Appendix 1

Reshaping Health & Social Care for Older Adults in Esk Valley: The Esk Valley Project

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Content:

1. Introduction

1.1 The Esk Valley Project has been delivered over a period of 6 months starting in May 2016 through to the preparation of the final project report in November 2016
1.2 The aim of the project has been to establish a robust evidence base which will inform planning for meeting the health and social care needs of older adults in Esk Valley (Langholm, Canonbie & Eskdalemuir), with specific focus on;

- Supporting older adults to remain in their own homes for as long as possible
- Reducing the need for admission to hospital
- Reducing delays in discharging older adults from hospital
- Older adults with higher level needs to have access to appropriate care options in their own home or in other suitable local accommodation
- Supporting informal carers of older adults

1.3 A project reference group was established with membership of the 4 Local Authority Ward Members, Langholm and Canonbie GPs, Chairpersons from the 3 Community Councils, the Annandale &Eskdale Locality manager and the Social Work Adult Services Manager.
1.4 The purpose of the reference group has been to ensure that the project established and maintained robust relationships with local communities with a view to guaranteeing the project has been informed by local communities and that local people have had opportunities for positive engagement in the process.
1.5 The Reference Group has met 5 times throughout the duration of this project
1.6 The project has comprised of 3 critical stages

- Stage 1: to identify and analyse hard data relating to population profile, population projections, current service use and projected service requirements.
- Stage 2: to engage with statutory, independent and third sector service providers to identify the challenges and opportunities around delivering support to older adults in Esk Valley
- Stage 3: to engage with the general public in ways which would inform them whilst assessing the community's appetite for change, taking account of and working within the National Standards for Community Engagement

2. Background

2.1 Discussions in relation to health and care services for older adults in Esk Valley have been taking place for a number of years. These were initially with regard to the potential to build a new day centre on land adjacent to the back of Thomas Hope Hospital but went on to include opportunities to consider the potential for a reconfiguration of other services and buildings.
2.2 Following an initial paper to the NHS Dumfries & Galloway Performance Committee in July 2013 a multi-agency group was convened, chaired by the Chief Executives of both NHS Dumfries and Galloway and Dumfries and Galloway Council to support this developing discussion.

Although this group has since disbanded some options were presented to the NHS Dumfries & Galloway Board in December 2013.

2.3 These options were originally influenced by both internal and external drivers applicable at that time. While these options may still be relevant they now require to be tested further through a robust process of evidence gathering and public engagement.

Table 1[1]: Options noted by NHS Dumfries & Galloway Board in December 2013

Options	Description	Discussion
1	Do nothing – Thomas Hope Hospital remains as is and is maintained and managed with current bed configuration.	Little opportunity for the development of services. Physical layout of the building challenges ability to deliver single room accommodation for e.g. end of life care.[2]
2	New build NHS facility with in-patient beds & potential new GP practice/ health centre on Thomas Hope Hospital site + adjacent health centre site. THH building is listed. Would require multi-agency partnership approach in line with agreed principles.	Offers potential to develop new health services in purpose built premises including potential development of GP and community health and care premises. Listed building restrictions may limit scope of opportunities.
3	NHS beds developed in a larger health and social care hub. Thomas Hope Hospital disposed of with opportunity for its development aligned to 'Total Place' vision for Langholm (e.g. developed as low cost housing or other community resource)	Offers the potential to develop a more flexible bed based approach without the NHS meeting all of the capital costs of new build. Revenue costs would still have to be met. Purpose built with ability to develop appropriate 'step up & step down' in partnership with care home provider while retaining NHS funded beds within the facility for identified higher level needs. Contingent on multi-agency working and securing an independent partner
4	Community based model of health and care, focussed on extra care housing and peripatetic care at home from primary and community care. No beds developed and THH retained to develop as an integrated hub with day hospital/day care, telehealth, community care and GP services	Offers the potential for a very different model of care across the community, focussed on developing hub and spoke models of extra care housing with appropriate peripatetic support. Opportunity to develop housing based respite provision and, if further care home capacity is developed, step up and step down provision in that setting. Contingent on multi-agency working.

2.4 The integration of Health & Social Care in response to the Public Bodies (Joint Working) (Scotland) Act involving NHS Dumfries & Galloway and Dumfries & Galloway Council presents opportunities to consider what had been proposed and possibly identify additional options which would make best use of existing resources and which would support older adults in Esk Valley in the most effective and person centred way.

3. Data Collection

[1] Source: NHS Dumfries & Galloway Development of Health and Social Care Options in Langholm and Esk Valley – Initial Options Appraisal and Update, 2 December 2013

[2] Source: NHS Dumfries & Galloway Property Survey 2012

A wide range of relevant data is currently recorded in different ways by different organisations, including the NHS and the Local Authority. To ensure consistent data capture data recorded for date zones S01007646, S01007647, S01007648, S01007649, S01007650, S01007651 or post codes in DG13 & 14 have been used as these relate to the same geographical areas.

Not all data was recorded at the same time. To ensure accuracy of data the most recently recorded has been used. Timescales for data recording or reporting have been provided.

This ensures that the most accurate and up to date data has been used to inform appraisal of any options or proposals.

4. Population

4.1 From 2015 to 2024 the projected population changes by age group show a drop of 9% in those aged 16-29 and 8% in those aged 45-59 with increases of 2% in those aged 0-15 years. There are also projected increases of 16% in those aged 60-74 and 29% in those aged 75 and over. Projected population changes through to 2039 follow similar trends with the most marked increase being those aged 75 and over where this is an increase of 85% between 2015 and 2039

Table 2: Projected populations changes by age group 2015-2039

Year	Total Population	0-59years	60-74years	75+ years
2015 [3]	4420	2945	1005	470
2024[4]	4653	2882	1165	606
2039[5]	4923	2888	1165	869

4.2 Alzheimer's Society research[6] concludes that 1 in 14 people aged 65 years and over will develop some form of dementia, but not all will have had a diagnosis of dementia. This suggests that 80 people in DG13 & 14 will currently have some form of dementia with this rising to 112 in 2039 as the number of people aged 65 and over is predicated to increase from [7]1123 to [8]1576

4.3 The most recent data[9] on informal carers in Esk Valley revealed there were 275 carers with 76 of these being aged 65 years and over. Further to that 47 % of carers aged 65 and over were providing at least 50 hours of care each week.

5. Community Based Services

5.1 Care at Home: The nature of the Care at Home service means the numbers are not static and can vary from day to day. For the purpose of this exercise service data recorded on 1 September 2016 has been used.

