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<b>Report To:</b>	<b>Community Health &amp; Care Partnership Sub Committee</b>	<b>Date: 1 March 2012</b>
<b>Report By:</b>	<b>Robert Murphy Corporate Director Inverclyde Community Health &amp; Care Partnership</b>	<b>Report No: CHCP/21/2012/BM</b>
<b>Contact Officer:</b>	<b>Brian Moore Head of Health &amp; Community Care</b>	<b>Contact No: 01475 - 715387</b>
<b>Subject:</b>	<b>OLDER PEOPLE'S STRATEGY (2012/13)</b>	

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## **1.0 PURPOSE**

- 1.1 The purpose of the report is to inform members of the CHCP Sub Committee of the outcome of the consultation exercise regarding the Older People's Strategy (2012/13).

## **2.0 SUMMARY**

- 2.1 The purpose of this strategy is to articulate Inverclyde CHCP's commitment to older people and to outline our vision to support older people. A draft of the strategy was presented to the Sub Committee in October 2011 and a three month consultation has resulted in minor amendments.

## **3.0 RECOMMENDATION**

- 3.1 Members are asked to note the outcome of the consultation activity and the revised Older People's Strategy.

**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.
- 4.4 Following a period of consultation the document has been amended to include reference to Inverclyde CHCP's Dementia Strategy and current services to Older People has been added.
- 4.5 The content of the strategy has also been shared with local independent providers. The plan has also been referenced during ongoing staff and stakeholders engagement events regarding the Change Plan.
- 4.6 The strategy will be refreshed on an annual basis and progress on actions will be monitored and reported to future Sub Committees.
- 4.7 The Change Plan for 2012/13 and the Older People's Strategy will become reference points for measuring progress in delivering the key commitments and outcomes for older people.

## 5.0 PROPOSALS

- 5.1 The Sub Committee is asked to note the revised content of the Older People's Strategy.

## 6.0 IMPLICATIONS

- 6.1 Legal:

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

- 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 has taken place over the past three months. Monitoring of and delivery of the action plans will require ongoing consultation with all stakeholders.

## **8.0 LIST OF BACKGROUND PAPERS**

- 8.1 None.

*Improving Lives*

*Making a difference for  
Older People*

**Inverclyde CHCP 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:

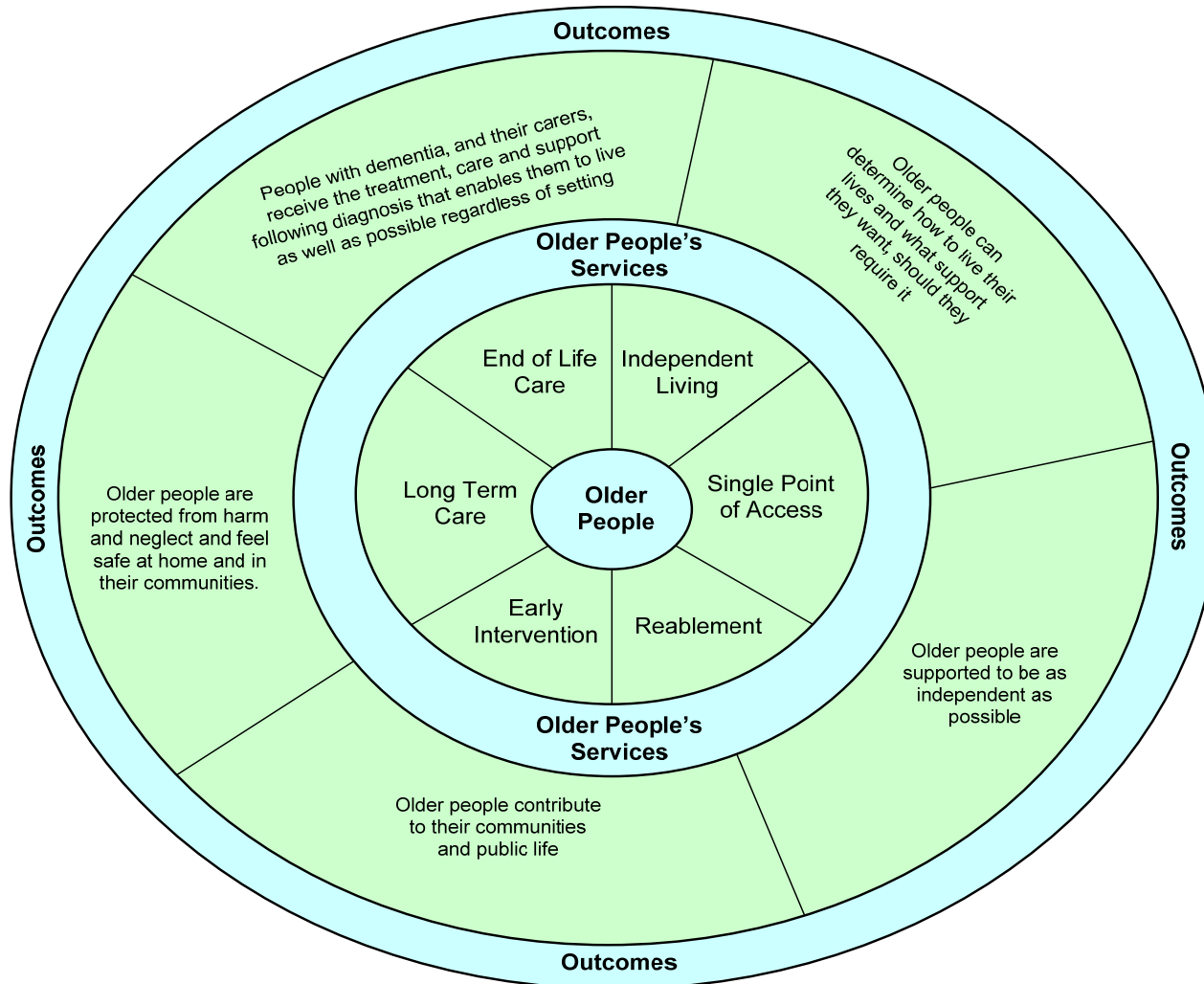
1. Older people are supported to be as independent as possible
2. Older people can determine how to live their lives and what support they want, should they require it
3. Older people contribute to their communities and public life
4. Older people are protected from harm and neglect and feel safe at 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 Joint Commissioning Strategy for older people's services in the CHCP by summer 2012. This Joint Commissioning Strategy, which includes the Independent Sector 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 3<sup>rd</sup> sector. The partnership referred to throughout this strategy relates to everyone from older people themselves to the smallest community group or 3<sup>rd</sup> 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 – 21<sup>st</sup> 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 carers<sup>1</sup>.

