To:	**Renfrewshire Integration Joint Board**
On:	**20 March 2020**
Report by:	**Chief Officer**
Heading:	**Older People's Services Review Update**

1. Summary

1.1 This report provides an update on the work taking place in Phase 2 of the review of services for older people and recommends the proposed next steps. This report builds on the work reported to the Integration Joint Board in September 2019.

1.2 This Review contains several work streams which form part of the overarching Transformation Programme.

1.3. This report also provides information on the work taking place as part of the review to develop a local dementia strategy.

2. Recommendation

2.1. It is recommended that the Integration Joint Board

- Agree the proposed approach to the next phase of the review, as outlined in sections 6.8 to 6.13;
- Agree that a draft dementia strategy be presented to the IJB for consideration in June 2020;
- Note the progress made in engaging with stakeholders during Phase 2 carried out by Journey Associates; and
- Note that regular updates will continue to be brought to the Integration Joint Board to report on progress.

3. Background

3.1. 'A Fairer Scotland for Older People: framework for action', [Scottish Government, 2019], sets out the Scottish Government's initial priority areas of action with the aim of ensuring that people are 'happy, healthy and secure in old age'. The framework was developed to address

inequalities older people face as they age and to celebrate and enable the vital role that older people play in local communities across Scotland.

3.2. The framework identified three core areas of action to (i) enable older people to remain actively engaged with, and involved in, their communities; (ii) ensure older people have access to the public services they need; and (iii) ensure older people are financially secure. These priority areas align closely with the outputs from the engagement work led by Journey Associates, described in further detail below [ref 5.2] , and with the commitments for Older People's services within the Health and Social Care Partnership's Strategic Plan 2019-22:

- Older people are supported to live in their own home, or in a homely setting, with links to their community, for as long as possible
- Older people are supported and encouraged to look after and improve their own health and wellbeing and live in good health for as long as possible.

3.3. The review of services for older people contains a number of work streams which form part of the overarching Transformation Programme and reflect the guiding principles of the Programme:

1. We share responsibility and ownership with our communities
2. We take a person-led approach to public health and wellbeing
3. We provide realistic care
4. We deliver the right services at the right time and in the right place

3.4. People in Renfrewshire are living longer but not necessarily healthier lives, often experiencing multiple long-term conditions and changing the nature and volume of demand for care and support. There are just over 14,542 people aged 75 years and over [Source: RHSCP Renfrewshire's Profile to inform Strategic Commissioning April 2018]. These figures are projected to increase by 64% by 2039, representing an increase from 8% of the total population in 2016 to 12% in 2039. People aged 75 years and over accounted for 34.22% of all emergency admissions to hospital in 2018-19.

3.5. Services in Renfrewshire are supporting more people at home for longer, often with more complex needs and with unpaid family carers who are themselves in poor health. The care at home census data shows the number of people who required care at home services from 2011-2018 has increased by 19%, while the number of hours of care required has increased by 161%, reflecting the number of care visits required per person and an increase in the number of those visits which require two carers. The percentage of people aged 65 and over with long term

needs receiving 10 or more hours of home care in Renfrewshire has increased from 21.6% in 2009 to 30.7% in 2018.

3.6. Renfrewshire is also projected to see a 47% increase in dementia prevalence by 2035. Current prevalence is 2,994 people at 2017, with a projected prevalence of 4,400 by 2035. This means that care and support services need to be increasingly designed to meet the needs of people with dementia and their unpaid carers.

4. Phase 1 - Overview

4.1. This paper builds on the Phase 1 report presented to the Integration Joint Board in September 2019.

4.2. The core purpose of Phase 1 was to establish a clear service user view of older people's service provision across Renfrewshire and to encourage aspirational thinking with regards to 'how good could we be when we work together.' In phase 1, eight emerging themes were identified. These were:

- Place (where do we provide services to enable connected communities)
- Health and Wellbeing (supporting people to live as healthily as possible)
- Early Intervention and Prevention (responding quickly and seeking to slow, delay or avoid care needs arising)
- Partnership Working (services working together and working with citizens)
- Information and Communication
- Range of Services and Supports (optimising what is available)
- People and Community (safe communities that place the need of people at the centre of what we do to connect services, people and communities)
- Enablers (e.g. technology to optimise care arrangements)

5. Phase 2

5.1 In line with the next steps outlined in the September paper to the Board the Steering Group, supported by Journey Associates, carried out a series of consultation and engagement events between September 2019 and February 2020 to explore the opportunities to develop and re design community based services for older people in a way that might best meet changing need and demand. Over the duration of the work there were 10 interviews, 12 workshops, 1 public event and a final feedback session, involving more than 150 participants drawn from across the partnership and including older adults and unpaid carers.

5.2 A copy of the presentation slides for the feedback session presented by Journey Associates is attached [Appendix 1] and provides an outline of the approach to the work and an indication of what is important to people accessing care and support services, partners and the cross section of staff who attended the events.

