
Strategic Service Statement

DEMENTIA

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1. Introduction

This strategic service statement for dementia services has been produced by West Lothian Council Social Policy - Adults and Older People's Services, having been developed via partnership working which was undertaken in conjunction with NHS Lothian as well as key partners and stakeholders groups within the voluntary and private sectors.

Overview

The statement aims to address the current and potential needs of people with dementia inclusive of younger people with early onset dementia living in West Lothian. Thought of course this condition does predominantly affect older people over the age of 65, noting an associated increase in prevalence associated with age, hence the importance of taking cognisance of the makeup of the local population when considering service provision.

Demographics show that older people currently represent a significant proportion of the population within West Lothian, this is set to rise substantially over the next 10 years with a projected increase of over 64% in those aged 75 plus by 2018. In addition those aged between 60 to 74 years are expected to increase by 45% over the same period. This will mean that by 2014 one third of the population within West Lothian will be over the age of 50 which will impact directly on the level of dementia related illness present within the local authority area.

In 2007 it was estimated that there were between 1,423 – 1,615 people with dementia living in West Lothian, this is projected to increase by 87% over the next fifteen years, reaching between 2656 and 3058 by 2024. To put into context the real challenge facing West Lothian it is worth noting that throughout the Lothians' the overall projected increase for the same period is just below 50%. Or to use another comparator West Lothian will see an increase in the rates of those with dementia within its population run at triple those projected for a neighbouring authority.

Naturally such factors do have a significant impact on future service needs, design and priority. Increasing numbers of older people will live longer and are likely to be working longer. Advancements in medicine will continue to enable people to be active until older age. Future provision of care services for people, including those with dementia, will focus more on a more community based service rather than hospital or long term residential setting. In addition the number of working age adults is likely to decrease and it is anticipated that this will have a significant impact on the number of people who will be able to undertake caring roles within their families and/or communities. Hence efforts continue to anticipate, plan and put in place services that will be fit for purpose, accessible, adequate and cost effective now and in the future.

Whilst this service statement focuses on people with dementia those with the illness may of course have a range of other needs, hence consideration also need to be given to other service statements such as those for older people and mental health.

In addition national strategy documents help define the context and direction of strategic planning at a local level. Whilst none are specific in relation to dementia all have some relevance for dementia services. It is necessary therefore to also consider the overarching policy papers produced by the Government in the last few years relating to age and ageing, these encompassing more generic themes, which have emerged in particular the "personalisation of support services", "service redesign", "re-enablement", self management" and "citizen leadership". Joint improvement, the development of managed clinical/care networks and a move to self-directed support, are all influential drivers in setting new service structures and challenges for local service planning and delivery.

In line with the key national and local policy drivers the following five key areas will underpin developments and initiatives depicted within this service statement:

- Shifting the Balance of Care
- Building community capacity.
- Use of assistive technology - telecare and telehealth
- Support and partnership with carer.
- Personalisation - personalising care and budgets.

Reflecting on current service design and delivery this Service Statement endeavours to highlight areas which will require us to rethink service provision to ensure we are well placed for the future to deliver services which are fit for purpose and in keeping with changing needs and available resources. In doing so we will also seek to highlight how we will engage with others to develop services and confirm our commissioning intentions for the next three years. The key priority ultimately is the provision of a future, which allows for greater choice and flexibility to enable people with dementia to remain at home as long as they wish and are able to do so.

2. Background and Approach

What is dementia?

Dementia is a clinical diagnosis made when acquired cognitive deficits in more than one area of cognition interfere with activities of daily living and represent a decline from a previous high level of functioning. This loss of intellectual functions includes memory, deterioration and ability to carry out day-to-day activities and often there are changes in social behaviour. Dementia can result from a number of single or combined underlying aetiologies and is usually progressive but can occasionally be reversible.

For definitions of the range and type of dementia related illnesses please see Appendix 1.

Dementia - Diagnosis and Early Signs

The early signs of dementia are very subtle and vague, and may not be immediately obvious. Early symptoms also vary a great deal. Although, people first seem to notice that there is a problem with memory, particularly in remembering recent events.

Other common symptoms include confusion, personality change and loss of ability to do everyday tasks. Sometimes people fail to recognise that these symptoms indicate that something is wrong. They may mistakenly assume that such behaviour is a normal part of the ageing process. Symptoms may develop gradually and go unnoticed for a long time. Occasionally people may refuse to act even when they know something is wrong. It is likely that members of the person's family particularly their partner may be the first to notice the changes in the individual in respect of functioning. There may be a period of denial on both the person and their families' part not wishing to recognise that the symptoms could be a form of dementia. While they may present to their general practitioner with associated symptoms it may not be picked up at that stage and it may be some time before an actual diagnosis is made. The warning signs usually involve the following:

- Recent memory loss that affects day-to-day functions.
- Difficulty in performing familiar tasks.
- Problems with language.
- Disorientation to time and place.
- Poor or decreased judgement.
- Problems with abstract thinking.
- Misplacing things.
- Changes in mood or behaviour.
- Changes in personality.
- Loss of initiative.

It is important to remember that many other conditions have symptoms similar to dementia which is why obtaining a correct diagnosis is important. Proper medical and psychological assessment may confirm the presence of dementia, with this having been established, there should be opportunities for appropriate treatment and support. Hence the need to ensure an early diagnosis is achieved to provide access to the aforementioned.

In our existing Social Work Services we are likely to be supporting people with early signs of dementia or those with early onset conditions because there may be no other means of support particularly if a diagnosis has yet to be confirmed. Many of social cares generic services in particular work with people who have a range of the warning signs as listed above.

While there is a concentration on those who suffer from the illness we cannot lose sight of the impact that all this will have on family members who will be required to move into the role of becoming a carer. It is as important to recognise the impact of the illness on them as it is on the individual concerned. Carers are likely to experience a range of very different and at times quite extreme feelings. This is because dementia gradually causes the person's abilities and personality to change resulting in the nature of their relationship also changing. Feelings commonly experienced by carers include distress, frustration, guilt, exhaustion, annoyance, frustration and anger.

Approach

Following the publication of "Better Health Better Care" and in light of the new Single Outcome Agreement there has been a drive by the Scottish Government to create a framework that will lead to measurable improvements in outcomes for service users and carers. As a result eight (high impact changes) were identified. They are:

1. Maximising care at home with carer support.
2. Better integrated health and social care for those in need and at risk.
3. Reduce avoidable unscheduled admission to hospital.
4. Improve capacity and flow for scheduled care.
5. Better use of non-medical skills and services outside of key hospitals.
6. Improve access to remote and rural populations.
7. Improve palliative and end of life care.
8. Better joint use of resources.

The approach taken in this plan is to mirror the strategic expectations of the Government in relation to these high impact changes while reviewing services, both provided and commissioned by the council and to establish what needs to stay the same, what needs to change and how this is to be achieved.

To date there has been no dementia plan on which West Lothian can draw. In the past, Dementia services have been encompassed within either Planning for Older People's Services or Mental Health or indeed both. West Lothian Council is now taking the opportunity to produce a discreet plan, which recognises the prevalence of dementia and it's likely growth in the future. This sets out how we think council services for people with dementia are likely to develop over the next ten years, this view having been informed by a range of legislation and national policy documents which have been issued in recent years as well as local strategies and initiatives. As a result of this, this service statement will also set out those council services that are expected to be developed, commissioned and provided over the next three years.

This service statement will outline what services and support the council is currently delivering or commissioning to this particular care group. We will then go on to describe the services and support that we believe will be a priority for us to commission or provide over the next three years. This will bring significant challenges to services and will require a degree of imagination and foresight to put together a strategic approach.

There will also be an extensive programme of consultation with key stakeholders, users and carers.

The dementia plan will inevitably crosscut with other plans, particularly the Older People's Plan which draws heavily on the activities associated with "shifting the balance of care" i.e. efforts being made by Health, Social Care and Housing to rehabilitate, re-enable, care and support individuals and their families/carers in their own homes and communities. These

activities have been the cornerstone of local planning and development activities for many years and are well demonstrated in West Lothian via:

- The review of care at home services in 2002.
- The introduction of a range of assistive technologies in 2001.
- The review and redesign of residential care 2000/2001. The new approach integrated smart technology into a model of care which emphasised choice, independence and capacity building. The new approach allowed many more people to remain in their own home or in newly built housing with care complexes as an alternative to residential care.

Generic Services v. Specialist Services

Much debate has taken place as to how best to provide care and support services, which best meet the needs of the individual and their carer(s) where appropriate. The same subject matter also of course being of interest to the Regulators such as the Care Commission in ensuring services are and remain 'fit' for purpose.

Our approach is to develop a 'spectrum of services'. While people with dementia should be supported and offered the same flexibility, choice, range and level of provision as anyone else, a 'one size fits all' approach is unlikely to meet the range of needs which people with dementia face. Specialist services offer many benefits in terms of knowledge, skill and continuity. However, where specialist services are developed, we will include in the specification, measures to mitigate against what are sometimes perceived as 'adverse' effects. In other words, we will aim to ensure that specialist services are delivered in the context of an integrated model.

Personalisation

Recognising that all individuals have capacity as well as unique personal goals, aspirations and outcomes, which they seek to achieve in life we recognise any intervention by social services will benefit from adopting a personalised approach.

In doing so we will ensure access to social service provision is made available via a participative and empowering assessment. We will also undertake to recognise any unpaid carers as providers of care alongside other professionals.

By doing so social service provision, which is made available will view the individual as being at the centre of shaping the services they receive, which will be flexible, adaptive and supportive in relation to their individual needs, whilst of course remaining affordable. This approach is founded upon building individual and community capacity, which enables the individual to retain and maximise wherever possible their independence.

Simple definition of personalisation "It enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive."

3. Strategic Context

National and Strategic Context

Several key national and strategic policy documents have been introduced in the last ten years. They will all have some relevance for dementia services', there are none however, which are specific to dementia itself at this stage. However a number of manifesto statements have been made and are outlined in more detail on page 12, under the heading Current Scottish Government Intentions.

Overarching Policy Direction

Society is ageing as the 2001 UK census showed. People over 60 now outnumber children under 16. The population pyramid is slowly being turned upside down and this represents a demographic challenge. Increasing numbers of older people will represent the fundamental challenge to service providers as they will have to provide services to rapidly growing numbers of older people. While numbers are important they only tell us part of the story. Current public debate around the ageing society mainly focuses on abstract demographic trends. However we cannot assume that future generations of older people will be the same as current generations of older people. Simply trying to read across from a set of abstract population projections to a coherent picture of what the next generation of older people will actually look like is a futile exercise. The numbers only provide a fragmented picture because so much of how the issues will play out will depend on other factors. The next generation of older people having transformed every life station they have passed through to date, show no sign of stopping in older age. They will demand different services and products than current generations of older people and they will want greater choice.

All these Health and Social Care intentions have to be seen in the wider context of the promotion of quality of life outcomes and in particular the opportunities for activities and/or employment, which promotes self esteem, mental health and wellbeing and support people to live "normal" lives. By doing so this should promote healthy living and enable, particularly older people, to stay as well as they can and for as long as they can.

The policy intention on health is to make services available to individuals within localities and to lessen the need for centralised hospital provision. This fits with the promotion of intermediate care services to act as bridges at key points and transition in a patient's journey from hospital to home and from illness to recovery.

The thrust of policy direction from a Health and Social Care perspective is to make services available which promote independence and re-enablement. Care services have been rebalanced over the past 10 years towards greater maintenance of support at home and to lessen the reliance on residential care provision. This is reflected in the resources, which have been made available to increase care at home services, re-provisioning care homes with housing with care and introducing new technology to individual homes.

Changing Lives

For the future of Community Care Services the Review of Social Work Services, Changing Lives, recommends, among others, the following:

- Services designed around needs of users.
- Build capacity to self-care.
- Public sector wide prevention and early intervention.

- Manage mixed economy of care.
- Redesign services to achieve transformational change.

Unpaid Care

Unpaid carers are recognised to be the largest component of the care workforce and the need for informal care will increase in line with the projected demographic increase. Any changes in the provision of informal care will therefore undoubtedly have an effect on the demand for both informal health and care services.

For the first time, the census of 2001 gathered data on informal care provision. The results show that 9.54% of the total population of West Lothian reported that they were looking after, giving help or support to family members, friends, neighbours or others because of long-term disability or problems relating to old age. The figure for Scotland was slightly lower at 9.51%.

The number of carers in West Lothian recorded in the last census was 15,147 of whom 62% were providing care for between one and 19 hours per week, 13% for 20 to 49 hours per week and 25% for 50 or more hours per week.

The Future of Unpaid Care in Scotland has as one of the recommendations of the Scottish Government, develop a national strategic framework for service providers to ensure unpaid carers are given a statutory entitlement to appropriate short breaks and breaks from caring. The breaks should include opportunities for breaks with or without the "cared for" person.

All Our Futures - Planning for Scotland with an Ageing Population

This strategy sets out the vision for Scotland, which will value and benefit from the talent and experience of older people by welcoming its ageing population. It undertakes to provide the following:

- Opportunities for older people to participate and to be involved in their communities through being volunteers and through paid work.
- Forging better links between the generations.
- Continuing to improve the health and quality of life for older people.
- Continuing to improve care, support and protection to older people who need it.
- Ensuring that housing, transport and planning progressively meets the needs of all ages.
- Offering learning opportunities throughout life.

