Ageing Well in Aberdeenshire

Joint Commissioning Strategy for Older People 2013-23

February 2013
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Executive Summary

Ageing Well In Aberdeenshire

Ageing Well in Aberdeenshire is Aberdeenshire’s Joint Commissioning Strategy for Older People 2013-23. The strategy proposes how local care and health services will develop over the next ten years, always aiming to provide the best possible outcomes, as defined by older people themselves, collectively and individually.

The document examines the current system and looks at the challenges facing the NHS, Aberdeenshire Council, the voluntary and independent sectors, as well as older people themselves.

It outlines the government’s policy, which includes person centred support with less bureaucracy; moving health care closer to where people live; and ensuring they can access the right support when they need it.

The strategy is designed to give older people confidence that throughout later life they can exercise choice and control over their care as well as how they live.

At the heart of this strategy is the belief that:

Old age should be celebrated, not stigmatised by society. Older people must be respected for the experience, wisdom and values that they bring to community, civic and family life throughout later life. Older people should expect to be treated with dignity as individuals within the health and social care systems which should be accessible and as close to home as possible.

BACKGROUND

Reshaping care for older people

In 2011, the Scottish Government outlined a national vision for reshaping care and support for older people in “Reshaping Care for Older People: A Programme for Change 2011-2021”

This is to be achieved against the background of a steep rise in the proportion of the population who are older, a reducing health and social care workforce, and long term public sector funding restraint.

Evidence shows that older people form the significant majority of patients in both primary and acute health services. Similarly, almost half of local authority total social work expenditure is attributed to care for older people (approx. 44%).

Our key aim is to promote wellbeing, self-care, personalisation and community resilience while improving access to a spectrum of locally-based health, social care, housing and support to help people maintain as much independence as possible throughout later life.

The government’s strategy is characterised by improving access to a range of clinical interventions and management of long term conditions within primary care settings, including local out-patient clinics and day surgery.
Acute hospitals would focus on specialist clinical interventions only. Simultaneously, concerted effort across Scotland is gradually shifting investment from institutional models of long term care such as continuing NHS care wards and care homes towards care at home or in homely settings, such as very sheltered or extra care housing.

**What has been achieved in Aberdeenshire to date?**

Since these policies were launched there is now evidence of greater emphasis on rapid response and supported early discharge arrangements, which prevent unnecessary hospital admissions and reduce a person’s length of stay in hospital by providing additional support to help people return home as early as is safe to do so.

Aberdeenshire has already seen a significant reduction in emergency bed rate days for people over 65 and over 75 for the last five years and we have lower than average numbers of patients in NHS continuing care beds.

The ratio of patients treated in local community hospitals, compared to those admitted to Aberdeen Royal Infirmary (ARI) is increasing, reflecting efforts to shift clinical diagnosis and treatment to community settings, as close to home where practical.

During the same period, there has been a sustained increase in numbers of older people receiving the care they need at home and an increase of 30% in the proportion of over 65s receiving intensive care at home.

We are supporting more people to maintain their own home or tenancy until the end of their life, if this is their choice. We can evidence that, particularly in sheltered and very sheltered housing settings, very few tenants move on to care homes.

These advances have been achieved through:

- **better communication** and joint ways of working by health and social care professionals at all levels;
- **increasing investment** in new models of community care, both within the NHS and local authorities, and
- **by promoting concepts of self care** and self management amongst patients, families and communities.

**Aims of Aberdeenshire’s Strategy**

- Improve the way local health and care systems work so that the experience people have when they need care is seamless, effective and accessible.
- Aspire to a single point of entry to health and care systems for older people with integrated care delivered by the right team at the right time, in the right place.
- Help future generations of older people to remain fit, healthy and active with informal support from families and communities, postponing and preventing dependency on formal health and social care.
- Shift public attitudes and challenge stereotypes of older people, ageing and self care.
- Improve choice for older people and help them have more control over their own lives.
- Engage all Aberdeenshire citizens in shaping and prioritising the future of health and social care.
Challenges

Demographics
The demographic profile of Aberdeenshire challenges the current model of health and social care. Life expectancy is 79.7 years, compared to a Scottish average of 77.8yrs. By 2020, the number of over 85 yrs olds is predicted to rise by 75%.

Housing
As people continue to live longer and be supported in their own homes, we expect to face local challenges linked to diversity in new-build housing and the need to maximise the use of existing housing through telehealthcare, equipment and adaptations. We anticipate that demand will rise from single households for living options that offer flexible combinations of care and support.

The extent of housing under-occupancy will be determined by the extent to which future generations of older people choose, or have opportunity, to downsize.

Location
Aberdeenshire is a largely rural area. Local people face particular challenges accessing services as a consequence. Local public transport is particularly inadequate to meet the needs of an ageing population.

Health
Aberdeenshire has a higher than average prevalence of people with specific long term conditions, namely dementia, obesity, hypothyroidism and chronic kidney disease.

There is a lower than average prevalence of diabetes, COPD, chronic heart disease and stroke compared with the rest of Scotland, but the incidence of cardiovascular disease is still poor compared with many European countries.

Workforce
There is a real challenge to recruit and retain all grades of staff and this situation is exacerbated by a vibrant employment market in Aberdeenshire. In common with other parts of Scotland, our care workforce is older and many will be retiring in the next ten years. New roles and skills will be required to deliver our vision.

How We Will Meet These Challenges To Achieve Our Aims

There is a growing understanding that the impact of a significantly ageing population cannot be met by the current model of public service or, indeed by the current level of resource available in statutory health and social care services.

Some of the financial impact of this demographic pressure will be defrayed by imaginative approaches to supporting future generations of older people. However, there remains a major funding gap that will require to be met from increased general taxation or from a mutual care approach where individuals and their families, meet the costs of their care in old age.

In the next three years we will refine our approach to measuring outcomes for people who use our services and their carers. Surveys in 2011/12 of older people at medium risk of unplanned hospital admission and their carers have evidenced general satisfaction with services and involvement in the design of their care. However, these confirm more needs to be done to support people to feel safe at home, and to support informal carers to continue in their caring role.
Many frail or vulnerable older people are supported to manage their health and independence by family, friends and communities. We will endeavour to ensure their contribution is valued and recognised through carer respite, training and guidance. As an integrated partnership we intend to use all means of communication to ensure people understand how they can live healthier lives and access support when they need it.

Commissioning Intentions

Aberdeenshire’s strategy for long term change focuses on three themes:

Early Intervention and Prevention

- **Living well in later life**
  By promoting and sustaining co-production activities linked to healthy eating, lifelong learning, regular exercise well into old age, reduction in alcohol consumption and smoking cessation we believe older people will be able to live fuller and healthier lives. Using a co-production focus we believe relatively small amounts of funding can stimulate diverse activity and good outcomes for people. A range of public health programmes are being progressed which will include older people in the target group. Encouraging and enabling older people, through an asset-based approach, to maintain good social relationships throughout later life and inter-generational participation will be an important element of our strategy.

- **Housing with Support**
  Over the next three years we will increase the number of very sheltered or extra care housing units by remodelling some sheltered housing complexes.

- **Supporting Informal Carers**
  We are committed to increasing the range, flexibility and quantity of support for carers in partnership with the third sector. Increasingly, carer services will be judged and measured on how well they enable carers to continue in their caring role. This outcome will become fundamental to our commissioning approach.

- **Personal Support Planning**
  We have made good early progress to establish new and simpler ways for people to manage their own budget for care so that individuals achieve better personal outcomes in terms of their personal development, recovery or quality of life.

- **Diagnosis and Treatment**
  We will continue to develop capacity for clinicians to investigate, diagnose and treat acute and chronic health conditions rapidly and locally. In the short term we aim to improve the capacity of primary care teams to diagnose, treat and manage patients with dementia close to home. Developments of this kind have already allowed us to manage more patients within General Practice or on an out-patient basis, avoiding unnecessary hospital admissions. This will be an increasing feature.

Access to timely diagnosis of dementia through increasing the capacity of primary care services to diagnose and manage patients with dementia is our short term priority, giving more people early opportunities to access advice, support, treatment, and, with their friends and family, plan for the future. Local capacity is being enhanced by new
peripatetic outreach teams, incorporating Alzheimer's Scotland link workers, supporting local assessment, post diagnostic support and community engagement.

- **Self Care and Managing Long Term Conditions**
  In recent years, we have successfully applied a range of approaches to managing long term conditions within primary care such as diabetes, coronary heart disease and COPD. The rate of deaths from heart disease in Grampian is decreasing and we aim to maintain this trend over the next ten years so that a smaller proportion of the population are living or dying with heart disease. During the next three years, we will develop our capacity to support people to self care and self manage their condition effectively.

- **Falls Prevention**
  A quarter to one third of falls by people over 80yrs old could be prevented. Much work has been done in Aberdeenshire to identify and reduce risks amongst older people at risk of injury from falls through better self management and will continue. Our success to date has been achieved in partnership with a wide range of professionals such as Fire & Rescue Service, Care and Repair Services and community organisations

**Rehabilitation and Enablement**

- **Moving from Maintenance to Recovery and Rehabilitation**
  The Aberdeenshire Partnership endorses a model of home-based recovery and considers that the function of community rehabilitation and enablement is the same (or better) than intermediate care in an institutional setting. Within the next five years, all primary and community care practitioners will, through training and practice development, re-orientate themselves from a maintenance mind set to one of recovery and rehabilitation.

- **Care at Home**
  Aberdeenshire Council currently provides and commissions in excess of 15,000 hours per week of care at home services. Increasingly our services operate as 24/7 services involved in the delivery of both planned and unscheduled social care activities. We acknowledge this may mean unavoidable cost pressures over the next five years in order to meet demand for skilled personal social care across our large remote and rural area. The Council’s policy is to remain as a significant provider of care at home services while creating and sustaining a viable independent care market across Aberdeenshire by gradually and continually increasing the procurement of high quality independent care at home services.

- **Telehealthcare**
  Our investment in telehealthcare has grown annually through joint investment. Creative and innovative technological solutions that give faster access to diagnosis, treatment and support, reduce risk and improve personal outcomes for older people will be a significant area of development for the Aberdeenshire Partnership over the next three to five years.

  All Aberdeenshire community hospitals have access to telemedicine and we intend to develop telemedicine opportunities to support out-patient activity and out-of-hours nursing care.

- **Day Support Activities**
  We recognise the value and potential of our existing traditional day care resources to re-focus their efforts in line with the needs, aspirations and lifestyle choices of future
generations of frail older people and those with dementia. By 2014 we will, with community planning partners and older people themselves, re-design day support with an emphasis on recovery, local, flexible integrated models of delivery.

Improving Long Term Care

- **Specialist Dementia Care**
  Increasing the capacity of primary care to diagnose and manage patients with dementia will free specialist and secondary care services to work with more complex cases and provide rapid response to primary care clinicians.

  Work will continue to drive up standards of care for people with dementia in acute hospital settings and across all sectors through training for nursing and social care staff in advanced dementia practice.

  A psychosocial training manual for informal carers, of people with dementia, will be cascaded to carer support providers to use to further guide and support carers.

  During the life of the strategy dementia care will increasingly be commissioned and managed locally within the Aberdeenshire Partnership. Secondary care services will be targeted on those individuals with complex behavioural problems or other exceptional needs. The use of specialist hospital beds overseen by consultants in community hospitals and, support to care homes will provide access within localities to the full spectrum of dementia care for people throughout their illness.

- **Long Term Care**
  Reshaping care for older people will have a significant impact on the care home market in Aberdeenshire. The local care home market has largely been shaped by speculative rather than planned development and we aspire, through the implementation of this plan, to shift the emphasis towards a care home market that is fit for 21st century living, targeted and tailored to meet the demands and expectations of future older generations.

  We anticipate that the average age, level of dependency and mental and physical frailty of people moving into a care home will continue to rise in the future, as we support many more older people with complex health and care needs to live at home with support, or in sheltered or very sheltered housing, if they choose to do so.

  By 2018, the council’s modernisation strategy will create and sustain the highest quality of accommodation and care, acting as an exemplar for the care home market and to ensure that older people have access to public provision in or near all main settlements of Aberdeenshire.

  We will refine our approach to commissioning and contracting to support and promote care home providers who consistently record positive outcomes for residents and high inspection grades for quality.

  By 2018 we aspire to offer, in partnership with registered social landlords and private developers, very sheltered or extra care housing facilities embedded as part of communities where there is currently none or insufficient capacity, subject to available revenue.
Extra care housing that can meet the particular needs of older adults with a learning disability will also be a feature of our commissioning plans over the next 10 years and we anticipate that some of the planned new 134 very sheltered flats in six complexes will be allocated to older adults with a learning disability.

- **Acute and Intermediate Health Care**
  Acute inpatient care will continue to be delivered in Aberdeenshire’s community hospitals for those patients whose illness can be diagnosed, treated and rehabilitated without the specialist facilities of a major acute hospital although the number and configuration of these facilities will be subject to further review during the life of this plan. Over the next five years, we will explore opportunities to commission GP acute beds in care homes, particularly in remote and rural areas.

- **Palliative and End of Life Care**
  Our aim in Aberdeenshire is to offer access to cohesive and equitable care for patients and families living with and dying from any advanced, progressive or incurable condition wherever people chose to receive it.

  Through successful integrated approaches to palliative and end of life care, the proportion of people from Aberdeenshire dying in acute hospitals in 2012 reduced from 35% to 29.9%, whilst those dying in care homes and community hospitals had risen by 3.8% and 1.8% respectively.

  Our forward plan, over the next three years is to build on the skills, confidence and expertise of care staff and to strengthen existing out-of-hours nursing care in a partnership arrangement, so that more people with terminal illnesses can die with dignity in a place of their choice.

**Consultation**

This ten year strategy has been developed by health and social care agencies supported by community planning partners, third and independent care sectors, carers and the citizens of Aberdeenshire.

We have adopted a diverse approach to capturing the views of older people and their carers through the individual assessment of need, care planning and review processes; through surveys, consultation events and by commissioning independent research.

In October and November 2012 we undertook a consultation process with the general public, including older people, carers and carers’ forums, Aberdeenshire Council and NHS staff and with our providers. Over 200 people participated. Results are detailed in Appendix C. Citizen Panels were also consulted and their results are to be found in Appendices D&E.

There was a strong similarity in the responses received with broad support for our strategic direction and a strong endorsement for a focus on early intervention and prevention.

**Conclusion**

Our ten year strategy, developed with the citizens and community planning partners of Aberdeenshire, analyses current and predicted trends, reviews our current state of effectiveness in meeting the needs of frail older people and those with dementia and outlines our future commissioning intentions and inbuilt review mechanisms.
Underpinning our three strategic themes is a clear philosophy: we want people to live well in later life by encouraging them to keep healthy, remain independent for as long as possible, assume their rightful place as valued members of the community and have access to reliable, high quality health and social care, when they need it,

Each year an action plan, incorporating our joint performance framework, will be drawn up to ensure we do what we say will. This will be overseen by the Older Peoples Strategic Outcome Group reporting to Aberdeenshire’s Health and Community Care Partnership and to the Community Planning Partnership.
Chapter 1: Introduction and Objectives of Strategy

In Aberdeenshire there has been significant population growth over the past 30 years. In 2009 total population was estimated as 243,810, of whom 39,194 (16%) were over 65yrs, 17,558 (7.2%) were over 75yrs. Life expectancy is 79.7 years, compared to a Scottish average of 77.8yrs. By 2020, the number of over 85 yrs olds is predicted to rise by 75%. Aberdeenshire is a largely rural area with low unemployment and pockets of deprivation. Local people face particular challenges accessing services as a consequence of rurality.

Aberdeenshire has a higher than average prevalence of people with specific long term conditions, namely dementia, obesity, hypothyroidism and chronic kidney disease. There is a lower than average prevalence of diabetes, COPD, chronic heart disease and stroke compared with Scotland, but the incidence of cardiovascular disease is still poor compared with many European countries.

Against this backdrop, the Aberdeenshire Partnership can evidence a marked shift in the balance of care. We have achieved a significant reduction in emergency bed rate days for people over 65 and 75 over the last five years and we have lower than average numbers of patients in NHS continuing care. The ratio of patients treated in local community hospitals, compared to numbers admitted to Aberdeen Royal Infirmary (ARI) is increasing, reflecting efforts to shift clinical diagnosis and treatment to community settings, close to home where practical.

During the same period, we evidenced a sustained increase in numbers of older people receiving the care they need at home and an increase of 30% in the proportion of over 65s receiving intensive care at home (i.e. over 10 hours per week). This has been matched by a reduction in people moving into care homes. We are supporting more people to maintain their own home or tenancy until the end of their life, if this is their choice, particularly in sheltered and very sheltered housing settings, where very few tenants move on to care homes.

1.1 Our Vision
Our vision, to optimise the independence and wellbeing of every older person in Aberdeenshire, echoes the Scottish Government’s Reshaping Care policy.

1.2 Definition of commissioning and citizen input
Strategic commissioning is the term used for the activities involved in assessing and forecasting population needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often using a pooled or aligned budget.

To be effective, strategic commissioning needs to involve and engage citizens so that their influence and participation helps to shape the future joint strategic plan.

Aberdeenshire’s Joint Commissioning Strategy for Older People 2013-23 proposes how local care and health services will evolve and develop over the next ten years, always aiming to provide the best possible outcomes, as defined by older people themselves, collectively and individually.
Our forward strategy draws on evidence of approaches and systems that have a greater impact than others on avoidable admissions to hospital of older people. We will focus on improving integrated pathways of care and professional practice to support a sustained reduction in emergency admissions to hospital and improve people’s journey and wellbeing through old age and at the end of their life. As a partnership, we are focusing our change agenda across three key dimensions:

- early intervention/prevention
- integrated rehabilitation and enablement
- quality, choice and control in long term care

Each theme will contribute to achieving our strategic outcomes.

1.3 Joint Planning Arrangements
Aberdeenshire has a strong history of joint working between statutory agencies and the voluntary and independent sectors. This ten year Joint Commissioning Strategy is developed by health and social care agencies supported by community planning partners, the voluntary and independent care sectors, carers and the citizens of Aberdeenshire.

In 2013/14 an integrated Health and Care Partnership Committee will be established to shadow the NHS CHP Committee. The revised joint planning structure linked to these policy-making committees will continue to oversee the work of the joint Older People’s Strategic Outcome Group (OPSOG) and the Dementia Strategic Sub Group, both of which have clinical and managerial representation from all sectors and fulfil a lead role in planning, reviewing, developing and re-designing the local health and social care system using pooled and aligned budgets as well as improving quality, performance and efficiency.

In each locality we have well-established multi-disciplinary teams, many of which are already co-located. We will, through this and other single points of access, continue to improve the quality of integrated professional practice and outcome focused working.

The Aberdeenshire partnership recognises the greatest impact is achieved through strong leadership, constructive relationships and effective multi-disciplinary working within and between primary and social care teams at the patient/service user interface. To enhance practice we established Aberdeenshire health and care learning network in 2011, creating opportunities for GPs, local managers and practitioners to come together to constructively challenge and improve practice, behaviours, and pathways of care, towards a shared goal of reshaping care for older people. The shared learning from this initiative has been significant and will help to shape our journey of integration over the next five years.

1.4 Equalities Intentions
The Joint Commissioning Strategy provides the Health and Social Care partnership with an important opportunity to put into practice the principles of the public sector equality duty. The main tenets of the strategy are:

- to assist older people to keep healthy,
- to remain independent for as long as possible,
- to have access to high quality health and social care when required, and
• to maintain their rightful place as valued members of the community.

These principles demonstrate very clearly our ambition to eliminate discrimination, to create opportunities where older people can realise their full potential, and to promote their greater respect and inclusion.

Information collected during the equality impact assessment process will be revisited when the strategy is reviewed. We intend to mainstream equalities monitoring arrangements into the partnership’s routine data collection during the next three years.

1.5 Facts & Figures
We have used the latest data available to us throughout the strategy. In some cases it has not been possible to present direct comparisons with other areas, or over time. To reduce the complexity of the document we have not quoted all sources but they are available on request. Most data originates from the Scottish Government, the General Register Office for Scotland, NHS Grampian, the Scottish Household Surveys, Aberdeen City and Shire Housing Needs and Demand Assessment and Aberdeenshire Council.
Chapter 2: National Policy Drivers

2.1 Reshaping Care for Older People
Shifting the balance of care and reshaping care for older people are Scottish policy initiatives which have evolved in various ways since the launch in 1998 of Modernising Community Care. These reshaping care policies form part of a continuum of long term change in the way society in general and health and care agencies in particular, view and address old age.

Evidence shows that older people form the significant majority of patients in both primary and acute health services. Similarly, almost half of local authority total social work expenditure is attributed to care for older people (approx. 44%). The key driver has been to increase access to a spectrum of locally-based health, social care, housing and support to help people maintain as much independence as possible throughout later life and to promote wellbeing, self-care, personalisation and community resilience.

The Government’s strategy is characterised by improving access to a range of clinical interventions and management of long term conditions within primary care settings, including local out-patient clinics and day surgery. Acute hospitals would focus on specialist clinical interventions only. Simultaneously, concerted effort across Scotland is gradually shifting investment from institutional models of long term care such as continuing NHS care wards and care homes towards care at home or in homely settings, such as very sheltered or extra care housing.

Since these policies were launched there is now evidence of greater emphasis on rapid response and supported early discharge arrangements from hospitals, which prevent unnecessary hospital admissions and reduce a person’s length of stay in hospital by providing additional support to help people return home as early as is safe to do so. These advances have been achieved through:

- better communication and joint ways of working by health, social care and housing professionals at all levels;
- increasing investment in new models of community care, both within the NHS and local authorities, and
- by promoting concepts of self care and self management amongst patients, families and communities.

The anticipated growth in population of older people, and particularly very old people (over 85 years) over the next ten years, along with a difficult economic climate and changing public expectations, challenge the sustainability of any configuration of investment and services that we might put in place. In other words, our future commissioning strategies will recognise that the status quo is not an option. Flexible, dynamic, efficient joint commissioning alongside significant additional financial investment is required to help a growing population of older people to age well and end their life with dignity in their place of choice.

2.2 Managing Long Term Conditions and Self Care
A major policy driver for the health system is to support more patients with long term conditions to increasingly care for themselves with guidance, support and access to health professionals when required.
The prevalence of some long term conditions, such as dementia, diabetes, and obesity is likely to rise in the future. Those who develop a long term health condition need to feel equipped with the information and skills to self manage their symptoms and maintain stable health as far as possible, with access to professional intervention when they need it.

In 2009 the Aberdeenshire partnership launched anticipatory care plans (ACPs) as a tool to help individuals and professionals manage long term conditions, maintain wellbeing and reduce unscheduled episodes of care in hospital. ACPs were tested by 3 practices within Aberdeenshire, targeted on individuals who were at high risk of emergency admission to hospital, based on their recent history. Data for the period January to July 2011 showed that, in those practices that used ACPs, the number and rate of emergency admissions had slowly and consistently decreased. GP practices, that had not yet implemented anticipatory care planning, recorded variable emergency admission rates, including some with increasing rates.

Between January 2010 and February 2012 those GP practices using ACPs recorded a significantly higher average reduction in occupied hospital bed days than GP practices which did not use ACPs. This improving performance has been achieved against a background of increasing numbers of frail older people in the community. ACPs have been delivered through Local Enhanced Service Agreements (LES), an arrangement whereby GP’s contract to undertake additional services, and whilst 61% of Aberdeenshire GP practices are now signed up to using ACPs through this mechanism, all practices have started to use them. In 2013 all practices will be adopting ACPs as part of the new Scottish GP contract and the Quality Outcomes Framework (QOF) linked to it.

By reducing the number of emergency admissions the Aberdeenshire partnership could create opportunities to shift resources towards prevention and early intervention and equip individuals to take greater control, in order to live well with life-limiting conditions. Through our strategic joint planning groups, like OPSOG, we are clearly articulating the types and proportion of admissions to hospital we believe are avoidable and we are investigating and applying evidence-based approaches that may improve local performance over the next three to five years. In doing so we endorse the appropriateness of admission to hospital for many older people, particularly the very old and those with complex conditions, where the severity of the exacerbation or their underlying health conditions mean that a hospital setting is the optimal environment for further assessment, diagnosis or treatment.

### 2.3 Unscheduled Care

Since the 1990s, the NHS and local partners have been implementing the Government’s policy to reduce inappropriate admissions to hospital and facilitate timeous discharge home from hospital. As well as making sub-optimal use of scarce resources, inappropriate hospital admissions and delayed discharges can be harmful to the wellbeing of frail older people.