Table 3 [10]: Care at Home Service Users

Post code	Number of visits that day	Number of service users visited that day	Number of service users not receiving a visit that day	Total number of registered service users that day
DG13	46	18	1	19
DG14	23	8	6	14
			Total	**33**

[3] Source: National Records of Scotland Mid-2015 - Small Area Population Estimates for 2011 Data Zones
[4] Source: National Records for Scotland – Projected percentage changes in Scotland's population by age group
[5] Source: National Records for Scotland - Projected percentage changes in Scotland's population by age group
[6] Source: Alzheimer's Society Dementia UK. Second edition November 2014
[7] Source: National Records for Scotland - Projected percentage changes in Scotland's population by age group
[8] Source: National Records for Scotland - Projected percentage changes in Scotland's population by age group
[9] Source: NHS Health Sector Health Inequalities Action Framework Dec 2013
[10] Source: Dumfries & Galloway Health & Social Care, Re-ablement & support

5.2 Langholm Day Centre: Langholm Day Centre is managed by a voluntary committee and has been in receipt of funding towards some of their operating costs from Dumfries & Galloway Council for some considerable time. Not all of the members registered attend all of the five days the centre is open and attendance varies from week to week. Membership of the centre is in the main self referral and does not require assessment. Membership numbers do change on a regular basis. For the purposes of this exercise data has been drawn from the most recent monitoring report

Table 4 [11] : Langholm Day Centre – age profile of members

Age of Members	Number	% of total
65-74	13	10%
75-84	51	40%
85 +	63	50%
Total	**127**	

50% of all people aged 85 and over in DG13 & 14 are registered with Langholm Day Centre. By 2039 the number of people aged 75 and over will have increased by 85%, potentially increasing the number of members to 210 which presents both a challenge and an opportunity for the service. This would however mean developing the staff, space and facilities suitable for supporting more frail older adults as part of their care plan following assessment.

5.3 Occupational Therapy. The community occupational therapy service is responsible for assessment in partnership with people and carers, making recommendations to meet need, including assistive equipment, adaptation and housing. The number of people in receipt of this service can vary from day to day. For the purpose of this exercise data recorded on 1st September 2016 has been used. A hospital occupational therapist is based at Annan Hospital but also covers Thomas Hope Hospital. No data relating to in-patients seen in the hospital is available. The community occupational therapist does not deal with in- patients unless the home environment needs adapting in which case there will be a joint visit involving both occupational therapists.

Table 5 [12]: Open Occupational Therapy cases and location of service

Location of service user	**Number of open cases**	**Number seen at home**	**Number seen in other location**
DG 13 & 14	11	10	1

5.4 Telecare

Telecare such as community alarms, sensors and remote monitoring equipment can enable people to live with greater independence and safely at home. Dumfries & Galloway has the third lowest uptake of telecare in Scotland at 11%[13] of those aged 75 and over per 1,000 of population. The Scottish average is 18% with North Lanarkshire highest at 35%. These figures don't separate care call systems from other tele-care services.

The latest data available on service users in DG13 & 14 suggests that 63 people in Esk Valley are linked to Care Call, 5 of these also received other community based services including meals on wheels. Lack of responders and complexity of the application process were cited as reasons for not using care call.

[11] Source: Monitoring visit – Langholm Day Centre 10/2/2016
[12] Source: Senior Practitioner Occupational Therapist, September 2016
[13] Source: Scottish Government Health & Community Care – Data sets 2014

5.5 Housing

5.5.1 Trust Housing Association provides 10 x 1 bedroom cottages and 1 x 2 bed cottage located at Greenbank Langholm on a site adjacent to Greenbank house. These properties are linked to Care Call 24/7 as there is no resident staff member. A coordinator is employed 9.00am-5.00pm Monday to Friday and part of the coordinator's roll is to arrange social activities in the communal sitting room. Meals are not provided. All of the properties are currently let and 9 people are on the waiting list.

The Eskdale Foundation, a local community enterprise, owns 4 x 1 bedroom flats in what was the Greenbank Care Home prior to it closing. These properties are for rent to local residents over retirement age. The other properties in the development are privately owned. Recently the Eskdale Foundation experienced difficulty finding a tenant for a vacant property although it is now currently full. Tenants can link into Care Call 24/7 but no additional support or activities are included in the tenancy.

5.5.2 There is no very sheltered housing available in Esk Valley or indeed the whole of Annandale and Eskdale. Very sheltered housing provides cottages or flats that are specially designed for older adults who require assistance to live independently and have all the facilities of sheltered housing but more, in particular communal facilities for the provision of meals and other opportunities for social interaction as well as support staff to provide extra assistance as required in the communal areas and the tenant's own home

5.5.3 A study commissioned by [14]Bield, Hanover and Trust Housing Associations found that the benefits of very sheltered housing include a reduction in the need for residential care home provision worth £19,000 per tenant of which the Scottish Government would have paid approximately 63% ; greater levels of confidence, independence, autonomy, and relationships with friends and family than would be the case in alternative residential settings and an overall reduction in the need for care of 63 hours a year for those who would otherwise have been in their previous home, with a cost saving of approximately £1,300 per person

5.5.4 The Dumfries & Galloway Draft Housing Needs & Demand Assessment [15] states there is a need to review whether the current models of sheltered housing provision in Dumfries & Galloway meet long term needs as demand for sheltered housing and specialist accommodation models is likely to increase . According to the Scottish Government's "Review of Sheltered Housing in Scotland" (2008) housing associations own 85% of the 4,000 or so very sheltered or "extra care home" units in Scotland. The general view is that overall demand for very sheltered housing and extra care housing will increase over the next decade.

The Dumfries & Galloway Council's current Strategic Housing Investment Plan (SHIP)[16] has identified 10 amenity/ very sheltered units of specialist provision to be built in Eskdale over the next 5 years. Loreburn Housing Association already has approval for specialist housing on a site Armstrong Court Langholm[17].

6. Third Sector Providers

A number of Third Sector organisations are delivering practical support services in Esk Valley which help older adults remain longer in their own homes. Other than Langholm Day Centre Third

[14] Source: Striking the Balance: A social return in Investment. A study of very sheltered housing. Proff D. Bell University of Stirling 2013

[15] Source: Draft Housing Need & Demand Assessment April 2016, Dumfries & Galloway Housing Market Partnership (Dumfries & Galloway Council)

[16] Source: Strategic Housing Investment Plan (SHIP) August 2016

[17] Source: Strategic Housing Investment Plan (SHIP) 2016/17 (Appendix I) August 2016

Sector service data has not been collated for this exercise. A range of organisations have however participated in the exercise by engaging with the service providers gathering event as detailed in Appendix I and also by providing information stands at the public engagement event as detailed in Appendix IV. These events evidenced that most Third Sector providers have a good understanding of the local communities and experience of delivering services which in the main meet needs. There is scope for some of these organisations to be delivering effective preventative and support services through a commissioning process within an agreed strategy for the area.

7. Hospital Services

7.1 Thomas Hope Hospital is a 12 bedded unit built in the late 1800s with funds bequeathed by a benefactor. Thomas Hope Hospital, Hospital Lodge, Mortuary and Enclosure Walls, Gates and Railings are B listed. The beds are accessible by local GPs, consultants from Dumfries & Galloway Royal Infirmary and Cumberland Infirmary, Carlisle.

