The Highland Council

Adult and Children's Services Committee

Minutes of Meeting of the **Adult Services Development and Scrutiny Sub-Committee** held in Committee Room 2, Council Headquarters, Glenurquhart Road, Inverness on Friday 30 August 2013 at 10.00 am.

Present:

Mrs I Campbell
Mr A Christie
Mrs M Davidson
Mr B Gormley
Mr K Gowans
Mr E Hunter (Video Conferencing)
Mrs D Mackay (Substitute)
Mr W Mackay (Substitute) (Video Conferencing)
Mr G MacKenzie
Mrs M Paterson
Ms K Stephen

In attendance:

Mr B Alexander, Director of Health and Social Care
Ms D Jones, Chief Operating Officer, NHS Highland
Mrs J Baird, Director of Adult Care, NHS Highland
Mr S Steer, Head of Strategic Commissioning, NHS Highland
Mr G McCaig, Head of Care Support, NHS Highland
Ms C McArthur, Co-ordinator – Prevention and Management of Falls, NHS Highland
Mr M Perera, Projects Manager, Mental Health, NHS Highland
Ms M Clark, Living It Up (dallas) Project Manager, NHS Highland
Ms I Murray, Commissioning Officer, Health and Social Care Service
Miss J Maclennan, Principal Administrator, Chief Executive's
Miss M Murray, Committee Administrator, Chief Executive's Office

Also in attendance:-

Mr I Donald, Strategy Implementation Manager, Scottish Ambulance Service
Ms R Mantle, Dementia Nurse Consultant, Alzheimer Scotland
Ms M Johnston, Alzheimer Scotland
Ms C Mainland, Alzheimer Scotland

Business

1. Apologies for Absence

Apologies for absence were intimated on behalf of Mr T MacLennan and Mrs B McAllister.

2. Declarations of Interest

The Sub-Committee **NOTED** the following declarations of interest:-

Item 8 – Mr B Gormley (Non-financial)
Item 11 – Mrs D Mackay (Non-financial)

3. Appointment of Chair

The Sub-Committee **AGREED** to appoint Mr A Christie as Chair.

Scrutiny

4. Adult Social Care Summary

There had been circulated Report No ASDS/12/13 dated 21 August 2013 by the Director of Health and Social Care which provided an overview with regard to the delivery of the Commission for Adult Social Care Services by NHS Highland.

During a summary of the report, the Director of Health and Social Care explained that the strategic commissioning structure was developing and the Statistical Group had been very helpful in progressing the population of the performance framework and reviewing performance indicators. A number of amendments to the performance framework had been proposed and these were detailed at item 7 on the agenda.

During discussion, the following comments were made:-

- the current governance arrangements in respect of the delivery of adult social care were unsatisfactory and there was insufficient focus in terms of scrutiny. A review was called for and it was suggested that consideration be given to a workshop to discuss the issues;
- constituents raised health and social care issues with their local Councillors on a regular basis yet Members felt disconnected from the delivery of adult care;
- the integration of health and social care services was not a single event but a process of change;
- it was important to change public perception of health and social care services and examine, at district level, how changing structures were interfacing with local communities;
- in relation to District Partnerships, it was necessary to strengthen scrutiny rather than simply report on changes;
- the strategic approach to change, whereby the detailed Change Plan informed the Change Fund, was welcomed;
- concern was expressed that Members had not been informed of the suspension of admissions to care homes in their Wards and an assurance was sought that they would be kept up-to-date;
- information was sought on how many people didn't immediately go to their preferred care home and the duration of interim placements;
- information on care home placements was not easily accessible and it was suggested that the process should be better explained to potential service users. In addition, it was suggested that there would be merit in a briefing for all Members on the care home process; and
- concern was expressed regarding the membership of NHS Highland's Health and Social Care Committee and it was suggested that consideration be given to increasing the Council's membership to improve the level of scrutiny.