Current Scottish Government Policy Intention

Manifesto statements on dementia include

- Incorporate the treatment of dementia within a set of national clinical priorities that allow us to bring particular focus to a small number of critical health care challenges.
- To increase public understanding and help people reduce their risk of dementia.
- It is important that across Scotland public bodies work to the same care standards.
- We will work with local authorities and health boards to agree a way forward.

In the Scottish government's document Better Health Better Care the following:

- Dementia as a national priority will be reflected in a new target from 2008, which will focus NHS boards on this condition and allow us to build national approaches based on new standards for an integrated pathway for dementia.
- Delivering For Mental Health - develop a National Mental Health Delivery Plan and in so doing accelerate improvements in mental health services.

Some initial ground breaking work in the form of the Forth Valley Dementia Project published in 2008 sets a clear focus in relation to pointing out what still requires to be done in terms of provision for those with dementia.

Lothian Dementia Project

Following on from the aforementioned, is the Lothian Dementia Project which will run over a three year period, commencing 08/09 with a view to achieving better support for people with a diagnosis of dementia. Current evidence shows that peoples experience is mixed at the point of diagnosis. Hence the need to adopt a whole systems approach which puts the older person at the centre of service delivery, to ensure the right support is available at the right time by addressing the entire range of needs. This Project will ultimately contribute to the implementation of the national Dementia Programme throughout Scotland the aim being:

- to optimise the overall experience and outcomes of care for people with dementia following on from the point of diagnosis, whatever the stage of illness and whatever the location of the individual.
- maximise the extent to which the person with dementia will begin, from the point of diagnosis to be supported in taking control of their lives and future plans for their care.
- to prevent adverse incidents and avoidable illness including depression and anxiety in people who are diagnosed with dementia and their carers.
- help co-ordinate dementia services between agencies by placing the person with dementia at the heart of decision making.
- enable teams to develop skills and confidence to continue to develop services around the person with dementia and help to deliver clinical governance

In addition to West Lothian's involvement in the Lothian Dementia Project mention also requires to be made of the proposed 'Demonstrator Site'. This innovative approach focuses on developing an all-encompassing resource for older adults with dementia and their carers. The aim being to provide within a single site suitable housing with care, respite, day support, telecare / telemedicine plus additional IT as well as carer information and advice. This menu of flexible and readily accessible services being the catalyst for supporting the development of community capacity as well as outreach provision, hence it is envisaged as the service matures over time additional benefits will be realised with for example enhanced informal carers support developing.

4. Key Principles and Values

West Lothian Community Health and Care Partnership believe the following principles are key to the planning, organisation and delivery of good outcomes for older people and people with dementia. The following four principles resonate with the values and views of older people and those with dementia and their carers.

- To be customer focused - organising services around the needs of service users and citizens. West Lothian Outcome Agreement 2007.
- To provide more efficient and effective services - providing more streamlined services which reduce bureaucracy. West Lothian Outcome Agreement 2007.
- To work with service users to ensure that people have the information and support to access services. West Lothian Outcome Agreement 2007.
- To provide local people with greater choice and influence over local decision making. West Lothian Outcome Agreement 2007.

The key themes from the National and Local Policy Framework and Drivers are:

Active Citizenship

All individuals have the same rights and responsibilities to contribute and participate in community life fully.

Social Inclusion

Older people and those with dementia and their carers should have the same rights and expectations of social inclusion. It is therefore important that services examine the attitudes of staff, the way agencies provide services, how agencies tell individuals about these services and how services can be made more accessible. Social inclusion is central to West Lothian CHCH vision.

Equity

Services, facilities and opportunities should be available according to need on an equitable basis across West Lothian.

Equality Diversity

Services, facilities and opportunities should recognise and support differences for persons of ethnic origin, disability, religion, gender or sexual orientation. Services should be sensitive to the needs of all individuals from minority ethnic groups.

Individuality and Dignity

Individuality and dignity should be fully respected wherever people need assistance in managing their lives. Individuals may make informed decisions about risks regarding their lives and circumstances, unless formal care and protection measures as defined in law are required.

Support for Carers

The needs of carers, in particular those providing high levels of care, should be fully recognised and supported.

Quality

Services should be of good quality and have the full confidence and support of the people who use them.

Effective Services

Services should be soundly based on best current practices, be effective from the users perspective, and will represent the best use of resources available.

Accountability and Transparency

Services should be clearly accountable, operating within transparent policy and resource allocation.

Choices and Priorities

Within the available resources, service choices and priorities should be based on the needs and preferences of older people and those with dementia and their carers.

Principles of Good Dementia Care

These have been described in a range of policy documents which highlight the need to:

- Improve the recognition of dementia, thus aiding earlier diagnosis and improving care management.
- Improve detection rates for depression and anxiety as a consequence of the better recognition of dementia.
- Ensure dementia services are person centred.
- Improve coordination between agencies to reduce delayed discharges and inappropriate acute hospital admissions.
- Develop a whole systems approach that puts the older person at the centre of service delivery and planning.
- Shift the balance of chronic disease management away from hospitals.

5. Ten Year Outlook

Vision Statement

People in West Lothian with any degree of dementia with an assessed need for care and support, will be able to access appropriate high quality services. The aim of these services will be to enable people to remain as independent as possible in their own home for as long as possible and to be included in community life. Service providers both internal and external will work together to maximise support for people and their carers by making best use of the resources made available to them.

What We Know

A recently published report by Alzheimer's Scotland (Meeting Our Needs? - The Level and Quality of Dementia Support Services in Scotland) highlighted deficiencies in the provision of core community care services for people with dementia and their carers throughout Scotland. While it acknowledged that many people with dementia and carers received good services and were successfully supported, there is a mixed picture across the country.

From a West Lothian point of view this report showed that of the number of people with dementia in West Lothian requiring a Community Care service, 31% received day care (Scottish average – 25%) and 42% received Care at Home (Scottish average – 22% figures based on 2006 Scottish Government Community Care statistics)

In considering a ten - year outlook it will be necessary to consider the key challenges. The following outlines what has been identified by research and significant others as the key challenges, their relevance being to give an indication of the issues which may require to be addressed by West Lothian Council over the next 10 years.

Key Themes / Aspirations

- To create simpler rules of access which should be clearly visible to people.
- To raise public awareness of older people's mental health and where and how to seek help.
- To create services which are local, accessible and equitable and promote choice.
- To create service provision which promotes enabling and empowering individuals and carers where they are involved.
- Services should be "age appropriate" with specific service provision for younger people with dementia and those who are mildly impaired.
- Develop services that will be more flexible with consideration being given to service provision outside normal working hours and within people's homes.
- Develop a robust pathway where people with dementia and their carer understand and receive information and support from diagnosis to continuing care.
- To create more flexible respite options e.g. provision of one to one respite in person's own home, a more individualised approach.
- To provide day care specifically for younger people who are more active which will meet the needs of younger people.
- Joint day care provision for those with dementia.

Services will aim wherever possible to take account of the above aspirations, depending on available resources.

Possible Outcomes

- Increase provision of specialist dementia day care and the development of the level and quality of day opportunities available for people with dementia.
- Development of care at home services to enable a support-orientated approach through high quality personalised care.
- Greater variety and choice in offering flexible respite options that recognise different needs.
- Improved training and dementia care for staff within community care services.
- Develop a consistent standard of dementia - specific data enabling accurate national statistics to be produced.

From a West Lothian Point of View

For almost 10 years West Lothian Council has remodelled and rebalanced its care services to older people through designing and delivering services, which have made a significant difference. The concept of Housing with Care and the development of Smart Technology have been key features of an ethos, which promotes independence and integration

However, in the context of a changing and challenging future, particularly in relation to the local demography, we aim to ensure that older people with dementia and their carers:

- Have the best possible quality of life
- Can remain living independently for as long as possible
- Have equal access to universal services in their own community and specialised services as and when required

We aim to do this by providing high quality, flexible and responsive services at times when people need them. Crucially however, the council will continue to support innovation with particular emphasis on the future capacity of telecare/telehealth to add value to those services and to provide creative solutions to a range of problems associated with dementia.

As more telecare solutions are developed, the potential of supported housing models to provide a safe living environment, for people with more severe dementia become increasingly more realistic. West Lothian Council has a robust history of designing for dementia in new build housing with care complexes. Where opportunities arise we will wherever possible continue to ensure that the needs of service users with dementia are accommodated in service design and re-design.

In the knowledge that telecare developments are currently being tested are likely to be fit for purpose in the not too distant future, we plan to explore the possibility of housing models which will deliver on that agenda in a way which is economically viable in the long term.

With this in mind we hope to explore the following possibilities

- A model of Housing with Care, which specialises in dementia to enable people to remain at home.
- Exploration of the campus model which has a suite of services to enable support to carers and the availability of short-term respite across a flexible staff group.
- Assistive care and technology services - redesign of our crisis care services. This will include the development of an improved out of hours service with the capability of offering more intensive support during periods of acute need/overnight.

- The development of self directed support and direct payments - as personalisation becomes a central feature of personal care services the opportunities for individual care packages designed by and or on behalf of an individual will become more prominent.
- The creation of specialist dementia teams will be concerned with creating an assessment service particularly for those with dementia and their carers.

This plan sits within a wider context and aims to give clear messages to partners and stakeholders which will enable them to make good decisions about developing their services as well as indicating how we anticipate deploying resources over the next three years.

The Three Year Plan aims to provide a strong foundation for the longer- term vision for those with dementia in West Lothian. The key challenge is to make a significant contribution to further changing the balance of care from group living either in hospitals or care homes to supporting a higher percentage of people at home. This will require different ways of thinking, innovation and close partnership working at all levels.

Social Policy Services will be developed in the context of a council committed to building personal and community capacity to ensure that opportunities for older people to remain healthy and well integrated with their local community are maximised. In support of this a council wide review of Older People's services will soon be published. This wider review has involved key internal partners such as; cultural services, sports and leisure activities, community learning and library services.

The council is also committed to a community planning process and has developed a Life Stage Planning Model where the central aim is to reduce social and health inequalities for those most at risk.

These wider planning processes are critical in supporting the overall objective of shifting the balance of care and have identified the particular challenges faced by people with dementia and their carers. This, combined with the emphasis on community planning and capacity building is a strong foundation for progressing the integrated, cross service planning processes which ultimately aim to ensure that people can live longer, healthier lives in their local community.

Chapter 6 Three year Service Plan

In considering how services will be designed in future we have drawn heavily on the work of the Government's Joint Improvement Team (JIT). The JIT is part of the Partnership Improvement and Outcomes Division within the Scottish Government's Health Directorate. The two key functions for the division are (a) performance measurement and management and (b) performance support and improvement.

JIT aims to help partnerships across Scotland deliver the services that people want. They strongly believe that joint working between Health, Local Authorities and the Independent Sector provides better, faster, safer, closer services.

While the emphasis is on a whole system approach, this section is structured in terms of current service areas as they are aligned to budget structures. We will outline all the services that can currently be accessed by people with dementia in West Lothian. Each category will describe the service, how it is delivered and any initiatives and developments associated with the service. West Lothian is mindful of the shift away from center based service provision, moving to a position of being more outcome focused.

As such, this section will describe the purchasing and development intent for the next three years which has been developed in the context of the ten year vision described in the previous section and aims to provide a strong foundation for moving in that direction.

While we have already made significant progress in developing more innovative and community based services, this statement focuses heavily on those changed groupings, aligning developments and initiatives with a view to making transparent and measurable linkages with National strategies.

The categories are as follows:

- **Assessment and Care Management** - this includes risk assessment and adult protection
- **Flexible Home Care and Carer Support**
- **Respite and Short Breaks from Caring (including Day Care)**
- **Self Directed Support and Direct Payments**
- **Occupational Therapy and Provision of Equipment / Adaptations**
- **Providing Telecare and Telehealth Support**
- **Support for Carers**
- **Housing Options for Older People**
- **Residential Care Homes**

6. 1 Assessment and Care Management

Service

Assessment, Care Planning, monitoring and review are central to the objectives of promoting independence and ensuring that services are responsive, targeted and appropriate

The Older Peoples Assessment and Care Management Teams are responsible for carrying out needs-led assessments for people with dementia and for developing appropriate care and support plans as a response to identified need. The Team carries out the ongoing monitoring and review of care and support providing a response to changing needs.

The Sensory Resource Centre (SRC), based at St. John's Hospital, provides a range of services and support for people with sensory impairment. Services are both directly provided by the council and commissioned from specialist agencies. Assessments are completed for care, support, equipment and technical services.

A specialist palliative care social worker offers assessment and care management across all service user groups. This is a service for individuals, their carers and families who are in need of palliative and end of life care and support.

This worker liaises closely with other partners in the field of palliative and end of life care including the McMillan Centre in St John's Hospital, the Advice Shop and colleagues in Health.

Central to this process is the identification of carers needs collated either as an integral part of the service user assessment or as a *stand alone* assessment.

Effective care management requires a strong multidisciplinary approach and this has been observed to be a particular strength in West Lothian as evidenced by a range of independent reports and statutory inspections

Delivery

The teams are located across three locations with one dedicated team in St. John's hospital. However, the nature of the service group combined with West Lothian's semi rural geography is such that most service is delivered almost exclusively on a visiting basis.

Referrals can be made by any member of the public or any other profession and we strive to ensure that there is equality of access by taking referrals via a number of different mediums.