7.2 The challenges for Thomas Hope Hospital are that the age of building and design are not conducive to modern healthcare. Bed spacing standards, visibility for staff, ability to move beds and equipment around in safety, compliance with Equality standards etc are all issues. There are backlog maintenance issues[18] and work can be undertaken subject to funding availability however the compliance issues previously mentioned will remain. The cost of addressing the maintenance issues is therefore not the defining concern but rather it is likely to be the inability to provide a fit for purpose and revenue cost effective modern health solution.

7.3 The hospital provides assessment of adults, rehabilitation and palliative care. There are 4 x 2 bedded rooms and 4 single rooms spread across the building. There are also facilities for podiatry 2 days a week, and physiotherapy 3 days a week which can either be in-patient or outpatient. Details of the number of out-patient appointments are set out in Table 13. Day care for frailer older adults is provided three days a week with places for up to 6 people per day.

7.4 The following inpatient data has been extracted from the local inpatient universe on 18/05/2016 for patients discharged from community hospitals in the financial years 2013-14, 2014-15 and 2015-16. This is the local dataset holding Scottish Morbidity Record (SMR 01) data. For average daily occupied bed calculations any stays greater than 365 days were capped at 365 days (i.e. 1 bed) attributable for that particular year of discharge. Percentage occupancy data for inpatient beds in community hospitals were extracted from Qlikview Wardstats module on 24/05/2016.

7.5 Bed usage at Thomas Hope Hospital has been changing over the last year with fewer local patients and a higher number of patients from Nithsdale being admitted from DGRI because of a shortage in suitable available alternatives closer to their homes. More recently bed occupancy has risen to between 10 and 12 beds occupied at any given time with on average at least 50% of patients from out with the area. This figure has been much higher on several occasions. This has contributed to a perception that the full quota of 12 beds is still required to support the local community

Table 6[19]: Community Hospital inpatient stays for patients discharged in the years 2013-14 to 2015-16. Average length of stay (in days) for discharges in year and average daily occupied bed equivalents for stays.

Hospital	Average Length of stay (days) for discharges in year	Average daily occupied bed equivalents attributable to stays

[18] Source: NHS Dumfries & Galloway Property Survey 2012

[19] Source: Inpatients Universe

Thomas Hope	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
	23	22	24	7	7	8

7.6 Almost three-quarters of the patients admitted to Thomas Hope Hospital have been transferred there from a general hospital – either the Dumfries & Galloway Royal Infirmary or a general hospital in another health board area.

Table 6 [20] : Location of admission to community hospitals for patients discharged for the years 2013-14 to 2015-16. Number and proportion for year and hospital.

Hospital	Year of discharge	Transfer from DGRI		Home/Private residence (GP Direct Access)		GCH Acute ward (Garrick)		Transfer from other health board		Other (e.g transfer from other CH or Dalyrmple)		Total
		No.	%	No.	%	No.	%	No.	%	No.	%	
Thomas Hope	2013-14	22	20%	40	37%	0	0%	46	42%	1	1%	109
	2014-15	25	23%	36	33%	0	0%	47	43%	1	1%	109
	2015-16	58	47%	34	28%	0	0%	29	24%	2	2%	123

7.7 Just over 50% of patients discharged from Thomas Hope Hospital go back to their own home. The number being discharged to a care home/ nursing home has remained fairly static over the last three years with a slight increase during 2015-16 rising to 13% of all discharges.

Table 8[21]: Location of discharge following a stay in cottage hospital for patients discharged for the years 2013-14 to 2015-16. Number and proportion for year and hospital.

Hospital	Year of discharge	Home/ Private residence		Died		Care Home		Transfer DGRI		Other (e.g. transfer to other community hospital)		Total No.
		No	%	No	%	No	%	No	%	No	%	
Thomas Hope	2013-14	64	59%	14	13 %	13	12%	8	7%	10	9%	109
	2014-15	61	56%	14	13 %	13	12%	11	10%	10	9%	109
	2015-16	66	54%	15	12 %	16	13%	14	11%	12	10%	123

7.8 The number of bed days lost because of delayed discharge has continued to rise from 2013 with a significant increase in 2015-16. However as shown in Table 8 there were only 12 delayed discharges in 2015-16 which accounted for 250 bed days lost.

Table 9[22] : Number and proportion of delayed discharges and bed days lost to delayed discharges for patients discharged from cottage hospitals in the years 2013-14 to 2015-16.

[20] Source: Inpatients Universe

[21] Source: Inpatients Universe

[22] Source: Inpatient Universe, NHS Dumfries & Galloway local delayed discharge data

		Number of delayed discharges			Bed days			Average daily occupied bed equivalents attributable to stays		
Hospital	Year of discharge	Number of delayed discharges	Total number of discharges	% discharges that were delayed	Delayed bed days	Total bed days	% bed days lost to delays	Delayed discharge	Not delayed discharge	Total
Thomas Hope	2013-14	2	109	2%	69	2,557	3%	0.2	6.8	7.0
	2014-15	2	109	2%	89	2,440	4%	0.2	6.4	6.7
	2015-16	12	123	10%	250	2,970	8%	0.7	7.4	8.1

7.9 The primary reason for delay in discharging patients from Thomas Hope Hospital in 2015-16 has been waiting for Care at Home availability which accounted for 2/3rd of all delayed discharges. The other 1/3rd were delayed while waiting for a care home place or a care home of choice.

Table 10 [23] : Number and proportion of delayed discharges for each year for patients discharged from community hospitals in the years 2013-14 to 2015-16 by reason for delay.

Hospital	Year of discharge	Awaiting home care availability for patient to live in own home		Awaiting place in care home or choice of care home		Awaiting Specialist housing		Delay due to other patient/ carer/family /legal reasons		Awaiting complete ion of post hospital assessment		Total
		No.	%	No.	%	No.	%	No.	%	No.	%	
Thomas Hope	2013-14	2	100%	0	0%	0	0%	0	0%	0	0%	2
	2014-15	2	100%	0	0%	0	0%	0	0%	0	0%	2
	2015-16	8	67%	4	33%	0	0%	0	0%	0	0%	12

7.10 In May 2016 a Day of Care audit was undertaken across all hospitals in Dumfries & Galloway when one of the measures was to identify those patients who were in a community hospital but who did not meet the criteria for being in a community hospital. The survey was carried out by clinical and operational staff and was a snapshot of a single day, giving a detailed picture of bed occupancy and the patterns of delays across the system. The survey was carried out in every community hospital within NHS Dumfries and Galloway and was then repeated in September

Of the 12 patients in Thomas Hope Hospital at the time of the May audit 5 met the criteria and 7 did not meet the criteria. In the September audit 6 of the 10 patients on that day didn't meet the criteria and while 4 did.

