current model of care:

Year	No of over 65s	Emergency admissions	No. long term residents in care homes	Home care numbers (individuals per whole population)	Intensive home care numbers receiving 10+ hours per day	Respite clients	Telecare clients
2013	3982	890	89	69	77	551	610
2017	4668	1027	112	75	93	654	1151
2022	5289	1164	127	85	106	740	1349
2027	5981	1316	144	96	120	837	1529
2032	6729	1480	161	108	135	942	1729
2037	7223	1589	173	116	144	1011	1945

If we remain with the current model of care, we will have needed to nearly double our current provision of services. We cannot afford to do this, and so we need to continue to work differently. The resources available for care centres is already diminishing, with half a million pounds less funding from the Shetland Charitable Trust by 2020 for the rural care centre

model. We will commission a piece of work within the next six months to help us develop a more precise action plan with detailed projections of accommodation requirements for older people over the next 20 years. This will need to take account of future developments, such as the increased use of Technology Enabled Care, and the potential for more Housing for Life Schemes. We know already that there is a waiting list for people needing alternative accommodation as they age and their abilities deteriorate, and any opportunity to develop a more diverse housing stock should be seized.

7. Funding of current services:

It is recognised that the provision of care for Older People is one of the main costs in both Health and care services. This is as a direct result of the demographic impact described elsewhere on this document. This continues to lead to increased hospital and Primary care activity, widening care needs and changing prescribing patterns.

Quantifying the cost of this to our services is challenging, because many of our services are not age specific. In the Joint Strategic Commissioning plan resources have been classified across some care groups and services and this gives us some idea of the scale of resources currently spent in this area.

	SIC	NHS	SCT*	Total
Older People's Services	£10,769,000	£3,488,000	£ 2,519,000	£16,776,000
Primary Care (all ages)		£4,170,235		£4,170,235
AHPs (all ages)		£992,610		£992,610
Pharmacy/prescribing (all ages) (includes the cost of medicines)		£4,810,110		£4,810,110
Total	£10,769,000	£13,460,955	£ 2,519,000	£26,748,955

*Shetland Charitable Trust

(It should be noted this excludes some significant costs associated with Older Peoples care, including for example Hospital costs associated with the Gilbert Bain Hospital and services provided in Aberdeen.)

Future Position
The potential financial pressure on our services has already been recognised. Against this must be set the current financial position for both the Health Board and SIC.

Over the next 5 years NHS Shetland has agreed a draft Financial plan that includes efficiencies of £6M, or approx 12% of the current total health budget. While these efficiencies will be retained in Shetland, they are required to address the currently projected increases in costs that we can expect, both as a result of inflation but also the service pressures highlighted above.

This level of efficiencies will require significant redesign of services so that they are delivered in different, more efficient and also more sustainable ways. Similarly, the Shetland Islands Council medium term financial plan sets out the efficiency challenges that need to be met in order to create a sustainable Council.

The Shetland Charitable Trust have begun to enact a 5 year programme of reductions in funding, and this is significant for older peoples care as the Charitable Trust fund a significant part of the rural care centre model. Shetland developed small care centres in a number of locations, which were originally funded by the Welfare Trust, which then became Charitable Trust funding. The diseconomies of scale mean that the cost per bed per week in the smaller care centres is as much as 4 times the cost of a similar service on the Scottish mainland.

8. Conclusions

The Christie Commission confirmed the need for a fundamental shift in public services, and the Reshaping Care agenda, introduction of the Social Care (Self-directed Support) (Scotland) Act 2013and movement towards integration reinforce this need.

There is a significant quantity of information collected in this strategy, both qualitative and quantitative, which we can and should use to guide decision making over the next few years.

What we do well

- Older people are valued across Shetland, for their knowledge, history & skills;
- There is a really strong culture of volunteering and caring in communities in Shetland;
- There is innovative practice and a willingness to look at different ways of doing things; Good informal volunteering and networks;
- There is a wide range of supports for carers throughout Shetland; and
- There is an opportunity and an appetite to change things at the moment as the community accepts that the status quo is not sustainable.

Planned service development

The priorities that are currently happening include;

- Implementation of Health and Social Care Integration.
- Review of Support at Home services, particularly in Lerwick and Central where demand is greatest, to ensure maximum efficiency and create greater capacity
- Specialist / dedicated resources are being used increasingly to provide training and peer support to colleagues who are providing care for older people with additional care needs for example due to dementia.
- Housing Support redesign to provide a community based service in locality areas

Doing things differently – what does this mean?

We should be focusing on personal outcomes for older people, as opposed to the traditional model of services deciding what is needed. It means preventing ill health and disability where we can. Some of the best evidence on how to slow down the aging process suggests that cutting out smoking, eating a diet low in red meat and rich in vegetables and whole grains, exercising 3-5 hours a week, and maintaining a reasonable waistline can increase your healthy life expectancy by 12 years compared with doing none of the above.[xx] The biggest positive impact on primary care workloads would be reductions in hypertension. Hypertension is the biggest preventable cause of ill health in older adults.

So...we should aim to reduce obesity, smoking, and alcohol consumption in the general population. In turn this will reduce Type II diabetes and complications from diabetes, chronic obstructive pulmonary disease, strokes, coronary heart disease and some cancers.

It means developing a third sector which is needs based and which provides more informal/flexible models of volunteering and/or paid employment. The development of Self Directed Support is an ideal opportunity for doing this.

It means making comprehensive anticipatory care planning a core of what we do as people age, starting much earlier – thinking about general adaptations *before* someone becomes frail or falls, identifying family and community supports before people become withdrawn and isolated. In doing this we should consider the role of community learning and development officers who have a wealth of knowledge and skills, and whose role is changing to include

community learning and prevention, and reduction in poverty and inequalities, alongside the Community Housing Support Workers. We also need to develop a dementia friendly community and services that meet the needs of older people with dementia who need more intensive care at home and those who can no longer be cared for at home.

It means preventing unnecessary admissions to hospital. We need to create a sustainable out of hours nursing and care model – perhaps involving a virtual ward in the community model. We need to further develop the use of With You For You to share information and do multi-agency care planning for vulnerable older people and those with additional support needs. It also requires having effective monitoring and evaluation systems to ensure we capture details of people's outcomes; through standardised review, quality assurance and audit procedures.

It means having public conversations about quality of life, positive choices, and good dying outlined in *' Good Life, Good Death, Good Grief'* a broad-based alliance to promote public openness around dying, death and bereavement. This should help to ease the process of advance/anticipatory care planning for the public, patients and professionals. This also supports 'Co-Production' approach in encouraging true collaboration with individuals and their carers in designing and delivering services that meet community need.

It means developing the right mix of housing, support and accommodation for older people in Shetland, as cost-effectively and appropriately as possible.

Where do we go from here?

Whilst the picture may appear bleak, with the challenges of an ageing population along with decreasing resources, we should highlight the positive aspects of living in a place which still has a strong sense of community, and where services have already recognised the challenges and have started to make plans for dealing with them. This strategy is part of planning for those challenges.

The themes for implementation of the strategy are summarised below, mirroring the National Health and Wellbeing Outcomes:

Strategic intent

1. People will stay well for longer with the support they need to meet their outcomes, by preventing those conditions that can be prevented and encouraging self management.
2. Older people's skills, abilities and knowledge will remain at the heart of communities.
3. People with long term conditions and their carers will be supported in a joined up planned way. We will reduce levels of unscheduled care episodes, but where these occur, ensure return to usual place of residence as soon as possible, ensuring that life-changing decisions are not made at point of crisis. Hospital based care will provide specialist diagnostic and treatment services that cannot be provided in the community.
4. Carers will be kept at the centre of care provision – identifying and acknowledging their role and working together as true partners, recognising the needs of carers in their own right. With appropriate support, especially support delivered early to prevent crisis, caring need not have an adverse impact on carers.
5. People will be supported to live independently at home through a re-focus of services, whilst reducing reliance on healthcare, and managing risk sensibly. Everyone will have the opportunity to remain independent in their daily lives, be actively supported to regain quality of life as defined by them through appropriate assessment of personal outcomes. Access to information, advice and housing

support services to enable independent living – and access to appropriate/appropriately adapted accommodation.

9. Strategic Intent, Outcomes and actions

1. Strategic intent – Keeping people well for longer		We will keep people well for longer by preventing those conditions that can be prevented and encouraging self management where conditions cannot be prevented.				
Medium term outcomes		1. Keeping/more healthy and active 2. Physical and social environments are more age-friendly 3. Keeping more socially connected 4. Keeping/more financially and materially secure 5. Systems work better for older people 6. Older people will be able to be resilient, have confidence and skills to manage their own health wherever possible.				
Short term outcomes	▪ Maximised physical activity levels ▪ More older people are socially active ▪ Reduced sedentary behaviour ▪ Eating well ▪ Drinking alcohol at moderate levels	More accessible, affordable transport, food and social opportunities Increased mobility/better able to get out and about	Secure & supportive relationships with family & friends Having confidence & motivation to participate in community life Feeling valued and making positive contribution to family and community life People and communities help and support older people in times of need.	Maintaining an adequate income/reduced poverty Better access to financial support Maintain ability to pay for basic commodities Continued opportunities for work (paid and voluntary)	Services and systems are designed to promote prevention, community action, independence and initiative. Greater investment in preventative services, less in acute care Service delivery and systems are more integrated and personalised More equitable access to services Use of limited	Able to stay positive, keeping in control of decisions, managing existing health conditions and medication, being resilient in major transition periods.

					public resources is optimised e.g through systematic implementation of national eligibility criteria	
Reach	Older people who are healthy, active and independent, including carers Older people who are at risk/in transition, including carers Older people who have high support needs, including carers	Older people who are healthy, active and independent, including carers Older people who are at risk/in transition, including carers Older people who have high support needs, including carers	Older people who are healthy, active and independent, including carers Older people who are at risk/in transition, including carers Older people who have high support needs, including carers	Older people who are healthy, active and independent, including carers Older people who are at risk/in transition, including carers Older people who have high support needs, including carers Those with or at risk of mental health problems, debt or insecure incomes	Professionals and service providers Community leaders and decision makers	Older people who are healthy, active and independent, including carers Older people who are at risk/in transition, including carers Older people who have high support needs, including carers
Activities	Brief interventions – smoking, healthy eating, physical activity and alcohol Development of activities identified by communities themselves, to reduce barriers to e.g. fresh fruit & vegetables, access to exercise programmes	Accessible buildings/activities Dementia friendly environments Communication training	Buddying, self help networks or group based emotional, social, educational or practical support to at risk e.g. widowed older people Volunteering undertaken by older people	Awareness raising on debt/financial insecurity Financial literacy programmes	WYFY in place and being used	Anticipatory care plans Self management support and resources

	Community based, supervised exercise programmes		Group activities with educational or support input, enabling older people to be involved in planning and delivering activities Community based individual or group counselling for carers of people with disabilities Social prescribing			
Inputs	Staff training in behaviour change, assets based approaches ,community development, Self-directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement	Staff training in behaviour change, assets based approaches ,community development, Self directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement	Staff training in behaviour change, assets based approaches ,community development, Self directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement	Staff training in behaviour change, assets based approaches ,community development, Self directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement	Staff training in behaviour change, assets based approaches ,community development, Self directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement	Staff training in behaviour change, assets based approaches ,community development, Self directed support, National Eligibility Criteria, and reablement principles Community and Third Sector involvement

2.Strategic Intent - Community	Nurturing and developing communities to support and utilize older people as full participants within those communities				
Medium term outcomes	1. Communities will play a bigger role in preventing loneliness and isolation of older people. 2. The skills and knowledge of older people will be better utilized in designing services and activities that promote health and wellbeing. 3. More local people involved in providing a range of support for older people living in our communities. 4. Voluntary Sector as integrated part of delivery of care 5. Increased openness about death and dying				
Short term outcomes	Older people are able to participate in local community	Communities actively support older neighbours	Older people are included in service planning and development	Third sector deliver services to meet the identified needs of older people's part of coordinated local service delivery	Less reluctance to speak more openly about disability, death and dying – speaking about it in communities and families.
Reach	Vulnerable older people, their carers and families	Communities – based on locality, but also on communities of interest.	Older people and carers through localities	VISP and community workers	Media, professionals, all staff and communities
Activities	Supporting older people to navigate health, social care and community systems Increase community support and strengthen networks	Community connections, good neighbour schemes community based enterprises through pooling Self-directed support budgets	Widening existing mechanisms such as PPF to be more inclusive Locality planning	Review current services based on identified needs and co-production Greater emphasis on local solutions for local needs	Locality - professionals
Inputs	Local care coordinators based in communities	Community development	Service planners and managers	Development of needs assessment and commissioning processes	Training for staff, media awareness

3.Strategic intent – Anticipatory care	People with long term conditions and their carers will be identified and supported, in a planned way. We will reduce levels of unscheduled care episodes, but where these occur, ensure return to the usual place of residence as soon as possible, ensuring that life-changing decisions are not made at point of crisis. Hospital based care will provide specialist diagnostic and treatment services that cannot be provided in the community.			
Medium term outcomes	1. People and those who care for them will get targeted health and social care support to prevent crisis and ensure effective treatment where needed. 2. Responsibility for delivery of care and crisis response will be shared by the person, their family and health and social care providers. 3. People will be able to access information about their conditions and care at the level they feel comfortable with.			
Short term outcomes	Potential crises are anticipated and prevented where possible Increased person centred care, dignity, choice and control. Effective coordination and communication between individuals, families, health and social care staff.	Quicker access to intermediate care services and wider anticipatory care planning	Increase in numbers of older people being seen, treated and discharged, without need for admission to hospital	Self management is possible – carers and patients have the information and skills needed to be as independent as possible.
Reach	All older people identified with long term conditions, frail, at risk of admission/readmission into hospital/care home Families and carers	All older people identified with long term conditions, frail, at risk of admission/readmission into hospital/care home Families and carers	Those at risk of entry/re-entry into hospital	All older people identified with long term conditions, frail, at risk of admission/readmission into hospital/care home Families and carers
Activities	Proactive, integrated case management which will include a shared risk prediction framework and anticipatory care planning. Implement WYFY and continue to improve the joint single shared assessment process. Anticipating potential crises, and preventing	Rapid access – alternatives to admission – that will enable as much care as possible to be provided safely at home Development of locality	Development of hospital discharge liaison role to work between community and hospital, linked to rapid response team. Immediate intervention to support individuals to avoid admission	Renew/update self-care/self management strategy Increase use of key information summaries

	the situation occurring wherever possible. Planning to take place at a stage where person can make preferences known, enabling them to be actively involved in own future.	models	Increased number of medication reviews for care home residents, and those cared for at home Anticipatory care plans completed if not already in place and up to date.	
Inputs	Staff time/consideration of different models	Health/social care/carers/families within localities	Emergency nurse practitioners, advanced nurse practitioners Rapid response team Pharmacy technician time	Health/social care/carers/families within localities

4.Strategic intent – Carers	With the agreement of the person being cared for, we will keep carers at the centre of care provision – working together as true partners, recognising the needs of carers and providing appropriate support		
Medium term outcomes	1. Carers involved as partners in the care and support plan. 2. Care plans will routinely reflect the needs of carers and their ability to continue in the caring role. 3. Carers will be confident to continue their roles with the knowledge that they are being listened to and supported as required.		
Short term outcomes	People identify themselves as carers and are included in the development of care plans	Needs of carers are identified and addressed	Carers' views are taken into account as part of care planning process and reviewed and supported appropriately.
Reach	Carers, carer supporters	Carers, carer supporters	Carers, carer supporters
Activities	Raise awareness with staff to enable them to work with carers	Carers assessments Training/support provided according to assessed needs	Training, carers support groups, self directed care, developing other ways of supporting carers
Inputs	Training/development		Training

5.Strategic intent – Independent living	Continued re-focusing of services to actively support people to live at home, whilst reducing reliance on care, and managing risk sensibly. 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. Access to appropriate/appropriately adapted accommodation			
Medium term outcomes	1. Care at home refocused to reduce dependency and place emphasis on personal responsibility and capability, where this is in the person's best interest. 2. Reduction in the proportion of people receiving long term care in a care home or hospital setting. 3. 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. 4. Older people are offered appropriate housing support services to sustain their choice of living arrangements and facilitate independent living.			
Short term outcomes	Older people are able to participate in local networks and services	Recovery and rehabilitation starts as early as possible Increase in self management plans – to record personal goals and supports needed to achieve these	Fewer people experience anxiety and lower level mental health concerns, with good support for families and carers	Shetland has an understanding of the type of quantity of accommodation needed to support older people at home over the next twenty years
Reach	Vulnerable older people, their carers and families	Vulnerable older people, their carers and families	Vulnerable older people, their carers and families	Shetland wide, based on epidemiological and demographic information
Activities	Supporting older people to navigate health, social care and community systems Increased use of telecare	Timely comprehensive multidisciplinary and multiagency assessment – rehabilitative needs identified	Access to psychological support, confidence and capacity building support Community capacity building	Commission work to understand accommodation needs of older people in Shetland, with a view to developing homes for life where possible.

