
Report To:	Community Health & Care Partnership Sub Committee	Date: 20 October 2011
Report By:	Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership	Report No: CHCP/44/2011/BM
Contact Officer:	Brian Moore Head of Health & Community Care	Contact No: 01475 - 715379
Subject:	OLDER PEOPLE'S DRAFT STRATEGY (2012/13)	

1.0 PURPOSE

- 1.1 The purpose of the report is to inform members of the CHCP Sub Committee of the detail of the draft Older People's Strategy.

2.0 SUMMARY

- 2.1 The purpose of this strategy is to articulate Inverclyde's CHCP commitment to older people and to outline our vision to support older people.

3.0 RECOMMENDATION

- 3.1 Members are asked to note the draft Older People's Strategy and the proposal to consult with all stakeholders over the next 3 months.

**Robert Murphy
Corporate Director
Inverclyde Community Health & Care
Partnership**

4.0 BACKGROUND

- 4.1 The strategy document sets out the key commitments and outcomes for older people. The key principle underlining the strategy is that most people including those with complex needs can and would prefer to be supported in their own homes.
- 4.2 The strategy confirms the commitment to partnership working and the importance of engaging with older people and carers.
- 4.3 The strategy details key challenges facing the Partnership and areas for priority action. The Reshaping Care for Older People policy initiative and change plan funding will provide a foundation for progressing these issues. The report also details the development priorities and related action plan. Full consultation on the draft Older People's Strategy will take place with all relevant stakeholders over the next 3 months. Following consultation the final version of the strategy document will be presented to Committee in January 2012.

5.0 PROPOSALS

- 5.1 The Sub Committee is asked to note the Draft Older People's Strategy and the proposal to consult with the stakeholders over the next 3 months.

6.0 IMPLICATIONS

6.1 Legal:

There are no implications for the Council's legal committees.

6.2 Finance:

There are no implications for the Council's capital and revenue budgets.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

There are no implications for Human Resources.

6.4 Equalities:

Equalities Impact Assessment will be completed on the final version of the document.

7.0 CONSULTATION

- 7.1 Consultation with stakeholders will take place over the next 3 months.

8.0 LIST OF BACKGROUND PAPERS

- 8.1 None.

Improving Lives

*Making a difference for
Older People*

Inverclyde CHCP Draft Older People's Strategy
2012/13

1. Our commitment to Older People Living in Inverclyde

Our commitment to Older People living in Inverclyde is that they should:

- Feel valued and respected as part of their community
- Be able to live a full and active life in safe and secure surroundings
- Have every opportunity to remain independent, to have freedom of choice and control over how they live their lives
- Be treated with dignity, courtesy and consideration
- Get timely access to the right level of support, information and intervention at times of crisis or transition

The belief that most people, including those with complex care needs, can and would prefer to be supported in their own homes underpins this commitment.

2. Key Outcomes

The following key outcomes for Inverclyde's Older People will result from our commitment:

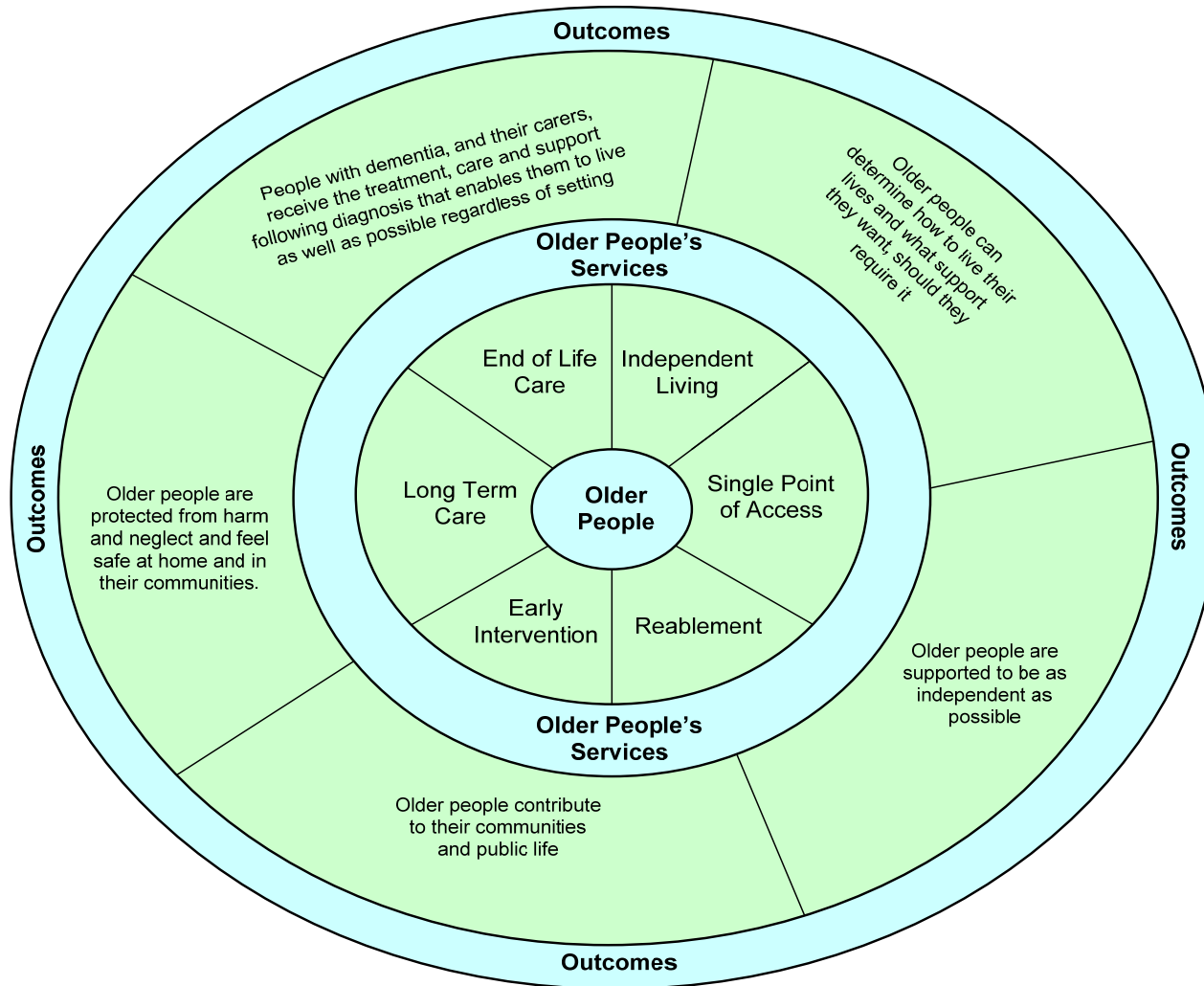
1. Older people are supported to be as independent as possible
2. Older people can determine how to live their lives and what support they want, should they require it
3. Older people contribute to their communities and public life
4. Older people are protected from harm and neglect and feel safe at home and in their communities.
5. People with dementia, and their carers, receive the treatment, care and support following diagnosis that enables them to live as well as possible regardless of setting.