Table 11 [24] : Number and proportion of people in community hospitals meeting or not meeting Day of Care criteria for requiring community hospital care 26th May and 22nd September 2016. (Excludes those patients being discharged on the day)

Thomas	DOC Audit Date	Number of patients	Day of Care Criteria Met	Day of Care Criteria Not Met	% Not Met

[23] Source: Inpatient Universe, NHS Dumfries & Galloway local delayed discharge data

[24] Source: Day of Care Survey Dumfries & Galloway (May 2016)/ Day of Care Survey Dumfries & Galloway (September 2016)

Hope Hospital	May 2016	12	5	7	58%
	September 2016	10	4	6	60%

7.11 Most community hospitals particularly in the Stewartry and east Annandale & Eskdale areas which are some distance from Dumfries & Galloway Royal Infirmary provide a site for some outpatient clinics in particular for a range of Allied Health Professional (AHP) specialties.

Table 12[25]. : Booked outpatient appointments at cottage hospitals in 2015-16. Number of New (N) and Return (R) appointments for all AHP, Nurse-led and Consultant-led clinics

Thomas Hope Hospital		
Specialty	**New**	**Returning**
Physiotherapy	163	265
Podiatry	34	870
Orthoptics	62	99
Dietetics	1	29
Old age Psychiatry	0	1
Public Health	1	0
Total	**261**	**1,264**

8. Residential Care for Older Adults

8.1 For the purpose of this exercise the sourcing of data on the number of residents living in a care homes, who had previously lived in DG13 or 14 was under taken during week commencing 15th August 2016.
8.2 A total of 8 care homes reported having 26 residents between them. The care homes were Virginia Lodge, Burnfoot House/Coach House, Dryfemount, Lydiafield, Notwen House, Singleton Park, Wesfield, Annan Court. Notwen House reported having one third of all of residents included in the audit.

8.3 The number of residents identified in the audit represents 5.5% of the 75 and over population of DG 13&14. This is in line with national trends. If the same % is applied to the projected 75 and over population going forward this suggests the need for a further 7 care home places by 2024, rising to 22 additional care home places required by 2039. However this projection assumes no change in the way older adults are supported and no change in the services/ facilities available in the local community

Table 13: Estimated number of care home places required by % of 75+ population

Year	Estimated population 75+	% of population 75+ in a care home	Number of care homes beds
2015	470	5.5%	26[26]
2024	606	5.5%	33[27]
2039	870	5.5%	48[28]

[25] Source: Qlikview outpatient
[26] Actual – August 2016
[27] Estimated % based on current occupancy

8.4 No data was collected on individual residents in this audit. However the Care Homes Census[29] undertaken in 2014 across Scotland reported that 53% of all residents in care homes had a diagnosis of dementia. The same Census reports that the % of older people resident in care homes in Dumfries & Galloway who had a diagnosis of dementia increased from 27% in 2000 to 52% in 2014. This data is not available on a post code or data zone basis but there is no reason to expect this trend to be any different for Esk Valley.

8.5 Despite this increase in the number of care home residents who have a diagnosis of dementia and the increasing number of people living longer the overall number of registered care homes, care home places and older adults being admitted to a care home across Scotland have been decreasing over recent years. If this trend continues the actual number of care home places required by 2039 may be less that estimated in Table 13

Table 14[30]: Care Homes, Registered Places, Residents and Occupancy Rate by Main Client Group in Scotland, March 2000 - March 2014

Unit Measured	% Change March 2000 – March 2014
Number of registered care homes for older adults	**-14.8%**
Number of registered places	**-1.9%**
Number of residents	**-3.6%**

9. Engagement with Service Providers

9.1 On 24th June 2016 the Esk Valley Project hosted a gathering of service providers and interested groups in the Buccleuch Centre, Langholm. By the morning of the event 36 people from a range of organisations had registered to attend. Details of those who participated are set out in Appendix II.

9.2 The first part of the event took the form of three presentations focusing on the Annandale & Eskdale Locality Plan and what that means for Esk Valley, some hard data relating to DG13&14 with some comparisons with the rest of Dumfries & Galloway and/ or the rest of Scotland and the Putting You First initiative which resulted in the One Team approach being developed locally.

9.3 The second part of the event took the form of facilitated discussion groups which were tasked to identify, from a service provider perspective, the challenges in delivering services in Esk Valley and where the opportunities are to do things better/ differently.

9.4 Responses were recorded on post-its and collated under the headings of Challenges and Opportunities. These are detailed in Appendix I. As would be expected the opportunities identified mirrored, to a great extent, the challenges put forward.

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[28] Estimated % based on current occupancy

[29] Source: ISD – NHS National Services Scotland Care Home Census 2014

[30] Source: ISD – NHS National Services Scotland Care Home Census 2014

9.5 **Summary of Feedback:**

9.5.1Care Staff: The issue which took prominence was the lack of paid care staff with related concerns about recruitment, training and retention. There was sufficient cross agency anxiety about this to justify some attention being given as a matter of urgency and to examine what was proposed as possible solutions.
9.5.2 Information: Not enough public information on the services available was the next highest concern with some additional comments about the impact this has on uptake. The most favoured solution was to establish a central point of information locally with some community based outreach. It would not be unusual to find that those engaged in the delivery of services may themselves be unaware of what is available so this may not only apply to members of the public.
9.5.3 Integrated working : Despite evidence being provided on the successful and much welcomed One-Team concept there were still concerns about the need to further improve communication and coordination between agencies and staff at a local level, with suggestions that this concept be expanded as a realistic solution and in particular to involve a wider range of practitioners.
9.5.4 Transport: Poor coordination of, and limited access to, public transport to hospitals and other health/ care appointments for both patients and visitors were also highlighted. As those present were in the main providers of services this suggests that transport issues do have a significant impact on people's lives. This is a matter which will be shared with many other areas of Dumfries & Galloway and as such suggests that a much wider strategic approach is required. More local solutions could be developed within such a strategy, in particular support for existing and/ or emerging local transport initiatives.
9.5.5. Telecare: The low uptake of care call and challenges around Telecare generally pulled together a number of issues. Solutions included employing paid responders and simplifying access to this support. It had been noted that Dumfries & Galloway has the third lowest uptake of Telecare in Scotland despite the high percentage of older adults.
9.5.6. Care Home provision/ specialist housing : Another theme covered where people lived and / or were cared for with this ranging from the need for additional care home places to the need for very sheltered / extra care housing neither of which currently exist in Esk Valley with the additional challenge of specialist housing not being available anywhere in Annandale & Eskdale. With regard to care home provision there was strong support for this to be local to allow residents to maintain links with their community. Extra care/ very sheltered housing was perceived to help fill the gap between mainstream housing and care home provision which would allow older adults to maintain a degree of independence in later life and possibly delay admission to a care home
9.5.7 Keeping people in their own home : Related to the previous section were a number of issues around early intervention, services to support early hospital discharge, promoting re-ablement, step-down rehab and better integrated hospital/ home services with access to locally based support like OT & physio being highlighted by a number of participants. Whilst quite a few comments suggested more of the same, there were other comments about changing the way services are delivered, how organisations should work together and the need to develop new approaches and possibly new services. This suggests further opportunities for changing practice with a view to reducing admission to hospital and supporting earlier discharge as well as supporting an individual's choice to live as long as possible in their own home.
9.5.8. Third / Independent Sector: A number of challenges were raised around the length and nature of funding for independent and third sector providers as well as levels of funding. Longer term funding arrangements was one potential solution which would provide greater stability to service providers, their staff and service users

10. Public Engagement

10.1 Day Centre Focus Group

10.1.1 A focus group was held in Langholm Day Centre on Friday 2nd September as this is the busiest day in the week and includes a good number of Canonbie residents. This was held in the main hall which allowed members to observe the event even if they chose not to participate. As it was only a limited number of members spoke.