In response to points raised, the Director of Adult Care explained that the Strategic Commissioning Group (SCG) had discussed governance arrangements at its recent meeting and it had been considered timely, 18 months into integration, to review

current structures with any proposed changes being presented to the next SCG in March 2014.

In relation to care homes, Members were assured that they would be kept up-to-date and a list of the homes affected by the recent Care Inspectorate inspections would be circulated for information. It was explained that homes had been downgraded not as a result of diminution of care but of a more robust inspection process. A review of Care Inspectorate reports had been carried out and grades had come down throughout Scotland since early 2012. A grade of 2 or lower was considered to be unsatisfactory and admissions were then suspended to allow changes to be made. This impacted upon delayed discharges as people were unable to move out of hospital in to their preferred care home.

NHS Highland was working closely with the Care Inspectorate and, as part of the new structure, a Service Improvement Lead had been appointed whose role was to drive both NHS and independent sector care homes to the top of the quality indicators. Where admissions were suspended, they would work with the care home on their action plan and decide whether they had made sufficient improvements to lift the suspension. Previously, suspensions were not lifted until premises were revisited by the Care Inspectorate which could take as long as six months.

With regard to interim care home placements, it was proposed that a report be presented to the next meeting of the Sub-Committee on issues surrounding choice.

Following discussion, the Chairman undertook to consider a briefing on the care home process but, as a first step, it was suggested that the information available to the public be circulated to Members of the Sub-Committee.

In relation to District Partnerships, it was suggested that the points raised be fed in to the meeting of District Partnership Chairs and the subsequent Seminar in September 2013. Thereafter, a report would be produced for submission to the Adult and Children's Services Committee.

With regard to the proposed review of governance arrangements, the Chairman undertook to meet with the Vice Chair, Councillor Davidson and the Depute Leader, as the Council's representative on the NHS Board, to discuss the arrangements and report back to a future meeting of the Sub-Committee. In addition, he would consider the Council's membership on NHS Highland's Health and Social Care Committee.

Thereafter, the Sub-Committee:-

i. **NOTED** the issues raised in the summary report;
ii. **AGREED** that a list of care homes affected by the recent Care Inspectorate inspections be circulated to the local Members for information;
iii. **AGREED** that a report on the legislation surrounding choice in relation to interim care home placements be presented to the next meeting of the Sub-Committee; and
iv. **AGREED** that the information available to the public on the care home process be circulated to Members of the Sub-Committee.

5. Highland Quality Approach to Adult Care – A Five Year Improvement Plan for the Highland Partnership

There had been circulated Report No ASDS/13/13 dated August 2013 by the Director of Adult Care, on behalf of the Chief Executive of NHS Highland, which explained that the Five Year Improvement Plan for the Highland Partnership reiterated the direction, processes and evidencing highlighted in the Partnership Agreement signed in 2012. The Plan pulled together the significant strands of work required to improve outcomes for adults across the Highland Council area and which were reflected at local level in the Operational Unit Delivery Plans. These included:-

- Strategic Commissioning;
- Co-production;
- Shifting the Balance of Care;
- Integrated service delivery;
- Community Development;
- Self Care;
- Anticipatory Care Planning;
- Outcome-focused approach; and
- Self Directed Support.

During discussion, the following comments were made:-

- it was necessary to encourage communities and individuals to take ownership of their own care – something which traditional NHS culture had discouraged;
- the importance of partnership working with the independent and third sectors was emphasised;
- the evaluation of children's services carried out by the University of Edinburgh had been a valuable learning process and it was suggested that consideration be given to working in partnership with UHI or another university to carry out an evaluation of adult care; and
- funding would be a key issue in future years and it was important that NHS Highland projected need, negotiated with the Council and understood where it had to free up money within its services.