5.3 Four thematic areas were identified through the consultation and engagement process and each has a series of potential areas for further work to be considered as the Partnership takes the next steps as part of the wider Transformation Programme. The four themes are:

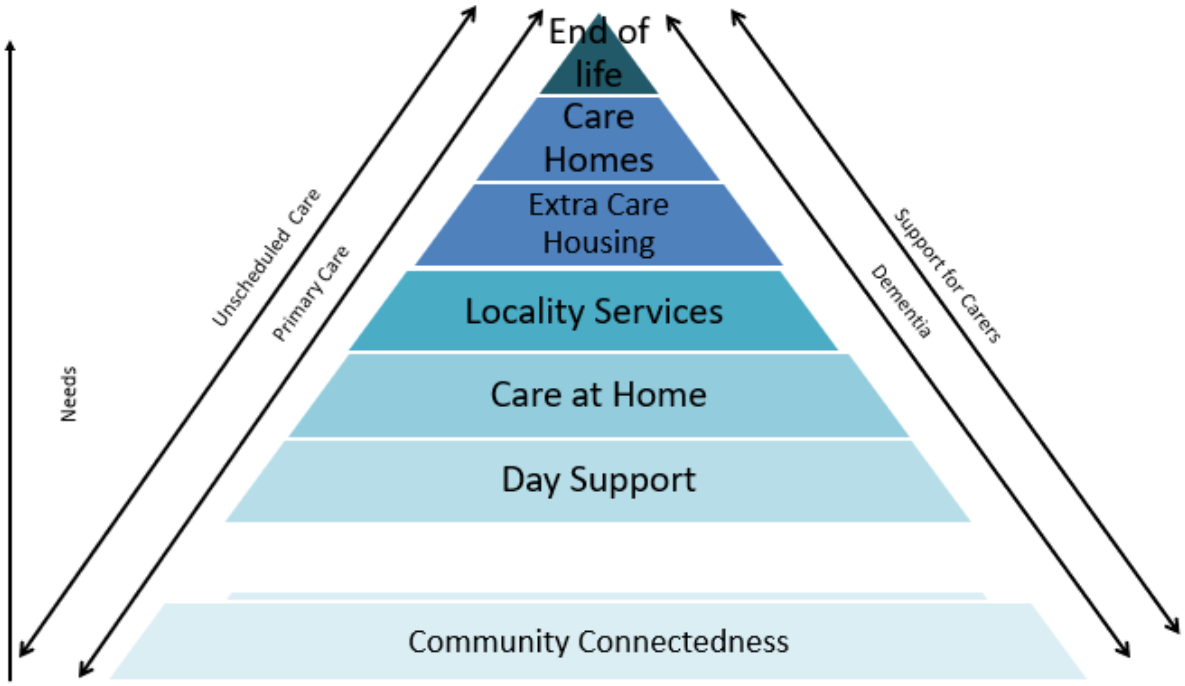
- Theme 1 - Services Provided by the Health and Social Care Partnership.
- Theme 2 - Health & Wellbeing
- Theme 3 - Early Intervention and Prevention
- Theme 4 - Living in our Community

5.4 The proposals outlined in this paper focus on theme 1. The Strategic Planning Group (SPG) will have a critical role in supporting achievement of the guiding principles that have been set out for Renfrewshire HSCP's Transformation Programme, and delivering upon these principles will underpin achivement against themes 2, 3 and 4. In particular, the first and second principles concentrate on ensuring that change activity improves the health and wellbeing of people in Renfrewshire, with a focus on prevention and early intervention. Further information on this work forms part of the Change and Improvement Update paper presented to the Integration Joint Board.

6. Next Steps

6.1 Care and support services for older people account for 65.49% of the Health and Social Care Partnership's budget. Services are a mixture of directly provided and managed services,and services commissioned from the third and independent sector under contract. Services operate across the range of Renfrewshire's communities, providing care and support ranging from prevention and early intervention through to complex needs. As noted earlier in this report, the level of demand for care and support has been increasing in line with the changing demographics of the population and changes to delivery models as older people are supported to live in their own home, or in a homely setting, with links to their community, for as long as possible

6.2 The following diagram illustrates the range of care and support services operating across the Partnership area and meeting a wide range of needs:



6.3 The facilitated consultation and engagement work carried out in Phase 2 provides a framework and areas of further enquiry to support the next steps in the review of care and support services for older people across Renfrewshire.

6.4 As the Board is already aware work is taking place to further develop the approach to transforming the way in which the HSCP delivers services, recognising the need for a step change in the way we work together to ensure sustainability of health and social care services. In common with all the work taking place across the HSCP the review of care and support services for older people will follow the finalised governance arrangements for the Transformation Programme.

6.5 A considerable amount of work is already underway in a number of areas – most notably the draft Carers Strategy [which is the subject of a report to todays Board meeting]; the ongoing work [as outlined in sections 6.9 to 6.12 of this report] on services to support people with dementia and the developing Local Dementia Strategy scheduled to be presented to the Board in June; and, loneliness and social isolation which will be taken forward by the Strategic Planning Group.

6.6 The next Phase to deliver Theme 1 [Services Provided by the Health and Social Care Partnership] of the review of older people's services requires to move into a focused series of service reviews. The scope of the work is large and requires to be prioritised and managed in planned stages to ensure effective management of both Change and Improvement and operational resources. It is also important to note that

there are a series of interdependencies between the service areas and risks [financial and practice] which need to fully recognised and taken into account in any programme. While carrying out changes to the models of service delivery to support wider transformation we do need to ensure the safe and effective delivery of current services to older people.