The outcomes above are aligned to the continuum for older people services in Inverclyde in diagram 1 below: The continuum forms the basis of our key strategic drive to reshape care for older people and underpins our vision for older people's services.

Central to our delivery of this vision is the need to fully explore and analyse the information we have in relation to the profile of older people in Inverclyde and the current usage of services to determine the balance of care. This analysis will provide a platform from which we can measure change. Maximising our intelligence around the needs and aspirations of older people, and how we respond to this is a critical action for the partners in this strategy. As part of this approach we intend to utilise examples of best practice and evidence from research.

We also need to look afresh at how we enable and empower older people and their carers to take charge of their health and abilities to ensure that our older population experience the best possible quality of life and sense of wellbeing. Central to our ambition is the drive to optimise independence for older people, in their own homes whenever possible, and when this is not possible, then in a homely setting.

Diagram 1: Older People's Services Outcome Wheel



3. The purpose of this strategy

The purpose of this strategy is to articulate our commitment to older people in our area, and to outline our vision to support older people. The strategy is simply a statement of where we want to be, how we will get there and how we will know we have reached that point. We will review our actions annually to ensure we are delivering on our commitment. The strategy is informed by the views of local people who have been engaged in discussions over a number of years. This engagement will continue and be strengthened as we move forward.

The CHCPs Development Plan and Annual Update, alongside the CHCP Directorate Plan provide a detailed account of our commitments across the services, including those specifically for Older People. This Strategy builds on those Plans, articulating the actions that specifically relate to changes necessary to meet the needs, aspirations and rights of our older people.

Inverclyde, in common with the rest of the country is set to see a stark rise in the population of older people relative to the population as a whole. Whilst most older people enjoy independent lives, as active members of their communities, there is a minority who, for various reasons, will need some degree of support from health and/or social care services. The aspirations of older people are changing and will continue to change; our challenge is to collectively meet these expectations by working in partnership with local older people and across services/ agencies to improve lives, by making a difference; providing high quality, responsive services.

The establishment of Inverclyde Community Health and Care Partnership (CHCP) in October 2010 affords a real opportunity for us to consolidate the excellent joint working that has taken place between local health and social care services for many years. The CHCP also provides the foundation and momentum to refresh our options for how we deliver the best possible outcomes for older people in our area, and respond effectively to changing patterns of need, expectation and demand.

This strategy will set the context within which the partners can develop a Commissioning Strategy for older people's services in the CHCP by summer 2012. This Commissioning Strategy will allow for an articulation of everything that must be in place to respond to the needs of local people, and how this will be resourced/organised. Central to this will be the requirement to articulate the financial planning challenges to delivery of our commitment, thus integrating financial and service planning.

It is a central aim of our collective vision for older people in the area that capacity in communities and amongst older people is maximised. Critical to this is the engagement of the community and voluntary or 3rd sector. The partnership referred to throughout this strategy relates to everyone from older people themselves to the smallest community group or 3rd sector provider with an interest in meeting the needs and aspirations of older people. Only by inclusive partnership working, maximising capacity to respond to changing needs, will our vision be met. Key players in the partnership, therefore, include; the CHCP, the acute sector, General Practitioners, the independent provider sector and voluntary/ community organisations as well as older people themselves and their carers.