In response to points raised, the Director of Adult Care acknowledged the huge cultural change required, not only in Highland but nationally, and that NHS Highland and the Council could not deliver the Improvement Plan alone. There was a lot of expertise in local communities and it was important to work with those communities and build District Partnerships so they were informing and assisting with the changes ahead. A significant amount of work had already been undertaken with independent and third sector partners in relation to commissioning.

With regard to evaluation, the exercise carried out in respect of children's services had been extremely valuable but it had also cost a significant amount of money which was not currently available from the Scottish Government. However, there continued to be a focus on partnerships with universities.

In relation to funding, the Council had commissioned NHS Highland to provide adult services and the Plan was about delivering outcomes. Inputs were agreed in other forums.

Thereafter, the Sub-Committee **NOTED** the five year plan reflecting commitments made during integration and in the Partnership Agreement.

6. Health and Social Care Adult Services Performance Framework

There had been circulated Report No ASDS/14/13 by the Director of Adult Care, NHS Highland which detailed performance in Adult Social Care Services for the period April 2012 to June 2013. Over that period considerable work had been undertaken to refine and develop the indicators in use. It was now proposed that the emphasis moved from the development of the framework to scrutiny of the performance information provided.

Given the wide range of performance indicators, the Head of Care Support suggested that Members give consideration to those on which they wished to receive more detailed information in future reports but which were not currently ragged red.

During discussion, additional information was sought in relation to the number of people aged 18 to 64 receiving a care at home service in the evenings or overnight and at weekends (Indicators 18a and 19a) and it was requested this be provided by email.

In response to a request for further information on delayed hospital discharges, a report on the up-to-date position was tabled. The Head of Strategic Commissioning summarised the report, explaining that as of 21 August 2013, excluding those coded complex, there were 24 patients waiting over 6 weeks, 35 patients waiting over 4 weeks and 63 patients waiting over 72 hours. As discussed at previous meetings, the aim was to reach a point where no patients were waiting over 72 hours.

The main issue, as discussed at item 4 on the agenda, was that 63% of residential and nursing home placements were currently suspended as a result of downgrading by the Care Inspectorate. The position was particularly serious in the far North where there were no nursing beds available.

A further difficulty related to the capacity of care at home services. There were issues to be addressed in relation to market management and facilitation as well as over-dependence on the in-house service. However, discussions were ongoing with the Chief Operating Officer regarding further investment and work had commenced in relation to building third and independent sector provision. Improvements were expected but it would take time as the market was in a relatively depressed state.

There were a number of other cultural and procedural issues to be addressed to reduce the turgidity of the system but Members were assured that delayed discharge was being treated with the highest priority.

In response to questions, it was explained that various options were being explored in relation to care home provision and a report would be presented to a future meeting of the Sub-Committee. Negotiations were at an early stage regarding the innovative use of existing NHS buildings, in partnership with the independent sector, to develop interim care facilities which would then lead in to expanding the available independent sector care home places. In addition, officers were examining how NHS resources were being utilised.

With regard to care at home, Members were assured that there had been a significant recruitment drive by the independent sector but, as previously indicated, the service was in a transition phase and it would take time for improvements to effect.

The Chairman thanked officers for the update and it was requested that a report on the up-to-date delayed hospital discharge position be a standing item on the Sub-Committee agenda.

Returning to the performance indicators, further information was sought in relation to the time taken to access mental health services. In response, it was explained that the picture was uneven throughout Highland with some clinics meeting 100% of targets while others were considerably lower. The position was being reviewed and a report would be presented to next meeting of NHS Highland's Improvement Committee after which it was suggested that an update be provided to the Sub-Committee.

With regard to reducing the number of younger adults in institutional care settings (Indicator 23), it was explained that People First had carried out a survey of people with learning disabilities in care homes which would be presented to the Learning Disability Improvement Group and it was suggested that the report be circulated to Members for information.

