APPENDIX 1: WORKING IN PARTNERSHIP

Working in Partnership

Stakeholder engagement is a process that goes well beyond the traditional ways of involving service users, carers, local people, organisations and health professionals. Engagement means giving the people of Moray the power in determining and designing services and in selecting providers. This document summarises our shared approach to commissioning and how we worked in partnership to develop the joint commissioning strategy

1.0 Change Fund Governance Group/Steering Group for Joint Commissioning Strategy

A Change Fund Governance/Steering Group was established with key stakeholders across the four sectors – local authority, NHS, Third and Independent Care. The group had a dual role of leading the development of the joint commissioning strategy and providing governance for change fund allocation ensuring the objectives of the change fund were met.

It was chaired jointly by the local authority's Head of Community Care and the General Manager of the Moray Community Health and Social Care Partnership.

The group reported to The Moray Council, the Moray Community Health and Social Care Partnership Board, NHS Grampian Board and the Moray Community Planning Board. The NHS Grampian Board is accountable for Change Fund monies.

1.1 Wider Commissioning Group

The Moray Community Health and Social Care Partnership invited a range of health and social care professionals, GPs, housing officers, representatives from the voluntary sector and independent sector and older people themselves, to join a joint commissioning group.

The group set out to work together to develop a credible joint commissioning strategy for health and social care services for older people which reflected the shared priorities of key stakeholders and set out the direction for future commissioning decisions and service development.

The new commissioning group worked actively with the older people of Moray to ensure their needs and expectations are being understood and responded to. The existing Older Peoples Reference Group and wider network of older people's community groups were key to providing feedback on what is important to older people and this contributed to the development of the strategy.

TABLE 1: The wider commissioning group

Andrew Fowlie	General Manager, CHSCP
Jane Mackie	Head of Community Care, Moray Council
Jamie Hogg	Clinical Lead, Moray, NHS Grampian
Graham Taylor	Chair of GP Consortium
Sandra Gracie	Strategy Development Officer/Change Fund Operational Lead
Sean Cody	Lead Nurse Moray, MCHSCP
Ken Hamilton	Business Manager, MCHSCP
Elaine Brown	Public Health Planning Lead, NHS Grampian
Bob Sivewright	Finance Manager, NHS Grampian
Deborah O'Shea	Principal Accountant, Moray Council
Eileen Bush	Third Sector representative
Ron Taylor	Independent Care Sector representative
Robin Paterson	Senior Performance and Quality Officer, Moray Council
Julie Mackay	Clinical nurse Manager Mental Health Services NHSG
Charles McKerron	Service Manager, Moray Council
Margaret Slorach	Service Manager, Moray Council
Roddy Huggan	Commissioning Manager, Moray Council
Tracey Wills	Quality Monitoring Officer, Moray Council
Ewan Riddick	GP, Moray Coast Practice, Lossiemouth
Mark Houliston	GP, Elgin Community Surgery
Lewis Walker	GP, Ardach Health Centre, Buckie
Fiona Geddes	Housing Strategy Manager, Moray Council
Amanda Croft	Lead System Manager Dr Gray's, NHS Grampian
Hazel Whyte	Lead Nurse (dementia standards) Dr Gray's, NHS Grampian
Alison Smart	Clinical manager community hospitals, NHS Grampian
Aileen Marshall	Older People's Reference Group
Harry Torry	Older People's Reference Group
Sandy Henderson	Older People's Reference Group
Heather Kelman	NHS Grampian Change Fund Lead
Tim Shallcross	General Medicine, NHS Grampian
Alison Sands	Geriatrician, NHS Grampian
John Todd	Consultant Old Age Psychiatry, NHS Grampian
Pauline Knox	Senior Carers Strategy Officer, Moray Council
Elena Geddes	Intermediate Care Officer, Moray Council
Steven McCluskey	Strategic Manager Health Improvement, Moray Council
Anne McKenzie	Allied Health Professionals Lead, NHS Grampian
Anna Jermyn	Research and Information Officer, Moray Council
Catriona Campbell	Research and Information Officer, Moray Council
Karen Thomson	Clinical Manager Acute, NHS Grampian
Dr Tok	Consultant in Old Age Psychiatry, NHS Grampian
Dr Emmanuel Okpu	Consultant in Public Health Medicine, NHS Grampian

The work of the commissioning group was facilitated by the Institute of Public Care, Oxford Brookes University, (http://ipc.brookes.ac.uk/) who brought a wealth of experience in commissioning and in supporting the development of partnership working across health and social care.

A range of workshops and other activities were undertaken by the wider commissioning group. The first workshop focused on developing a joint approach to commissioning in Moray where health and social care partners, including GPs, the voluntary sector, the independent sector and representatives from the Older People's Reference Group agreed a shared understanding of what is commissioning, the outcomes we seek for the older population and what evidence suggests could be effective models to achieve these outcomes.

Other activities included:

- Health needs analysis
- Service mapping analysis
- Developing hypothesis and testing options
- Feedback from older people

A communication plan ensured staffs across all sectors, and the wider older population were kept up to date and their views sought on a number of priority issues at key stages in the commissioning process – a communication plan was developed to reflect the activities.

1.2 Our commissioning Framework

This strategy has been developed by a wide range of stakeholders from across all sectors (including older people's representation), who worked together through the four stages of the commissioning cycle with IPC. A range of workshops and activities have been undertaken in the last 18 months.

The Social Work Inspection Agency (SWIA) in its guide to strategic commissioning, states: ***"Strategic Commissioning is the term used for all activities involved in assessing and forecasting needs, agreeing desired outcomes, considering***

options, planning the nature, range and quality of future services and working in partnership to put these in place.

Strategic Commissioning should provide a clear rationale for the development of services and procurement activity."

There are a number of benefits in jointly commissioning services:

- Agencies share common customers – people do not live their lives within the administrative or organisational boundaries we create.
- Services should be organised around the service user.
- Services are usually inter-dependent – decisions taken by one agency will often have a significant impact on its partner.
- Quality and cost effectiveness of services can be significantly improved when organisations work well together.
- Better outcomes can be achieved for older people.

In 2010, Moray Council produced an overarching Commissioning Framework for Community Care which set out the principles of commissioning. This plan is part of the broader commissioning framework for Community Care. Joint Plans between Moray Council and NHS Grampian are also in place for other care categories such as physical and sensory disabilities and learning disabilities (currently in initial draft form).

1.3 Commissioning Cycle

The commissioning cycle developed by the Institute of Public Care has been adopted as a model for Moray (Figure 1). The key principles of the agreed model are that:

- All four elements (analyse, plan, do and review) are sequential and of equal importance. Commissioners and contractors should spend equal time, energy and attention on the four elements
- Commissioning strategies for all client areas should be developed, which focus on the needs of the clients across different agencies.

- The outer circle of the model, the commissioning cycle, should drive the inner circle, purchasing and contracting activities. However, the contracting experience must inform the on-going development of commissioning.
- The commissioning process should be equitable and transparent, and open to influence from all stakeholders via on-going dialogue with service users, carers and providers.

Figure 1: Institute of Public Care commissioning cycle model

1.4 Agreed Commissioning Principles

The partnership agreed the following principles to guide those working to commission older people's services. These principles are important and we expect those working on the commissioning of services for older people, their carers and families to use them as a basis of their work.

1. Commissioning activities and decisions will be based on a clear rationale for improving outcomes for older people, their carers and their families.
2. Commissioning is based on robust evidence of current and future needs of older people, their carers and their families, and about the quality and cost effectiveness of services.
3. We promote equality of opportunity by commissioning, specifying and securing services appropriate to the needs of older people and their carers and families.
4. We prioritise investment in preventative services, asking older people for their solutions, and strengthening their support to meet their needs.
5. We engage meaningfully with older people, their carers and families as equal partners in all of our joint commissioning activities.
6. We build and maintain good long-term relationships with service providers, investing in a culture of trust and mutual respect.
7. Our process of developing and implementing the joint commissioning strategy are as open and transparent as possible.
8. We ensure that there is an appropriate level of skills, expertise and capacity available to develop and implement our joint commissioning strategy.
9. We ensure our procurement and contracting arrangements are compatible with EU and UK law, regulations and guidance.
10. Our purchasing and contracting arrangements are proportionate to the scale and complexity of the service we are buying. And we do not discriminate against organisations from different sectors of the market.
11. We encourage the development of a diverse local market so that there are a range of flexible, personalised support/services available to older people.
12. Our contracts and service level agreements are based on priorities and direction outlined in the commissioning strategy.
13. We manage and monitor contracts and service level agreements effectively and regularly within our sectors
14. We use the outcomes of monitoring and review to help set priorities and inform future plans and commissioning priorities.

1.5 Wider stakeholder engagement and communication

Wider stakeholders included

- Broad 65+ community and general public
- Wider network of community groups for older people
- Unpaid carers of older people
- Community Health and Social Care Staff
- Independent Care Sector
- Acute sector staff
- Voluntary sector
- Current service users/patients
- Community planning partners (police, fire and ambulance service)
- Housing, including sheltered housing and extra care housing
- Respective committees across all agencies

A range of Communication methods have been used including committee reports, briefings, meetings, workshops, web information, newsletters, press releases and consultation events.