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.

A consultation exercise on the draft strategy, which ensured that relevant points were heard from older people, ran for 3 months between October 2011 and December 2011 and was widely advertised. Comments from Older People gathered during the consultation are reflected in the Action Plan at section 7.

## **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

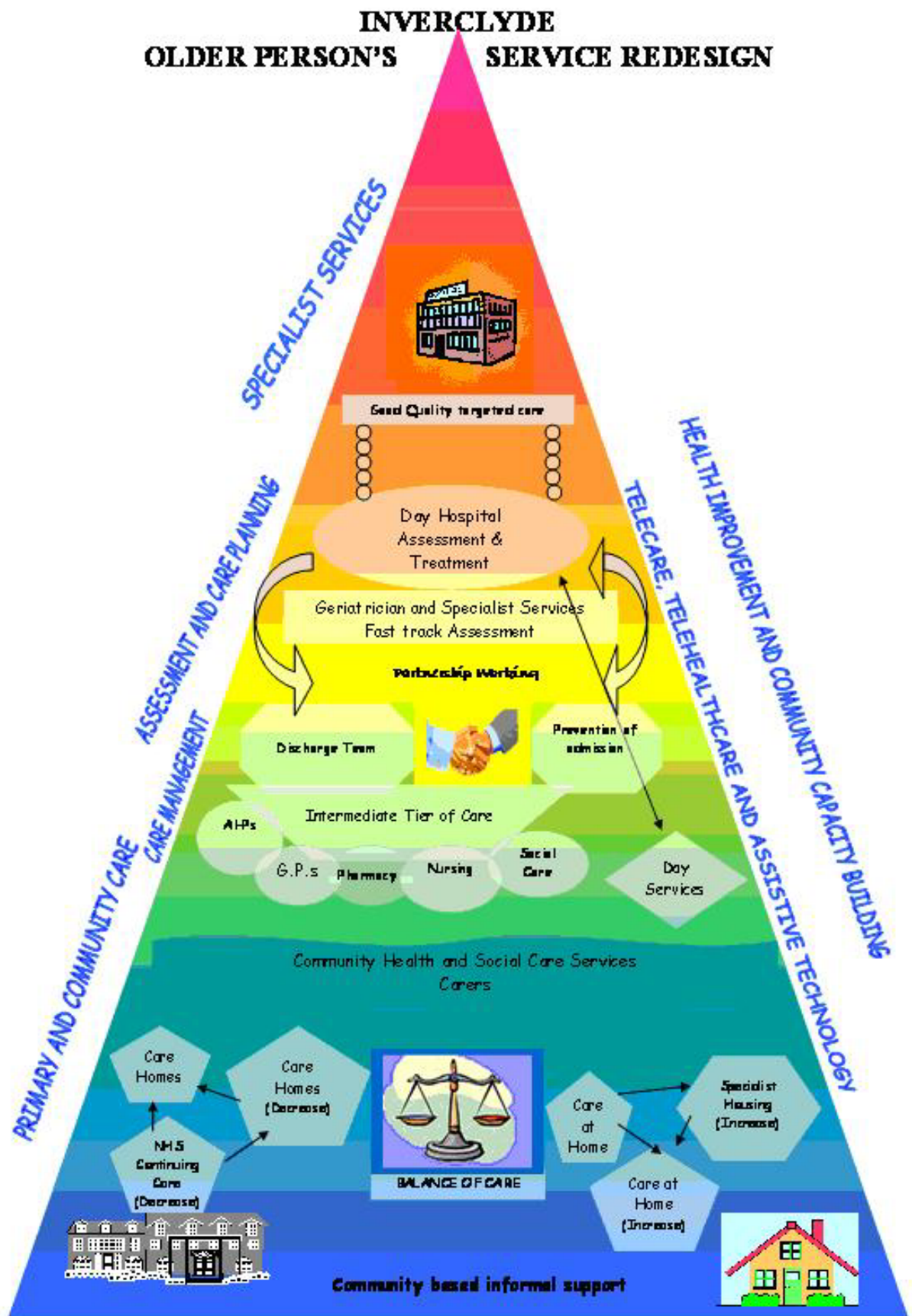
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<sup>1</sup> Hillend Focus Group Reports / Your Voice Tea Dance Reports March and June 2011/ Inverclyde Celebrates International Older People's Day 2010 Report  
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improving communication flow up and down the pyramid to reflect the pathway and journey of the people who use services.