Unscheduled or emergency care is care that is required in response to a crisis in a person’s health. Some crises are clearly not preventable, such as appendicitis. Other unscheduled hospital admissions can be prevented, for example, following a fall or failure to monitor or address chronic health conditions (e.g. COPD). It is a priority of the Aberdeenshire partnership to reduce the number of inappropriate unscheduled admissions and the length of stay a patient has in hospital following
such admissions. The Aberdeenshire partnership has made good progress in the past three years to reduce emergency admissions and reduce the length of time people stay in hospital. However, recent indications across Scotland are that this trend may be unsustainable in the longer term. Our performance in delivering these national policies is detailed in Chapter 3. Over the next three years, Aberdeenshire’s health and social care partnership will increase its attention to this area of work.

A person’s discharge from hospital is considered to be delayed when medical treatment has been completed but the individual cannot be discharged to a more appropriate setting for a variety of reasons e.g. the care they need is not available at that particular time, or a person’s mental capacity to make informed decisions about their future has diminished. In 2008 the Scottish Government determined that the process of planning and arranging care for people following discharge from hospital should take no longer than 6 weeks from the time a person is declared medically fit for discharge. In Aberdeenshire since 2008 we have typically recorded no delayed discharges over 6 weeks. This strong and sustained performance has been achieved through effective collaboration, communication and shared responsibility for resolving problems between health and care teams. Since October 2012, however, some delayed discharges have been recorded, caused by a multiplicity of factors. By April 2013 the Scottish Government’s target is that no patient should be delayed in hospital for longer than four weeks and by April 2015 this target will reduce to two weeks. While this will be a very challenging target to meet, we are committed to continually improving our performance when this is clearly linked to better outcomes for older people.

2.4 Personalisation, Choice and Control

The pre-eminence of user and carers’ voices in shaping access to good quality care has been a growing feature of the way we plan, deliver and measure success. In a modern society, public expectations are of rapid access to support, which an individual feels they need, when they need it and in a form which reflects their particular circumstances and preferences. The post war “baby boom” generation and others who follow do not aspire to a limited tariff of pre-ordained services in old age to help them live long and fulfilling lives. During the life of this plan their expectations and demand for individually tailored solutions to meet the conditions of ageing will come into sharp relief against a backdrop of significant increases in the numbers of people living longer than ever before.

In August 2012, 205 people with community care needs were receiving direct payments from Aberdeenshire Council to meet the costs of their care. 16 of these individuals are purchasing care from an independent agency and 178 are using a direct payment to employ personal assistants to help them manage their lifestyle and care needs. The number of people receiving direct payments in Aberdeenshire is higher than average (2011/12 data) compared to other Scottish Local Authorities. In 2010, in response to feedback from service users and carers, Aberdeenshire Council revised its direct payment guidance and procedures to make them easier to use. Since then there has been an increased take-up of direct payments and we continue to promote this route, as one way by which individuals can exercise greater choice and control over their lives. Notwithstanding the improved flexibility of these options, most service users continue to opt for services that are arranged or delivered by Aberdeenshire Council. Over the next five years we expect this to change markedly in favour of an increasing number of people opting for self-directed support.
In September 2010 Aberdeenshire Council launched a pilot project called “In Control”. This route offers a more flexible option than Direct Payments for individuals who wish to arrange their own support using an agreed individual budget linked to achieve their personal outcomes and goals. 66 people are using “In Control” to shape and manage their own care. These include 13 older people, some with dementia, and their carers as well as children and adults with physical or learning disabilities and people with mental health problems. The relatively small number of older people who have chosen to be “In Control” is linked to financial disincentives compared to free personal care services.

“In Control” was evaluated in 2012 and the results will influence our commissioning and service delivery models over the next five years. Forthcoming legislation in relation to self directed support will strengthen people’s rights to self direct their own care using a personal budget from the local authority. For the first time it is likely that service users will be able to use their budget to purchase Council services, if they choose.

Aberdeenshire embraces this new approach which places choice, control and personalisation firmly in the hands of the individual. We are at an advanced stage of developing a revised policy and practice framework to deliver the local authority’s new statutory duties from 2014 in relation to self directed support.

2.5 Outcome Focused Care

In line with government policy, Aberdeenshire council is developing capacity to plan, deliver, measure and commission models of care that deliver positive outcomes for individuals with health or community care needs. Since 2010 our social care commissioning and contracts processes have been based on outcomes. We use national and local outcomes drawn from the Single Outcome Agreement and service priorities published in our three year Housing and Social Work Service Plan to demonstrate the strategic relevance of services we commission. These are expressed in our care contracts as outcomes to be achieved by the service provider. Contract monitoring is used to determine whether the contractor is meeting the expected outcomes. Individual Service Agreements specify the outcomes that individuals want to achieve from a service. Care providers are expected to monitor and assess their own performance against these individual service agreements, in collaboration with social work care managers. We continue to refine our methods of measuring and evidencing that achievement of individual outcomes is directly related to care that we commission. Over the next three years we will continue to refine and extend outcome focused commissioning arrangements.

Aberdeenshire offers a programme of intensive mandatory training to develop the skills of social workers and care managers on outcomes focused assessment and care management. We will continue to evolve this programme over the next three years to reflect changing policy and practice and ensure that Health and social work professionals are skilled in delivering outcome-focused assessment.

In respect of wider outcomes, our performance on four of the national community care outcome measures were reported in 2012 using the results of research with a sample of older people at median risk of re-admission to hospital. These show that 89% of those who responded were satisfied with their involvement in the design of their care package; 87% of people felt safe; 92% were satisfied with opportunities for spending time with others; and 86% of carers felt able to continue in their role. It is important to note the sample size was small and response rates
were relatively low. However, this provides us with a basis to build improvement, over the next year.

2.6 Early Intervention and Prevention
The cornerstone of Aberdeenshire’s long term commissioning strategy is an emphasis on encouraging people and communities to act early to maintain and prolong a healthy lifestyle. We will continue to focus on helping people to add healthy years to life.

Since 2011 the Partnership has sought to harness the concept of co-production, where, natural communities and communities of interest work together to identify and deliver solutions to shared issues or challenges. Many local groups are already rising to the challenge. Others are welcoming support in the form of community capacity building. The challenge facing Aberdeenshire cannot be met by statutory services alone and co-production will continue be a powerful policy driver in our commissioning strategy.

Older people have a critical role to play in supporting each other to stay well, keep active and involved in the lives of their families and communities. Growing and sustaining this capacity is essential in the next 10 years as we face an unprecedented increase in the proportion of our population who are over 75yrs, combined with a lengthy period of financial constraint in the public sector.

Later in the strategy we describe in greater detail why this is so crucial to our commissioning strategy. It is worth noting that most older people receive no formal services from the NHS or social care on an ongoing basis and although the proportion of older people requiring care is increasing, 65% of those aged 85 and over do not require formal support and care.

Community Planning partnerships (CPPs) are now renewing Single Outcome Agreements which increase the focus on prevention and secure continuous improvement in public service delivery.

“Outcomes for Older People” is one of six key priorities for CPPs set by the Scottish Government. Preventative and early intervention approaches in the care of older people have the potential to deliver significant gains over the medium to long term and reduce inequalities. The drive is towards “actions which prevent problems and ease future demand on services by intervening early, thereby delivering better outcomes and value for money”.

Community Planning Partnerships are required to develop a clear plan detailing spend on prevention across all activity and priorities and detailing actions to improve outcomes. As part of the national priority to support older people, the Aberdeenshire Community Planning Partnership aims to demonstrate a shift in philosophy from services done to people towards services done with people, using co-production approaches.

2.7 Planning and Delivering Integrated Health and Care
Since the Scottish Government’s policy on Joint Future in the late 1990s, considerable progress has been made to improve integrated approaches to health and care delivery, particularly in respect of older people’s care. In 2011, the Scottish Government indicated an intention to legislate in order to achieve closer, formal integration of health and social care. The precise impact on localities of this legislation still requires to be determined. Within a broadly prescribed
framework, it is anticipated local partnerships will be able to design delivery mechanisms and structures that best suit local needs and priorities. Partnerships may choose to delegate functions, budgets and responsibility for some aspects of service delivery if there is local agreement to do so, as in the type of lead agency arrangement implemented in Highland in 2012.

These reforms occur within the context of wider public service reform and in tandem with the central role of community planning in delivering the right configuration of local services to reflect the needs and aspirations of communities. Housing and transport, for example, are particularly important features in sustaining the independence and wellbeing of older people.

A three year joint financial framework totalling £86,627m, comprising all social work and primary care resources for older people is in place in Aberdeenshire and a comprehensive joint performance framework which includes challenging targets for the partnership to evidence how it is shifting the balance of care year on year, overseen by the Older People’s Strategic Outcome Group (OPSOG).

Assessment and care management activity for older people in Aberdeenshire is delivered from 24 health and community care teams (HCCT), all of which comprise co-located primary care and social care practitioners. HCCTs are aligned to GP practices and comprise district nurses, physiotherapists, community hospital ward managers, care managers, local area co-ordinators and health and local authority occupational therapists. These aligned teams remain accountable to their respective NHS or local authority agency management arrangements for practice, budget allocation and workload. Professionals in these teams provide in-reach services to 11 local community hospitals, which include GP acute, rehabilitation, stroke and old age psychiatry assessment beds. Care managers have individual purchasing budgets to support their care management practice. There will be opportunities to build from this well-established model of joint working over the next 3 – 5 years.

2.8 Rehabilitation and Enablement

The Aberdeenshire partnership is at an early stage of re-positioning local care and health services towards a rehabilitation and enablement approach. By this we mean adjusting our assessment, care planning, treatment and review activities to help older people who require care to recover optimum cognitive and physical ability in the period immediately following an episode of acute illness or degeneration in their condition. Our model is informed by the results of Edinburgh City Council’s re-ablement service and subsequent best practice evidence.

Enablement represents a sea change in the way we work with people and in the attitudes and contributions of service users, their families and communities to recovery and self-care. It forms a major strand of our work to shift the balance of care and address the demographic profile of Aberdeenshire over the next 10 years. Our initial pathfinder projects comprise integrated home care, occupational therapy, physiotherapy, nursing and telehealth care within a single health and care team. We have introduced awareness training for around 700 staff and designed an integrated rehabilitation and enablement care pathway which we are testing in three localities (Turriff, Peterhead and Inverurie). To be effective, we believe it is essential that our rehabilitation and enablement system is fully embedded in mainstream services and that we have capacity in place to identify individuals who can benefit from such an approach: with clear goal-setting, and
time-limited, intensive, integrated team working around the older person and his/her family. Early implementer sites will be independently evaluated in 2013 to provide learning that will shape our future mainstream approach over the next three to five years. Rehabilitation and enablement will significantly change the way we prioritise and allocate resources and the way we design and review care in the future.

2.9 Dementia
Dementia is “a term used to refer to a variety of illnesses and conditions which result in a global impairment of brain function and a decline in intellectual functioning, personality changes and behavioural problems which disrupt independent living skills and social relationships”.

Scotland’s Dementia strategy, along with the Standards of Care for Dementia in Scotland, provides the framework for our commissioning plans for people with dementia, their families and carers. Aberdeenshire’s dementia strategy 2013-16 will be influenced by the Scottish Government’s new dementia strategy and will set out a vision and commitment to a network of care and support that people with dementia in Aberdeenshire, and their carers, can access to improve their experience of living with dementia. The strategy will also set out the results of a local joint needs assessment exercise which included those with early onset dementia. These are informed by what people with dementia and their carers have told us they need as well as best practice. They include:

- raising awareness and understanding of dementia
- early diagnosis
- support to help people live well with dementia

We plan to develop our commissioning approach during the next three years in partnership with people who have dementia, through Alzheimers Scotland local users group, Positive About Dementia, and through Dementia Cafes and day services operating throughout Aberdeenshire. Further references to dementia are to be found later in the strategy.

2.10 Adult Support and Protection
Most older people manage to live comfortably and securely, either independently or with assistance from caring relatives, friends, neighbours, professionals or volunteers. However, for a small number of people, dependence on someone can lead to them being exploited, harmed or abused.

Both vulnerable men and women are at risk of being harmed in different ways: the five most common types of harm being physical, psychological, financial, sexual and neglect. In 2007, research by Action for Elder Abuse, indicated that 4% of older people experienced abuse in their own homes.

Protecting adults from harm is a high priority for the Aberdeenshire Partnership. We do this by seeking to empower individuals and their carers, with knowledge of what they should expect, an understanding of their rights and access to responsive complaints and advocacy services.

Grampian Interagency Policy and Procedures were initially produced in response to the growing awareness and documentation of the range, level and frequency of harm towards adults. Developed by Grampian Adult Protection Steering Group,
these provide a framework by which agencies can apply a consistent and clear response to situations where adults may be at risk of harm.

Aberdeenshire’s Adult Protection (ASP) Committee is accountable to the public. It monitors and advises on adult protection procedures, ensuring appropriate cooperation between agencies and improving the skills and knowledge of those with a responsibility for the protection of adults at risk. Over the last reporting period older people accounted for 41% of adult protection concerns reported in Aberdeenshire.

The Adult Protection Committee has a clear action plan which is reviewed and updated regularly. The Committee will continue, in the period ahead, to give priority to:

- raising public awareness of adult protection and how to apply it
- raising the skills, knowledge and experience of professionals in dealing with adult protection
- strengthen inter-agency working to protect adults at risk.
- Consult with people who use the service and the public about inter-agency services for the protection of adults at risk.

### 2.11 Free Personal Care

Since July 2002, free personal and nursing care (FPNC) has been offered as a universal benefit for older people, in Scotland for everyone aged 65 and over who needs personal care services to help them live independently in their own home. Personal care is defined as assistance with washing, dressing and eating, including food preparation.

The impact of this national policy in Aberdeenshire is discussed in more detail in Chapter 3.

### 2.12 Supporting Unpaid Carers

In Aberdeenshire many older people are supported by unpaid carers, including a spouse, siblings, sons, daughters, other relatives, friends, neighbours and community volunteers. Many of these supporters are themselves older. Research indicates that caring, in many cases, gives older people an important role which sustains their physical and mental health for longer. However, it has been identified that 75% of unpaid carers in Scotland do not have a life outside their caring responsibilities. Therefore, caring has to be balanced with opportunities for breaks to ensure carers have a life of their own, alongside training and support to help them manage their responsibilities. There is also a need for more flexible working opportunities to enable carers to choose to maintain employment. Recognising and supporting unpaid carers has been a high priority for Aberdeenshire Council and the Community Health Partnership and this will remain an important area for investment in the future. Aberdeenshire Carers Charter, endorsed by the Community Planning Partnership in 2012 and all voluntary providers of carer services, makes a fundamental commitment to carers in line with the national policy direction.
Chapter 3: Environmental Scan

3.1 Demography
In 2011, the population of Aberdeenshire was estimated to be 247,600. 16.6% (41,095) were aged 65 or over and 2.1% (5,143) were aged 85 or older. Aberdeenshire has traditionally had a relatively young population, primarily as a result of inward migration. The proportion of older people in Aberdeenshire is slightly lower than the national average (19.1%) but the proportion of over 85yr olds is comparable (2.1%). 54.1% of those aged over 65 in Aberdeenshire are women, compared with 57.1% in Scotland.

The local population has been increasing in recent years and this trend will continue. Growth in the proportion of older people is the most significant change we face in our population due to increases in life expectancy (see Table 1 and Figure 1). The biggest increase by far is expected in the 75+ age group (130.7% in 2035 compared to 2010). The proportion of 50-64 year olds will decrease (-5.1%). Overall, there will be a 96.3% increase in the population aged over 65 by 2035.

Table 1: Projected populations by age Aberdeenshire

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Population in 000s (% change from 2010)</th>
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<tbody>
<tr>
<td></td>
<td>2010</td>
</tr>
<tr>
<td>50-64</td>
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<tr>
<td>65-74</td>
<td>22.1</td>
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<td>75+</td>
<td>17.9</td>
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</table>

Figure 1: Population projections by age, Aberdeenshire

During the life of this strategy, the over 65 population of Aberdeenshire is predicted to grow by 34.8%, with the largest percentage increase in the over 85s. The pattern of growth is consistent across the six administrative areas of Aberdeenshire.
Women have a higher life expectancy than men. Older women have specific health needs that differ from men, and service design and delivery will need to reflect this fact.

Population Projections by GP Practices

In 2012 the practice populations of people aged 65 and over were:

Table 2: GP Practice Populations at July 2012

<table>
<thead>
<tr>
<th>Age</th>
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<th>2017</th>
<th>2022</th>
<th>2027</th>
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<td>BANFF &amp; BUCHAN</td>
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<tr>
<td>65-74</td>
<td>3799</td>
<td>4518</td>
<td>4874</td>
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<td>806</td>
<td>956</td>
<td>1187</td>
<td>1479</td>
<td>1946</td>
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<tr>
<td>TOTAL</td>
<td>6842</td>
<td>8047</td>
<td>9225</td>
<td>10477</td>
<td>11765</td>
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<td>BUCHAN</td>
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<tr>
<td>75-84</td>
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<td>3273</td>
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<tr>
<td>85+</td>
<td>748</td>
<td>888</td>
<td>1103</td>
<td>1375</td>
<td>1809</td>
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<td>TOTAL</td>
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<td>9884</td>
<td>11179</td>
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<td>1080</td>
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<tr>
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<td>757</td>
<td>898</td>
<td>1115</td>
<td>1390</td>
<td>1829</td>
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<tr>
<td>TOTAL</td>
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<td>8193</td>
<td>9370</td>
<td>10615</td>
<td>11895</td>
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<td>KINCARDINE &amp; MEARN</td>
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<tr>
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<td>822</td>
<td>1021</td>
<td>1273</td>
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<td>10481</td>
<td>11961</td>
<td>13502</td>
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</tbody>
</table>

(Source: GROS 2010)

3.2 Strategic Health Needs Assessment

Deprivation
On both income and employment deprivation indicators, Aberdeenshire performs better than Scotland as a whole. Aberdeenshire is one of the least deprived areas
in Scotland. The least deprived data zone in Scotland is Banchory in Aberdeenshire (Scottish Index of Multiple Deprivation, SIMD). However, small areas / pockets of deprivation are a feature in Aberdeenshire, where deprivation data is amongst the worst 20% in Scotland. These tend to be concentrated in parts of Fraserburgh and Peterhead. Educational, skills and training deprivation have worsened over time, especially in these areas.

Analysis of the income deprivation domain of SIMD (2009) indicates that there is income deprivation across Aberdeenshire but that approximately 50% is in the two north areas (Buchan and Banff & Buchan) with the rest almost evenly spread across the other four areas. This data is not restricted to the older population but we assume that income deprivation amongst older people is evident in all areas of Aberdeenshire.

Although the statistics show Aberdeenshire is one of the least deprived areas in Scotland, individual and dispersed deprivation is masked. The number of income deprived individuals (40-64 yrs) is similar in Aberdeenshire and Aberdeen City indicating a level of hidden deprivation across Aberdeenshire.

A high number of data zones across Aberdeenshire rank in the most deprived 5% of Scotland in terms of geographical access to services, reflecting the remote and rural nature of Aberdeenshire. There is dispersed rural deprivation and isolation across Aberdeenshire where access issues, lack of public transport, high dependency on cars and fuel poverty particularly affect the older population. High dependency on cars places an extra burden on those with low incomes.

**Accommodation & Environment**

The type of accommodation and environment in which people live contributes significantly to their state of health, social wellbeing, quality of life and their capacity to live independently with minimum formal supports. The high rate of owner occupied housing and also private rented housing in Aberdeenshire is a concern in an area with a significantly ageing population. The condition and concern about disrepair of housing stock as well as a need for better insulation is an issue in Aberdeenshire. Houses with poor energy-efficiency and thermal conditions can increase a person’s risk of flu, heart disease, stroke and respiratory illness. Houses in disrepair may increase the risk of falls and accidents. Installation of energy efficiency measures has been identified as a strategic priority in the Aberdeenshire Fuel Poverty Strategy (2010) and the revised Aberdeenshire Local Housing Strategy (2012 – 2017).

In 2010 Aberdeenshire recorded 103,770 separate households, an increase of 6.5% since 2005. This rate of increase is higher than in other parts of Grampian and higher than the Scottish average and we expect this trend to continue as the population grows. We anticipate an increased demand for smaller properties, as the number of older person households increases.

**Fuel Poverty**

A household spending over 20% of its income on all household fuel is defined as being in extreme fuel poverty. Fuel poverty is linked to increased risk of ill health, particularly due to exacerbation from diseases such as influenza, heart disease and other respiratory diseases. Survey data shows that Aberdeenshire has a higher proportion of fuel poor households than Aberdeen City but a slightly lower proportion than the Scottish average. A recent survey indicated that fuel poor households could make up more than one third of Aberdeenshire’s households.
Since 2008-10 the proportion of fuel poor households in all areas has increased, the biggest increase in Grampian appears to be in Aberdeenshire. Households with older adults are more likely to be fuel poor and extremely fuel poor. For example 55% of single pensioner households in Scotland are fuel poor compared to just 6% of small family households. Fuel poverty also has a disproportionate effect on the older population because they are likely to have less income that people of working age, spend more time at home and require a warmer temperature to stay healthy and safe.

Rurality
Since the 1980s there has been recorded movement of young people from rural areas of Aberdeenshire towards the towns and also a significant decline in key rural amenities. The largest decline has been recorded in Kincardine & Mearns and Banff & Buchan areas.

Health Profile
In those aged over 70, Aberdeenshire has the highest proportion of population in Grampian with a long-standing illness or disability. This may reflect the longer life expectancy of Aberdeenshire citizens. This population of people aged over 80 and over 90 are more likely to have disabling age-related conditions such as dementia and stroke. In 2011, the three most common diagnoses on emergency admission for people registered with Aberdeenshire GPs were urinary tract Infections, unspecified acute lower respiratory infections and Chronic Obstructive Pulmonary Disease (COPD).

In this section we identify those health conditions that have a strong link to ageing, high morbidity and/or mortality, are preventable and which will present a significant burden upon health, social care, and unpaid carers unless we change the current lifestyle patterns and the way we design and deliver public services for older people. We have therefore focused on the prevalence in Aberdeenshire of mental ill health (dementia, depression and wellbeing), stroke, coronary heart disease, COPD, diabetes and cancer. Based upon age alone, these conditions are predicted to increase by the same proportion i.e. 96% by 2035. This does not take into account other adverse or unfavourable influences, such as the impact of increased alcohol consumption and obesity on healthy life expectancy of Aberdeenshire’s population. In other words, if people continue to display similar patterns of food and alcohol consumption into old age as they currently do in younger age, their likelihood of living with chronic health conditions in later life is greater. This is a significant public health concern and to address it, prevention represents a major priority in our long term commissioning strategy.

The WHO lists Ischaemic Heart Disease as the leading cause of death and second highest cause of burden of disease in high income countries. Cerebrovascular disease (which includes stroke and TIA) is the second highest cause of death and the third highest cause of burden of disease in high income countries. Stroke is linked to increasing age and the risk factors are similar to those for coronary heart disease, e.g. lack of exercise, obesity, smoking, alcohol and Diabetes Mellitus. It is possible to prevent many strokes through targeting modifiable risk factors. Our commissioning intentions will reflect the importance of reducing these risks and improving outcomes for future generations of older people.
A transient ischaemic attack (TIA) has the same causes and symptoms as stroke. The only difference is that symptoms resolve within 24 hours. The occurrence of a TIA is a strong predictive risk factor for a future stroke.

Estimates of prevalence of stroke are drawn from the Quality Outcome Framework data.

**Table 3: Estimated number of people in Aberdeenshire with stroke**

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2035</th>
</tr>
</thead>
<tbody>
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<td>Population</td>
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<td>258,629</td>
<td>269,625</td>
<td>280,383</td>
<td>299,404</td>
</tr>
<tr>
<td>Estimated number with stroke</td>
<td>4522</td>
<td>4759</td>
<td>4961</td>
<td>5159</td>
<td>5509</td>
</tr>
</tbody>
</table>

Estimated rates of consultations with a GP or Practice Nurse for stroke increase with age. If consultation rates increase in the same manner as the number of strokes, there could be between 1,749 and 2,825 GP or Practice Nurse consultations in Aberdeenshire for stroke per year by 2035. If the numbers increase with the projected increase in stroke cases there could be between 37 and 59 elective discharges due to stroke in 2035 utilising between 6,523 and 10,534 bed days.

Deaths from cerebrovascular disease in Grampian have decreased over recent years. This is a national trend thought to be due to improved diagnosis and management. Whilst this is positive it may mean increasing care needs in survivors of stroke.