1.6 Older Peoples Reference Group

The Older Peoples Reference Group was established to follow the progress of our previous strategy and has fulfilled the engagement function and been an integral part of the development of the Joint Commissioning Strategy. Three members sit on the wider commissioning stakeholders group and participated in the range of IPC workshops which were undertaken

All members represent a number of local groups and organisations and provide a two way communication link between the health and social care partnership and the wider network of older people's groups.

The main concerns fed back to the group via their communities using this mechanism can be summarised as follows:

- **Chiropody** – the need for a service for older people who because of restricted mobility cannot carry out their own foot care (or that of someone they care for) but who do not quality for NHS chiropody
- **Communication** – must be clear and jargon-free
- **Dignity in care** – particularly around patients receiving the necessary help to eat and drink; the way staff talk to older people and the importance of listening to them and their wishes
- **Hospital discharge procedures** - particularly from hospitals out with Moray without support at home being in place
- **Time to care** – workload pressure on hospital staff and home carers in particular

1.7 Engaging with older people

Building on our earlier engagement and involvement in the Living Longer Living Better strategy for older people, the Older Peoples reference group was instrumental in inviting the Scottish government to hold a reshaping Care engagement event in Moray where older people contributed to the content of the Programme for change document published by the Scottish government.

The voices of older people have come across loud and clear during the development of the joint commissioning plan, and by drawing on their personal experiences - as well as those of their family and friends - they have made a valuable contribution to the development of the plan.

Consultation get-togethers were held to raise awareness of the Reshaping Care agenda and the progress being made locally, which offered older people the opportunity to outline what is important to them.

Older people in Moray understand that as our population ages, ways need to be found of delivering services in future to many more people as affordably as we can while continuing to improve quality and standards.

They came forward to tell us what works and what needs to change, putting across their ideas for what would make a positive difference to their lives. This contributed to the development of our shared vision and the outcomes the partnership want to achieve for older people over the next ten years.

"We will promote a culture of choice, independence and quality with older people in Moray, where they are supported to share responsibility for leading healthy and fulfilling lives in active communities that value and respect them."

1.8 Feedback from the national consultation

Confidence in the care system now is being tested by financial restraints; older people raised concerns over the loss of services and reduction in staffing levels which left staff with less time to "care". Lack of staff training was also highlighted as a concern, particularly around dementia.

Poor communication – This included communication between health and social care colleagues at key points in the patient journey such as on discharge from hospital – too often led to older people falling through the net and gave older people reduced confidence that adequate systems were in place. Poor communication also meant they were not given proper explanations as to why decisions were being taken, such as around eligibility to services and equipment.

Lack of continuity in care was an issue, particularly as older people appreciated the relationships they had with family GPs in the past but now felt GPs do not know them or have a rounded awareness of their health needs and concerns.

Improved dignity and respect was one of the cornerstones older people want to see firmly embedded in any new way of working. They want to be listened to and treated as individuals.

Support to be independent was at the forefront of everyone's thoughts when it came to considering the type of care they prefer. People made it clear they want to remain at home for as long as possible, particularly if their home could be adapted to meet their changing needs and perhaps with additional support at home. They also embraced the concept of "home" being somewhere they feel comfortable, safe and in control, and that this could be sheltered or community housing or a care home.

1.9 Feedback from local consultation and engagement events

The following consultation and engagement events were held. These were promoted through a variety of methods, including the Moray Council website, local media and invitations to voluntary organisations and older people's groups.

- Scottish Government Reshaping Care – July 2010 – Elgin Town Hall
- Enabling Health and Wellbeing – April 2011 – Elgin Town Hall
- A Get Together – September 2011 – Holy Trinity Church Hall, Elgin
- Living Longer, Living Better – December 2011 – Elgin Town Hall
- Homecare reablement – January 2012 – Elgin, Forres, Rothes, Buckie
- Living Longer, Living Better – February/March 2011 – Elgin Town Hall; Forres Town Hall; Buckie Fishermen's Hall; Aberlour Fleming Hall; Keith Longmore Hall.

Examples of good practice from other parts of the country were shared during the consultation get-togethers and opportunities provided for those attending to give their opinions and suggest initiatives they would like to see progressed locally.

Two 'Living Longer, Living Better' newsletters were produced to provide background information to Reshaping Care, highlighting the challenges and opportunities Scotland's aging population will bring, introducing the Change Fund and explaining

how people can become involved in the work to produce the Joint Commissioning Strategy.

The feedback from the above events are summarised below around the reshaping care for older people pathway.

1.10 Early Intervention and Prevention

Older people recognised there was a need for a shift in thinking towards early intervention and prevention and felt people were becoming much more aware of what they could do to maintain a healthy lifestyle.

They agreed a wide range of services were important to support the change in attitude from “help me recover from illness” to “help me stay healthy” and want to be made aware of what is available.

They were supportive of citizen leadership and welcomed opportunities to have power and influence and responsibility to make decisions. They want service providers to involve them and give them some control over services, enabling them to take action for the benefit of other citizens.

Access to Information

Better co-ordination of information which supports older people to self-manage health conditions, to plan for the future and live well now, was called for. People were aware of a wealth of material being produced but were unsure where to access it and which was the best source to meet their needs.

Others felt they were not aware of what services are available and how to access them. All were keen to point out that information has to be provided in a variety of ways and not just made available on line.

Transport

In such a rural area as Moray, public transport is an issue for many older people, particularly when it becomes too costly to continue to run their own vehicle. For many the difficulty is not living close to a regular bus route or having access to a community transport scheme, although there were also concerns over having support to use public transport and to provide help at the destination.
People were very supportive of the role of community transport schemes but want to see a more strategic approach to co-ordinating transport.

Community Capacity Building

Support to avoid or reduce loneliness and isolation featured in the responses. When opportunities for contact are reduced through changes to services, new initiatives need to be progressed to ensure social networks are not lost. Befriending was important, along with lunch clubs, and volunteering was recognised as a way to make good use of free time.

People need activities and opportunities to feel useful in their communities – and they want to know what is working well in one community so that it can be replicated in others. They liked the idea of time banking as a way of continuing to utilise their skills for the benefit of others.

Opportunities to make use of existing community facilities – there should be no barriers to older people using the same facilities and services as everyone else.

GP Practices

Difficulty in getting GP appointments was raised as a concern by many older people during consultation events, which included making telephone contact during time slots set by practices and of getting an appointment within what they considered to be a reasonable timescale. They also want better communication between hospitals and GPs.

Regular GP/nurse-led health checks were considered important and there was a call for age limits on screening to be removed.

Technology

Advances in technology were welcomed, particularly the social side of keeping in touch with friends and family around the world and many older people want support to be able to utilise IT. Opportunities for intergenerational working were considered important, particularly in field of IT.

1.11 Proactive Care and Support at Home

Recognition of the value of carers was regarded as a priority and they in particular need support to stay well, such as respite breaks and the offer of training in areas such as moving and handling.

Housing

First and foremost, there was an overwhelming desire from older people to remain in their own home for as long as possible.

Older people expressed concerns at the Moray Council housing allocations policy and the difficulties faced by older tenants when people with disruptive lifestyles move in next door. There was some support for particular housing being specifically "reserved" for older people and it was considered if properties had been adapted for the needs of an older person, the house should not be returned to general stock after it was vacated.

Bungalows were preferred over flats, with suggested lay-out for new builds being in clusters to allow neighbours to keep an eye out for one another. Developers were urged to consider the needs of older people by providing smaller homes or consider the addition of granny flats to new family homes.

Low level support services, such as help with gardening, housework and minor repairs, were said to be important.

1.12 Effective Care at points of transition

People acknowledged the benefits of telecare as a means of supporting them to maintain their independence. They want advice and information on what could make a difference to their situation, easy to access and responsive services such as equipment to make daily living easier.

1.13 Intensive Care and Specialist support

Older people highlighted the importance of people listening to what they had to say – not just professionals but family members, too. They want to feel valued as individuals, have their place in society and have their life skills and experience recognised.

Older people acknowledged that people are living longer often with multiple long term health conditions. These, they felt, should not be looked at by health and social care professionals on an individual basis, but addressed as a whole.

They remained clear, however, that they want to avoid inappropriate hospital admission and want care as close to home as possible. Being cared for could mean being in their own bed rather than a hospital bed.

There was strong support during consultation for alternatives to hospital admission such as the use of district nurse-led step up/step down beds in care home, and for services – including low level support provided by the voluntary sector – which enable people to return home as soon as possible following admission.

There was also clear backing for the reablement focus of services, where older people are supported short term to relearn skills and confidence for independent living, such as regaining mobility after a fall.