6.7 All the activity outlined within this paper requires to be carried out in a way that maximises our collective resources to ensure Best Value and meets the needs of the population moving forward.

6.8 The core workstreams are reflected in the triangle of the illustration above and it is proposed that the first tranche of work undertaken focuses upon:

- **Care at Home services -** where the HSCP are currently undertaking a series of rapid development sessions to identify and implement improvements to support the service in managing challenges around increasing demand, recruitment and retention.

- **Day Support -** to ensure that the provision of day support within Renfrewshire continues to deliver individuals' desired outcomes as part of the overall provision of community-based services.

6.9 As noted in section 6.5, the HSCP has also been developing a Local Dementia Strategy with partners in the Renfrewshire Dementia Strategy Group (RDSG). The RDSG was formed in 2011 with the aim of ensuring that Renfrewshire HSCP, and partner agencies, implemented the commitments of successive national dementia strategies. The strategy being developed will inform how the services within scope of the workstreams above develop to meet the needs of those with dementia.

6.10 Work to date on the strategy has included focus groups, an online survey and engagement with service users, carers, other members of the public and staff from a wide range of internal and external services. This has enabled the RDSG to develop a patient pathway based on the areas that were highlighted as the most pertinent to people living with dementia. The pathway has ten key themes: (i) prevention and early intervention; (ii) assessment; (iii) diagnosis; (iv) my life; (v) my health & wellbeing; (vi) my family and carers; (vii) my home; (viii) my community; (ix) my independence; and (x) my services.

6.11 These themes align with those identified through the engagement sessions undertaken by Journey Associates and with the guiding principles for the transformation programme. Each theme encapsulates

a vision and sets out the standard of support that a person living with dementia has the right to expect and the relevant areas within scope.

6.12 The RDSG will work with all of the partners in developing an implementation plan to support delivery of the local strategy. The RDSG will support the delivery of improvements and monitor progress against agreed actions. An annual update and a final evaluation report will be submitted to the IJB as work progresses.

6.13 The following actions have been identified as the key to move forward the review:

- A robust and detailed data baseline of current services prioritised within scope will be developed. This will be combined with an assessment of available good practice across Scotland, the UK and internationally to develop a sound evidence base for change.
- All of the activities above will be underpinned by the development of a communications plan identifying key stakeholders and their communication requirements. This plan will include both ongoing project communications and required statutory consultation processes at appropriate points throughout the next phase of work.
- Initial information sessions will be carried out, as part of the development of a full consultation and engagement plan for service users; unpaid or family carers; staff; trade unions and staff side; key stakeholders; and regulatory bodies such as the Care Inspectorate.
- A refreshed steering group, and supporting Reference Group will be launched to ensure membership reflects the focused scope of the next phase of work.
- Consistent project management tools and processes will be implemented across each workstream to provide ongoing assurance to the steering group of the emerging business case for proposed changes and the ongoing effectiveness of risk management.

6.14 An indicative timeline for the focused reviews of service is contained at Appendix 2. It is anticipated that this will be reviewed as the final scoping work is completed.

Implications of the Report

1. **Financial –** None at this stage of development
2. **HR & Organisational Development** – Future proposals developed through the next phase of work may have HR and Organisational Development implications. Trade Unions and staff side will be engaged throughout the development of proposals.
3. **Community Planning** – None
4. **Legal –** None at this stage of development. Legal advice and support will be taken as required.
5. **Property/Assets –** None at this stage of development.
6. **Information Technology –** None at this stage of development.
7. **Equality & Human Rights –** None. However, it is noted that any future proposals will be assessed in relation to their impact on equalities and human rights.
8. **Health & Safety –** None at this stage of development.
9. **Procurement** – any future procurement activity influenced by the next phase of work will remain within the operational arrangements of the parent bodies. Guidance from commissioning and procurement services will be sought at appropriate junctures.
10. **Risk –** None at this stage of development.
11. **Privacy Impact** – None

List of Background Papers: Update on Review of Older People's Services in Renfrewshire (September 2019)

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Appendix 1

Journey Associates:
Presentation slides – Feb 2020

Renfrewshire Health & Social Care Partnership

Brighter futures

Renfrewshire Older People's Services Review

Action Areas - Draft

19th February 2020

Renfrewshire Health & Social Care Partnership

Journey Associates

Theme 1

Services Provided by HSCP



Overview

Renfrewshire HSCP provides a range of services for older people which are valued by the communities who use them. However, there is a need to enhance the spectrum of services provided to ensure that the needs of older adults are met and that better outcomes are achieved – these are the things that older people value, that give them pleasure and meaning and enhance their quality of life. Many older people want to remain independent and services should help citizens retain independence while accessing the support they need and without an over-reliance on services. Each individual will value experiences and services in different ways, therefore, to deliver services that are outcomes focused requires responsive and more flexible services.

To deliver services that meet citizen's needs, the workforce needs supported to enhance capability, think creatively and build confidence in new ways of working.

"Don't dumb it down"
"We're people, not antiques"
"I've always made my own decisions… I want to be in charge of my own affairs"

Theme 1

Services Provided by HSCP



Action Area 1.1 / Caring for Carers

Carers play a vital role looking after and supporting older citizens. The caring role can vary considerably from providing occasional help though to deep involvement in all aspects of a loved one's life.