Coronary heart disease (CHD) describes a range of conditions which arise due to a narrowing of the blood supply to the heart. The importance of CHD lies in the fact that it is preventable (many of the listed risk factors are modifiable) and that it is a major cause of death in Scotland. Risk factors include: smoking, high blood pressure, high cholesterol, being physically inactive, being overweight/obese, having a family history of heart disease, certain ethnic backgrounds (e.g. South Asian communities) and older age. Men are more likely to develop CHD at a younger age than women. Our joint commissioning intentions will reflect the priority of encouraging and informing the older population and people approaching old age of how to maintain a healthy lifestyle and reduce their risk of CHD.

**Table 4: Estimated population with CHD in Aberdeenshire, based on Scottish Health survey data**

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 65+ (000s)</td>
<td>40</td>
<td>48.2</td>
<td>55.4</td>
<td>63</td>
<td>78.5</td>
</tr>
<tr>
<td>Estimated number with IHD (000s)</td>
<td>8</td>
<td>9.6</td>
<td>11.1</td>
<td>12.6</td>
<td>15.7</td>
</tr>
</tbody>
</table>

The crude CHD QOF prevalence has remained broadly stable since 2008/09.

As with stroke, the increasing prevalence of risk factors such as poor diet, lack of exercise, obesity and alcohol consumption mean that these figures are likely to underestimate the numbers of people in Aberdeenshire with CHD. The death rate from heart disease in Grampian is decreasing. This is positive but also suggests...
more people are living with heart disease and could suggest increased health and social care requirements in the future.

The prevalence of smoking is less in older people due to the high rate of premature death in smokers. Older smokers are at a higher risk than those who do not smoke of developing the conditions described above. Smoking is also strongly associated with deprivation. The most recent SHS figures in 2009/10 suggest smoking prevalence in Aberdeenshire is lower than the Scottish average and other parts of Grampian and this may lead to a corresponding decrease in rates of COPD and lung cancer in Aberdeenshire in the future.

Increasing age, in itself, is not significantly associated with poorer mental wellbeing but good mental wellbeing is important to individuals in itself and also acts as a determinant of health. Mental wellbeing can allow individuals to cope better with adversity, make healthier behavioural choices and recover from illness. The quality of long term relationships is a particularly important factor amongst older people.

The prevalence of depression in older adults is often under-recognised or unreported by older people themselves and is therefore not treated adequately. Depression is the most common mental health problem in later life. Risk factors for depression which are more common amongst older people include losing a spouse through death or divorce, loneliness, a change in role, loss of social status (e.g. retirement and decrease in income), and being in institutional care. Being female, having chronic disease, pain, or organic brain disease such as dementia and stroke are also likely to increase the chance of an older person experiencing depression. The prevalence of depression is increased markedly in brain disorders such as dementia and may be around 30% in Alzheimer’s patients. The prevalence of depression in older adults ranges from 4.6% to 9.3% of the population. Older people with depression have higher disability and poorer outcomes from illness. If recognized, older people with depression can respond well to treatment. Our commissioning intentions will raise awareness of preventing and treating depression amongst older people as a key way of improving quality of life outcomes for older people.

Older people have less tolerance to alcohol and the recommended safe levels for adults may be excessive for older people. The effect of alcohol can be greater due to physiological changes meaning blood alcohol levels are higher with the same intake. Adverse interactions with medication and a higher risk of injury from falls may also be a feature amongst older drinkers. The number of older people who are harmful and hazardous drinkers in Aberdeenshire is higher than in the rest of Grampian. Alcohol misuse amongst older people may be a response to the loss of a spouse, isolation or chronic illness.

Table 5: Number of hazardous and harmful drinkers in Aberdeenshire who are older people

<table>
<thead>
<tr>
<th></th>
<th>Hazardous drinkers</th>
<th>Harmful drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65-74 yrs</td>
<td>&gt; 75 yrs</td>
</tr>
<tr>
<td>Male</td>
<td>2582</td>
<td>964</td>
</tr>
<tr>
<td>Female</td>
<td>1291</td>
<td>412</td>
</tr>
</tbody>
</table>

A hazardous drinker is a person who is drinking above the recommended maximum alcohol level but not currently experiencing social, physical or
Psychological harm. A harmful (high risk) drinker is drinking above the recommended maximum alcohol level and is experiencing social, physical or psychological harm.

It is likely that a significant number of older people attending A&E departments are affected to some degree by alcohol. However, numbers are not regularly recorded by age and alcohol may not be identified as a cause.

Our commissioning plans, including those of Aberdeenshire Drug and Alcohol Partnership, over the medium term will include increased attention to drinking habits in older age, improved assessment, screening and access to brief interventions.

Being overweight or obese increases the risk of disease and mortality. Type 2 Diabetes, high blood cholesterol and high blood pressure are more likely. These factors also increase the risk of vascular disease such as ischaemic heart disease and stroke. Musculoskeletal disorders such as osteoarthritis in the joints and respiratory problems like obstructive sleep apnoea are more common. There is an increased risk of certain cancers such as colorectal, breast and endometrial cancer. The prevalence of obesity is increasing at a national level. The prevalence of obesity in the Scottish Health Survey increases by age until late middle-age. It is 13.3% in those aged 16-24 and 38.3% in those aged 55-64. The prevalence in the two oldest age groups is sequentially lower.

Alzheimer’s and other dementias are collectively the sixth highest cause of death and fourth highest cause of burden of disease in high income countries according to the World Health Organisation (WHO). The cost of caring for people with dementia (in terms of healthcare, social care and friends and relatives) as well as the projected drastic increase in the number of affected individuals due to an ageing population means dementia presents all of society with one of the most significant challenges of the 21st century. Alzheimer’s disease and vascular dementia make up around 75% of all diagnoses of dementia. Increasing age is the predominant risk factor, so with an increasing population of older people there will be a corresponding increase in those people with dementia. The main symptom of dementia is progressive memory loss. People may increasingly struggle to reason and make decisions and can have personality changes which, as the disease progresses, limit a person’s ability to self-care. This can become increasingly challenging if individuals stop recognising family and carers and require help with activities of daily living such as dressing and eating.

It is not possible to prevent the majority of cases of dementia. However, steps can be taken to reduce the risk of vascular dementia and Alcohol Related Brain Damage, in particular, by targeting the key risk factors. There is some evidence that the risk of all forms of dementia can be reduced by being mentally and physically active, following a healthy diet, not smoking or drinking harmful levels of alcohol.

There is significant literature evidence which suggests under-diagnosis of dementia is substantial and a systematic review estimated around 50% of people aged over 65 living with the condition were not diagnosed as having dementia by their GP. Estimates of the number of people with dementia in 2012 are based upon European level data. In Europe, the prevalence of dementia in those aged 65-69 is 1.6%. This rises with age to 26.2% in those aged 85-89 and 46.3% in those aged 95 and over. In Scotland, it is estimated that in 2012 over 81,000
people aged 65 years and over had dementia. By modelling prevalence for Aberdeenshire based on the latest national population data available, we estimate that about 3,191 people aged 65 years and over in Aberdeenshire had dementia in 2010. This is a prevalence rate of 8%. These projections are likely to underestimate the true position due to the rate of increase in the over 75 yrs population relative to the increase in the younger population (i.e. 65 to 75 yrs).

Table 6: Estimated number of people with dementia, Aberdeenshire 2010-35

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 65+ (000s)</td>
<td>40</td>
<td>48.2</td>
<td>55.4</td>
<td>63</td>
<td>78.5</td>
</tr>
<tr>
<td>Estimated no. aged 65+ with dementia (000s)</td>
<td>3.2</td>
<td>3.9</td>
<td>4.4</td>
<td>5.0</td>
<td>6.3</td>
</tr>
</tbody>
</table>

(Base: European Prevalence Estimates)

Diabetes Mellitus (DM) is a condition which arises when the body has a lack of endogenous insulin. Up until the age of 80 the risk of DM increases and then starts to decline. It is a significant health issue not only because of its direct health effects but because it increases a person’s risk of other health conditions, such as cardiovascular disease and stroke. It is preventable. Using survey data there are an estimated 4,400 people aged 65 and over with DM in Aberdeenshire and this could rise to 8,600 people by 2035. The increasing prevalence of obesity means that these figures may well underestimate the future scale of this problem.

Cancer continues to be of growing significance to us. The Information Services Division of NHS Scotland (ISD) predicts that new cancer cases will increase by approximately 8% every five years up to 2020 due primarily to an ageing population. The most common cancers in Scotland in 2010 in men were prostate, trachea, bronchus and lung cancer and for women were breast, trachea, bronchus, lung and colorectal cancer.

Trachea, bronchus and lung cancer were the most common cause of death from cancer, followed by prostate cancer in men and breast cancer in women. The incidence of lung and colorectal cancer is lower in Grampian than in Scotland as a whole. Cancer mortality rates in Grampian tend to be slightly lower than Scotland as a whole. The leading four causes of emergency admissions due to cancer in Grampian in the over 65 population were malignant neoplasms of the bronchus and lung, colon, prostate and rectum; the leading four causes of elective admissions were malignant neoplasms of the bronchus and lung, breast, colon and prostate.

Malnutrition has been identified as a major public health problem on admission to hospital, the risk of malnutrition is 34% for those aged 80 years and older. It is worst for those living alone. Additionally older people have been found to be more likely to be undernourished when admitted to hospital and remain undernourished during their stay there.

3.3. Increasing Life Expectancy

In 2008-10 male and female life expectancy in Aberdeenshire was the highest in Grampian and higher than the Scottish average. However, Scotland has one of the worst levels of life expectancy in Western Europe. The estimated average life expectancy for males and females varies significantly across Aberdeenshire from more affluent to deprived data zones indicating significant inequality in health outcomes. While the average life expectancy (79.9 yrs) is higher than the average...
for Scotland (74.5 yrs), the worst life expectancy in Aberdeenshire is significantly below the Scottish average. For example male life expectancy in Aberdeenshire varies from 88.9 years (Banchory Devenick) to 66.3 yrs (Fraserburgh harbour and Broadsea).

Life expectancy is increasing with each generation as is healthy life expectancy (HLE) but not at the same rate. HLE is an estimate of how many years an individual may live in a 'healthy' state. This is an important measure as the health of a person, not solely longer life expectancy, impacts upon the degree to which they are able to contribute to society (economically and socially) as opposed to the extent to which they require health and care resources. It also has a lower expected period in which individuals experience being unhealthy. This places us in a more advantageous position than many other parts of Scotland and may reduce the impact on public services of the higher increases that we face in the older population.

**Figure 2: Healthy Life Expectancy**

![Healthy Life expectancy (HLE)](image)

3.4 Financial Security In Older Age

The percentage of the population up to pensionable age seeking benefits is lower in Aberdeenshire than in Grampian and Scotland as a whole. The guaranteed pension credit provides financial help to those aged 60 or over whose income is below a certain level and it is a useful indicator of the financial health of older people. In 2010 11.1% of the population of Aberdeenshire aged 60 or over claimed guaranteed pension credits compared to 12.4% in Grampian and 17.7% in Scotland as a whole.

However, there is considerable variation within Aberdeenshire and there are some more deprived populations especially in the Banff and Buchan and Buchan administrative areas.

3.5 Population Dependency Ratio

The population dependency ratio is the ratio of the population aged under 16 and over 65 (“dependents”) to the population aged 16-64 years (“working age”). The
projected dependency ratio for Aberdeenshire in all years is higher than Scotland as a whole. This increase in dependency ratio could potentially result in fewer people being available to informally care for those in the older population. There may be resource implications due to a potential decrease in tax revenues combined with an increase in use of statutory public services by older people.

Theoretically, this could be offset to some degree by older people choosing to work longer or by a reducing requirement for other services, such as education, due to a smaller child population. In Aberdeenshire, the higher healthy life expectancy could also mitigate some of the impact of this trend. Therefore, although a greater proportion of our population will be economically dependent than other parts of Scotland, there are mitigating factors that we can assume will mean public services are no more adversely affected in terms of demand, than other areas.

A clear demographic challenge awaits us in planning health and care provision for older people. However, while the weight of numbers is likely to place a greater burden on public services, we are fortunate to have a relatively healthy and wealthy older population whose dependency on statutory health and care is likely to be focused on the last few years of life. We can influence this trend by ensuring that we focus attention and resources on early intervention, prevention and promoting awareness of the benefits of adopting healthy lifestyles.

The data from our environmental scan has been used to inform our commissioning intentions outlined in a later chapter.
Chapter 4: Delivering Better Outcomes 2008-12

A range of local and national strategies and initiatives to shift the balance of care and promote joint delivery of health and social care have become firmly established during the decade preceding this strategy/plan. The challenge of an ageing population and its impact on our capacity to deliver health and social care services was recognised at the turn of the new century. “Living Life To The Full”, Aberdeenshire’s Joint Strategy for Older People (published 2000) predicted a 50% increase in the 60-75 population by 2016, and current data would suggest this prediction is being exceeded. Since then the national report of the Joint Future Group, Better Outcomes for Older People, and All Our Futures (2007), among other policies, have reinforced this agenda. Locally, the Joint Strategy for Older People in Grampian (Ageing With Confidence, 2002), and annual Joint Community Care Plans, helped to shape a new reality of joint working and service delivery and to shift the balance of care. Progress over the last ten years forms the bedrock of this strategy as we move forward to address greater challenges in the next decade.

4.1 Shifting the Balance of Care 2008-2012

Continuing to reshape care for older people from institutional settings to home represents something of a challenge for the next ten years in the context of a significantly changing demographic and diminishing public sector resources.

Insights from national data demonstrate the huge progress we have made in addressing the balance of care over the past 10 years. Between 2003 and 2011 the number of people living in residential care in Scotland reduced by 17%. The care home population in Aberdeenshire shows a similar but more gradual trend since 2008 (11%).

In the same period the number of people receiving home care in Scotland reduced by 19%. Fewer people received lower levels of home care (i.e. under 10hpw) than in previous years as social care became more focused on people with complex care needs. However, in Aberdeenshire the number of people receiving home care continued to rise between 2003 and 2009, since when it has gradually declined but remains around 4% higher than the number in 2003. The proportion of people, aged 65 and over in Aberdeenshire, who receive 10 or more hours of home care per week compared with those receiving lower levels of home care has started to rise in 2012 and is expected to continue to do so.

By comparing local trend data from 2004-2011 (figure 3), there is a consistent picture of a gradual shift in the balance of care, but a more significant one when mapped against the growth in people aged 65 and older as shown in Figure 11 and 12. Progress is in the right direction but needs to increase in pace so that more older people can choose to remain at home with access to the right care when they need it, rather than moving to hospital or to care homes.
4.2 Free Personal Care

Approximately 12 people per 1000 population aged 65 years and over receive free personal and nursing care (FPNC) in care homes in Aberdeenshire. The number of older people living in care homes in Aberdeenshire has fallen by 11% since 2001 (from 1,821 - 1,614) and consequently the cost of providing FPNC in care homes has also reduced by around £1.3m per annum. (Source: Scottish Care Home Census, March 2012). The number of people receiving free personal care at home has risen by 5%, between 2002 and 2012. (From 1,210-1,840).

Since 2003, the volume of free personal care at home has grown by 97% (from 6,200- 12,200 hours per week and now costs Aberdeenshire Council £12m per annum, over three times the cost of delivering the policy when it was first introduced. Based on population growth predictions and the growth trends, a further £25m will be required to pay for FPNC in Aberdeenshire by 2023.

The rate at which uptake of free personal care has grown in Aberdeenshire is lower than it is across Scotland (150% growth nationally since 2003.) This may reflect a healthier population of older people or more family support than is prevalent in other parts of Scotland. By focusing our commissioning intentions on early intervention, prevention, recovery, enablement and community capacity-building we aim to reduce the financial burden of free personal care on the public sector.
Figure 4: Number of people 65+ in receipt of FPC/FNC in Care Homes in Aberdeenshire (per 1,000 65+ Population)

![Bar chart showing the number of people 65+ in receipt of FPC/FNC in Care Homes in Aberdeenshire from 2004-2012.]

Figure 5: Number of people 65+ in receipt of FPC at home in Aberdeenshire (Per 1,000 65+ Pop.)

![Bar chart showing the number of people 65+ in receipt of FPC at home in Aberdeenshire from 2004-2012.]

Figure 6: 2005-2010 Comparisons in Aberdeenshire
No. of people aged 65+ in receipt of Free Personal Care/Free Nursing Care

![Bar chart showing the number of people aged 65+ in receipt of Free Personal Care/Free Nursing Care from 2005-2012 in Aberdeenshire.]

Legend:
- IN CARE HOMES
- AT HOME
4.3 Housing and Living Accommodation for Older People

Currently there are in the region of 2000 sheltered housing flats available in Aberdeenshire. These and owned and operated by the Council and Registered Housing Landlords (RSLs).

Despite the increasing older population, there has been no significant increase in the number of applications for sheltered housing since 2008. Applications from those aged 65-84 to move into sheltered housing have declined, but applications from people over 85 have increased (Aberdeenshire Local Housing Strategy).

Table 7: Number of applicants for SH between 2008-2012 by Age Groups

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>232</td>
<td>229</td>
<td>193</td>
<td>175</td>
<td>174</td>
</tr>
<tr>
<td>75-84</td>
<td>344</td>
<td>338</td>
<td>342</td>
<td>331</td>
<td>308</td>
</tr>
<tr>
<td>85+</td>
<td>112</td>
<td>116</td>
<td>127</td>
<td>152</td>
<td>148</td>
</tr>
<tr>
<td>Total</td>
<td>688</td>
<td>683</td>
<td>662</td>
<td>658</td>
<td>630</td>
</tr>
</tbody>
</table>

Meantime the majority of sheltered housing tenants are aged between 76 and 90.

Figure 7: All Sheltered Housing Tenants by Age Group 31.3.2012

Since 2008, in line with national trends, there has been a steady decline in the rate of new tenants moving into sheltered housing. We conclude this arises from a combination of factors:

- more people are choosing not to move house as they get older as they are able to receive the care and support they need in mainstream housing, including access to community alarm and telehealthcare systems; and
- more sheltered housing tenants are choosing to stay in their tenancy for longer with increased support, rather than moving into residential care as their care needs increase.

This implies that the projected increase in older households will, over time, lead to more older people living in mainstream housing rather than in specialist care accommodation, particularly sheltered housing. This is already evident in the rapidly growing demand for aids, adaptations, community and primary health care services, which allow people to modify their home environment to meet their
increasing dependency and reducing functional abilities. This will be a consistently growing trend and reflects what we already know, i.e. that most older people want to remain in their own home and community for as long as possible, with support when they need it.

**Table 8: New tenants – Aberdeenshire Council Sheltered Housing**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Tenants</td>
<td>195</td>
<td>151</td>
<td>185</td>
<td>173</td>
</tr>
</tbody>
</table>

**Figure 8: New tenants – Aberdeenshire Council Sheltered Housing**

Very sheltered, or, as often described, extra care, housing offers a real alternative to residential care for people who choose to live more independently in their own tenancy. Increasing the range of accommodation options with care for older people is likely to have the greatest impact upon the partnership’s ability to deliver key national health and community care policy targets. Aberdeenshire’s Local Housing Strategy supports the development of at least 40 extra care housing unit as a way of improving access to affordable housing for people with higher level of care and support needs and freeing up larger properties for family living, which may otherwise be under-used.

Currently there are five very sheltered housing (VSH) complexes, comprising 135 flats, in Aberdeenshire; one is council owned and four are owned by Registered Social Landlords (RSLs). This is a priority for development described in detail in our commissioning intentions in Chapter 6.

Smaller 1 and 2 bedroom mainstream housing continues to offer valuable options for older people. The Local Housing Strategy prioritises maximising the use of these properties with appropriate aids and adaptations, where required, allowing people to live longer at home. Chapter 6 also discusses this in more detail.
4.4 Care at Home

Compared with other areas in Scotland, Aberdeenshire Council provides an average number of home care hours per head of population. In terms of the number of older people with complex needs (i.e. those in receipt of more than 10 hours per week of home care) Aberdeenshire is again close to the average.

The data in Figure 10 may be an indication that our policy intent of supporting people to recover, when possible, and resume self care appears to be working, exerting a downward pressure on lower levels of need. Whilst the proportion of over 65s needing a lower level of home care is declining, the proportion of people requiring and being provided with 10 or more hours of home care has remained fairly constant. As the number of older people grows, this change will allow us to reallocate resources to support people with the most complex care needs to live at home.

Figure 9: Number of people per 1000 65+ population in receipt of home care in Aberdeenshire 2004-11

Figure 10: Number of people per 1000 of 65+ population in receipt of 10 hrs or more per week home care in Aberdeenshire 2004-12
4.5 Care Homes
In line with our policy goal, there has been a steady decline in the number of older people moving into care homes since 2006, except for a slight rise in 2008-9 (figure 12) there has been a similar downward trend in placements when compared with the population aged 65 and over (figure 13).

Figure 12: Number of People Aged 65+ placed by Aberdeenshire Council in a Care Home 2004-12 (Per 1,000 of 65+ Pop.)
In March 2012, 3.3% of the population in Aberdeenshire aged over 65 were living in a care home, compared to the national rate in Scotland of 3.4%, with 15% of those who are 85 or over living in a care home. However, Aberdeenshire had the seventh highest number of over 65s living in a care home out of 32 Scottish local authorities. As a consequence, mainly of improving choice, expanding the range of care and accommodation options, we anticipate a continuing downward trend, in the short to medium term, of people moving into care homes, in spite of the growth in the over 85yr old population.

In 2011, 55.4% of older people living in care homes in Aberdeenshire had dementia (45.7% medically diagnosed). Although we anticipate fewer people will choose to move into residential care in future, a significant majority will be living with dementia and the model of care and staff training will require to address this trend in order to support residents to manage daily routines safely and well.

4.6 Hospitals
Since 2008 the Aberdeenshire Partnership has taken a number of concerted actions which have reduced the average length of stay in hospital for people aged 75 and over following an unplanned admission. This is a significantly more positive trend than the national position. Between 2008 and 2010 the number of emergency inpatient bed days attributed to people over 65 decreased: in 2011/12 there was a 7.8% reduction in the emergency bed day rate for people aged over 75. Against the significant rise in the older population, the actual reduction in emergency inpatient bed days for people over 65 in 2011 was 11% lower than would have been expected if there had been no changes in health and care practice.

However, during 2012 adverse trends were recorded in relation to unscheduled care and the use of hospital beds. The rate of people over 65 experiencing two or more emergency hospital admissions increased during this year, as did the number of people admitted to A&E following a fall. The number of hospital bed
days lost to delayed discharge also increased slightly. The Partnership acknowledges that it will be challenging to sustain the strong performance we have achieved over recent years, due to the significant rise in the population of older people living longer with a long term condition.

**Figure 14: Emergency Occupied Bed Days**

![Graph: Emergency Bed Days for Over 75s in Grampian](image)

The rate per 1,000 population of older people admitted twice or more to an acute hospital has followed a fluctuating trend since 2008. Nevertheless the Aberdeenshire trend against the numbers one would have expected is significantly better than the national position.

Nationally there is concern about the year on year increase in the number of emergency admissions for those 65+ and it is rising faster than expected. In 2010/11 the rate rose by 7%.

Data is not available for Aberdeenshire but across the NHS Grampian area (i.e. Aberdeen City, Aberdeenshire and Moray), there is a real decrease in emergency admissions against a rising number of older people as the following figures demonstrate.

**Figure 15: NHS Grampian Emergency Admissions Actual 2011-2012**

![Graph: Emergency Admissions](image)
This holds true even though the overall proportion of hospital beds are increasingly used by older people.

The effectiveness of integrated pathways is improving between primary and secondary health care systems and patient flow throughout the whole system is improving. This coupled with the desire to manage ‘interim’ patients out of the system, should ensure the intermediate care agenda is a vital but flexible part of holistic care.

Community hospitals have traditionally provided a wide and varied range of services. Although there is no standard definition of a community hospital or its role in Scotland, the most commonly used is:

“A community hospital is a local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources. Medical care is normally led by GPs, in liaison with consultant, nursing and allied health professional colleagues as necessary and may also incorporate consultant long stay beds, primary care nurse-led and midwife services”
There are 11 community hospitals managed by Aberdeenshire Community Health Partnership providing a mix of in-patient facilities including GP acute beds, rehabilitation beds and old age psychiatry assessment beds. Fraserburgh Hospital has six slow stream stroke rehabilitation beds. 80% of community hospital patients are aged 65 and over.

A range of diagnostic and treatments are now routinely available in community hospitals in Aberdeenshire, such as dermatology, minor surgery, orthopaedics, diabetes care, INR testing, ENT, Endoscopy, Ultrasound, Cardiac Assessment, dialysis and plain X-ray. This accords with our vision to provide local access to health care, reducing the need for people to travel to Aberdeen as far as is practicable.