Inputs	Local care coordinators based in communities Training on Reablement principles	GP, Nurse practitioner or consultant review within 24 hours	Community work, housing support workers, community resources	Develop specification for piece of work and commission it.

10. Appendix 1

Four Key Proposals from the Institute of Public Policy Research: The Generation Strain (England based – would need adapting to Shetland context)

1. New neighbourhood networks to help older people to stay active and healthy , help busy families balance work and care and reduce pressures on the NHS and social care.

In future, unevenness between local authorities in the quality of community support for older people and their families will only become more apparent as more people use the services.

We recommend that a minimum five-year programme of leadership and peer support is run by the Local Government Association (LGA) and Adult Directors of Adult Social Care Services (ADASS) to oversee this, based on the successful 'London Challenge' model in education.

Funding of an estimated £2 million per local authority should be made available from local public health budgets to fund the development of 'neighbourhood networks' with the aim of funding more of this from mainstream provision over the five-year period

In developing neighbourhood networks, the UK should follow the example of the German *Mehrgenerationenhauser* (multigenerational houses) national programme and house services for different age groups such as childcare and eldercare under one roof, removing artificial boundaries between young and old.

2. Care coordinators providing a single local point of contact, to replace the 'case management' currently provided by adult social services in every area by 2020, for all but the most complex cases of care.

Instead of 'case management' from social workers, older people, their families and carers should be given a local care coordinator based in the community to help them make the most of local networks and services.

Based on the Local Area Coordination scheme developed in Western Australia, which is providing better care outcomes at lower cost, local care coordinators based in accessible community locations should support the navigation of both the health and social care systems for older people.

All but the most complex cases of care should be handled by care coordinators, with care management decommissioned by adult social care services by 2020.

3. Option of a 'shared budget' to enable those using community care to arrange this collectively.

Giving older people, their families and carers the money to pay for services directly is a powerful way of putting people in charge of their own care. However older people, their families and carers are frequently discouraged by the responsibilities that come with this.

Older people, their families and carers with a personal budget should have the option to pool their 'direct payment' with other local people to create a local 'shared budget' to meet their care needs collectively.

More third-party organisations, such as community groups, faith organisations, mutual support groups and micro-enterprises should be invited to take on responsibility for developing packages of care and support for individuals in this way if they meet certain core criteria.

This option should be promoted by care coordinators and could be carried out by community organisations including neighbourhood networks.

4. Stronger employment rights for those caring for people who need more than 20 hours of care a week, to make it easier for family members to combine work and care.

Workers caring for those with high physical and mental support needs should be given enhanced employment protection rights to allow them to combine work with care, rather than taking up a welfare payment.

This could be through a right to adjusted hours or an adjusted role, with protection of their employment contract, for those with an underlying entitlement to carer's allowance. It could also be through various options that have been put forward for family caring leave.

Further assessment should be done of the costs and benefits of these approaches.

To take part, community organisations have to meet criteria including community engagement and ownership; having an inclusive approach; a commitment to drawing on local community resources

11. Appendix 2

Building a service for Older people in Lanarkshire[xxi] – this is an example from elsewhere that might well be used locally to start to determine what a particular community needs and how they might shape it themselves.

In 2009, NHS Lanarkshire and North Lanarkshire Council undertook a Review of Integrated Day Services For Older Adults. The review was conducted very much in conjunction with the older people who were the potential users of services. 40 people were surveyed and were asked the following questions:

- What do you do with your day now?
- What do your friends and family do?
- What would you like to do?
- What stops you doing this?
- Where, in your community, could these activities happen?

Staff in the area team, housing office and day hospital services were also involved.The data gathered from individual interviews indicated that the vast majority of people were very lonely and isolated, with almost 80% spending their day alone watching television or reading.

When people were asked what they wanted to do, 100% stated that they wanted to meet others, the majority (80%) expressed a desire to go to local clubs, 60% wanted to go shopping, 30% to the bookies or pub and 10% wanted to access the cinema, or local church.

It became clear that very few people had access to information about what was available in their community, others had lost confidence in going to places on their own or in meeting new people and some people had significant health needs that resulted in them needing transportation and sometimes support to get out of the house.

What was really interesting was that although **all of those interviewed were on a waiting list for day care**, no one asked for a day care service and each person was able to identify other resources in the community where they could access activities in line with their interests.

The project has moved on, with the establishment of Locality Link Officers, whose role is to identify alternative resources in the wider community and assist older adults to engage with them. In this way many of the problems of loss of confidence and lack of information are overcome.

The project team felt that there were a number of factors about the way they worked that allowed success. These factors were considered to be:

- Openness
- Mutual trust and respect
- Commitment
- Ability to compromise
- Shared beliefs and values
- Sustained effort

The service was designed with the expectation that the following outcomes and benefits of an integrated service would be delivered:

- **A smoother journey for the person through services**
- **A reduction in crises through early intervention and identification**
- **A person-centred approach across the agencies**
- **A faster response to changing needs**
- **A reduction in duplication of assessments**

- **Increased staff confidence**
- **Designing solutions to changing needs together.**

12. Appendix 3

Our Vision of Shetland Health & Care in 2020

In 2020… Shetland continues to deliver high quality, local health and care services, which have developed to ensure they are suited to the needs of the population in 2020. We make best use of our community strength, community spirit and involvement, which has helped to shape our services as well as our way of life. People feel responsible towards each other within their own community. Self-help includes making healthy lifestyle choices, and people using their knowledge and own capacity to look after themselves and each other.

In 2020… Recognition of the positive elements of Shetland life and determination to preserve them has been achieved through a united approach across the local public sector, communities and commercial interests. Through necessity, Shetland's economy has diversified to maintain high levels of employment. We value our local environment, which we work hard to protect and share with those who visit to admire it. We have also fought successfully to achieve investment in remote and rural areas in Shetland, to allow us to build sustainable, viable communities. These communities and Shetland as a whole continue to value diversity and promote equality; both within our everyday lives and in the way we deliver services.

In 2020… We have fought hard against, and continue to tackle, the major threats to our health – fewer than 10% of people in Shetland smoke, we have cut obesity by 50%, the whole community has been encouraged into more exercise and healthier eating. We teach and support children and families in emotional and mental well-being from an early age, and have changed the impact of early death and illness from the major preventable diseases.

In 2020… People are in control of not just their own health, but how they use services and make decisions about their own care – working in partnership with professionals. Development of technologies has brought electronic patient records that patients can hold and carry with them. Communication technologies, such as the internet and videophones, are routine public facilities that have been integrated into service delivery. This has helped to improve professional and patient access to diagnostic tests, information and advice, and to enable remote consultations for patients, helping to counter some of the isolation of remote island living that can affect access to services.

In 2020… Community and primary care services (first access services) are provided in localities from flexible shared facilities for the range of services that can be provided close to people's homes (for instance, schools and community education sharing facilities with leisure and social activities as well as health and social care staff). We have close relationships amongst teams in local areas maintaining continuity of care and 'family health and care' services. The high quality infrastructure of Shetland care services have been maintained and are used flexibly to support people and enable them to be cared for in their local

communities, whether they live with disabilities or are frail and elderly. Integrated local community transport ensures equitable access to all health and care services, made as easy as possible for those living most remotely.

In 2020... People with disabilities live their lives to their full potential within their local communities, supported as necessary either within their own families or living independently. In addition to employment and/or social support as necessary, communities have taken on the skills and knowledge to include people with disabilities in all aspects of life.

In 2020... Shetland's population receive emergency care, assessment, diagnosis, treatment and a range of sub-specialist care through the local Remote and Rural General Hospital. Multi-disciplinary teams providing these services consist of consultants, nurses, allied health professionals and clinical support staff who work within flexible, patient-friendly facilities to deliver care in a way that cuts across traditional and professional boundaries to provide a patient-centred hospital service. Our local workforce delivers care in all available facilities across Shetland, using locality facilities where possible and the hospital only where necessary. Staff are skilled in roles relevant to the local service to deliver the range of care needed locally. For additional specialist and tertiary care, patients travel to mainland centres, but only where care cannot be delivered safely and efficiently in Shetland. Transition through these external services is smooth thanks to efficient transport links, the use of a single patient record system and appropriate local support.

Glossary, Acronyms & Abbreviations

Acute condition	Acute conditions are severe and sudden in onset. This could describe anything from a broken bone to an asthma attack. A chronic condition, by contrast is a long-developing syndrome, such as osteoporosis or asthma. Note that osteoporosis, a chronic condition, may cause a broken bone, an acute condition. An acute asthma attack occurs in the midst of the chronic disease of asthma. Acute conditions, such as a first asthma attack, may lead to a chronic syndrome if untreated.
Acute services	Hospital services – Acute health service are provided mainly in hospitals. They deal with sudden and more serious health problems. Your GP usually refers you to acute services, although you might refer yourself e.g. to accident and emergency.
Anticipatory Care Plan	A plan that anticipates significant changes in a patient (or their care needs) and describes action, which could be taken, to manage the anticipated problem in the best way. It is used by healthcare professionals to record decisions agreed with patients about their anticipated care needs and wishes
BMI	Body Mass Index
CCF	Climate Challenge Fund
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
Co-production	The public sector and citizens working together to make better use of each other's skills, money and energy to achieve better outcomes and improved efficiency
CPP	Community Planning Partnership
Datazone	Key small area statistical geography in Scotland
Demography	The statistical study of human populations especially with reference to size and density, distribution, and vital statistics.
DLA	Disability Living Allowance
Enablement	(sometimes called reablement or re-enablement) is about helping people become more independent and improve their quality of life.
Episodic care	A pattern of medical and nursing care in which services are provided to a person for a particular problem, without an ongoing relationship being established between the person and health care professionals.
GRO	General Register Office (of Scotland)
Incidence	The incidence rate is the number of new cases per population at risk in a given time period
Inpatient	A patient staying overnight in hospital
Intermediate Care	Care to bridge the gap between hospital and home
Multi-Morbidity	A number of illnesses at the same time
Multidisciplinary	Involving people from several different staff groups e.g. nurses, doctors, therapists, non-clinical staff
NCDC	Northmavine Community Development Company
Outpatient	A patient visiting hospital for advice or care, but not being admitted to hospital
Personalisation	Personalisation means thinking about public services and social care in a different way – starting with the person and their individual circumstances rather than the service
PIP	Personal Independence Payment
Primary Care	The first place you go to get health advice or services. This is usually the GP, practice nurse, dentist, pharmacist or optician and their teams of healthcare staff, such as therapists.
QOF	Quality and Outcomes Framework
Quintile	One of five classes where the population is divided equally into those classes
Secondary care	Secondary care is usually provided at a hospital. For example, your GP might send you to see a hospital consultant about a health problem.
SCT	Shetland Charitable Trust
SIMD	Scottish Index of Multiple Deprivation

Social capital	The network of social connections that exist between people, and their shared values and norms of behaviour, which enable and encourage mutually advantageous social cooperation

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Agenda Item

3

Shetland Islands Council

NHS Shetland

SHETLAND HEALTH AND SOCIAL CARE PARTNERSHIP

Social Services Committee and CHP Committee **30 September 2015**

Shetland Dementia Strategy	
CC-42-15 D1	
Alan Murdoch, Dementia Services Nurse Manager.	**Dementia Services**

1.0 Summary

1.1 The purpose of this report is to present the progress made towards meeting the aims of the Dementia Strategy for Shetland and to support the plans for the next steps (see Appendix 1).

2.0 Decision Required

2.1 That the Social Services Committee RESOLVES to, and the CHP Committee recommends that the Shetland NHS Board, adopt the Dementia Strategy, including the action plan which sets out the further work necessary to achieve the ambitions of the Strategy.

3.0 Detail

3.1 Provision of services for people living with dementia is central to the Scottish Government's agenda and as such there have been two National Strategies developed to outline expectations for the future.

3.2 The first Dementia Strategy in 2010 developed a greater awareness of dementia and has resulted in a greater number of people with a diagnosis. This has also resulted in an increased understanding within the general public of the importance of building dementia friendly communities that help keep people living with dementia engaged and supported within their community.

The second strategy was published in 2013 and this strategy has been developed to reflect the requirements of that strategy.

3.3 The challenges for dementia services in Shetland are similar to those of older people in general and include:

- **Growing public expectations** that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- **Demographic change** with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- **Increasing prevalence of long term conditions** and increasing multiple morbidity;
- **Technological change** e.g. in how care can be delivered through technology enabled care, for example, and through changing public expectations in how services can be accessed through advances in internet and mobile technology;
- **Provision of care in the person's own home or a 'homely setting'** and the need to keep the person living with dementia from becoming confused, disorientated and upset as a result of removing them to unfamiliar environments;
- **Avoidance of inappropriate hospital admissions** as acute hospitals are known to increase the risks of dementia worsening and the person living with dementia often loosing their independence;
- **Reductions in public funding** due to the recession and current ongoing difficult economic climate;
- **Persisting inequalities in health**;
- **The need to demonstrate outcomes** not just process; and
- **The need to consider the sustainability of services** in a very small and highly specialist service.

3.4 Shetland is already making good progress in changing its ways of working, but we need to do more. This will consist of:

- Continuing to raise awareness of dementia and the importance of seeking early diagnosis
- Encouraging people to live well with their condition by continuing to remain involved with their community and continue to participate in previously enjoyed activities. Also to encourage them to take up new activities, in particular ones that increase their levels of physical activity.
- Encourage carers to become involved with other carers, either individually or through carer support groups to receive and provide support to each other.
- Nurturing and developing communities to support and involve people living with dementia as full participants within those communities.
- With the agreement of people living with dementia, keeping families and carers at the centre of care provision – working together as true partners, recognising the needs of families and carers and providing appropriate support when required.
- Continuing to re-focus services to actively support people to live at home, while reducing reliance on care, and managing risk sensibly. This will involve having access to information, advice and appropriate/appropriately adapted accommodation

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities
The Dementia Strategy for Shetland is being delivered in partnership and supports delivery of a number of SOA (Single Outcome Agreement) priorities.