Picture 1: Service Description



## **Services for Older People**

A range of service to support people to live independently at home for as long as possible are provided by Inverclyde Council and a number of private and voluntary organisations.

*Services include:-*

### **Homecare Service**

The Homecare Service is available to people living at home in the community, whether living alone or as a family member. The service is provided to a wide range of people including frail older people, people with physical or sensory impairments, people with learning disabilities, people with mental health problems and other vulnerable groups.

The principal aim of the service is to enable people to live as normal and independent a life as possible in their own home with the assistance of a homecare service.

Homecare is provided to approximately 1275 people with 11500 hours of service being delivered weekly.

Services include personal care which is available free of charge to people aged over 65 years and non personal care services which are chargeable in line with the Council's Charging Policy.

The Care and Support at Home Service is currently undergoing a redesign to begin to establish a reablement approach to care with people being supported to maintain and regain their independence.

### **Meals of Wheels Service**

The Meals on Wheels Service delivers approximately 585 meals across Inverclyde geographically, providing a hot cooked meal to 160 service users. The service is provided at lunch times on specific days during the week and also in the evenings 7 nights per week.

The service is delivered in conjunction with partners and volunteers from the Woman's Royal Voluntary Service (WRVS) and Inverclyde Community Development Trust.

### **Telehealthcare/Community Alarm Service**

The Community Alarm service is an emergency response service for vulnerable people and their carers living within the Inverclyde area. The service is provided 24 hours, 7 days per week and is currently used by approximately 2000 service users who are supported by a mobile response team.

In addition to the community alarm, Telehealthcare services include a range of monitoring and assistive technology devices which are used to support vulnerable people to live independently and remain safe within their own homes. Equipment includes:-

- Door contact monitor
- Smoke/heat detector
- Natural gas/CO monitor
- Bed exit monitor
- Flood detector
- Epilepsy bed monitor

- Fall detector and other devices

To access the above service, an assessment of need is carried out in the first instance.

### **Intensive Day Care Services**

Day care services are provided by both the local authority and voluntary sector. There are services for older people and more specialist services for older people with dementia.

The services are designed to meet the needs of vulnerable older people who require support, sustenance and stimulation. They are also designed to assist carers by providing respite during the day.

The services provide personalised care and assistance with maintaining and developing new skills.

A wide range of activities, outings and links with other community services are provided.

Refreshments are provided throughout the day with a two course lunch provided.

Transport to and from service users homes to the day centre is provided with an escort.

The centres allow the opportunity for joint working across a range of services including District Nursing and Podiatry.

### **Small Group Day Services**

Small Group Day Care Services are provided over six days with groups meeting both during the day and in the evenings. There are currently 21 groups meeting weekly across 15 geographical areas within Inverclyde who provide support to 190 service users. Criteria for access to the service is that service users should live within the geographical area of a group.

Small Group Day Care services are provided to older people who require less intensive support and also offers an opportunity for service users to meet in small group numbers within their local community and enjoy social interaction. This can reduce the risk of isolation and is also designed to assist carers by providing respite during the day. The service provides personalised care and assistance with maintaining and developing new skills.

A wide range of activities, outings and links with other community services are provided. Refreshments are also provided throughout the day with a two course lunch included which is provided by the local school kitchens and community halls.

Transport to and from service users homes to the venue is provided with an escort where assessed as required.

### **Respite Services**

Hillend Centre is the base for a small, respite facility with provision for 3 adult service users. The service creates a safe and welcoming environment where respite can be provided overnight or up to 2/3 weeks to allow carers a break. There is a ratio of 2 staff to 3 service users and one waking member of staff overnight.

There are a range of activities that service users can participate in including attending day services. Service users can continue their normal daily routines and can be accompanied to appointments and so on. Service users can also receive other community based services during respite and the service has access to transport.

Community respite services are also managed from Hillend Centre where respite can be provided within people's own homes. The service can be provided for a few hours to allow a carer to have a break or attend appointments and so on.

Respite is also available within local care homes in Inverclyde.

People who care for an older person, someone who has a learning or physical disability, or mental health problem can access respite services following an assessment.

A Respite Bureau provides information about choices across a range of services so that people can access less traditional forms of respite as part of their care package.

## **Care Homes**

Residential and Nursing Home care is provided through a range of independent sector providers across Inverclyde. There are 16 homes in the Inverclyde area. The provision ranges from small family run homes to larger purpose built homes.