Standardised practices have been established in community hospitals, including setting expected date of discharge for each patient on admission, co-ordinated discharge planning and moving on policies which have helped to reduce lengths of stay and delays in the discharge of patients who are medically fit. There has also been an increasing focus on rehabilitation by community hospital staff.

### 4.7 Primary Care
Aberdeenshire’s primary care sector comprises four independent health contractor services, General Practice, Optometry, Dentistry and Pharmacy. It is estimated that people aged 65yrs and over represent at least 60% of those who regularly use primary care services.

There are 36 GP practices providing general medical services with aligned District Nurses, Health Visitors, Community Psychiatric Nurses (CPNs) and Allied Health Professionals (AHPs). AHPs include community dieticians, speech and language therapists, physiotherapists and occupational therapists.

37 independent optometry practices offer free NHS eye examinations to all. Some practices offer an extended service through an enhanced service contract as members of the Eye Health Network.

There are 35 dental practices in Aberdeenshire the majority of which are independent. Not all offer dentistry to NHS patients. The NHS community and salaried service specifically targets vulnerable groups. The NHS provides dentistry to the prisoners in Peterhead prison and, from Dec 2013 with the opening of HM Prison Grampian, this service will expand to meet the needs of the increase in the prison population from 120 to 550.

There are 53 pharmacies in Aberdeenshire that are mostly independent contractors, with dispensaries within a small number of GP Practices. Many pharmacies offer additional services such as Chronic Medication Service (CMS), Minor Ailment Service (MAS) and smoking cessation.

### 4.8 Living Well with Dementia
Since 2010/11 the number of older people with dementia who receive either respite care, care at home, or are living in a care home has increased slightly. A key priority of our commissioning strategy is to extend and improve support for people with dementia, ensuring that people have a timely diagnosis and ready access to advice, information and care when they need it to help them to live well with dementia.
Figure 18: People aged 65 and over with Dementia by Service Received 2010-12

Figure 19 demonstrates the increasing proportion of people in care homes with a diagnosis of dementia. This understates the true position, since many care home residents exhibiting the symptoms of dementia have no formal diagnosis. In order to ensure care homes are equipped to deliver the highest standards of care to people with changing needs, we will ensure all care home staff in the private, third and local authority sectors have access to relevant training in dementia care.

Figure 19: % of Aberdeenshire Care Home Residents with Dementia 2004 -2012
4.9 Day Services
Aberdeenshire Council spends over £1m per year delivering or commissioning day services for older people. It continues to fulfil an important element in the spectrum of care and support for older people and their carers, enabling people to maintain and/or restore their daily living skills, improve their independence at home and within their own community. In June 2012, 476 people over the age of 65 (1.2% of the 65+ population) were using our day services.

In 2011, using a simple modified dependency tool (Barthel Index), 30% of older people using day services in Aberdeenshire were assessed as having high or very high dependency levels. The majority of people using day service are over 75yrs of age, with over 50% aged over 80 and significant numbers over 90. This represents a marked change over a period of five years with new service users joining at an older age than was traditionally the case.

Aberdeenshire’s 28 day centres offer social activities, physical and mental stimulation as well as respite for informal carers and dedicated transport to access this. Day services help many older people to maintain their wellbeing and expand social networks. The number of day care facilities and sessions has remained relatively constant for many years, each facility is configured according to local circumstances (i.e. transport, size of building, demand etc). Although the current arrangements remain a popular choice for many older people, the model of care has broadly remained the same for several years. In anticipation of changing demands and expectations of future generations of older people, significant re-design and development is planned over the next three years. Details are outlined later in the strategy.

Lunch is a key element of the service that enables older people to remain independent, socially engaged and well-nourished.

Volunteers play a vital role in Aberdeenshire’s day services. The level of volunteer involvement is unusually high compared to other parts of Scotland. Volunteers are highly valued as part of the core team, supporting paid staff so they have more time to focus on care planning and co-ordination of varied activity programmes. The Council also supports eight day services operated by volunteer groups with formally constituted committees. Support is provided in the form of funding, accommodation, transport and in some cases, paid staff.

Five specialist dementia day care facilities in Aberdeenshire are operated by the Council and voluntary organisations in addition to Alzheimers Scotland day services in five locations across Aberdeenshire. These services are targeted to those with a diagnosis of dementia at an advanced stage of illness. They offer higher staff ratios, complementary services such as home support and carers groups and have strong links with the specialist old age psychiatry service.

4.10 Supporting Carers
Traditionally carers have been supported to carry out their caring responsibilities by offering short breaks or respite for the person they care for, usually in a residential setting. The number of weeks of respite care provided to people over 65 in residential settings has risen from 3470 in 2009 to 3876 in 2012.

Carers who want to holiday with the person can now receive direct funding from Aberdeenshire Council to allow them to arrange short breaks which best suit their lifestyle. Many carers value opportunities to attend appointments alone, join a
class or participate in a leisure pursuit, with access to special concessionary rates for Aberdeenshire Council facilities. Increasingly Aberdeenshire carers are choosing to access community respite, allowing the carer to have some personal time away from home while the person they care for remains at home with a paid or volunteer carer.

A range of options such as Time to Live and Self Directed Support allow carers to purchase innovative short breaks for things like driving lessons or relaxation classes that provide a boost for the carer and ease their caring responsibilities. A number of third sector organisations offer local information, advice, training and support to carers, with funding from Aberdeenshire Council and NHS Grampian.

The changing pattern of respite demand in Aberdeenshire demonstrates the need for us to better understand what helps carers to continue to care. This is further addressed in Chapter 6.

4.11 Telehealth Care
Telehealthcare is a rapidly developing concept in health and social care and has tremendous potential to give older people more choice and control over their lifestyles, to live more independently and safely than ever before, and to better manage their own health and care. In 20011-12, 11% (2002 people) of the population aged 75 years and over used telehealthcare in Aberdeenshire. This is broadly comparable with other parts of Scotland.

Our capacity to harness its potential is central to our plans to reshape care for older people over the next decade and beyond. Aberdeenshire’s current investment in telehealthcare systems is around £132,000 per annum or 0.2% of the partnership’s joint financial framework. If we continue to evidence positive outcomes, the Partnership will commit further investment to expand the range and access of telehealthcare. This is addressed in Chapter 6.

Telehealthcare in Aberdeenshire utilises alarm and sensor activated alert systems, daily activity monitoring, assistive devices to optimise physical, sensory and cognitive abilities, environmental controls, and devices to enable clinicians to remotely monitor vital signs and conduct ‘virtual’ consultations with a patient over a wide geographical distance. Telehealthcare functions effectively as part of a network of care and support around an individual. It has a key role in strengthening personal support networks and communities.

In Aberdeenshire we believe a comprehensive 24 hour care at home and responder service is critical to the effectiveness of telehealthcare. It relies on a fast, skilled and personalised response to alarms and alerts from service users and professionals utilising local knowledge backed up with timeous data reporting facilities that allow us to measure trends, risks and areas for improvement.

Through Aberdeenshire’s joint equipment service, health and social care professionals can rapidly procure and install telehealthcare equipment as part of a personalised care and support plan. Staff are encouraged to support clients to find creative and innovative solutions using technology and we promote the use of professional “champions” who stay abreast of innovation and development in practice. We have piloted the use of telehealthcare technology to support stroke patients and to facilitate consultations by clinicians in rural areas, reducing travel time and cost for patients.
In 2009-10, telehealthcare prevented 39 unplanned hospital admissions in Aberdeenshire, equivalent to 337 acute hospital bed days, a saving of £192,090. Since 2010, the impact of telehealthcare on use of hospitals and home care services has been evident (i.e. reduces pressure on mainstream services). However, we no longer collect or report data on telehealthcare in the same way as we did during the pilot phase.

Table 9: Number and percentage of over 75 population using telehealthcare 2011-12

<table>
<thead>
<tr>
<th>Area</th>
<th>No. clients aged 75+</th>
<th>Population aged 75+</th>
<th>% 75+ population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grampian</td>
<td>4,647</td>
<td>41,439</td>
<td>11.21%</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>1,503</td>
<td>15,888</td>
<td>9.46%</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>2,002</td>
<td>17,925</td>
<td>11.17%</td>
</tr>
<tr>
<td>Moray</td>
<td>1,142</td>
<td>7,626</td>
<td>14.98%</td>
</tr>
</tbody>
</table>

4.12 Change Fund 2011-14

Since 2011/12 the Scottish Government’s ‘Reshaping Care: A Programme for Change’ (RCOP) Change Fund has provided Partnerships with additional short term resources and capacity to progress the policy goals and outcomes outlined in the introduction to our joint commissioning strategy, and act as a catalyst to drive sustainable improvements through greater collaboration and integrated working within and across sectors. Our partnership has used the funding to make faster progress to move away from reactive, institutional care and towards more preventative and anticipatory care that enables older people to remain safe and well in their own homes: seeking to transform the culture and philosophy of care from maintenance services provided to people towards preventative, anticipatory and coordinated care and support delivered with people in communities.

Aberdeenshire’s joint performance framework tracks the Partnership’s progress in achieving the aims of the Change Fund. It comprises 30 performance indicators with annual targets along with the results of regular surveys of older people who are most at risk of emergency admission to hospital, and their carers. These are reported in more detail in Chapter 7. Activity data across the local health and care system is reported quarterly to the Older People’s Strategic Outcomes Group and actions are agreed to address adverse trends in reshaping care during the four year life of the Change Fund.

In 2010/11, the first year of the Change Fund, slow but positive progress was evidenced in reshaping care towards a greater emphasis on self care, care at home and in local communities for those with complex care needs. This reflected earlier trends but gave impetus to our strategic plans and accelerates our direction of travel.

Considerable attention has been paid, using the Change Fund, to co-production approaches. The OPSOG recognised there is a plethora of activities and opportunities for engagement of older people in Aberdeenshire but it is not always easy for older people to find a way into such diverse and varied networks. Through the Change Fund, Aberdeenshire Signposting Project has been successful in linking many older people with the most appropriate community
groups, activities or services to meet their needs and interests. Based in GP surgeries, community hospitals and also accepting self referrals, the Signposting Project works with older people to find tailored solutions to the non-medical issues affecting their lifestyle, mood and wellbeing with the aim of enhancing their quality of life and promoting positive mental health. The project is in its infancy but is already reporting great successes, with some individuals needing a reduced level of medication and medical contacts as well as improved wellbeing.

A Reshaping Care Co-Production Steering Group was formed in 2011 to coordinate and stimulate activities that support early intervention and prevention in the older generation. Interest from groups wanting to develop options has been high. Enabling older people to maintain good social relationships is critical and a connectivity project has been funded to connect people with shared interests, particularly cultural pursuits. Being curious is helped by stimulation and we are delighted to support new groups such as Philosopher and dementia cafes, which are growing in popularity. Arts development workers with a small grant are provided taster sessions to diverse groups of older people and are now facilitating Create: Connect an Aberdeenshire wide arts training project that aims to build capacity across all sectors to work with vulnerable groups and carers and there are growing numbers of drama, art groups, tea dances and choirs establishing themselves, sometimes as adjuncts to care homes or dementia cafes but open to all. Aberdeenshire is fortunate to have a vibrant Community Planning Partnership where officers and councils for voluntary service are working with local communities to establish co-production ventures such as Westhill Mens Shed, community allotments and kitchens. We are aware that certain groups such as older men, ethnic minorities and the lesbian gay, bisexual and transgender individuals can be particularly vulnerable and we wish to support all efforts to engage them. There is also an ongoing arts project to increase access to health checks for Gypsy Travellers and this includes their older members.

Using a community development approach we are facilitating inter-generational engagement in an area that has experienced recent rapid population growth and helping sheltered housing tenants build sustainable and mutually beneficial connections with their local communities.

Using the Change Fund we are testing an integrated model of community rehabilitation and enablement in three areas of Aberdeenshire (Turriff, Peterhead, Inverurie) to support early hospital discharge of older people who have high clinical needs alongside personal care and rehabilitation needs. The three test sites provide rapid intervention to assist people to regain functional competence (i.e. the ability to care for oneself and manage one’s own affairs (Willis, 1996), which may have been compromised due to illness, hospitalisation or disability. Multi-disciplinary teams comprising NHS and local authority occupational therapists, home carers, district and ward nurses, care managers and physiotherapists form the Rehabilitation and Enablement in Aberdeenshire for Care at Home (REACH) service. REACH delivers intensive supports to older people at risk of dependency to enable them to regain independence within a 6-8 week period. The REACH initiative has actively encouraged carer and family involvement in setting and achieving an older person’s agreed goals. The context for such interventions is always the individual’s home or an appropriate community setting.
An independent evaluation of REACH by Robert Gordon’s University in 2012/13 will inform our future model of integrated rehabilitation and enablement by measuring and analysing user satisfaction and effectiveness; the burden of care on informal carers; and the experience of agencies involved in the design and delivery of REACH.

The Change Fund is also contributing to demonstrable improvements in supporting older people with complex needs at home:

- more people manage their care through an anticipatory care plan;
- levels of care at home delivered at weekends and overnight have significantly increased;
- number of people receiving more than 10 hours of home care per week has increased;
- more people over 75 and more people with dementia use telehealthcare to help them remain independent at home;
- short breaks for carers of older people is rising and remains above the Scottish average;
- more people received an early diagnosis of dementia, in accordance with national policy and targets

Of those people, aged 65 and over needing care, the proportion of people over 65 living at home with support increased and the number of people moving into care homes reduced.

Three early implementer teams applying an integrated rehabilitation and enablement model were established in 2011. Although numbers of people referred to the teams are low, some positive outcomes have been recorded as well as valuable learning points that will shape our approach to mainstreaming reablement over the next 3 to 5 years.

In 2011-12 funding to expand the out of hours responder service developed for sheltered housing tenants was approved. At present around 2,500 people in Aberdeenshire have a community alarm and have three named contacts, of people, who can be called on to respond or provide necessary assistance. The new 24 hour responder service will allow significantly more older people who have no close family or friends to assist them, to benefit from the service. The new extended service, called ARCH, will be fully operational in 2013 and has the potential to expand its role as demand grows. Whilst it will not respond to emergencies such as those requiring medical, police or fire services, ARCH will be capable of providing a rapid response and avoid inappropriate hospital admissions by providing care and support until other services can be arranged or by averting social care crises. ARCH will forms a key part of Aberdeenshire’s comprehensive 24/7 care at home service.

Using the Change Fund, we have invested in the development of our workforces in the statutory, independent and third sectors to improve knowledge, skills and practice in palliative and end of life care and working with people who have dementia.

Appendix F gives full details of projects and developments designed to reshape care for older people using the Change Fund between 2010 and 2012. Chapter 5 provides further information on the financial context of Change Fund.
Chapter 5: Finance and Investment Patterns

5.1 Overview
Aberdeenshire Council and Community Health Partnership have been working together for some time to produce an integrated budget and the first iteration was achieved in 2011-12. We call this our joint financial framework. The total aligned net budget is £106,660m for 2013/14. This includes resource transfer funding passed from the NHS to the local authority to fund care for older people who would traditionally have remained as patients of the NHS. Figure 20 below shows the categories and details of expenditure for 2012-13. These budgets continue to be refined and may increase as budget setting progresses.

Figure 20; Joint Resource Framework 2012-13

Our aim is to develop the joint financial framework as a three year rolling budget comprising all social work and primary care funding available during 2012-15 for the care of older people: at present confirmed NHS budgets are available up to March 2014. It would be accurate to say that, despite long and formally established joint planning arrangements, it is only now that work is being undertaken to ensure that local authorities and the NHS undertake medium term financial planning and monitoring activities together. Budget setting processes and timescales are not aligned and plans and governance around efficiency targets are not yet joined up. In addition, responsibility for financial management is not devolved by the Health Board to the CHP for all primary and community health services such as General Medical Services and community mental health services. For these reasons it has been difficult to capture the short, medium and long term configuration of health and social care expenditure on a comparative basis. Locally developed IRF data provides some of this but not in terms of current or recent expenditure. This remains an area for development between NHS Grampian and local authorities over the next three years.

Aberdeenshire Council has approved indicative budgets for the next four years. Although budgets are managed and accounted for by the NHS and Aberdeenshire Council respectively, the Partnership has agreed, in principle, that plans for investing, disinvesting or changing the allocation pattern of these budgets should
be planned and approved jointly through Aberdeenshire Older People’s Strategic Outcome Group and the Joint Community Care Partnership group.

5.2 Integrated Resource Framework
In 2010 an exercise was completed to compare patterns of activity and spending on health and care services by area across Grampian and per head of population. This is called the Integrated Resource Framework (IRF) and those for Aberdeenshire covering 2008-11 are detailed in Appendix B. At present, data for 2011-13 is not yet available.

5.3 NHS Expenditure
Two significant areas of expenditure not currently under the control of the CHP but traditionally regarded as core community health care for older people are general medical services provided by GPs and their primary care teams (£9.27m in 2013-14), and GP prescribing budget (£14.79m).

In 2010-11 NHS Grampian spent £87m per annum on acute hospital care of older patients originating from Aberdeenshire. Predominantly these are patients receiving assessment or treatment at Aberdeen Royal Infirmary, Woodend Hospital or Dr Gray’s in Elgin, but includes expenditure for older patients using the Aberdeenshire community hospitals. Monitoring and investment decisions around most of this significant proportion of health care spend are outwith the scope of Aberdeenshire’s joint financial framework. (*It is not possible from the IRF to extract the costs of Aberdeenshire community hospitals managed by the CHP but estimates suggest it is around £11.547m per annum)

In 2010-11 70% of expenditure on older patients from Aberdeenshire is attributable to hospital based health care, 30% to community based health services. GP prescribing accounts for the biggest element of community health expenditure and community nursing comprises the smallest area of expenditure. Specialist mental health services for older people, primarily dementia services, accounts for 3% of NHS total expenditure in Aberdeenshire. Figure 21 below shows the broad categories of health expenditure for 2010-11.

Figure 21: Health Expenditure 2010-11

5.4 Social Work Expenditure
In 2010-2011, Aberdeenshire ranked 24th out of 32 local authorities in terms of the level of social work spend on older people’s services per head of population over 65yrs old.
In 2012-13 the proportion of community or home based to institutional care spending was 46% to 54% respectively.

Figure 22: Social Work Community: Institutional Spend 2012-13

Aberdeenshire Council has acknowledged that social work services face unprecedented demographic and significant inflationary pressures and are committed to protecting or increasing resources as far as possible. In the short term, the Council has injected £1.5m on a non-recurring basis in 2012/13 to improve faster access to care at home and in 2013 is re-tendering care at home services. In the context of medium to long term economic forecasts, partners are committed to adequately fund the local health and care systems but acknowledge this will become increasingly difficult.

35% of social work expenditure funds the costs of older people living in care homes and approximately 27% of the budget funds care at home services. These comprise the two biggest single areas of social work expenditure. Over the life of this plan, the Aberdeenshire Partnership aims to shift the balance of expenditure towards a wide range of non-residential support which facilitates greater independent living, choice and control for frail older people and people with dementia at home and in their community (e.g. home care, day support, respite care etc). To assist us to measure progress, we propose to set short, medium and long term expenditure and resource transfer targets

Both residential care and care at home services are provided by the Council and by private and third sector care providers. Aberdeenshire Council has explicitly decided to remain as a provider of care within a mixed economy of private and third sector care providers. The Council commissions approximately 30% of care which is delivered, under contract to the Council, to older people at home. The remaining 70% is provided by services and staff under the direct control of Aberdeenshire Council. Until now, the number of care at home providers has been relatively low, geographical spread has been patchy and a higher than average number of providers have terminated their business in the area at short notice. In 2012 a joint planning group was established between the Council and private home care providers to explore and develop new approaches to commissioning and contracting for care which will improve the consistency, sustainability and growth of the local market for care at home. This initiative has led to a managed transfer of home care business from the Council service to
private care providers during 2012 and incentivised payments for providers who are willing to move into areas of high demand, e.g. Banchory, Stonehaven, Inverurie.

Aberdeenshire Council commissions 77% of care home places from the independent sector and provides 23% in Council run care homes. The balance is likely to remain similar as Aberdeenshire Council plans to retain their current 200 care home places in reconfigured and modernised provision.

5.5 Funding Carers Support
In accordance with the Scottish Government’s requirement to dedicate at least 20% of Change Fund to carer support, the Aberdeenshire Partnership is committing £1.05m from the Change Fund in 2012-13 to support informal carers. In addition the Scottish Government has provided funding directly to some third sector carer organisations.

This is additional to core funding of Aberdeenshire Council commissioned direct support for carers with funding of £517,224 per annum for third sector organisations such as VSA, Mental Health Aberdeen, Alzheimers Scotland and Cair Scotland.

Carers in Aberdeenshire also benefit from funding linked to the NHS Carers’ Information Strategy, such as access to online training for health staff to improve their knowledge and awareness of carers’ needs and rights. Funding has also been used to develop a carers’ advocacy service.

5.6 Capital Funding
In addition from March 2010-March 2013 Aberdeenshire Council spent £17.2m of capital on re-provisioning two Council Care Homes with extra care bungalows and £ 0.9m on converting a sheltered to a very sheltered housing complex.

The Council plans to invest a further £10.872m of capital before April 2016 on reprovisioning another care home and upgrading several sheltered to very sheltered housing complexes.

Recently Aberdeenshire CHP has spent £12.3m upgrading Banff Community Hospital and Health Centre and £1.053m on a dental practice in Fraserburgh. Whilst these are universal services it would appear that a high proportion of the facilities are used by older people.

Aberdeenshire CHP are involved in considering reprovisioning primary and community services to the Inverurie Hospital site but as yet there are no firm commitments or timelines.

5.7 Change Fund 2010-14
Aberdeenshire Partnership has focused our reshaping care programme on three themes and spent and committed the following sums:

- 2011-12 spent £0.467m with £1.058m committed in 2012-13 on Early Intervention and Prevention.
- 2011-12 spent £0.240m with £0.871m committed in 2012-13 on Rehabilitation and Reablement.
- 2011-12 spent £0.237m with £0.994m committed in 2012-13 on Improving Long Term Care.
Whilst prevention will remain a key aim, funding has been used for capital such as x-ray equipment which will be non recurring and in the future will mainly be used to support communities to start activities which will become self sustaining, so the overall resources required from the Council do not grow significantly. However, as the move continues from acute hospital to community hospitals and care in the community, more funding will need to be released from the acute sector or provided by the Scottish Government.
Chapter 6: Strategic Commissioning Intentions 2012-22

An Overview

6.1 Integration of Health and Social Care
We are committed to improving the way local health and care systems work so that the experience people have when they need care is seamless, effective and accessible. We aspire to a single point of entry to outcome-focused health and care for older people with integrated care pathways delivered by the right team at the right time, in the right place.

The demographic profile of Aberdeenshire outlined earlier in this plan challenges the current model of health and social care. The joint commissioning plan aims to address these challenges through reshaping the way we envision, design and deliver health and social care for older people. Some of these challenges have been reported in our Change Plan performance framework in 2011-13.

6.2 Reducing Inequalities
Good transport links are of vital importance in rural communities to enable people to participate, remain active and provide support to each other. Creating and establishing sustainable transport solutions continually feature as a priority in all our consultations with older people and communities. Aberdeenshire health and care partnership is committed to working as an active member of the Community Planning Partnership to deliver this within the life of this joint commissioning plan.

Throughout the life of this plan, we will give priority to improving equity of access to essential social and health care provision across Aberdeenshire by identifying and reversing the widening health inequalities between those living in areas of deprivation and older people in more affluent parts of Aberdeenshire. Over the next 3-5 years, we will systematically improve identification of health inequalities, increasingly target resources towards communities and individuals with greatest needs. Deprivation will positively influence our decisions and recommendations for investment.

Aberdeenshire Council uses eligibility criteria to target resources fairly and transparently. Our eligibility criteria, which are based on Scottish Government guidance, address both the severity of risk and the urgency of intervention required to address risks. Our eligibility framework prioritises risks into categories of critical, substantial, medium and low.

6.3 A Sense of Place
As more and more older people are supported to live in their own home throughout later life, we anticipate local challenges associated with diversity and scale of new housing and the need to maximise the use of existing housing through telehealthcare, equipment and adaptations. The extent of under-occupancy will be determined by the extent to which future generations of older people choose, or have opportunity, to downsize. We anticipate rising demand from single households for living options that offer flexible combinations of care and support.

In order to meet these challenges, we will develop capacity to forge effective links with the wider public sector family, building on existing effective Community Planning networks, engaging with communities and business and third sectors.
6.4 Better Outcomes
During 2012/13 we are experiencing increases in the rate of people over the age of 65 admitted to hospital twice or more within a year as an emergency. The numbers of people over 65 attending Accident and Emergency units following a fall have also increased. Simultaneously, NHS Grampian is reducing the number of acute medical admission beds.