Further detailed comments can be found in the tables below

Preventative and anticipatory care	Comment
Advice and information	• Publicity for events and help groups • More information on what groups are available. Older people friendly information such as larger print • There is an overwhelming amount of information available. It needs to be kept up to date and co-ordinated • Lot of information out there but a lot of people are not getting it • Better sharing of information between voluntary groups, health and council and within groups themselves. People living in the same village were not aware what was available. • Information networks are really important but how do you get information out to people? Should be an essential emergency contact list given to every older person • Some kind of over-all co-ordination of all groups out there. Someone you could contact to find out what is available in your area. • Information to be placed in a lot of different locations – people may not necessarily go to the library for example • Practical information on how to cope in an emergency, especially when you live alone • Information stands in more prominent areas • Older people's awareness day where all services contribute to raising awareness in the local community • Talks to local groups such as BALL groups, senior citizen clubs etc to tell them what is out there • Great services are no use if no one knows they exist
Communication	• Remember not everyone uses the Internet • Workshops, not talks, where the elderly may have their say • Comprehensive communication/networking between the Third sector and public sector • Frontline staff need to be more informed of the voluntary services available
Reducing social isolation	• Contact is important, especially in rural areas. When services close we need to build things up in place of this social network

Preventative and anticipatory care	Comment
Social networks	• Need to protect social networks such as lunch clubs • Better use of community facilities and assets with services being provided for older people. Mini gyms in communities • Issue over separating older people rather than encouraging them to get involved in mainstream activities • What if you can't or don't want to be involved? • Should be more integration between young and old. • Making sure people connect. Social inclusion is a real priority and getting younger people involved in volunteering • There needs to be a means of connecting isolated people before there is a problem such as the flu jab clinic in Lossiemouth which includes a cup of tea. Is the onus on older people? You can't force them to join in but need to make them more aware of what is out there • Funding for voluntary groups is scarce. Is support possible from the council and NHS in kind through venues and printing which support small local groups which are struggling for funding? • A good supportive neighbourhood is great – too many people look to the Government for everything
Opportunities to be involved/volunteering	• People need activities and to feel useful in their communities • How do you get older men involved in activities? • Time banking could be really good and many older people could offer their services without feeling they are on the take all the time
Transport	• Improve public transport • It's not just about the physical transport but someone to support people using transport or going round the shops with you • Rising petrol prices are a real problem particularly for people on a low income but a lot of people do still drive • Transport is a real issue, particularly with disabled/wheelchair access, and in upper Speyside. We need more community transport schemes such as BABS dial a bus which

Preventative and anticipatory care	Comment
	should be spread across Moray • We need a public transport matching services. The swimming pool at Speyside runs classes for older people but people living in rural areas can't get to them • Transport which is central and co-ordinated • Hospital transport expenses. Frequency of public transport makes it difficult for people to get to hospital appointments • More support for car sharing schemes may be the answer particularly with rising fuel costs.
Remaining independent	• I would like to live independently for as long as possible and I am happy to be trained • I'm very independent, I manage myself • The more independent you are, the better. • I would like to do for myself for as long as I can. • A training system to help older people to regain lost skills would be good • I would like to do more things for myself • We would like support to stay at home longer so we don't need to go into old people homes and lose our independence • I do as much as I can for myself most days – but this changes day by day depending upon how fit I feel on the day • If we use our care services better it releases carers to go to someone else
Nutrition	• Good food services for people who require them – is that meals on wheels or another service? • Supermarkets tend to sell things in large quantities. Is there a social enterprise opportunity where you can buy two rashers of bacon and one banana? Nutritional requirements need to be looked at, as many older people are not getting enough variety in their food

Proactive care and support at home	Comment
Reablement	• I would like to live independently for as long as possible and I am happy to be trained • Families need to allow older people to do for themselves • People in their 60s may be reabled better than someone in their 80s, it might be too later
Homecare	• Need continuity of home carers as it's confusing for old people to understand and know who is coming. Have a team so we don't develop dependency • I would like more variety of meals other than what my carers give me
Long-term conditions	• We need to help younger people to deal with long term conditions so that they can live as good a life as possible
Single point of access for Community Care	• Older people need a quick response from the council when things go wrong • Have one number and one contact so people don't have to call this one and that one and be passed around from department to department • 24 hour number which can be easily accessed
Day services	• Need to identify and help older men who have lost their wives and won't come to day services • I'm keeping up my skills and confidence at day services to enable me to do things at home
Carers/respite	• Provision of short breaks • More acknowledgment by professionals of the role played by family carers and the voluntary sector • Dementia training for carers • Specific time spent with unpaid carers to talk about how they are and what their needs are • Someone in during the night to enable me to sleep • Some "me" time • Go and do "normal" things while someone sits with the person I care for • It's difficult to muster the energy to think of how to access care • I'm confused about what I'm entitled to • Carers are stuck in a rut and just coping becomes a way of life • I don't want the person I care for to feel abandoned

Proactive care and support at home	Comment
	• Specific time spent with unpaid carers to talk about how they are and what they need
Support at home	• Pet care service as it is a time of stress for owners when they are ill • Help with housework is essential • need some help I just with emptying bins/ putting bins out
Primary healthcare	• I do not feel confident that in the future will be looked after – GP doesn't remember who you are until they consult their files, and when it is a new one, sometimes they cannot remember all your ailments • Difficulty getting GP appointment – have to phone at certain time, can't get through • Better support from GPs needed – they seem to be missing from the picture • There should be health checks for the 60+ and 65+. It would be a way of reaching those who are social isolated and finding out about any problems they might be having • Abolish age restrictions on screenings • More health screening for men
Housing	• There is a great need for housing allocations policy to be reviewed so that elderly people do not find themselves next door to a youngster with no thought for elderly folk • Older people's housing should be for older people. • Current tenants are reluctant to down-size as they worry who their new neighbours will be. Re-housing people causes a lot of trauma • Older people can't afford the kind of home which will be more suited to their needs. They see their home as their legacy for their children • Older people should be educated about the need to look at their housing needs before they are in crisis • We want bungalows not flats • Should be small so it is cheaper to heat. Main bedroom should be big enough for two single beds. Second bedroom for when family needs to stay. • New build sheltered housing should be close to amenities and public transport, as many older people having to give up their cars

Proactive care and support at home	Comment
	• People want to stay in their own community, even if they do have to move home • Walk in showers, wider doorways, no steps should be standard. Take into consideration the needs of people who are hard of hearing – loop system; flashing doorbells as standard; special phones; flashing smoke detectors. • If a council house is fitted with adaptations, it should be kept for tenants who require the adaptations. Don't take them out again. • Developers should be building smaller homes with a granny flat • Could grants be offered to people to put extensions on their homes for their parents? • Developers should offer smaller plots so people can afford to build smaller homes
Dignity, choice and control	• To be free of worry about health and finances. • Ensuring the more socially vulnerable are informed or supported to gain access to the choices they have available to them, via GP, health services, electoral roll, community care officers, social workers, carers etc, family, friends, day services • More consideration of older people's wishes • Able to be involved and interested if that is what you want • Feel valued – not having to apologise for being slow or whatever • A more dignified way of living • Privacy in every aspect of life • Choice of care • Time not rushed • Why is there someone telling me what I want? They should be listening to me
Finance	• Cost of getting help if you don't quality for support • The cost of equipment and charges • The welfare benefits check is good
Technology	• The community alarm gives me more confidence. More people should have one

Effective care at times of transition, including palliative care	Comment
Intermediate care	• It's a good approach, giving flexibility and choice • I like idea of being assessed in my own home • It will free up beds in hospitals • It's good to have a mixed team with all the specialist supporting you • Don't scare people about going into hospital
Home from Hospital team	• Sounds like a good idea; brilliant • Flexible; tailored, needs led • Could prevent another hospital admission • Gives peace of mind to clients and their families • As long as people are willing to accept help. There must be care with dignity • Gets people back into their own homes • Cheaper • People able to build up their confidence • Linking in with other services/voluntary groups in the community is a positive • Easier for family and friends to visit people at home • Good to have a team • Encourages people to get back to normal in their own surroundings where they feel more confident and secure • There is a lack of communication/co-ordination from hospitals, particularly those out with Moray, and people are sent home with no support • Need to get the timing right – don't send people home too early • Too many new faces can be confusing • People then need continued support to make use of community facilities and get active • There should be a home assessment, after a hospital admission, to check it is suitable for your needs • I used the Home from Hospital team while I needed it – then I decided that I didn't need it

Effective care at times of transition, including palliative care	Comment
	anymore and it stopped
Step up/step down beds in care homes	• It's good you are looked after by your own GP or district nurse who are also able to given professional support to care home staff • This allows time for an assessment; takes away worry of something going wrong e.g with medication • Not so many restrictions in care homes compared to hospital • Good idea; offers choice • It could offer palliative care for single, isolated people • It would be alright providing the care home has a good reputation • Better than hospital admission • Closer to home, easier for family visiting, easier for transport • Good to have something in Elgin • Room to yourself; opportunity to mix with other people • Some care homes are too big and don't feel homely • Person may be affected by the attitude of staff • Care homes are still a strange environment • Would be short-sighted to reduce community hospital beds just because you have this

Intensive care/complex care	Comment
Training	• I know of a woman with dementia, who ended up being treated like a child because staff are not trained for specifically on how to treat people with dementia
Health and social care system	• Cannot have confidence when there is no community hospital. After a GP, the next stage up for a hospital is 20 miles away
Care homes	• A negative is the costs and quality of some care homes • In care homes, and when carers are involved, if an older person needs to go to the toilet, they should be taken there and then, they should not suffer the indignity of being told to wait. This is particularly important for people on diuretics

2. Final consultation on draft strategy

The draft strategy was approved for consultation at a meeting of the Moray Council Health and Social Care Partnership on 28 November 2012.