4.2 Community /Stakeholder Issues
The strategy outlines the case for earlier diagnosis and treatment of dementia and access to quicker, more person centred care, as close to home as possible. This reflects the feedback from the people, professionals and communities which were engaged with through the development of the strategy.

4.3 Policy and/or Delegated Authority
The Social Services Committee, as the managing body for strategic plans under Community Health and Care, has delegated authority to take decisions in relation to those functions within its remit, including community care and community health and wellbeing.

The CHP Committee ceased to be a formal sub-committee of Shetland NHS Board on 1 April 2015. It has been agreed that the CHP Committee would continue to meet in an informal advisory capacity until such time as the IJB is established.

4.4 Risk Management
The risk of not delivering the strategy's intended outcomes is that Government objectives and targets in terms of increasing earlier diagnosis and post diagnostic support will not be met. Without developing new ways of supporting people living with dementia it is likely that there will continue to be increasing resource implications for both health and social care providers.

4.5 Equalities, Health And Human Rights
The strategy promotes equality, diversity and respect for people as individuals as well as taking account of the needs of those caring for them. People living with dementia can still contribute to their community if they are encouraged and allowed to fully participate in the life of their community.

4.6 Environmental
No major implications identified, other than a general requirement to maintain or increase opportunities for involving people living with dementia to access mainstream services that provide opportunities for physical activity and socialisation and to work towards creating a Dementia Friendly community.

Resources

4.7 Financial

The strategy recognises the future reduction in resources for health and social care in Shetland and Scotland, and the need to do more with less and work differently. The strategy suggests some ways of achieving this and through changing the way we care for people living with dementia it is likely that in time this can be done in a more cost effective way that is of greater benefit to those living with dementia and their families and carers.

4.8 Legal

There are no implications arising directly from this report. However there are legal resources implications from implementing some of the key strands of the strategy such as new models of care delivery.

4.9 Human Resources

The strategy describes the challenges facing the workforce, including recruitment and retention. There are already examples of well established integration of health, social care and third sector provision of care and services and there needs to be a greater recognition of the role that is played by organisations such as Alzheimer Scotland in the provision of post diagnostic care for both people living with dementia and their carers. Although dementia is a disease and in it's later stages will likely require significant input from health and social care services, in the early stages self-management and planning for the future can be encouraged. Identification of future wishes and needs can personalise and improve the care provided when it is needed later in the illness.

4.10 Assets and Property

The strategy recognises that the current rural care centre model as it currently stands is unsustainable. Work is underway to understand the right mix of accommodation to meet the needs of people living with dementia in Shetland. Changes have already been made and new models developed that are working. The future model is likely to involve a mix of residential care, housing with support, and adaptation of people's existing homes where possible.

5.0 Conclusions

5.1 Services for people living with dementia and their carers will remain at the core of the Government's Adult Health and Social Care Integration Agenda and the Public Bodies (Joint Working) (Scotland) Act 2014. This strategy aims to meet the national health and wellbeing outcomes for people living with dementia in Scotland. The Strategy will drive improvements, which will involve innovation and redesign to ensure that services remain sustainable.

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September 11th 2015

List of Appendices

Appendix 1 – Shetland Dementia Strategy

Shetland Dementia Strategy

2015 - 2018

Date: January 2015

Version number: 7

Author: Alan Murdoch

Review Date: *not yet known*

If you would like this document in an alternative language or format, please contact Corporate Services on 01595 743069.

NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

Name of document	**Shetland Dementia Strategy 2013-2016**		
Registration Reference Number	**CSSTR006**	**New** ☒	**Review** ☐
Author	**Alan Murdoch**		
Executive Lead	**Simon Bokor Ingram**		

Proposed groups to present document to:	
Shetland Mental Health Partnership	PFPI
CH&SC Operations Group	Dementia Services Partnership
Joint Acute/CH&SC Strategic Group	Senior Management Team
Area Clinical Forum	Joint Social Services/CHP Committee

DATE	VERSION	GROUP	REASON	OUTCOME
27/11/14	1	Shetland Mental Health Partnership	C/S	PRO
21/01/15	2	Senior Management Team	C/S	PRO
19/03/15	3	Shetland Mental Health Partnership	C/S	MR
10/04/15	4	CH& SC Operations Group	C/S	MR
16/04/15	4	Area Clinical Forum	PO & C/S	PRO
28/04/15	5	Joint Acute/CH&SC Strategic Group	C/S	PRO
26/05/15	5	Strategy & Redesign Group	C/S	PRO
30/07/15		Social Services Committee		
		NHS Shetland Board		

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)

Please record details of any changes made to the document in the table below

DATE	CHANGES MADE TO DOCUMENT
14/01/15	Added more background narrative and reference to an Implementation Action Plan.
27/02/15	Restructuring of document in order to highlight local priorities.
06/04/15	Executive summary added and some minor changes made following suggestions from SMHP and Director of Health and Social Care.
07/04/15	Changes to layout and style.
20/04/15	Draft Action Plan added to Appendix 1.
26/05/15	Incorporated comments and suggestions made by Area Clinical Forum, Joint Acute/CH&SC Strategic Group and Strategy & Redesign Group.
26/06/15	Draft high level outcome measures added to Action Plan.

CONTENTS

1. Executive Summary

Since the publication of the first Dementia Strategy in 2010 a greater awareness of dementia has resulted in a greater number of people with a diagnosis. This has also resulted in an increased understanding within the general public of the importance of building dementia friendly communities that help keep people living with dementia engaged and supported within their community.

The second Dementia Strategy identified 17 National commitments highlighting key areas for improvement in care for people living with dementia and their families and carers. This local strategy develops a series of local priority actions that will support these commitments.

It is estimated that the number of people with a diagnosis of dementia will double in the next 25 years. In order to meet their needs we need to ensure that services are designed and developed to meet the needs of people living with dementia and their carers with the best possible care. We also need to ensure that the general public are educated to allow them to play their part in supporting people living with dementia to remain connected with their community.

It is estimated that in the next 25 years the population of people over 65 will increase at a greater rate than those of working age. There is already a population drift towards towns from more rural parts of Shetland. Taken together, we will have to identify ways of supporting people living with dementia to continue to live within their own communities for as long as possible with the best use of available resources. This strategy outlines the range of specialist services available to support people living with dementia and their families/carers provided by statutory and third sector agencies. However it is important to understand that the care of people living with dementia must be seen as integral within all services provided in Shetland.

There is a growing use of telecare/telehealth within Shetland and this document will outline a range of technology that is already being used to support people living with dementia to remain at home. It is intended that this will be further developed to also allow people to be better connected within their community, leading to less isolation.

This strategy links with the Older People's Strategy and as such public consultation on these strategies took place jointly in Shetland.

In developing this strategy it is essential to take account of the good progress and achievements that have already been made since service improvements were begun in 2009. Since then there has been the development of a specialist assessment and diagnosis service with support from Post Diagnosis Link Workers, support to Gilbert Bain Hospital and Care Centres from a Dementia Clinical Nurse Specialist, links to the National Dementia Nurse Consultant Group, new models of housing for people living with dementia and local support from Alzheimer Scotland.

Despite these developments there remain challenges that will be examined in more detail. Raising public awareness, knowledge and training across all parts of Shetland and with all levels of the population will be a target to aim for within this strategy as well as meeting the needs of people living with dementia as close to their own home as possible and without them having to leave Shetland.

In developing this strategy it was important to identify other key areas of work that are being progressed by the Scottish Government that will impact on people living with dementia and their carers. Some of these will be outlined in more detail. Although this Strategy has been written to reflect the National Dementia Strategy, it also acknowledges that there are a number of other general health and social policy documents and strategies that will impact on people living with dementia. As this strategy is written to address the development of care and support in the community for people living with dementia and their carers, it is not the intention of this strategy to address these areas specifically. It will be expected that these other documents will reflect the needs of the population as a whole and as such include people living with dementia.

A series of key outcomes were identified in the National Strategy and this strategy has taken account of these when identifying our local priorities. These priorities have then been developed into a series of actions that will outline how they will help to meet the 17 National commitments. Progress towards these actions will be tracked within an action plan that will indicate timescales and responsibilities for each one.

2. Overview

Scotland's first National Dementia Strategy was published in 2010 and focused on improving the quality of dementia services through more timely diagnosis and on better care and treatment, particularly in hospital settings. It began the process of the transformation of care across all sectors in anticipation of the growing number of people living with dementia.

This initiative led to an increase in diagnosis rates, with around 64% of people with dementia in Scotland now receiving a diagnosis.

Although a diagnosis of dementia has a huge impact on individuals and families, timely and sensitive diagnosis, backed by effective and holistic post-diagnostic support, is vital in helping people build their personal resilience and knowledge about dementia and enabling them to live a good quality of life at home for as long as possible. To help achieve this, the Scottish Government introduced a national commitment on post-diagnostic support for everyone diagnosed from 1 April 2013.

There are also huge challenges for us in ensuring that people with dementia are not admitted to hospital unnecessarily and that they get effective and dignified care while in hospital. A National Action Plan was developed to support NHS Boards in helping to make the required changes to our services and to maximise workforce initiatives such as the Alzheimer Scotland Dementia Nurse Consultants and the Dementia Champions.

The Scottish Government is also working closely with The Life Changes Trust as they begin to make funding available for initiatives across Scotland to build dementia-aware local communities – among other benefits, these will help tackle the isolation and depression often felt by people living with dementia and help them remain connected to their friends and neighbours.

All of this activity is to be aligned with the 2020 vision for health and care in Scotland, which will work to enable all people, including those living with dementia, to live well for longer at home or in a homely setting. This will be backed by an integrated health

and care system with a focus on areas like supported self-management and on ensuring community-based health treatment wherever and whenever possible.

3. National Commitments.

The national strategy describes 17 commitments that the Scottish Government has identified and these are listed below.

COMMITMENT 1: We will sustain and, where appropriate improve further, dementia diagnosis rates.

COMMITMENT 2: We will transform the availability, consistency and quality of post-diagnostic support by delivering the new post-diagnostic HEAT target.

COMMITMENT 3: We will implement the most effective means of providing integrated care and support on the basis of the 8 Pillars model, centred on a Dementia Practice Coordinator role.

COMMITMENT 4: Scottish Government will commission Alzheimer Scotland to produce an evidence based policy document outlining the contributions of AHPs to ensuring implementation of the 8-Pillar model.

COMMITMENT 5: We will take further action to support safe and supportive home environments and the importance of the use of adaptations and assistive technology, in maintaining the independence and quality of life of people with dementia and their carers

COMMITMENT 6: We will take further action to support and promote best practice in advance care planning, the assessment of capacity to consent to treatment and adherence to proper procedures for making decisions for people with dementia who lack capacity.

COMMITMENT 7: Scottish Government will publish a report on implementation of the dementia standards to date.

COMMITMENT 8: We will continue to improve staff skills and knowledge by working with NES and SSSC to take forward a second Promoting Excellence training plan across the period of this Strategy.

COMMITMENT 9: We will work with NES, SSSC, NHS Health Scotland, NHS 24 and Alzheimer Scotland to develop and launch an innovative digital platform for dementia, which will help inform and empower people with dementia and their families and carers in being equal partners in care.

COMMITMENT 10: We will develop and deliver a 3-year National Action Plan to improve care in acute general hospitals.

COMMITMENT 11: Scottish Government will set out plans for extending the work on quality of care in general hospitals to other hospitals and NHS settings.

COMMITMENT 12: We will work with national agencies (e.g. Scottish Care, SSSC, NES) and others to assess the need for, and take further action on, improving service response around care homes, care at home and adult day care services. This will include attention to staff training and support for the implementation of the post-diagnostic HEAT target and the commitment on reducing inappropriate prescribing of psychoactive medication for people diagnosed in care homes.

COMMITMENT 13: Scottish Government will finalise and implement a national commitment on the prescribing of psychoactive medications, as part of ensuring that such medication is used only where there is no appropriate alternative and where there is clear benefit to the person receiving the medication.

COMMITMENT 14: We will take account of the expectations and experience of people with dementia and their carers in taking forward the work on outcomes for the integration of health and social care.

COMMITMENT 15: Scottish Government will continue to support research through funding The Scottish Dementia Clinical Research Network and supporting the work of the new Scottish Dementia Research Consortium in its objective to bring together the range of dementia research interests in Scotland and maximise the impact of and funding opportunities for research capacity here.

COMMITMENT 16: Scottish Government will undertake a brief piece of work focusing on the care pathway for people with dementia in these groups, through diagnosis and support, through treatment and care, taking account of the particular challenges for carers and family members with the objective of identifying what further actions are required to ensure that each of the key improvement areas – diagnosis, post-diagnostic support, care co-ordination requires modification to take account of the needs of different groups.

COMMITMENT 17: Scottish Government will oversee and ensure progress on the dementia agenda and in implementing the National Strategy, it will carry over from the first Strategy an Implementation and Monitoring Group to co-ordinate, support and monitor progress on the commitments outlined in the Strategy.

This strategy will outline our local priorities and how they link to the national commitments.

4. Local context

Dementia is one of the foremost public health challenges worldwide. As a consequence of improved healthcare and better standards of living more people are living for longer. This means in Scotland that the number of people with dementia is expected to double between 2011 and 2031. This presents a number of challenges, most directly for the people who develop dementia and their families and carers, but also for the statutory and voluntary sector services who provide care and support.
For Shetland, we could expect to see a rise in the number of people with a diagnosis of dementia from 189 today to 368 in 2031. (Estimated number based on EuroCode prevalence rates and population projections)
Over time we expect that a greater proportion of health and social care expenditure will focus on dementia, and there is evidence of that change already.
This document sets out the actions that we will take to make progress toward achieving our vision of providing the very best of dementia care in Shetland.

It is our vision that both professionals and the general public must work together to create a Dementia Friendly community.
There will be a greater awareness of dementia in order to reduce the stigma associated with the illness and encouragement to communities to support people living with dementia to be able to remain connected with their community, living within their own home for as long as possible.

There is no particular measure which can prevent dementia. The interplay between the benefits of a healthy lifestyle and the increasing risk of developing dementia with age is complex and difficult to assess. There is evidence that healthy living behaviours, such as better diet or physical activity, may reduce the risk of a person developing dementia, or delay its onset. At the same time, the increase in life expectancy, also a consequence of healthy living behaviours, is the main factor behind the increasing number of people with dementia. More work is needed to understand these interactions at a population level, though the benefits to the individual of healthy living are clear.
Although not exclusively a condition affecting older adults, dementias are predominantly a feature of an aging population. Dementia is an umbrella term for a

range of illnesses and disease symptoms, which primarily or secondarily affect the brain. Alzheimer's disease and vascular dementia are the most frequently occurring illnesses.

Nationally, as our population ages, the number of people living with dementia will increase and it is expected that the number will double over the next 25 years. Prevalence of dementia increases with age; around 1.5% of the 65 to 69-year-old population are affected, increasing to about one in three of the 90-plus age groups. Dementia is a key health issue facing Shetland in the coming decades. As our population ages there is a projected 50% increase in the number of those affected by the disease. Dementia is a major cause of disability in people aged 60 and over. It contributes 11.2% of all years lived with disability, which is more than stroke (9%), musculoskeletal disorders (9.8%), cardiovascular disease (5%) and all forms of cancer (2.4%). (***The Dementia Epidemic****- where Scotland is now and the challenge ahead, Alzheimer Scotland, June 2007*)

Therefore, to ensure effective delivery of services and most efficient use of resources this strategy has been developed in harmony with Shetland's Older People's Strategy. The following section on Demography has been shared with that strategy.