10.1.2 The overriding issues for a few members were the perceived threat of closure of Thomas Hope Hospital and the need for a local care home.

10.1.3. With regard to Thomas Hope Hospital there was an apparent view that almost any older person being discharged from a general hospital will need to spend time in Thomas Hope Hospital before going home and that without Thomas Hope Hospital people being discharged home would be at risk. There was little belief in the possibility of changing the care at home service / One Team approach to provide additional support to people in their own homes.

10.1.4 After showing a short video describing how a hospital at home service model works in other areas discussion suggested some support for avoiding hospital admission to a general hospital but Thomas Hope Hospital was still seen to be the best alternative. It was suggested by a small number that it's best to be in hospital when you are unwell as you would have company rather than be at home on your own.

10.1.5 Discussion around the need for a care home revealed there is a widely held belief that the Local Authority can build and operate a care home in Langholm. There was little understanding that the Local Authority has not owned and operated care homes for a very long time. One of the members challenged the current policy and suggested that this needs to change. There was also a view shared that the Council was in fact stopping the development of a care home. This appeared to be feeding the local campaign for a care home.

10.1.6 It was also apparent that many of those present feared what would happen to them if there was no care home. There was a strong view that they wish to remain in the local area and not be "shipped off" to somewhere else. There did seem to be a view that a care home was the only option once an older person was unable to "manage" in their own home. There was some evidence that this was to some extent informed by past practice when older people were admitted to care homes at an earlier stage of their life. Fear of isolation and loneliness was very real and a care home was seen to be a solution for this.

10.1.7 A short video explaining very sheltered housing elicited a positive response from a number of members with suggestions that this should be explored.

10.2 Care Fair

10.2.1The second public engagement exercise took the form of a Care Fair in the Buccleuch Centre on Monday 5th September from 2.00pm – 7.00pm. This was advertised widely in the local media and posters and fliers were displayed in numerous visible locations through DG13 & 14. The main rationale for using this platform was to ensure wider engagement with the general public with opportunities for one-to-one conversations rather than having a public meeting where quieter people could be drowned out by others more confident about speaking at such an event. The other reason was responding to what had been identified at the Providers Gathering which was that many people may not know what is currently available. A summary of feedback from this event is set out in Appendix III

10.2.2 There was a total of 15 stalls with stall holders present, one general stall with information only and an additional 4 advisors in attendance. Details of the organisations are recorded in Appendix IV

10.2.3 A total 78 survey forms were handed out when people arrived although it's likely that some people were missed and that the actual number of people who attended the event was higher. A copy of the survey form is attached as Appendix V
10.2.4 The front page of the form was to be filled in on entry and the back of the form filled in on exit. 63 fully completed forms were returned

10.2.5 The overriding issues which came through this process were a strong desire to remain in the local community until end of life and a fear that the care and support people will need in later life will not be available locally. This was articulated in a range of ways with lobbying for a care home and the retention of Thomas Hope Hospital being seen by some as the only solutions. Because no other options have been presented to the community it is quite hard for people who have concerns to see that there are other ways to support older adults in later life in their own community.
10.2.6 The care fair which allowed those attending to see what is already available, to view some possible alternatives and to have one-to-one conversations resulted in some shift in perception and understanding. A significant number indicated strong support for exploring new or different ways to support older adults and after having attended the care fair a reasonable number were identifying a wider range of issues and solutions.
10.2.7 Many reported being better informed through the event and the exit survey showed strong support to move on from consultation and surveys and to see some action.
10.2.8 The next stage of public engagement could therefore be to present a worked up visual presentation with a good amount of details so that the community can see how their views and concerns have been addressed.

11. Summary

11.1 The main concern coming from the people who have engaged with this process has been around there being enough support of the right kind which allows older adults to remain in their own community for as long as possible as their care needs increase in later life.
11.2 Concerns about becoming socially isolated in later life are very real
11.3 Perception of the kind of services required has to a great extent been influenced by current and past practice and experience of how and where support has been provided
11.4 Data on Thomas Hope Hospital occupancy over the last three years suggests that in the longer term the local community could be served with a reduction in the number of beds
11.5 The physical layout and condition of Thomas Hope Hospital is unlikely to ever provide a fit for purpose and revenue cost effective modern health solution.
11.6 There is a need for more local residential care places but population data suggests a projected modest increase in numbers which may not be economically viable as a standalone facility.
11.7 There is an accommodation/ housing gap between a person's own home and a care home with a current waiting list for the available sheltered housing
11.8 There is limited access to sheltered housing which can partially fill that gap but not for older adults who require a higher level of support.
11.9 Very sheltered housing is a safe, more economical and acceptable alternative to residential care and more consideration needs to be given to increasing access to this type of provision
11.10 Better use could be made of tele-care and tele-medicine which includes care call but could include other technology which support people in their own homes
11.11 There is a need for increased day centre/ day care provision, in particular day care as part of a care plan for frailer older adults
11.12 Community based services supporting people in their own homes could be better coordinated and more responsive to individual assessed needs
11.13 The "One Team" concept could transform how older adults are supported through the true integration of services at a very local level

11.14 A Hospital-at-home service, as part of the One Team approach, could help reduce hospital admissions and enable earlier supported discharge from hospital
11.15 The clear message from the community was for no more consultation and surveys and for something to be done even if that means change.

12. Development Opportunities: Non-building

During the lifetime of this project a number of opportunities for change and improvement have been identified. Where there has been good evidence to support immediate change this work has commenced rather than do nothing until the conclusion of this project. These opportunities have in the main been in community based/ non-building areas.

12.1: One-Team The Integration of Health& Social Care presents opportunities to change how older adults are supported in their local community which are not dependent on buildings. The most obvious one is the creation and development of the One-Team approach which will fully integrate health & social care services within the local community. Services to be involved include, as a mimimum, GPs, social work, Thomas Hope Hospital, community nursing, CASS carers, STARS, physiotherapists, occupational therapists, community link workers, day centre and telecare

This will improve and speed up assessment, simplify the delivery of integrated care packages for individuals and their carers, improve communication, identify where changes in services are required in order to meet needs & use local knowledge to inform on-going planning and delivery of services.