The consultation was launched on 12 December 2012 and closed on 11 January 2013 to enable the finalised Moray document to be considered for approval at a meeting of the NHS Grampian Health Board on 5 February 2013 together with the strategies produced by the Aberdeenshire partnership and Aberdeen City partnership, prior to submission to the Scottish Government in February 2013.

The draft strategy and background appendices were made available on the Moray Council website with a link from the NHS Grampian website and publicised by way of a press release.

A summary newsletter providing an update on the work to date and the consultation questions was designed by the Older People's Reference Group, including the wording used.

For each of the seven commissioning themes a summary of the long term (10 year) commitment was set out along with areas of development to be carried out over the next three years. Respondents were then presented with tick boxes to answer whether they agreed that the development areas would help achieve the commitment on each theme. For each question further comment was invited.

Copies in printed and electronic format were made available to the general public via the libraries services and distributed to stakeholders including: the Older People's Reference Group; older people's community groups; service user involvement groups; the Public Patient Forum (PPF); health and social care staff; the Third Sector; Independent Care Sector (care homes); GP surgeries; community hospitals; community councils/area forums.

Further information was offered by way of telephone contact with the strategy development officer.

2.1 Responses

While it was acknowledged that it was not ideal to be holding wider stakeholder consultation over the festive period, the timescale was necessary to enable consideration of the draft strategy and final version at meetings of The Moray Council and NHS Grampian Board.

A total of 60 responses were received; 35 online and 25 by paper return.

Respondents were asked to identify themselves by ticking all boxes which applied, meaning people could select more than one category. A number of people chose not

to complete this question and accordingly numbers do not match the total number of returns.

Are you?	
Aged 65 and over	28
A carer	6
Employed in health or social care	14
Someone who currently receives health or social care services	5
None of the above	3
Not stated	14

All comments made have been captured and reported to the leads of the commissioning theme work streams for consideration and potential incorporation as part of the ongoing work on the emerging action plans which form the implementation part of the strategy.

Two additional detailed responses were received from a clinician and from a Third Sector organisation which have been reflected in the final strategy.

2.2 Breakdown of responses and common themes

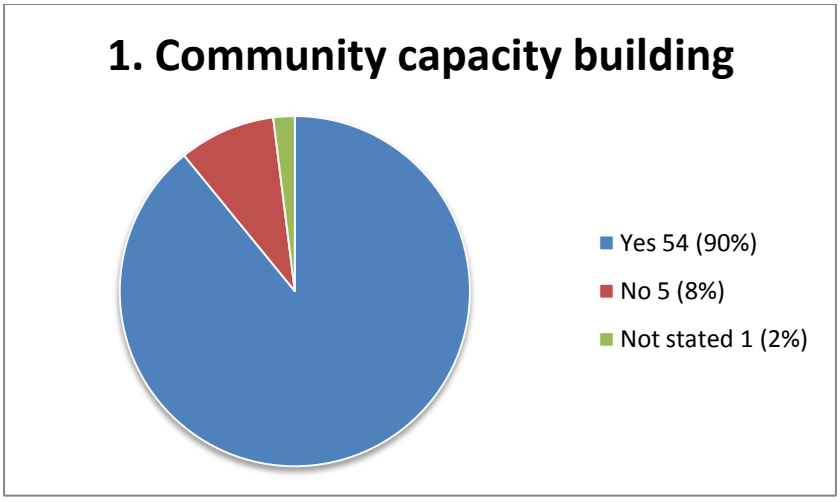
The questionnaire asked respondents if they agreed that the development areas will help us achieve our commitment in respect of the seven commissioning themes.

All themes were supported by a positive response rate of 80% or higher.

A common point made by many respondents, whether in agreement or not with a specific development area, was to question how funding would be secured and where additional staff would be recruited from to provide more care at home.

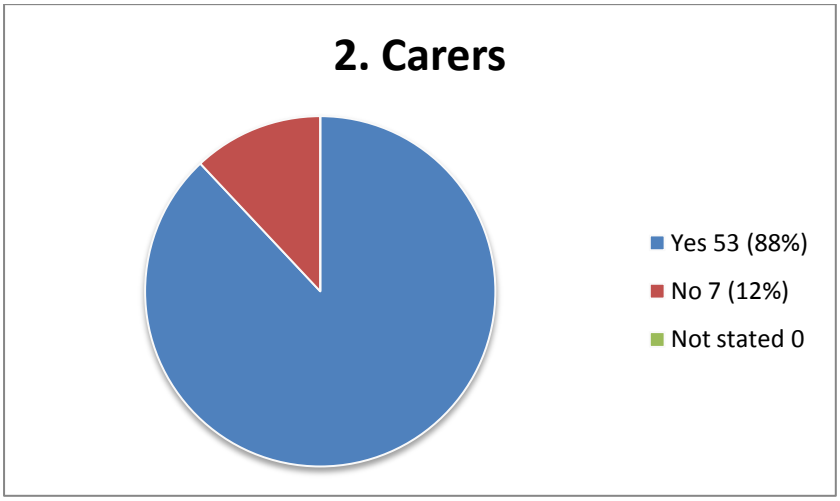
One said: "Having read through the full strategy - and I do appreciate the extent and thoroughness of the 18 month project - the start giving the facts as to how the older population is growing so alarmingly, I cannot envisage how with the limited additional budget the project will be accomplished over the next 10 years."

Respondents also took the opportunity to comment on previous difficulties with existing services.

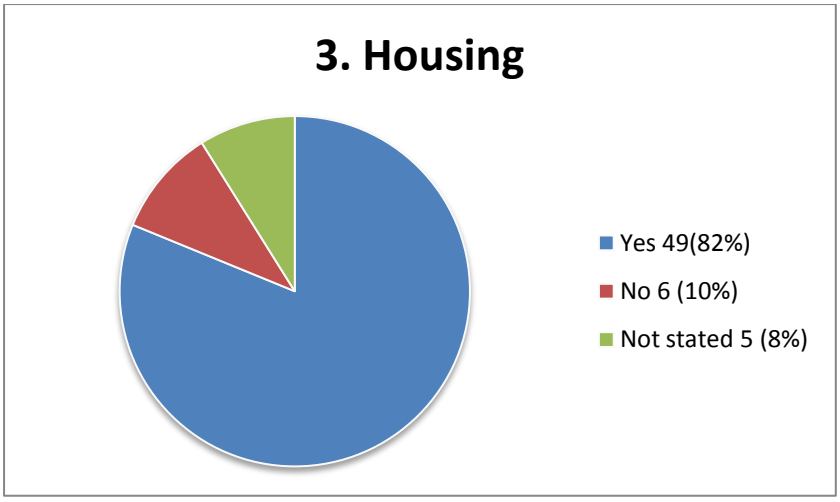


While supportive of community/voluntary provision and encouraging more intergenerational working, points were made that statutory services still had to be in place as a safety net to ensure no one falls through the gap and that independent living did not push people into social isolation.

The importance of oral health was raised and on the need to capatalise on the good community support which already exists.

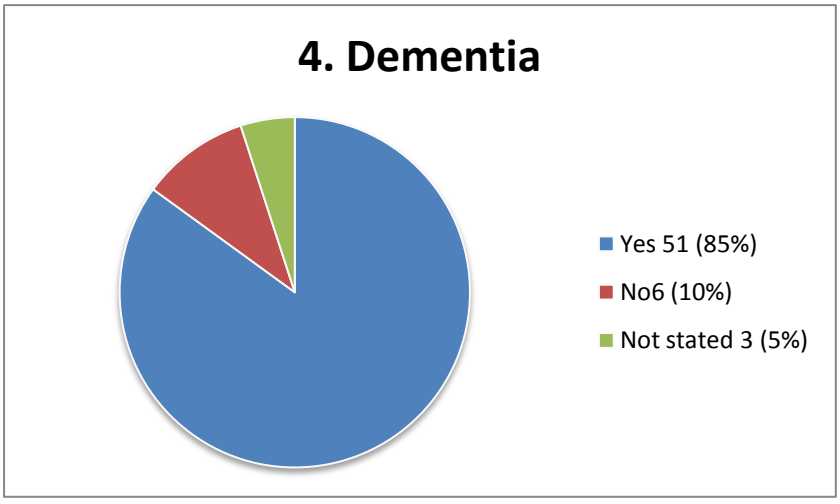


The vital role played by carers was commented on by many who highlighted the importance of supporting the health and wellbeing of carers through respite, training and recognition.