While caring for someone can be rewarding, it can also be challenging. The Carers (Scotland) Act 2016 was introduced to support carers in their role and ensure their health and wellbeing does not suffer as a result of this. However, participants suggested that more person-centred support for carers is needed and that carer support plans should be promoted and regularly reviewed. Young carers may face particular challenges that can affect their education and impact on social connections. Local authorities have a duty to offer support and to involve carers in the design of carer services.

Participants noted that many carers can feel isolated in their role, finding it very difficult to access information and find out about services and support that is available. Some carers will not seek help or may be dissuaded from asking for help as they will be met with resistance from the person they care for. It was suggested that existing carer support groups and activities should be more visible and that support be available in more locations.

Participants noted that the SDS process and caring for people with dementia can be particularly challenging for carers. The SDS assessment should be triggered at the point of diagnosis and the process streamlined.

It is important that an individual's needs are acknowledged and their outcomes met to allow carers to have a good quality of life in their role, to plan ahead and prepare for the future. This could include accessing respite for carers and emotional support services.

Potential areas to explore include:

- **Supporting the health and wellbeing of carers to help them fulfil their caring role while ensuring their outcomes are met**
- **Developing the assessment process and administration of SDS to ensure that it is accessible for carers**
- **Approaches (including the use of technology) that can help minimise the pressure on individuals or families who are caring for people with dementia**

"SDS is great once you get it. It's just a difficult and lengthy process to get through"

Theme 1

Services Provided by HSCP



Action Area 1.2 / Accessing HSCP Services

Feedback received suggested that having a hub as a designated and widely recognised 'go to' place where information on services and activities in the local community are readily accessible could help centralise access and enhance the wider engagement of older people. This could be a physical hub complemented by centralised online information. Each community, town or area should have a hub.

Participants felt that a physical hub in a central location could help connect older people to what is going on in the local community. This could include clubs, groups, public services and third sector activities. It could provide training for local businesses and organisations on adapting services to be more appropriate for older people including being dementia friendly and embracing kindness to tackle loneliness and social isolation. Existing community venues including day centres and libraries could become hubs. Third sector organisations could provide the information and content for the hubs.

Participants also thought that having a single point of contact in the hub who could assist with identifying services to suit individual needs, assessing eligibility and in supporting the SDS process would make services more accessible.

Some people noted that they would be willing to pay for or contribute to the cost of services such as Care and Repair and taxi services.

Potential areas to explore include:

- **Making information easily accessible by older people and the wider community in a way that reduces stigma**
- **Create a network of local hubs that share information across the region**
- **Exploring ways that people can pay for or contribute to the cost of services**

People have told us that it is very difficult to access and find relevant information to your situation, "you don't know what you don't know".

In relation to ASeRT, "you have to know how to navigate the system - it's hard"

Theme 1

Services Provided by HSCP



Action Area 1.3 / HSCP Processes

Feedback from a selection of staff who attended staff engagement workshops noted their ambition to work in more integrated ways. This would support improved communication and joined up support between the services delivering health and social care. Feedback suggested that a care coordinator could be identified who has most regular contact with the service user and whom all other professionals should update on any changes. They could then liaise with families.

A more coordinated approach to delivering services could be enabled through IT systems that are accessible to all professionals and co-location of staff across the HSCP. Those with more complex needs would benefit from multi-disciplinary teams with a clear understanding of the roles and responsibilities of each member. Although, it was noted that increasingly complex needs can present particular challenges for coordinating teams.

People noted that they liked the flexibility and choice that SDS can provide but do not feel clearly informed about it. It was suggested by both citizens and staff that having a designated person in place to help coordinate strands of activity and signpost to services would be beneficial.

Participants also suggested that a clearer focus on individuals' outcomes could allow for the provision of social time within service delivery. For example, having a conversation or time to spend while a person is eating can ensure they are receiving the nourishment they need and the social contact can help reduce loneliness, in line with Scottish Government strategy. At the moment, meals are delivered with no or little conversation, missing the opportunity to check in with the older person and to engage them in conversation. This may be an opportunity to work more closely with third sector and community partners.

Feedback received also suggested that improving the procurement process and commissioning could help improve equality in service provision across the region.

Potential areas to explore include:

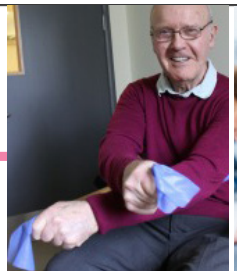
- **Continuing to develop a more integrated and coordinated approach to care which is outcomes-based.**
- **Further developing SDS to clarify the offer and simplify the process**
- **Partnership working to help shift the focus of service delivery to better meet the outcomes of older people**
- **Delivering equality of access across the region**

In relation to staff, "[they] just don't have time"' and it feels like "the targets are more important than people"

People have told us that, "the service feels disjointed wherever you are in the system"

Theme 2

Health & Wellbeing




Overview

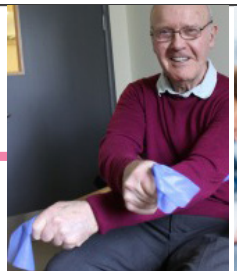
Many older people want to remain independent for as long as they can while others need to be encouraged and supported to have an active role in their health and wellbeing. To support independence, we older people should have the freedom to choose how they spend their time and which activities they take part in. To encourage citizens to be active, activities and services must connect to the individual's personal outcomes – these are the things that are important to them in their life.