5. Demography

Total population size

There are different ways of measuring the total size of the population. According to the 2011 Census there were 23,167 people living in Shetland on census day. Of these, 3,777 were aged 65 or older (16%).

In Shetland, we can also use GP registrations as a good indicator of population size because we know that most people are registered with a GP. This can give us much more up to date information compared to the census which was done three years ago. According to GP registration on 1st April 2014, there were 22,886 people registered with a GP in Shetland and of these, 4,184 people were aged 65 or over.

Age structure

The table below shows the number of people in each age band in Shetland according to the Census and GP registration data. The age bands are not equal: they are based on how we tend to group people by age for purposes of statistics or service delivery for example.

	'Pre-school'	'School age'	'Young people'	'Working age adults'		'Older people'		
	0-4	**5-14**	**15-24**	**25-44**	**45-64**	**65-74**	**75-84**	**85+**
2011 Census (% of total population)	1389 (6%)	2776 (12%)	2746 (12%)	5859 (25%)	6620 (29%)	2143 (9%)	1178 (5%)	456 (2%)
2014 GP registrations (% of total population)	1303 (6%)	2592 (11%)	2615 (11%)	5659 (25%)	6533 (29%)	2454 (11%)	1256 (5%)	474 (2%)

Sources: *Scotland's Census 2011 website (www.scotlandscensus.gov.uk/r1-downloadable-files). Local GP data.*

The table above shows that there are slight differences in the percentages of people in each age grouping between the GP registration and the census data. There is a slightly higher proportion of people in the 65-74 age group, and a slightly lower proportion in the school age and young people groups in the 2014 GP registration data compare to 2011 Census data. This could reflect that there is a higher proportion of older people registered with a GP compared to young people (although we would expect a high registration amongst school age children) and / or that the proportions have shifted in the past three years.

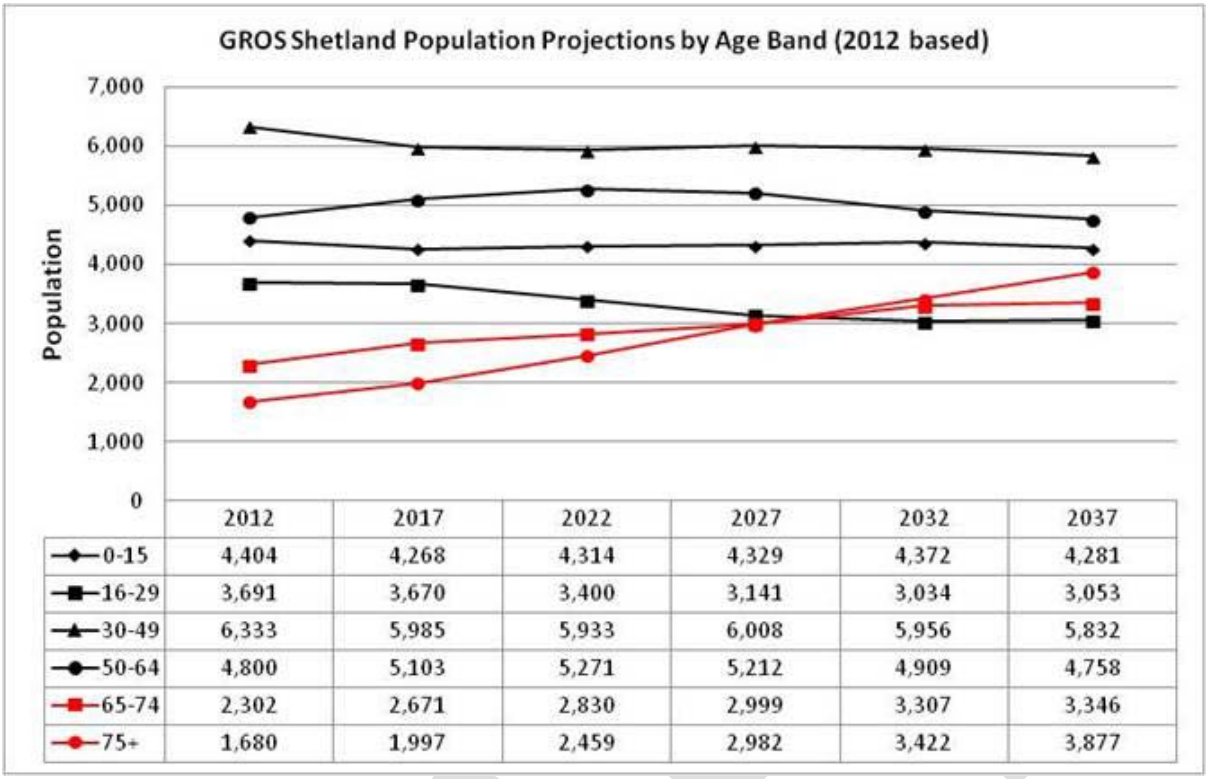
Population projections

Looking at current or recent figures for population size can help in understanding what health and social care needs are now for the current population, and would be useful for future service planning if the population profile remained static. However, we know that the 'shape' of the population has changed over time, with an increasingly aging population because people are generally living longer. It is predicted that this trend will continue. Therefore we can use 'population projections'

to understand what the population is likely to look like in the future, and therefore help to understand what the future needs are likely to be.

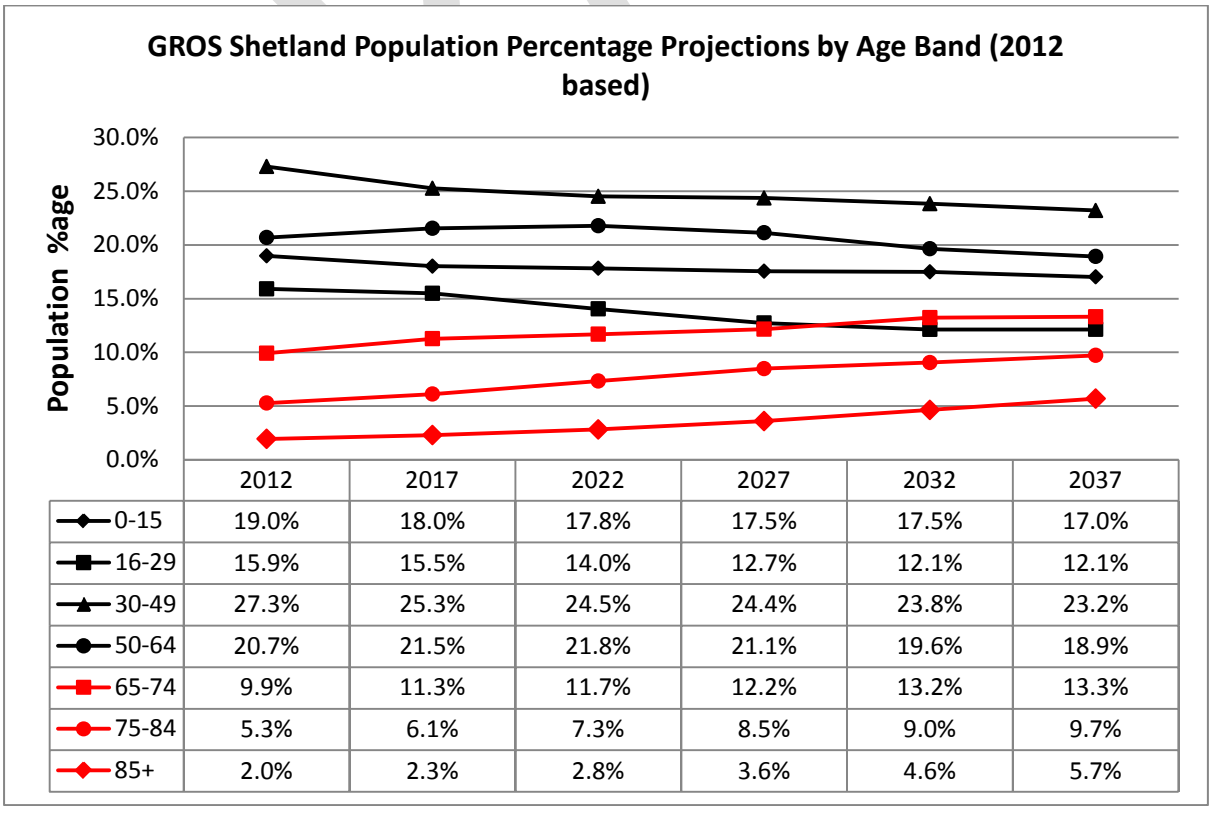
However, projections should be interpreted cautiously because they are estimated figures based on a set of underlying assumptions. They use past trends to predict what will happen in the future. There are four basic factors that dictate population size: births, deaths, immigration into the population and emigration out of the population. So population projections take into account the predicted numbers of births, deaths, immigrants and emigrants in a population based on past experience. They do not take into account the impact of significant behavioural or policy changes in the population or any unexpected variations in the birth, death, immigration and emigration rates. This caution is particularly required where the population is already small, such as in Shetland.

It can be seen, that for the over 65 age group, there is a predicted increase in both the total number of people and the percentage of the overall population. For the group aged 65 to 74, it is predicted that there will be an increase from 2302 people in 2012 to 3346 in 2037. And for the 75 and over age group, an increase from 1680 to 3877, more than double. Overall that is an increase of just over 3200 people aged 65 and over in the next 20 years, an 80% increase.

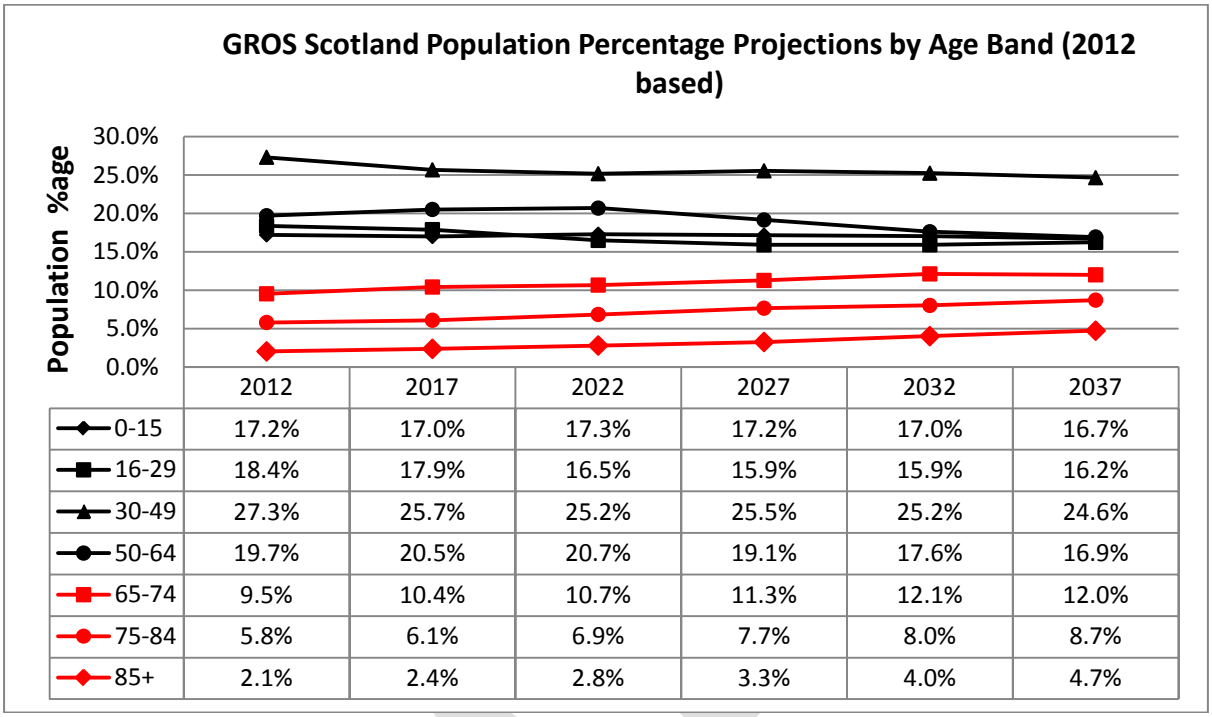


	2012	2017	2022	2027	2032	2037
0-15	4,404	4,268	4,314	4,329	4,372	4,281
16-29	3,691	3,670	3,400	3,141	3,034	3,053
30-49	6,333	5,985	5,933	6,008	5,956	5,832
50-64	4,800	5,103	5,271	5,212	4,909	4,758
65-74	2,302	2,671	2,830	2,999	3,307	3,346
75+	1,680	1,997	2,459	2,982	3,422	3,877

The charts below show that as well an absolute increase in the number of older people, they will also make up a bigger percentage of the Shetland population. The percentage of older people in Shetland compared to the rest of Scotland will also increase.



	2012	2017	2022	2027	2032	2037
0-15	19.0%	18.0%	17.8%	17.5%	17.5%	17.0%
16-29	15.9%	15.5%	14.0%	12.7%	12.1%	12.1%
30-49	27.3%	25.3%	24.5%	24.4%	23.8%	23.2%
50-64	20.7%	21.5%	21.8%	21.1%	19.6%	18.9%
65-74	9.9%	11.3%	11.7%	12.2%	13.2%	13.3%
75-84	5.3%	6.1%	7.3%	8.5%	9.0%	9.7%
85+	2.0%	2.3%	2.8%	3.6%	4.6%	5.7%



	2012	2017	2022	2027	2032	2037
0-15	17.2%	17.0%	17.3%	17.2%	17.0%	16.7%
16-29	18.4%	17.9%	16.5%	15.9%	15.9%	16.2%
30-49	27.3%	25.7%	25.2%	25.5%	25.2%	24.6%
50-64	19.7%	20.5%	20.7%	19.1%	17.6%	16.9%
65-74	9.5%	10.4%	10.7%	11.3%	12.1%	12.0%
75-84	5.8%	6.1%	6.9%	7.7%	8.0%	8.7%
85+	2.1%	2.4%	2.8%	3.3%	4.0%	4.7%

Gender

The number of men and women aged 65 to 74 is similar, but there are more women than men across the older age groups, which is the same pattern across Scotland. However, it is predicted that over the next 20 years, the number of older men (aged 70+) is projected to increase more rapidly than the number of older women, especially among the very oldest groups.

The difference in the number of men and women is significant because they may have different health needs (for example breast and gynaecological cancers which affect women and become more common with age). And their care and support needs may also be different: for example a preference for same sex care workers.

Gender breakdown of the older age groups in Shetland

	65 - 74	75-84	85 -94	95 and over
Male	1051	508	139	7
Female	1092	670	181	29

Source: *Scotland's Census 2011 website www.scotlandscensus.gov.uk*

Geographical variation in population ageing

There are differences in the age profile of different communities across Shetland. This can be demonstrated using the practice population data. The table below shows that four practices, including the largest in Lerwick, have an over 65 population of around 18%. Brae and Scalloway have younger populations; there are known to be more younger families and a larger working age population in Brae and Scalloway. The three island practices of Unst, Yell and Whalsay along with Walls on the Westside have the highest percentage populations of older people: around a quarter, and nearly 30% in Unst. This clearly has implications for service provision in these areas.