While the zero target for discharges delayed by six weeks or more has mostly been achieved by the Aberdeenshire Partnership since 2008, the number of bed days lost to delayed discharges has been increasing. We are working to overcome challenges to achieve zero discharges delayed by four and two weeks over the coming year.

Over the next 3 – 5 years the Aberdeenshire Partnership will maintain its focus on better management of chronic conditions, falls prevention and anticipatory care planning through increased public knowledge and awareness of health conditions and how to self-manage these. In the same period, planned care will be an increasing feature of the local health system evidenced by clear pathways which include re-direction strategies, early discharge followed by community rehabilitation and re-ablement. We anticipate our sustained approach to managing unscheduled care will bring further reductions in the number of occupied bed days arising through older people being inappropriately admitted to or remaining in hospital.

Building on well-established links with local communities, local authority and other community planning partners, NHS Grampian’s vision for community hospitals is to provide access to local, safe and sustainable diagnostic services, including casualty/minor injury; clinical and therapy treatment, GP led in-patient care, day case activity and both nurse/therapist and specialist led outpatient services. Although Community Hospitals are already centres for the delivery of Telemedicine there is potential for these to be developed as satellite centres for telemedicine linking into specialist and secondary health care services. The respective role and contributions of ARI and Aberdeenshire’s community hospitals will be refined to improve rapid access to out-patient assessment, diagnosis and treatment and appropriate, planned transfers between acute and community health and care facilities.

During the next three years we will refine our approach to measuring outcomes are met for people who use our services and their carers. Surveys in 2011/12 of older people at medium risk of unplanned hospital admission and their carers have evidenced general satisfaction with services and involvement in the design of their care. However, these also confirm that more needs to be done to support people to feel safe at home, and to support carers to continue in their caring role.

6.5 Public Expectations, charging for care and the mutual care debate
We recognise and embrace the broader strategic challenge of changing public attitudes amongst traditional north-east rural, agricultural, and fishing communities. Many Aberdeenshire communities have a strong sense of civil society and a tradition of self-sufficiency. 'Grass roots' initiatives have grown up across Aberdeenshire over the past decade that provide social and practical support to older citizens of local communities. Some (such as the Silver Circle
initiative in Strathdon) are regularly cited as exemplars of what communities can achieve to directly advance the health and wellbeing in a holistic and inclusive fashion. We aspire to see the whole of Aberdeenshire served by a comprehensive network of local initiatives, so that older people are included in the life of their local community, wherever they happen to live. In many instances, the creation, and continued existence, of successful community initiatives in a particular village or neighbourhood can be attributed to the existence within that community of one or more dedicated community activists and 'social entrepreneurs' - people with the motivation, confidence, resourcefulness and commitment to 'get things done' within their own locality. As part of our commissioning intentions, we will seek to develop capacity within all of Aberdeenshire's diverse communities, so that those communities too are enabled to look after the needs of their older generation, either through 'importing' and adapting ideas that have been tested elsewhere, or by crafting initiatives specifically tailored to the needs and resources of their particular community.

There is a growing understanding that the impact of a significantly ageing population cannot be met by the current model of public service or, indeed by the current level of resource available in statutory health and social care sector. Even though some of the financial impact of this demographic pressure will be defrayed by imaginative approaches to supporting the older generation, there remains a major funding gap that will require to be met from increased general taxation or from a mutual care approach where individuals and their families, meet the costs of their care in old age.

In 2012 many frail or vulnerable older people are wholly or partly supported to manage their health and independence by family, friends and communities and we will endeavour to ensure these people are recognised, offered support, respite, training and guidance to allow them to continue to care. Finally our role will be to change society's view about what people can do for themselves to improve and maintain good health and, to maximise their quality of life through self management of illness or chronic conditions. As we outline later in this chapter we intend to use all means of communication to ensure people understand how they can live healthier lives and support people to do so in multiple ways with all our partners.

6.6 Improving Personalisation, Choice & Control
Patient centred care and self directed support will have an increasing influence on our commissioning intentions over the next 3 - 5 years. Increasingly, individuals will manage their own personal care budgets and will be commissioners in their own right. The social work role will re-focus more on stimulating the market and facilitating access to information and advice so that people can source the support they need to meet their outcomes, and ensuring people can access information and advice.

We anticipate that, within five years, internal and external care markets will mature and evolve to reflect citizen demand for greater choice and control over their care arrangements.

6.7 Creating A Sustainable Local Market for Care
We are succeeding in our aim to reduce the proportion of older people in Aberdeenshire moving into care homes (see figure 13 in Chapter 3). Within the next 3 years, this will present a challenge for private care home providers, who will
require to plan future capacity in line with these trends, and diversify business plans to meet the aspirations and expectations of a new generation of older people.

The Aberdeenshire Partnership will have a growing and important role in mapping the local market for care to ensure adequate capacity and diversity exists in each of the six areas of Aberdeenshire, offering choice and high quality residential care, care at home and community support services. In the short term (1-3 years), the Council plans to strengthen the local independent care market by attracting new providers and offering mutually attractive contract terms which will sustain a strong, healthy private care market offering older people choice, responsiveness and high standards of quality.

The local authority will continue to have an important role in monitoring commissioned care services to ensure they are safe, reliable, responsible and meeting the expectations and needs of our citizens. Only those services which can clearly demonstrate that they are delivering outcomes will continue to be commissioned.

A. Early Intervention and Prevention

A.1 Strategic Outcomes
We will deliver the following Strategic Outcomes so that Older People can;

- remain independent and in their own home for as long as possible
- live life to the full, maximising their health and wellbeing
- feel safe and secure within their home and community
- access a range of housing options
- increase their choice and control over their lives
- feel part of their community and socially engaged
- have unpaid carers who are supported to continue in their caring role

A.2 Living Well in Later Life – Building Individual and Community Capacity
In Aberdeenshire, we recognise that the social, environmental and economic determinants of health and wellbeing, in other words the circumstances in which people live, work and retire, will continue to change dramatically from those of previous generations. The majority of older people receive no formal services from the NHS or social work on an ongoing basis and although the proportion of older people requiring care is increasing, 65% of those aged 85 and over receive no formal support or care. Far from being a “burden” on society older people are themselves volunteers in many settings, with some volunteers being older than those they support. Many are carers.

In 2008 the National Economic Foundation reviewed the interdisciplinary evidence of over 400 scientists from around the world. They identified a set of evidenced based actions to improve mental and physical wellbeing which individuals can build into their daily lives. We will promote these as a key element of our approach to early intervention and prevention:
• connect with the people around you,
• be active,
• take notice,
• keep learning, and
• give.

In the short to medium term, a dedicated communications officer, funded from the Change Fund is using a range of media to disseminate messages, challenge stereotypes and promote events and activities which involve and engage whole communities around support for older people.

We will work closely with those taking forward the Fuel Poverty Action plan; ensure all health and social care staff working with older people are aware of fuel poverty and the services of SCARF (Save Cash and Reduce Fuel) and are equipped to identify fuel poverty, energy efficiency and insulation measures, as well as help people access the support to maintain and repair their homes.

Poor diet, lack of exercise and obesity are associated with an increased risk of stroke, coronary heart disease, Type 2 Diabetes and certain cancers. Physical activity can also improve mental wellbeing. Physical activity levels appear to decrease with age and obesity currently increases with age until a peak in those aged 55-64 and then declines.

Public health programmes are being commissioned which, though not directly aimed at older people, will include them in the target group. Our strategic intent is to co-ordinate and link older people’s services and universal programmes. Examples include community training kitchens offering food skills, healthy eating, nutrition and community allotments; health promoting NHS with an increased emphasis in the hospital setting to ensure that “every health care contact is a health improvement opportunity” paying particular attention to smoking cessation, physical activity, food and health and active travel; social prescribing by Aberdeenshire primary care teams and leisure services; developing a generic exercise pathway and physical activity brief interventions in accordance with national guidelines; and developing a Healthy Eating Active Living Strategy with associated activity such as healthy weight programmes delivered through GP practices; alcohol brief interventions delivered by GPs and other health or third sector professionals. Prevention programmes targeting younger adults will be designed to change the health outcomes for future generations of older people.

Grampian NHS will continue its proactive approach in the community, hospitals and care homes to ensure dietary intake, fluid intake and output is recorded and monitored.

The remote and rural circumstances of Aberdeenshire have contributed to the evolution, over decades, of a plethora of community groups and organisations but finding out about them and how to access them is not easy for many older people. Using the Change Fund we have sought to promote and improve access by establishing a signposting service based in primary care settings and community hospitals.

The Reshaping Care Co-Production Steering Group will continue to work with Community Planning Partners to co-ordinate and stimulate activities that support early intervention and prevention in the older generation.
It is important that lifelong learning fully encompasses older people and all opportunities are maximised to ensure a wide range of opportunities for older people to continue to participate in learning.

The Aberdeenshire Partnership anticipates that over the next 3 – 5 years, all these measures will collectively and individually have a positive and continuing impact on the mental and physical health and well being of our older generations, preventing or delaying their need for formal care.

By adopting a co-production focus, we believe a relatively small amount of funding can stimulate widespread and diverse activity and good outcomes for individuals and communities. The Aberdeenshire Partnership is committed to continue this approach, in close collaboration with the Community Planning Partnership, firmly focused on the five important activities and growing a network of early intervention and prevention organically and opportunistically without specifying exactly what will be commissioned in future. We plan to develop mechanisms to scale up initiatives which demonstrate particularly good outcomes, where appropriate.

In planning for the major changes that face us in the local population profile, in 2010 Aberdeenshire Council commissioned Lowland Research, an independent research company, to gauge the views, aspirations and intentions of a representative group of Aberdeenshire “baby boomers” about their care and living arrangements in older age. The findings underscored the aims of our policy direction in terms of people’s aspiration to live independent lives for as long as possible in their current communities, with access to a tariff of care and support tailored to meet individual needs in a variety of accommodation types including bungalows, sheltered, very sheltered housing and care homes. A citizens panel survey in 2011 expressed the same preferences regardless of age of respondents.

The Aberdeenshire partnership recognises the fundamental importance to individuals as they age, of maintaining natural circles of support and opportunities to continue living in their existing communities with augmented care when they need it. We aspire to reflect these views in the way we plan and deliver care, health and accommodation across Aberdeenshire for future generations of older people.

### A.3 Housing with Support

The Aberdeenshire asset management strategy for older people addresses a wider vision for Aberdeenshire’s citizens: creating choice through a mixed provision of care home supported living and augmented housing for older people across the council area. This approach is reflected in the Local Housing Strategy and the Council’s Strategic Local Plan (SLP), which includes planned development of 1 and 2 bedroom bungalows over the next 3 years.

Between 2012 and 2015 some of the Council’s existing 63 sheltered housing complexes will be re-modelled to create very sheltered housing options in localities where none exist at present and where need is identified for this type of accommodation with care and support. In addition opportunities to consider alternative uses and re-design Council and RSL owned and operated Sheltered Housing, in line with population needs, will also be considered as part of our strategy.
Maximising existing stock across all tenures for older people is also a key action in the Local Housing Strategy and corresponds with the aim of this strategy to maximise independent living opportunities. Adaptations and dementia design principles work well to provide often simple and effective ways of assisting people to remain in their own home for longer. It is well known that these are important factors that can enhance independent living opportunities. Telecare and Community Alarms continue to contribute significantly in allowing people to remain in mainstream housing with varying levels of support.

A.4 Supporting Informal Carers
In 2009/10 about 11% of adults of all ages in Aberdeenshire provided unpaid care (source: Scottish Household Survey). This is broadly comparable with the Scottish average. Although there is no local data available, national data demonstrates that older adults between 45 and 64 (i.e. of working age) are more likely to be carers and older people aged above 64 are more likely to require care. Carers aged over 65 self-assessed as having better health than non-carers of the same age. This suggests that older carers derive some benefit from caring but this may depend on factors such as the availability of local support and how financially secure they are.

We are committed to increasing the range and quantity of support available to carers over the next three years. We will continue to fund third sector organisations to deliver support, advice, information and training for carers. Further efforts will be made to make it easier for carers to pursue a life outside their caring role; evidence has shown us that small amounts of funding allow carers to access personal development or leisure facilities, and we will seek to mainstream these approaches. A wide range of flexible short break options will be possible, in addition to residential and community support models, and individual budgets will create opportunities for carers themselves to design flexible, tailor-made short breaks, which may include friends and families offering support and care for service users to accompany their carer to a chosen holiday destination.

Increasingly, carer services will be judged and measured on how well they enable carers to continue in their caring role. This outcome will become fundamental to our commissioning approach.

A.5 Care Management and Personal Support Planning
During the next three years, new self-directed support arrangements will mean more people, including older people, will be managing their own budget for care, using a relatively simple supported self-assessment. An older person choosing to manage a personal budget will work with a care manager to decide the outcomes he/she wants to achieve, in terms of their personal development, recovery or improved quality of life. Services, activities or products, designed to deliver desired outcomes, may then be purchased by the individual using his/her individual service fund or purchased for them by a nominated provider organisation or arranged by a care manager. This new approach to designing and delivering care and support, aims to increase the choice and control that people have over their lives and their care and support arrangements. It avoids people being fitted into a tariff of available services, which are often costly and may not deliver the outcomes the person wants or needs to improve their wellbeing and quality of life.
A.6 Diagnosis and Treatment

A key strand of our approach in Aberdeenshire to early intervention and prevention in older age is to develop capacity to investigate and treat problems more speedily, either locally or in specialist hospitals. To achieve this, we will improve access to early diagnosis of dementia and increase the capacity of primary care teams to treat and manage patients with dementia close to home. We will continue to grow the range of locally-based services that facilitate rapid diagnosis and prompt access to treatment of acute and chronic health conditions as close to home as possible. This includes local access to plain X-ray, ultrasound, endoscopy, cystoscopy, exercise ECG, echocardiography, Holter monitoring, minor surgery, cancer follow up, dermatology, orthopaedics, diabetes, point of care testing for INR (tests that a GP can do to test for heart failure, DVD (deep vein thrombosis) or whether people are having a heart attack and cardiac markers, which taken with a clinical assessment and ECG can eliminate 60% of patients presenting to A & E unnecessarily with chest pain.

During the next 3-5 years we have ambitions to add DEXA (a machine which measures bone density and checks for osteoporosis), MRI (Magnetic Resonance Imaging used to diagnose health problems affecting organs, tissues or bone) and CT (Computerised Tomography a special kind of X-ray machine, which allows more detailed images to be constructed than ordinary X-rays) scanning and chemotherapy to the range of locally-available facilities.

We will base these services within natural communities where it is safe and affordable to do so; we will improve access to diagnostic and treatment facilities at Aberdeen Royal Infirmary when it is not and we plan to harness the potential of telemedicine to routinely diagnose, treat and manage a range of conditions.

Developments of this kind have already allowed us to manage more patients within General Practice or on an out-patient basis, avoiding unnecessary hospital admissions. This will be an increasing feature as we develop the range of locally accessible diagnostic and treatment services.

Access to timely diagnosis for people who have concerns about their cognitive function will continue to be a priority for the Aberdeenshire partnership. We intend to increase capacity of primary care services to diagnose and manage patients with dementia. This will include direct access by GPs to CT head scans. Through timely diagnosis, more people have opportunities to access advice, support, treatment, and, with their friends and family, plan for the future while they remain well. Aberdeenshire GPs believe that local capacity would be enhanced by recently established peripatetic outreach teams, incorporating Alzheimers Scotland link workers, who support assessment, post diagnostic support, and engagement in community activities.

Over the next three to five years we will continue to promote and commission opportunities for people with dementia to be supported in their local communities such as dementia cafes, local projects and groups and specialist day services.

A.7 Self Care and Managing Long Term Conditions

Our commissioning intentions reflect the importance of reducing risk and improving outcomes for future generations of older people in Aberdeenshire, as outlined in the environmental scan chapter of this plan. We will do this by promoting, encouraging and reinforcing ways that people can address factors such as lack of exercise, poor diet, obesity, smoking or alcohol consumption that
increase their risk of developing debilitating health conditions in later life and we will facilitate early diagnosis and self-management of high blood pressure and high cholesterol. Self care is a vital part of developing personal autonomy, but is also a key enabler for the NHS to manage changing demography and rising demand.

In recent years, we have successfully applied a range of approaches to managing long term conditions within primary care such as diabetes, coronary heart disease and COPD. The rate of deaths from heart disease in Grampian is decreasing and we aim to maintain this trend over the next ten years so that a smaller proportion of the population are living with heart disease and, in turn, placing less demand on statutory health and care services in the future.

Self-management programmes for patients with established chronic conditions are evolving incrementally and we plan to accelerate the pace of change in the next five years so that more people are safely self-managing their health conditions. During the next three years, we will develop our capacity to support people to self care when they experience minor ailments or conditions, e.g. with the help of internet advice, local pharmacies etc.

A.8 Falls Prevention
One in three people over 65 and half of those aged 80 and over, fall each year. A quarter to one third of these falls could be prevented. Around half of attendances at A&E for people 65 yrs+ can result from falls and evidence shows that 50% of those who fall will have another fall within 12 months. Much work has been done in recent years in Aberdeenshire to identify older people at risk of injury from falls and help them to reduce their risk. This has been achieved, in line with national falls strategies, by co-ordinating the efforts of a wide range of professionals such as the Fire & Rescue service, Care and Repair Services and third sector organisations and groups supported by Dietetics, Occupational Therapy, Pharmacy, Physiotherapy and Podiatry specialties.

Our forward strategy emphasises the importance of individuals taking responsibility for their own safety and having a central role in planning how to reduce their risk of falls, e.g. by taking opportunities to improve their strength and balance and address other causative factors in falls. We are already making progress in the self management of falls by delivering a nationally evidence-based home exercise programme (OTAGO). We will explore how best to develop community pathways for those who fall and how to support individuals who fall in their own home, rather than admit to hospital.

There is a link between increased risk of falls amongst older people and alcohol misuse, poor memory and harmful interaction with medication. This is an emerging area of concern and we aim to improve self-awareness of these risks and influence a change in culture. We will encourage those who routinely come into contact with frail older people to consider falls risks and signpost individuals to appropriate help to reduce their risk of injury.

B. Rehabilitation and Enablement

B.1 Strategic Outcomes
We will deliver the following Strategic Outcomes so that Older People can:

- be supported to regain and retain daily living skills and abilities and remain independent at home for as long as possible
- live life to the full, maximising their health and wellbeing
- feel safe and secure within their home and community
- increase choice and control over their lives
- feel socially engaged and part of their community

Moving from Maintenance to Recovery and Rehabilitation

Our aspiration in Aberdeenshire is that older people experiencing acute illness or exacerbations receive treatment in the most appropriate place, with as few moves as possible. We believe treatment should be delivered at home if at all possible or in a hospital if an older person requires close medical supervision. We recognise the importance of rapid and intensive rehabilitation and enablement within community hospitals and in primary care. In pursuit of our vision, we have used Change Funding in 2012/13 to increase core physiotherapy and occupational therapy provision in local hospitals. Where it is no longer considered appropriate for older people to complete their recovery or treatment in hospital we support a model of intermediate care at home, rather than a short stay in another facility. There is good evidence that bed-based intermediate care models lead to beds being inappropriately used in a place other than a hospital, and that many people do not receive the intensive therapeutic interventions promised by such an intermediate move.

The Aberdeenshire Partnership promotes a model of home-based recovery and considers that the function of community rehabilitation and enablement is the same (or better) than intermediate care in an institutional setting. The fact that it happens at home leads to better outcomes for the individual than a short stay intermediate placement. An independent evaluation of our pilot rehabilitation and re-ablement projects will inform our future model of integrated rehabilitation and enablement. Within the next five years, all primary and community care practitioners will, through training and practice development, re-orientate themselves from a maintenance mind set to one of recovery and rehabilitation.

### B.2 Care at Home

Our strategic commissioning intention is to provide a seamless care at home service 24 hour a day 7 days a week, which provides a combination of planned and unscheduled care, responding to unplanned need through its recently commissioned responder service, described in Chapter 3. It should be capable of a flexible, tailored response to meet the full range of specialised and general personal care needs of people with dementia, terminal illness, physical frailty as well as recovery and rehabilitation as described above. It is likely that recovery will be embedded in our delivery model and in time occupational therapists will support that agenda.

In 2012/13 Aberdeenshire Council provides and commissions in excess of 15,000 hours per week of care at home services. Around 70% is delivered by the in-house home care service and 30% is commissioned from third and independent sector care providers. 20% of the population aged 85 and over receive care at home.
The Council’s policy is to remain as a significant provider of care at home services while creating and sustaining a viable independent care market across Aberdeenshire by gradually and continually increasing the procurement of high quality independent care at home services over the life of this plan. The expansion of self directed support is likely to have an impact on the care at home market but we anticipate that people will choose high quality services delivering good outcomes for the best price.

We recognise the future challenges faced by all care providers of staff recruitment and retention in an area of low unemployment combined with the impact of rurality on costs and availability of services and we acknowledge this might mean an added unavoidable cost pressure over the next five years in order to meet demand across the large remote and rural area that is Aberdeenshire.

Further attention is being paid to the role and remit of care at home workers, with implications for an increased level of training as they are increasingly expected to provide rehab and enablement, dementia care, support good nutrition and, under community nurses and pharmacist’s guidance, medicine management.

B.3 Telehealthcare
Creative and innovative technological solutions that give faster access to diagnosis, treatment and support, reduce risk and improve personal outcomes for older people will be a significant area of development for the Aberdeenshire Partnership over the next three to five years. Professional “champions” within the health and social care workforce will help us step up the pace of innovation and change in the way we harness and supply emerging technologies in our everyday work with frail and vulnerable people.

Our investment in telehealthcare has grown annually through joint investment by both the local authority and the NHS, augmented in recent years by the Change Fund. Long term financial sustainability will be achieved through income generated from charges and savings generated through reductions in care home and hospital admissions. Our target between 2011-13 has been to increase the number of people over 75 who are supported with telehealthcare by a minimum of 1% per year and this has been considerably exceeded. In the last eighteen months we have increased the proportion of people aged 75 and over with a telehealthcare package (excluding community alarms) from 3.9 per 1000 to 6.8. We will review our target in 2013 with a view to increasing the rate of take-up.

All Emergency Departments in Aberdeenshire community hospitals currently have access to telemedicine, mainly to support fracture management. Over the next three years it is intended to develop opportunities to support out-patient activities and out-of-hours nursing support.

B.4 Day Activities for Frail Older People & People with Dementia
We recognise the value and potential of our existing traditional day care resources to re-focus their efforts in line with the needs, aspirations and lifestyle choices of future generations of older people. By 2014 we will, with community planning partners and older people themselves, re-design day support for older people with an emphasis on recovery, community-based, flexible and integrated approaches to delivery.
C. Improving Long Term Care

C.1 Strategic Outcomes
We will deliver the following Strategic Outcomes so that Older People can;

- be assured of high quality of health and care commissioned or provided by Aberdeenshire Council or CHP
- live life to the full, maximising their health and wellbeing
- feel safe and secure wherever they receive their health and care service
- have access to a range of housing with care options
- exercise greater choice and control over their lifestyle and health & care arrangements
- feel socially engaged and part of their community
- have informal carers, friends and relatives who are content with the high quality of health and care, wherever it is delivered

C.2 Specialist Dementia Care
Increasing the capacity of primary care to diagnose and manage patients with dementia will free specialist and secondary care services to work with more complex cases and provide rapid response to primary care clinicians.

In line with the National Dementia strategy, Aberdeenshire has access to a Dementia Nurse Consultant in the acute hospital sector, supporting the work of dementia champions and best practice in dementia care nurses. An important element of their work is to improve the quality of care and experience for older people in acute hospital settings. In 2012/13 the Change Fund has been used to drive up standards across all sectors through training for nursing and social care staff in advanced dementia practice and feedback on this multi agency and sector approach has been extremely positive.

During 2012, a training manual in psychosocial care has been developed for carers of people with dementia, by RGU and a consultant neuropsychologist. Following evaluation of the project (funded by the Change Fund) it is intended that training and use of the manual will be cascaded to carer support providers to continue the initiative routinely once funding ceases.

We envision that care for people with dementia will increasingly be commissioned and managed locally within the Aberdeenshire Partnership. Over the next three years secondary care services will be targeted on those individuals with complex behavioural problems or other exceptional needs. The use of specialist hospital beds overseen by consultants in community hospitals and, support to care homes will provide access within localities to the full spectrum of dementia care for people throughout their illness.