We need to find new ways of connecting with people ensuring that they know how best to look after their own health and wellbeing. Information about what impacts our health and wellbeing should be easy to understand and services and activities that can support individuals to make positive choices should be easily accessible.

To enable older people to support themselves and retain their independence, we should take a strengths-based approach, drawing on the existing wealth of knowledge, skills and potential that our citizens and communities already have access to.

Theme 2

Health & Wellbeing




Action Area 2.1 / Volunteering

Volunteering may have a vital role to play in supporting individual health and wellbeing. It also helps to build social connections that benefit both the volunteer and the recipient and can reduce the potential for loneliness and isolation that can be detrimental to our health and sense of wellbeing.

Volunteering can be very rewarding and a great way to get people active in their communities, whether giving something back to the community, meeting new people or learning a new skill. To ensure no-one is exploited and the principles of mutuality and reciprocity are upheld, a 'volunteer ready' programme could help prepare people to volunteer. The programme could help build self-esteem and skills for people to volunteer effectively and that they can add to their CV. Volunteering could be incentivised and Renfrewshire volunteering prizes might encourage momentum and build a movement. Additional information on how to volunteer, training and ongoing support also needs to be in place.

Participants suggested that activities underpinned by shared interests are most rewarding. There are many types of volunteering programmes online and offline from those that offer assistance in taking people to appointments (e.g. Emergency Mum); buddying services to learn something new (e.g. digital buddy groups in libraries), to those that help with shopping (e.g. at Braehead Shopping Centre). Soft options for volunteering (e.g. keeping an eye out for a neighbour) and supporting citizens to micro-volunteer also need to be easily accessible. It was suggested that the HSCP could be more proactive in signposting and linking volunteering opportunities to SDS. This would help ensure more of a two-way flow of information between programmes and potential beneficiaries and support grass-roots activity.

Mapping the variety of volunteering programmes could help identify opportunities for new ways to engage citizens, exchange life skills and build relationships (e.g. bringing generations together based on shared interest where older people teach young people how to play traditional card games, whilst young people teach older people how to do online shopping). This could build on the existing knowledge and expertise of organisations in Renfrewshire and beyond. It was suggested that existing halls and other community assets could be used to reach older adults and connect people to services and help others recognise vulnerabilities in their own communities. Initiatives that connect generations can help to break down social divides and finding ways of linking through shared interests earlier in life could help connect the generations.

There may be RHSCP services, that could connect to a volunteer programme for services that are outside of their remit.

Potential areas to explore include:

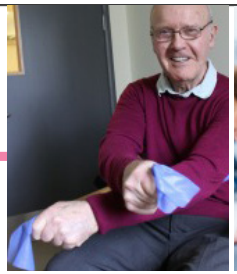
- **Encouraging and supporting connections between peers and across generations who have similar interests**
- **Helping older adults and carers to understand the variety of volunteer programmes that exist**
- **Putting in place the right structures to encourage volunteering and ensure citizens are 'volunteer ready' and are supported in their roles**
- **The role of RHSCP in signposting and linking existing RHSCP services with volunteer programmes**

"It gave me great pleasure to start a lunch club at the community hub - people get dressed up and enjoy going out together"

"Getting volunteers is difficult - often there aren't enough people and when you do get some, they often let you down"

Theme 2

Health & Wellbeing




Action Area 2.2 / GP Surgeries and Services

GP surgeries serve our local communities and can be a valuable route to connecting older people to other services and opportunities in the community. For many people, GP-based services can feel less daunting and more accessible than council-based services.

Community Link Workers based at GP surgeries provide access to community support and opportunities for citizens to self-manage their health and wellbeing.

As a hub serving all generations in the local community, participants suggested that GP surgeries could play a wider role in supporting the health and wellbeing of older adults through signposting to local services and groups. One suggestion was creating a 6-monthly 'what's on' brochure, targeted at vulnerable groups and funded by local businesses and disseminated through GP surgeries.

To support preventative action, it was also noted that increasing knowledge and awareness in the community to look after your own health and wellbeing could assist in keeping people healthier for longer.
A 'Social MOT' was suggested as a way of checking in with older adults and signposting to information, resources and activities that can help ensure good mental health and address the potential for loneliness or social isolation. This could be carried out by community connectors in a local GP surgery or alternative suitable locations.

Older people who attended the workshops said they would value having a deeper relationship with their GP. Suggestions included having a single GP as the point of contact, from the age of 65, helping to build the relationship, allowing for consistency, and reducing the need to have to repeat their history with different doctors. Workshop participants also suggested that longer appointments for older people could help them feel less rushed.

Some participants acknowledged that any proposals considering such changes would need to reflect the GP contract and Primary Care Improvement Plan which are currently being implemented and which set out the role of extended HSCP and NHS Board employed health professions in and around general practice. These changes include new ways of working and signposting and support to patients.

Potential areas to explore include:

- **Options around Community Health provision that would enable older people to have a more active role in their health and wellbeing**
- **The role of GP surgeries in connecting older adults to appropriate information and support**
- **The role of a 'Social MOT' as a means of supporting early intervention and prevention for health and wellbeing**

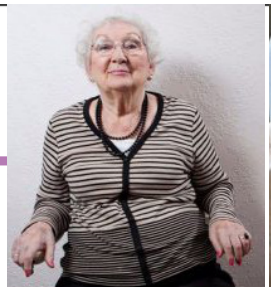
GP's are citizen's main point of contact:

"my GP service feels smaller and more manageable - the Council feels huge"

"Once diagnosed you're forgotten about. It would be good to have 3 to 6 month reviews."

