1. NATIONAL CONTEXT

Modernising Community Care: An Action Plan summarises its main aims as being to secure:

- ***Better and faster results for people by focusing on them and their needs***
- ***More effective and efficient joint working based on partnership***

Within that broad framework it seeks to modernise community care by moving :

- ***From "service-driven" to "needs-led" approaches***
- ***From rigid "traditional" services to flexible "modern" services***
- ***From doing things to people to doing things with and for them***
- ***From "processes" to "results"***

The Report of the Joint Future Group

The Group's main agenda is rebalancing care of older people and improving joint working. The group makes specific recommendations about:

- ***More intensive care at home***
- ***Rapid response teams in every local authority area***
- ***Free home care for the first 4 weeks after discharge from hospital***
- ***A shopping/home maintenance service in every area***
- ***More short breaks***
- ***Joint resourcing and joint service management of services for older people***

Regulation of Care (Scotland) Bill

This Bill proposes a new Scottish Commission for the Regulation of Care. Work is currently being undertaking on draft National Care Standards for a wide range of social care provision including residential care for older people and homecare. The standards attempt to focus on service users experience of the care service (outcomes) rather than on whether a unit has various procedures or not (processes). The Bill also seeks to establish registration criteria for a single care home rather than separate criteria for residential and nursing homes.

With Respect to Old Age – Report by the Royal Commission on Long Term Care (The Sutherland Report)

Key recommendations are:

- ***Increase capital disregard to £60,000 when assessing eligibility for charging for long term care.***
- ***Nursing care and personal care should be free for individuals who need it***
- ***Living costs and housing costs to be met by individual or state, following a means test***

The Scottish Parliament is considering implementing these recommendations. This would mean a major change to the current arrangement for placing people in residential and nursing care and for how people in these establishments pay for their care. If free personal care in people's own homes is to be provided then South Ayrshire Council's Homecare Charging Policy would need to be reviewed.

Judicial Review of a Decision By South Lanarkshire Council

This decision would mean that Local Authorities could not operate a waiting list for people assessed as requiring residential or nursing home care but would require to find funding immediately. This would have a knock on effect on funding for other services.

Supporting People

This is a government initiative which seeks to *"ensure that vulnerable people have the opportunity to live more independently. Through working partnerships with local government, services and support agencies it promotes a straight forward, cost effective and reliable housing related solutions which compliment the available care services, cost effective and reliable housing related solutions which compliment the available care services and support independent living."*

It will make provision for funding visiting support services to enable older people to remain in their own homes as long as they wish and to provide services in sheltered schemes.

A Framework for Mental Health Services in Scotland seeks to assist the people who use these services, those who care for them and staff in voluntary and other agencies to play their part as partners and stakeholders. It promotes the development of a joint approach to the planning, commissioning and provision of integrated mental health services.

These services come under the headings of assessment, specialist treatments and interventions, support to remain in one's own home, respite for carers, and continuing care.

Our National Health: A plan for action, a plan for change echoes some of the themes of **Modernising Community Care** and **Designed to Care** in terms of a desire to make a difference by improving the speed, responsiveness and the quality of care. It also makes a commitment to accelerate the implementation of the **Framework for Mental Health**.

The Adults with Incapacity (Scotland) Act 2000 replaces parts of the Mental Health (Scotland) Act 1984 with new provisions, particularly in relation to guardianship and the management of patients' funds. **The Millan Report on the Review of the Mental Health (Scotland) Act 1984** recommends that there should be a new Mental Health Act, which should clarify and improve the rights of service users and carers, and make it easier for these rights to be used effectively. In particular, it should ensure that care and treatment are provided, wherever, possible without resort to compulsion.

- ***Alzheimer Scotland's Planning Signposts for Dementia Care Services** seeks to provide signposts for planners and service commissioners by modelling the range and volume of services estimated to meet the needs of people with dementia and their carers.*

2. LOCAL CONTEXT

Ayrshire and Arran Health Board, Health Improvement Programme, 2000-2005

This emphasises the benefits of inter-agency working and primary care focused services including community based memory clinics.