C.3 Long term Care
We recognise that reshaping care for older people will have a direct and significant impact on the care home market that exists in Aberdeenshire at present in terms of the size of the sector, physical environments and philosophy of care for future generations of older people. Traditionally, Aberdeenshire has had a sizeable private care home market with almost 1500 beds available.
Approximately 60% of the market, if all care home residents are fully funded by Aberdeenshire Council. The geographical locations and quality is not equitable in terms of choice for individuals. There is an imbalance between demand and availability of specialist dementia care units and an over-provision of units for frail older people. The local care home market has largely been shaped by speculative rather than planned development and we aspire, through the implementation of this plan, to shift the emphasis towards a care home market that is fit for 21st century living and tailored to meet the demands and expectations of future older generations. In recent years, confidence in the quality and sustainability of the private care home market has been adversely affected by business failures, closures and poor inspection reports from the regulator.

Aberdeenshire Council’s care home modernisation strategy embodies the policy aims of improving choice and quality, creating homely accommodation and modern sustainable care environments for older people with complex care needs. We anticipate that the average age, level of dependency and mental and physical frailty of people moving into a care home will continue to rise in the future, as we support many more older people with complex health and care needs to live at home with support, or in sheltered or very sheltered housing, if they choose to do so.

The Council intends to remain a minority provider in a mixed economy of care accounting for approximately 14% of care home places in Aberdeenshire. By 2018, the council’s modernisation strategy will create and sustain the highest quality of accommodation and care that act as an exemplar for the care home market and to ensure that older people have access to public provision in or near all main settlements of Aberdeenshire. Each care home will incorporate specialist dementia provision and on-site nursing care delivered in a partnership with the CHP. Care homes will offer a home for life to people who move in, with capacity to deliver palliative care, respite for carers and short term rehabilitation. The modernisation strategy promotes a care village concept combining care home provision located alongside affordable rented housing for older people, linked by telehealthcare, where older people can live independently, semi-independently or in fully supported care home accommodation throughout later life while remaining in and close to their established community networks. The partnership is currently exploring the potential to incorporate acute assessment in-patient services in one or more care home in future acknowledging the benefits of co-locating health and social care provision.

In 2012/13 there were 41 independent care homes for older people in Aberdeenshire. Occupancy levels are generally declining in many homes and we anticipate this is likely to increase in the next five years as our reshaping care for older people plans become embedded and older people have greater personal choice and control over their care and accommodation arrangements. To some extent, these choices will drive change in the care home market. Equally the Aberdeenshire health and social care partnership will seek to manage the decommissioning process in a planned and transparent way that minimises disruption to existing and potential residents. Within the next three years we will bring forward a coherent plan, involving care providers locally and nationally, the regulators, community planning partners, local authority Area Committees and planners.

The quality of care in care homes in Aberdeenshire is generally assessed as good but we aspire to continuously drive up standards across the area. A mentoring
officer, funded by the Change Fund, is engaging the care home sector in approaches which will share best practice and support providers to address deficits. Over the next three years we will be refining our approach to contracting and commissioning to support and promote care home providers who consistently record positive outcomes for residents and high inspection grades for quality.

In policy terms, very sheltered or extra care housing could potentially have the greatest impact on the partnerships’ ability to achieve key national health and care policy targets relating to reshaping the balance of care for older people, personalisation and self-management of long term conditions. Aberdeenshire’s housing for particular needs strategic outcome statement aims to support access to affordable housing for people with higher levels of need. We will do this mainly by increasing the number of very sheltered housing complexes towards a target of offering very sheltered housing in each area of Aberdeenshire. Some of our 63 sheltered housing complexes offer potential for remodelling and, using the Change Fund, plans have already been approved to remodel three sheltered to very sheltered housing complexes in localities where the growth in the older population is predicted to create the greatest pressure on living accommodation. These additional housing units will increase the number of very sheltered housing units from 135 to 243 by 2016.

Our commissioning intentions extend beyond this, however, and by 2018 we aspire to offer, in partnership with registered social landlords and private developers, very sheltered or extra care housing facilities embedded as part of communities where there is currently none or insufficient capacity, i.e. Marr, Banff and Buchan and Kincardine and Mearns, subject to available revenue. Three new council care homes are being developed within a care village concept which incorporates affordable housing for rent by older people on the same campus as our 24 hour care facilities.

A growing number of adults with learning disabilities are living longer and facing the challenges of ageing alongside their pre-existing conditions and disabilities. Extra care housing that can meet the particular needs of older adults with a learning disability will be a feature of our commissioning plans over the next 10 years and we anticipate that around 134 very sheltered flats in six complexes will be allocated to older adults with a learning disability.

C.4 Acute and Intermediate Health Care
Acute medical inpatient care will continue to be delivered in Aberdeenshire’s community hospitals for those patients whose illness can be diagnosed and treated without the expertise or facilities that are a feature of a major acute hospital. Over the next five years, we will explore opportunities to commission GP acute beds in care homes, particularly in remote and rural areas. Community hospitals will also continue to operate in-patient rehabilitation facilities although the number and configuration of these facilities will be subject to further review in the next five to ten years as we develop models of care which reduce reliance on in-patient care, shorten lengths of stay in hospital and increase the range of clinical interventions that can take place on an out-patient basis or in the patient’s own home.

C.5 Palliative and End of Life Care
Our vision in Aberdeenshire is to offer access to cohesive and equitable care for patients and families living with and dying from any advanced, progressive or incurable condition wherever people live in Aberdeenshire. Palliative care is the
treatment of a person’s symptoms where cure is no longer considered an option, usually when a patient is dying. Some people survive for many years with an incurable disease and effective palliative care helps them to experience a good quality of life. Palliation focuses on controlling pain and other symptoms, helping a person and their family to optimise their wellbeing through social, emotional and spiritual support.

Living & Dying Well, published in 2008, is Scotland’s national action plan for palliative and end of life care. A person-centred approach to good care and advance care planning is the key to Living and Dying Well. The importance of communication, collaboration and continuity of care across all sectors and at all stages of the patient journey is an important element of successful palliative care.

In 2008 35.6% of deaths in Aberdeenshire occurred in an acute hospital. Since that time we have put in place new services, staff training and pathways of care to reduce that number and allow more people to die in a place of their choice e.g. at home, in a care home or a community hospital. By adopting a strong joint approach to palliative and end of life care, the proportion of people from Aberdeenshire dying in acute hospitals in December 2012 had reduced to 29.9%, whilst those dying in care homes and community hospitals had risen by 3.8% and 1.8% respectively. There was a slight increase (1%) in those dying at home. Recent national research has demonstrated that individuals with the highest social care costs tend to have low average hospital costs (Georghiou, Nuffield Trust 2012).

Our forward plan, over the next three years is to build on the skills, confidence and expertise of care home and home care staff and to strengthen existing out-of-hours nursing care in partnership with Marie Curie and McMillan nurses and Roxburghe House, so that more people with terminal illnesses can die with dignity in a place of their choice.

An electronic Key Information Summary (KIS) of a patient’s medical history and preferences will gradually be rolled out nationally and across Grampian, replacing paper based information sharing between GP practices and GMeds Out of Hours medical service. This will ensure out-of-hours staff have up to date information about a patient’s wishes and care needs and will minimise inappropriate transfers.
Chapter 7: Workforce

7.1 Overview
Health and social care are services which rely on a skilled and committed workforce and in Aberdeenshire the partners are committed to working together to ensure a sufficient pool of people continue to choose to work in the health and social care field locally and have access to training, support and good career opportunities. In common with other parts of Scotland, and indeed, the UK, we are experiencing increasing difficulties in attracting sufficient applicants of the calibre we require to meet our requirements.

The Scottish Government’s proposals for formal integration of health and care are at an early stage. However these will add another dimension to the complexity of our workforce configuration. It is envisaged that staff will retain their current employer but increasingly will be working in multi-agency teams where different terms and conditions of employment apply and some single manager arrangements operate. Co-location of related disciplines in each locality will be a priority for the Partnership to explore in the next two years. Our aim will be to shorten lines of communication between professionals, make it easier and simpler for people to access the services they need in their locality or as close to home as possible. Simultaneously, we will be seeking to reduce the number of operational or office bases we use, accompanied by modern ways of working and digital technology which is compatible with both local authority and NHS systems. Integration may lead to merging of some services over the next three years, particularly support ones, which will generate retraining and redeployment opportunities.

The Aberdeenshire Partnership is committed to ensuring that all professional staff are mentored by someone from their own discipline to ensure that the highest professional practise is maintained.

7.2 Community Health Partnership
Aberdeenshire CHP employs 526 whole time equivalent (WTE) staff working with older people; this workforce has grown to 563 WTE staff following investment from the Change Fund.

Whilst many health professionals are engaged in delivering universal health care to all ages and care groups, we have apportioned average staff time which can be attributed to working with older people. Using whole time equivalents (WTE) 64 managers, 115 allied health professionals and 50 staff are employed by Aberdeenshire CHP to work with general practice. In addition 208 staff are employed in community hospitals and 81 in the community. Between 2012 and 2015 it is anticipated the number of managers will reduce slightly, allied health professionals and community nurses will increase by 27 and 8 respectively, whilst community hospital nursing staff will reduce by 8. At present the gender mix is 92% women: 8% men, and the ratio of part-time to full time staff 1.5:1. The CHP aims to have absence levels at 4% or less and with robust management in the last quarter of 2012s it was at 4.3%.

Aberdeenshire CHP aspires to maximise the skills of appropriately trained staff to ensure that people have the skills and training to do the jobs we need. This will require changes of grades/bands, changes in job roles, allocating relevant/appropriate tasks to the most appropriate/skills grade of staff, delivering the most cost effective outcome. An example of this is that we are working to
ensure that where reasonable and practicable, administration will be undertaken by professional administrative staff rather than clinicians.

Challenges include:

- enhancing and enriching job roles to maximise benefits to both patients and staff
- optimising skill mix to ensure the most effective models of care can be delivered
- maximising benefits to the whole system through the implementation of the recommendations of the Safe Affordable Nursing Establishment and Safe Affordable Workforce programmes
- working with local authority and other partners through the productive community programme
- introducing improved performance management locally, to ensure continued service improvement

The opening of ARI Emergency Care Centre in November 2012 and the planned reduction in Aberdeen Royal Infirmary (ARI) hospital beds will have an impact on the utilisation of ARI’s workforce. The CHP will provide opportunities for acute and community hospital staff to be redeployed to community based roles in line with our reshaping care strategic objectives.

New ways of working will form a key element of our workforce strategy, revisiting core values and reinforcing essential attributes of good practice:

- being more patient centred, involving the patient, their family and friends in the design of their care and support;
- encouraging autonomy and participation as far as possible;
- supporting anticipatory care;
- adopting a rehabilitation and re-ablement approach to working with all patients;
- local, rapid access to diagnosis and treatment;
- minimising dependence on statutory providers (using a co-production approach);
- performance managing an average length of stay in community hospital GP acute wards of 12 days and bed occupancy level of 80%, enabling 80% of unscheduled admissions from Aberdeenshire being able to be admitted to Aberdeenshire community hospitals.

Currently the CHP is experiencing some difficulties recruiting qualified and unqualified nursing staff in some areas, particularly Marr and Garioch, and some challenges are presenting in attracting GPs to some areas, particularly Banff and Buchan.

### 7.3 Aberdeenshire Council

Aberdeenshire Council Social Work service employs 1,760 staff working with older people. Of these 139 (106.6 WTE) are professionals, such as care managers, care home managers and occupational therapists; 796 (438.3 WTE) are para professionals working in the community, such as home carers; and 699 (464.5 WTE) are para professionals working in long term housing and care settings, such as sheltered housing and care home staff. A further 126 (99.3 WTE) provide support services which range from commissioning and contracting through staffing and administration to finance and accountancy.
The workforce reflects the same distribution of ethnicity as the residents of Aberdeenshire and reflects the same proportion of people with disability as the rest of the Council workforce, around 4.5%.

It is primarily a female workforce. 90% of professionals are female and 96% of paraprofessionals are female. This presents a challenge in respect of the paraprofessional workforce as younger women tend to be responsible for families and these demands tend to clash with the shift patterns required of them.

The following graph shows this, it also shows that 52% of paraprofessional community staff are already 50 and older, with 34% 55 and over. It is not dissimilar for professionals (49% and 25%) and paraprofessionals in long term settings (48% and 30%).

As most paraprofessionals appear to move into this career in middle age this age distribution may be of less concern than for the professionals.

**Figure 23: Paraprofessional Community Staff by Age and Tenure**
However, Aberdeenshire is starting to experience some difficulties in recruiting and retaining paraprofessional staff in the context of a local economy with high employment. It is undertaking a number of recruitment initiatives to attract more people, especially younger people, into a career in care.

Working time lost by professional staff working with older people is 3.4% or 6.8 days per year, which is recognised as appropriate, and better than the overall Council average of 5.3%. However, there is concern that for paraprofessionals the sickness level is 9.5% or 15.7 days per year and this has a detrimental effect on the quality and consistency of care provided. Managers are taking a supportive but robust attitude to absence management as a reduction, particularly in short term absence, would greatly improve overall levels of provision and quality of care.

7.4 The Independent Sector
The Council also commissions services from the independent and third sector, who employ similar staff, and are having similar recruitment and retention issues. There is no single source of information about the third and independent sector workforces for older people but we are in dialogue to consider how to size. The Scottish Social Services Council has recently provided us with some data on workforce but it includes information only on registered services and includes provision for all adult and older people’s services. As such it is only an indicator for this strategy.
Table 10; Aberdeenshire Staff by sector in Adult and Older People's Registered Services 2011

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<th>Voluntary Sector</th>
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<td>&amp; Care at Home</td>
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<tr>
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<td>1,840</td>
<td>3,060</td>
<td>1,038</td>
<td>5,938</td>
</tr>
</tbody>
</table>

Some of the independent sector are starting to withdraw from some areas and the Council has had to raise the rates it purchases at, although this might not assist.

Some providers are starting to recruit abroad from European countries with severe unemployment but this may have consequences in the longer term, if their home countries economy recovers. It will also be important from a qualitative perspective that the staff are linguistically fluent and understand the North East culture and this will require significant training to take place.

7.5 Challenges

The care workforce is older and so many will be retiring in the next ten years. There is a real challenge to recruit and retain all grades of staff and this situation is exacerbated by a general high level of employment opportunities across Aberdeenshire.

As the service increasingly moves from an institutional to a community service, training requirements change and staff need to be more self reliant. There is also a need to ensure all staff understand and can address individual needs and outcomes as services become more personalised. All staff need to understand and operate within a recovery, rehabilitation and re-ablement model and for some this includes the challenge of stepping back and reducing activities which encourage dependency. Training has started to be delivered in these areas and needs to be further enhanced.

The Scottish Social Services Council (SSSC) have set requirements for registration and training in the near future for many para professionals within social care and all sectors have robust training plans in place to meet these challenges.

As older people live longer it naturally follows that their informal carers are aging too. This means that we cannot expect too much of them and must ensure they get the support they need to continue to care. This may be more actual support and respite, although individual budgets may allow more tailored and often more cost effective options. Significant levels of training for informal carers are being provided and seem greatly appreciated. Informal carers should be provided with the skills required to deliver the best quality care. Many, once they are no longer carers themselves, stay in many settings supporting other carers.

A previously untapped area of skill could be found through more effective use of transferable skills of patients, families/friends, informal carers and the wider community through the development of co-production initiatives and peer support. The Change Fund has allowed a number of community workers to be employed.
and it is hoped that they will empower communities, often of older people to organise activities, mutual aid and even some services for themselves.
Chapter 8: Involving and Engaging People

8.1 Capturing Views of Older People and Their Carers

“Is it only when you become like me that you will hear what I have to tell you?”
(From – ‘A Better Life’ by Sir Andrew Motion)

It has been essential to the development of the Joint Commissioning Plan for Older People that the views of older people, their families and carers, and the wider community were incorporated.

This process has been underway for many years as part of Aberdeenshire’s standard practice in service planning and development, adhering to national standards in community consultation and engagement. It has long been recognised now that a diverse approach to consulting and engaging with older people, families, carers, and the wider community is important. One approach is not sufficient and risks excluding certain groups.

Within the delivery of health and social care services, individual views are captured through the assessment, care planning and review processes. Views from individuals and groups are also obtained through the use of surveys, consultation events, and the use of independently commissioned research.

Recent examples include:

- Ageing Well 2008, a conference involving 66 older people as well as professionals from across Aberdeenshire
- Carers consultation events in 2009, to which 200 carers came to talk to elected members and senior managers
- Quarterly carers forums facilitated by VSA throughout Aberdeenshire
- ‘Talking Points’ survey in June 2010 of 320 service users and 102 carers
- Lowland Market Research into Care and Accommodation Needs of Older People (August 2010) (focus group methodology)
- Evaluation of Dalvenie Gardens, Banchory, a very sheltered housing and day resource complex, where the views of 90 people were recorded.
- Surveys of care home residents
- Development of a network of older peoples’ forums (‘Your Voice’)
- Citizen Panel Surveys on accommodation and care for older people (2010); and this joint commissioning strategy for older people (Nov 2012)

Consistent messages from these consultations and engagements have told us:

- most users, but not all, are satisfied with the involvement they have in planning their care arrangements
- most service users, but not all, feel safe
- older people need better information on housing options
- more people should have access to a diagnosis of dementia at an earlier stage and should have better access to support when they need it
- accessing respite and day services should be easier
- carers need better information about respite care and short breaks
- training should be available for informal and family carers
- quality of care services should be consistently high
- we need to listen more to people’s views about what they need and make consultation local
we need to increase the numbers of carers who have been offered an assessment of their needs
people are particularly prone to isolation and depression after the onset of chronic illness and bereavement

8.2 ‘Your Voice’ – Network of Older Peoples Forums
In 2010, Mearns and Coastal Healthy Living Network were commissioned to develop a network of older people’s forums across Aberdeenshire. This was in recognition that a mechanism for older people to articulate and communicate their views about the development of health and social care services was required.

A community capacity building approach was expressly taken, incorporating the principles that groups should aim to be self-sustaining, identify their own strengths and those of their localities, develop their own solutions rather than expecting ‘more of the same’ from the statutory agencies, and complement other forms of consultation.

9 groups are active in Inverbervie, Laurencekirk, Portlethen, Peterhead, Cuminestown, Fraserburgh, Banff, Ellon and Insch. Issues identified have included:

- the difficulty of understanding how the health and social care system works
- transport
- support to live at home
- social isolation and access to day activities
- remaining part of the community when living in a care home

7 groups were visited as part of the consultation about this strategy. A healthy variety of views were expressed about health and care services, and about the experience of ageing in general, often reflecting the wide variety of views held in the general population. More needs to be done to improve society’s understanding and appreciation of ageing, including strengthening inter-generational understanding and support. Views were divided on the role of families in caring – some felt the family needs to play a greater role, whilst others felt that they did not wish to increase the burden on their families. Having sufficient money to live on was extremely important.

Support to maintain independence at home was given a high priority, including support to combat isolation, health screening, improvement to care at home services, assistance in home maintenance and better aids and adaptations. Improvements in waiting times to see the GP and ancillary health services, decentralisation of hospital treatments, speedier housing adaptations, patient laundry services and hospital transport were identified as key areas for improvement.

Finally, the GP surgery retains a high profile for older people as a source of information about help and support.

8.3 Consultation on the Joint Commissioning Strategy
The draft Joint Commissioning Strategy for Older People was consulted on in October and November 2012 by means of an online and paper questionnaire.
201 responses were received, expressing general support for the themes and direction of the Plan (Appendix C):

- An active lifestyle is good for health and well-being
- Diagnosis and treatment is better received at the GP practice and community hospital
- Resources should focus on enabling quick recovery and re-ablement following illness
- Increase the range of accommodation available for older people
- Improve quality of long-term care

There is no room for complacency, however. 44% of responses did not perceive standards of care in Aberdeenshire to be good or improving.

8.4 Citizens Panel
The Aberdeenshire Citizens Panel comprises a representative cross section of the general public, who are surveyed twice a year. As part of the consultation, an online survey about the themes of the Plan was conducted with a small sample of the Panel. The full November 2012 survey (Viewpoint 31) consulted the Panel on the Joint Commissioning Plan. The report from the online survey is attached at Appendix D. The full survey report is not published until March 2013, but an interim report is attached at Appendix E. The full report will be available online at http://www.aberdeenshire.gov.uk/consultations/citizens/index.asp

The majority of the respondents to the online survey supported the importance of the three main themes of the Plan, but were not aware of the extent they were being developed at present in current services. The most important theme to respondents was that of early intervention and prevention. The full Citizens Panel confirmed that early intervention and prevention was the most important priority.

There was overwhelming agreement that:

- Active lifestyles are important
- Recovery and support to self-care independently should be a priority
- Local treatment and diagnosis is important
- Increasing the range of accommodation for older people is a priority
- Improving the quality of care in all settings is a priority

However, there was less agreement that:

- Services supported people to eat healthily, stay active and connected
- Standards of care were good or improving
- People should take sole responsibility for maintaining an active lifestyle
- There is an appropriate range of accommodation when people need long term treatment and support.

8.5 Taking Action
The progress report on Aberdeenshire’s Change Plan 2011-2013 summarises what we have been doing to respond to these priorities (Appendix G).

The response to the range of views expressed and summarised below is contained within Chapter 6 on the Strategic Commissioning Intentions for 2012-2022. People have told us improvements are required in:
- Helping people to understand how the health and social care system works (Integration of Health and Social Care)
- Promotion of the understanding and appreciation of ageing, including intergenerational understanding and support. (Public expectations, charging for care and the mutual care debate)
- Transport & Hospital Transport (Reducing Inequalities)
- Support to live and maintain independence at home (Rehab & Reablement, Care At Home Telehealthcare)
- Reducing social isolation and access to day activities (Living Well in Later Life and Day Support Activities)
- Enabling people to remain part of the community when living in a care home (Long Term Care)
- Waiting times to see the GP and ancillary health services (Reducing Inequalities)
- Decentralisation of hospital treatments (Scheduled and Unscheduled Care)
- Speedier housing adaptations (Integration of Health and Social Care)
- Improving quality of long-term care and standards of care in all settings (Improving Long Term Care)

What is important:

- Promotion of an active lifestyle as good for health and well-being (Living Well in Later Life)
- Diagnosis and treatment being better at the GP practice and community hospital (Diagnosis and Treatment)
- Focussing resources on enabling quick recovery and re-ablement following illness (Rehabilitation and Enablement)
- Increasing the range of accommodation available for older people (Housing With Support)
Chapter 9: Conclusions

Older people form the majority of users of all health and social care services. However, most older people receive no formal ongoing care, and many older people are carers themselves.

In 2011 the proportion of older people (17%) in Aberdeenshire is slightly lower than the Scottish average, but the proportion of over 85s (2%) is comparable. Growth in the proportion of older people is the most significant change we face in our population due to increases in life expectancy. The biggest increase by far is expected in the 75+ age group (131% in 2035 compared to 2010). Overall, there will be a 96% increase in the population aged over 65 by 2035. The rate of increase in the over 65 population is similar across Aberdeenshire. The total population is increasing but has been relatively young in the past. In Aberdeenshire the older population is comparatively wealthy and healthy.

Aberdeenshire aims to challenge stereotypes and respect and value older people and the contribution they make; to assist older people to add healthy years to their lives: to improve personalisation, choice and control; to shift public attitudes to aging, recovery and self care, and to shift the philosophy of care from *interventions done to people to people helping themselves with support, guidance and access to professionals when necessary*.

Some of the challenges outlined include the fact that people are living longer than expected and there is an increasing prevalence of long term conditions such as diabetes and dementia, but they are having an improved quality of life by being assisted to self manage their conditions. There will be a renewed focus on targeting the preventable or modifiable diseases of old age such as stroke, dementia, coronary heart disease, COPD, diabetes and cancer through regular physical and mental exercise, diet, smoking cessation and reducing alcohol consumption.

The strategy outlines the three strands of future commissioning: early intervention and prevention, rehabilitation and enablement and improving the quality of long term care.

Underpinning our themes is an important philosophy that we want people to live well in later life by helping older people to keep healthy, remain independent for as long as possible, have access to high quality health and social care when required and to assume their rightful place as valued members of the community.

In respect of early intervention and prevention we already have a vibrant community life in Aberdeenshire and where it is less strong we are supporting a co-production and community development approach. We are ensuring that older people are aware what will keep them mentally and physically healthy and ensuring that there are opportunities for people to be active, connected to other people, able to take notice, learn and give.

Rehabilitation and enablement means that we no longer merely support people but encourage and assist them to recover. We will be changing service models to help people recover optimum cognitive and physical abilities; improve choice and control and systems of self-care and help older people to feel safe and secure in their homes and communities.