In response to increasing demand, the Older People's team, which provides a service to most people with a dementia type illness, reviewed the skill mix in the assessment and care management team to ensure that the scarce skills of highly qualified professionals could be targeted to those complex interventions requiring that level of skill. The introduction of staff with a range of qualifications has enabled the older people's team to increase the number of staff and keep pace with demand. Recognising that staff with different care qualifications had a significant contribution to Assessment and Care Management processes and building on the recommendations of the 21st century review, we were able to introduce what the review would recognise

as a 'para professional' role. This has contributed significantly not only to maintaining responsiveness but also to workforce development and planning.

These teams work in a complex environment where promoting independence requires an empowering approach to taking risks. The balance between taking risks and keeping people safe/protected from harm can be difficult to achieve but it will not be possible to encourage more people to remain at home if there is a 'risk averse' approach in the organisational culture.

The UK agenda that is moving both health and social care services towards "Personalisation" emphasises an individuals' right of choice and independence. Across all services robust risk assessment and management practices must underpin these rights if vulnerable adults are to be helped to stay safe and be protected from harm.

While proportionate risk management is central to all care management processes, it's most complex level applies to statutory duties associated with Adult Support and Protection. West Lothian council along with its multiagency partners in Lothian and Borders Police Public Protection Unit in Bathgate and NHS Lothian comply with the Edinburgh Lothians and Borders Interagency Guidelines "Protecting Vulnerable Adults – ensuring rights and preventing abuse" (2003). In addition West Lothian council implemented an "Enhanced Adult Protection Guidance and Procedure" for social work practitioners and managers in 2006.

The Adult Support and Protection (Scotland) Act 2007 (ASPA) was introduced in October 2008 and in addition to creating a legislative framework for adult support and protection practice and procedures it has also introduced a requirement for each council to establish a multiagency Adult Protection Committee to overview and scrutinise strategy and performance in each local council partnership area.

Critical to the effective management of all the processes described above is an infrastructure which allows the safe storage of information which, with consent, can be shared across appropriate disciplines and agencies. West Lothian has developed and implemented a highly functional shared information system (e-care) which provides the capacity to build a whole person view for service users in West Lothian. This has and will continue to improve outcomes for older people in terms of reduction of duplication and supporting single shared assessment allowing faster access to services. It is worth noting that the JIT emphasise that local e-care support is central to placing an outcome focus at the centre of assessment and care management. (JIT – Fourth Bulletin on Outcomes for Community Care, August, 2008.)

Developments and Initiatives

1. Single Shared Assessment (SSA). The SSA framework and assessment tool used in West Lothian is currently undergoing a complete review. The format for assessment is being redesigned in order to improve information gathering and to enable relevant electronic reporting from the e-care system. The new format will also incorporate the information requirements from IoRN. The aim is to also increase the use of the SSA framework by partners in Health and Housing.
2. Joint Care Management. The national training framework for care management underpins the move towards enabling Health and Housing staff to take on the role of care manager. Care planning and service monitoring and review has been largely undertaken by social work staff up until now. Joint Care Management processes and protocols are to be further developed and implemented across the partners.

3. Expert Assessment Tool We are currently working with key partners to develop a 'safe at home' electronic assessment tool, based on the 'expert system', such that non specialist staff in the health, housing and social care sectors can accurately identify people who would benefit from telecare, occupational therapy and falls prevention services or equipment.

4. Specialist Dementia Teams. The assessment and care management team are proposing to move from a generic to a specialist model for people with dementia. This will allow for greater alignment and collaboration with health colleagues who's services are structured in a more specialised way. In addition we hope to achieve the following outcomes
 - Better trained and skilled practitioners.
 - More continuity for Service Users and Carers.
 - Improved liaison arrangements with key partners such as housing and health.
 - Better support for providers.
 - More opportunities for front line staff to contribute to strategic developments.
 - Facilitating and accelerating learning particularly in relation to new and creative approach to support people with dementia in the community (telecare/telehealth).
 - Consistency of approach to risk assessment and management, building practitioner and carer confidence.
 - Co-ordinating dementia services between agencies.
 - More clearly defined roles leading to reduction of duplication of effort
 - A more robust infrastructure for the development and support of shared care management
 - Opportunities to develop and improve integrated care pathways.
 - Faster access to services.

The dementia team will have a key role in contributing to the Lothian Dementia Project (see chapter 9). We hope to maximise the impact of the project locally not only by consolidating learning but by having a clearer more focused approach to the role out of training and development

5. Adult Support and Protection

The following activities are either currently underway or are planned in the near future. Many of these initiatives and developments are responding to additional duties and responsibilities that have been introduced with the Adult Support and Protection (Scotland) Act 2007 (ASPA)

- The appointment of a multi-agency post to support the activities of the Adult Protection Committee and multi-operational supports and developments.
- The appointment of an additional .5 admin support for frontline and first line operational managers
- Review and delivery of the Adult Protection Multiagency Training programme.

- Consideration of how best to access expertise in relation to systems of support for people at risk of financial exploitation.
- Review of the Appropriate Adults Scheme.
- Review of the Provision of Advocacy – in particular how best to ensure availability of advocacy to “adults at risk” performance measures.

6.2 - Flexible Home Care and Carer Support

Service

The personal care at home service works closely with community health services to support people with care needs to remain living independently in their own homes. This service is targeted increasingly to people with complex health and care needs and a range of service developments *have* resulted in a significant impact on changing the balance of care. For example;

- *While the average number of care hours per person have increased by 20% since 2003, the number of service users has remained relatively static - a strong indicator that we are meeting the service aims in terms of supporting increasingly complex care*
- *The average length of time in a care home has decreased from 36 months to 12 months – again a strong indicator that people are being maintained at home for longer periods*
- *Consistently reducing the number of Delayed Discharges, ensuring that people are discharged safely but with a focus on maximising independence*

A strong emphasis on both service re-design and partnership with valued independent providers has resulted in West Lothian enjoying one of the most efficient and responsive personal care services in Scotland. Services are delivered seven days a week between the hours of 7.30 a.m. and 10.00 p.m. and are therefore capable of offering customer choice in terms of time and pattern of delivery.

These service developments have required significant investment in training for personal care workers in all sectors and their skills are increasingly focussed on delivering complex personal care interventions. To support this focus, West Lothian has been committed to developing a range of creative and innovative services which compliment the personal care service and maximise independence, e.g.

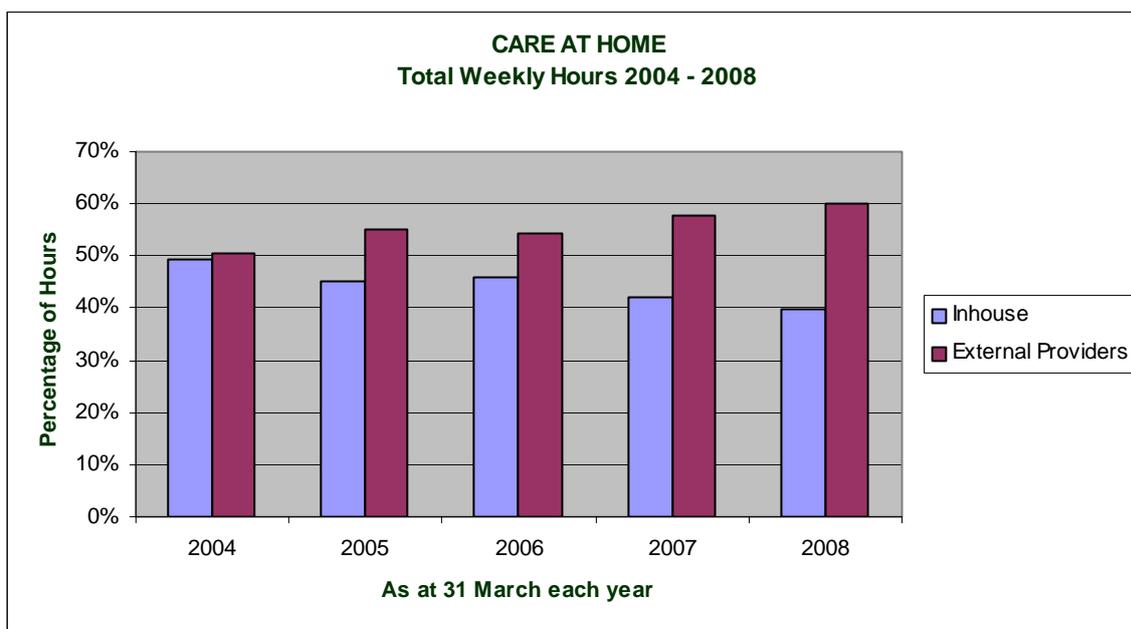
- Development of an alternative meals service
- Developing a home shopping service
- Care and Repair, equipment to assist activities of daily living and house adaptations
- Dedicated teams to support discharge and offer intensive re-enablement services promoting independence and reducing reliance on personal care interventions
- Developing innovative telecare solutions which complement personal care services

Delivery

West Lothian has developed a rich ‘mixed economy’ of provision with a purchasing strategy which has aimed to manage the sometimes difficult tensions around an ‘open market’ v continuity/quality of care and business stability. This has resulted in a range of contractual

agreements which balance the need to support existing providers to invest in service development and improvements while also leaving market capacity for new providers to build a business base in our community.

In recognition of the increasingly significant contribution of the independent sector, West Lothian council's purchasing strategy in the past five years has been almost exclusively targeted at growth of the independent sector. West Lothian Council's in house service now provides 40% of the total business with the other 60% being shared across a range of providers as below



Source; West Lothian Council, Caremaster

West Lothian Council is committed to retaining an in-house service but recognising the associated cost premium, the business plan has been increasingly to focus on specialist tasks such as;

- Crisis intervention
- Supporting people with dementia
- Re-enablement
- Hospital Discharge
- Reaching remote geographical locations

In the next three years we will continue to develop and support in-house staff to develop these specialist skills and services but we will also transfer resources on an incremental basis to the independent sector which has a good track record of delivering robust mainstream services for people who have complex needs.

We will continue to support and promote Personal Direct Funding to maximise choice and independence. As demand requires, resources will be diverted from the purchase of more traditional services to support this.

Developments and Initiatives

West Lothian Council is committed to making a further significant impact on shifting the balance of care. We will do this in a number of ways but in terms of Care at Home, we want to improve services specifically in relation to;

- Support to Carers
- Crisis Response and Overnight Care
- Falls Prevention and Response
- Avoidance of Hospital Admission

Our three key developments and initiatives will therefore be;

1. The development of an Assisted Care and Technology Service (ACTS) in Partnership with Health which will be expected to respond to emergencies over a 24-hour period and provide
 - Initial assessment of service user need for an emergency service (0-5 days)
 - Risk assessment including the use of a housing with care flat as a means of keeping people safe temporarily
 - Comprehensive multi-disciplinary assessment and fast track to appropriate specialist services including falls prevention, medical review, re-enablement and assistive technology
 - Respite service to designated key holders at times of holiday and illness
 - Check visits during the night

The team as a whole will comprise a diverse range of staff including a Falls Co-ordinator funded via the NHS Falls Prevention Programme.

2. We will work with Health to support the action plan for long term conditions, promoting self managed and anticipatory care with a view to improving quality of life and reducing emergency hospital admissions. The development of telecare and remote healthcare will be central to the service redesign process which aims to maximise independence.
3. We will, over the next three years, continue to monitor and review contracts relating to care at home. This work will be supported by the Single Outcome agreement which allows a more creative approach to developing the capacity of services previously constrained by ring fenced funding streams.

6.3 - RESPITE AND SHORT BREAKS FROM CARING (INCLUDING DAY CARE)

Service

Short breaks from Caring are acknowledged as key pillars of integrated services, which will support the shift in the balance of care from residential to community based services. Short breaks from caring are available in a variety of ways and can vary in length from a few hours at home to several weeks in a care home.

Delivery

Day Support

Day Care as it is currently constituted is accessed through assessment for this particular provision and is to enable individuals to be supported in the community. There are a range of providers, by far the largest being the voluntary sector but with some provision delivered by West Lothian Council and a specialist dementia service via a Housing Association. All providers offer a service where trained staff provide comfortable and stimulating environments with healthy meal provision and transport to and from the centre.

Short breaks at Home

Short breaks from caring at home are currently commissioned almost exclusively via the voluntary sector that also fund raises to offer extended services. Trained carers visit the service user at home up to two times per week, offering support and social contact, leaving the carer free to get out of the house for a few hours

Residential Respite

Contractual arrangements are in place offering a service to those with an assessed need, providing respite to unpaid carers. This is in circumstances where the cared for person is unable to remain at home alone for short periods or requires constant supervision at least during waking hours. Opportunities for short breaks away from the home are available in both housing with care and care homes. Again, there are a range of providers including the independent sector

Developments and Initiatives

- **Day Care**

Over the next three years we will be seeking to redesign day care services in line with national strategic direction which will include an emphasis on individual and community capacity building. The themes in terms of service re-design will be;

- Community inclusion – working with colleagues in other service areas to promote additional opportunities for older people to engage in universal services delivered more locally
- Integration – diverting existing resources to work with individuals to promote independence and support them to find ways of re-integrating with communities from which they have become isolated
- Seeking to deliver services more locally
- Seeking opportunities to invest in additional specialist services for dementia
- Targeting centre based care on those with high levels of care needs
- Seeking agreement with all providers on a more streamlined, transparent and targeted access system.

Short Breaks from Caring

West Lothian Council recognises that the development of short breaks from Caring will be crucial in terms of supporting carers to continue in their role in a way which does not impact adversely on their physical and mental health.

We have described in previous chapters a range of service developments, which aim both to keep people safe and also reduce the stress on unpaid carers. These can be summarised as;

- the development of a range of telecare options which will have an emphasis on prevention, remote monitoring and reducing social isolation
- the development of an assisted care and technology service which will offer crisis responses including enhanced overnight care on a visiting basis for short periods of time.