The Care Homes are supported by a range of Primary Care services including District Nursing, General Practitioners and a range of Allied health professionals.

## **District Nursing**

Adult Community Nursing Service is available 365 days a year. The district nursing teams provide holistic care to the permanently or temporarily housebound population of Inverclyde, with the treatment rooms operating a skilled technical service to the "walking wounded". There are a small number of specialist nurse posts providing care to discreet client groups including continence care and respiratory nursing.

Adult Community Nursing activities cover a wide range of duties which include;  
Health needs assessment to identify actual and potential problems.  
A care management and monitoring of complex complicated cases.

Nurse prescribing

Palliative and terminal care

Wound management

Pain assessment

Post operative care

Administration of medicines

Physiological measurement

Equipment provision

Skin Care

Teaching/Education to support patients carers and relatives

Rehabilitation and self management

Health Improvement and Health promotion

Signposting to other agencies

With the balance of care shifting from secondary to primary care the need for a fluid and dynamic adult community nursing service becomes increasingly more important to meet the challenges presented.

An NHS Boardwide review of District Nursing is underway to ensure appropriate skills and staffing levels are available to continue to provide support to an increasing number of people living in the community.

### **NHS inpatient Services**

A small number of NHS assessment and continuing care beds are provided within the Larkfield Unit at Inverclyde Royal Hospital. These facilities cover Medicine for the Elderly and Psycho-geriatric services, providing specialist assessment and support to older patients.

There are also specialist day hospital services where assessments can be provided without the need for hospital admission. There is also a fast track assessment service to ensure assessments are carried out at the earliest stage.

### **Inverclyde RES team (Frail elderly team + rapid assessment team)**

The Inverclyde RES team has been in operation since 1<sup>st</sup> may 2010 and has now fully incorporated the Rapid Assessment team (RAT'S) since 16<sup>th</sup> January 2012 when PhysiO & OT joined the team on a full time basis. The RES team consists of: Dietitian, Occupational Therapists, Podiatrist, Speech & Language Therapists, Support workers, administration support & the team leader.

#### **Referral criteria:**

- >65yrs
- Living within the Inverclyde catchment area in their own home, care home or hospice
- Have complex health & care needs arising from a physical impairment
- Require rehabilitation services to be delivered on a domiciliary basis or where the patients needs are best served in the community with a multidisciplinary team approach

#### **Additional criteria for Rapid Assessment Team**

- >18 yrs
- Medically fit for discharge from hospital & have been an inpatient for less than 72 hrs where rehabilitation needs would be better met at home.
- To support patients home from A/E avoiding the need for unnecessary hospital admission
- Crisis intervention
- Patients who require rapid functional & mobility assessments in the community to avoid the need for unnecessary hospital admissions

Referrals to the RES team (including the Rapid assessment team) are made through the single point of access (SPOA):

SPOA  
1<sup>st</sup> Floor  
Greenock health centre  
20 Duncan Street  
Greenock  
PA15 4LY

Tel 01475 501307  
Fax 01475 727140

All referrals to the RES team are triaged on a daily basis by a member of the Multi Disciplinary Team & prioritised. Patients are screened at home using the Single shareable assessment (SSA) within 10 working days (routine referrals). Referrals to the Rapid Assessment team from A&E are screened & assessed within 1 hr. All other RAT's referrals are screened & assessed within 6hrs of receipt of referral.

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
<b>Total NHS expenditure</b>	<b>£36,486,449.00</b>

#### **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
<b>Total Local Authority Expenditure</b>	<b>£23,562,209.00</b>

**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.



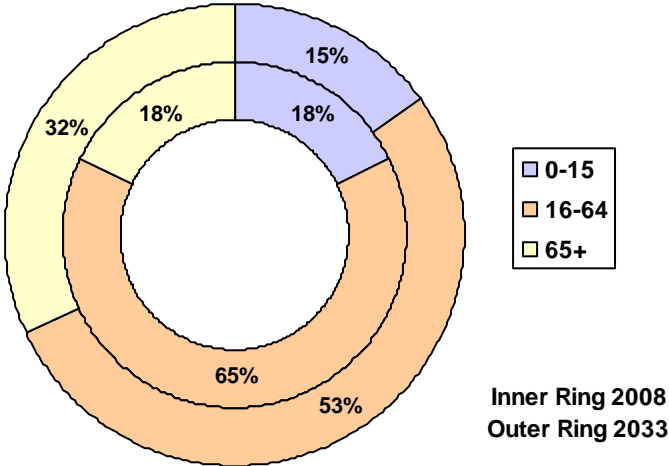
**6. Background and Context**

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.