The top three priorities for development are:

1. ***The introduction of comprehensive support by applying the Care Programme Approach***
2. ***To enhance support to the individual and carer by expanding availability of respite services***
3. ***To expand the named contact person service so that all people are supported in accessing services.***

Ayrshire and Arran Primary Care NHS Trust Implementation Plan 2000-2005

- ***Expand Day Health Resource Centre for elderly people with mental health problems***
- ***Enhance over 75 screening and agree on protocols for assessment between sectors***
- ***Explore the possibility of an intermediate care facility***
- ***Introduce Contact Person Service***

Conclusions from the Fact File

EURODEM studies suggest that two thirds of people with dementia will have "mild" dementia.

40% of people with dementia receiving social work support receive it from the Elderly Mental Health Team based at Ailsa Hospital.

3. ACTION PLAN FROM 1998-2001 JOINT COMMUNITY CARE PLAN

Objective

- ***To establish a co-ordinated approach to assessment and care planning***

ACTION	ACHIEVEMENTS
Establish a model of collaborative working across health, social work and housing which will bring together the distinctive expertise of specialist and local services across disciplines and agencies	• 2 Community Mental Health Teams formed and in situ at Stair Team Base, Ailsa Hospital together with Elderly Mental Health Social Work Team • Work on Integrated Assessments ongoing

Objective

- ***To secure specialist housing/residential services***

ACTION	ACHIEVEMENTS
Establish a model of accommodation and care which meets the distinctive needs of people with dementia	• Joint working with health and housing colleagues (including Scottish Homes) has identified dementia friendly design features.

Objective

- ***To identify those people in the community at particular risk and to establish appropriate support.***

ACTION	ACHIEVEMENTS
To monitor the welfare and safety of those at risk because of dementia and other psychiatric illnesses associated with old age.	• There are currently 2 older people on CPA • The use of SMART technology to monitor and reduce risks for people with dementia is being assessed

4. WHAT HAS BEEN ACHIEVED DURING THE LIFE OF THE PLAN?

Case Studies

Mrs B

Mrs B, age 71 lives alone in a sheltered housing complex. She was diagnosed as suffering from dementia and depression with associated behavioural problems. There has also been a history of alcohol abuse.

Mrs B is very suspicious of her two daughters and verbally abuses them in public places for no apparent reason. This behaviour was increasing and her daughters noted that she was not attending to her everyday needs. This resulted in Mrs B's admission to a psychiatric hospital.

A Community Care Assessment was undertaken and identified the need for a substantial support package. Due to Mrs B's lack of insight into her condition she would only accept a minimal home care service.

Initially the Social Worker worked jointly with Community Psychiatric Nurse until it was felt that nursing input was no longer required as Mrs B's mental health was stable. Problems encountered by social Worker when working with Mrs B:

- ***Mrs B's belief that her family were stealing her money***
- ***Debt – due to inability to manage finances***
- ***Poor living conditions***
- ***Management of anxiety due to family dynamics***
- ***Social isolation, compounding disorientation***
- ***Possible hospital admission***

Strategies adopted by worker to address these problems:

- ***Negotiation with Mrs B and family resulting in agreement that Social Worker would assist Mrs B in managing her finances***
- ***Installation of a safe in Mrs B's house with only named persons having access***
- ***Opening of a bank account and supporting Mrs B to save and enabling her to pay debts***

- ***Having accumulated savings, supporting to upgrade home environment***
- ***Family support and counselling***
- ***By working in the mentioned areas built up trust which allowed worker to introduce Mrs B to day care reducing isolation***

Mrs B is successfully living at home without further hospital admissions. Relationships with her family are much improved as the burden of caring has been reduced and there are no longer allegations of theft.

Mrs B now attends social day care 4 days per week which she thoroughly enjoys.

This year Mrs B had saved enough money to join a group of her day care peers on a holiday in Italy.