Thereafter, the Sub-Committee:-

i. **NOTED** progress in improving and refining the performance framework indicators;
ii. **AGREED** that additional information in relation to the number of people aged 18 to 64 receiving a care at home service in the evenings or overnight and at weekends (Indicators 18a and 19a) be emailed to Members of the Sub-Committee;
iii. **AGREED** that a report on the up-to-date delayed hospital discharge position be a standing item on the Sub-Committee agenda;
iv. **AGREED** that, following consideration by NHS Highland's Improvement Committee, an update on the time taken to access mental health services (Indicator 59) be provided to the Sub-Committee; and
v. **AGREED** that the report on the survey of people with learning disabilities in care homes by People First be circulated to Members of the Sub-Committee for information.

7. Amendments to Adult Services Performance Framework

There had been circulated Report No ASDS/15/13 by the Director of Health and Social Care which set out proposed amendments to the Performance Framework for Adult Services from 2013/14.

The Director of Health and Social Care summarised the background to the performance framework and explained that there had been challenges in populating it and refining some of the indicators. A Statistical Group comprising a range of officers from the Council and NHS Highland, including Directors of Operational Units, had been established to fast track an improved performance framework. The process had been challenging but worthwhile and was commended to Members. There was now a much better populated framework with comprehensive information. In addition, the

first tranche of recommended amendments to improve the performance framework had been arrived at. The process had not been ideal in terms of consultation with the various improvement groups and stakeholders but Members were keen that improvements be implemented as soon as possible. The procedure was that the Sub-Committee should recommend the amendments to the SCG. However, due to a scheduling issue, the SCG had met the previous week and endorsed the proposed amendments subject to the Sub-Committee recommending them. The amendments would also require to be considered by the NHS Board and the Council's Adult and Children's Services Committee.

He then explained the proposed amendments to the performance framework as detailed in the report. In relation to Indicator 31, it was highlighted that the SCG had not approved the proposed changes and had asked that they be reviewed.

During discussion, clarification was provided on a number of specific points. In particular, it was explained that:-

- Indicator 6 - people's perceptions of their health was very important and consideration would continue to be given to how this could be measured. The Single Shared Assessment was being replaced with a Personal Outcome Plan which involved people assessing themselves in terms of health, wellbeing, safety etc so information was being collected on an individual basis;
- Indicator 7 – people were remaining healthy for longer but hospital mortality rates were changing. To date, end of life had not been incorporated in the framework but the two new indicators were driving towards that and officers would continue to reflect on the data and which indicators would be most meaningful. Measuring the number of flu vaccinations was being considered. However, the view of public health was that, as a consistent measure throughout Highland, it was not particularly informative;
- Indicator 10 – the Learning Disability Improvement Group was examining the new learning disability strategy, "The Keys to Life", and it was suggested that a presentation on the strategy be undertaken at a future meeting of the Sub-Committee which might lead to some ideas for relevant performance indicators;
- Indicator 36 – the 5% target in relation to anticipatory care plans was based on evidence in terms of the number of people who could, at any one time, have successful anticipatory care. In terms of the development of anticipatory care, there was a school of thought that the next stage would be how to access people of a younger age range (45 to 60) to develop anticipatory care plans; and
- Indicator 57 – consideration would continue to be given to how to measure quality of assessment.

During further discussion, Members emphasised the importance of focusing on indictors which identified areas where services could be improved.

An update on the Adult Protection Committee, including qualitative data, was sought and the Chairman confirmed this would take place at a future meeting of the Sub-Committee.

In response to a question regarding support for carers, particularly in the period between discharge from hospital and home care being put in place, it was acknowledged that the current indicator relating to the number of Carer Support Plans was quite crude. However, Members were assured that support for carers formed part

of discharge planning. A piece of work had recently been undertaken which examined a cohort of 40 delayed discharge patients and this would inform the Highland Quality Approach to admission, transfer and discharge.

With regard to the relationship between the indicators and the outcomes in the Partnership Agreement, it was explained that the indicators were the evidence that outcomes were being achieved. A document setting out both the outcomes and the relative indicators would be presented to a future meeting of the Committee.