4. Engagement

Engagement with older people in Inverclyde has a long history. Over a number of years engagement has identified the following areas as important to Inverclyde's older people:

- 1. Independence**
- 2. Social Activities**
- 3. Access to Information**
- 4. Building Relationships**

Older people living in Inverclyde have told us they wish to be treated with respect and dignity, continue living in their own homes, be an active part of their community, remain in control of their own lives and have choice over their care if/when they need it (Your Voice, Evidence of Need Pilot – 21st Century Life, 2010).

Specific engagement around services has given us a range of evidence both for what to retain based on positive feedback, and where we need to change based on views of service users and carers¹.

The CHCP is committed to working with local people to ensure the people who use our services are at the heart of all we do. Involving partners is critical to this and a process has been set up through a CHCP Advisory Group which will allow for the routine gathering of user/carer feedback, and puts in place a mechanism for feeding back to communities. This work, and the ongoing engagement in this strategy, will be governed by the CHCP People Involvement Framework, which is informed by the National Standards for Community Engagement.

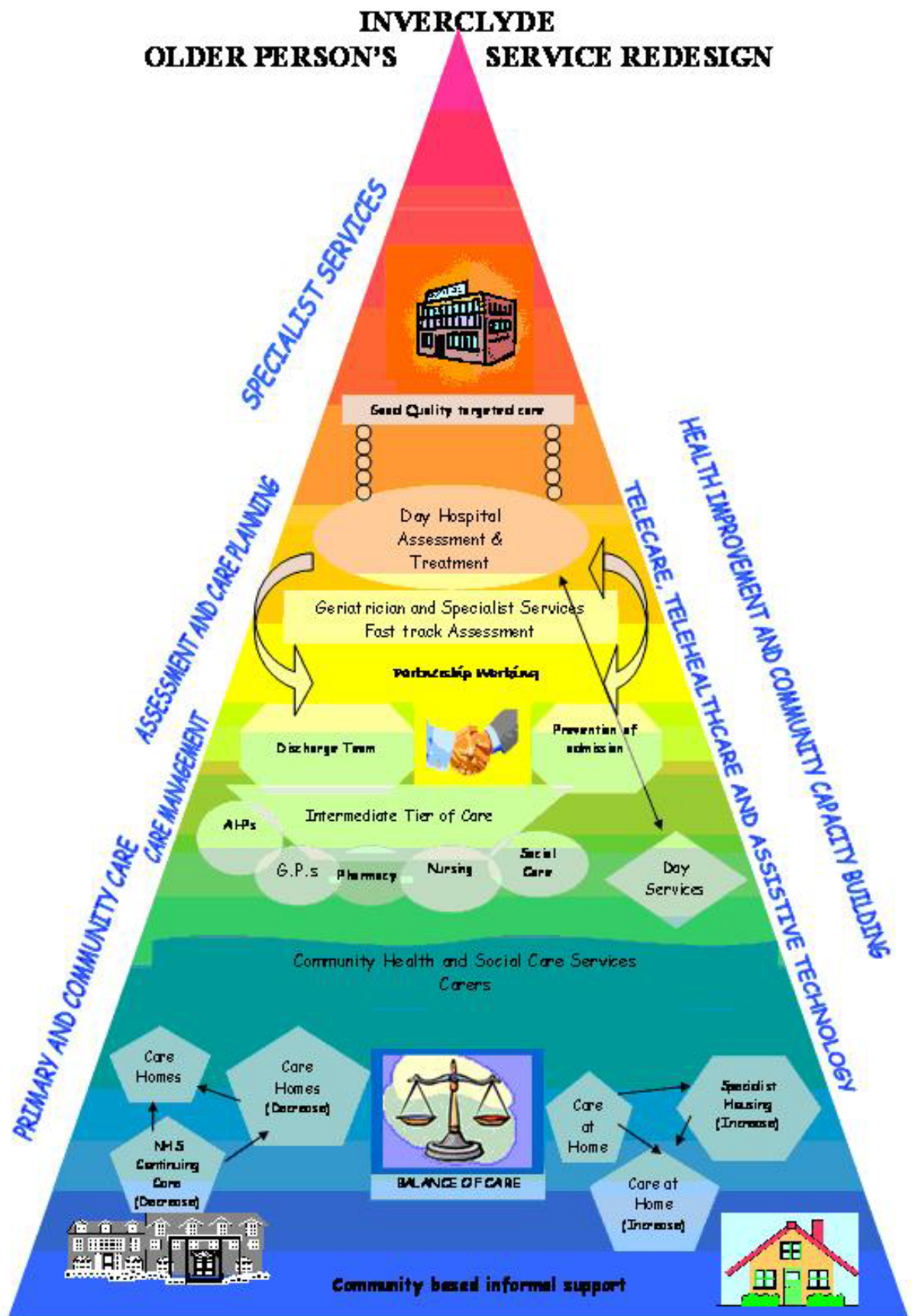
In order to ensure that the views of older people in our community are heard Inverclyde Council established, in 2010, an Older People's Champion (elected member) and a Community Older People's Champion (Chair, Inverclyde Elderly Forum). In order to each as many people as possible we intend to hold an Older People's conference regularly.

5. Current Services and Resources

The picture below (Picture 1) demonstrates the wide range of services and supports there are in place for older people from those at community level to those at specialist service level. It is crucial to understand that the pyramid of services reflects the fluid nature of our collective responses to the needs of older people, and that we strive for there to be no barriers precluding the movement up and down the pyramid as and when needs dictate. We are committed through this strategy to improving communication flow up and down the pyramid to reflect the pathway and journey of the people who use services.