Mrs G

Mrs G is 87 years old. She was alone and her nearest relatives live abroad. Various neighbours had contacted her GP reporting that Mrs G had been discovered wandering about outside, hiding large sums of money in her garden, suggesting that she was not eating and may be suffering from memory problems. Mrs G was already known to Community Psychiatric Nurse and Occupational Therapist but would not co-operate with either.

It was agreed after discussion that too many professionals were involved in Mrs G's care and it was felt that the Community Psychiatric Nurse and Occupational Therapists should withdraw leaving the Social Worker as the responsible person in Mrs G's case.

A Mental Health Officer received a request from the G.P. for consideration of Section 24 of the Mental Health (Scotland) Act. A bed had already been booked in the local psychiatric hospital.

The M.H.O. interviewed Mrs G and elicited an agreement that she would undergo assessment at the Day Hospital one day per week. In view of this the Mental Health Officer did not agree to the Section. During her Day Hospital assessment her daughter came home from abroad to be with her.

Mrs G completed her 6-week assessment with a diagnosis of Mixed Alzheimer's and Ischemic Dementia. Her daughter then returned home.

Mrs G was obviously still at risk at home. Mrs G reverted to her wandering behaviou. She categorically refused all offers of risk reducing services and the question of using guardianship to remove her to a place of safety was mooted. Mrs G's consultant favoured this course but agreed to support a further attempt to allow Mrs G to have a say in her future care.

A care plan was devised with the help of an agent from a voluntary sector service provider.

- ***Mrs G would be introduced to a variety of community resources by the Social Worker***
- ***She would be encouraged and facilitated to visit an identified residential establishment on a flexible basis***
- ***Social Worker would initially accompany when possible***
- ***Social Worker would ensure that there was food in the home***
- ***Residential unit would provide meals when needed***
- ***Residential unit staff would telephone daily and offer meal***
- ***If Mrs G agreed to visit, residential unit would provide an escort***
- ***Residential unit would work towards Mrs G accepting respite care***

This process took 9 months with Mrs G progressing from lunchtime visits to week-long stays, returning home at weekends with home support.

Mrs G has now taken up permanent residency in the residential unit at her express request.

5. WHAT REMAINS TO BE ACHIEVED? GAPS IDENTIFIED

a) Lack of nursing home day care places – these are only required for a small minority of people with moderate/severe dementia but are an important resource for these individuals who do require it.

b) Lack of planned nursing home respite care i.e. if respite is part of a complex care package, this cannot be reserved or guaranteed and therefore nullifies the planned relief to carers etc. and endangers the ability to maintain the person "at home"

c) Further steps need to be taken to achieve a seamless service between health and social work in relation to people based in the community.

6. ACTION PLAN 2001-2004

Objective

- ***To establish a co-ordinated approach to assessment and care planning***

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
To consolidate joint working with the CMHT's	• By October 2001 to have agreed a single shared assessment process between Social Work, Housing and Health in keeping with the requirements of the Joint Future Group Report
To ensure that assessment of people with dementia's housing and environmental needs are an integral part of all assessments	• By October 2001 arrangements will be in place to ensure that all assessments regarding people with dementia will clearly indicate any adaptations to their housing or environment that would be of assistance to them in remaining safely at home.
Continue to support the WISDOM Project to ensure that advice and information is available to people with dementia and older people with mental health problems and their carers	• By 2003, 100 people per annum will have received an advice and information service from WISDOM.

Objective

- *To secure dementia friendly accommodation*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
To ensure that "dementia friendly" design features are built into a proportion of all new build housing stock and specifically into any reconfiguration of existing residential provision	• "Dementia friendly" housing will be available for people with dementia whose current accommodation cannot be suitably adapted to meet their support needs.