Thereafter, the Sub-Committee:-

i. **AGREED TO RECOMMEND** to the Strategic Commissioning Group approval of the proposed amendments to the Adult Services Performance Framework as set out in the report, with the exception of Indicator 31 *(endorsed by the SCG on 23 August 2013)*;
ii. **AGREED** that an update on the Adult Protection Committee, including quantitative data, be presented to a future meeting of the Sub-Committee;
iii. **AGREED** that a presentation on the new learning disability strategy, "The Keys to Life" be undertaken at a future meeting of the Sub-Committee; and
iv. **AGREED** that a document setting out both the outcomes and the relative performance indicators would be presented to a future meeting of the Sub-Committee.

8. Charging for Telecare

There had been circulated Report No ASDS/16/13 by the Director of Adult Care, NHS Highland which provided the information requested regarding the numbers of clients and income generated through the provision of telecare. It also detailed the potential risks involved in any change to the current charging policy.

The report explained that of 2105 telecare users 1342 were 80+ and the estimated income generated by charging this age group was £295k. Any proposal to change the charging policy would require to take into account the cost of collection and how the income gap would be addressed.

Members were reminded that the telecare service was linked to the ability to pay. However, because of the relatively small amount involved, many users chose not to have the financial assessment.

During discussion some Members, whilst recognising the consequent budget gap, were of the view that telecare should be provided free of charge to the 80+ age group. It was felt that the report was incomplete in that it didn't include information such as the cost of collection and how many people did and did not pay for telecare. £22.60 per month was a considerable amount of money and many older people didn't want to have a financial assessment solely for a personal alarm. In relation to the income gap, how the costs would be met was a matter for negotiation between the NHS and the Council.

In response to questions, it was explained that the cost of collection was marginal as the mechanism to send out the bills was already in place and the cost of issuing an individual invoice was very small.

The agreed budgets for the provision of adult services were based on income streams and if the income streams changed then further negotiations would be required. The current policy was that telecare was a chargeable service and any proposed policy change would require to be considered by the full Council and the NHS Board.

Following discussion, the Chairman suggested that a more comprehensive report, focusing not on how the costs would be met but on the needs of the beneficiary group and what made a difference in terms of allowing people to remain in their own homes for longer, be presented to the next meeting of the Sub-Committee, with input from the Director of Health and Social Care and the Commissioning Officer.

Thereafter, the Sub-Committee:-

i. **NOTED** the provision of the information requested regarding numbers of clients and income generated;
ii. **NOTED** the risks involved in reducing or exempting from charging a particular client group on an age-related/service type basis;
iii. **NOTED** that such reduction or exemption would generate a budget gap of up to £295,000; and
iv. **AGREED** that a more comprehensive report, taking into account the points raised during discussion and with input from the Director of Health and Social Care and the Commissioning Officer, be presented to the next meeting of the Sub-Committee.

9. Care at Home Service – Response to Care Inspectorate Report March 2013

Mr B Gormley declared a non-financial interest in this item on the grounds that a family member resided in a household which received a Care at Home service but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that his interest did not preclude his involvement in the discussion.

There had been circulated Report No ASDS/17/13 dated August 2013 by the Director of Adult Care, on behalf of the Chief Executive of NHS Highland, which explained that the Care Inspectorate, as part of their regulatory process, inspected the NHS Highland in-house Care at Home service in February 2013. On receipt of the verbal feedback and in advance of the publication of the completed report, an action plan had been developed. The Chief Executive of NHS Highland led a working group to ensure all issues raised in the report were addressed with immediate effect. The action plan had been agreed with the Care Inspectorate and was updated regularly.