The emphasis on preventive services as a strategy for reducing stress on unpaid carers in the long terms cannot be overstated if in the context of demographic changes we are to enhance the services which are targeted on very complex needs and caring situations.

Much of the support made available to carers in West Lothian comes through Carers of West Lothian, an organisation primarily funded by West Lothian Council, the NHS and to a lesser extent others. They currently are in contact with over 2,000 carers however the Organisation is conscious of the need to identify in addition the many "hidden" carers and is seeking ways to actively identify and offer a core information and support service to them. Evidence shows that if carers are supported at an early stage they are less likely to suffer poor health due to their caring role.

However, for those complex needs, the council recognises that there is an urgent need to find additional investment to re-design and expand services which will offer short breaks from caring in ways which are more flexible, appropriate and responsive.

A particular need is identified for those people whose needs cannot easily be met by scheduled services and this will include people with dementia.

The future role of respite in care homes will be kept under review in the context both of demand and of the impact of service developments that support people in their own homes.

6.4 Self Directed Support and Direct Payments

Service

Since the Community Care (Direct Payment) Act (1996), local authorities have been allowed to make payments directly people eligible for a community care service to employ their own personal assistants or buy care directly from an independent provider and in 1997, West Lothian Council was one of the first Scottish Councils to set up a Direct Payments Scheme. The range of people eligible to receive direct payments has grown since then and the West Lothian Scheme has been reviewed and amended to reflect these changes.

Recipients can use a direct payment to buy support for personal care, daytime activities, respite care and temporary adaptations and equipment. The only community care service that cannot be funded by a direct payment is permanent residential care.

Service users and carers are given the opportunity to consider whether they would wish to receive a direct payment instead of direct service provision at the point of assessment and developing the care and support plan.

Delivery

The Social Policy Older People's Assessment and Care Management Teams carry out assessments and arrange and monitor direct payments for older people.

West Lothian Council has recognised that becoming an employer can be a daunting prospect for people even if they are keen to have the flexibility and control over their own care delivery that direct payments can offer. Therefore, West Lothian Council commissions and funds training and support services from the Lothian Centre for Independent Living which include preparing and supporting people as they take on the role of an employer; supporting people as they recruit and hire personal assistants; a training programme for recipients of direct payments and ongoing information, advice and support in managing a direct payment.

There has been ongoing promotion of the availability of Direct Payments and a range of information leaflets have been produced and distributed to inform potential service users and carers of this service option.

Developments and Initiatives

The national policy agenda of shifting the balance of care and the management of long-term conditions within local communities will clearly require the increased personalisation of services and the recent Scottish Government revised guidance on self directed support endorses this.

Despite the availability of Direct Payments as an alternative to direct service provision, the take up in West Lothian has been limited. It is anticipated that this situation will change and that there will be a growing demand for Direct Payments and personalised care. There are no additional resources attached to the introduction of the new guidance with the government expecting that the move to a greater level of self directed support from be funded from service re-design. However many service users and carers are likely to opt for direct service provision and the challenge will be for the council and key partners to manage these competing demands and the transition into alternative forms of service delivery. This may be particularly attractive to those with dementia and their carers as it will afford a degree of flexibility as well as a more imaginative use of support which continually goes beyond the scope of mainstream services.

Service pressures and developments in the area of self-directed support include:

- Revision of the West Lothian Direct Payments policy, guidance and procedures in line with the new national guidance for Self-Directed Support published in 2007. (Funded by Social Policy)
- Staff training on the revised guidance and procedures
- Strategies for freeing up resources from within existing services
- Provision of service user and carer training and support to manage a Direct Payment

- Commissioning of services to deliver the training and support to service users and carers
- Information and promotion of self directed support services

6.5 Occupational Therapy and Provision of Equipment / Adaptations

6.5.1 Community Occupational Therapy (OT)

Central to the multidisciplinary care teams, Occupational Therapists offer specialist input to promoting independence by;

- Assessment of everyday tasks and the environment through activity analyses to find the most suitable means of maintaining that person in the community.
- Offering advice and professional guidance on how to carry out particular tasks differently
- The provision of equipment to improve independence with day to day tasks
- Recommending alternations to make facilities more accessible
- Practice to promote confidence, ability and independence
- Getting support and advice from other agencies

OT Services are offered by both community and hospital based staff and are delivered to people who have a temporary or permanent physical, mental or learning difficulty and there is an established commitment from both health and council staff working in partnership to deliver OT and rehabilitation services. This has successfully seen a reduction in duplicated work, with processes in place allowing Council and NHS staff access to Community equipment store disability equipment. A recent survey evidences a streamlined approach with appropriate use of each areas specialist skills. This multi-agency approach to service delivery is underpinned by the more recent development of joint service objectives and by joint staff training and development.

Work with Housing Partners, WLC Grants Section and Care and Repair forms a significant part of community OT service delivery, supporting people by making their home more accessible.

Delivery

Occupational Therapists provide a generic service and are based across two West Lothian Social Work offices. Key areas of priority for older people would be:

- Facilitating hospital discharge and contributing to zero delayed discharges
- Helping to prevent hospitalisation
- Supporting people with long term conditions to remain at home
- Reducing the risk of falls

We aim to offer a seamless and responsive service and provide:

- a range of small equipment and adaptations without the need for an assessment (the Occupational Therapy Self Selection service). The service can be accessed directly by the public or by other professionals working with a service user. This simple, successful scheme has been in operation since 2000 and contributes significantly to reducing risk at home with everyday tasks. In a recent survey to

users of this Service (December 2008), 24% of respondents requested a handrail following a fall and 66% requested a handrail to help prevent a fall.

- Occupational Therapists offer specialist professional advice on a range of equipment which without that specialist professional assessment might generate a risk either to the service user or to their carer. Examples would be equipment for getting in and out of bed and specialist shower chairs.
- Large equipment and adaptations can be recommended following assessment, such as showers, stair lifts or ramps. The Occupational Therapist can arrange the provision with the housing provider or with the house owner using Home Improvement Grant funding.

6.5.2 Community Equipment Store (CES)

The CES is a joint service provided by NHS Lothian and West Lothian Council Social Policy. The CES provides a wide range of equipment and specialist items which are issued, usually on loan for as long as they are required, to service users following an assessment of their needs and/or the needs of their carers. Equipment ranges from simple items such as dressing aids to specialist beds, seating and hoists. The aim of the equipment service is to enable people to remain living within their own home as independently as possible for as long as possible.

The CES also arranges the scheduled delivery of continence products across West Lothian and has a highly sophisticated and effective cleaning and refurbishment facility

Staff at the CES provide advice by telephone and at the point of installation for equipment users.

Delivery

Based centrally in St John's Hospital the store is ideally suited to delivering services across West Lothian and is an early example of single shared assessment in practice where a range of equipment can be accessed across service boundaries. Some equipment will still require the specialist input of a particular profession but this is well documented in joint agreements with NHS and Council staff.

Shared staffing and premises allow both the Council and Health to deliver services more cost effectively. For example, in addition to servicing the Self Selection Service for equipment delivery, the CES arranges the scheduled delivery of continence products across West Lothian. We will also soon localise the delivery of continence and urology products to care homes in the independent sector ensuring that local partners can enjoy the same high standard of service delivery.

Committed to efficiency and responsiveness the CES has a strong record of continuous improvement in relation to;

- Delivery and response times (82% of deliveries within 5 days)
- Cleaning and repair service allowing a higher percentage of reissue
- Using IT to ensure the best use of skilled people resources

6.5.3 Developments and Initiatives

Occupational Therapy and Community Equipment Store

- Equipment and Adaptations Guidance, draft published by Scottish Government, 3 December 2008, recommends standards for how best to deliver the occupational therapy service and equipment provision. Areas not already of the required standard in West Lothian will be improved with partners in social policy, housing and NHS and implemented by staff.
- The Housing Scotland Act 2007, with Scheme of Assistance is to be introduced April 2009 and will replace the existing Home Improvement Grant scheme. Occupational therapy will work with partners in Housing to develop West Lothian guidance to assist with the provision of disability adaptations for owner-occupier households
- We will work with Housing Allocations to make best use of adapted Council housing stock and in assisting with allocating suitable housing to disabled applicants.
- Improved stock control and re-cycling of equipment will help to meet increased demand. The range of occupational therapy equipment and eligibility is regularly reviewed, in consultation with service users – this has allowed us to continue to target those in greatest need without any increase in budgetary provision over the last four years
- Localising the supply and delivery of continence and urology products to independent care homes in West Lothian, ensures all partners benefit from the same high standard of service delivery.
- Recent completion of GPRS hand held devices project allows equipment delivery drivers in the field to update requisitioners on progress of deliveries. Updates will be made direct to requisitioners' PCs
- There has been a recent review of the equipment range provided for hearing impaired service users, in consultation with Deaf Action ensuring best value for service users.

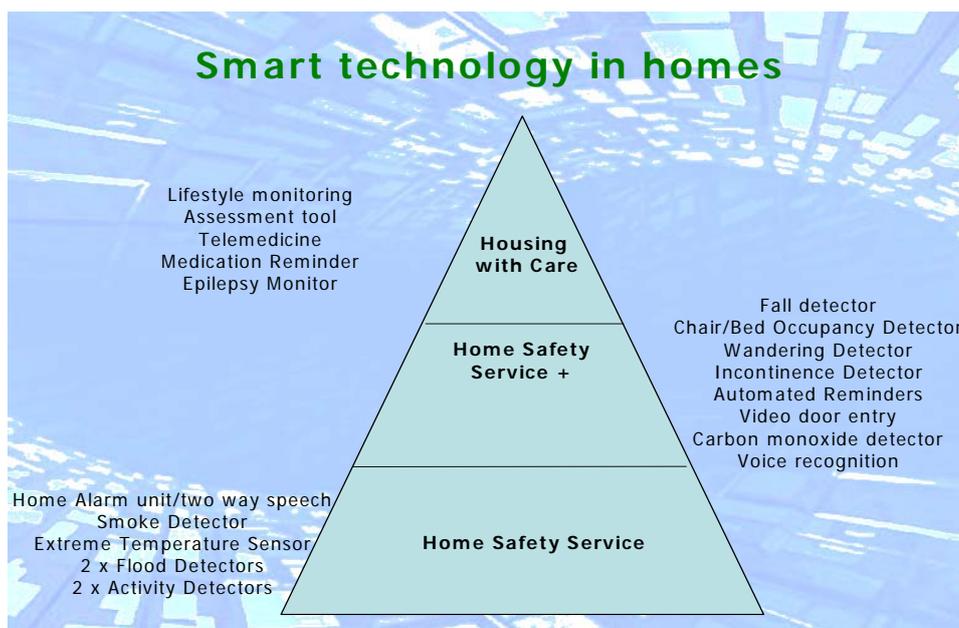
6.6 – Home Safety Service (HSS) - Providing Telecare and Telehealth Support

Service

The Joint Improvement team describe telecare as; the remote or enhanced delivery of services to people in their own home by means of telecommunications and computerised systems. It offers the prospect of preventative care services that maintain vulnerable people in the community with increased independence and at lower overall service cost.

West Lothian Council has invested heavily both in the development and provision of innovative telecare solutions, which will achieve these aims at three different levels:

- Promoting and sustaining independence for those people with low levels of need
- Complimenting personal care services by offering more effective personal and home safety monitoring mechanisms, including improved response to emergencies such as falls
- Improved care management for those with chronic long terms condition



The above diagram depicts how technology can be targeted and adjusted over time as necessary to meet changing levels of need enabling the individual to maintain their independence. The home safety service being appropriate for the lower levels of need, with progression to housing with care if needs become greater.

An independent evaluation of the service concluded:

- The overwhelming user response to the technology has been positive, with users reporting an increased sense of personal safety and security
- Informal Carers report increased peace of mind
- Weekly costs of telecare based care service provision were around £145 - £185 less per week than a West Lothian Care Home Provision

[Bowes, A and Mc Colgan, G (2006) Smart Technology and community care for older people; Innovation in West Lothian, Scotland, Edinburgh, Age Concern Scotland]

The Home Safety Service offers individual customised packages of technology and a back up service on an assessed needs basis to increase home and personal safety where there is actually a perceived risk to anyone resident in West Lothian.

Anyone in receipt of this service receives a core package and enhanced packages of technology are then developed on the basis of a specialist assessment of individual need. The service aims to support service users in their own homes and provide reassurance to their carers to avoid the need for a move into a care home setting and prolong the time they can remain living at home.

Delivery

To date West Lothian Council currently has installed 3,200 households (serving 4,500 people) in the community with the Home Safety Service. Both the core and the enhanced services are customised to accommodate individual lifestyles with variable parameters depending on identified need. The service is supported by a dedicated call centre and response service with links either to informal carers or formal services to ensure a robust response system.

The telecare strategy has contributed to all of the following

- Maintenance of zero delayed discharges
- Reducing average length of stay in a care home
- Delivering an average response time to falls of 22 minutes (for those who have Careline) against a Scottish average of 4 hours

Telecare also supports the capacity building philosophy underpinning the Housing with Care model where people with complex needs can live in an independent tenancy in a supported housing complex with a dedicated call service and support team.

West Lothian Council will commit significant financial resources to continue to expand the service user base to benefit from Home Safety Initiatives. We have already included in the financial forecast a commitment of 480 new service users for each year over the next three years.