Theme 3

Early Intervention (Prevention)



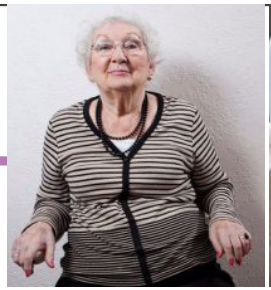

Overview

The demographics of society are changing, with increasing numbers of people living longer, often with multiple or complex health conditions requiring specialised support which demands more from our public services while public finances are increasingly constrained. Keeping well and having a good quality of life can benefit from early intervention and preventative action. Therefore, supporting older people to maintain their independence, from choosing what to eat, keeping in touch with friends and family, and living in one's own home are important in meeting personal outcomes and maintaining a good quality of life.

Loneliness and social isolation can be deeply detrimental to an individual's health and wellbeing. Supporting older people to remain connected and reducing the chances of social exclusion are vital. This is particularly important at times of transition, when life changes such as having a health scare, becoming a carer, or losing a partner can affect our health and wellbeing. Reaching those who do not engage with services, and before they are at risk, is a challenge.

Theme 3

Early Intervention (Prevention)




Action Area 3.1 / Services Available to All

Connecting Citizens

Participants noted their view that citizens want existing activities such as arts and cultural activities (cinema and concerts), and Renfrewshire Leisure classes to be more accessible, including having better transport options. For some services, accessibility could be enhanced by making small changes, for example, having a someone in a 'meet and greet' role, cinema showings with lights on and sing-along for those living with dementia, talking books to convey information, and using sign language and translation services. Other suggestions included engaging pubs, clubs (e.g. golf, bowling), leisure centres and other local amenities advised and supported by a compliance outreach programme. It was also suggested that it is important for services to be welcoming to encourage people to engage.

Participants suggested that services could be more accessible through peer support, grassroots activities (such as setting up a neighbours' lunch club) and volunteering opportunities as well as a community link worker hub. Some participants had proactively set up small social activities to involve their peers and neighbours.

Potential areas to explore include:

- **Ensuring existing services and activities are accessible for everyone**
- **Supporting people to volunteer on a small scale in their own community**
- **Supporting older people to feel comfortable and confident to join a group for the first time**

Loneliness & Social Isolation

To minimise loneliness and social isolation, feedback noted that we need to find ways to reach seldom heard groups to ensure everyone has equitable access to services and in advance of crisis. Although, we must also respect people's desire to stay isolated (and safe).

Particularly vulnerable people include those who are housebound, those who have undergone a life transition such as retirement, losing a partner, becoming a carer, having a medical condition and those with mental health issues.

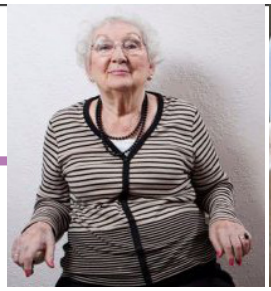
Potential areas to explore include:

- **Engage those who are difficult to reach**
- **Engage those who have experienced a major change in life or crisis**

"It gave me great pleasure to start a lunch club at the community hub - people get dressed up and enjoy going out together"

Theme 3

Early Intervention (Prevention)




Action Area 3.2 / Self-management

Connecting to Services and Community Activities

It was recognised that there is a broad range of existing services that citizens value but some participants noted that it can be difficult to find information about them. ALISS (A Local Information System for Scotland) and WIRE (Well in Renfrewshire) are good information resources but they are not well known and can be difficult to find and need to be updated regularly. One professional took 16 clicks to access ALISS from the RHSCP web site.

Feedback provided noted that information about services should be available in different formats, with potential options including:

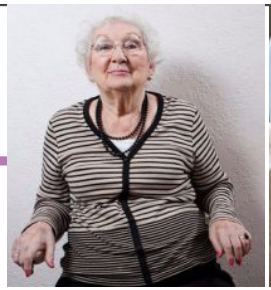
- **Printed information** that is easy to read and can be found in everyday settings – local newspapers, 'keep' leaflets like the waste collection diary, and be combined with information mailed to those over 65, e.g. pension updates, heating allowance and when signing up for services
- **Online**: information that is only accessible online can exclude citizens who do not have access. Resources like ALISS and WIRE could be made available in other formats including in posters and leaflets, and in easily accessible locations such as libraries, housing associations, GP surgeries, leisure centres, hospitals, and other community locations. Phone numbers and direct email addresses should be easy to find
- **In person**: having a person at the end of the phone rather than a recorded message is preferable and more helpful for older people. Stakeholders suggested that there should be a balance between online and in-person contact. Human interaction is very important as not everyone has access to or can use technology. While future generations will be more familiar and comfortable with online resources and apps, technology could be an isolating factor and exacerbate social isolation
- **Local services**: information could be made available through local radio, community groups, volunteer groups, housing associations and other community activities.
- **Supporting inclusion**: information should be made accessible for those who are non-English speakers, blind, hard of hearing, lack literacy skills, dyslexic, etc.