The Director of Adult Care reiterated the points made at item 4 regarding the more robust inspection process by the Care Inspectorate but, nevertheless, the grades awarded for the Care at Home service were unacceptable. The action plan referred to was appended to the report and detailed the steps taken to resolve the issues. Care at Home was a central service at present but the intention was that it would form part of the district teams and discussions were ongoing with the Care Inspectorate regarding future service structure and integration as well as building relationships with District Managers in terms of regulation and inspection.

During discussion, Members commended officers for their efforts in addressing the issues although there was still some way to go.

In response to questions, it was explained that the inspection process had highlighted significant issues in terms of capacity of Care at Home officers and staff. Development of the action plan had enabled processes to be put in place which would then be monitored and audited to ensure they continued. Self-evaluation was seen as the way forward to give confidence that, when the service was inspected at any time, grades would be good.

Thereafter, the Sub-Committee **NOTED**:-

i. the actions to be progressed in response to the report; and
ii. the process of monitoring progress in relation to the recommendations and requirements.

10. Management and Prevention of Falls in Older People

There had been circulated Report No ASDS/18/13 dated 16 August 2013 by the Falls Co-ordinator, on behalf of the Director of Adult Care, detailing the work trialled in Argyll and Bute Community Health Partnership and in partnership with the Scottish Ambulance Service to prevent falls and specifically reduce emergency admissions to hospital. It also emphasised the need to extend the work across the whole of the NHS Highland area and the opportunity now presented through the implementation of the single point of access and the Health and Social Care Co-ordinators in South Skye, Sutherland, Nairn and Invergordon.

Workbooks, which had been developed in Argyll and Bute to enable all those working with older people to identify modifiable risks, were tabled for information.

In addition to the report, Mr I Donald, Strategy Implementation Manager with the Scottish Ambulance Service, undertook a presentation during which it was explained that developing falls pathways was particularly relevant in areas such as the Highlands where a journey to the nearest hospital could take several hours. Falls pathways fit in with the Scottish Ambulance Service's Quality Strategy and Strategic Framework as well as NHS Scotland's Quality Strategy. A national task group had concluded that, if more people were supported to remain at home and fewer were unnecessarily conveyed to hospital after minor falls and illnesses, it would reduce the pressure on hospitals as well as providing a better service to the patient. In addition, increasing the rate of referrals to appropriate community based services would mean that emergency ambulances could be retained in the community.

Statistics on falls activity were provided which highlighted that there was a high level of conveyance to hospital although the number of injuries was relatively small. Redesigning the unscheduled care pathway for older people who fell or were frail would enhance patient experience, increase capacity, deliver efficiencies and improve outcomes.

In relation to the work trialled in Argyll and Bute, diagrams were presented which demonstrated the procedures followed and the four main strands of work, namely, triage and assessment; decision support; non-urgent referral; and urgent referral. Examples of the opportunities presented by such a system were provided.

In conclusion, there were many organisations with a role to play in redesigning care pathways and the aim was to work with partners to achieve a better system to serve patients.

During discussion, Members welcomed the work being undertaken. However, it would be challenging to change community expectations and understanding. The ambulance service had evolved from a transport service to a health service but many people thought that the way to keep people safe when there was an accident was to take them to hospital.

Concern was expressed that, although a multi-agency approach was referred to in the report and presentation, pathways remained clinical. It was emphasised that community groups could be very successful in addressing issues such as falls prevention and reference was made to the Dornoch Firth Action Group which had contacted 30 local groups, met with 400 people and issued questionnaires to identify those at high risk. They had obtained funding for a qualified nurse who had visited those at high risk in their homes and taken a soft assessment approach as well as a clinical approach. In the following 18 months, none of the people visited had had further falls. The group was now looking at ways to work with the ambulance service and have trained people in the community who patients would feel comfortable and safe with.