Shetland GP practice populations by age group (April 2014)

Practice	Total	Age under 65	65-74	75-84	85 and over	% aged over 65
Lerwick	9005	7383	930	497	195	18.0%
Scalloway	3296	2815	275	144	62	14.6%
Levenwick	2685	2188	296	156	45	18.5%
Brae	2486	2107	248	97	34	15.2%
Whalsay	1144	881	149	84	30	22.9%
Bixter	1143	935	123	68	17	18.2%
Yell	1073	810	151	91	21	24.5%
Hillswick	754	614	80	37	23	18.6%
Walls	722	561	94	41	26	22.3%
Unst	578	408	108	41	21	29.4%

Source : Local GP data

Ethnicity

According to the 2011 census; 23,167 people living in Shetland, 22,813 (98.4%) described themselves as white. Of the 3777 people aged 65 and over, 3762 (99.6%) described themselves as white as did every person aged 75 and over. This means that at the present time, there are very few older people within minority ethnic groups. However, as the under 65s grow older, then the percentage of older people within minority ethnic groups will increase (albeit still small numbers in Shetland). We may also need to look at language and communication needs of the older white, non-British population – there are currently 64 people in this category over the age of 65.

	0-15	16-24	25-64	65 and older	Total
White British	4262	2316	11691	3716	21985
White non-British	119	80	583	46	828
Asian	52	21	153	8	234
African	2	8	10	3	23
Caribbean /black	0	3	4	1	8
Other Ethnic group	2	3	10	2	17
Mixed / multiple ethnic group	34	9	28	1	72
	4471	2440	12479	3777	23167

Source: *Scotland's Census 2011 website www.scotlandscensus.gov.uk*

6. Current Service Provision

Dementia Services Partnership

The Dementia Services Partnership (DSP) consists of a range of professionals working within health, social care and the third sector. This partnership was developed to ensure a collaborative holistic approach to the treatment, care and support of individuals with a diagnosis of dementia and their carers. The group meets fortnightly and provides a Single Point of Referral for all people with a diagnosis of dementia. The aim is to ensure that people are in receipt of appropriate services and that they continue to be followed up as necessary.
The DSP is designed to meet the needs of clients of any age who have a diagnosis of dementia as well as supporting their carers.

The vision of the Dementia Services Partnership is to provide an integrated service to support individuals living with dementia, their families and other carers. We aim to do this by:

- Supporting people to remain independent.

- Providing a person-centred service to individuals with a diagnosis of dementia and their carers.
- Promoting positive risk taking.
- Offering ongoing and crisis support to avoid hospital admissions.
- Playing an active role in hospital discharge to support carers and other professionals.
- Ensuring individual's health and social care needs are being met.
- Encouraging each person living with dementia to participate in care planning and to play an active role in their own treatment.
- Encouraging and assisting individuals to remain part of the local community.
- Working alongside carers to develop a holistic and flexible treatment plan.
- Providing health promotion and education.
- Promoting the practice of evidence-based care.
- Offering people living with dementia a single point of access to a range of specialist services.

Dementia Assessment Service

The Dementia Assessment Service (DAS) has been developed as a partnership initiative between NHS Shetland and Alzheimer Scotland. The service is led by the Dementia Service Manager who also fulfils the function of the Alzheimer Scotland Dementia Nurse Consultant and has links with the National Nurse and AHP Consultant Group. The nurse led DAS is delivered by the following staff:

- Dementia Services Manager (DSM)
- Dementia Clinical Nurse Specialist (DCNS) (Alzheimer Scotland funded)
- Consultant Psychiatrist (weekly video conference service)

Referrals to the service for those suspected of having a dementia are received from GPs, the Community Mental Health Team and Gilbert Bain Hospital Consultants. The following services are provided:

1. Specialist dementia assessment is delivered with the support of two sessions weekly of Old Age Psychiatry input from NHS Grampian. Referrals of people suspected of having dementia are discussed with the psychiatrist, at a weekly clinic via videoconference. They are then assessed, usually in their own home, by one of the nurses. The referral is discussed in the weekly VC clinic and, where appropriate, a diagnosis can be made. If further assessment is required from the psychiatrist the person can be seen by them via videoconference.

2. Support to staff in the Gilbert Bain Hospital and Care Centres to assist in the assessment and management of people with dementia

3. Support to the Dementia Services Partnership (DSP). All people who are diagnosed with dementia are discussed in the DSP meeting ensuring that any support needs can be addressed.

4. Supporting the Alzheimer Scotland Dementia Advisor and Activities Coordinator (DAAC). In partnership with NHS and SIC staff the DAAC provides access to a wide range of specialist support, advice, activities and raises awareness of dementia issues.

5. Support to the Directorate's learning disabilities services as part of an ongoing commitment to provide care and support to people with learning disabilities who subsequently develop a dementia (NB some learning disability diagnoses are linked to early on-set dementia).

Community Dementia Support Service

This is provided by:

- Service Manager
- Senior Social Care Workers
- Social Care Workers

The service is based at Annsbrae House and delivers a range of community support services for people who have a new diagnosis of dementia and/or complex dementia needs and is proactive in seeking and promoting the views of all those who access the service.

Referrals to the service are primarily received through the Dementia Services Partnership. The services provided include:

1. Supported Accommodation
2. Outreach service
3. Post Diagnostic Link Workers
4. Short break/respite service
5. Duty Service
6. On call Service

There is one shared supported tenancy at King Erik House for up to three people living with complex dementia conditions who would otherwise require residential care.

The Outreach Service provides support to people with complex dementia in their own homes. This service is tailored to individual needs supporting people to live as

independently as possible. Support may be provided with a variety of life and social skills, such as cooking, shopping, budgeting and personal care.

Everyone who is newly diagnosed with dementia is offered the support of a Post Diagnostic Link Worker (PDLW) who will help support the person with dementia and their family for the first year following diagnosis.

A short break/respite service is available to provide family or carers' breaks for those who support individuals living in their own homes with complex dementia.

Annsbrae House, Duty Service offers access to advice or support on any aspect of social care for those with dementia needs and their family. This is provided by telephone, face-to-face, and where feasible, outreach contact.

Where physical frailty is the main presenting problem, a person living with dementia is more likely to receive care from one of the care services in their locality (e.g. Edward Thomason House, Overtonlea etc).

Alzheimer Scotland Services

Alzheimer Scotland provides a Dementia Advisor and Activities Coordinator. They are based in a Resource Centre where people can meet in private or as a group to get advice and support. The resource centre also has a range of information available for people to access.

They provide support to people living with dementia and carers on any aspects of dementia and coping with it.

They also raise awareness about dementia through talks, media involvement and training in order to help make the community more dementia friendly.

They also provide a range of activities which include,

- Four dementia cafes; Lerwick, Levenwick, Brae and Walls
- Art group
- Music and singing group

- Dancing
- Knitting group
- Sports group
- Reminiscence group
- Carers support group
- Sons and daughters support group

Housing and Telecare Services

SIC Housing has made many adaptations to social housing in order to make the person's house more dementia friendly. This is done in conjunction with the Telecare Manager who can advise on a range of assistive technology that can be used to help maintain a person living with dementia safely in their own home for as long as possible.

Simple devices such as door sensors to alert carers if someone goes out their house at unusual times of the day and doesn't return within a given time has proven to be very helpful. These can be linked to a community alarm which will alert a named carer or can alert someone else in the house.

We also have been using monitoring devices such as the Buddi tracking device which can help to identify where someone is if they go out and can be used to communicate with the person if required.

A very successful system that has provided reassurance for carers where the person with dementia lives alone is the Just Checking system. This provides movement sensors in different parts of the house that relays real time information via the internet that can be monitored online by anyone with permission to access it. This allows family to be able to check at any time where the person is in the house and can monitor their movements over a longer period to pick up any issues regarding night time activity if it is suspected the person is active during the night.

Non-Specialist Services

Most people living with dementia and their carers can also be supported by a wide range of non-specialist services and often only get support from the specialist services at the point of diagnosis, for the first year following diagnosis and later in the illness when their care needs may become more complex.

Mostly their support will come from their GP, Practice and Community Nurses, Care at Home staff, Housing support Workers as well as other mainstream services that would be accessed by the general public.

7. Preparation of this Strategy

The second national strategy and Shetland's first Dementia Strategy has been produced on the basis of participation and dialogue at a national and local level.

It was agreed that as an Older Person's Strategy was being developed alongside this Dementia Strategy that there would be a degree of duplication and as such this strategy should be read in conjunction with the Older People's one for additional generic information.

Insert details of the joint local consultation and engagement processes described in the Older Person's Strategy once completed.

8. Progress and Achievements

The Scottish Government made dementia a national priority in 2007, set a national target on improving diagnosis rates in 2008 and published an initial 3-year National Dementia Strategy in 2010, underpinned by a rights-based approach to care, treatment and support. The work over the last three years has been based on strong collaboration in developing and implementing the strategy in a coordinated way.

In 2011 the Scottish Government published the Standards of Care for Dementia in Scotland and the Promoting Excellence framework, which supports the health and social services workforce to meet the standards.

In 2009, NHS Shetland developed the Dementia Assessment Service, outlined in the Current Service Provision section above in order to improve the quality of assessment and increase the number of people with a diagnosis. The 3-year diagnosis target was achieved locally and nationally and the Alzheimer Society's second annual dementia map – published in January 2013 – showed that at March 2012, in Scotland around 64% of those with dementia were being diagnosed. This was significantly higher than England and Wales and shows what can be achieved by clinicians and statutory and voluntary organisations working together.

From April 2013, a further target was introduced which guarantees that everyone newly diagnosed with dementia will be entitled to at least a year's worth of post-diagnostic support, coordinated by a named Link Worker. Locally we took the decision to develop Social Care Staff within the Community Dementia Support Service to fulfil the role of the Link Worker.

Since 2011 the Chief Nursing Officer has led an improvement programme with NHS Boards on the care of older people in hospitals. Alzheimer Scotland Dementia Nurse Consultants have been appointed to Boards across Scotland and 300 Dementia Champions were in place by March 2013.

NHS Shetland took the decision to develop the role of the Dementia Services Nurse Manager to fulfil the Dementia Nurse Consultant role and he participates in the National Dementia Nurse Consultant Group. This post is supported by the Alzheimer Scotland funded post of Dementia Clinical Nurse Specialist who takes the lead in providing support to the Gilbert Bain Hospital as well as all Care Centres in Shetland. Currently there are 7 Dementia Champions in place locally with 1 further one about to be trained.

Locally we have seen several developments in care for people and their families developed since 2010.

- We achieved our three year diagnosis target and have maintained it, continuing to increase the number of people being diagnosed with dementia.
- We are offering support following diagnosis for a year from a named person
- We are developing new models of housing support as well as adapting people's own homes to be more dementia friendly
- We are providing support for hospital and care centre staff to better support people with dementia and manage behaviour that may challenge them without resorting to pharmacological methods where possible
- We are supporting earlier, more appropriate discharge from hospital for people living with dementia
- We are developing Anticipatory Care Plans to better support a person living with dementia if they have to go into hospital or care
- We have established a local Alzheimer Scotland presence in Shetland with the development of a Dementia Advisor, Activities Coordinator, Resource Centre and a local branch of Alzheimer Scotland along with the associated support and activities they provide

9. Challenges

Over the next period of time there are three main challenges that we must address.

First, we must offer care and support to people living with dementia and their families and carers in a way which promotes wellbeing and quality of life, protects their rights and respects their humanity. This is a moral imperative and it is unacceptable that too often the experience of people does not meet this standard.

Second, we must continue to improve services and support from when someone presents for diagnosis, and throughout the course of the illness, including the support needs of carers. This support must be truly person centred, and should understand care and support from their perspective, not the perspective of service managers or clinicians.

Third, we must recognise that with increased life expectancy the challenge of providing high quality care and support to people living with dementia and their carers will increase over time. We must embrace the process of redesign and transformation of services to ensure that we deliver services effectively and efficiently.

Locally, it has been acknowledged that there are particular challenges in delivering aspects of the National Strategy in the context of a remote and rural island group. Some of these challenges are as follows.

1. There is a need to embed dementia care within non-specialist health & social care providers whilst acknowledging that the same group of staff is required to work across many diverse areas of knowledge/skill (e.g. mental health, learning disability, palliative care, all long term conditions).

2. We must ensure co-ordination of service delivery across all health & social care providers.

   In Shetland current community capacity supporting people living with dementia is complex and often hidden.

3. Diseconomies of scale when providing facilities that are appropriate for managing behaviour that others experience as very challenging. This behaviour in people living with dementia is usually temporary and exacerbated by inexperienced responses from staff and families and poor design of facilities and care processes.

   Transferring the person to mainland Scotland will not prevent reoccurrence of the behaviour when the person is returned home after stabilisation.

10. Policy Context

The work on dementia is one strand of the wider work that Scottish Government is taking forward to transform and improve health and social care services. Other key strands of that work include:

Integration of Health and Social Care: the Scottish Government has enacted legislation to allow for the local integration of adult and older people's health and social care services in Scotland; the need to improve the response to dementia is one of the key policy drivers for this work and health boards, local authorities and the voluntary sector are involved in this process.

Reshaping Care for Older People/Change Fund: the Scottish Government is investing £300 million to facilitate changes in the way services are designed and care is delivered, including services for people living with dementia.

Health and Social Care Partnerships will set out their intentions for the future delivery of care for people living with dementia and their carers in their respective planning documents and have the ability to develop plans together through joint commissioning processes.

Carers Strategies: Caring Together: The Carers Strategy for Scotland 2010-15, which is underpinned by £98 million of investment between 2008 and 2015, recognises that carers must be seen as equal partners in the delivery of care as their support enables people living with dementia to live at home and in their own communities safely, independently and with dignity.

Self-directed Support: self-directed support is a major reform to the way in which social care and some healthcare services are delivered and gives greater choice and control to those who receive support; the Alzheimer Scotland pilot on self-directed support in Ayrshire showed that self-directed support offers benefits to people living with dementia.

Housing: older people, including those living with dementia, consistently tell us that they want to live in their own homes for as long as possible, rather than in hospitals

and care homes. Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021 emphasises the role of housing and housing-related support in 'shifting the balance of care' towards independent living in the community and reducing the use of institutional care settings.

Palliative Care: Living and Dying Well; a National Action Plan for Palliative and End of Life Care (2008) and Living and Dying Well: Building on Progress. Work (2011) promote the provision of palliative and end of life care to all, regardless of diagnosis, and is consistent with, and highly supportive of, improvements in care for people living with dementia and their families.

11. Key Outcomes for Shetland

The key outcomes from this Strategy, which emerged from the National Dementia Dialogue as priorities, and were reflected in our local consultation and engagement processes, were:

- more people living with dementia living a good quality life at home for longer.

- dementia-enabled and dementia-friendly local communities, that contribute to greater awareness of dementia and reduce stigma.

- timely, accurate diagnosis of dementia.

- better post-diagnostic support for people living with dementia and their families.

- more people living with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness.

- better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment.

- people living with dementia in hospitals or other institutional settings always being treated with dignity and respect.

A local Implementation Action Plan will be developed in partnership with local and national partners. The plan will be subject to regular monitoring and review.

12. Local Priority Actions

This Strategy will identify our local priorities that we will develop in order to meet the 17 National Commitments that the Scottish Government has made in order to achieve the outcomes listed above.

These priorities are as follows:

- ***Further develop the Dementia Assessment Service***

People can be reluctant to go to the doctor when they are worried that they may have dementia because the benefits of diagnosis for them are not clear. There are challenges around diagnosis and we recognise that accurate diagnosis in the earlier stage of the illness can be difficult. But we also know that appropriate support in the early stages can have a very significant impact on the degree to which someone is able to manage the condition over time and live independently.