The provision of telecare has enabled services in West Lothian to promote and support the management of long term conditions, including dementing illnesses, within the community, to implement shifting the balance of care and to maximise independent living options for older people.

Case Example - a 90 year old man with advanced dementia, still living at home with telecare, and being supported by his son who lived 10 minutes away, was in danger of being placed in care due to his growing tendency to leave his home in the late hours, disorientated and inadequately dressed. On assessment, it was clear that he was happy at home and despite limited insight he was agreeable to further telecare equipment. It was also clear that his son was hugely committed to preserving his right to stay at home; he however had grave concerns that it was no longer becoming feasible due to the risks involved. Additional telecare was installed and tailored to the man's individual circumstances with the result that soon after, the alarm was raised on a frosty winter's night at 2am. On arrival his son found nobody at home and on further exploration discovered his father lying fallen at the end of the street. His son is convinced that he would have come too significant harm had the telecare system not raised the alarm. However, he experienced no serious consequences and as a result his son was able to return him home safely. Nevertheless, without the telecare alert, the potential for serious physical discomfort and harm is obvious with the likely outcome for the man being at best an emergency hospital admission.

Developments and Initiatives

Developments in telecare and telehealth and the technology underpinning these are occurring at a rapid rate and the challenge for service is keeping pace with these changes and ensuring that service users and carers have access to the appropriate and personalised technology packages. The national drive towards shifting the balance of care and individualised support within the community means that technology will have an increasing role to play in enabling health and social care agencies to support people with a range of complex needs to manage their conditions at home.

It is important to emphasise that technology is used to support personal care services and not replace them. Delivering better outcomes requires efficient and effective mechanisms for collating and communicating key information. Our key objectives in this respect can be summarised as:

- Improving service experience at the points of contact, assessment and service delivery
- Maximising needs within available resources
- Equipping the staff people come in contact with, with the best information and backup that we can provide
- Making the end result for people as quick and as comprehensive as we can make it

We are confident that the following developments will deliver on some or all of these objectives within the next three years.

- the development of a 24 hour crisis response service one of the key features being to fast track installation of Home Safety Service for people at risk of falls followed by a comprehensive multi-disciplinary assessment and care plan aimed at preventing further falls and related injuries
- working in partnership with health to pilot telehealth with a view to improving the management of long term conditions
- Investing in the development of a new assessment tool based on an 'expert system' approach, such that non specialist staff in the health housing and social care sectors can accurately identify people who would benefit from telecare, occupational therapy/equipment and falls prevention services
- identify a core package of telecare monitoring equipment for older people with dementia

Other initiatives may not be deliverable within a three year time frame but we will continue to be committed to investing our time and expertise in working with key partners to harness different technologies to work together to add greater value to the experience of the service users. Examples would be:

- whether there is a technological solution which will allow people with dementia to have maximum freedom of movement within safe parameters but also alerting carers to potential risks
- whether a range of technologies could be channelled through a 'set top box to offer a more streamlined, customised and holistic service to promote independence

6.7 Services and Support for Carers

Service and Delivery

Unpaid carers make up the largest group of care providers in Scotland, making an enormous contribution to society, and there is an ever increasing recognition of the role unpaid carers play and its economic implications. Supporting carers is central to the health and social care agenda.

The Future of Unpaid Care in Scotland Report made 22 recommendations creating a ten-year agenda for valuing and supporting carers. The Scottish (Executive) Government response, whilst accepting the recommendations as a whole, identified four priority areas for public service providers and their partners to focus on. These priorities are better support for young carers, improved provision of respite services and short breaks from caring, safeguarding the health of carers and carer training to develop the knowledge and skills to support them in their caring role.

Based on the 2001 census, there are 15,147 carers in West Lothian (9.5% of the population) with 3,794 carers providing 50 or more hours a week of unpaid care. It is clear that the development and delivery of services and support for carers will not only benefit those they are caring for by enabling them to remain living at home for longer but will also benefit service providers who would otherwise be attempting to meet people's care needs in their entirety.

Ensuring that unpaid carers are identified and supported to enable them to continue in their caring role for as long as they would wish to do so has been a key challenge. The growing awareness of the impact of caring on carers' health along with a recognition of the essential role unpaid carers play in reducing dependence on formal service provision and preventing admission to long term care has led to developments in carer services and support.

In West Lothian, carers are now seen as key partners in the planning and delivery of care and there have been a range of initiatives developed to support unpaid carers and to work collaboratively with them to develop and deliver the services and supports available to those they care for. In addition, work has been done with local medical practices to encourage the earlier identification and referral of patients who also have a caring role. The aim is to promote carers' health by enabling earlier intervention and support and thereby reducing or preventing situations reaching crisis point before support is accessed.

Services and support for carers includes:

Carers' Assessments

A Carers' Assessment Framework and assessment tool has been developed and implemented along with practice guidance for staff. Staff and carer monitoring and evaluation forms have been introduced to ensure that staff are offering carers' assessments to carers and feedback is regularly analysed.

There has been an active promotional campaign to highlight entitlement to carers' assessments with almost 200,000 leaflets being developed and distributed across West Lothian in partnership with health and the independent sector.

There has been a steady increase in the numbers of assessments being completed and the aim is to show continued progress in this area.

Carers of West Lothian

The independent sector organisation, Carers of West Lothian, has been integrated into the CHCP Centre at Strathbrock. West Lothian Council is a key funder of the organisation and remains committed to continuing to be so. There is an established relationship of co-operation and collaboration between the agencies that has created an ethos of partnership working when addressing carer issues and there is an ongoing commitment to continued joint working to support carers and take the carer agenda forward.

The range of services and support offered by Carers of West Lothian has expanded and includes:

- Information and advice
- Carer Support Groups
- Carer Training Programmes on a range of needs and topics
- Carer Support Workers
- Young Carer Support Worker
- Hospital Discharge Carer Support Worker
- Support to establish 'Carers' Voice', a carers' forum

NHS Lothian Carer Information Strategy

The requirement to develop NHS Carer Information Strategies was introduced in response to recommendation 6 of the Future of Unpaid Care in Scotland Report (2006) and these were required to be developed in partnership with local authority partners and the independent sector. West Lothian Council has been involved in the development of the NHS Lothian Carer Information Strategy

Initiatives and Developments

The essential role of unpaid carers in implementing national policy initiatives such as shifting the balance of care has been increasingly recognised as has the need to support carers in their caring role and to ensure that their health is not put at risk as a result of their caring responsibilities. Discussion with key partners including the local carers' organisation, Carers of West Lothian, has identified that local priorities are broadly in line with the four early priorities identified by the Scottish Executive in their response to the Future of Unpaid Care in Scotland Report which were:

- Respite
- Carers' health
- Carer Training
- Young carers

A fifth priority was identified locally, carer access to appropriate support.

Carers want flexible and responsive services with transparent eligibility criteria.

Local service pressures and areas for development include:

- Forward and contingency planning to be available to carers as part of the overall assessment and care management processes, linked to anticipatory care and the management of long term conditions
- Develop our ability to respond to overnight crises and to create the capacity to provide interventions to support people while they are ill
- Carer Training Programmes, for example, in understanding long-term conditions, including the various presentations of dementia, financial issues including Guardianship, safer moving and handling and so on
- Accessible and comprehensive information for carers and the implementation of the Carers Information Strategy in partnership with health – there should be an emphasis on promoting and sustaining carers' health
- Promotion of carers' assessments and working in partnership with GP's and other agencies and colleagues to facilitate the take up of these assessments. An updated Carers Assessment Tool is being developed as part of the review of SSA processes and protocols.
- Partnership working with other Council services and agencies to identify young carers and offer appropriate support and services
- Availability of day support and care at home services to enable carers to maintain employment if requested – services should be flexible, responsive and available
- Carer engagement and consultation should be a routine part of service planning and development

6.8 - Housing and Housing Support Options

Central to the success of 'shifting the balance of care' is the need to ensure that a range of housing options for older people are in place within West Lothian.

In West Lothian there has been a significant shift in the balance of care for older people from more costly care home provision to new forms of care and housing support that are more appropriate to client need and choice. This shift originated through the Opening Doors for Older People Partnership, which was the catalyst for mainstreaming housing with care developments and the use of telecare technology to assist older people to continue living at home where they choose to do so. The weekly costs of the Opening Doors new build housing with care model are around £185 per week lower than care homes. (Smart Technology and Community Care for Older People; University of Stirling 2006).

Critical to the success of the model has been ensuring that individual capacity building is firmly embedded in care practices with a move from a 'hands on' approach to assisting and supporting older people.

In April 2007, along with a number of service areas, the ring fencing for housing support was removed under the Concordat signed between COSLA and Scottish Ministers. This agreement will provide opportunities in developing services, which are more flexible and

holistic in terms of meeting the needs of service users as well as considering the possibility of streamlining contracts, which have been previously separated.

Service Delivery

The council currently contracts with 7 providers (6 voluntary sector and WLC) to provide 46 housing support services across West Lothian. Table 1 below outlines the current housing support provision in West Lothian and breaks this down into provision by the voluntary sector, including Registered Social Landlords (RSLs), and WLC as of end October 2008.

Table 1: Housing Support Provision in West Lothian

| Type of Provision | No of Units | No of Hours | Voluntary Sector | WLC |
|-------------------|-------------|-------------|------------------|-----|
| Amenity | 44 | n/a | 100% | 0% |
| Sheltered Housing | 754 | n/a | 90% | 10% |
| Very Sheltered | 30 | n/a | 100% | 0% |
| Housing with Care | 176 | n/a | 18% | 82% |
| Extra Care | 26 | n/a | 100% | 0% |

(Housing Support – West Lothian)

Table 1 illustrates that the voluntary sector mainly through registered social landlords is the main sector for the provision of sheltered housing, amenity housing and very sheltered housing. However, the Council is responsible in the main for the provision of housing with care. This position is partly due to historic development and staffing of supported accommodation for older people through RSLs while in more recent years the Council has taken forward in partnership with RSLs and others new models of care such as housing with care.

Overall the void levels in supported accommodation for older people is low. Some providers are experiencing problems with the design of accommodation (e.g. bed sits are less popular) and have put strategies in place to address this.

The overall aim in West Lothian is to develop an ever-increasing range of housing options with the right level of surrounding support. Central to this will be the overall Housing Strategy and we will work in partnership with housing services to inform that process. The need identified in the context of the Older People's Review (see 10 Year vision) is for accessible housing in town centres close to local amenities and services.

Sections 6.1 – 6.6 of this chapter outlined the range of enhanced and developing services designed to support people in their own home, regardless of tenure. The initiatives and developments in this section focus on the development of specialised housing options with dedicated support, which may be provided on site or remotely. While many more people can be supported in their own homes, the availability of alternative housing support options is critical for people where their existing home does not lend itself to maximising independence

Case Example

Mrs T is an 87-year-old lady who has been in Housing with Care for two years six months.

Medical History

- Bilateral Cataracts - operated on 2004

- High Blood Pressure - controlled with medication including diuretics
- Diabetes - diet controlled
- Alzheimer's disease - diagnosed 2005

Mrs T had lived alone in a three bedroom, semi detached house in East Calder since her husband died three years previously. Her two sons and one daughter live locally. They were becoming increasingly concerned about her as she had lost two stone in weight over a very short period of time; also they were noticing that she was not taking her medication regularly, resulting in dizzy spells and falls due to her blood pressure being erratic. She had left her cooker ring switched on three times which also was a major concern to them. She was very socially isolated having previously enjoyed going out but had lost her confidence. They decided with her permission to apply for housing with care and within three months was allocated a tenancy in Cunnigar House.

Mrs T has a care package, which consists of

- A morning call to assist her with her breakfast preparation, medication prompt, eye drop installation, bed making and kitchen and bathroom hygiene. She is also prompted to wash and dress which she does unaided.
- A mid morning call to escort her along to the main lounge where she enjoys a cup of tea with some of the other tenants who meet daily.
- A lunchtime call to escort her to the dining room for lunch and another medication prompt.
- A teatime call to escort her to the dining room for tea and another medication prompt.
- A night time (8.30 pm) call to assist her with her supper preparation and another medication prompt, eye drop installation and prompt her to undress and put on her night clothes.
- 2x weekly laundry.
- 2x weekly housework and hovering as required.
- 3x weekly shower with assistance.

Her family continue to deal with her finances and her shopping.

Mrs T has put on over one stone in weight as she now eats regularly.

She gets her medication regularly which has resulted in less dizzy spells and more importantly falls.

She does not require a cooker in her flat, which is a major relief to the family.

She enjoys the social interaction with her neighbours in Housing with Care and any social/generation arts events that are organised.

Her family have more quality time to spend with her as the Housing with Care staff now does the Housework tasks and Laundry.

Developments and Initiatives

We intend to build on our strong foundation and further extend and enhance the options for accommodation with support for older people in West Lothian and will do this in the following ways:

- By working in partnership with existing supported housing providers to consider how recent care developments such as technology might offer an opportunity to redesign services in a way that achieves a better outcome for older people in West Lothian.
- Propose to undertake in partnership a review of Sheltered/very Sheltered Housing provision in West Lothian
- We will consider what opportunities are generated by the single outcome agreement to streamline and refocus services who's development may have been constrained by ring fenced funding
- We will seek to increase the number of housing with care tenancies. We are confident that the three year budget profile will accommodate the development of 50 Housing with Care tenancies, some of which will be in existing sheltered housing complexes. We will continue to seek to identify additional funding opportunities to support this programme.
- We are interested in testing the market in terms of owner occupied housing with care and will consider the viability of this in future developments.
- Capital funding is available within the next five years to further develop Housing with Care with an emphasis on dementia. Over the next three years we will be developing the concept with a view to further pushing the boundaries in relation to supporting people with more severe dementia.