In response to questions, it was explained that:-

- a toolkit had been developed to facilitate a co-production approach whereby local communities and stakeholders were brought together to discuss the issues and shifting the balance of care. Ambulance statistics were presented and information was captured on how people would feel if they were taken to hospital when they weren't injured;
- having community services which were competent and confident in dealing with people's anxieties was key;
- historically ambulance crews had waited for a callout but work was ongoing to make them more accessible to local communities and build a degree of trust;
- as part of the falls pathway, if an ambulance crew had welfare concerns they would contact the single point of access. Who would provide the necessary support would vary from community to community. For example, it could be a Community Responder or the Red Cross had indicated a willingness to be involved in some areas. Building and supporting community resilience was key and local services and community groups would be identified at the stakeholder event at the outset; and
- the pathway would be rolled out across the four test sites for a single point of access in Highland and the solutions would have to be very local but the outcome, ie keeping the patient safe at home, would be the same.

Thereafter, the Sub-Committee **NOTED**:-

i. the development work in Argyll and Bute; and
ii. the proposals to implement the learning and improved outcomes across the NHS Highland Board area.

Development

11. Dementia Post-Diagnosis

Mrs D Mackay declared a non-financial interest in this item as a Director of Dementia Friendly Communities but, having applied the test outlined in Paragraphs 5.2 and 5.3 of the Councillors' Code of Conduct, concluded that her interest did not preclude her involvement in the discussion.

There had been circulated Report No ASDS/20/13 by the Director of Adult Care, NHS Highland which explained that the Scottish National Dementia Strategy 2013-2016 was launched in June 2013. This succeeded the previous 3 year national dementia strategy and built on the commitments therein. The implementation of the Charter of Rights, the Dementia Standards and the national training package "Promoting Excellence" were all key elements of the 2009-2012 strategy. The new strategy had introduced a Health, Equality, Access and Treatment (HEAT) target.

In addition, information was tabled on levels of dementia, by GP practice, in Highland and it was suggested that it also be emailed to Members of the Sub-Committee.

Mr M Pererra, Projects Manager, Mental Health, NHS Highland undertook a presentation during which it was explained that the national HEAT target had been implemented on 1 April 2013 although there had been some activity around supporting people post-diagnosis prior to that. At present, there were approximately 4000 people living with different stages of Alzheimers in the Highland Council area and every GP practice had to maintain a register of those who had received a diagnosis. The target was to deliver expected rates of dementia diagnosis and that, by 2015/16, all people newly diagnosed would have a minimum of one year's post-diagnostic support co-ordinated by a Link Worker. The Health and Social Care Partnership had commissioned Alzheimer Scotland to provide the one year of guaranteed support and seven Link Workers had been appointed in Highland.

The Link Workers followed the five pillars approach which addressed planning for future decision making; understanding the illness and managing symptoms; supporting community connections; peer support; and planning for future care. The types of data collected were summarised together with the reporting systems which were in place and it was explained that the Health and Social Care Partnership would receive a formal report from the Scottish Government in 2015. Performance monitoring was undertaken by NHS managers.

Ms M Johnston and Ms C Mainland of Alzheimer Scotland then explained the connection between the five pillars model, which related to self-management, and the eight pillars model, which related to accessing community care services. The second dementia strategy contained a commitment to test the eight pillars model in four sites across Scotland and a key component was the Dementia Practice Co-ordinator who would lead care, treatment and support for the patient and their carer on an ongoing basis, co-ordinating access to all the pillars of support and ensuring effective intervention across Health and Social Care.

A map of Alzheimer Scotland services and branches in Highland was provided and it was explained that the organisation had always had direct relationships with colleagues in all sectors. Integration presented an opportunity to build on that and the key components which it had been agreed, in partnership, were important were summarised. Knowledge of local networks and resources was particularly important

and it was essential to take a community asset mapping approach to ensure that people had access to services in activities in their local community.

Details were provided of a project involving 140 families living with dementia in Highland which had received funding from the Big Lottery. One of the outcomes of the project was the production of eight locality specific resource guides containing information on the dementia pathway, how patients could personalise their own support and links to organisations that could signpost to community activities. A project report had also been produced and the recommendations therein were being used to inform needs assessment in the area. Both the resource guides and the project report were also available online.