Improving quality of long term care includes ensuring access to high quality, specialist health and care when needed, providing a choice of accommodation with care options in later life, being supported to maintain circles of support and interests throughout old age and being able to live and die well in a place of choice.

Whilst we strive, by pooling health and care budgets and redesigning services to be able to invest in new ways of working it does appear that whilst we may be able to care for many older
people within the same resource envelope, it may not be possible to disinvest to allow further growth in new services.

There would also appear to be challenges in regard to recruitment and retention of health and social care staff in Aberdeenshire and we will require investing in training for new ways of working.

In conclusion this strategy, developed with older people and all community planning partners, has analysed the current and predicted trends, reviewed our current responses and outlined our future commissioning intentions.

Each year an action plan supported by our joint performance framework will be drawn up to ensure that what is outlined in our strategy is delivered effectively and efficiently. This will be overseen by the Older Peoples Strategic Outcome Group reporting to the Health and Community Care Partnership and to the Community Planning Partners.
APPENDICES

A. Joint Resource Framework 2012-14
B. Integrated Resource Framework 2010-11
C. Consultation Results
D. Citizens Panel Online Survey Results
E. Citizens Panel Interim Report – Viewpoint 31
F. Aberdeenshire Change Plan Progress Report January 2013
G. Equality Impact Assessment
H. Environmental Screening
I. Housing Contribution Statement
### Appendix A: Joint Resource Framework 2012-14

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<th>2012/13</th>
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<th>NHS Resource Transfer £'000</th>
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### Appendix B: Integrated Resource Framework

#### C3 Split in balance of care for +65's

**2008/09**

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**TOTALS**

| 48,11 | 115,7 | 163,8 | 4,616 |

| Weighted population (000's) | 35   |

| Expenditure/head (£) | 4,616 |

| Institutional | 2,858 | 62% |
| Non-institutional check | 1,759 | 38% |

#### 2009/10

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Weighted population (000's) 35
Expenditure/head (£) 4,943

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**2010/11**

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Institutional
- **3,164** 62%
- **1,899** 38%

Total: **5,063** 100%

Check: **5,063** 100%
Appendix C: Consultations Results

Consultation on Draft Joint Commissioning Strategy

In October and November 2012 we undertook a consultation process with the general public, including settings where there were older people, carers and carers forums, staff in the Council and Health and with our providers. We briefly outlined the purpose, rationale and themed direction for our Joint Commissioning Strategy for Older People and used an online and paper format questionnaire.

There were 201 written responses although not everyone answered all questions. The results were as follows:

86% were broadly content with the direction of the strategy.
Of those who expressed disagreement, 3 remained angry about changes to the warden service in Sheltered Housing and 3 were unhappy about lack of out of hours health and social care support; 7 were cynical about whether there would be staff and/or funding to deliver the strategy, 1 commented on charging for care homes, 1 on respect for what older people wanted, 1 each commented on computer access for older people, wanted same day access for frail older people to see GP and that by 2025 working to 70 so should we change definition of older people

100% were aware that an active lifestyle throughout old age is good for a person's health and wellbeing.
People were invited to make suggestions as to how to get older people to be more active, engaged and learning.
27 suggested that older people need to be encouraged to get or stay involved,
20 suggested exercise is important and suggested gentle exercise, walks, Tai Chi, dance and sessions for older folk at swimming pools and sports centres,
21 suggested more activities should be arranged and more communal centres & sheltered housing opened for meals and activities,
13 focused on the need for transport and low cost or free activities.
10 said it is important to keep doing all one can and to be aware of consequences of stopping,
8 reminded about the importance of diversity and choice,
7 suggested more publicity for local activities, circulars etc,
6 advised older peoples skills can be used by communities
3 wanted more intergenerational activities
2 suggested volunteering,
1 suggested training in computer skills opening many doors

90% agree that it is better for older people to receive diagnosis and treatment at their GP practice and local community hospital than in Aberdeen.
Most of those who disagreed mentioned the need for additional expertise or resources, 2 criticised one community hospital and one their GP.

95% agree that the NHS and LAs should focus their resources on supporting older people who experience illness to recover quickly and regain their abilities to self care independently, as far as possible.
Concerns expressed focused on the current position with the lack of sufficient staff time, especially the lack of physiotherapists and Occupational Therapists with a number wanting to know how to access such a service.

86% were aware local health and social work services are already supporting people in Aberdeenshire to recover from illness and helping them to manage independently. However, 14 felt they knew little about such a service, 26 complained about long waits and/or lack of help especially for therapies, rushed or poor support, 9 praised services they had received, a few made comments about loneliness/lack of encouragement and not being valued or listened to.

90% agreed that over the next ten years we should focus on increasing the range of accommodation available for older people in Aberdeenshire to help them live independently. Concerns were expressed by 15 about the current level of care and support in Sheltered Housing complexes and 3 about people with high needs not receiving the required level of support.

85% agree that we should focus on improving the quality of care in all settings not least by encouraging more voluntary, family, and community involvement. 18 worry about families who are too far away, about people without family and for existing informal carers getting old and too much being expected of them, 4 resent it as a "cheap" option and 4 worry about the reliability/ vetting /Health and Safety and management of volunteers.

56% perceive standards of care for older people in Aberdeenshire as good and improving. 27 were critical of current services in general, 18 specifically criticised recent Sheltered Housing changes, 13 criticised lack of home carers and pressure on them to deliver in too short a time, 3 referred to loneliness, 2 expressed concern about the lack of monitoring of frail older people who live alone, one stated need to expand rehabilitation teams and another was concerned by the lack of a housework service.

89% do not think we have omitted anything from our strategy. Areas that people felt had been omitted from the strategy include the need to instil confidence and self esteem in older people, better access to equipment, transport for rural communities including communal facilities, continuity of care, being included in discussions about care, complementary therapies, better out of hours medical care, earlier diagnosis of bladder and bowel problems to reduce urinary tract infections, and more mini hospitals.
Appendix D: Citizens Panel Online Survey Results

In Aberdeenshire we also have a Citizens Panel comprising of a representative section of the general public. An online survey was undertaken with a subset of the panel, who are willing to participate in extra online surveys, to gauge their initial thoughts with regard to our Joint Commissioning Strategy’s emerging themes of:

- Prevention and early intervention
- Rehabilitation and enablement
- Quality, choice and control in long term care.

A total of 164 responses were received (a response rate of 39.5%) and these responses form the basis of the following feedback.

Respondents were asked to what extent they felt that the theme of early intervention and prevention was important and the result of this is shown in Figure 25

As can be seen, a majority of respondents felt that this theme was ‘very important’ (73% of those who gave a definitive answer) with a further 24% feeling that it was ‘quite important’. Only 3% of respondents felt that this theme was ‘neither important nor unimportant’.

**Figure 25: Importance of Early Intervention and Prevention**

Respondents were then asked about integrated rehabilitation and enablement. Their perceived importance of this theme is illustrated below.
Again, a majority of respondents felt that this theme was ‘very important’ with 73% answering this way and 24% feeling this theme to be ‘quite important’. 3% felt that this theme was ‘neither important nor unimportant’.

The third theme is quality, choice and control in long-term care and the perceived importance of this theme is summarised below.

A somewhat higher proportion of respondents considered this element to be “very important” (84%) and no respondents considered this element to be unimportant.

Given that there was a high level of importance given to each of the three themes that are the focus of the survey, it is important to consider the relative importance of each of these themes. To do so, respondents were asked to rate each of the themes in order of importance (ranking these 1, 2 and 3); the results of this are shown below.
Figure 29: Importance of Themes

From this analysis, it is clear that the most important theme to respondents (relative to the other themes) is that of early intervention and prevention (58% of respondents who provided a response to this question ranked it as the most important theme) followed by quality, choice and control in long-term care (24% ranking this as the most important theme) and integrated rehabilitation and enablement (18% ranking this as most important).
Appendix E: Citizens Panel Interim Report – Viewpoint

Citizens Panel Interim Report Feb 2013

The following question was posed to respondents to identify their views on priorities for the Joint Commissioning Strategy for older people:

“The draft Aberdeenshire Joint Commissioning Strategy has the following three themes. Please tell us how effective you think each of these approaches will be over the next ten years in helping to meet the health and care needs of older people in Aberdeenshire.”

Respondents were asked to rank these three elements 1, 2 and 3. The results for the most important element are shown in Figure 30 below:

---

**Figure 30: Joint Commissioning Strategy for Older People (Most Effective Theme)**

- **Prevention and early intervention**: 60%
- **Quality, choice and control in long-term care**: 21%
- **Rehabilitation and enablement**: 19%

Base: 713

---

Overall, a significant majority of respondents highlighted “prevention and early intervention” as the “most effective” approach from the three choices provided with a broadly similar proportion identifying “quality, choice and control in long-term care” and “rehabilitation and enablement” as the most effective approach (21% and 19% respectively).

The full results, containing respondents’ top three rankings are shown in Table 11. It should be noted that some figures may not sum to 100% due to rounding and also that results have been expressed as a proportion of those that provided any ratings for this question (i.e. a very small number of respondents provided a top rating but not a second and / or third rating).

These figures suggest that the majority of respondents overall place “rehabilitation and enablement” as their second choice for the most effective approach behind “prevention and early intervention”.

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01 03 2013  JCS for OP Version 32  94
Table 11: Joint Commissioning Strategy for Older People (prioritisation of all three themes)

We have broken down results for this question by location, age and gender in Table 12 below:

Table 12: Joint Commissioning Strategy for Older People “Most Effective” Theme (Breakdown)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Ranking of Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
</tr>
<tr>
<td>Prevention and early intervention</td>
<td>60%</td>
</tr>
<tr>
<td>Quality, choice and control in long-term care</td>
<td>21%</td>
</tr>
<tr>
<td>Rehabilitation and enablement</td>
<td>19%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent Characteristic</th>
<th>Prevention and Early Intervention</th>
<th>Quality, Choice and Control in Long-Term Care</th>
<th>Rehabilitation and Enablement</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Banff and Buchan</td>
<td>60%</td>
<td>15%</td>
<td>25%</td>
<td>96</td>
</tr>
<tr>
<td>Buchan</td>
<td>53%</td>
<td>28%</td>
<td>19%</td>
<td>113</td>
</tr>
<tr>
<td>Formartine</td>
<td>59%</td>
<td>19%</td>
<td>22%</td>
<td>146</td>
</tr>
<tr>
<td>Garioch</td>
<td>62%</td>
<td>18%</td>
<td>21%</td>
<td>130</td>
</tr>
<tr>
<td>Kincardine and Mearns</td>
<td>59%</td>
<td>23%</td>
<td>18%</td>
<td>110</td>
</tr>
<tr>
<td>Marr</td>
<td>64%</td>
<td>21%</td>
<td>16%</td>
<td>107</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45s</td>
<td>56%</td>
<td>24%</td>
<td>20%</td>
<td>162</td>
</tr>
<tr>
<td>45-64s</td>
<td>61%</td>
<td>19%</td>
<td>20%</td>
<td>376</td>
</tr>
<tr>
<td>Over 65s</td>
<td>59%</td>
<td>24%</td>
<td>18%</td>
<td>164</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>64%</td>
<td>19%</td>
<td>17%</td>
<td>324</td>
</tr>
<tr>
<td>Female</td>
<td>55%</td>
<td>23%</td>
<td>22%</td>
<td>378</td>
</tr>
<tr>
<td>Overall</td>
<td>60%</td>
<td>21%</td>
<td>19%</td>
<td>722</td>
</tr>
</tbody>
</table>

Whilst the general pattern of responses is broadly similar, there are some modest distinctions that are worth noting:

- Banff and Buchan respondents were slightly more likely to see “rehabilitation and enablement” as the most effective theme.

- Buchan respondents were slightly less likely than others to see “prevention and early intervention” as the most effective theme, although a majority still did so; they were significantly more likely than others to see “quality, choice and control in long-term care” as the most effective theme).

- Under 45s were slightly less likely to see “prevention and early intervention” as the most effective theme (although a majority still did so).
Males are more likely than females to see “prevention and early intervention” as the most effective theme (although it is still a majority for both groups).

Separate data tables have been provided with a full breakdown of responses.

A further set of statements were put to respondents and they were asked about their level of agreement or disagreement with these statements. The overall results are tabulated in Table 13 below:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree Strongly</th>
<th>Agree</th>
<th>Neither / Nor</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
<th>Don’t Know</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>An active lifestyle throughout old age is important for a person’s health and wellbeing.</td>
<td>63%</td>
<td>35%</td>
<td>2%</td>
<td>&lt;1%</td>
<td>0%</td>
<td>&lt;1%</td>
<td>732</td>
</tr>
<tr>
<td>People should take sole responsibility for maintaining an active lifestyle and the NHS and Council have no role to play.</td>
<td>5%</td>
<td>22%</td>
<td>23%</td>
<td>40%</td>
<td>9%</td>
<td>1%</td>
<td>729</td>
</tr>
<tr>
<td>Local Health and social work services support people in Aberdeenshire to eat healthily, stay active and remain connected in the community as they get older.</td>
<td>9%</td>
<td>39%</td>
<td>32%</td>
<td>9%</td>
<td>2%</td>
<td>8%</td>
<td>724</td>
</tr>
<tr>
<td>It is better for older people to receive diagnosis and treatment at their GP practice and local community hospital than in Aberdeen.</td>
<td>46%</td>
<td>44%</td>
<td>7%</td>
<td>2%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>732</td>
</tr>
<tr>
<td>Statement</td>
<td>Agree Strongly</td>
<td>Agree</td>
<td>Neither / Nor</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Don’t Know</td>
<td>Base</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>---------------</td>
<td>----------</td>
<td>-------------------</td>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>A priority for NHS and Council resources over the next 10 years should</td>
<td>42%</td>
<td>53%</td>
<td>4%</td>
<td>1%</td>
<td>&lt;1%</td>
<td>1%</td>
<td>733</td>
</tr>
<tr>
<td>be supporting older people who experience illness to recover quickly and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>regain their ability to self-care independently as far as possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The NHS and social work services support older people who</td>
<td>24%</td>
<td>39%</td>
<td>22%</td>
<td>6%</td>
<td>2%</td>
<td>6%</td>
<td>730</td>
</tr>
<tr>
<td>experience illness to recover quickly and regain their ability to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>self-care independently as far as possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A priority for NHS and Council resources over the next 10 years</td>
<td>38%</td>
<td>46%</td>
<td>11%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>729</td>
</tr>
<tr>
<td>should be increasing the range of accommodation available for older</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>people in Aberdeenshire, to help them live independently. This</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>may include fewer hospitals and care homes, more sheltered housing and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>more adaptations to existing housing so people can stay at home.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In relation to some of these statements, there is an overwhelming level of agreement (albeit a significant proportion indicate that they “agree” rather than “strongly agree”). Examples include:

- The perceived importance of active lifestyles for older people (98% agreement).
- The view that it should be a priority to help people recover and self-care independently (95% agreement).
- The preference for older people to receive their treatment and diagnosis locally (90% agreement)
- Agreement that a priority for NHS and Council resources over the next 10 years should be increasing the range of accommodation available for older people in Aberdeenshire, to help them live independently (84% agreement).
• Agreement that a priority for NHS and Council resources over the next 10 years should be improving the quality of care in all settings (81% agreement).

Overall agreement is somewhat lower but still represents a clear majority of respondents with regard to the view that the NHS and social work services support older people who experience illness to recover quickly and regain their ability to self-care independently as far as possible (63% agreement).

With respect to the remaining statements, opinions are much more divided with only a minority expressing outright agreement with the statements. The statements in this category include:

• Agreement that local Health and social work services support people in Aberdeenshire to eat healthily, stay active and remain connected in the community as they get older (48% of respondents did agree with this statement and only 11% expressly disagreed but the remainder of respondents gave a neutral or “don’t know” response).

• Agreement that standards of care for older people in Aberdeenshire are good (30% agreed with this statement and, whilst only 15% expressly disagreed, 37% gave a “neither / nor” response and a further 18% gave a “don’t know” answer.

• The view that people should take sole responsibility for maintaining an active lifestyle and that the NHS and Council have no role to play (although 28% agreed with this statement, 49% expressed outright disagreement).

• Agreement that there is an appropriate range of accommodation choices in Aberdeenshire for when people need long term treatment and support (26% agreed with this statement but 32% expressed disagreement with the balance giving neutral and “don’t know” responses).

• Agreement that standards of care for older people in Aberdeenshire are improving (24% agreed with this statement and, whilst only 12% expressly disagreed, 40% gave a “neither / nor” response and a further 23% gave a “don’t know” answer.

The reader is referred to the accompanying data tables for a full breakdown of these responses by location, gender and age.
Appendix F: Aberdeenshire Change Plan Progress Report January 2013

Theme 1 – Early Intervention and Prevention

Early screening for falls
Significant numbers of individuals identified and offered support

Falls classes
Classes are continuing and those individuals who have completed the programme have improved function. Patient satisfaction with the classes has been high.

Point of Care testing
GPs have been trained and the project continues to produce good outcomes for people. Project has been evaluated. Patient experience has been improved by providing tests locally and reducing the need to travel to Aberdeen.

Cardiology in Aboyne
This service has not yet started due to shortage of cardiology staff

Colonoscopy
GP training underway and will be completed by May 2013. The service will be evaluated

X-Ray facility in Aboyne/Inverurie
This is expected to be operational during 2013/14.

Low Vision Clinic
This will start in April 2013

Redesign of heart failure service
Three specialist nurses provide support to primary care patients and are an educational and advisory support to GP practices, community and ward bases nurses and the multi-disciplinary teams.

Uptake of LES
Patients with a high risk of admission to hospital are identified and will benefit by having an Anticipatory Care Plan which will reduce the risk. For early implementer practices, an average of 10% reduction in emergency occupied bed days was achieved.

Action Learning Sets
Action Learning Sets or ALS have created opportunities for GPs, team managers and practitioners to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care.

Enhanced Pulmonary Rehabilitation
Classes taking place throughout Aberdeenshire delivered by a physiotherapist and support worker.

Improvement of assessment and care management
All care managers have been trained in outcome-focused assessment. Assessment is located in care management, and additional senior practitioner, care management and local area coordinator posts have been created to improve capacity.
Investment in Preventive Services and Co-Production
16 projects, managed within the third sector, have been invested in, building community capacity and developing preventive services. These include signposting GP patients to community supports and connecting individuals to provide mutual support, shopping services, screening for falls and quick access to repairs by Care and Repair, a men's shed, arts participation, developing community capacity in sheltered housing, creative arts work with people with dementia, developing walking groups’ networks and a walking strategy, development of older peoples’ forums, befriending in hospital, and hospital transport.

Link Workers, Alzheimer Scotland
Three link workers will provide post diagnostic support to people newly diagnosed with dementia. Project started February 2013.

Psycho-social programme for family carers of people with dementia
This 18 month project aims to develop and implement a psychosocial programme to improve post diagnostic support and training for people with dementia and their carers who live in the community.

Theme 2 – Rehabilitation and Enablement

Early Implementer Rehab and Enablement Teams
Three early implementer multi-disciplinary rehab and enablement teams have been funded to provide rehab and enablement to individuals, increasing independence and reducing the need for care at home, using goal-setting, and care planning over a short period of intervention. Independent evaluation has been funded to commence Feb 2013 (2.1.11).

Telehealthcare
Investment in additional telehealthcare equipment and technician support is increasing the proportion of people supported at home.

Liaison Nurses AMAU
This project aims to discharge patients home or transfer patients to a local community hospital within 72 hours of their admission to AMAU.

Additional Physiotherapy at Aboyne Hospital
Physiotherapy now provided 5 days a week instead of 2.5 days. This has reduced length of stay.

Expansion of ARCH
Major investment made to develop and expand out-of-hours home care response service. Recruitment and redesign of shift patterns is underway.

AMPS Training
This course will run in September 2013 (1 week of tuition) and will improve the standardised quality of OT assessments in the area of A.D.L.

Staffing levels at Joint Equipment Store increased

Increase in AHP time at Community Hospitals
Increased OT and Physiotherapy cover for community hospitals to deliver a 5days/week service to reduce delays and lost admission days where patient is not seen and assessed
Redesign of Day Care Provision
Project Officer post funded to lead on a redesign of day services for older people.

Use of dementia design principles for housing providers
Two housing staff trained.

Senior Improvement Officer for ALS
Action Learning Sets

Theme 3 – Improve Quality of Long Term Care

Increase number of VSH Units
Investment in remodelling 3 sheltered housing complexes to very sheltered housing. Another is at feasibility study stage.

Redesign of 24 hour community based palliative care
A project with Marie Curie to provide consistent and equitable out-of-hours nursing care to palliative care patients. The service operates from Peterhead and Stonehaven. This allows patients to remain in their preferred place of care.

Palliative care training for care home staff
All relevant care home staff in Aberdeenshire care homes trained in palliative and end-of-life care. Project completed.

Project Manager Palliative Care
The project manager will continue to visit care homes (see 3.2.2) and is providing this training to staff in community hospitals.

Short Breaks and Respite Options
Development of opportunities for creative, innovative and flexible short breaks for carers, and in particular older carers.

Carers Co-ordinators
Additional local area coordinators appointed to carry out carers’ assessments.

Support for Older Carers
Three Carers Support and Development Workers and Information Officer have been appointed in VSA to support older carers.

Best Practice in Dementia Care
Staff seconded and training packs purchased to deliver training in best practice in dementia care for care home, care at home, day services and health care staff.

Independent Sector Mentor
Project officer appointed to support care home managers in sharing good practice.

Communications Officer
Communications officer appointed to promote positive messages about ageing and raise awareness of reshaping care for older people.

ALS Facilitation for Health and Community Care Strategic Partnership
Action Learning Sets with members of the Health and Community Care Strategic Partnership. These will be completed by May 2013.
Appendix G: Equalities Impact Assessment

**EQUALITY IMPACT ASSESSMENT**

<table>
<thead>
<tr>
<th>Stage 1: Title and aims of the activity (“activity” is an umbrella term covering policies, procedures, guidance and decisions).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service.</strong></td>
</tr>
<tr>
<td><strong>Section.</strong></td>
</tr>
<tr>
<td><strong>Title of the activity etc.</strong></td>
</tr>
<tr>
<td><strong>Aims of the activity.</strong></td>
</tr>
<tr>
<td><strong>Signature</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2: List the evidence that has been used in this assessment.</th>
</tr>
</thead>
</table>
| **Internal data (customer satisfaction surveys; equality monitoring data; customer complaints).** | Aberdeen Change Plan Performance Indicators  
Single Outcome Agreement P.I.s  
Housing and Social Work Service Plan P.I.s  
Ethnic Monitoring Data from LA and NHS systems  
Activity data from Housing and Social Work Carefirst and Northgate systems, and NHS (Local Health Intelligence and ISD) |
| **Internal consultation with staff and other services affected** | Responses from consultation on Joint Commissioning Strategy for Older People via online survey and public leaflet. |
| **External consultation (partner organisations, community groups, and councils).** | Ageing Well Conference 2008  
Talking Points Survey 2010  
‘Your Voice’ Older Peoples Forums  
NHS Grampian Public Forum October 2012  
Citizens Panel Surveys – Viewpoint 22 (Transport and Accommodation and Care for Older People) 2011  
- Viewpoint 24 (Caring for Others in the Community) 2011  
- Viewpoint 31 (Joint Commissioning Strategy for Older People)  
- Online Citizens Panel Survey (Joint Commissioning Strategy for Older People) Nov 2012 |
## Stage 3: Evidence Gaps.

<table>
<thead>
<tr>
<th>Are there any gaps in the information you currently hold?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment from representatives of protected groups (Race, Religion, Sexual Orientation, Gender Reassignment).</td>
</tr>
</tbody>
</table>

## Stage 4: Measures to fill the evidence gaps.

<table>
<thead>
<tr>
<th>What measures will be taken to fill the information gaps before the activity is implemented? These should be included in the action plan at the back of this form.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measures:</strong> Share draft strategy for comment with Grampian Regional Equality Council</td>
</tr>
<tr>
<td><strong>Timescale:</strong> Dec 2012/Jan 2013</td>
</tr>
<tr>
<td><strong>Measures:</strong> Share draft Strategy with representative of community of older LGBT people (Age Scotland)</td>
</tr>
<tr>
<td><strong>Timescale:</strong> Dec 2012/Jan 2013</td>
</tr>
</tbody>
</table>

## Stage 5. Are there potential impacts on protected groups? Please complete for each protected group, by inserting “yes” in the applicable box/boxes below.