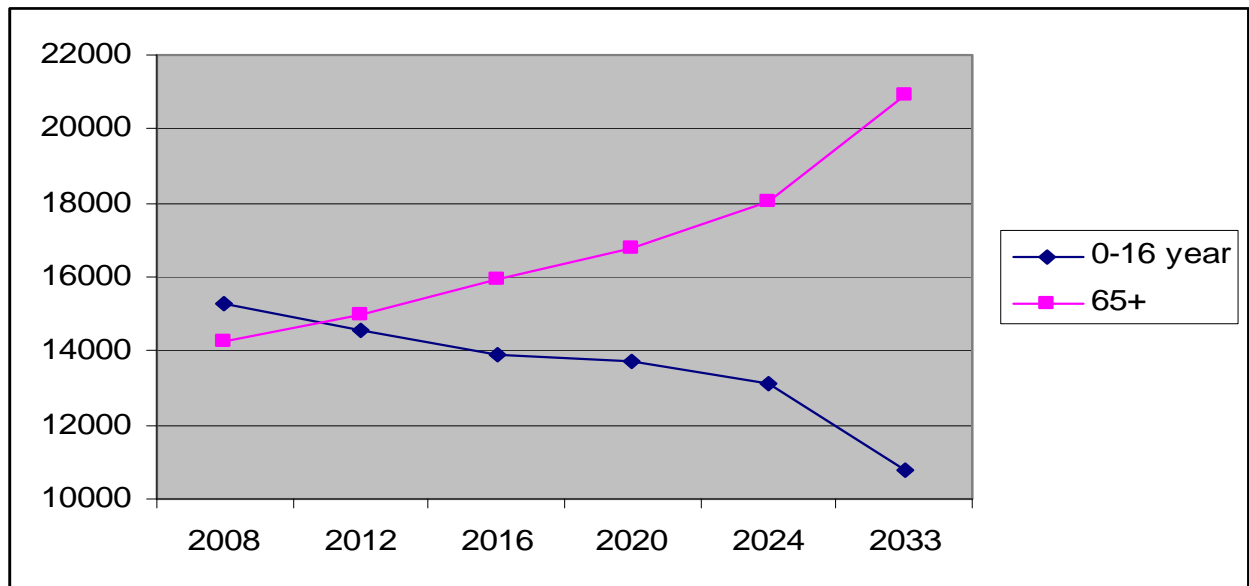
- Over the next few years the number of people aged 65 and over will rise
- Over the next 20 years
  - the number of people below the age of 65 will decline
  - the distribution of older age groups rising above the age of 85 is showing a 45% increase

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

Although the population of Inverclyde is expected to fall to 73003 by the year 2024 the number of older people is expected to increase with a projected 27% increase in the older population. The prevalence rates for older people with dementia aged 65+ is approximately 10% of the older population and an anticipated 30% for people aged over 80. In Inverclyde we anticipate there will be an increase of 10% of those aged 85-89 year with dementia and a 26% increase in those aged 90 or above.

## 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, older people in Inverclyde also suffer as a result of the overall level of deprivation. Thus older people in our area face multiple deprivation as a result of their own characteristics, their age and where they live.
- 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 aims to support service redesign that will allow a shift in the way we deliver care to older people. The focus will be on moving service away from care homes and hospital settings to enabling older people to remain in their own home if that is their choice. In Inverclyde we were awarded £1.228M in 2011/12. To continue the work which is already underway to shift this balance. The fund is continuing for the next 4 years and we have made a submission for the year 2010/13 which is currently with Scottish Government. Future awards for funding in the year 2012/13 will be dependent on achieving outcomes and moving towards joint commissioning.

- *Older People Dementia and Mental Health*

### **Dementia Care Pathway**

Inverclyde CHCP is developing work around the Dementia Care Pathway as part of the implementation of the Modernising Mental Health Services Strategy. This includes a need to link the interface with wider community care services, older people's services and the acute sector. The Reshaping Care for Older People and its Change Plan, presents us and our partners with the opportunity to develop an integrated approach towards planning future supports and services for older people, including those with dementia. Whilst there are discreet areas of work, which will be developed through the Inverclyde Dementia Action Plan, it is important that an integrated approach is taken within Older People's Services to include meeting the needs of those with dementia. The outcomes stated earlier in the strategy apply just as equally to older people with dementia, who also have the right to continue living safely in their community with support to access social activities and relationships.

The main strands of the work in relation to the Dementia Care Pathway include :-

- A Dementia Care Pathway Action Plan, which has been updated to include the National Dementia Strategy 2010 and the Standards of Care for Dementia in Scotland 2011
- Use of the Dementia ICP to inform service elements required and redesign of existing service provision
- Use of improvement techniques with redesign work groups, including engagement with the Mental Health collaborative
- The piloting of different approaches to supporting people with dementia at home within the local Telecare development work
- Pilot approaches with the third sector in respect of early interventions to support people with dementia and their carers
- A robust partnership approach with the GPs locally to improve early diagnosis, and post diagnosis support
- Development of specialist support to non dementia inpatient services to improve the quality of care and ensure appropriate care is provided.

The redesign of Older Peoples Mental Health services is currently being implemented within Inverclyde Mental Health service with operational processes developing alongside this. The model is based on a tiered approach to interventions, which are matched to need with functions identified, as below, and cross referenced to the Reshaping Care Programme.