¹ Hillend Focus Group Reports / Your Voice Tea Dance Reports March and June 2011/ Inverclyde Celebrates International Older People's Day 2010 Report

Picture 1: Service Description



The financial cost of services and support to older people within the Inverclyde area is £60m. The detail of the dissemination of current costs across the different sectors, CHCP, Acute, independent providers and the community lead sector is detailed below.

Summary of current partnership budget for older people

RESOURCES CONTRIBUTING TO CARE FOR OLDER PEOPLE - INVERCLYDE

NHS Estimated Costs for over 65's

DENTAL CONTRACT	£2,911,159.00
OPTOMETRISTS	£883,331.00
PHARMACY CONTRACT	£1,991,439.00
GMS	£6,261,929.00
Prescribing	£9,704,972.00
Community AHPS	£367,501.00
District Nursing	£1,366,583.00
Elderly Inpatients	£3,409,109.00
Other HCC	£1,316,043.00
Eld Community MH	£479,752.00
Accommodation/Admin & Others	£1,112,163.00
Ambulance service - delayed discharge	£54,468.00
Hospital Based NHS services	£6,628,000.00
Total NHS expenditure	£36,486,449.00

RESOURCES CONTRIBUTING TO CARE FOR OLDER PEOPLE - INVERCLYDE

Local Authority Community Care expenditure

Home Care	£7,473,275.00
Day Services	£1,116,153.00
Community Alarms	£538,020.00
Meals on Wheels	£147,240.00
Other services	£903,001.00
Assessment and Care Management	£1,334,340.00
Care Homes	£9,936,170.00
Residential respite	£141,960.00
Housing support	£689,850.00
Direct payments	£180,200.00
Adaptations	£950,000.00
WOOPI (lottery funding)	£152,000.00
Total Local Authority Expenditure	£23,562,209.00

NB The above figures include expenditure from Resource Transfer and a pooled budget for delayed discharge

The Reshaping Care for Older People programme will require, in the longer term, a redistribution of resources from the acute to other sectors.

Over the next 12 months the partnership will maintain and review the current distribution of financial resources. The shift in the distribution of resources across the sectors will be a measure of how the balance of care is shifting.

6. Background and Context

The population of Inverclyde is changing. Increasingly there will be more older people and fewer younger people in our area. The impacts of this will be felt across services, and by the community. It must be appreciated, however, that despite widely publicised challenges of demographic change it should be celebrated that older people are living longer lives, and that the chances of a full and active live into old age are greater than ever before.

The 2001 Census places Inverclyde’s population of pensionable age people at 12,054 people. The General Registrars Office (2008) placed the population of Inverclyde people 55 years or over at 24,545.

- Over the next few years the number of people aged 65 and over will rise
- Over the next 20 years
 - the number of people below the age of 65 will decline
 - the distribution of older age groups rising above the age of 85 is showing a 45% increase

The diagram below illustrates the demographic change in Inverclyde in the longer term.

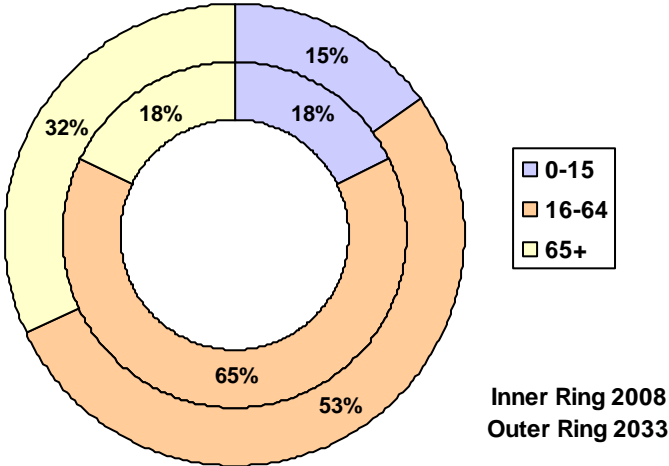


Figure 2: Ageband proportions 2008 to 2033 (Note: The percentage figures for 2008 data do not equal 100 due to rounding)

Figure 1 shows the projected fall in the number of children and young people aged under 17, from 15,261 in 2008 to 10,769 in 2033, whilst the number of people aged over 65 is predicted to increase from 14,236 to 20,942.