<table>
<thead>
<tr>
<th>Age – Younger</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age – Older</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race – (includes Gypsy Travellers)</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion or Belief</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex – i.e. men/women</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy and maternity</th>
<th>Positive</th>
<th>Negative</th>
<th>Neutral/No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Protected Characteristics</td>
<td>Positive Impact</td>
<td>Negative Impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation – (includes Lesbian/Gay/Bisexual)</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment – (includes Transgender)</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please detail the potential positive and/or negative impacts on those with protected characteristics you have highlighted above. Detail the impacts and describe those affected.

**Age - Younger**

A strategic priority is the development of preventive health interventions to promote healthy living. This will impact on the health of younger people.

Support of young carers and carers under the age of 65 is a priority.

Promotion of intergenerational activity to improve older people’s well-being will improve young people’s well-being, skills and abilities.

Employment and career opportunities created in the care sector of the economy.

Younger people will be able to plan for old age with confidence.

**Age –Younger**

More younger people will be required to participate in the care of older family members and older members of the community.
<table>
<thead>
<tr>
<th>Age – Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>The whole intention of the strategy is to create the best possible delivery of health and social care for older people, “to optimise independence and well-being of older people in Aberdeenshire”, and achieve the best possible outcomes for them. Older people will have more control over care provided. Older people will have greater opportunities for involvement in their communities. Older people can have increased confidence that they will be able to live at home, independently, and in safety, for as long as possible, and that they will be able to end their lives in a place of their choosing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age – Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>The strategic emphasis on increased independence, support from communities, and greater ability to manage their own long-term conditions, with less reliance on traditional provision of statutory services may impact on older people’s confidence in their future well-being, safety and independence. Some older people will not wish to be supported, and cared for, by their families.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>The strategy promotes development of support for carers that is more flexible, innovative and tailored to the needs of the individual, many of whom will be older people. The promotion of rehabilitation and enablement will impact on individuals’ abilities to live independently, reducing dependency. The introduction of self-directed support and the further promotion of personalisation in assessment, care planning and care delivery will positively impact on independence, and control over personal circumstances and allow more bespoke support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race (incl. Gypsy Travellers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of self-directed support and personalisation of services will enable individuals and families to make choices about care and support that will be suited to their particular needs, culture and circumstances. Focus on improved quality of long term care necessitates more training in respect of the equalities and respect agenda.</td>
</tr>
<tr>
<td>Religion or Belief</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Introduction of self-directed support, outcome-focused assessment and personalisation of services will enable individuals and families to make choices about care and support that will be suited to their particular needs, culture and circumstances.</td>
</tr>
<tr>
<td>Focus on improved quality of long term care necessitates more training in respect of the equalities and respect agenda.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex – i.e. men/women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of self-directed support, outcome-focused assessment and personalisation of services will enable individuals and families to make choices about care and support that will be suited to their particular needs, culture and circumstances.</td>
</tr>
<tr>
<td>Increase in investment in community capacity to share in delivery of preventive services and other services will require culture change in traditional gender roles.</td>
</tr>
<tr>
<td>Strategy recognises particular needs of the ageing male, especially in terms of combating social isolation and maintenance and use of skills developed throughout their working lives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual orientation – (includes Lesbian/Gay/Bisexual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of self-directed support, outcome-focused assessment and personalisation of services will enable individuals and families to make choices about care and support that will be suited to their particular needs, culture and circumstances.</td>
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<tr>
<td>Focus on improved quality of long term care necessitates more training in respect of the equalities and respect agenda.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex – i.e. men/women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on women from increased expectations and demands in their role as informal carers.</td>
</tr>
</tbody>
</table>
### Gender reassignment – (includes Transgender)

Introduction of self-directed support, outcome-focussed assessment and personalisation of services will enable individuals and families to make choices about care and support that will be suited to their particular needs, culture and circumstances.

Focus on improved quality of long term care necessitates more training in respect of the equalities and respect agenda.

---

### Stage 7: Have any of the affected groups been consulted?

If yes, please give details of how this was done and what the results were. If no, how have you ensured that you can make an informed decision about mitigating steps?

- **NHS Grampian Public Forum 27 Oct 2012**
- **G:\Admin\Bill Stokoe\ Older Peoples Strategy**
  - General public consultation in Nov. 2012.
- **Citizens Panel Online Survey Nov 2012**
- **G:\Admin\Bill Stokoe\ Older Peoples Strategy**
  - Citizens Panel Survey Nov 2012
  - Engagement with Older Peoples Forums
- **Draft strategy sent for comment to:**
  - a) Grampian Racial Equality Council
    - Response:
    - **G:\Admin\Bill Stokoe\ Older Peoples Strategy**
  - b) Age Scotland (including LGBT older people rep)
    - Response:
    - **G:\Admin\Bill Stokoe\ Older Peoples Strategy**
### Stage 8: What mitigating steps will be taken to remove or reduce negative impacts?

<table>
<thead>
<tr>
<th>Mitigating Steps</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age - younger</strong>&lt;br&gt;Development of bespoke respite care, and outcome focussed assessments of the needs of young carers. Support for young carers’ support groups.</td>
<td>Implementation of self-directed support in 2014-15.</td>
</tr>
<tr>
<td><strong>Age – older</strong>&lt;br&gt;Development of the capacity of communities to participate in the care and support of older people. Promotional of the contribution older people can make to their communities, using their skills and experience.</td>
<td>Lifetime of strategy – 2023.</td>
</tr>
<tr>
<td><strong>Sex – i.e. men/women</strong>&lt;br&gt;Development of flexible and bespoke respite care services. Further development of support groups for carers Use of outcome focussed carers assessments Development of capacity of communities to participate in the care and support of older people</td>
<td>Mid-way through implementation – 2018 Current and ongoing Current – 2014 with implementation of S.D.S. Lifetime of strategy - 2023</td>
</tr>
</tbody>
</table>

These should be included in any action plan at the back of this form.

### Stage 9: What steps can be taken to promote good relations between various groups?

Training of health and social care staff develops the skills of the workforce in promotion of good relationships between groups, including conflict resolution, risk assessment, and the achievement of good outcomes for all service users and carers.

The development of capacity in communities to care and support older people through co-production, community learning and development and community planning strengthens links between groups in the community and strengthens community networks.

These should be included in the action plan.

### Stage 10: How does the policy/activity create opportunities for advancing equality of opportunity?
The strategy aims to optimise the care and support for all older people in Aberdeenshire irrespective of age, disability, race, religion/belief system, sex, sexual orientation, gender, or marital status. An explicit aim of the strategy is to enable equality of, and equity in, access to care and support services.

Stage 11: What equality monitoring arrangements will be put in?

These should be included in any action plan (for example customer satisfaction questionnaires).

- The implementation of the strategy is monitored by the Older Peoples Strategic Outcomes Group.
- Ethnic monitoring data is routinely collected as part of social work and NHS patient and service user data collection.
- Annual User and Carer Satisfaction Surveys

Stage 12: What is the outcome of the Assessment?

Please complete the appropriate box, Choose 1, 2 or 3.

1. No impacts have been identified —please explain

2. Impacts have been identified, these can be mitigated - please explain

   Negative impacts on younger age groups, older age groups, and women have been identified. Mitigation of these impacts is achieved through implementation of the strategy, including the development of self-directed support, outcome-focussed and personalised services, community capacity to provide care and support, and training of health and social care staff.

3. The activity will have negative impacts which cannot be mitigated fully – please explain

   * Please fill in Stage 13 if this option is chosen

* Stage 13: Set out the justification that the activity can and should go ahead despite the negative impact.

Stage 14: Sign off and authorisation.

<table>
<thead>
<tr>
<th>Sign off and authorisation.</th>
<th>Department</th>
<th>Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Policy / Activity</td>
<td>Joint Commissioning Plan for Older People 2013-2023</td>
<td></td>
</tr>
</tbody>
</table>
We have completed the equality impact assessment for this policy/activity.

<table>
<thead>
<tr>
<th>Name: Linda Reid/Bill Stokoe</th>
<th>Position: Project Manager (Integration)/Strategic Development Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 18.02.13</td>
<td></td>
</tr>
</tbody>
</table>

**Authorisation by Director or Head of Service**

<table>
<thead>
<tr>
<th>Name: Patricia Maclachlan</th>
<th>Position: Head of Older Peoples Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 18.02.13</td>
<td></td>
</tr>
</tbody>
</table>

Please return this form, and any supporting assessment documents, to your Services Corporate Equalities Group Representative.
<table>
<thead>
<tr>
<th>Action</th>
<th>Start</th>
<th>Complete</th>
<th>Lead Officer</th>
<th>Expected Outcome</th>
<th>Resource Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share Joint Commissioning Plan for comment with Grampian Regional Equality Council</td>
<td>Dec 2012</td>
<td>Feb 2013</td>
<td>Bill Stokoe</td>
<td>Comment and recommendations for amendments to Plan to address any equalities impacts</td>
<td>None</td>
</tr>
<tr>
<td>Share Joint Commissioning Plan for comment with representative of older LGBT people</td>
<td>Dec 2012</td>
<td>Feb 2013</td>
<td>Bill Stokoe/Alan Young</td>
<td>Comment and recommendations for amendments to Plan to address any equalities impacts</td>
<td>None</td>
</tr>
<tr>
<td>Develop bespoke respite care</td>
<td>Sept 2012</td>
<td>March 2014</td>
<td>Iain Ramsay/Sheena Swinhoe</td>
<td>Range of flexible and bespoke short breaks available for all carers</td>
<td>£50k Change Fund investment in Creative Breaks 2012-14</td>
</tr>
<tr>
<td>Develop outcome focussed carers assessments</td>
<td>July 2012</td>
<td>2015</td>
<td>Iain Ramsay/SDS Team</td>
<td>Range of options for self-directed support, including assessment and care planning pathway, implemented. All carers offered an assessment.</td>
<td>Investment in Team Manager post for 2 years. £25k Change Fund investment in additional staff to undertake carers assessments.</td>
</tr>
<tr>
<td>Support young carers groups</td>
<td>2013</td>
<td>2018</td>
<td>Bob Driscoll</td>
<td>Young carers identified and supported by carers support workers and through participation in carers’ forums</td>
<td>Existing resources</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>------</td>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Develop capacity of communities to participate in support and care of older people</td>
<td>2013</td>
<td>2023</td>
<td>Co-production Group/Chair Alan Young</td>
<td>Communities engaged and involved in care and support of older people</td>
<td>Resources for implementation of Joint Commissioning Plan</td>
</tr>
<tr>
<td>Promote contribution by older people to their communities</td>
<td>2013</td>
<td>2023</td>
<td>Stuart Ritchie</td>
<td>Older people fully active and involved in their local communities</td>
<td>£70k 2 year investment in communications officer post from Change Fund. Resources for implementation of Joint Commissioning Plan</td>
</tr>
<tr>
<td>Training health and social care staff</td>
<td>2013</td>
<td>2023</td>
<td>Rhoda Hulme/Eunice Chisholm/Jillian Brannan</td>
<td>Health and social care staff equipped to promote good relations between individuals and groups, including conflict resolution, risk assessment and achievement of good outcomes.</td>
<td>£124k Change Fund investment in dementia training. £56k Change Fund investment in palliative care training and staff support. £39k Change Fund investment in mentor for independent care home sector. Investment in workforce development as part of implementation of Joint Commissioning Plan</td>
</tr>
</tbody>
</table>
## SEA PRE-SCREENING REPORT (COVER NOTE)

### PART 1

**To:**  
SEA.gateway@scotland.gsi.gov.uk  
or  
SEA Gateway  
Scottish Government  
Area 1 H (Bridge)  
Victoria Quay  
Edinburgh EH6 6QQ

### PART 2

An SEA Pre-Screening Report is attached for the plan, programme or strategy (PPS) entitled:

Ageing Well in Aberdeenshire Joint Commissioning Plan for Older People 2013-23

The Responsible Authority is:

Aberdeenshire Council

### PART 3

**Contact name**  
Bill Stokoe

**Job Title**  
Strategic Development Officer (Community Care)

**Contact address**  
Housing and Social Work  
Aberdeenshire Council  
Woodhill House  
Aberdeen  
AB16 5GB

**Contact tel no**  
01224 664981

**Contact email**  
Bill.Stokoe@aberdeenshire.gov.uk

**Date**  
24 January 2013
<table>
<thead>
<tr>
<th><strong>Responsible Authority</strong></th>
<th>Aberdeenshire Council</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose of PPS</strong></td>
<td>To optimise independence and wellbeing of older people in Aberdeenshire</td>
</tr>
<tr>
<td><strong>What prompted the PPS</strong></td>
<td>The Scottish Government’s Reshaping Care for Older People policy</td>
</tr>
<tr>
<td>(e.g. a legislative,</td>
<td></td>
</tr>
<tr>
<td>regulatory or</td>
<td></td>
</tr>
<tr>
<td>administrative</td>
<td></td>
</tr>
<tr>
<td>provision)</td>
<td></td>
</tr>
<tr>
<td><strong>Subject</strong></td>
<td>Care (Wellbeing of Older People)</td>
</tr>
<tr>
<td>(e.g. transport)</td>
<td></td>
</tr>
<tr>
<td><strong>Period covered by PPS</strong></td>
<td>2013-2023</td>
</tr>
<tr>
<td><strong>Frequency of updates</strong></td>
<td>As and when necessary</td>
</tr>
<tr>
<td><strong>Area covered by PPS</strong></td>
<td>Aberdeenshire Council Area</td>
</tr>
<tr>
<td>(e.g. geographical area – it is good practice to attach a map)</td>
<td></td>
</tr>
<tr>
<td>**Summary of nature/</td>
<td>The plan covers introduction, objectives, national policy drivers, environmental scan, delivering better outcomes, current &amp; future service &amp; investment configuration, strategic commissioning intentions, workforce as well as involving and engaging people.</td>
</tr>
<tr>
<td>content of PPS**</td>
<td></td>
</tr>
<tr>
<td><strong>Are there any proposed PPS objectives?</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>Copy of objectives attached</strong></td>
<td>YES (See Appendix 1)</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>24 January 2013</td>
</tr>
</tbody>
</table>
### SEA PRE-SCREENING REPORT

#### TITLE OF PPS

**Ageing Well in Aberdeenshire Joint Commissioning Plan for Older People 2013-23**

#### RESPONSIBLE AUTHORITY

**Aberdeenshire Council**

<table>
<thead>
<tr>
<th>Criteria for determining no or minimal effects on the environment</th>
<th>Likely to have no or minimal environmental effects</th>
<th>Summary of significant environmental effects (negative and positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(a) the degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources</td>
<td>No effects</td>
<td>The plan does not intend to set a framework for land take, development, new projects or activities that are likely to have environmental effects on any receptors. The need may not be there. Indeed evidence suggests that more people are choosing not to move house as they get older as they are able to receive the care and support they need in mainstream housing, including access to community alarm and telecare systems; and more sheltered housing tenants are choosing to stay in their tenancy for longer with increased support, rather than moving into residential care as their care needs increase. Thus this PPS seeks, among other things, to continue to support more people to maintain their own home or tenancy until the end of their life, particularly in sheltered and very sheltered housing settings, where very few tenants move on to care homes.</td>
</tr>
<tr>
<td>1(b) the degree to which the PPS influences other PPS including those in a hierarchy</td>
<td>No effects</td>
<td>The plan will influence and is, in turn, influenced by Aberdeenshire Dementia Strategy, Fuel Poverty Strategy and Aberdeenshire Local Housing Strategy. However these influences are unlikely to have any significant spatial or environmental effect in as far as joint commissioning is concerned.</td>
</tr>
</tbody>
</table>
1(c) the relevance of the PPS for the integration of environmental considerations in particular with a view to promoting sustainable development

No effect

While the plan acknowledges that energy efficiency considerations are relevant to the needs of older people, it is not its intention to integrate environmental considerations in the joint commissioning process.

1(d) environmental problems relevant to the PPS

No effects

There is no discernible environmental problems relevant to this PPS

1(e) the relevance of the PPS for the implementation of Community legislation on the environment (for example, PPS linked to waste management or water protection)

No effect

This PPS does not intend to implement any EU legislation

<table>
<thead>
<tr>
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<th>Likely to have no or minimal environmental effects</th>
<th>Summary of significant environmental effects (negative and positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (a) the probability, duration, frequency and reversibility of the effects</td>
<td>No effect</td>
<td>The implementation of this joint commissioning plan is not likely to have any environmental effects likely to have a measurable probability, duration, frequency or reversibility.</td>
</tr>
<tr>
<td>2 (b) the cumulative nature of the effects</td>
<td>No effect</td>
<td>The PPS merely seeks to deal with how the independence and wellbeing of older people will be optimised rather than planning and allocating resources for development. For this reason, there is no potential for any additional, secondary or induced effects to accumulate to any significant or synergistic environmental effects.</td>
</tr>
<tr>
<td>2 (c) transboundary nature of the effects (i.e. environmental effects on other EU Member States)</td>
<td>No effect</td>
<td>The effects from the PPS, if any, are not likely to transcend local, regional, national and international boundaries.</td>
</tr>
<tr>
<td>2 (d) the risks to human health or the environment (for example, due to accidents)</td>
<td>No effect</td>
<td>There is no discernible risk to human health or to the environment arising from the implementing of this plan.</td>
</tr>
<tr>
<td>2 (e) the magnitude and spatial extent of the</td>
<td>No effect</td>
<td>Although this PPS relates to the whole of Aberdeenshire area, it is not likely to have...</td>
</tr>
<tr>
<td>Effects</td>
<td>Any effects on the environment. It is not about land take and development.</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2 (f)</td>
<td>No effect Because this PPS is not about land take and development, it is not likely to have any effects on designated and sensitive sites.</td>
<td></td>
</tr>
<tr>
<td>2 (g)</td>
<td>No effect Because this PPS is not about land take and development, it is not likely to have any effects on designated and sensitive landscapes.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I: Housing Contribution Statement

This template should be completed jointly by appropriate lead officers from local authority housing and the health and social care partnership. Once completed the template should be incorporated as a discrete element within the Joint Strategic Commissioning Plan for Older People.

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

<table>
<thead>
<tr>
<th>Theme</th>
<th>Detail</th>
</tr>
</thead>
</table>
| Outcomes relevant to the housing contribution (Note1) | The Scottish Government's National Outcome Statement 10 states - "We live in well designed, sustainable places where we are able to access the amenities and services we need."  
Nationally the Housing Strategy “Age, Home and Community: A Strategy for Housing Scotland’s Older People: 2012-2021” responds to the National Outcome and SBC policy to support people to remain independently at home as long as possible. Five key themes are set to achieve this and the LHS encompasses all these elements in our work streams.  
1. Ensure an appropriate balance of housing provision.  
2. Provide specialist housing with care and support.  
3. Provide housing adaptations and other preventative property-related services.  
4. Build new housing.  
5. Support local communities through wider activities.  
Locally, Aberdeenshire Council aims to meet the housing and support needs of an increasing aging population and number of people with dementia.  
There are two strategic documents that identify the main issues and key actions in relation to Older People; The Aberdeen City and Shire Housing Needs and |
Demand Statement (HNDA) and the Local Housing Strategy (LHS).

Chapter 5 of the LHS focuses on Particular Needs Groups which include Older People. It states;

“The Particular Needs Housing Strategic Outcome Statement aims to enable people with an identified particular need have access to appropriate affordable housing and support to allow them to sustain and improve their health to live as independently as possible”.

The 3 key overarching actions are:

1. Ensure there is sufficient diversity in all housing, all sizes and tenure to meet the changing needs of Aberdeenshire residents; ensuring a minimum of 15% of new build affordable homes are developed each year and existing stock is reconfigured for those with particular needs.

2. Continue to review ways to best maximise existing housing stock, through the provision of equipment and adaptations in order to reduce the number of households with an unmet particular housing need by 2,310; 1,550 in the private sector and 760 in the public sector per year.

3. Identify current and future housing support needs and harmonise housing support services across Aberdeenshire.

Link to the LHS

Link to the HNDA
http://www.aberdeenshire.gov.uk/about/departments/HNDA2011_000.pdf
Strategic direction of travel and proposed investment changes within the draft Joint Strategic Commissioning Plan for Older People *(Note 2)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retain sheltered housing as a tenure for older people in areas where there continues to be identified demand.</td>
</tr>
<tr>
<td></td>
<td>Consider alternative use of sheltered housing complexes where demand in decreasing, for example, use for people with learning disabilities.</td>
</tr>
<tr>
<td></td>
<td>Increase the number of very sheltered housing complexes across areas of Aberdeenshire where there is identified need.</td>
</tr>
<tr>
<td></td>
<td>Provide residential care homes for older people and deliver a programme of new build care village concepts across Aberdeenshire.</td>
</tr>
<tr>
<td></td>
<td>Develop, where possible, affordable new build properties suitable for older people, incorporating dementia design principles.</td>
</tr>
<tr>
<td></td>
<td>Maximise best use of existing housing stock to meet the varying needs of older people. For example, properties with adaptations or dementia design principles.</td>
</tr>
<tr>
<td></td>
<td>Increase preventative and proactive response to older people housing needs; holistic assessment of housing, care and support needs as part of their housing application.</td>
</tr>
<tr>
<td></td>
<td>Housing and planning policy supports the delivery of new build smaller properties suitable for older people across all tenures.</td>
</tr>
<tr>
<td></td>
<td>Promote the Care and Repair service as providing essential services to older people to retain independence and remain at home for longer, e.g., adaptation grants, small repairs services and dementia design assessments. Contributes to unnecessary hospital admissions and supports early discharge.</td>
</tr>
</tbody>
</table>

The housing contribution – investment already planned

| Chapter 5 and 7 including the resources statements of the LHS sets out the planned projects and investment in new build and existing stock. However the |   |
on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock) (Note 3) main projects and investment can be listed as:

- Remodelling of 5 Sheltered Housing Complexes to become Very Sheltered Housing complexes across Aberdeenshire between 2010 and 2015. Approximate total investment: £1.6m.

- Two new build developments incorporating 6 x 1 and 2 x 2 bed bungalows to compliment the proposed new build 60 bed care homes, creating a care village concept. Approximate total investment: £100k per unit.

- Maximise existing stock by investing in aids and adaptations across all tenures.

  Private Sector Housing Grant (PSHG). Committed annual investment of £1.2m. 2013/13, 2014/15.
  Social Work equipment and adaptations including Telecare. Approximate annual investment: £250k.
  Stage 3 adaptation grant: Approximate annual investment: £250k

- Sheltered Housing Support. Approximate annual investment £700k
- Community Alarm. Approximate annual investment £180k

Likely future impact of plan upon housing resources (Note 4) Meeting identified housing and support needs – capital and revenue impact.

Future legislative requirements, for example, welfare reforms, building and fire regulations.

Increased capital costs and capacity of HRA prudential borrowing as well as access to SG grant to develop new build housing suitable for older people; 1 bed bungalows/ground floor flats, SH, VSH.

Funding capacity to deliver the predicted increase in aids and adaptations across
all tenures. Capacity for necessary capital upgrades of SH and VSH to meet statutory regulations, e.g. fire regulations requiring installation of sprinkler systems. Reducing demand for SH; resulting in long term voids and low demand complexes impacting on revenue income to the HRA. Competing priorities between older people and general needs housing requirements. Increase revenue costs to deliver proactive and reactive levels of housing support.

| Process for integrating the housing contribution to the Joint Strategic Commissioning Plan for Older People in future (Note 5) | The Older Peoples Strategic Outcome Group and the Housing for Particular Needs Strategic Outcome Group are the two main overarching strategic joint planning groups in relation to older people. Members from housing, health and social care are represented on both groups and jointly plan the direction of older people accommodation and services locally. The identified priorities are represented in the LHS and JCS identifying the key issues and actions to deliver positive outcomes for older people. |
| Outline and understanding of shared data sources, and gaps to be addressed (Note 6) | Aberdeen City and Shire Housing Needs and Demand Statement (HNDA) Local Housing Strategy 2012-2017 GP Population data Prevalence rates of dementia GROS data Northgate SX3 - housing stock data Housing Strategic Local Plan – proposed new build projects over the next 3 years Apply4homes - Number of older people on the housing waiting list Carefirst 6 - number of older people using housing support, social care services and health services; home care, community alarm, telecare. |

Key challenges going Competing housing and support priorities across all social work clients.
continued capacity to deliver affordable housing and support to meet the needs and aspirations of older people to remain at home for longer. Low demand for some exiting SH complexes; consider alternative uses. Sufficient funding to deliver the anticipated increasing number of major and minor adaptations required to allow people to remain independent at home for as long as possible.

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

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

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

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

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

**Note 6:** This should describe the data sources that have been used by both health and social care and housing in compiling the JSC Plan for Older People and the Local Housing Strategy and identify any currently apparent gaps in the data that, were they to be addressed, would better support joint working between the sectors.

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