Work on developing the One Team is now well advanced with a multi-disciplinary group in place.

12.2 Hospital at Home: This would be a new service that has been successfully piloted and rolled out in other parts of the country which would enable older adults to have a higher level of health care in their own homes thereby reducing the need for admission to hospital. Esk Valley could pilot this innovative service with a view to it being replicated in other parts of the Region. Whilst no work has begun on a Hospital at Home proposal it is something to be explored as it would fit well with and could be developed as part of the One Team approach

12.3: Care at Home: Care at Home have started work on improving retention and recruitment of care at home staff. This is aimed at increasing the number of local carers and making the services more responsive to needs. The Care at Home service is also reviewing the allocation of staff and shift patterns in ways which benefit service users and staff.

12.4: Telecare: The Telecare service is seeking to increase the number of older adults using care call and potentially other tele-care facilities which will support older adults to remain safely in their own homes. This includes simplifying the process for obtaining care call and the possibility of paid responders where no one else is available

12.5: Day Centre: there has been recognition of the high number of day centre members aged 85 and over and the number of members who require a degree of personal care whist at the day centre. Arrangements are in hand to locate a health care assistant at the day centre so that the personal care needs can be met in an appropriate way.

13. Development Opportunities: Building Dependent

A key element of reconfiguring services to meet the needs of older adults in Esk Valley is the use of buildings, both existing and potential new ones. Options range from doing nothing other than

maintain existing premises through to innovative new build which would bring a range of services together in an integrated way.

13.1: Day Centre: the significant increase in the 85+ population by 2039 (85%) suggests the need to expand in terms of space and also the type and range of services offered. Consideration needs to be given to whether the current building will be suitable for extended services or whether additional/ alternative premises will be required.

13.2: Very sheltered sheltered housing: increasingly across the country this type of provision, along with supported housing is considered to be a more acceptable option for enabling older adults to remain in their own communities whilst providing them with the care they need. The development and operation of very sheltered housing would require securing a specialist housing agency as a partner and for the funding for such a development to be included in the Strategic Housing & Investment Plan. It is not yet known if the housing in Langholm planned by Loreburn Housing Association will be sufficient to address the current gap between mainstream housing and residential care in a way which will delay or reduce admission to a residential facility or indeed if any alternative site in Langholm could be more appropriate for very sheltered housing development.

13.3: Care Home: population projections do not support the need for more than 7 additional residential care home beds in total by 2024 if the way older adults are supported in their own homes does not change. Taking account of the proposed changes detailed above that number could be lower, particularly if very sheltered housing was available as an alternative where appropriate. However there will still be a need for some level of residential care home provision. The development and operation of a care home will require to attract an independent care home provider as the Local Authority does not own and run care homes. This is not well understood by many local people. A small residential care facility could be a satellite services supported by a larger operation in order to be attractive to a provider.

13.4: NHS bed based facility: There is strong evidence that the removal of the NHS bed based facility currently offered at Thomas Hope Hospital would be detrimental to the local community if no suitable alternative was put in place. Transport challenges have been highlighted by both service providers and the local community and these would be exacerbated if any additional travel to hospital was required. There is also a strong emotional connection with Thomas Hope Hospital as it has served the local community well during the lifetime of the local residents which makes it difficult to separate the service from the building.

Any re-provision of the service delivered at Thomas Hope Hospital would require to meet the needs of the local community with priority being given to step up/ step down, palliative care and respite. Such a facility would however require to operate within agreed admission criteria. This service could be provided in partnership with a residential care provider through a mix of residential and nursing beds which could make a new combined facility more viable. Such a development would need to have residential and nursing home registration and would require careful and sensitive communication to the community in order to reassure them that a free NHS service would still be available even if it wasn't in the current building.

13.5 Health Centre: Relocation of the services currently delivered from Thomas Hope Hospital could leave the current Health Centre isolated and create a disconnect between the GP and patients in any new facility. Taking account of the One Team approach and the benefits of locating a range of support and services on one site this could be the ideal time to relocate the health centre on the same site. This would provide a fit for purpose facility which would meet the

needs of a modern health service and would reassure the local community that appropriate clinical support would still be close to the re-provided nursing beds.

14. Review of Options 1- 5

The list of potential options set out in Table 1, page 3 include different permutations of some of the above and the evidence gathered to date could support a number of aspects of these options.

Options	Description	Commentary
1	Do nothing – Thomas Hope Hospital remains as is and is maintained and managed with current bed configuration.	Evidence on bed usage over the last three years and evidence of maintenance challenges do not support this option
2	New build NHS facility with in-patient beds & potential new GP practice/ health centre on Thomas Hope Hospital site + adjacent health centre site. THH building is listed. Would require multi-agency partnership approach in line with agreed principles.	Listed building restrictions limit potential for any new build on the Thomas Hope Hospital site. This option does not address identified need for residential care places, sheltered/ very sheltered housing and increased day care support
3	NHS beds developed in a larger health and social care hub. Thomas Hope Hospital disposed of with opportunity for its development aligned to 'Total Place' vision for Langholm (e.g. developed as low cost housing or other community resource)	Offers the potential to develop a more flexible bed based approach. Purpose built with ability to develop appropriate 'step up & step down' in partnership with care home provider while retaining NHS funded beds within the facility for identified higher level needs. Contingent on multi-agency working, securing capital funding and an independent partner This option would meet some of the identified need. However the number of beds required, based on available evidence, may be less than has been suggested anecdotally.
4	Community based model of health and care, focussed on extra care housing and peripatetic care at home from primary and community care. No beds developed and THH retained to develop as an integrated hub with day hospital/day care, telehealth, community care and GP services	Offers the potential for a very different model of care across the community, focussed on developing hub and spoke models of very sheltered housing with appropriate peripatetic support. Opportunity to develop supported housing. Contingent on multi-agency working. This option does not address the need for some residential care facility in the local community. It is not clear if this option includes retention of the current Thomas Hope Hospital beds but if it does there is no evidence to support retaining the same number of beds. Significant refurbishment of THH and on-going maintenance cost would be involved. Given the condition of the building and listed restrictions this may not be a viable option

However there is one other option which draws on some of what has previously been proposed but which also takes account of the changes in how health & social care are being delivered going forward as well as the evidence gathered through this exercise.