Effective diagnosis – including how it is imparted and how people are supported immediately after diagnosis – can mean that the traumatic aspects of receiving a diagnosis can be counterbalanced. Timely diagnosis enables people to plan ahead while they still have capacity to do so and means they can get early and effective access to drug and other interventions which can sustain their cognition, mental wellbeing and quality of life. Current medications available for some forms of dementia can help to slow the symptoms and sometimes improve symptoms in the short term, although they do not treat the underlying disease; the main form of treatment is human intervention. Too often in the past diagnosis has been late, well after the condition is having a significant impact on daily life, causing confusion and distress to the individual and family around future planning.

The current nurse led service was developed on the islands supported by input remotely through video link from a consultant in old age psychiatry based in Royal Cornhill Hospital in Aberdeen. At present this service is able to provide assessment of people suspected of having dementia and if confirmed deliver and discuss diagnosis with the person and their family. The nurses can then review those prescribed medication for up to 6 months and then hand the care back to the GP to continue to review. Those not on medications are passed back to the GP for follow up at point of diagnosis.

Although input from a Post Diagnostic Link Worker is offered at point of diagnosis, not everyone wants this and so the uptake rate at present is around 60%.

There are a number of people living with dementia that would benefit from some further post diagnostic nursing input, which at present, due to service capacity, is difficult to meet.

It has been identified that building additional nursing capacity within this team is essential to meet their needs.

Meeting this priority would contribute to National Commitments 1, 2 & 3.

- ***Embed the role of Post Diagnostic Link Worker within all Care at Home Teams.***

Supporting people living with dementia and their families and carers (commonly known as post-diagnostic support) was one of the key change areas in the first Dementia Strategy. Better post-diagnostic support helps people to adjust to the diagnosis and its likely impact – both practical and emotional – and help them plan for future care, including through advanced care planning for the delivery of preferred end of life care. It can help services work better with people's "natural" family supports during this important stage of the illness. It can contribute to people with dementia living a better quality of life and living as independently as possible and as part of their community as for as long as possible.

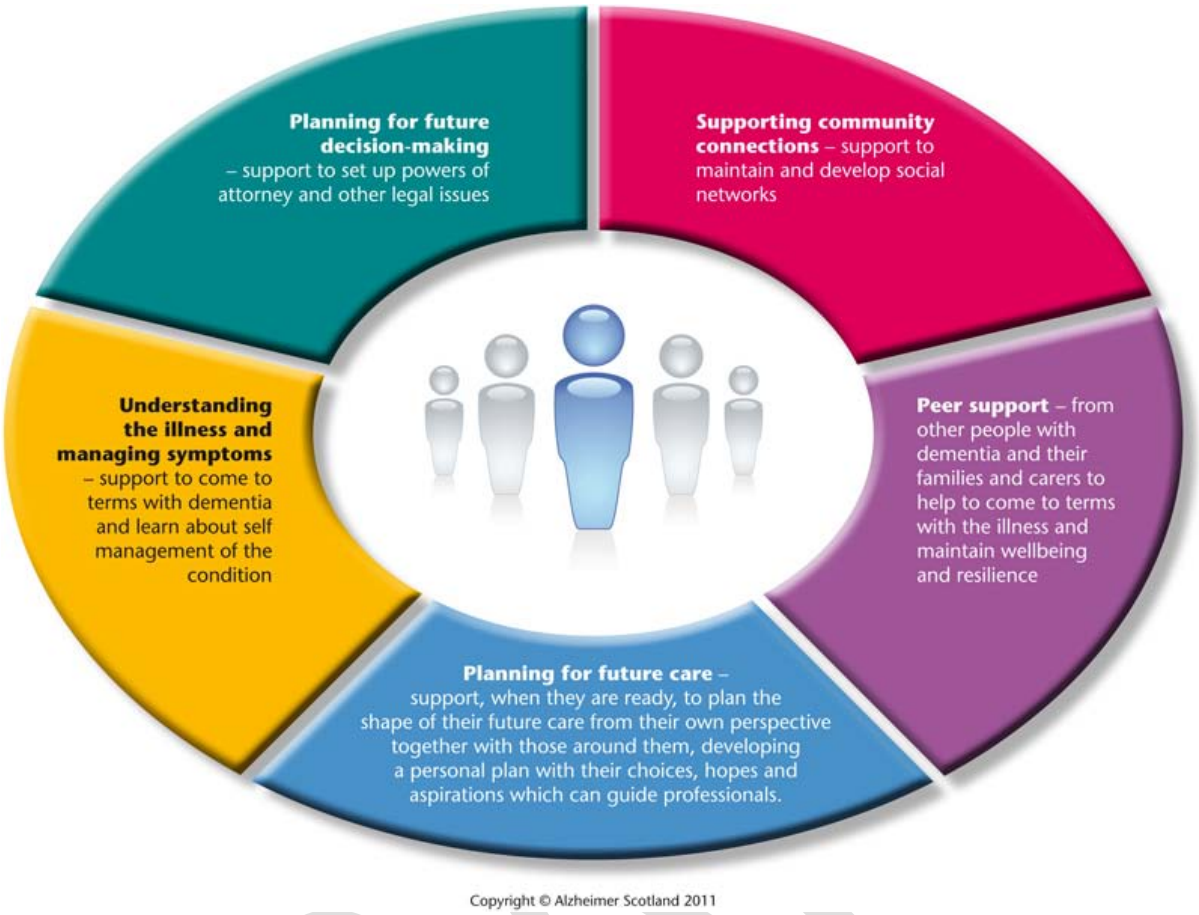
The Scottish Government HEAT target states that,

'To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a Link Worker, including the building of a person-centred support plan'

The post-diagnostic target is designed to give people time and space to access services and receive high quality support in a way that meets their individual needs over the course of a year. It recognises that a diagnosis of dementia can have a huge impact on individuals, carers and families and that coming to terms with a diagnosis and what it will mean for an individual and their loved ones can take time and expert support.

While the target is primarily designed to support people in the earlier stages of the illness, it applies equally to everyone diagnosed from 1 April 2013 and in every care setting, including care homes and hospitals.

The post-diagnostic HEAT target is informed by Alzheimer Scotland's "5 Pillars" model of post-diagnostic support shown below



The 5 Pillars highlight key areas of activity for post-diagnostic support and each person's needs are assessed against each of the 5 pillars. The Link Worker operates at a minimum of 'Enhanced' level on the *Promoting Excellence* framework and has had specific training in post-diagnostic support and in the 5 Pillars model before undertaking this role.

The Link Worker works flexibly with each person living with dementia, and with the person's family and natural support networks, introducing each of the 5 pillars in a personalised and holistic way and at the appropriate time for the person.

Recognising the key roles of carers and families is essential in helping design and implement a person-centred support plan.

Although everyone diagnosed from 1 April 2013 will be allocated a Link Worker, some individuals may not want support right away, or may decide they do not want support further down the line before the end of the 12 months. There may be some people who do not want any support at all during the 12 month period. The Link

Worker keeps in regular contact with every individual on their caseload (as appropriate) and the post-diagnostic support is available for the individual to access in a manner of their choosing and which suits their individual needs and circumstances.

At the end of the 12 month period, each individual's support needs are assessed. At this point most people in the earlier stages of the illness are assessed as being able to move to self-management, drawing on support when needed; other people need more time-limited support while others with complex needs may require longer term support and treatment.

Locally the Post Diagnostic Link Worker is one of the Social Care Workers within the Community Dementia Support Service based in Lerwick. These workers have received additional training to take them to Enhanced Level within the Promoting Excellence framework but as they are based in Lerwick it means that they are supporting people living with dementia in all parts of Shetland which requires them to travel fairly lengthy distances with associated travelling time and costs.

In order to address this it is essential that this role is developed within existing locality care teams.

Meeting this priority would contribute to National Commitments 2 & 8.

- ***Develop Occupational Therapy (OT) support for people with dementia***

It is recognised that the role of the OT can be crucial in supporting active non-pharmacological interventions for people living with dementia as well as contributing to maintaining the independence of the person living with dementia to enable them to live at home for as long as possible.

People with dementia can benefit from timely health and social care supports, to enable them to live a good quality life at home for as long as possible as the illness progresses. Historically, interventions have tended to occur at a stage when the person with dementia's physical and mental capability and resilience has

deteriorated. In line with key principles underlying the integration of health and social care, we need to move more towards a system of care which maximises and promotes resilience and independence and which supports and promotes the capabilities of the person living with dementia at home during the moderate to severe stages of the illness, as they move from self-managing the illness with support to needing more intensive support.

The Standards of Care for Dementia recognise the importance of people living with dementia being enabled not only to stay at home and in their community. They should also be, as much as possible, visible, connected and active participants in their local communities – including in social events, the arts, and religious and community groups. Nurturing and supporting dementia-aware and dementia-friendly local communities is important in creating and sustaining a society where people living with dementia and their families and carers feel included and at the heart of the community.

While the post-diagnostic commitment for everyone diagnosed on or after 1 April 2013 will also help drive wider changes in dementia services, we know that there are a large number of people who have been living with dementia who are at the stage of the illness when they require more intensive support.

Alzheimer Scotland's policy paper *Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support* proposes an integrated care model to address these issues.

This 8 Pillar model focuses specifically on that stage of the illness where more intensive community services are needed to enable people to stay living well and as independently as possible at home for as long as possible. The model is based on a coordinated, holistic approach which also aims to provide continuity of care in the form of that key contact point for people living with dementia and their carers.

The 8 Pillars Model is shown below and the pillars are:

Pillar 1: The Dementia Practice Coordinator (to coordinate the 8 Pillars)

Pillar 2: Therapeutic interventions to tackle the symptoms of the illness

Pillar 3: General health care and treatment

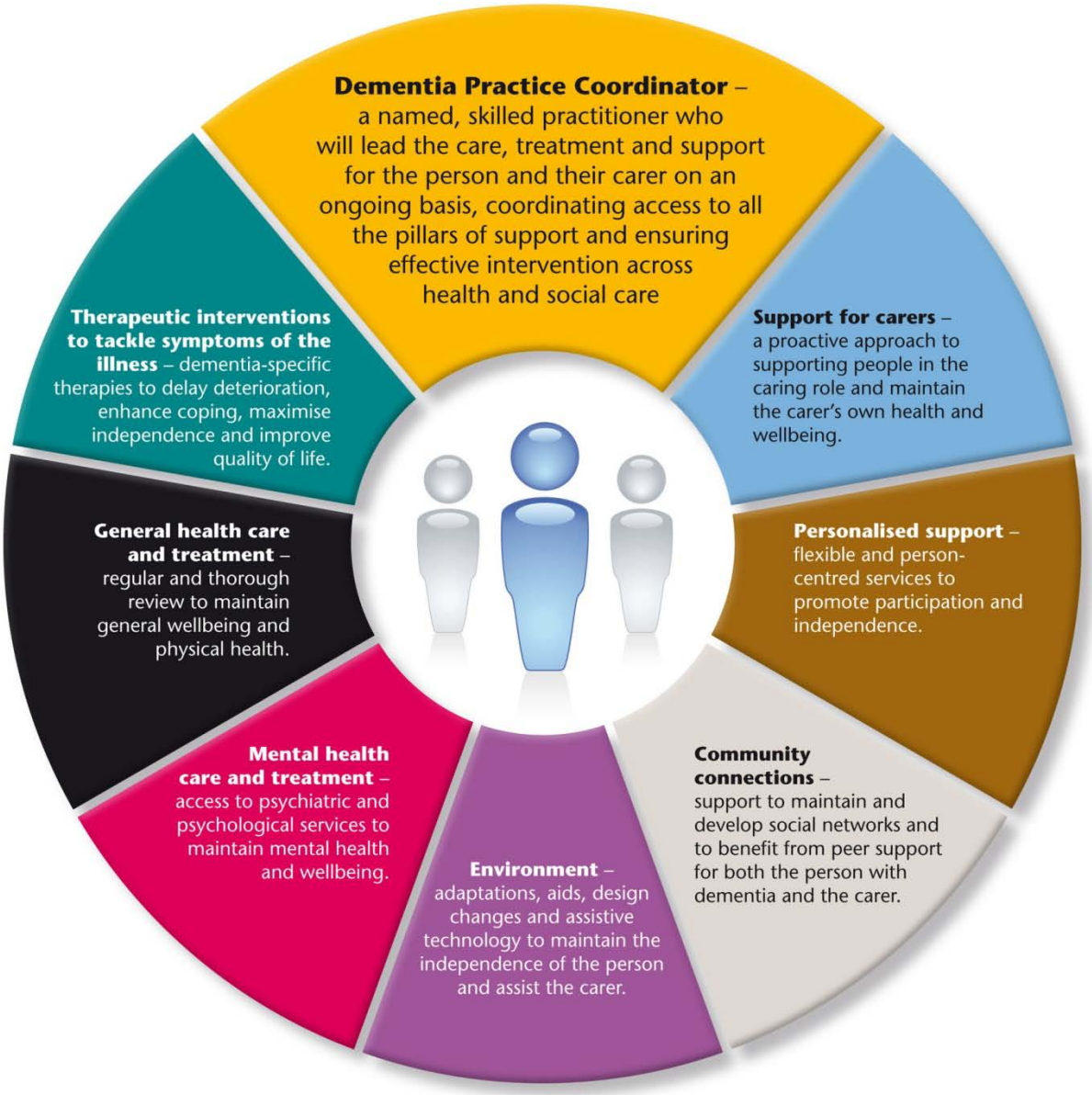
Pillar 4: Mental health care and treatment

Pillar 5: Personalised support

Pillar 6: Support for carers

Pillar 7: Environment

Pillar 8: Community connections



National testing and evaluation of a range of approaches based on the 8 Pillars Model is in progress in Demonstrator Sites across Scotland and the outcomes of this pilot will inform Shetland's service development.

It is likely that it will be essential to develop the role of Dementia Practice Coordinator locally and it would be sensible to consider this being an OT.

Meeting this priority would contribute to National Commitments 3, 4 12 & 16.

- ***Develop housing design support and interventions***

As people age, their housing needs change and some people, such as those living with dementia and mobility problems, will also need specialised housing-related support services. If these needs are not met, it may be more difficult for people to remain in their own homes.

A familiar home environment is particularly important to people living with dementia. Most people living with dementia live in their own homes in the community but in homes that were not built to today's standards of accessibility. Well-designed housing is particularly important to people living with dementia and can extend the amount of time that they are able to remain living at home, by reducing accidents and delaying the need for residential care.

Since most people living with dementia live in ordinary housing, the housing services that support them to remain in this environment are key, with housing adaptations, handypersons, small repairs and housing support services of particular importance. These services are generally provided by social landlords (local authorities and housing associations) for their tenants, and by Care and Repair services for people living in private sector housing.

The frontline housing officers and technical staff, who deliver these housing-related services, may often be working with people who have dementia, most likely in the early (sometimes undiagnosed) stages. Many staff would benefit from an increased understanding of what dementia is, how to identify the signs and what to do next to help support people living with dementia.

We will work closely with SIC Housing and Hjatland Housing Association to ensure that by becoming more understanding of the needs of people living with dementia they will consider these needs when making adaptations to existing housing as well as when designing new build.

Meeting this priority would contribute to National Commitments 5 & 8.

- ***Further trial and develop assistive technology***

Shetland has a good track record in the use of innovative new technologies and is committed to implementing telehealth and telecare solutions where these are proven to be of benefit. We will promote knowledge and awareness of these resources within the local community.