Potential areas to explore include:

- **Helping connect older adults to existing services**
- **Making information about existing services accessible for anyone**
- **Improving links to ALISS and other online resources**

Theme 3

Early Intervention (Prevention)




Action Area 3.2 / Self-management

Understanding the Life Journey

Participants suggested that story-telling and sharing the journey of ageing with younger people could help build understanding and empathy between the generations and allow people to plan for older age, helping ensure they have choice and control over the services or activities they might want to access.

We can future-proof for our needs by knowing what questions to ask and what information or services are available and where to access them. It was suggested that this should happen earlier life, such as with school pupils and in mid-life. Many older people noted that they do not want to feel like a burden on their families or friends. Creating a care plan (such as an Anticipatory Care Plan) for the future helps to put the individual in control and can help avoid a crisis situation. Another suggestion was nurturing a shared or societal responsibility for caring for oneself.

Those who participated in the engagement sessions noted that many people value their independence and want to retain this. Providing prompts, such as activity planners can encourage individual action; and toolkits on how to start a group or activity locally can help guide and give confidence to initiate activity. Keeping physically active through groups and classes could also help reduce the risk of frailty and has the additional benefit of helping participants be socially connected reducing the chance of loneliness and social isolation.

Prevention and early intervention projects play an important role in identifying those at risk, whether related to frailty, the need for post-bereavement support or foot health. For older vulnerable adults, it was suggested that a more joined up approach is needed to connect with and introduce them to services earlier e.g. toenail cutting is one of the first signs of things failing, therefore people who request a toenail cutting service should be targeted for other prevention services.

"You need to know what to search for to begin understanding how you need to be supported" and "I don't know what I'm entitled to"

Potential areas to explore include:

- **Approaches to supporting a shift in mindsets to motivate people to manage their own health and wellbeing before reaching older age**
- **Providing useful support to help older people identify and look after their own needs throughout their lives**
- **Options for helping citizens of all ages understand the process of ageing and plan for the future and understand how to live thriving into older age**
- **Extending prevention and early intervention services to avoid crisis**

"Things used to be really good and it raised expectations. People now need to recognise they have a responsibility to solve issues first before accessing services"

Theme 4

Living In Our Community




Overview

The way that services are designed and delivered is changing. The needs of each individual are different and so the services or activities that they use will also be different.

We need to ensure that older people have access to local services that meet their needs and their desires and to do this we need to involve the diverse voices in communities in shaping the services. Involving older people in the planning and delivery process, we can enable them to live independently by ensuring we create robust communities and safe, desirable neighbourhoods e.g. providing housing, access to transport, public services such as libraries, leisure and social activities.

Many citizens think we have lost a sense of caring in our communities. We need to encourage a culture of neighbourliness, across the generations and all sectors of the community including local businesses, where embracing approaches to embed kindness and compassion can help counter loneliness and social isolation.

Theme 4

Living In Our Community




Action Area 4.1 / Caring for our Community

Intergenerational

Participants recognised that activities that happen across the generations can be energising and motivating. They are particularly enjoyable where the connections are made through shared interests e.g. community choirs, reading groups with the focus on connection, inclusion and community rather than age. Feedback suggested that opportunities to share knowledge, skills and experience could help build stronger, more compassionate communities where older generations mentor younger people for example in cooking or life skills (such as communication and relational skills), and that younger people could support older adults to develop technology and digital skills. Opportunities for sharing knowledge or experiences and exchanging skills could be online and offline and through Community Link Workers.

Potential areas to explore include:

- **Supporting connections across the generations to build compassion and share knowledge that enhances each person's quality of life**

"We often talk about 'Getting it right for every child'. But we should also be looking to 'Getting it right for every adult' too!"

Dementia

Dementia brings particular challenges for the person living with the condition and for those who support them. Dementia sufferers need a broad range of support to live well in the community, and their needs can change over time. Support can include help remembering to eat and to take medication and they may need to be escorted shopping and to attend appointments and be encouraged to socialise.

Participants suggested that educating all sectors of the community (including young people, business owners and older adults) about how best to reduce the risk of dementia such as keeping active, eating well, keeping your brain active and socialising (alzdiscovery.org) could help keep people well for longer. Communication between services is key and Community Link Workers could have a valuable role here, for example, providing drop-in sessions at libraries. Bringing awareness to the symptoms and challenges faced by dementia suffers could help nurture empathy and understanding and encourage more kindness in the community. By addressing the needs of people with dementia, all citizens can benefit.

Potential areas to explore include:

- **Options for helping communities to be dementia aware and considerate in the products and services they provide**
- **Ways to encourage more kindness to support vulnerable members of the community**
- **Options where technology could support dementia suffers and their carers.**

Theme 4

Living In Our Community




Action Area 4.2 / Community Businesses and Connectors

Local businesses and tradespeople are key members of our community providing services and activities to a wide range of people. Participants proposed that such people and organisations could provide information and also help reach people who have not sought assistance nor used services in the past. In this way they could provide a new link to support and information that is available for older people helping to connect citizens in the community.

In developing this idea, stakeholders thought that linking with organisations like 'Trusted Traders' who vet and approve trades people, could identify opportunities for training on services available to older people and to signpost them to relevant assistance e.g. VAT-free goods for over 65 year olds, Care and Repair services, or that grants might be available to make adaptations to your home.