#### **Tier 1: Primary Care:** Preventative and Anticipatory Care: Proactive Care and Support at Home Pathway Links

The focus within Primary Care Mental Health Services is on a timed programme of intervention for people who present with functional illnesses. These include Depression; Anxiety; Adjustment Disorders and assessment of people with dementia and post diagnosis support. Functions of the Primary Care Team are:-

- To enable single point of access to mental health services, with initial determination of the level of need in the context of the pathways applied by the GP

- Provide diagnostic service either by the GP or in conjunction with then Consultant
- Provide treatment and support to GP prescribing and medication review
- Post diagnostic support form people receiving a diagnosis of Dementia
- Access to psychological intervention for people with functional illness presentations
- Enabling access to wider support services at home and within the community e.g. day activities and homecare
- Elective access to second tier mental health services, when the need arises.

**Tier 2: Secondary Health services and specialist Mental Health teams.** Proactive Care and Support at home and Effective care at times of transition, hospital and Care Home Pathways. Access to the mental health service for those with complex needs arising from Dementia; Psychosis and more complex or enduring functional illness.

- Fast track assessment for people with within the community requiring assessment by the mental health service;
- Supplementary mental health interventions within existing care arrangements in the community;
- Fast track assessment to support care within other settings I.e. General Hospital inpatient services; Care Homes;
- Routine liaison to support care within other settings;
- Care management of people requiring ongoing mental health service intervention due to complexity of mental health needs
- The priority work is focused on the implementation of the fast track assessment and liaison services

### **Interface with the Change Plan for Older People**

The next phase of the Change Plan presents us with the opportunity in 2012-13 to create an interface between mental health services and the wider services for older people through the Older People's Strategy, which will meet the needs of older people and their carers. This will be addressed through the Change Fund by employing a development worker and in the following ways:-

- **Develop an Anti Stigma and Awareness Programme-**By identifying a potential range of training programmes, appropriate levels of training can be aimed at staff working with older people in different settings, to address issues and enhance their understanding of working with older people with dementia.
- **Improve post diagnosis support-** This can be achieved through developing further post diagnostic support for older people and their carers within primary care services( community clinics) and enabling staff in acute sector to access support for their patients.
- **Community Services-** Review the existing approaches to assessment with a view to shifting towards the use of complementary assessment tools, which enable older people with dementia and their carers to continue living safely at home. Also to consider the use of advance statements and life story work, which will facilitate effective care at home. Then use of fast track assessment should also assist in preventing inappropriate hospital admissions and facilitate appropriate care at home.

- **Liaison service**-Need to develop a liaison service modeled on the Mental Health liaison between primary care and acute as well as care homes to promote the most appropriate form of support and care for older people with mental health issues. Also to facilitate access to the Dementia Care Pathway for older people whose care is provided in those settings.
- **Development of alternative psychological approaches** and interventions across all older people's services. Ensure that service impact assessments on the Standards of Care for Dementia (2011) are adopted within services and action plans developed to address gaps.

### *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:*

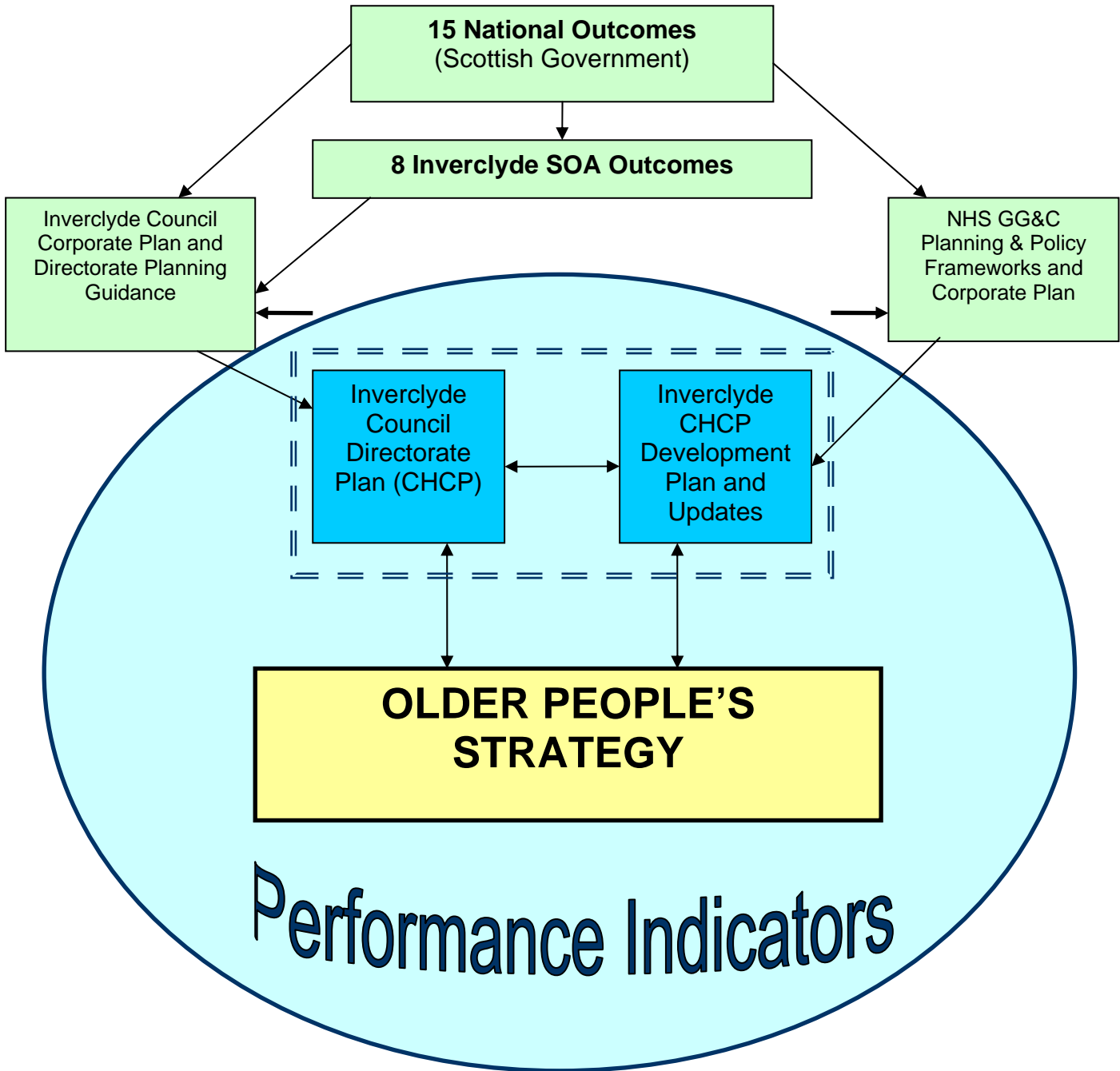
- Inverclyde Reshaping Care for Older People Change Plan
- Inverclyde Local Housing Strategy
- Inverclyde Carers Strategy 2012 – 15
- Inverclyde Joint Community Care Plan 2010 – 2012
- Inverclyde CHCP Development Plan/ Directorate Plan
- NHS GG&C Clyde Mental Health Strategy
- NHS GG&C Long Term Conditions 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
- The need to acknowledge the interface between the developing joint commissioning with the third sector and the activities relating to the Change Plan.
- The need to address the interface with the Care Inspectorate and Health Inspectorate teams in relation to older peoples services that are required to be registered.