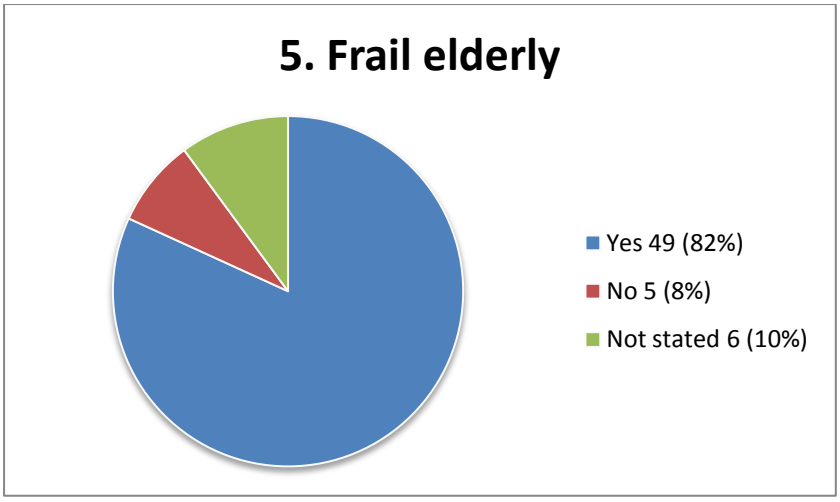


Of those who answered, 82% were in agreement.

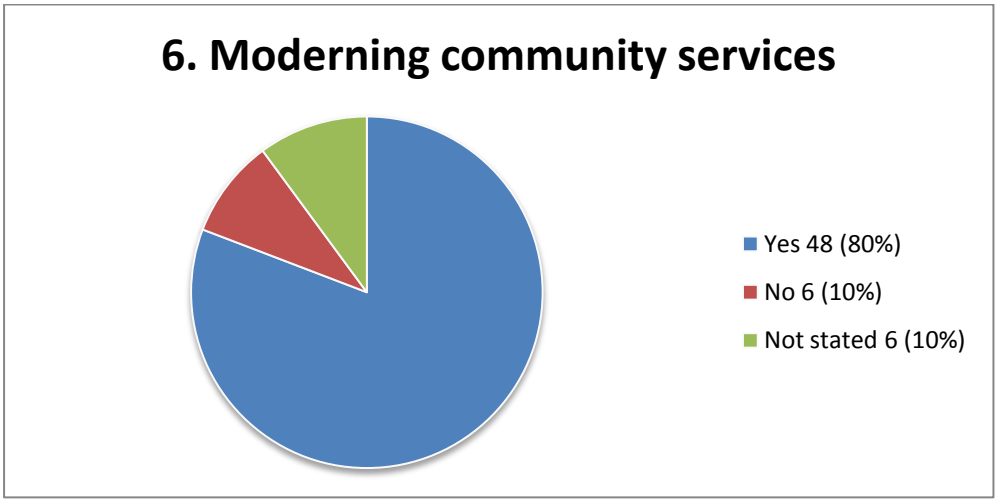
Funding was highlighted as a major issue while the use of technology to support independent living was commented on along with adaptations and the need for housing support for older people with mental health, drug and alcohol issues.



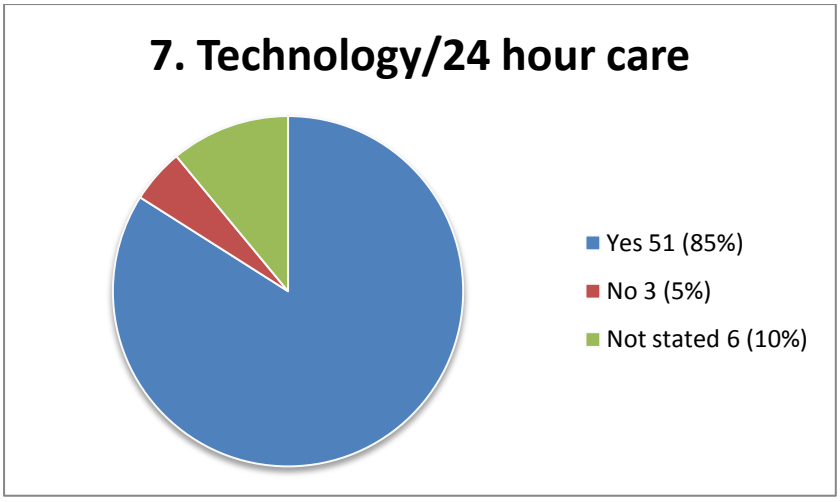
The scale of the challenge posed to health and social care services by rising rates of dementia was noted, with funding and staffing levels requiring to be bolstered as a consequence. Training, both of professional staff and in the wider community, was flagged.



A “bolder approach of anticipatory care planning” was called for, with the suggestion that out of hour’s service remains a weakness in efforts to take a “whole system person centred approach”. There was backing for an annual health check and for more support services to be in place following a comprehensive geriatric assessment.



Closer integration of health and social care was urged, with support for more opportunities for people to be cared for closer to home, better planning for end of life care and reablement. The importance of treating older people with respect was underlined as was help for those returning home on discharge from hospital.



More explanation of the dallas technology programme was called for. It was suggested older people may not be familiar with or trust technology to support them.

2.3 Equality impact

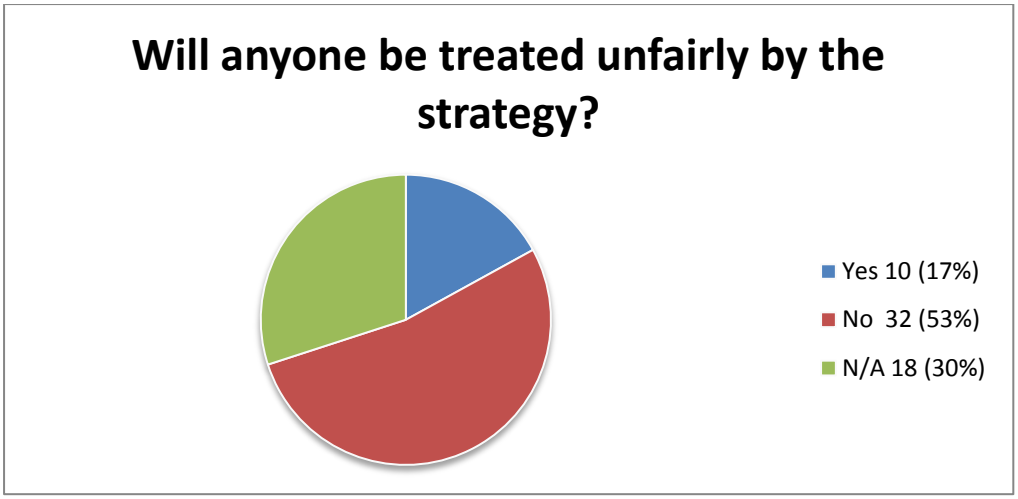
Respondents were asked to consider if they felt anyone was likely to be treated unfairly as a result of the strategy being put into practice.

The question on discrimination received the lowest number of responses (42) and the lowest level of support with 53.5% (30) considering the strategy would not have a negative impact.

Many respondents considered that no matter how good the intentions of the strategy, in providing services to individuals it was impossible to ensure everyone was treated the same.

One considered this was the case in particular for people with mental health problems. Another commented on media reports of mistreatment of older people. It was also stated that it was important people feel able to raise concerns about the way they are treated.

No specific comment were made that anyone would receive unequal treatment on the grounds of age, disability, race, religion and belief, gender or sexual orientation.



2.4 Continued involvement

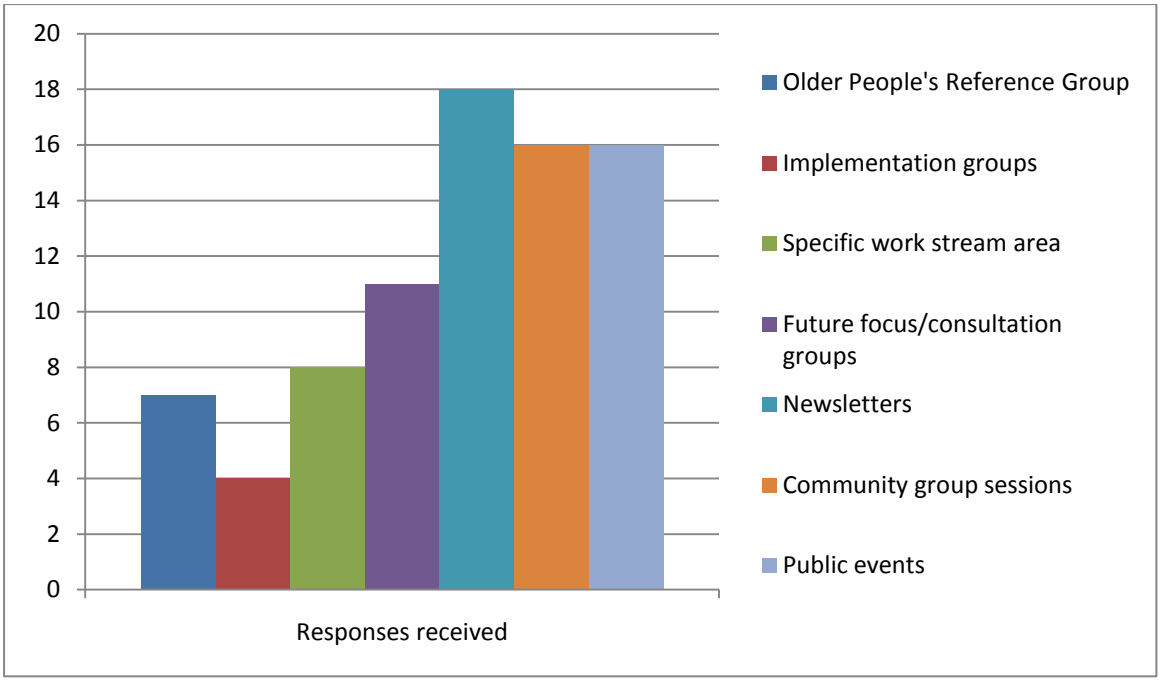
The consultation took the opportunity to underline the importance of older people coming together with professionals and voluntary services to ensure the delivery of services that achieve best outcomes for older people.