Options	Description	Commentary
5	A single site approach which would include- • Very sheltered housing • A bed based facility which would include residential and nursing care places • Communal areas (dining and sitting areas) to be shared by very sheltered housing tenants and care home residents • Day care in the communal areas for people with higher level needs • Therapy area for use by a range of services and agencies • Central shared administration area for use by all on-site services and a base for some out- reach services. This could also be a central point for the One Team • Health Centre as part of the integrated development	• The required level of in-patient service currently delivered in Thomas Hope Hospital could be re-provided in a new facility which is fit for purpose and which meets the needs of a modern health service (beds still funded by NHS) • Residential care beds would be available in the local community and this model may be more financially viable for a provider. • Very sheltered housing would help delay or avoid admission to a care home and allow frailer older people to remain at home. • Day care provision could be expanded to allow for more people to be supported in their own home • Services for older adults provided on the same site would allow people to move through and/ or between services as their needs dictate, with the minimum of disruption. • Operational / running costs would be reduced through integrated working and shared facilities • Would require a new model of integrated working with several agencies. • Would free up Thomas Hope Hospital for alternative use. • Would be contingent on capital funding being secured • Would be contingent on already approved housing development being moved to a different site and/ or additional very sheltered housing to be included in the SHIP • May have to be developed in phases rather than all at the same time • Re-provision of Thomas Hope beds would require alternative to be in place before decommissioning the hospital

Option 5: Additional Commentary

Option 5 is an innovative approach to supporting older adults in a sparsely populated rural area by bringing together a range of services on one site so that some development and operational costs can be shared. This is particularly relevant to proposals relating to residential and nursing beds which will need to be economically viable as well as delivering the services the local community requires. Sustainability of services will therefore have to be a consideration when determining the number of beds to be provided.

The evidence which is available suggests that no more than 6 nursing beds will be required for the re-provision of Thomas Hope Hospital beds .Evidence also suggests that approximately 33 residential places will be required by 2024 however that assumes no change in the range of services available as alternatives.

When factoring in access to very sheltered housing, increased day care and the benefits of the One Team approach the number of residential places required will be fewer. Also it cannot be assumed that everyone resident in DG 13 & 14 would be seeking a residential care place in Langholm as proximity to family elsewhere may be a factor when making a choice.

There is no expectation that older adults already resident in care homes out with the local community would be transferred to a new residential care home facility if and when it became available if this could be detrimental to their well being. This suggests some challenge in ensuring the viability of such a facility whilst prioritising places for local residents.

Taking all of the above into consideration a bed based facility with 16/20 residential beds and 6 nursing beds could meet projected local needs as at 2024 with the addition of 10 very sheltered houses. The design of such a development could allow for expansion at a later stage if required. A larger residential facility would require to attract residents from out with the area in order to operate at a viable occupancy level.

The Option 5 proposal will also be dependent on availability of an appropriate site and securing the necessary planning permissions

15. Conclusions

The findings set out in this report confirm that if we are to rise to the challenge of making Esk Valley the best place for Older Adults to live active, safe and healthy lives by promoting independence, choice and control, this will require a reshaping of current services and the development of new ways of supporting Older Adults and their carers. The main concern coming from the people who have engaged with the Esk Valley Project has been around there being enough support of the right kind which allows older adults to remain living in their own community for as long as possible as their care needs increase in later life.

As well as continuing to develop the One Team way of integrated working at a local level and making better use of new technology to support people in their own home there is sufficient evidence to conclude that the development of a new nursing\ residential care facility, new extra care housing and new health centre on a single site should be explored through the commissioning of a detailed business case. The range of services recommended by the Esk Valley Project are set out in Option 5 (page 23) of this report. Subject to the findings of a more

detailed business case, such a range of services would ideally be housed on single site to promote ease of access.

Appendix I

Esk Valley Service Providers Gathering
Feedback Summary: Challenges & Opportunities

1. Challenges

Care Staff

- Lack of paid care staff
- Unable to recruit staff
- Training for all carers and how to fund
- Need to increase care staff wages
- Inflexible deployment of care staff
- Not enough time allowed to provide adequate support
- Rurality and distance between patients/ clients

Assessment

- Unable to identify everyone requiring support
- Time it takes to assess patients and secure placements

Integrated working

- Need to improve communication between agencies/ staff at community level
- IT infrastructure impacting on communication/ service uptake

Information

- Not enough information for the public on what is available - impact on uptake
- Power of Attorney/ Guardianship not in place
- Public perception about loss of independence/ stigma

Telecare

- Process and procedure hindering uptake of care call
- Lack of care call responders hindering uptake

Transport

- Poor coordination of and limited access to transport to DGRI
- Not enough funding for community transport
- Lack of transport (non specific)

- Travel costs being carried by providers in rural areas

Care home provision

- Shortage of care home beds
- Waiting lists (non-specific)

Keeping people in their own homes

- Poor range of housing options - no access to extra care/ very sheltered housing
- Not enough early intervention
- Need services to support earlier discharge
- Range of services reduced in rural area

Community involvement

- Volunteer sustainability
- Volunteer training
- Nature of funding (i.e. Grants) and lack of funding impact on ability to plan and deliver services longer term

2. Opportunities

Care staff

- Improved shift patterns for home carers (not spilt shifts)
- Increase support for home care
- Fund providers to up-skill staff and pay better wages

Integrated working

- Range of expertise available locally
- Expand one-team concept
- Pooling of budgets
- Reduce hierarchy and invest more in local services

Telecare

- Simplify telecare access and improve marketing
- Paid responders for care call
- Night time/ overnight service

Care homes provision

- Local care home places

Keeping people in their own home

- Integrated care - hospital/ home service
- Promote / expand re-ablement
- Step-down rehab
- Local access to OT/ Physio
- Wider range of locally delivered services
- Space for more visiting services

- More use of social prescribing
- More personalised care packages
- Specialist / extra care housing
- Self referral for adaptations
- Increased use of self directed support

I**nformation**

- Provide information about, and promote, existing services from a central point
- Improve access to advice and information (e,g, at day centre)
- Advice on managing long term conditions
- Educate the public about the cost of prescribing

Community Involvement

- More community led/ volunteer delivered services e.g. Time banking, befriending, adopt a granddaughter
- Annandale community transport initiative
- Community support/ willingness to help
- Families taking responsibility for their cared-for person

Appendix II

Organisations Participating in the
Esk Valley Service Providers Gathering
(some organisations were represented by more than one delegate)

- Annandale Transport Initiative
- Annandale & Eskdale Health Improvement Team
- Carers Centre
- Richmond Fellowship Scotland
- Langholm Cardio Club
- Langholm Probus Club
- Social Work
- Crossroads (A&E)
- Annandale &Eskdale Podiatry
- Care Training Consortium
- Trust Housing - Greenbank Court
- Thomas Hope Hospital
- Health & Social Care Project (East) Third Sector
- G.P Langholm
- Alzheimer's Scotland
- Langholm Initiative
- Occupational Therapy
- Annandale &Eskdale Localities Third Sector
- Care coordinator
- Handy van
- Langholm Day Centre
- Loreburn Housing Association
- Community Charge Nurse
- Food Train
- Eskdalemuir Community Hub
- Langholm Action Group
- Scottish Care

- Food Train

Appendix III

Public Engagement Care Fair
Feedback from Exit Survey Forms

1. Part One: On Entry

1.1. Location

- 54 of those who provided post code details live in DG13. 3 live in Eskdalemuir and 1 in Westerkirk. Not everyone gave their full post code so fuller analysis is not possible
- 6 of those who provided their post code live in DG14, 1 in DG12 and 1 in DG11

1.2. Gender

- 21 were male
- 35 were female
- 7 did not indicate gender

1.3. Ages

- 16 were aged under 65 years
- 34 were aged 65-74 years
- 10 were aged 75 and over
- 3 did not indicate their age

1.4.Main Concerns

Some people indicated more than one concern so the number of issues raised does not correlate with the number of people completing forms.