We have an excellent resource in the Independent Living Centre where there is a wide range of resources available for people to access and consider what would work for them.

Through the Northern Periphery Partnership we have participated in the RemoDem project in partnership with Norway, Sweden, Faroe Islands, Western Isles and Greenland to identify and test innovative ICT solutions and models of care to support older people living with dementia in rural areas to access professional health and care services based in larger towns and cities without having to travel or leave their homes, to maintain social contact with friends and family who may not live nearby, and to continue to feel and to be a part of the communities in which they live.

From this we have been working closely with colleagues in the Western Isles in a joint trial of innovative new technology to assist people to remain independent in their own homes.

A second project with the original RemoDem partners has been approved to further develop these models of care which will begin in 2015 and run for three years.

We will ensure that an awareness of what is available in the way of assistive technology that can keep people independent is developed in order that other alternatives to residential care are considered for older people in general and in particular, those living with dementia.

Meeting this priority would contribute to National Commitments 3, 4, 5, 15 & 16.

❖ ***Develop local expertise in rights based care***

In the first Dementia Strategy, the Standards of Care for Dementia in Scotland were developed**,** based on the Charter of Rights developed by the Parliamentary Cross Party Group on Alzheimer's disease**.** The dementia standards are based on six overarching statements of individual rights:

- I have the right to a diagnosis
- I have the right to be regarded as a unique individual and to be treated with dignity and respect
- I have the right to access a range of treatment and supports
- I have the right to be as independent as possible and be included in my community
- I have the right to have carers who are well supported and educated about dementia
- I have the right to end of life care that respects my wishes.

The standards are designed to inform care providers of their responsibilities and to help them self-audit services and to empower people living with dementia and their carers. A guide to the standards is available from Alzheimer Scotland. In conjunction with *Promoting Excellence*, they form a crucial part of work to improve knowledge and practice. Rights-based training has been developed for care home staff.

We will take more action specifically in relation to dignity and respect, including attention to human rights and the principles and requirements of mental health and incapacity legislation, including:-

- earlier identification of people with palliative care needs, to promote advance care planning, to facilitate the sharing of key information across settings through the development and roll out of the Electronic Palliative Care Summary

- promoting best practice in advance care planning based on the wishes of the individual and taking account of carers' views in accordance with the principles of incapacity legislation

- promoting best practice in assessing capacity and providing care and treatment in line with the law.

- in particular, promoting best practice on Do Not Attempt Cardiopulmonary Resuscitation decision-making and communication and supporting, with greater awareness of proper procedures for making decisions for people living with dementia who lack capacity.

- ensure that environments, especially in hospital, are sufficiently enabling for people living with dementia and that individual care planning based on the individual's life story is in place. The introduction of 'Getting to Know Me' has allowed for increased input from carers and people with dementia into their care. The introduction of person centred care will further this aim.

We have identified individuals from CMHT/Health/MHO who will be developed to become local "experts" and be available to provide advice and support to those required to carry out capacity assessments.

Meeting this priority would contribute to National Commitments 6, 7, 8, 10, 12 & 14.

❖ ***Continue to develop workforce skills and competencies***

Promoting Excellence: *a framework for all staff working with people with dementia, their families and carers* was launched in June 2011, together with the Standards of Care for Dementia in Scotland. Between 2011 and 13, NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC) have undertaken a programme of work to support workforce development against the *Promoting Excellence* Framework, including the development of a number of educational

resources, the roll out of a number training programmes, and establishing infrastructures to ensure spread and sustainability of this work.

We have been developing the workforce locally in line with this and some aspects of *Promoting Excellence* has become embedded in both the SIC and NHS Shetland's staff development. Details of local education and training will be identified and recorded to ensure we maintain and develop the knowledge and skills of people working with those who are living with dementia.

We are also currently in negotiations with NES to further develop our workforce to better deliver post diagnostic support by delivering the *Promoting excellence in supporting people through a diagnosis of dementia* training locally.

Training will be delivered through a range of mediums including facilitated teaching, self directed, remotely through video links and online.

We will continue to improve staff skills and knowledge by working with NES and SSSC to take forward a second Promoting Excellence training plan across the period of this Strategy.

Meeting this priority would contribute to National Commitments 2, 8, 9, 10, 11 & 12.

- ***We will contribute to and deliver on the 3-year National Action Plan to improve care in acute general hospitals***

Our objective is to do two things: to make the current system of care in hospital work better for people living with dementia in ensuring better quality of care; and to begin to look at how we remodel the wider system of care, including care in hospital, to address how we best provide acute health care for people living with dementia in a way which keeps them at home wherever possible and which ensures they are discharged from hospital safely and timeously. The wider context for this work is the integration of health and social care.

A **10-Point National Action Plan** has been developed by an expert Dementia Standards in Hospitals Implementation and Monitoring Group (IMG), chaired by the Chief Nursing Officer and including representation from key partners such as Alzheimer Scotland, Healthcare Improvement Scotland, the Mental Welfare Commission, clinicians and healthcare services, to support implementation of the Standards of Care for Dementia in acute care to make sure the current system of hospital care is working and to maximise the impact of the investment over the last 2 years in the capability and capacity of staff operating in those settings. It will support service transformation and support strategic ownership of this agenda at an NHS Board level. The Action Plan will help focus and coordinate a range of initiatives taken forward over the last two years.

The Action Plan's 10 headline areas have been developed over recent months by the National Dementia Standards in Hospitals Implementation and Monitoring group.

The 10 Actions are listed in the table below:

1. Identify a leadership structure within NHS Boards to drive and monitor improvements
2. Develop the workforce against the *Promoting Excellence* KSF
3. Plan and prepare for admission and discharge
4. Develop and embed person-centred assessment and care planning
5. Promote a rights-based and anti-discriminatory culture
6. Develop a safe and therapeutic environment
7. Use evidence-based screening and assessment tools for diagnosis
8. Work as equal partners with families, friends and carers
9. Minimise and respond appropriately to stress and distress
10. Evidence the impact of changes against patient experience and outcomes

We will contribute to a detailed delivery plan with the intention that the 10-point Dementia Care Action Plan is implemented over the next 3 years. The implementation plan will identify key deliverables, action leads and improvement support. It will align and integrate where possible with other existing national programmes and initiatives, such as the Person Centred Health and Care Programme.

We will continue to develop integrated partnership working with all areas in the Gilbert Bain Hospital in order to support staff there in the implementation of the 10 Care Actions. We will further develop the principals of the 10 care actions within Care Centres.

Meeting this priority would contribute to National Commitments 3, 8, 9, 10, 11, 12, 13, 14 & 16.

- ***Develop a model of involving people living with dementia and their carers in deciding on future service direction***

It is recognised that the views of people living with dementia and their carers is essential when developing services for them. At present there are a small number of people living with dementia, carers, ex-carers and interested members of the public who have been actively involved in raising awareness about dementia.

It is important that their voices are heard when it comes to influencing local policies and as such developing a forum to take this forward should be one of our priorities in this strategy.

We will work in partnership with people living with dementia and their carers to develop a Dementia Working Group to contribute to helping to improve services for people living with dementia and to improve attitudes towards people living with dementia.

Meeting this priority would contribute to National Commitments 3, 9, 14 & 16.

- ***Develop Shetland as a Dementia Friendly Community***

It was identified in the Deep Dive Report commissioned from Dementia Services Development Centre at Stirling University that one of the underpinning issues to improving care for people living with dementia is to engage with the public in Shetland to obtain a commitment to becoming Dementia Friendly.

There are many examples of models to follow to develop a dementia friendly community and this will be a long-term commitment as it will involve engaging with a wide range of organizations and individuals. The intention will be to work with a few interested communities initially to pilot approaches and see what works well and what doesn't.

Work has already been carried out in Bigton with the Community Shop having had an audit carried out and action taken to make the shop more dementia friendly. Training was also carried out with staff. It is intended that further work will be undertaken in the community to build on this.

Some work has also been started in the Mossbank area, raising awareness in the local shop and pub which has been well received.

Enquiries have been made in Whalsay and it is likely that this will be the next area to engage with to work toward them becoming the first Dementia Friendly island and this will commence this summer.

We are aware that people with dementia are supported by a wide range of services and individuals and not just within Health and Social Care. The statutory agencies will need to adopt a more inclusive approach to capacity development, helping the public understand that they themselves are as critically important to dementia support as professional services have been.

As such, we need to focus on where financial resources are currently deployed with a view to challenging these deployments in terms of value and impact in supporting a fully functioning dementia-friendly island.

We will continue to build on the work that has been carried out in raising awareness of the importance of Dementia Friendly Communities and enlist further support throughout Shetland to make this a priority for everyone.

Meeting this priority would contribute to National Commitments 1, 5, 8, 9, & 14.

- ***Develop expertise and environment to manage behavior that is challenging within Shetland***

It was identified in the Deep Dive assessment that there were particular challenges for Shetland in managing certain types of more challenging behavior in a small number of individuals. There was a perception that only staff who were more experienced could manage these people and that there were occasions when the person could only be managed in off-island placements. There was also the perception that Shetland did not have an appropriate space where someone who is challenging for others to manage can be maintained safely during such episodes

Such behaviour in people with dementia is usually temporary and can often be a result of inexperienced responses from staff and families and poor design of facilities and care processes. As such it is likely that with the right response from carers and families and the right environment it is possible to minimise such behaviour.

This assessment also indicated that it should be possible to develop a small unit that can be staffed with appropriated experienced staff when required.

We will further develop the necessary skills to manage behaviour that is challenging and will develop an appropriately designed space that can be used, when necessary, to manage the person during this phase.

Meeting this priority would contribute to National Commitments 3, 5, 8, 9, 11, 12, 13, & 14.

13. Summary

This strategy aims to highlight the importance of effective forward planning to address the challenges involved in meeting the needs of the growing number of people who will be diagnosed with dementia.

To meet the challenge we need to work with those professionals who assist people living with dementia and the general public in Shetland to raise awareness of our community responsibilities.

To do this we need to ensure that dementia is kept firmly on the agenda when decisions that affect older people are being made. Dementia also needs to be kept in the public consciousness through ongoing awareness raising within the local media.

By striving towards the goal of creating a Dementia Friendly community we will ensure that people living with dementia and their carers will feel less stigmatised and will be able to live well with their diagnosis, remaining integrated, within their community, and where possible, within their own home for the rest of their lives.

Dementia Strategy Action Plan
2015 - 2018

Action	Descriptor	What needs to be done	Responsibility	Date due	Progress
Develop the Dementia Assessment Service	Capacity to deliver ongoing nursing input beyond assessment and diagnosis is very limited within the Dementia Assessment Service	Review of current service provision and capacity to determine future needs	Dementia Services Nurse Manager Service Manager, Mental Health	January 2016	
Embed the role of Post Diagnostic Link Worker (PDLW) within all Care at Home Teams	Post diagnostic support requires to be provided throughout all parts of Shetland in an efficient and cost effective manner	Review the current model of the Post Diagnostic Link Worker to ensure that it meets the Scottish Government HEAT target requirements and determine if this is the best model for Shetland. Identify key individuals in each locality team have the required experience and training to deliver post diagnostic support and provide further training to become PDLWs	Dementia Services Nurse Manager Executive Manager, Community Care Resources	December 2015 April 2016	
Develop Occupational	Implementation of the 8 Pillar	Review current capacity within OT service to identify ways that	Executive Manager,	April 2016	

Therapy (OT) support for people with dementia	Model requires a Practice Coordinator. Support for people with dementia to remain as independent as possible, as the condition advances, requires the skills associated with an OT	this role could be developed prior to the implementation of the 8 Pillars Model once it has been evaluated in the test sites.	Occupational Therapy		
Develop housing design support and interventions	Design of housing that meets the needs of people living with dementia is essential to support them to live safely at home and delay the need for residential care	Continue to develop current social housing stock to be more dementia friendly Consider the needs of people living with dementia when building new social housing stock Invest in developing further models of housing such as those found in King Eric House and Brucehall Terrace	Team Leader, SIC Housing Support Hjatland Housing representative	Ongoing	
Further trial and develop assistive	People living with dementia have a right to	Building on from the experience of participating in the RemoDem project in partnership with	Telecare/telehealth Manager	May 2018	

technology	remain as independent, living safely in their own home for as long as possible. They also have a right to remain integrated within their own community	Norway, Sweden, Faroe Islands and Greenland, we will further identify and test innovative ICT solutions to support people living with dementia living in rural areas. We will trial ways that will allow people to access professional health and care services based in larger towns and cities without having to travel or leave their homes. We will use assistive technology to trial ways of allowing people living with dementia to maintain social contact with friends and family who may not live nearby, and to continue to feel and to be a part of the communities in which they live.	Dementia Services Nurse Manager		
Develop local expertise in rights based care	Identify people with palliative care needs, to promote advance care planning	Deliver Training in palliative care to a range of staff Further develop Anticipatory Care Plans for people with dementia	Dementia Clinical Nurse Specialist Dementia Services Nurse Manager Chief Nurse, Directorate of Community Health and Social Care	Ongoing April 2016	

	Capacity assessments and provision of care and treatment must reflect best practice Provision of person centred care must be central in all care settings	Develop “expert advisors” skilled in supporting those carrying out assessments of capacity Develop shared person centred care plans for SIC and NHS staff to use for people living with dementia	Dementia Services Nurse Manager Service Manager, Mental Health Dementia Services Nurse Manager Team Leader, Annsbrae Community Support Services	December 2015 December 2015	
Continue to develop workforce skills and competencies	Everyone who is in contact with people living with dementia requires to be educated to the appropriate level of need within the	LearnPro and Brightwave training modules for Promoting Excellence will be further promoted to encourage all NHS and SIC staff to complete. Training needs analysis to be carried out for NHS and SIC staff to determine levels of	Training Manager, SIC Staff Development Manager, NHS	Ongoing April 2016	

	Promoting Excellence framework	training required A learning event will be facilitated for hospital nurses to commence progression of Promoting Excellence, Skilled Level. This will be further developed for community nurses	Dementia Services Nurse Manager Dementia Clinical Nurse Specialist	December 2015	
Contribute to and deliver on the 3-year National Action Plan to improve care in acute general hospitals	The 10 Care Actions in Hospital is a Scottish Government priority and as such must be delivered	Continue to develop the local dementia nurse champions network Identify and implement projects to meet the identified Care Actions ensuring that these fit in with wider improvement work at ward/departmental level	Dementia Clinical Nurse Specialist Senior Nurses, GBH Director of Nursing & Acute Services	Ongoing April 2016	
Involve people living with dementia and their carers in deciding on future service direction	Establish a group of appropriate people living with dementia (PLWD) and carers to take forward the Strategy. Ensure the views of PLWD	Engage with PWD and carers to develop a focus group and invite to an initial meeting. Set up regular meetings and invite further members as appropriate.	Dementia Services Nurse Manager. Alzheimer Scotland Dementia Advisor	September 2015	

	and carers are widely represented.				
Develop Shetland as a Dementia Friendly Community	Dementia Friendly Communities are defined by the Alzheimer's Society as 'villages, towns, cities and organisations that meet set criteria to show a high level of public awareness and understanding so that people with dementia and their carers are encouraged to seek help and individuals and communities know about dementia to be able to help someone with	Develop an initial pilot in the North Isles, as part of the RemoAge project, to engage with the public through a series of events, meetings and workshops. Identify Community Leaders to assist with this task and agree most appropriate means of engagement. Use the data gathered in this project to further develop in other areas of Shetland Continue to work with and further develop dementia awareness in community businesses. Build on and develop community resources for PLWD and carers.	Dementia Services Nurse Manager. Telehealth/telecare Manager Dementia Services Nurse Manager Alzheimer Scotland Dementia Advisor	April 2016 Ongoing Ongoing	

	the condition' (Alzheimer's Society 2012)				
Develop expertise and environment to manage behavior that is challenging within Shetland	There needs to be a resource on-island to support people presenting with disturbing behaviour who need short-term time out from the environment that is likely to be causing the behaviour.	Develop a small unit that can be made operational at short notice when required. This would be staffed by specially trained staff who would work in other roles when not required. It is being considered that this could be developed as a resource that would also meet the needs of people with a mental illness requiring short-stay treatment that does not necessitate admission to hospital off island as well as a designated "place of safety" for people awaiting transfer to a psychiatric hospital, whether with a diagnosis of dementia or other mental illness. Various options are being explored at present to determine the best one to proceed with. Once a unit is identified, agree on and provide training and support for staff from colleagues in NHS Grampian.	Service Manager, Mental Health Head of Estates and Facilities Interim Executive Manager, Mental Health and Community Care Dementia Services Nurse Manager Team Leader, Annsbrae Community Support Services	April 2016	

Dementia Strategy Action Plan
2015 - 2018

The following outcomes are taken from the Scottish Government's National Health and Wellbeing Outcomes. The three selected are the ones seen as having the greatest relevance to the work that will be developed from this strategy.