Developments and Initiatives

In pursuing its aspirations within this area the council's intentions are to consider a range of housing options, which are likely to support a further shift in the balance of care. One possible option could be for example the possible development of a campus style approach which may include some of the following:

- A new housing with care public sector development of supported tenancies.
- Potential involvement of private sector housing (HWC) with care units if a need and a market can be established.
- More adapted use of adjacent buildings to offer a menu of services, which are capable of catering for a range of varying needs via flexible staff working arrangements.

The overall scheme is intended to improve service provision for older people, with an emphasis on support for those with dementia, and may involve over time a number of innovative features such as:

- Development of a suitable "core package" of telecare and telehealth monitors to support older people with dementia to remain in the community where they live in proximity such a development.
- Establishment of new assessment tool based on an "expert system" approach, such that non specialist staff in Health, Housing and Social Care sectors can accurately identify people who would benefit from telecare, occupational therapy and falls prevention services or equipment.
- An approach to providing services to older people with dementia, which focuses on re-enablement, mutual care and community capacity building.

The overall timetable involves having all new facilities and services in place by 2012. This will be progressed in stages, with stage 1 involving development of the new Housing with Care facility, and phase 2 the re-development of an existing sheltered housing development and adjacent land to provide the Dementia Care Centre and related services facility.

Agreement will be sought from the relevant parties as to this new model of day and breaks from caring and also within residents support services for people living in the vicinity of the new Housing with Care/adjacent buildings.

6.9 - Residential Care Homes

Care Homes continue to provide a crucial element in the range of care that is available to people with dementia in West Lothian. There are 17 Care Homes in West Lothian, four of which are run by West Lothian Council. The market in West Lothian is robust with demand and supply being well matched. The Council enjoys a positive working relationship with providers and contractual arrangements are based on the National Care Home Contract finalised in 2007

All care home services are required by statute to register with the Care Commission and are subject to inspection twice yearly. These inspections apply the requirements of the Regulation of Care Act and the National Care Standards.

Delivery

Like many care services, access to care homes is arranged on the basis of an assessment of need. West Lothian Council has a well-established policy on choice, the provisions of which ensure that there is a fair and equitable allocation of placements while also providing for interim arrangements until the placement of 1st choice becomes available.

Providers in every sector have consistently applied the principles of the policy on choice and have worked in partnership with West Lothian to develop and implement a single placement allocation system. The support of the independent providers in maintaining this transparent allocation process has been invaluable in terms of maintaining our excellent performance in relation to delayed discharge

Developments in community-based services have resulted in people staying at home longer with the average length of stay in care homes, decreasing to approximately 12 months. It is anticipated that this trend will continue and that with a further shift in the balance of care there will be a net reduction in care home purchasing. In the West Lothian context and given local demographic trends, it is anticipated that this will result in a continuation of current purchasing levels i.e. that the *proportion* of the older population who live in care homes will decrease, whilst the proportion of the older population supported in the community will increase.

Developments and Initiatives

The key aims of promoting healthy living, choice and independence are as central to the service objectives in residential care as they are in community-based services. Always fundamental to the inspection process, the new graded inspection framework has an added emphasis on evidencing choice and participation.

Care Home developments over the next few years will focus on further promoting healthy living and preventing the lifestyle disruption associated with unscheduled admissions to hospitals. Care Homes have been implementing a range of new best practice guidance to progress this agenda:

- A focus on Nutritional Health supported by a new screening tool. The *Malnutrition Universal Screening Tool* (MUST) has been introduced in care homes in collaboration with Health Service colleagues. An initiative to implement this tool commenced in late 2008 and further consultation and development is being undertaken in 2009 for implementation in care homes this year and beyond.
- Related to Nutritional Health is recognition of the difficulties associated with oral hygiene in residents of long term care facilities. Lothian Health has recently launched the Life smile project to improve team working and the effectiveness of oral healthcare delivery. The pilot has involved four care homes in West Lothian and the initial evaluation is very positive.
- Care Homes are being encouraged build on existing good practice in relation to palliative care and are further implementing the recommendations of 'Making good care better' and 'Living and Dying Well'
- There will be an emphasis on improving care planning in relation to falls prevention and this will be supported by the recently appointed falls co-ordinator
- We will actively promote the benefit of physical activity as a means of reducing the impact of long-term conditions on both physical and mental health. 2008 saw the development of West Lothian's Care Home Network, co-ordinated by the council's Health improvement team. The network aims to raise awareness of the risks of inactivity and allows the care homes to come together, engage with one another and share knowledge, experience and resources.
- We will encourage all providers to work in partnership with primary health care teams to implement anticipatory care plans to improve the management of long term conditions
- There will be a focus on more a more systematic approach to falls prevention will be encouraged and this will be supported by the Lothian NHS falls prevention programme with a local co-ordinator having been appointed.
- Similarly, we will seek to raise the profile of the importance of positive mental health for residents in care homes and seek to consider the recommendations of Lothian Care Homes Mental Health Improvement programme.
- We will implement the National Care Home Contract with Care Homes being required to offer staff dementia training.

Chapter 7

Lothian Dementia Project/Major Local Initiative

A proposal from Alzheimer Scotland and the Dementia Services Development Centre at the University of Stirling for 'practical solutions for deliverable and effective post-diagnosis support services, to be piloted in three NHS Board areas (Greater Glasgow and Clyde, Shetland and Lothian), to commence within 2008-09 has been accepted by the Scottish government.

There is a three year programme which will help the achievement of the Scottish government HEAT targets, through better support of people with a diagnosis of dementia, immediately after diagnosis and this paper describes the service improvement deliverables to be achieved through an improvement pilot and the potential benefits that a phased-in model could delivery. This work will also be supported and complemented by the flow within the Mental Health Collaborative concerned about the achievement of the dementia HEAT target.

Specific Scottish Government targets related to this programme

The overall goals of the programme are outlined within the context of achieving the targets set out in respect of the Scottish government performance targets and the implementation of the standards for the Integrated Care Pathway (ICP) for dementia and generally the new emphasis on dementia as a national priority.

Current issues

There is evidence that people with dementia have a mixed experience at the point of diagnosis. There are some excellent examples of good practice, but the lived experience of a number of people is that they are given very little support and that staff do not think that it is their job or are not trained in how to go about this.

Encouraging the development of better-integrated systems is a key feature of policy imperatives across older people's services over a long period. The 2005 framework *Better Outcomes for Older People* states that 'the whole system approach puts the older person at the centre of all service delivery and planning. It provides the right support, at the right time by addressing the entire range of their needs'. The 2005 Audit Scotland review of delayed discharges comes to a similar conclusion, stating that 'delayed discharges are a symptom of a wider, systemic problem and cannot be treated as a stand alone issue'. It is clear that those system difficulties are the result of often avoidable situations which could be made better by giving people with dementia and their carers more power over their lives, through information and support at and soon after the point of diagnosis. The current review by audit Scotland of mental health services and the investigation of the Health and Sport Committee of the Scottish Parliament into what happens to people with dementia in Accident and Emergency departments will also offer some interesting and potentially valuable learning.

The aim of the programme

The three pilots will ultimately support the implementation of a Dementia programme throughout Scotland. Central to the improvement approach is the concept of spreading and adapting existing knowledge to multiple sites to achieve service improvement. The approach makes best use of current thinking on the effective spread of improvement and places a heavy emphasis on integration within the wider local organisation development agenda. It is clear from experiences elsewhere that such an approach does deliver significant service improvements and that success depends greatly on effective project management and excellent facilitation at a local level. The programme will:

- Optimise the overall experience and outcomes of care for people with dementia following on from the point of diagnosis, whatever stage of the illness and whatever location of the patient.
- Maximise the extent to which the person with dementia will begin, from the point of diagnosis, be supported in taking control of their own lives and future plans for their care.
- To prevent adverse incidents and avoidable illness including depression and anxiety in people who are diagnosed with dementia and their carers.
- Help to co-ordinate dementia services between agencies by placing the person with dementia at the heart of decision making.
- Enable teams to develop the skills and confidence to continue to develop services around the person with dementia and help to deliver clinical governance.

Approach to be taken in Lothian

The approach, which will be led by the Dementia Services Development Centre (DSDC) involves:

- Developing a set of strategies, principles, ideas and actions for change that local multi-agency teams can use to improve services.
- Sharing these ideas, in conjunction with appropriate change management/improvement methodologies, among participating health and social care staff, along with other independent and voluntary agencies.
- Enabling these teams to adapt and apply the learning to their own real life situation through rapid and intensive change management methods.
- Sharing the learning across all participating sites to help support the broad roll out of good ideas and practice.

Through a formal change process staff will:

- Establish clear care pathways for post-diagnostic support as groundwork for the implementation of the NHSQIS implementation of care pathways for dementia.
- Improve skills and knowledge of staff caring for people with dementia in techniques of empowerment.
- Ensure that all people with dementia have care plans in place to cover all contingencies.
- Contribute to improved inter-agency partnerships within localities, particularly between statutory and voluntary sector organisations.

In order to ensure rapid diffusion of good practice it is important to develop the model for Scotland through the pilot phase. The work done in Lothian will be shared with other Health Boards on a regular basis to ensure that a learn and spread approach is adopted.

The pilot will involve a series of training sessions and meetings, which will facilitate those teams involved to develop improvement skills and to reach agreement on the measures for the programme. Pilot project teams will take the work forward between these meetings. The Pilot will support the spread of good ideas and innovative ways of working with examples of good practice forming the basis of the programme.

The pilot will involve Primary and Secondary Care, social services, private providers and voluntary organisations in Lothian and will seek to appropriately involve patients and carers. The team will co-ordinate joint working across all sectors of care to delivery outcomes for people with dementia. The pilot will run for three years.

Key to the success of the pilot is the response of every organisation or agency to be involved in developing the pilot. Evidence from the Forth Valley project shows that this may require a lengthy lead in time to the start of the action phase and to spread the learning taken from the pilot to develop other local teams.

Management

A project manager will be appointed within the host pilot area to work with the team. This person will assist with the administration of the project and ensuring that the processes run smoothly and effectively and that information is shared through different mediums. The project lead will be accountable to the Director, Dementia Services Development Centre, the University of Stirling for the purpose of the project. The Director has considerable experience of management of improvement programmes within the Scottish Health and Social Care system.

- A steering group will be set up with membership from HEALTH, Social, Voluntary and hopefully Independent Sector - to include representatives for carers.
- Key contacts will be identified from each sector at a senior level and they will be contacted in order that views on what needs to be changed, why and what aspirations stakeholders have can be included in the scoping and then project deliverables.
- One project manager, as listed above will manage the business processes to allow the project lead to focus on staff development.

Performance Management and Accountability

- The Director, Dementia Services Development Centre, the University of Stirling, will provide a monthly report to the Scottish government and to NHS Lothian and other stakeholders by request and place the report on the DSDC website and on a website of choice of NHSD Lothian.
- Project performance will be measured against the delivery of the programme outcomes.
- The project manager will report on a monthly basis to the steering group.
- The project manager will be accountable to Director, Dementia Services Development Centre on a day-to-day basis.

Forward Programme

Capacity to initiate and lead change must be embedded at local level. The process for sharing the learning/experiences from this pilot will be clearly planned at the outset. It is proposed that the Project Manager working with the local teams will be supported locally by existing initiatives within primary, Secondary and Social Care and link closely with members of Local Development Teams both in health and Social Care.

Through this programme based approach we would expect a local pool of expertise to be gathered and to continue to develop to support future change programmes on a whole system basis. Board level sponsorship will help to ensure that the service improvements delivered locally can be sustained. We would expect to see this reflected in local development plans.

First Steps

The collaborative programme and the HEAT target means that there will be:

- People newly diagnosed with dementia that are already in the care home sector or receiving home care.
- People who have not been diagnosed who are in the acute health care system and are cared for by generalist staff in Accident and Emergency/medical/other settings.
- People newly diagnosed who have considerable information and support needs that could be served in part by peer group support.

In addition the new interest and focus on dementia will mean:

- Pressure on existing dementia related staff.
- Increased demand for dementia related education for staff across all systems.
- Need for increased awareness.

In the light of this the programme will take first steps in this year to April 2009 by:

- Planning a change event in March 09, which will bring together all interested parties to decide on future action and create the action plan. This event will target up to 200 staff across Lothian and will be held with Lothian. Date to be agreed ASAP. Executive NHS Lothian sponsorship and support will be sought for this event, as this will be a key milestone.
- Preparation of briefing for those parties on demographics, policy directions and current examples of good practice.
- Creation of a section on the intranet or the DSDC website (or both) for communication of this information and the monthly reports and records of good practices as they emerge.
- Starting education programmes for care homes where new diagnosis is being made using the care home assistant training programme.
- Starting education support for dementia related staff in the NHS by offering places on the Dementia Certificate distance-learning programme.
- Offering the manager as leader of dementia practice programme to a cohort of charge nurses, care home managers and home care supervisors from February.
- Providing free places on all DSDC programmes currently running for any Lothian based health or social care staff, in addition to the reduced price places for voluntary sector staff.
- Offering a free book account for up to £200 of books and other learning materials on the DSDC on line book shop to staff designated by the dementia programme lead.
- All of the above programmes offer a real value to staff across the health and social care systems in Lothian and offer a real opportunity to learn together at different levels but with a clear focus in improving quality and experience of care.