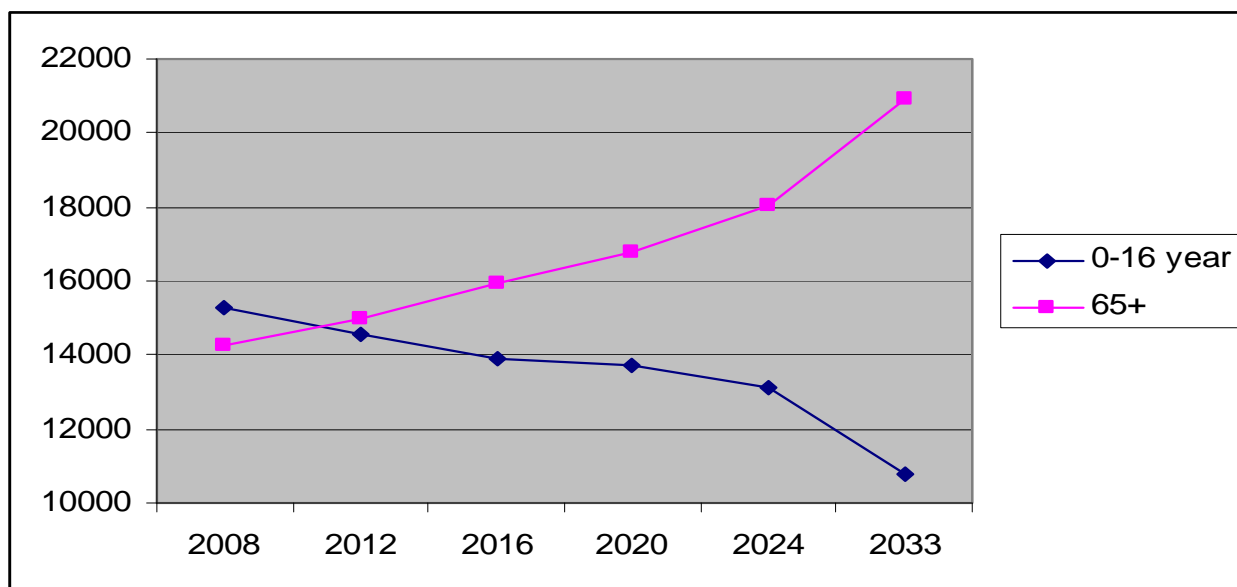


Figure 1: Trends for Children/ Young People and Older People

The 2008 figures for Inverclyde show that people living in designated older people's housing (for frail and mobility impaired people) totaled 524 places. The figures also show that placements for living in sheltered housing total 691 and 71 placements using very sheltered housing. These combined figures add up to a small minority of older people living in sheltered housing in Inverclyde. Thus, the majority of older people are living in their own homes. A number of these older people are able to live independently with minimal or no support from services. Others require high levels of care from a wide range of services. Some require to be hospitalised or cared for in residential care. There were 58,840 unplanned admissions to hospital of people over 65 in 2009/10, and 4045 emergency admissions of people over 65. The latest figures (June 2011) show that there are 563 people over 65 in permanent residential care placements in Inverclyde. There are around 1800 people who use a community alarm and over 1200 users of 'telecare' in Inverclyde.

The number of working age adults (aged 16 to 59/64) within Inverclyde is projected to decrease by 16,543 from 59,775 to 33,232, equating to a -33% fall by 2033, which will have serious implications for the local economy and poorer health outcomes associated with deprivation. There will also be a reduction in the number of people who are able to take on caring roles, either paid or unpaid, adding further pressures to already stretched health and social care services

6.1 Main Challenges

Current service activity information indicates a number of key areas that require action, including:

- The level of general population deprivation in Inverclyde (41% of Inverclyde's population live in the most deprived 15% of SIMD data zones). This means that while older people may suffer inequalities and challenges linked to age,

- Rising expectations of older people and their families
- Reducing numbers of informal carers, and more older age carers with their own health and social care needs
- Welfare reform – the percentage of adults claiming incapacity benefit/ severe disability allowance is significantly higher than the Scottish average
- Limited availability of adapted housing
- Growing number of people living longer with complex health care needs/ long term conditions etc
- High numbers of people aged over 75 years with multiple emergency hospital admissions
- A high number of bed days used in the hospital sector by people aged over 75 years with 2 or more emergency admissions per year
- A high number of bed days used by people awaiting discharge from hospital
- A high percentage of people aged 65+ being supported in care homes
- A high proportion of people aged 65+ receiving intensive homecare support
- A low proportion of people getting overnight homecare

We have a pressing need to refocus how we will meet the needs of older people in Inverclyde in the future. The following sets out the **Policy and Planning Context and Key Strategic Drivers** within which we are working in this field, and which we aim to respond to in a clear and concise way via this strategy

- *Reshaping Care for Older People: A Programme for Change: 2011 – 2021*

The Scottish Government has allocated funding to local partnerships in response to the challenges we face in redesigning services for older people to support independence and address need, in the face of our changing demographic profile. The Reshaping Care for Older People Change Fund means that in Inverclyde, during 2011/12 we have been awarded approximately £1.228M to support service redesign that will enable a real shift in the way we deliver care, away from care homes and hospital settings, making the older person's own home the first place of choice. This is in line with what older people have been telling us they want for many years.

National Policy:

- Changing Lives
- Better Outcomes for Older People
- All our futures: Planning for a Scotland with an Aging Population (2007)
- Shifting the Balance of Care
- Community Care Outcomes Framework
- NHS HEAT Targets
- National Dementia Strategy and Standards for Dementia Care
- National Carers Strategy
- NHS Scotland Quality Strategy 2010
- National Older People's Housing Strategy
- Reshaping Care for Older People: A Programme for Change 2011-21

Local Policy:

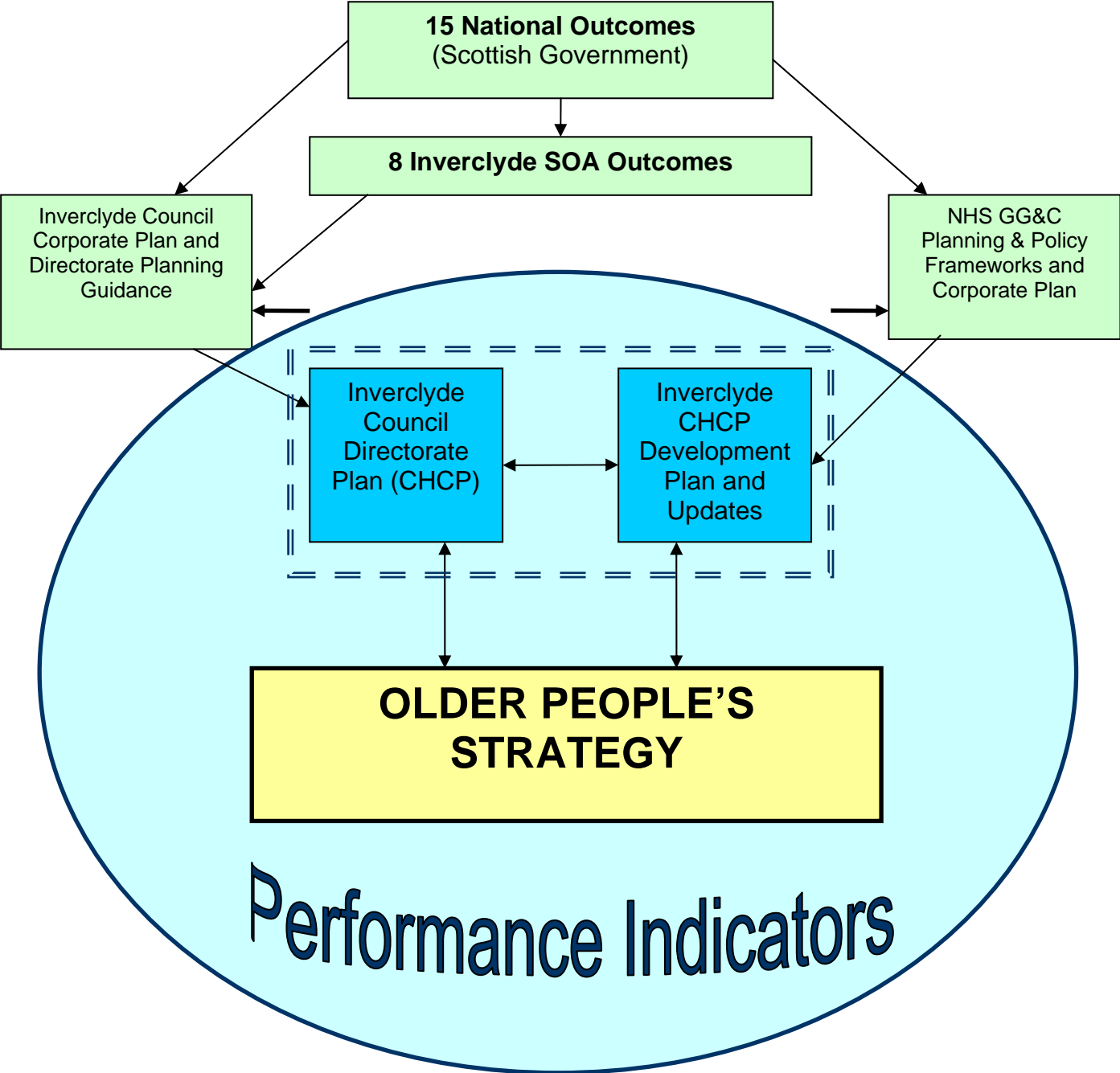
- Inverclyde Reshaping Care for Older People Change Plan
- Inverclyde Local Housing Strategy
- Inverclyde Carers Strategy 2012 – 15
- Inverclyde Joint Community Care Plan 2010 – 2012
- Inverclyde CHCP Development Plan/ Directorate Plan
- NHS GG&C Clyde Mental Health Strategy
- NHS GG&C Long Term Conditions Strategy
- NHS Greater Glasgow and Clyde Planning and Policy Frameworks (Older People/ Disability/ Long Term Conditions/Carers)
- Inverclyde Council Corporate Plan
- NHS GG&C Acute Services Review (ASR)
- Inverclyde CHCP People Involvement Framework (to be published January 2012)

Key Strategic Drivers:

- Reablement
- Creating mutual health and social care services
- Rehabilitation Framework
- Self Directed Support and Personalisation
- Telecare and Telehelath
- Community Capacity Building/ Community Development
- Co-production – working together with users and cares to develop services and supports

Diagram 2 below sets out the context in which this Strategy sits graphically

Diagram 2: CHCP Planning Landscape



7. Development Priorities and Action Plan

We have identified the improvements we aim to deliver. Working in partnership with local people and all relevant agencies is central to the delivery of these improvements. What we want to do is set out below:

- Establishment of a single point of access for assessment and service delivery
- Development of a re-ablement service that focuses on improvement and supporting and developing abilities
- Increased early intervention approaches and improved access to preventative services
- Changes to the shape of long term care from inpatient services to care at home provision, including use of housing with care
- Improving end of life care
- Development of capacity within communities to support independent living
- A reduction in the number of NHS EMI continuing care beds
- A reduction in the number of hospital bed days lost due to delayed discharge

There are six areas of development and redesign that have been identified through a number of pieces of work undertaken in Inverclyde over the past 18 months. Each of the key areas are interlinked and co-dependent.