A total of 25 comments were made on ways in which people, their team or organisations can contribute, ranging from individual goals such as keeping fit and active and providing feedback, to promoting services, improved communication and safety awareness.

Respondents were also asked for their preferred method of engagement and involvement as the commissioning strategy is implemented and 32 people (53%) indicated they want to be further involved.

Strongest support was for the continuation of the newsletter, public events and sessions for community groups.

People with an interest in specific group work will be invited to be further involved.


20
18
16
14
12
10
8
6
4
2
0
Responses received
Older People's Reference Group
Implementation groups
Specific work stream area
Future focus/consultation groups
Newsletters
Community group sessions
Public events

3. Draft commissioning strategy consultation responses

Q1: Do you agree that our development areas for the next 1 to 3 years will help us to achieve our commitment in relation to building supportive local communities	
YES 90%	• Simple to understand benefits advice would be welcome. Would this have to be done at a national level? • Sometimes can be a tension between supporting 'independence' and loneliness so need to support social links alongside independence? • There will be links to some of these areas from the national Living it Up Project too - certainly until 2015 in the first instance • I think that involving ALL those interested in supporting those in the community should be included; e.g. young people supporting & learning skills etc from older people- i.e. intergenerational working- this links into curriculum for excellence & therefore fits the mutual benefits of the community, rather than notions of charity from those younger & fitter- allows older people to contribute to society & community they live in. • I agree that it will go some way towards developing supportive local communities. I think we need to embrace what already exists and capitalise on this - and this doesn't necessarily always mean introducing new partners • go head with this it looks good and sounds good and is what is needed • There also needs to be a safety net of state provision to fulfil needs when community/voluntary provision breaks down for any reason. There needs to be a more gradual shift of balance from state provision to community/informal support to ensure gaps are not left in provision and the more complex, difficult to support people are protected and not missed. • I would like to see oral care included. Especially within the following - Commissioning theme 2 - carers - development areas for the next 3 years could include - Carer training around oral care. Commissioning theme 6 - modernising community services - long term commitment, health promotion and self care approach. I am oral health improvement co-ordinator, NHS Grampian. I am already involved in home care training for carers around oral health. I am also heavily involved with oral health training for the care homes and would love to be involved with the unpaid carer side, especially when the predictions are clear that unpaid carers will increase. • Diligently applied. • But a representative should address groups on an annual basis to keep people informed on progress.

	• Yes it sounds good but I wonder where the money is coming from to be able to achieve these things. • Access to information is very important to us so that we have choice to make our own decisions. Access is the key word. Some of us live on our own but are not able to leave home without support or use public buses. Would the council consider using sheltered housing common rooms/communal areas closer to us, as information hot spots/hubs? (Older people's day service group response) • Much needed commodity
NO 8%	• For years other folk, besides myself, have emphasised the importance of foot care for ailing and inelastic people, especially those who are medically forbidden to attempt foot care. Realise that strong limbs, lungs and other organs are worthless if feet will not support or transport a body (and its weight) normally. • I think there are many people who are not interested in joining or unable to join community based groups. I think there remains a need for services to go into people's own homes for a section of the population. • We don't have a local bus in Forres; one part of Forres no bus at all – Mannachie Terrace, Mannachie Rise, Allan Drive, Anderson Crescent etc. A lot of elderly people cannot get into Forres, plus connections to Nairn, Inverness, Elgin and train station
N/S 2%	• Getting volunteers to get older persons to understand that there us little to no cost to getting advice. Chin wag on getting out of their comfort zone. Putting persons at ease and not pushing them too hard to accept help.

Q2: Do you agree that our development areas for the next 1 to 3 years will help us achieve our commitment in relation to carers?	
YES 88%	• Sounds good but expensive. • Reablement may apply to dementia in some cases to a degree, perhaps by way of reducing 'excess disability' through partner or paid carers doing too much for person. May be some capacity to re-learn tasks etc but against a background or deterioration of skills. Term 'cognitive rehabilitation' may apply more to dementia group. Reablement likely to require increased investment in terms of staff time/training/supervision, with any savings coming later if scheme is successful. • Re: re-ablement; comments from service users have been that they would be keen to use re-ablement flat facility but would like to be there with their partner would give true reflection of what goes on at home, & carer could be

	supported by staff & advised of re-ablement; sometimes this can prove difficult subject for couples who have been fixed in roles for years- a 'professional' input can support couples to buy into re-ablement- giving female (predominantly) permission to take step back. • The best is what is needed = carers need caring as well as the person who is being cared for - short breaks together is something which is dear to my heart. • Flexible support needs to be available to ensure unpaid carers can continue to have independent lives. Those without available networks of support need to be considered and ensure that services & support remain available for them. A shift to informal care can precipitate a reduction in the availability of formal provision that adequately meets needs. • Agree it is vital to keep carers healthy so as they can sustain their caring role. This is probably the most important part of the whole strategy, without unpaid carers the system wouldn't cope. The spend on unpaid carers can only increase as the population gets older. Spend a little to save a lot. Working in partnership with carers organisations and any voluntary groups that support carers is also crucial - carers as partners, yes - but organisations who support carers also as partners. • Partnership working is vital and every aspect of health and wellbeing should be included. Knowledge of various support groups and training for carers - Oral health training. Oral cancer is on the increase and quite often the elderly do not see the need to visit the dentist as they "have false teeth" The oral cavity is one of the easiest to explore and in relation to oral cancer, early detection is vital. As in the comments in the previous question. Oral health training for carers advice and training by NHS Grampian - Anne Cousins Oral health improvement co-ordinator. Improving the oral health of older people in Scotland is a key government priority. Many dependant older people cannot perform their own oral care satisfactorily and rely on others for help. Care staff therefore play an essential role in the delivery of oral care. “Oral health is a standard of health of the oral and related tissues which enables an individual to eat, speak, and socialise without active disease or embarrassment and contributes to general wellbeing" Oral health means more than having "good teeth". It is part of (and should not be separated from) general health and it could be argued that you cannot have a healthy body without having a healthy mouth. It is essential for physical and mental wellbeing and is a determinant of quality of life. • Financial capability notwithstanding. • The aim is very good but I am an emergency contact for a 92-year-old lady at 71 my self and the system does sometimes break down. When she was sent home from Keith hospital a year ago in the afternoon, no carer came until bedtime and is she had been unable to contact another friend and myself, she would have had no food until

	bedtime. On another occasion the carer did not come at lunch time and she had no food between breakfast and tea time. Lack of communication needs to be addressed here as people do generally prefer to remain in their own houses. Also carers need to be carefully screened before appointment. • I think carers should be paid and supported by all the necessary agencies and they should have regular respite to enable them to carry on caring. • It ought to. Unpaid but untrained? Does "encourage and support" mean substitute for training? Will a budget be provided for training? Training for carers – provide syllabi, qualification standards. Standardise carers' assessment. • I also think it is helpful to people to recognise that they are carers so they know they can get assistance. • We have never received any breaks/respite care, even though we have to support each other. We take breaks together which we pay for ourselves. • It sounds great but I'm not convinced that these things will happen. How is training them going to help when they don't have the time and money to do it now? • We agree in principal. Having access and information on our choice for respite/short breaks as we are not aware that this is an option. Support for anyone suffering from or caring for a loved one with dementia is a positive step. (Older people's day service group)
NO 12%	• The present system does not work, even with the Change Fund money; new staff taken on but no improvement in services. • Many carers are struggling with manual handling issues which peer support and the above training does not address. Some unpaid carers would welcome paid carer support as well as the support listed in the development areas. Sometimes it is the day to day issues of dealing with incontinence or changing someone's clothes or bedding, or moving them safely around the house which is a burden to an unpaid carer. • Carers are not sufficiently valued. They save the NHS thousands and millions of pounds and also keep patients at home rather than blocking hospital beds. They should be paid for the hours they spend attending to patients.