Evaluation

An evaluation of this programme commissioned by DSDC will also be built in, in order to measure the change both in systems but also in culture and behaviours towards this population.

These actions will kick start the programme, but the two years of planned work will be based on the outcomes of the convention in March.

The Scottish government recently announced that Lothian had been one of three NHS Board areas in Scotland to enable practical solutions for deliverable and effective post diagnosis support services to be piloted commencing in 2009.

This is a three-year programme, which will help the achievement of the Scottish Government to HEAT targets, through better support of people with a diagnosis of dementia, immediately after diagnosis, which will be achieved through an improvement pilot and the potential benefits that a phased model could deliver.

8. Consultation

West Lothian Council aims to develop local services which suites the needs of our local communities.

It recognises that in order to do so it requires to engage and consult with a wide cross section of the community as well as partnership agencies, this approach being entirely in keeping with the expectations and guidance issued by the Scottish Government.

As a mechanism for translating this requirement into reality it currently engages and consults at a variety of levels. Within the Community Health and Care Partnership the approach has been to create a Public Partnership Forum, which comprises of individual members of the public, patients, carers and well as existing community voluntary groups. It is via this Forum local people are informed, consulted and enabled to raise issues which in turn feed into the planning and decision making process with regards to future health and social care needs and subsequent provision.

However, this is not in any way the end of the process. Underlying this activity is the actual service-planning phase itself, where detailed service statements are developed with input from a wide range of internal and external stakeholders as well as agencies working within the statutory, voluntary and independent sectors, this one relating to the provision and development of services for those with dementia.

It is only by harnessing and utilising this collective input at a range of levels that we have been able to set out within this document our clear vision for the future of dementia care within West Lothian.

9. Summary

West Lothian has a reputation for designing and delivering innovative services for older people. In 2007 the Social Work Inspection Agency awarded the service an excellent grade for the category "Impact on the Community" In the same year West Lothian Council was the first Scottish council to attain a corporate Chartermark status for customer service. However times move on and West Lothian faces many challenges in sustaining these accolades and in continuing to respond to changes in both national and local policy direction and political imperatives.

Two key challenges are themed throughout this Service Statement. Firstly, demography -the reality is that there is going to be a huge increase in the number of older people in West Lothian in the next 15 years and hence the prevalence of those with dementia given its association with increasing age. It is incumbent on Social Policy, its partners within the council and its partners and stakeholders external to the council to work collaboratively to anticipate, identify and meet the needs of those who are most vulnerable in this respect within our communities. This collective approach being reflected in the extensive engagement and consultation, which took place with statutory, voluntary, and independent sector agencies and others to initially develop and then refine our stated intentions based on identified needs.

What is clear is it is unlikely that there will be additional resources to meet these needs. It is therefore quite clear that we cannot just keep "doing more of the same". It is also clear from customer feedback that older people including those with dementia their families and carers do not want "more of the same". This service statement starts to outline how the council proposes to meet these challenges. It includes

- Listening and involving our customers
- Working collaboratively with other council partners, external statutory services – including the health and police service, and the independent sector
- Building individual and community capacity – supporting individuals and communities to maintain their personal independence, but also their social connection to their own communities

The second theme emanates from the national and local policy directive to "shift the balance of care". Essentially this means that health, social care and housing services should endeavour to rehabilitate, re enable, care and support individuals and their families / carers in their own homes and communities. West Lothian embraced this agenda about 10 years ago, best evidenced in the last 5 years by the consistently lowest delayed discharge figures nationally. The establishment of alternative housing with support options such as Housing with Care and the introduction of assistive technology have also made a great impact on this agenda. The emphasis here is more so on what we do and intend to do to continue to shift the balance of care. It includes

- Commissioning of services – an increase in commissioning services from the independent sector and a focus on designing and delivering more specialised services in house
- Increasing and enhancing the use of Telehealth and Telecare services
- Increasing support for carers
- A redesign / streamline of out of hours services
- Establishing a specialist service for people with dementia and their families / carers

Our overall aim, in line with the Scottish Governments “ Outcomes for Community Care” is to achieve better health, improved social inclusion, improved well-being and improved independence and responsibility. This Service Statement outlines the approach, priorities and methods to be employed in reaching these outcomes.

10. ACTION PLAN

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|---|--|--|--------|-----------|
| Maximising Care at Home with Carer Support | 1. Develop more flexible response to crisis and out of hours care. | Develop Assisted Care and Technology Service (ACTS) | AB | 2009 |
| | 2. Day Care Service Redesign | <ul style="list-style-type: none"> - Implement recommendations of day care review. Re-focus on re-enablement, respite for carers. - To create specialist provision for those with dementia and their carers, both centre based and on an outreach basis. | PM/VdS | 2010 |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|------------------|----------------------|--|--------------------------|----------------------------|
| | 3. Personalisation | <ul style="list-style-type: none"> - Promote the use of Direct Payments and Personal Direct Funding, re-allocating funding from existing services. - Review the existing policy framework for DP's and PDF. | <p>CS</p> <p>JAD</p> | <p>Ongoing</p> <p>2009</p> |
| | 4. Support to Carers | <ul style="list-style-type: none"> - Increase by 5% the number of Carers assessments each year - Work jointly with NHS to implement the Carers Information Strategy (including the rollout of the Carers Training Programme). - develop in partnership with carers, flexible short breaks service for people with dementia. | <p>CS</p> <p>PM /VdS</p> | <p>Ongoing</p> <p>2010</p> |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|---|---|---|---|--------------------------------------|
| Better Integrated Health and Social Care for those in need and at risk | 1. Shared Information Systems | - Conclude the review of single shared assessment and implement new 'refreshed' framework. | IQ/JMcD | 2009 |
| | 2. Multi-agency strategic overview of adult support and protection. | <ul style="list-style-type: none"> - Establishment of an Adult protection Committee and sub committees. - Establishment of a multi-agency post. - Report to COG. - Report to Scottish government. | VdS VdS VdS VdS/SDO VdS/SDO | 2009 2009 2009 2009 2010 |
| | 3. Risk Assessment | Implement risk assessment and management framework. | CS | 2009 |
| | 4. Specialist Assessment and Care Management Dementia Tenancies | Re-structure assessment and care management team to build specialist dementia teams to further extend joint working with specialist health teams and promote SSA. | CS | 2010 |
| | 5. Advocacy | Review of Advocacy Services | RB/VdS | 2009 |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|---|-------------------------------------|---|-------------|--------------|
| Extending and enhancing the options for accommodation with support | 1. Housing with Care (HWC)/Dementia | <ul style="list-style-type: none"> Continue to increase the number of HWC tenancies by 50 over the next three years by redesign of existing resources. | MR/SDO | 2009-ongoing |
| | 2. Sheltered Housing | Review of Sheltered/ Very sheltered Housing. | MR | 2009-ongoing |
| | 3. Housing with Care/Dementia | <p>Develop design concept for a specialist housing with care model for dementia.</p> <p>Explore potential for a 'campus' model with a suite of services providing a range of support services to carers</p> | SDO/MR | 2009-2011 |
| | 4. Assistive Technology | Increase the level and range of assistive technology in both Care Homes and Housing with Care. | AS/SDO/ACTS | 2009-ongoing |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|--|-------------------------------|--|-------|--------------|
| Reduce Avoidable Unscheduled Admissions to Hospital | 1. Crisis Care | <ul style="list-style-type: none"> - Develop (via ACTS) a falls prevention/ confidence building service, which will include fast track assessment and installation of telecare for those at risk of falls. - Extend out of hours service (via ACTS) to provide capacity to support 144 clients annually that need short term overnight care. | AB | 2010/11 |
| | 2. Anticipatory Care Planning | Work in partnership with health to further develop and integrate anticipatory care in the care management framework. | CS/DE | 2009 - 2011 |
| | 3. Telehealth | Work in partnership with health to further develop telehealth potential once pilot is completed. | AB | 2009-ongoing |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|---|----------------------|--|-------|-----------|
| Improve Capacity and Flow for Scheduled Care | 1. Delayed Discharge | <ul style="list-style-type: none"> - Maintain zero delayed discharge. - Develop further local target of reducing bed days lost by 15% over the next three years. | PM/CS | 2011 |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|--|---|---|-------|-----------|
| Better use of non medical skills and services outside acute hospitals | 1. Falls prevention and overnight crisis care | Development of ACTs Team | AB | 2010 |
| | 2. Management of long term conditions | Consider and support the outcomes for the Lothian Telehealth pilot. | AB/AS | 2010 |
| | 3. Active Healthy Living | To support the activities of the Health Improvement Team | All | |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|---|---------------------|--|------|-----------|
| Improve access to remote and rural populations | 1. Social Inclusion | <p>To consider in the context of the day care review whether services could be improved by adopting a 'dispersed' model.</p> <p>To work with other service areas in the context of the Review of Older People's Services to promote a more inclusive approach in universal services.</p> | | |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|--|---------------------------------|---|------|----------------|
| Improve Palliative and end of life care | 1. Living and Dying Well | To support the implementation of anticipatory care planning in West Lothian. | DE | 2010 |
| | 2. Living and Dying Well | Engage in shared learning and maximise opportunities to share resources with the independent sector | DE | 2009 - ongoing |
| | 3. NHS Palliative Care Strategy | To cooperate with the development and implementation of the NHS Palliative Care Strategy. | JMD | 2009-ongoing |

| Area of Priority | Themes | Action(s) | Lead | Timescale |
|--------------------------------------|--------------------|--|------|-----------|
| Better use of joint resources | 1. housing Options | <ul style="list-style-type: none"> - Review Housing Allocations - better use of adapted properties. - Implementation of the Housing Scotland Act. - Improved Stock Control and re-cycling of equipment via Joint Equipment Store. | | |

Key:

| | |
|------|-----------------------------|
| PM | Pamela Main |
| VdS | Val de Souza |
| CS | Charles Swan |
| RB | Ronnie Barnes |
| AB | Alan Bell |
| AS | Anne Sherriff |
| IQ | Ian Quigley |
| JMcD | Joyce McDermott |
| MR | Marion Reid |
| DE | Dan Easton |
| JAD | Jill Derby |
| JMD | Jillian Dougall |
| SDO | Service Development Officer |
| ACTS | Team |

11. DEMENTIA SERVICES LEARNING AND DEVELOPMENT PLAN

| Develop Requirements | M | N | R | O | Target Group | Est. Timescale | Arranging Provider | Numbers Required | 2009 - 2012 | | | |
|---|---|---|---|---|--|----------------|--------------------|------------------|-------------|--------------------|------------------|------------|
| | | | | | | | | | Per Service | Number Per Service | Cost Per Service | Total Cost |
| Dementia Awareness Training | X | | | | Manager Team Manager CCA's SW's SP's OT's DCO's SCW's Deputes | 2009/12 | Social Policy | | | | | |
| The Manager as Leader of Dementia Practice | | X | | | Managers | 2009/12 | DSDC | | | | | |
| Enabling Communication for People with Dementia | | X | | | | 2009/12 | DSDC | | | | | |
| Study Course for Healthcare Assistants | | X | | | DCO's SCW's | 2009/12 | DSDC | | | | | |

12. Performance Indicators 2009 / 2010

WEST LoTHIAN COUNCIL

SERVICE: CHCP AND SOCIAL POLICY

| Activity | Objective | Corporate Planning Priority | Performance Measure and Target 2009/10 | Projected Output Narrative for 2009/10 |
|--------------------------------|---|---|--|--|
| Assessment and Care Management | To provide assessment and care management services to older people, their families and carers | Improving The Health And Wellbeing Of Communities | <p>All assessments/ reviews to be completed within 13 weeks of referral</p> <p>% of care plans reviewed within agreed service timescale</p> <p>% of user assessments completed to national standards</p> <p>% of users and carers satisfied with their involvement in the design of care packages</p> <p>% of community care service users feeling safe</p> <p>% service users satisfied with opportunities for social interaction</p> <p>Number of people waiting longer than target for assessment per 1,000 population</p> <p>% of people 65+ admitted twice or more as an emergency who have not had an assessment</p> <p>Number of patients waiting in short stay setting, or more than 6 weeks elsewhere, for discharge to appropriate setting</p> | Number of assessments/ reviews completed |
| Assessment and Care Management | To offer support to informal carers | Improving The Health And Wellbeing Of Communities | All assessments/ reviews to be completed within 13 weeks of referral | Number of assessments completed |

| | | | | |
|-------------------------------|--|---|---|---|
| (continued) | | | <p>% of carer assessments completed to national standard</p> <p>% of carers who feel supported and capable to continue in their caring role</p> | |
| | Adult Protection | Improving The Health And Wellbeing Of Communities | All referrals to be allocated within 24 hours of receipt | Number of Adult protection referrals investigated |
| Purchased Care Home Placement | Purchase Care Home placements | Improving The Health And Wellbeing Of Communities | <p>Care home placements secured as required</p> <p>% of care staff who have appropriate qualification for post held</p> <p>a) private</p> <p>b) voluntary</p> <p>% of occupied places for older people that are single rooms</p> <p>% of occupied places for older people that have en suite facilities</p> | Number of purchased placements |
| Provision Care Home Placement | Provision of Care Home placements | Improving The Health And Wellbeing Of Communities | <p>Care home placements secured as required</p> <p>% of care staff who have an appropriate qualification for post held</p> <p>% of occupied council places for older people that are single rooms</p> <p>% of occupied council places for older people that have en suite facilities</p> | Number of placements provided |
| Interim Care Home Placement | Provision of Interim Care Home Placement | Improving The Health And Wellbeing Of Communities | <p>a) maintain zero delayed discharge</p> <p>b) provided responses to emergencies</p> <p>% occupancy levels</p> <p>% of care staff who have an appropriate qualification for post held</p> <p>% of occupied council places for older people that are single rooms</p> | Number of placements made in Craigmair |

| | | | | |
|---------------------------|---|---|---|--|
| | | | % of occupied council places for older people that are en suite | |
| Short Breaks from Caring | Purchase of short breaks from caring in registered accommodation | Improving The Health And Wellbeing Of Communities | 2,184 nights of respite available to carers | Number of bed days purchased |
| Short Breaks from Caring | Provision of short breaks from caring in registered accommodation | Improving The Health And Wellbeing Of Communities | 2,184 nights of respite available to carers | Number of bed days purchased |
| Short Breaks from Caring | Purchase of short breaks from caring services at home | Improving The Health And Wellbeing Of Communities | Number of hours purchased per month: 1,050 | No. of Short breaks provided |
| Day Care Support Services | Provision/Purchase of Day Support and activities outwith the home which promotes independent living and supports carers | Improving The Health And Wellbeing Of Communities | Service is available when required | Number of days supported provided annually |
| Direct Payments | To provide personal direct payments to older people | Improving The Health And Wellbeing Of Communities | To increase the number of people in receipt of personal direct payments | Number of service users |
| Advocacy | To purchase an independent advocacy service to people in a care home or hospital | Improving The Health And Wellbeing Of Communities | Responding to requests for service within seven days | Number of people who have been provided with an advocacy service |