- **Single Point of Access** – Combining initiatives and developments to speed up access, especially in times of crisis, and reduce duplication in services.
- **Re-ablement** – A range of services will be designed that work together in a model that moves away from dependency, focusing instead on rehabilitation and enablement.
- **Early Intervention** - Where we know that older people are at risk of decline, we will proactively provide appropriate support at the earliest possible time to preserve, and where possible, improve function.
- **Changes in the Balance of Care** – We will continue wherever possible to reduce the need for older people to be looked after in hospital or in care homes, favouring support in people's own homes.
- **End of Life Care** – Working across agencies and in partnership with voluntary organisations, we will establish expertise, choice and rapid access to services required for end of life care.
- **Independent Living** – We will develop supports that promote confidence and wellbeing for older people to remain as independent and active members of their communities, including buddying, telecare and housing-related support.

An action plan setting out the key actions to be taken to deliver on these priorities is set out at 7.1 below; including measures of change we will use to manage our performance in relation to this strategy. We will review our progress against the commitments we have made, on an annual basis, reported through the CHCP Committee structure.

7.1 Action Plan

The following are the actions we intend to pursue in the lifetime of this strategy to delivery on commitment and vision, aligned to the key outcomes. It is our intention during the course of the consultation period of this strategy to baseline the measures of success in order that we can determine change over time as a result of our actions. It is hoped that the measures of change will be informed by our consultation so that stakeholders can ensure things that matter to them are measured.

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 1: Older people are supported to be as independent as possible					
1.1	<u>Reablement:</u> Design a range of services that work together in a model that moves away from dependency, focussing instead on rehabilitation and enablement	Pilot completed: November 2011 Full implementation: October 2012	CHCP Service Manager (Older People's Services)	Inverclyde Change Plan - Core Objective	Reduction in unplanned admissions over 65 Reduced lengths of stay over 65 Increased use of telecare Increase in number of people receiving reablement via home care Increase in number of older people achieving personal outcomes Increase in the number of people over 65 engaging in vitality, Live Active or other physical activity programmes Reduction in direct admission to care homes

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 1: Older people are supported to be as independent as possible					
					<p>from hospital</p> <p>Increase in carers assessments</p> <p>Increased use of care and repair</p> <p>Increase in equipment and adaptations for older people wishing to remain in their own home</p>
1.2	<p><u>Early Intervention:</u> where we know older people are at risk of decline we will proactively provide appropriate support at the earliest possible time to preserve and where possible, improve function.</p>	October 2012	CHCP Service Manager (Assessment and Care Management)	Inverclyde Change Plan Core Objective	<p>Reduction in unplanned admissions over 65</p> <p>Number of polypharmacy reviews undertaken (over 65)</p> <p>Number of fast track assessments carried out</p> <p>Increased early identification of carers</p> <p>Usage of SPARRA and risk prediction tools</p>
1.3	<p><u>Independent Living:</u> Develop supports that promote confidence and wellbeing for older</p>	October 2012	CHCP Head of Service (Health and Community Care)	<p>Inverclyde Change Plan Core Objective</p> <p>Local Telecare Strategy</p>	Increase in the number of people over 65 engaging in vitality, Live Active or other physical activity

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 1: Older people are supported to be as independent as possible					
	people to remain as independent as possible and active members of their communities, including buddying, telecare, housing related support, mental health improvement and physical wellbeing				programmes Health Improvement indicators (TBC) Increased uptake of telecare packages by older people
1.4	<u>Self Management</u> – Develop an Inverclyde CHCP approach to self management/ self care and promote usage of the approach across other workstreams	October 2012	CHCP Service Manager (Health Improvement, Inequalities and Personalisation)	Self Care/ Self Management polices	Implementation Plan in place by deadline (Oct 2012)
1.5	<u>Community Capacity Building</u> – we will work in partnership across the statutory and 3 rd sector to increase community capacity to meet the needs of older people within their own communities, including the development of buddying	October 2012	CVS Inverclyde/ community sector partners		Indicators TBC

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 1: Older people are supported to be as independent as possible					
	and increased support to carers				
1.6	<u>Active Living</u> – we will contribute to the development of the Inverclyde Active Living strategy where it relates to maintaining active lifestyles in later life	December 2011	CHCP Service Manager (Health Improvement, Inequalities and Personalisation)	Inverclyde Active Living Strategy	Increase in the number of people over 65 engaging in vitality, Live Active or other physical activity programmes
1.8	<u>Housing</u> – Address aspects of National and Local Housing Strategies that relate to older people	October 2012	Team Leader, Inveclude Council Housing Strategy Team	National Older People's Housing Strategy Local Housing Strategy	Indicators TBC
1.9	<u>Shifting Balance of Care</u> – we will continue wherever possible to reduce the need for older people to be supported in care homes or in hospital, favouring support for people in their own homes	October 2012	CHCP Head of Service (Health and Community Care) General Manager – Rehabilitation and Assessment Directorate (Clyde)		Care home admissions Admissions 65+ Delayed discharges
1.10	<u>Single Point of Access</u> – we will combine initiatives and developments	October 2012	CHCP Service Manager (Rehabilitation and Enablement)		Reduction in unplanned admissions over 65