Objective

- *To identify those people in the community at particular risk and to establish appropriate support*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
To continue to purchase day care and intensive home care from South Ayrshire Dementia Support Association at the existing level	• South Ayrshire Council will continue to purchase 14,500 hours service per annum. This represents approximately 60 people using day care of which approximately 30 will also receive intensive home care.
To continue to provide specialist home care and day care in Girvan and Maybole through the Council's home care service	• 300 hours intensive home care will be provided per week and 18 day care places 5 days per week
To ensure that Care Programme Approach is available to people assessed as requiring this kind of support	• All people with dementia assessed as requiring it will be provided with Care Programme Approach.
To introduce the use of SMART technology to monitor and reduce risks to people with dementia	• There will be a reduction in the number of people with dementia admitted to residential/nursing care.
To quantify the need for nursing home day care places and negotiate the provision of these	• People with dementia who are assessed as requiring day care in a nursing home setting will have this provision available to them
To quantify the need for nursing home respite care and to negotiate the provision of this through the tendering process.	• People with dementia who are assessed as requiring planned respite in a nursing home setting will have this provision available to them.

ACTION	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	PROVIDER	FUNDING SOURCE
SUPPORT SERVICES							
Ailsa Hospital Team	151920	151920	156478	161172	166007	Local Authority	Social Work, Housing & Health AAHB
Biggart Hospital	63310	63310	65209	67166	69181	Local Authority	Social Work, Housing & Health AAHB
Rapid Response Team	14220	20120	20724	21345	21986	Local Authority	Social Work, Housing & Health AAHB
Social Worker - South Carrick	44160	44160	45485	46849	48255	Local Authority	AAHB
Carers Services	Shown on Seperate Sheet						
Support/Advocacy Service	45000	45000	45000	45000	45000	Alzheimer Scotland	AAHB
DAY CARE							
Day Care	35450	35450	36514	37609	38737	Voluntary Sector	Mental Illness Specific Grant/
							Social Work, Housing & Health
Day Care	196650	220550	227167	233981	241001	South Ayrshire Dementia	Mental Illness Specific Grant/
						Support Association	Social Work, Housing & Health AAHB
Dementia Outreach Day Care	128570	128570	132427	136400	140492	Local Authority	Mental Illness Specific Grant/
							Social Work, Housing & Health
Intensive Home Support	310220	141010	145240	149598	154085	South Ayrshire Dementia	Social Work, Housing & Health AAHB
						Supp Association Local Authority	
Home Care Services	950120	950120	978624	1007982	1038222	Local Authority/ Independent Sector	Social Work, Housing & Health AAHB
SUPPORTED ACCOMMODATION							
Sheltered Housing	210420	210420	216733	223235	229932	Local Authority	Social Work, Housing & Health
DAY CARE							
Day Centres	20930	20930	21558	22205	22871	Local Authority	Social Work, Housing & Health
Meals at home	12820	12820	13205	13601	14009	Local Authority	Social Work, Housing & Health
Augmented Care at Home	61360	61360	63201	65097	67050	Local Authority	Social Work, Housing & Health AAHB
Community Alarm Service	16610	16610	17108	17622	18150	Local Authority	Social Work, Housing & Health Strategic Services
Flexible Care Packages	156440	156440	161133	165967	170946	Independent Sector	Social Work, Housing & Health AAHB
NURSING CARE							
175 permanent places	1808810	1808810	1863074	1918967	1976536	Independent Sector	Social Work, Housing & Health AAHB
2 permanent places	22100	22100	22763	23446	24149	Voluntary Sector	Social Work, Housing & Health AAHB
700 respite placements	151610	151610	156158	160843	165668	Independent Sector	Social Work, Housing & Health AAHB
RESIDENTIAL CARE							
48 permanent places	302680	302680	311760	321113	330747	Independent Sector	Social Work, Housing & Health AAHB
4 permanent places	27580	27580	28407	29260	30137	Voluntary Sector	Social Work, Housing & Health AAHB
56 permanent places	786990	786990	810600	834918	859965	Local Authority	Social Work, Housing & Health
4 respite placements	26750	26750	27553	28379	29230	Independent Sector	Social Work, Housing & Health AAHB
418 respite placements	59630	59630	61419	63261	65159	Voluntary Sector	Social Work, Housing & Health AAHB
113 respite placements	55030	55030	56681	58381	60133	Local Authority	Social Work, Housing & Health
Total	5659380	5519970	5684219	5853396	6027648z		