Domiciliary Care

Performance Indicators 2009 / 2010

WEST LoTHIAN COUNCIL

SERVICE: CHCP AND SOCIAL POLICY

| Activity | Objective | Corporate Planning Priority | Performance Measure and Target 2009/10 | Projected Output Narrative for 2009/10 |
|--------------------------|--|---|--|---|
| Support at Home Services | Maintain and promote independence for individuals and provide support for carers | Improving The Health And Wellbeing Of Communities | <p>Service is available as required</p> <p>% of people 65+ receiving personal care at home</p> <p>a) provided</p> <p>b) purchased</p> <p>% of people 65+ with intensive needs receiving care at home (10+ hours pw)</p> <p>a) provided</p> <p>b) purchased</p> <p>no of people waiting longer than the target time for service per 1,000 of the population</p> <p>% of homecare clients receiving personal care</p> <p>% of homecare clients receiving a service at weekends</p> <p>Total number of homecare hours provided as a rate per 1,000 of population aged 65+</p> | Number of care at home hours purchased per week |

| Activity | Objective | Corporate Planning Priority | Performance Measure and Target 2009/10 | Projected Output Narrative for 2009/10 |
|---------------------------------------|--|---|---|--|
| Rapid Response and Re-enablement Team | Avoid unnecessary admissions to hospital and enable early supported discharge from hospital including the provision of a re-enabling service | Improving The Health And Wellbeing Of Communities | Number of people receiving a service per annum Number of hospital admissions avoided | Number of service users per week |

The measures highlighted in green are those additional measures to be gathered in future as part of outcome focussed reporting.

APPENDIX 1

Definitions

- Alzheimer's Disease. This is the most common cause of dementia. Symptoms include memory problems, a progressive deterioration and ability to perform basic activities of daily living and behaviour changes, mainly apathy and social withdrawal, but also behavioural disturbances. Alzheimer's Disease causes abnormal function and eventual death of selected nerve cells in the brain. The average survival period for patients following diagnosis is eight to ten years.
- Vascular Dementia. Vascular Dementia is caused by a shortage of blood supply to specific areas of the brain. Consequently patients co-present or present signs of stroke or other vascular problems, for example ischaemic heart disease or hypertension. Onset may be abrupt or there may be periods of sudden decline following relative stability. Physical problems such as urinary incontinence, decreased mobility and balance problems are more commonly seen in vascular dementia than in Alzheimer's disease.
- Dementia with Lewy Bodies. Characteristic features are fluctuation of awareness from day to day, signs of Parkinsonism such as tremor, rigidity and slowness of movement or poverty of expression. Visual hallucinations or delusions occur very frequently. Falls are also very common.
- Fronto-Temporal Dementia (including Pick's disease). Fronto-Temporal Dementia is uncommon by comparison to Alzheimer's disease or vascular dementia but represents a significant proportion of people who present with dementia under the age of 65. Changes in behaviour such as disinhibition, lack of judgement, loss of social awareness and loss of insight are much more common than memory problems. Disturbance of mood, speech incompetence are frequent. Positive family history of a similar disorder is not uncommon.
- Mixed Dementias. It is not uncommon to find mixtures of two or even all three of the active dementias in the same person, with one or other usually dominating. Response to treatment or side effects from treatment may be different in mixed dementia from that which would be expected in people with a specific diagnosis.
- Creutzfeldt-Jakob Disease. A very uncommon illness of which an abnormal protein accumulates in the brain and leads to a rapid destruction of nerve cells. Tremor, impaired mobility and balance problems are common as are behavioural and mood disturbance. Death is within one or two years of the onset of clinical symptoms is common.
- Alcohol Related Dementia - Korsakoff's Syndrome. This condition results from the consumption of too much alcohol particularly if associated with a diet deficient in thiamine (vitamin B 1) which can lead to irreversible brain damage. The development of alcohol related dementia and Korsakoff's Syndrome has not been reported in people drinking regularly at or below the levels for the safe use of alcohol. The most vulnerable parts of the brain are those used for memory and for planning, organising and judgement, social skills and balance.

APPENDIX 2

Current Resource/Service Provision in West Lothian

Day Care Services

Rosebery Centre. Provides day care, support and counselling to people with dementia. Day care uses specialist activities to meet the needs of people with dementia. Also provides respite advice, counselling and training to carers.

West Port Resource Centre. Offers places to four people six day out of seven as part of a service that can be provided for evenings and weekends.

Answer Project. Caters for people with mild to moderate dementia two days per week offering a caring and stimulating environment for up to 12 users per day.

Braid House. Day care provision for those with mild to moderate dementia. Also includes carer support.

Acredale House. Runs "Stepping Stone" group for people with dementia (up to 10 people per day). Provides activities, outings, social events as well as individual support.

Limecroft Day Centre. Accepts those with mild to moderate dementia.

Whitdale Day Centre. Accepts those with mild to moderate dementia.

Holmes Gardens Day Resource. Accepts those with mild to moderate dementia.

St Michael's Day are Centre. Two days per week are particular focus for people with dementia.

Health Services

West Park Day Hospital. Monday to Friday day hospital service offering assessment and treatment for persons aged 65 years and over with mental health problems.

West Lothian Memory Treatment Service. A small group of professionals who make up a multi-disciplinary team and who specialise in drug treatment for people with memory problems.

Maple Vale and Craigshill Care Facility. This is a unit which accepts those with challenging behaviour over the age of 65.

Ward 3 St John's Hospital. Assessment ward for older people with mental health and behavioural problems. People with dementia are admitted at time of diagnosis or for a period of assessment.

SHEDS (Specialist Health Care Elderly Day Service). This service visits difference areas of West Lothian on pre-arranged days. The service provides day care and respite and is also for patients who need on-going monitoring of mental health problems.

CPNE Service. A West Lothian Community Psychiatric Team who provide support and care to patients of relatives who are over 65 suffering from mental illness including dementia.

Care Homes in West Lothian

These provide long stay care when other options are no longer suitable for a person with dementia.

The following care homes either specialise in dementia or have specialist units:

Heatherfield
St Andrew's Court;
Linlithgow
Burngrange in West Calder
Woodlands in Livingston

Alzheimer's Scotland - Action on Dementia. A specialist service offering a range of practical, social and emotional support to meet the needs of young people with dementia and their families.

Crossroads Care Scotland. Provides care attendance to allow a carer to have some time off. Part of this service in West Lothian is targeted to those with dementia.

Carers of West Lothian. A carer led voluntary organisation and charity that aims to provide support, information and advice to all carers within West Lothian.

Support at Home Services

Personal Care Service

The Personal Care Service provides both personal and practical care services to enable older people to continue to live safely and independently at home. Examples of help available include helping with washing, dressing, catheter management and incontinence care, bathing, showering and assistance with medication.

Home Meals

The Home Meals service provides ready prepared meals that can be heated in the oven, microwave or a steamer. The meals are of modest cost and there are over a hundred choices including special diets and ethnic meals.

Home Shopping Service

Scotmid in conjunction with West Lothian Council has established a home delivery shopping service. Orders are taken in store then packed and delivered including putting the groceries away in the home.

The Community Laundry

The Community Laundry service helps people who are incontinent but who have other medical conditions and are living at home or with relatives to cope with the practical problems of washing sheets. A fresh supply of sheets is brought on a regular basis to each home.

Community Equipment Store

The Community Equipment Store provides and delivers a wide range of equipment to help people to live independently or with nursing support in their own home or in the community. The equipment is supplied after an initial assessment. All equipment and any fitting work is provided free of charge.

Occupational Therapy Services

Occupational Therapists employed by the council will carry out an assessment of an individual's needs if he/she has problems in maintaining their independence at home due to either physical disability or general frailty.

Following an assessment, a wide range of equipment and adaptations may be provided in order to meet the needs of an individual. This may be simple bathing equipment, or dressing/kitchen aids.

Home Safety Service

The Home Safety Service can be applied for or on behalf of anyone who is considered to be vulnerable at home. There is no charge for this service but a working telephone landline is essential.

It is a package of technology comprising of a lifeline unit and a range of sensors protecting the person and their home by means of a 24 hour telephone link to West Lothian Careline.

Small Repair Service

Care and Repair West Lothian is a small repair service for people over the age of 60 and disabled residents in West Lothian.

Assistance ranges from:

- Giving practical advice on household repairs
- Small joinery repairs, including replacement locks, fence repairs and minor window repairs
- Tap washers, unblocking sinks, changing light bulbs and fuses/batteries

Housing with Care

Housing with Care introduced a real alternative to institutional care for older people in West Lothian. There are eight developments, each providing one bedroom tenancy supported by a core package of Smart Technology. The aim is to help individuals to remain as independent as possible by continuing to do as many of the tasks they would normally do for themselves. People who require at least 12 hours formal or informal care a week can apply for these tenancies.

Respite Care

The Council offers a respite care service for frail older people (including those with dementia) and their carers. Short breaks can be arranged for those with an assessed need in a suitable care home setting.

Assessment and Care Management

These teams are responsible for carrying out needs and assessments for people with dementia and for developing appropriate care and support plans as a response to identified needs. The teams carrying out the ongoing monitoring and review of care and support, which is provided.

Sensory Resource Centre

The Sensory Resource Centre is based at St Johns Hospital and provides a range of services and support for people with sensory impairment. Services are both directly provided by the council and commissioned from specialist services.

Independent Advocacy Service

Advocacy enables people to be heard and is a process of encouraging and supporting someone to speak up for themselves and/or presenting their views to others.

This service is provided by EARS West Lothian and is free, confidential and independent. This service is targeted at older people who are in residential care or long term hospital care.

Health and Wellbeing in Later Life

There is growing evidence of the importance of physical activity for everyone, especially as people grow older. This includes the immediate and long term physiological, psychological and social benefits in maintaining mobility, flexibility and independence particularly for certain conditions directly associated with old age.

Research demonstrates the benefits to health and wellbeing of any form of physical activity. While many people think it is natural to slow down and do less, research has shown that people who are less active have much more trouble with simple tasks of daily living therefore reducing independence. There is now evidence to suggest that diseases and conditions such as coronary heart disease, stroke and diabetes which are the primary causes of dysfunction and loss of independence in later life are preventable and that physical activity can play an important part in risk reduction and prevention of these diseases. Physical activity also has important preventative and therapeutic benefits in other issues pertinent to older people including preserving mobility which significantly reduces the risk of falls and fractures. This improves muscle strength and flexibility thereby enhancing aspects of mental wellbeing and quality of life. There is no evidence to show that physical activity can both delay the onset of dementia and also be beneficial to those who have contracted the illness.

Providing appropriate activities for older people at different stages of dementia will require the selection of an activity or activities that match the cognitive level of the participant. There are four developmental stages that correspond to the different stages of dementia. These stages are reflective, symbolic, sensorimotor and reflexive. There are activities that are suitable for each stage. Theories of play related to movement, liberation, creativity, festivity and fantasy may also apply to older people with dementia. In particular play described as "free unimpeded movement" can be interpreted as:

- Opportunities to be physically active, including vigorous bodily action, dance or display, clapping of hands and concepts associated with images of flitting or fluttering, flickering, glittering, rippling, vibrating and swaying.
- Activities for amusement or diversion, including sports, games and musical and dramatic performances.

In considering the planning and commissioning of appropriate services and opportunities for those with dementia it will be important to take the results of this research and inculcate it into our thinking and planning for such services and opportunities. This will have learning and development implications to ensure that the message of the importance of continued activity has benefits beyond that which is currently appreciated. It is believed that only intense physical activity such as going to an aerobics class or gym will benefit health. This is not the case. Health gains can be achieved through activities that require effort at a moderate intensity such as walking briskly, dancing, gardening or any activity that raises the heart rate enough to make you feel warm and breath slightly faster. It will be an important part of our future planning that the opportunity to promote appropriate activities should not be missed.

This will be part of a corporate responsibility for ongoing health and wellbeing ensuring accessibility to a range of universal services.