Community leaders and connectors could link older citizens to services and help with planning for the future. These could include solicitors, funeral directors, religious leaders, local clubs such as the Bowling Club or Polish Club, libraries, and local shop assistants. Local cafes and bars could run incentives for older people to socialise e.g. with a lunch discount or designating a space to encourage people to sit together and talk.

It was suggested that trust underpins the success of this type of activity. It was also noted that information should be made available and be disseminated through a range of channels.

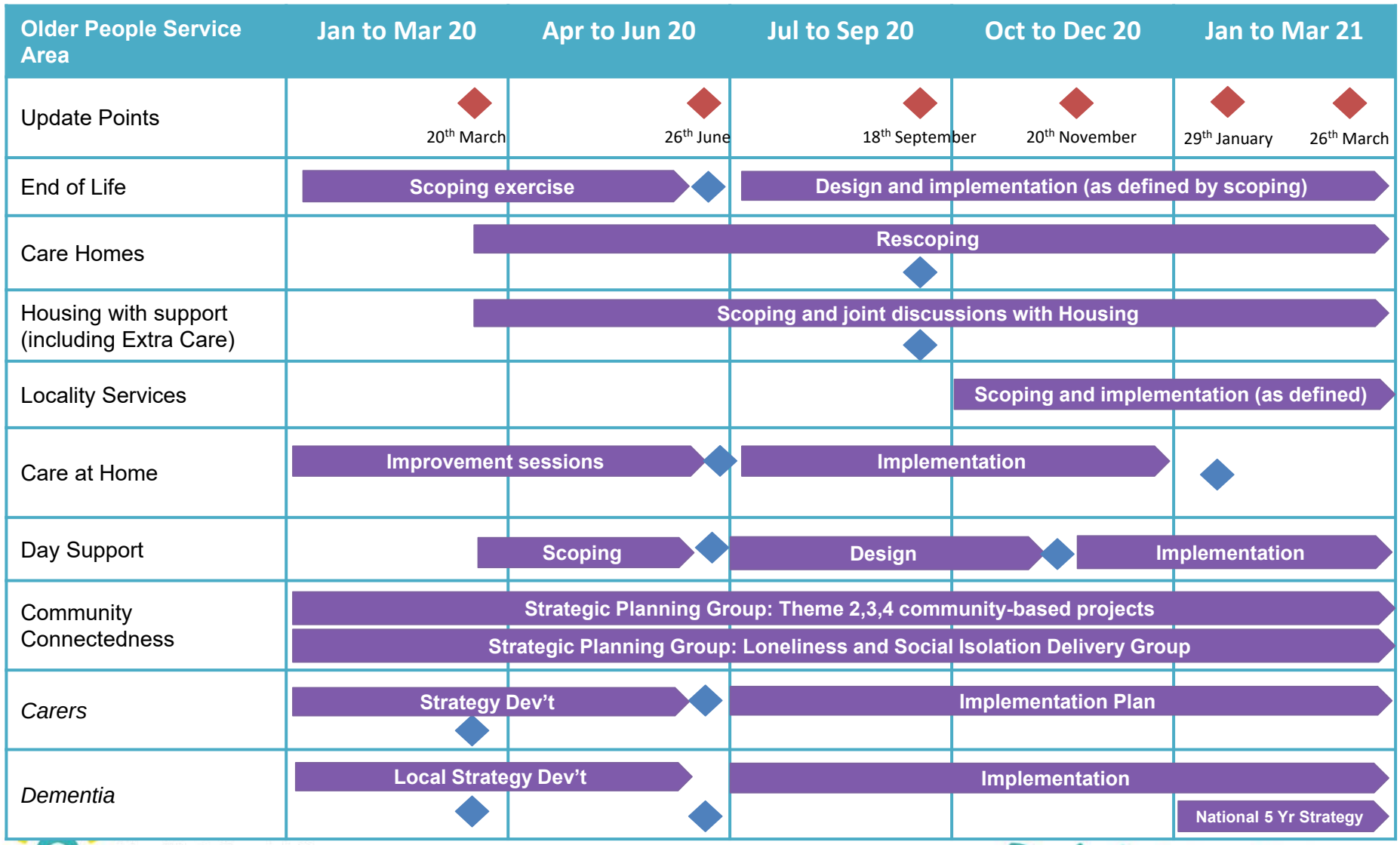
Potential areas to explore include:

- **Options to engage with local businesses to create a more dementia-friendly, compassionate town**
- **Helping those delivering services to be aware of the needs of older people, e.g. bus drivers give enough time to enter and exit the bus, that music is not too loud, that flooring is not slippery, etc**
- **Options to engage with local businesses to help them be more aware of needs of older people in the community and the support available to them**
- **Opportunities to engage employers to encourage and motivate staff to look after their own health and wellbeing**

"I paid for the adaptations to my home from my own pocket. It was only after that I was told I could get a grant. Why didn't I know before?"

"One Saturday afternoon in Wetherspoons I saw 5 older men each sitting by themselves. It made me feel sad and I thought, wouldn't it be good if there was a way to connect them?"

Appendix 2: Indicative phasing of older people review activity



Health & Social Care Partnership

Short update in OP services review paper

Brighter futures