- 34 - people cited the lack of a local **care home.** There were some qualifying comments added which in the main were concerns about what would happen to them if they were through time unable to manage in their own home and a desire to remain within the local community
- 11 - people mentioned a shortage of **paid carers** available to provide enough care at home
- 10 - people flagged up poor local **transport** to other towns, particularly where health services are located and also local transport if unable to drive.
- 8 - people highlighted the lack of appropriate and accessible **housing,** including sheltered housing and housing with 24hr wardens (staff)
- 8 – people recorded concerns about the possible closure of **Thomas Hope Hospital**, with some mention of on constant threat of closure being an issue
- 6 – people cited concerns about their being **enough care** available without being specific about which care they had concerns about.

- Other individual concerns recorded included what would happen if terminally ill, the cost of heating a home, lack of information about what is being proposed through this project, isolation, remaining fit and independent, falling, lack of joined up working between health and social work, having to leave current home

1.5 Having Enough Information to Make Own Choices

- 40- people though they didn't have enough information to make choices
- 23-were confident they did have enough information

1.6. New and Different Ways to Support Older Adults

- 57 – people said they would like to know about new / different ways to support older adults
- 2 – said they were not interested
- 4 – did not answer this question

2. Part Two – On Exit

2.1 Feeling Better Informed

- 41- people said they felt better informed about the support available to older adults
- 15 – said they did not but a number qualified this by saying they already had this information
- 7 – people did not comment

2.2 What They Found Most Interesting

- Care at Home – 11
- Handy van – 10
- Food Train – 8 (included befriending)
- Telecare – 7 (includes care call)
- Dementia Services – 5
- Occupational Therapy – 5
- Day Centre - 4
- Housing – 3
- CAB – 1
- Hard of Hearing – 1
- Care Home – 1
- Care Training Consortium – 1
- All – 4

2.3 Would Use or Recommend Any Services

- 52 – said they would either use or would recommend the services featured at the Care Fair
- 1 - said they wouldn't
- 10 - did not complete

2.4 Currently Using Services

- 42 **–** people don't currently use any of the services
- 10 – people didn't complete

- 11 – people do use some services – these are care call, handy van, home care, OT, frozen meals, dementia services

2.5 Stop Doing

- Consulting/ surveying/ talking/ project like this – 8
- Paying for too many Councillors/ officials/ staff/ highly paid people from out with the area – 4
- Centralising services in Dumfries at the expenses of rural areas – 2
- Duplication between organisations – 1
- Red tape – 1
- Running down Thomas Hope Hospital – 1
- Free bus passes – 1
- Free prescription for people who are working - 1

2.6 Do More Of

- More home carers – 20
- A local care home – 11
- Accessible information – 5
- Home carers to be allocated more time with clients - 5
- Supported living accommodation/ 24hr care at home/ something between home and hospital/ care home/ accessible housing – 5
- More care in the community (non specific) - 4
- More for young adults/ adults with long term conditions – 3
- Single responses were recorded for – a nursing home, rural services, care packages tailored to needs, integration of health & social work locally, field staff empowered by HQ, awareness event, more beds in Thomas Hope Hospital, more consultation, information/ education on healthy eating & exercise, night support

2.7 How to provide existing services in a more person centred and efficient way

- Local care home – 5
- Sheltered housing/ supported housing/ housing with 24 hr staffing – 5
- Fully joined up approach between all agencies locally – 5
- Change shift patterns for home carers/ allocate more time where required - 4
- Expand/ do more with Thomas Hope Hospital – 3
- Single responses were recorded for - more help to access personalised care, help provided by GP, switch resources from managers to front line, discussion with family carers to ensure priority for the services required most, send information into people's own homes, use video / tele-health technology, spend money
- 2 responses proposed the status quo with regard to keeping Thomas Hope Hospital open

2.8 Any other comments (not covered elsewhere)

- South east Dumfries & Galloway is badly served
- Don't want to leave the local area
- Very good information
- A lot of publication – less is more!

- Hopefully this has raised questions/ answers for the future
- Change needs to be implemented before its rendered obsolete
- Less talk, more action
- Thought I was coming to a lecture telling us about future developments
- Support the model - waiting to see if it can be implemented
- Can't get a decent response about the future of Thomas Hope Hospital
- Thank you
- Keep up the good work

Appendix IV

Esk Valley Care Fair

Stall Holders/ Advisers in Attendance

- Alzheimer's Scotland
- Care at Home D&G Council
- Care Coordinator D&G Council
- Care Training Consortium (CTC)
- Community Link Worker (Esk Valley)
- D & G Carers Centre
- D & G Handy Van
- DAGCAS (Citizen's Advice Service)
- D& G Hard of Hearing Group
- Food Train
- Trust Housing Association
- Greenbank Court Sheltered Housing
- Langholm Day Centre
- Notwen House Residential Care Home
- Royal Voluntary Service (Meals on Wheels)
- Occupational Therapy D&G Council
- A&E Podiatry
- D&G Telecare
- User & Carer Involvement

Appendix V

Esk Valley Public Engagement Event

"Esk Valley Care Fair"

Survey

Gender : male/ female/ other (please circle)

Age:

Post code:

- What concerns you most about growing old in Esk Valley?

_____
_____
_____
_____

- Do you feel you have enough information about the services and support available to be able to make your own choices?

Yes ☐ No ☐

- Would you like to know about new / different ways older adults could be supported

Yes ☐ No ☐

- Do you feel you are better informed about the support available to older adults in Esk Valley

Yes ☐ No ☐

- Which services/ organisations did you find most interesting?

  _____

  _____

- Would you use or recommend any of the services featured here today?

  Yes ☐ No ☐

  - If yes which ones _____
  - Do you already use these services Yes ☐ No ☐
  - If No please explain why _____

- Health & Social Care resources are limited and may in real terms reduce. Using these resources to deliver support in the most effective and efficient way will require change. So :
- What do we need to stop doing?

  _____

  _____

- What do we need to provide more of?

  _____

  _____

- How can we provide existing services in a more person centred and efficient way?

  _____

  _____

Any other comments

_____

_____

_____

Thank you for coming along today and taking time to comment