Q3: Do you agree that our development areas for the next 1 to 3 years will help us achieve our commitment in relation to housing?	
YES 82%	• Dementia friendly housing and workers with specific dementia care skills are important. • In addition - consideration/investigation of Smart housing using assistive technology - including specialist supported housing for specific conditions such as dementia. • More support for older adults who have mental health & drug/alcohol issues; e.g. specialist support for people with personality difficulties/disorders who misuse alcohol. Intensive support for older adults dealing with past issues of abuse- unresolved issues can lead to tenancy becoming insecure & increased anxiety at being alone. • Computer literacy is becoming so important as so many services are moving in the direction computer only information including bills. There are many elderly people who do not own a computer so they will have a problem in the future. • We need safe financially available housing and adaptations to houses to ensure that all are safe, can remain in the home that they have built up for as long as possible leading a free independent and happy life - this is essential - this looks good • Home insulation should include external cladding where cavity wall insulation is not feasible. • With an increase in the Occupational Therapy staff to deal with the increasing elderly population and an increase in extra care sheltered housing provision and improvements in equipment and alteration, the commitments could be met. • Ensure that the housing has adequate safety i.e. fire in place and that the staff (full or part-time) know what to do in an emergency. • Definitely bungalows, not flats. Would like to think that removing bulkhead lights that cover pensioners' access will never be allowed again (see 131, 133, 135 Robertson Road, Lhanbryde). • We have a wheelchair accessible bungalow (Moray Housing) but we have to rely on Handy Persons Services for non-urgent repairs. • Is this realistic? Where's this money coming from to pay for all of this new development and improvements? • Again using existing buildings such as sheltered housing common areas as a community resource where we can attend which is closer to us, build relationships with our neighbours and staffing to support us with any queries. (Older people's day service)

	• As long as the above is definitely met. Adjustments to the person/persons home is vital for the elderly and nothing too complicated for them to use. No high tech use of instructions etc just 'Plain English' as in the twilight years trying to remember new ways of working can be difficult - especially in the early onset of Alzheimers or the plain ageing process. Keep it simple.
NO 10%	• Yet again funding. • It goes some way to begin this process. There are too many unanswered outcomes - of discussion to say that it will categorically meet the target • Present arrangements in Moray leave a lot of unanswered questions and until this is resolved I can not see you achieving your aim. • Does “community resource centres” mean existing communal facilities or are new build budgets envisaged? Building plots and vehicle garages can be built at Leanchoil hospital’s grounds and at Kinloss barracks. Moray Handypersons Services is at a low level; it needs more financial and human resources; contact is abysmal but its newsletters are glossy. Publish information on community resource centres. Link adaptation services with hospital discharge personnel; OTs can’t operate well in such tasks. The Joint Equipment Store doesn’t recycle assets efficiently; seek users’ suggestions. Fuel poverty – liaise with Energy Savings, Scotland’s scheme to devise efficient methods. • Also build several co-housing developments for over 50's in both rural and town areas, so that older people can take responsibility for their own lives, and support one another. Build these as eco housing to keep running costs low.
N/S 8%	• Good luck with this, sounds very ambitious in a three year period. • It looks good on paper but the finance could be a major stumbling block.

Q4: Do you agree that our development area for the next 1 to 3 years will help us achieve our commitment in relation to dementia?	
YES 85%	• I hope you do well in this area as the need is growing with the increase in numbers. Sad that GPs require support to diagnose dementia. • Consider that specialist dementia units within the independent sector may be soon filled creating a bottleneck and waiting list. Specialist units should not detract from care homes efforts to continue to look after more 'challenging' patients rather that be looking to move them on.

	• Services require to be more tailored for people with dementia rather than 'days out'; needs to be practical to support routines in place as well as providing social opportunities. Appears to be lack of focus re medication management. • Go for it - access the funds available at national level - ensure that Moray gets its fair and just settlement. • In care homes, provide facilities for those who do not suffer from dementia to be apart from those who do when eating etc as this increases medical stress on the mentally still fully alert. • In consultation with Alzheimer group for example. • Amplify/explain “post diagnostic support”; very little basic knowledge exists. How many carers exist – might they receive derogatory labels. What is the independent sector? What other themes exist? • This should work if properly implemented by all concerned. I suggest that the cafes be in keeping with the age of the people attending and mix with a younger element to bring understanding to the needs of the people concerned. To keep the dignity for the elderly person and make them feel wanted in this environment. A lot of elderly people feel ostracised in such places, especially if they are on their own.
NO 10%	• I think we are underestimating the scale of the challenge to change how everyone involved in looking after older people changes their approach and becomes skilled in using a person centred approach for everyone who has dementia and other mental illnesses including delirium and depression. Too many people die sad and alone and depression is more common than dementia. • I can see short term posts created for workers and at the end funding being stopped. Good intentions but need to follow through with funds. • No assurance given and target or measure not apparent. Can see that it has the potential to improve the situation. • Some Alzheimer patients require one to one care and this is not available now and I can not see it being available in the next 1 to 3 years, Also from my own experience I have found that dementia patients appear to be on a less than priority list, that is they appear to be left until some thing needing urgent treatment happens and even then they are not treated as quickly. In deed at least 2 to 3 hours have passed until action is taken and in one case, 19 hours delay nearly ended in death and the family being sent for and having to travel approx. 650 miles to be at their mothers bedside. • You need to involve community health and social care staff too - bolster staffing levels and increase training for front line staff in dealing with clients with dementia. • Use of common rooms to support groups to meet on a regular basis, also for anyone to access information if required. This could be close to our homes with no need for hospital or GP visits. (Older people’s day service group).

	• Ask older people with dementia and their carers what they need.
N/S 5%	• No experience in this area but it seems good.

Q5: Do you agree that our development areas for the next 1 to 3 years will help us achieve our commitment in relation to frail elderly?	
YES 82%	• Do hope that a regular MOT will once again be a reality for the over 75s. • Reablement can work well with this sort of relatively cognitively in tact older population. • Continue to consult with frail elderly population to evaluate development in areas people see their need. • A once a year MOT would pick up many problems at an early stage. • This looks as the best we can offer - the best is only good enough - after all many have worked in Moray paid their taxes and we should take care of them in their older years. • If the above was implemented then it could help you achieve the commitment. But extra AHP staff will be required to provide a comprehensive assessment of older people's needs and to improve identification of frail elderly in the community. All too often it is not until they fall or have a health crisis that the frail and vulnerable elderly are identified and receive services/support. • Repeat - financial considerations. • Regular checks by doctors and community nurses needed without being sent for only in emergencies. My have difficulty getting appointments through the present system and then see a different doctor each time. Some people have difficulty explaining time and time again to a different doctor their needs and the whole health picture is not looked at. Continuity of care needed as used to happen. • The plan will go some way to achieving the objective but there needs to be much more funding available. • We have had to shout for help after hospital admissions i.e. cancer operations, heart attack, hip replacement even though the later had been requested by Woodend Hospital. • Community care officers should make themselves more available within the community by using communal areas, working from hot desks closer to us and for us to have face to face contact. Regular “open surgery” times would be of benefit to us. (Older people’s day service group)

	• All it needs is a little tenderness, dignity and a feeling of self worth. The rest comes naturally.
NO 8%	• Our approach to anticipatory care planning needs to be bolder and a whole system person centred approach needs to be taken. The weakest part of this system is the out of hours GMED service which cannot operate to this standard in its current configuration. • Again where is the money coming from? • Specialist assessment is not effective unless supported by other services. There doesn't appear to be any mention of services that will actually support the population following a CGA. “Develop a workforce that will support frail elderly and carers” to do what? • I appear to be negative in my answers, but can only answer by my own experiences of the present system, which have not been good and until the complacency and thought patterns of our professionals are radically changed I can not see anything getting better over the next 1 to 3 years I include MSPs and local government officials. • It will meet many needs, but where will all the carers come from?
N/S 10%	• They need to go out with frail elderly. Frailty can affect anybody of any age, for example disabled. Not all elderly are frail. • Is comprehensive assessment for older people’s needs and increase in geriatric provision the same theme? By what methods will identification of frail and vulnerable elderly be improved? Will support for care homes be funding or staffing? In workforce development, are there budgets for training? Could there be annual screening at flu jab events?

Q6: Do you agree that our development areas for the next 1 to 3 years will help us achieve out commitment in relation to modernising community services?	
YES 80%	• Need for professional & sensitive interventions to support individuals & families plan for 'good deaths' & what this would realistically look like; discussion re palliative hospice facilities if those living alone do not want to be alone? Within all interventions taking a harm reduction as well as risk management approach; where people do not want to access care/services- ensuring professionals aware of adult protection & use appropriately & effectively as means to support as well as protect- can bring people into services, whilst respecting their views. • But only if the areas being developed are successfully developed.