Aims and Objectives

Directorate Plan Aims	Action
Outcome 2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	There will be ongoing public awareness raising of the importance of maintaining the independence of people living with dementia to allow them to live safely in their own home wherever possible. There will be further investment in development of models of housing such as those found in King Eric House and Brucehall Terrace. There will be further investment in assistive technology that allows people to live safely and independently in their own homes wherever possible.
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	All people in receipt of care from health and social care services can expect the same quality of service from all health and social care staff regardless of where they live. There will be ongoing training of all health and social care staff in the care of people living with dementia.
Outcome 4. Health and social care services are centred on helping to maintain or improve the	People living with dementia and their carers can expect to be able to access a range of services provided in partnership between health, social care and the

Dementia Strategy Action Plan
2015 - 2018

Directorate Plan Aims	Action
quality of life of people who use those services.	third sector that will maintain and improve the quality of their lives. We will focus on developing support to improve resilience and quality of life of people living with dementia by enabling them to remain connected to the communities in which they live.

Service Aims/Priorities	Objectives/Actions
Ensuring people can access information on the assessment, care and treatment of dementia	Develop information in electronic and paper version on services and initiatives for people living with dementia and their carers.
Promoting resilience and independence in people living with dementia	Work with communities to identify local supporters to assist in maintaining the involvement of people living with dementia in their communities. Develop methods of improving the quality of life of people living with dementia. Continue to promote the concept of reablement of people living with dementia to maintain and develop skills and abilities that promote their independence.
Early recognition and treatment of dementia	Continue to raise awareness of the importance of seeking early diagnosis of dementia.

Dementia Strategy Action Plan
2015 - 2018

Service Aims/Priorities	Objectives/Actions
Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carers and families	Further development of the role of the Post Diagnostic Link Workers in all localities in Shetland will ensure consistency of approach to person centred care and will include the development of robust personal care plans for all people living with dementia.
Ensuring people living with dementia are at the centre of care and treatment	All people living with dementia will be consulted about their care at key points in the care process. Treatment and planned care will only be agreed following consultation with them and with their agreement. In the event of them having lost capacity to make decisions, care will be agreed with their Power of Attorney.
Effective engagement of families and carers to support care and treatment	Family members and carers will be invited to take part in all assessments and care planning and will be encouraged to participate in the care of the person living with dementia.
Embedding the concept of risk enablement in the care of people living with dementia.	Care providers will work with people living with dementia and their carers to ensure that they are encouraged to remain independent and, in all cases, that they balance risk of harm to the person living with dementia with potential benefits to the emotional and physical wellbeing of them. In doing so the person living with dementia will be able to experience a better quality of life.

Dementia Strategy Action Plan
2015 - 2018

Service Aims/Priorities	Objectives/Actions
Redesign of the Dementia Assessment Service in line with service demands.	Identify permanent funding for the Dementia Clinical Nurse Specialist role. Consider the development of the Dementia Assessment Service to become an Old Age Psychiatry service including the assessment and treatment of older people with functional mental health problems.

New Planned Actions Due to Start in 2015/16

Title/Heading	Team	Start	End	Output	Expected Outcome/Supported Aims/Objectives
Review clinical workforce within the Dementia Assessment Service to build a stable and sustainable service structure, and move towards an Old Age Psychiatry Service.		July 2015	March 2016	Better patient outcomes with additional nursing support. Development of an Old Age Psychiatry Service covering all	Recruitment of additional staff that can provide a wider range of care and skills for people with functional mental health problems as well as dementia.

New Planned Actions Due to Start in 2015/16					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
				aspects of mental health needs.	
Develop existing staff to have in depth knowledge of the assessment of capacity to act as “expert advisors” to support those carrying out assessments of capacity		September 2015	March 2016	Availability of access to someone with knowledge of assessing capacity.	Support to those carrying out assessments of capacity to ensure greater clarity and consistent approaches and decisions when required.
We will develop staff providing care for people living with dementia and their carers to adopt a personal outcome focussed approach to delivery of care needs.		September 2015	March 2016	All people living with dementia will have individual personal support plans in place. They will also have an Anticipatory Care Plan	Information about current and potential future care needs for the person living with dementia and their carer will be gathered and will ensure that their wishes will be reflected in any care requirements.

New Planned Actions Due to Start in 2015/16					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
				developed which will be shared with staff in the Gilbert Bain Hospital.	
A project focussing on the North Isles will pilot innovative ways to involve the community as a whole in supporting people living with dementia to remain integrated within their communities.		May 2015	April 2018	Involvement of people living in these areas in the support of people living with dementia.	People living with dementia in these areas will have an improvement in the quality of their life by feeling they are able to continue to be part of their community. A trial of the use of different types of technology in supporting this group to assess its suitability.

Agenda Item

4

Shetland Islands Council

NHS Shetland

SHETLAND HEALTH AND SOCIAL CARE PARTNERSHIP

Social Services Committee and CHP Committee **30 September 2015**

Delays in Discharge from Hospital to a Community Setting Update	
Report No: CC-41-15 F	
Report by : Director of Community Health & Social Care	**Community Health and Social Care Directorate**

1.0 Summary

1.1 The purpose of this report is to inform Members of Social Services Committee and CHP Committee of the work that is being carried out between Acute and Community Health and Social Care Services to minimise the number of people whose discharge from hospital to a community setting is delayed.

1.2 This report summarises the actions being taken within Community Health and Social Care Services and Acute Services. The issue of delayed discharges has particular relevance to Winter Planning and ensuring that there is adequate capacity in Acute Services to admit patients who need inpatient care and also that there are adequate hospital beds for elective care (including planned surgery).

2.0 Decisions Required

2.1 The Social Services Committee and CHP Committee NOTES the actions being taken by both Community Health and Social Care Services and Acute Services and comment and advise on the progress made and future plans for tackling the issues of delayed discharges.

3.0 Detail

Background

3.1 "A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge and who continues to occupy the bed beyond the ready for discharge date". (*Delayed Discharges Definitions and Data Recording Manual, 2012*).

3.2 The Scottish Government target from April 2015 is for no people to wait more than 14 days to be discharged from hospital to a more appropriate care setting.

3.3 At the time of writing this report the situation is:
- 5 delayed discharges in total
- 2 delayed discharges over 14 days
- 0 delayed discharges coded 9/71X (Exemption)

3.4 Since the start of reporting at each business cycle to the Committee, the number of delayed discharges has averaged around 8 people at any given time (this average is the measure for 2014/15), where the delay has been from one day and upwards. The average will continue to be measured within this financial year (see Appendix 1) which has begun to show an improvement compared to 2014/15.

During 2014/15 the number of bed-days used by patients who were delayed was 3583, with 214 patients contributing to this total. From April 2015 to July 2015 inclusive, the number of bed-days used by patients who were delayed was 583, with 45 patients contributing to this total.

3.5 The cohort of delayed discharges is almost entirely older people. The longest delayed discharges are usually people waiting for a residential care bed.

3.6 Both Community Health and Social Care Services and Acute Services recognise the imperative to reduce delayed discharges, as spending longer than necessary in hospital reduces the likelihood of maximising an individual's independence in the longer term. The issue of delayed discharges is recognised as an end to end pathway issue and both services are working together to reduce delays.

3.7 There are immediate and longer term actions to reduce delayed discharges. Immediate actions include ensuring that there is robust information available on capacity within the system and the progression of actions for each individual delayed person from the whole multi-disciplinary team. The Intermediate Care Team, funded through the Reshaping Care for Older People Change Fund and in 2015/16 to continue with financial support from the Integrated Care Fund, is actively recruiting on a permanent basis to create a level of resilience. Another initiative within the Integrated Care Fund is a home from hospital service that is in the process of being procured from the Third Sector. This will support individuals to return home in a timely manner, or to be supported as part of a package if hospital admission can be avoided.

The With You For You assessment process has undergone a review and an action plan has now been developed and is being implemented, which includes measures that will streamline the referral and assessment pathway.

3.8 The Adult Social Work Service has recruited to increase the amount of Social Work time that is available in the Gilbert Bain Hospital using non

recurrent funding. This increase in Social Work time will better support individuals, their families and carers, and staff so that decisions can be made and those decisions supported to expedite discharge to a non-institutional setting wherever possible. The cost of this arrangement totals £69,000 and is supported by carry forward of underspend from 2014/15. This is non-recurrent funding.

3.9 Further actions are being developed over time, to put in place robust mechanisms for reducing delayed discharges and create a sustainable process. Both the existing Acute Services Strategic Group and Health and Care Partnership Strategic Group (formerly CHP Strategic Group) met together for the first meeting in April 2015, where a standing agenda topic of discharge planning was discussed. One of the first tasks of this joint strategic group will be to build on the work to date to reduce delayed discharges and to capture further actions going forward in a new action plan for 2015/16. This new group were to be holding a workshop in July however due to summer break, this was reorganised to 1 October to develop a delayed discharge action plan, which will collate actions from existing plans and capture new initiatives.

4.0 Implications

Strategic

4.1 Delivery On Corporate Priorities

The Integrated Care Fund People Programme supports and is integral to the priorities in the Single Outcome Agreement, the Community Care Health and Care Directorate and Service Plans and the Local Delivery Plan for Shetland NHS Board. Shetland's Draft Joint (Commissioning) Plan 2015/16 is the Commissioning Strategy for Shetland's Health and Care Partnership. There is a national requirement for each health board to work with Partnerships to develop a Local Unscheduled Care Action Plan which contains work packages that collectively drive a shift in the balance of care from acute to community services. Shetland's plan is due to be refreshed in quarter one of 2015/16.

4.2 Community /Stakeholder Issues

The ongoing commissioning cycle and guidance on development of health and care plans, requires that customers and carers and third sector colleagues have full involvement. Details of stakeholder involvement are set out in the Draft Joint (Commissioning) Plan 2015-16. This includes a number of planning groups involving third sector providers and service user and carer representatives and the Public Partnership Forum.

There is no alternative to local acute hospital care other than off island facilities and if the local hospital has no spare bed capacity, then moving patients off island would be the only alternative. This risk is managed on a daily basis with twice daily bed statistics distributed widely to the whole health and care system.

4.3 Policy And/Or Delegated Authority

The Council's Scheme of Administration and Delegations provides in its terms of reference for Functional Committees (2.3.1 (2)) that they monitor and review achievement of key outcomes within their functional areas by ensuring – (a) appropriate performance measures are in place, and to monitor the relevant Planning and Performance Management Framework; and (b) best value in the use of resources to achieve these key outcomes is met within a performance culture of continuous improvement and customer focus.

The CHP Committee ceased to be a formal sub-committee of Shetland NHS Board on 1 April 2015. It has been agreed that the CHP Committee would continue to meet in an informal advisory capacity until such time as the IJB is established. The CHP Committee can therefore make recommendations to Shetland NHS Board.

4.4 Risk Management

The main risk is that of not developing and establishing new service provision models. We know that traditional models of care that rely on institutional settings are resource intensive and unsustainable. Good progress has been made in recent years to shift the balance of care. We must continue to promote new ways of working and provide flexible, responsive health and care services in the community that make fullest use of new technologies such as Telehealthcare. We must work in collaboration with Acute Services, with Third Sector partners and communities to promote prevention, early intervention and health improvement programmes.

4.5 Equalities, Health And Human Rights

Shetland's Draft Joint Strategic (Commissioning) Plan supports and promotes equalities, health and human rights.

4.6 Environmental

None

Resources

4.7 Financial

From the 1 April 2015 to 31 July 2015, a total of 583 hospital bed days were lost to delayed discharges. The impact is a reduction in the opportunity to shift resources to community services. On a figure of £572 per bed day (from the NHS Blue Book) for a hospital stay, the cost associated with 583 bed days would be £333,476.

The Integrated Care Fund for 2015/16 has an overall budget of £410,000 of which £285,000 has been allocated to the Intermediate Care Team. This does not include the carry forward from the Change Fund allocation of £171,141, giving a total budget of £456,141 for the Intermediate Care Team for 2015/16.

The £69K carry-forward is also supporting the efforts to control the level of delayed discharges

4.8 Legal
All services provided and supported by the Joint Commissioning Strategy including Reshaping Care Projects are subject to statutory provision in accordance with the Social Work (Scotland) Act 1968 and other related Acts.

4.9 Human Resources
Any change in the way services are delivered will involve engagement with affected staff. The Council and NHS have a range of policies that will apply to any staff affected by an organisational change. There is also regular consultation with Trade Unions through the consultative mechanisms in place in both organisations and through the Joint Staff Forum.

4.10 Assets And Property
There are no implications arising directly from this report.

5.0 Conclusions

5.1 Minimising delayed discharges is important for a number of reasons. The primary reason is that when people stay in hospital for longer than necessary there is a loss of independence and this can adversely affect the longer term outcomes for an individuals' rehabilitation.

5.2 It is important that the link between hospital discharges and the ability of the hospital to accept new patients is understood. There is no alternative to local acute hospital care other than off island facilities and if the local hospital has no spare bed capacity, then moving patients off island would be the only alternative.

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9 September 2015

List of Appendices

Appendix 1 – Monitoring of weekly reported delays

Background documents:

Shetland's Draft Joint Strategic (Commissioning) Plan 2015-16
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/DraftJointStrategicCommissioningPlan2015-16Version4.pdf

Delayed Discharges Definitions and Data Recording Manual
http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/delayed-discharges-manual-120613.pdf

Date	Total number of delayed patients	number of patients delayed > 2 weeks excluding code 9
07/04/2015	6	0
14/04/2015	6	0
21/04/2015	5	0
28/04/2015	5	3
05/05/2015	5	4
12/05/2015	8	4
19/05/2015	7	3
26/05/2015	4	3
02/06/2015	9	4
09/06/2015	3	3
16/06/2015	2	2
23/06/2015	4	2
30/06/2015	3	1
07/07/2015	3	1
14/07/2015	2	0
21/07/2015	0	0
28/07/2015	1	0
04/08/2015	1	0
11/08/2015	3	0
18/08/2015	2	0
25/08/2015	2	1
01/09/2015	5	0
08/09/2015	5	2

Average number of patients delayed	4.0