The importance of raising awareness of dementia in local communities was emphasised and an example was provided of an initiative undertaken in a local primary school in conjunction with Dementia Friendly Communities. In addition, a case study of a 65 year old man diagnosed with dementia was provided.

During discussion, Members welcomed the presentation and reinforced the importance of raising awareness and helping families living with dementia to remain part of their local community. In addition, the welfare of the carer was as important as that of the patient.

In response to questions it was explained that, at present, the work being undertaken by the Link Workers related solely to those newly diagnosed with dementia. However, wider services were available to support those already living with the condition. Of the approximately 4000 people living with dementia in Highland, 2600 were on the GP register, all at different stages of the illness. Around 900 of those were in care homes. Not everybody was in touch with services but a great many people were being supported. The scale of the challenge ahead was significant as the number of Highland residents with dementia was expected to rise significantly over the coming years. The average life expectancy from diagnosis was five years. However, there were a number of different types of the illness and factors to be taken into consideration.

Thereafter, the Sub-Committee:-

i. **NOTED** the presentation;
ii. **NOTED** the publication of Scotland's National Dementia Strategy and the introduction of the one year guarantee of support; and
iii. **AGREED** that information on levels of dementia, by GP practice, be emailed to Members of the Sub-Committee.

12. Highland Living It Up (Dallas) Project Implementation

There had been circulated Report No ASDS/19/13 dated August 2013 by the Living It Up (dallas) Project Manager, on behalf of the Director of Adult Care, which outlined the developing project known as *living it up* which sought to build the use and spread of assistive technology across the communities of Highland. Beyond this it recognised the value of technology in keeping communities connected and was especially valuable to the remote and rural parts of the Highland and Argyll and Bute areas.

Ms M Clark, Living It Up (dallas) Project Manager, NHS Highland undertook a presentation during which it was explained that the aim of Living It Up was to co-design sustainable and innovative improvements and choices in health, care and wellbeing for 55,000 people in Scotland by 2015. It was a large scale project with a budget of £10.3m covering five local partnership areas, namely, Lothian; Forth Valley; Moray; Western Isles; and Highland. There were six high level outcomes relating to promoting healthier living; promoting independence; supporting carers; making more effective use of resources; a more engaged workforce; and wealth creation. The target age group was 50+ and there were a number of sub-groups which were summarised together with the timescales for recruitment. A number of partner organisations were involved and the overall ambition was to combine service innovation and technical innovation. Engagement with the community took place via pop-up events, individual interviews, focus groups, workshops and a community engagement website.

Slides were presented which demonstrated the various stages of the project, prototypes of web pages and the Living It Up Portal which incorporated four elements, namely:-

- Shine – what are you good at?
- Flourish – what keeps you well?
- Discover – what's available for you locally?
- Connect – who would you like to talk to?

A number of key themes were emerging and these were summarised together with the benefits of the project and how they tied in to the high level outcomes.

During discussion, Members commented that it was an extremely diverse piece of work and it was suggested that it would be helpful for all Adult and Children's Services Committee Members to have sight of the presentation.

The Chairman undertook to give consideration to how this could best be achieved in the near future, given that the presentation slots at the Adult and Children's Services Committee were booked up for the next several months.

The Director of Adult Care explained that similar presentations were taking place at various NHS Highland Committees, operational units etc to raise awareness of the project. It was a very complex nationally run initiative and initially there had been a lack of clarity about the objectives but the four elements referred to in the presentation had provided a focus and the message could now be rolled out throughout Health and Social Care.

Thereafter, the Sub-Committee:-

i. **NOTED** progress with Living It Up; and
ii. **AGREED** that consideration be given to how best to deliver the presentation to all Adult and Children's Services Committee Members.

The meeting concluded at 12.55 pm.