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 1: Older people are supported to be as independent as possible					
	to speed up access, especially in crisis. And reduce duplication of services				<p>Reduced lengths of stay over 65</p> <p>Increased involvement in care planning</p> <p>Increased respite provision for carers</p> <p>Increase number of carers accessing income maximisation advice</p> <p>Increase in carers assessments</p>
1.11	<u>Out of Hours services:</u> undertake a review of existing out of hours provision across home care and adult community nursing	October 2012	CHCP Service Manager (Older People's Services)		<p>Review complete</p> <p>Indicators TBC</p>

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 2: Older people can determine how to live their lives and what support they want, should they require it					
2.1	<u>Self Directed Support/ Personalisation</u> – we will implement the personalisation agenda cross CHCP services to facilitate an increase in the numbers of people able to take up self directed support	Reviewed annually	CHCP Head of Service (Health and Community Care)	National Self Directed Support Strategy	Uptake of SDS
2.2	<u>Information</u> – we will work across the partnership to enhance and increase information available to local older people/ families about services and supports that are available, allowing people to determine their own care/ support where it is needed.	Ongoing	CHCP Communications Group/ CHCP Head of Admin/ Partners	Reshaping Care for Older People	Indicators TBC
2.3	<u>Financial Inclusion</u> – we will respond to the issue of financial poverty amongst older people and contribute to the local financial inclusion strategy, and financial inclusion partnership to maximise the	Ongoing	CHCP Head of Service (Planning, Health Improvement and Commissioning)	Inverclyde Financial Inclusion Strategy	Number of income maximization assessments (over 65)

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 2: Older people can determine how to live their lives and what support they want, should they require it					
	income of local older people. We will provide support where income maximisation advice is needed.				
2.4	<u>Short Breaks</u> – we will deliver a range of short breaks to carers to ensure they access a break from their caring role to help maintain their own wellbeing	Ongoing	Head of Service (Health and Community Care)	Inverclyde Carers Strategy National Carers Strategy	Number of short breaks delivered Respite Performance Indicator
2.5	<u>Older Carers</u> – we will work through the multiagency Carers Development Group, and the Inverclyde Carers Strategy to anticipate and respond to the needs of older people who are carers.	Ongoing	CHCP Service Manager (Planning and Performance)	Inverclyde Carers Strategy National Carers Strategy	Indicators as per Inverclyde Carers Strategy
2.6	<u>Day Care/ Day activities</u> – undertake a full review of day care activities and provision	October 2012	CHCP Heads of Service (Health and Community Care/ Mental Health, Addictions and Homelessness) General Manager – Rehabilitation and Assessment Directorate (Clyde)	Reshaping Care for Older People Change Plan CHCP Development Plan	Indicators TBC
2.7	<u>End of Life Care:</u> we will recognise the right to choice	Ongoing	CHCP Service Manager (Planning and Performance)	Change Fund Core Objective	Indicators as per local Pal Care plan

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 2: Older people can determine how to live their lives and what support they want, should they require it					
	and control in death and work in partnership to implement the Inverclyde Palliative Care Action Plan and the Compassionate Inverclyde programme to ensure the best possible supports are available for death and dying, where these are required.			Inverclyde Palliative Care Action Plan Living and Dying Well and Building on Progress	

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 3: Older people contribute to their communities and public life					
3.1	<u>Engagement and participation</u> : we will work across the partnership to ensure that the voice of older people is heard across the range of agencies and services involved.	CHCP People Involvement Framework to be developed by January 2011 Ongoing	CHCP Service Manager (Planning and Performance)/ Your Voice	CHCP People Involvement Framework (publication date: January 2012) National Standards for Community Engagement	Use of VOiCE plans Numbers of older people involved in engagement events

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 4: Older people are protected from harm and neglect and feel safe at home and in their communities					
4.1	<u>Adult Protection</u> : Ensure full implementation of Adult Protection to safeguard older people.	Ongoing	CHCP Head of Service (Health and Community Care)		Indicators as per Adult Protection Quality Assurance Framework
4.2	<u>Community safety</u> : work through SOA2 Outcome Delivery Group and Community Safety Partnership to address community safety issues specific to older people.	Ongoing	CHCP Head of Service (Planning, Health Improvement and Commissioning)	SOA	Indicators TBC
4.3	<u>Homes safety</u> : Continue current provision to improve and maintain home safety for older people (e.g. fire safety checks/ security advice etc)	Ongoing	CHCP Head of Service (Health and Community Care)		Indicators TBC

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS
Outcome 5: People with dementia, and their carers, receive the treatment, care and support following diagnosis that enables them to live as well as possible regardless of setting.					
5.1	<u>Dementia Strategy</u> : Implement the local dimensions of the National Dementia Strategy.	October 2012	CHCP Head of Service (Mental Health, Addictions and Homelessness)	National Dementia Strategy	Indicators TBC
5.2	<u>Dementia Standards</u> : Implement the National Standards for care of dementia in Scotland.	October 2012	CHCP Head of Service (Mental Health, Addictions and Homelessness)	National Standards for care of dementia in Scotland	Indicators TBC
5.3	<u>Dementia Prevention</u> : target health improvement activity on lifestyle changes which may reduce incidence or slow progress of dementia (e.g. physical checks, screening).	Ongoing	CHCP Heads of Service (Mental Health Addictions and Homelessness / Planning, Health Improvement and Commissioning)		Indicators TBC