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. We wil continually refine the measures of success for each action in the lifetime of the strategy.

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
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	'Welcome the approach but need to ensure that it is working for people.' ' Social activity is also required to assist peoples recovery and maintain their mental health.'  'Good to be able to do thing for themselves and get support where needed.'

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
					physical activity programmes  Reduction in direct admission to care homes from hospital  Increase in carers assessments  Increased use of care and repair  Increase in equipment and adaptations for older people wishing to remain in their own home	
1.2	<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,	October 2012	CHCP Service Manager (Assessment and Care Management)	Inverclyde Change Plan Core Objective	Reduction in unplanned admissions over 65  Number of polypharmacy reviews undertaken (over 65)  Number of fast track assessments carried	General agreement that this is important and that people have the chance to get plans in place at an early stage. Older people

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
	improve function.				<p>out</p> <p>Increased early identification of carers</p> <p>Usage of SPARRA and risk prediction tools</p>	<p>linked this action to issues around the role and duties of home care and community services. Some people also gave positive feedback about effective referral pathways. Information and choice is important at an early stage of intervention to assist people to make plans.</p> <p>People valued the role of the home help but expressed concern about the changes in their duties.</p>

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
1.3	<u>Independent Living:</u> Develop supports that promote confidence and wellbeing for older 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	October 2012	CHCP Head of Service (Health and Community Care)	Inverclyde Change Plan Core Objective  Local Telecare Strategy	Increase in the number of people over 65 engaging in vitality, Live Active or other physical activity programmes  Health Improvement indicators (TBC)  Increased uptake of telecare packages by older people	'Important to have assistance to remain at home, including home help service, telecare, meals on wheels.' 'Aids and adaptations are also important for remaining at home and enabling independence. Isolation is a barrier to independent living'.  'Transport is often a problem in getting to places in order to attend activities, courses etc.'

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
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)	‘It is a good thing to assist older people to manage to do things and/or relearn tasks and skills so that they feel included.’
1.5	<u>Community Capacity Building</u> – we will work in partnership across the statutory and 3 <sup>rd</sup> sector to increase community capacity to meet the needs of older people within their own communities, including the development of buddying and increased support to carers	October 2012	CVS Inverclyde/ community sector partners		Indicators TBC	‘Its important that older people have company and support get involved in community activities. ‘ ‘It is good to encourage people to take part in their community and promote community spirit. ‘
1.6	<u>Active Living</u> – we will contribute to the development of the	December 2011	CHCP Service Manager (Health Improvement, Inequalities and	Inverclyde Active Living Strategy	Increase in the number of people over 65 engaging in vitality,	Regular medical examinations

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
	<p>Inverclyde Active Living strategy where it relates to maintaining active lifestyles in later life</p> <p>Develop support to care homes with primary care colleagues with an emphasis on prevention and outcomes</p>		Personalisation)		<p>Live Active or other physical activity programmes</p> <p>Work with primary care staff, including GPs will be explored in relation to implementing the change plan.</p>	<p>by GP's nurses or health visitors to identify the development of problems which can be dealt with early to keep older people mobile and independent. 'More health promotion for pensioners who live alone.'</p>
1.7	<u>Housing</u> – Address aspects of National and Local Housing Strategies that relate to older people	October 2012	Team Leader, Inverclyde Council Housing Strategy Team	National Older People's Housing Strategy Local Housing Strategy	Indicators TBC	'Housing Associations should reconsider their criteria with regards to aids and adaptations (four step rule).' Tenants are positive about living in



Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
						sheltered housing accommodation which helps promote independence and provider company. 'Family members have concerns over lack of staff overnight was raised.'
1.8	<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	Older people support the principal of shifting care more towards community based care, but there needs to be more flexibility and provision for tuck in services.
1.9	<u>Single Point of Access</u> – we will	October 2012	CHCP Service Manager (Rehabilitation and		Reduction in unplanned admissions	Older people found the idea

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 1: Older people are supported to be as independent as possible</b>						
	combine initiatives and developments to speed up access, especially in crisis. And reduce duplication of services		Enablement)		<p>over 65</p> <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>	<p>of a single point of access a good idea which could help identify people who need help more quickly without having to wait on multiple assessments.</p> <p>People should only have to give their information once as failure to do this can cause more confusion.</p>
1.10	<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 Head of Service (Health and Community Care)		<p>Review complete</p> <p>Indicators TBC</p>	Concern was shown in respect of a carer taking unwell – who will give medication etc to older person.

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 2: Older people can determine how to live their lives and what support they want, should they require it</b>						
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	Older people are interested in exploring and having more information about these options.
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	Older people wish more information to be available regarding services and community supports in easy to read and plain language with clear contact names and numbers.  Information regarding community activities needs to be made available to older people. In order that they know what is

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 2: Older people can determine how to live their lives and what support they want, should they require it</b>						
						available.
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 income of local older people. We will provide support where income maximisation advice is needed.	Ongoing	CHCP Head of Service (Planning, Health Improvement and Commissioning)	Inverclyde Financial Inclusion Strategy	Number of income maximization assessments (over 65)	Older people and their families want access to information on benefits and other financial related issues which is clear and easy to follow.
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. We will also assist carers to address crisis/emergency planning.	Ongoing	Head of Service (Health and Community Care)	Inverclyde Carers Strategy  National Carers Strategy	Number of short breaks delivered  Respite Performance Indicator	Getting out of the house is important as well as mixing with other people.
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	Many older carers don't know how to access services and worry about what will happen if they have an accident or are admitted to

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 2: Older people can determine how to live their lives and what support they want, should they require it</b>						
						hospital.
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	Some older people go to day centres however, there is a waiting list for these. Others feel that they are not as active and are unable to carry out the activities they used to e.g. going into town. Getting out and about in the community is a good idea, the tea dances are a good example of this.
2.7	<u>End of Life Care:</u> we will recognise the right to choice 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,	Ongoing	CHCP Service Manager (Planning and Performance)	Change Fund Core Objective  Inverclyde Palliative Care Action Plan  Living and Dying Well and Building	Indicators as per local Pal Care plan	It is important that older people have a choice. Family members should also be involved. Getting advice and access to support on aspects of care

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comments
<b>Outcome 2: Older people can determine how to live their lives and what support they want, should they require it</b>						
	where these are required.			on Progress		brings peace of mind and a sense of calm that everything is in hand.

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Persons Comment
<b>Outcome 3: Older people contribute to their communities and public life</b>						
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 February 2012  Ongoing	CHCP Service Manager (Planning and Performance)/ Your Voice	CHCP People Involvement Framework (publication date: February 2012)  National Standards for Community Engagement	Use of VOiCE plans  Numbers of older people involved in engagement events	Some older people commented on how important planning is and that being involved gives people a chance to have their say on how services effect their lives. Most agreed that older people should be asked their opinion about every aspect of their lives and what support they needed.  Things need to be explained in a simple manner to ensure that no person is left out.

Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Peoples Comments
<b>Outcome 4: Older people are protected from harm and neglect and feel safe at home and in their communities</b>						
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	A lot of concern over the lack of care staff within sheltered housing facilities overnight.
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	The condition of pavements is often a hazard for older people and can put people off going out.  People within sheltered housing showed concern about ambulance services gaining access to people in case of emergency at night time. Sheltered housing tenants feel they have peace of mind with Telecare and community alarms services.
4.3	<u>Homes safety:</u> Continue current provision to	Ongoing	CHCP Head of Service (Health and Community		Indicators TBC	Telecare is appreciated but limitations are



	improve and maintain home safety for older people (e.g. fire safety checks/ security advice etc)		Care)			<p>recognised with this. Telecare and community alarms are viewed as safety nets, giving people reassurance and peace of mind.</p> <p>Easy access to minor home improvements improves safety for older people who are becoming unsteady e.g. bath rails/handrails etc.</p>
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Ref	ACTION	TIMESCALE FOR DELIVERY	LEAD RESPONSIBILITY	STRATEGIC FIT	MEASURE OF SUCCESS	Older Peoples Comments
<b>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.</b>						
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	Older people and their carers need to be able to access information easily including memory loss and early stages of dementia.
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	It is a good idea to keep skills intact to help keep mind active e.g. reciting poems.  Having the opportunities to talk and meet people is important in maintain good mental health.