	• Everything has to be done to allow us to remain active, decent, long, enjoyable lives in our final years and this looks as if what we want will be delivered to the best of all abilities. • There also needs to be a better recognition that persons with more advanced dementia will have a limited capacity for 're-ablement' due to the degenerative nature of their condition and good provision needs to be developed to ensure that these people can have access to ongoing support with independence rather than focussing on time limited intervention. Some people cannot be re-abled as they will only ever deteriorate in their ability. This is not to diminish the huge value of re-ablement in early stages of dementia. • Commissioning theme 6, modernising community services - Oral health could be included within the health promotion and self care approach. • Train staff to respect the elderly and not leave them in their beds without food and drink, which we have read about recently and if someone cannot feed themselves then staff must help them. • I asked to go into a care home for the time my husband was in Aberdeen receiving a replacement hip in March 2011. I'm still waiting. I am a wheelchair user. • Local hospitals such as Leanchoil should have more beds so that people can be cared for closer to home. Sending a 92 year old lady to Keith made visiting for elderly friends very difficult as visiting hours did not fit easily with bus times. The care in the hospital was excellent but collecting washing and visiting was difficult. The same applies to the other outlying hospitals. There is a great deal of concern about the few beds available in Leanchoil. • Joint working and regular communication between community services, day services, wardens, GP/nurse, practice etc would help us stay at home longer and recover quicker. We want to do as much as we can for as long as we can but we need support and safe places to do so (Older people's day service group). • Great ideas as long as they come to fruition and we can really go forward on these suggestions they are certainly badly needed commodities for the elderly especially as we are an ageing nation.
NO 10%	• Care homes need more staff as it is. More nurses and care workers are required at the moment and that does not happen so how will it happen in the future? • Too much delay has been a problem and the back log of support both in help and money terms will take much longer to achieve you aims. • This won't happen without bolstering current AHP services. Community services should always have been promoting rehabilitation, re-ablement and recovery - that is not down to 'modernisation'. OTs have been doing that for decades. Care officers/social workers need to take more responsibility for carrying out proper client based, evidence based

	holistic assessments and deal with all issues not just immediate care needs. Care Officers could be doing more education and preventative work with clients and their families. What is different in the above list from what has been attempted by the Intermediate care team and change fund money in past 12 months? It needs to be more structured and organised. Speak to front line staff who are already doing the work. • Much more liaison is needed between care providers. Social carer and health care are like two different entities – social care should be locally controlled, not through large department in Elgin. • Care in the community needs to be improved. • Develop intermediate care facilities within the home or close to home – promulgate ideas. Respond in a "timely fashion" – is vague and a loophole for slackers. Delete the words and insert promptly. • No – (sections marked) develop joint working arrangements to enable health and social care to better arrange and access services; develop intermediate care facilities within the home and close to home. • Reablement needs to address actual needs, including needs for conversation, not just needs such as washing and dressing which can be easily measured.
N/S 10%	• Short -term intermediate care beds (reablement unit) may be more productive/acceptable to patients, as opposed to care home environments? • Ensure that persons, when discharged, have the ability to look after themselves when on their own and have close access to an alarm system if necessary. • The problems aren't unique to the elderly. These changes (health promotion and self care, intermediate care facilities and pathways in and out of hospital) should be done for everyone.

Q7: Do you agree that our development areas for the next 1 to 3 years will help us achieve our commitment in relation to embracing technology / 24 hour care?	
YES 85%	• With dallas, the emphasis has shifted from developing a '24 hour monitoring service' to provision of the most appropriate responses to emergencies. Working with dallas private industry and technology partners has given early glimpses into the fact that it is highly likely that the current 24/7 Telecare alarm monitoring services will be

	superseded. With what, has yet to be defined. • More info required on 'dallas approach'- I've searched internet with little results- is this a technology system? I think that access points throughout moray need to have up to date info on what is available- moray is a rural area & as such people will continue to drop into local offices, not necessarily get on a 1hr bus journey to Elgin. • Great idea. • We do not have any family support. • Will telecare become more advanced? We have sat nav and 4G technology now but my telecare product only works with 30 meters of my home. How can this be improved if I'm further away independently and require support? Does dallas recognise this? (Older people's day service) • We have to go forward - technology is the future not just for now but for years to come and we the community care who must embrace it with both hands to expand the greater needs of others it is plain common sense to embrace the future. I for one would have no hesitation in doing so.
NO 5%	• No as older people don't trust their local council and most will not have computer literacy, again as they have not been brought up in a computer age.
N/S 10%	• The dallas acronym/jargon must be explained. Dallas is sited in Moray (and Texas). The Independent Living Centre is too far to visit often to update – use a dedicated column in local press. Possibilities exist at Kinloss Barracks and RAF Lossiemouth to improve telecare call centre arrangements. Technology enriched housing should include rapid broadband email • Why over 75 (for focus on telecare packages)? Age has nothing to do with ability.

Q8: This strategy needs older people to come together with professionals from public and voluntary services to ensure we deliver services that achieve the best outcomes for older people. How do you feel you/your team/your organisation can contribute?
• Keep on consulting regularly on progress and really listen to carers and families who are living with the problems. • We have an established Telehealthcare Involvement Group, who I'm sure would be willing to contribute user and potential user views.

- Falls prevention
- My own objective is to keep fit.
- By observing the needs for my wife and myself and other older people with whom we have regular contact
- Create more opportunities for older people and their carers to express their views such as regular open days within each area not just in Elgin.
- Better consultation with service users
- we already do as part of the older people's reference group
- Early interventions. More sheltered housing.
- I don't as I do no trust them. They only give establishment jargon in their answers and do not show any compassion for their job!
- Moray Council needs to ensure that the Access/Intake team is properly staffed and resourced and that processes are clarified and followed so that the area teams can take a more measured approach to the long term work that is needed to identify older people's outcomes and support them to achieve their outcomes. Arguing the toss over who should deal with crises that arise does not facilitate this.
- Promotion of dental services available and oral health training for unpaid carers, carers and care home staff.
- OTs are in a good place to help deliver best outcomes for older people. Meet with front line health and social work OTs regularly and keep them up to date with services/developments.
- local knowledge engagement and onward communication
- As a dance group we keep all our pensioners fit and out of the clutches of the NHS. We will always welcome those who cannot dance but would welcome those who would like to come and listen to good music, have a chat with tea, cake and biscuits at half time
- As most/some of the elderly population believe GPs don't care anymore, every GP should be involved in activating and implementing this strategy – without financial incentives. They should be accountable for those who slip through the net.
- Providing feedback and comment. Involvement with Age Concern (Scotland) has proved both interesting and informative. Had no idea so many organisations available to help. Lack of communication generally in the community prevents people using these
- We provide a meeting place where over 60s can socialise, have entertainment and where people can come and talk and let them know what's available in the area

- Send a representative to speak and question our members. An annual commitment to update and obtain their views
- I really don't know as I never have had any contact with the public or voluntary services
- Monitoring actual responses e.g. by MCHSCP to elders' opinions and suggestions, then mentoring further improvements
- Provision of short/long term beds; focus on reablement (SCH)
- We are currently working in the community to raise fire safety awareness and targeting older people as part of our campaign to help vulnerable people.
- Through forum discussions.
- I can contribute by offering a disabled perspective.
- By keeping my group informed of what is going on as I go to OPRG meetings
- Meeting more people
- We as a day service group welcome anyone to join us to discuss the strategy further
- Co-housing
- The BALL Groups provides fun laughter, exercise, companionship, learning new skills a good all round way to help the aging process of the elderly - run by elderly people themselves which gives each one a purpose in life to enjoy in their twilight years
- By keeping in touch with all local organisations and helping to achieve a strong carer force which can be relied upon at all levels in the community.

Q9: We would like to continue the engagement and involvement with older people and partners. Please indicate how you would like to be involved (tick as many as apply).	
Older People's Ref Group	7
Implementation groups	4
Work streams	8
Focus/consultation groups	11
Newsletters	19
Community group sessions	17
Public events	16

Comments
• Keep language simple and easily understood. I had difficulty finding the website and had to enlist the help of a librarian as there was no printed copy available in the library. The instructions as to where to find it were not clear enough as older people either do not use the internet or like me need exact instructions and clarity of language in everyday terms and usage. • Please keep care homes involved and updated • A focus group not around the elderly, I would attend • One of us has reached mid 80s, the other member of the family has just reached 80 and both have health problems. Apart from attending meetings we are sorry we can do no more. If you are having more meetings we would be obliged to hear of them and hope to attend. • We find it difficult to attend independently but welcome people to join our group.

Q10: Treating people equally and fairly is important to us. Do you think anyone is likely to be treated unfairly because of age, disability, race, religion and belief, gender or sexual orientation when this strategy is put into practice?	
YES 18%	• People with cognitive impairments or other mental health problems will continue to be treated differently and inappropriately until there is a paradigm breaking change to the health and care system and a move to person centredness. Too many old folk die sad and alone. Too many people with dementia are not given the support they need to live full lives. Too many are seen as requiring end of life rather than palliative care. • This is happening now. • The newspapers tell us of malpractice almost every day and it is regrettable that respect for ones fellow man no longer exists as it did when I was younger – but how it will ever come back I just don't know. Perhaps make it a subject in schools. • Unfortunately yes. • Yes – people of all ages domiciled in remote, sparsely populated areas. • We can never say that some of these points above, such as unfairly treated because of age, will never happen, but

	because of this Joint Commissioning Strategy things will improve over time. • Disability i.e. blindness, deafness or inability to speak English will cause unequal treatment
NO 53%	• However, there will always be some people who don't want to manage their own condition and want to be socially isolated - how do we support them through this strategy? • Well done - you seem to have covered all the bases • Assuming resources and effort are not inappropriately directed to older people at expense of others • You can never get rid of some form of discrimination as some people will always breach conditions/protocols. • I sincerely hope not - we are a civilised nation and should treat all as equal - there should be no discrimination to anyone who is willing to work for the better of their community.
N/S 30%	• In an ideal world this would work perfectly, but no matter how well put into practice, the X element is not perfect and problems will arise. Hopefully these will be reduced. • Not if it is done properly and if people are aware it is OK to raise concerns if they feel they are not being treated properly • I think you will try to treat everyone equally but there is so much focus on the elderly that other groups (disabled) may be discriminated and neglected. • Having access to this information is important and any mobility/disability may prevent us from gaining this, but not treated unfairly. • I don't know.