Southern Health and Social Care Trust

Quality Care - for you, with you

‘Changing Times: Older People Living Life to the Full 2010-2013’

DIRECTORATE OF PERFORMANCE & REFORM
Community Planning Department
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Chapter 1: Setting the Scene

Introduction

More people than ever before are likely to survive to old age. Across the Southern area there is an expected increase of 29% of people over the age of 65 between 2009 and 2018, this will include an increase of 7,456 people over the age of 85. With an increasing ageing population, more people are living longer, fuller lives and are able to maintain their independence while some people will have more complex needs. Considering that as people age they are more likely to experience disability or illness, there will continue to be increased demands placed on health and social care services.

In talking to older people we know that the majority of them want to remain in their own home and in order to do so they may need access to a network of care and support services. Changing demands and choices by older people have led to many developments in community care services over recent years. The availability of more appropriate care in the community means that older people are better supported to maintain independence and quality of life. This has helped to reduce unnecessary admissions to hospital and has led to shorter hospital stays for older people. Hospitals are now able to provide more focused support for those in need of hospital-based services.

The Trust is making every effort to avoid duplication of services so that services can be delivered in a better way within available resources. We are continuing to improve and modernise our systems and processes and are developing new integrated care teams across the Trust so that staff who previously worked in separate services will now work together to provide more effective community care services to older people.
The Trust recognises that working in partnership with older people, their families, people in their local communities and other providers of services, such as the voluntary and community sectors, is essential if we are to support the delivery of a better overall service for older people. With so many services and staff being involved in providing community care services, the Trust are keen to ensure older people know how best to access and use the services that are most appropriate to meet their needs and therefore support them in ‘living their life to the full’.

Providing a Continuum of Care

Too often in the past older people were given a limited choice in the support and care services available to them as it became more difficult for them to remain at home.

There has since been a shift towards a focus on prevention, providing care closer to home, developing a range of long term living options, addressing the needs of people with long term conditions and developing services for older people with dementia.
The Trust is developing a new model of care which recognises that older people want more choice and control. There will be times when older people will need help for a period of time in order to help them maximise their independence and wellbeing.
Chapter 2: Service planning and delivery principles

The Trust publicly consulted on its 5 Year Strategic Plan ‘Changing for the Better’ in 2008/09. This document set out a clear strategic direction for the care of older people in the Southern area and the priorities which will shape our development of care and services. The following paper describes the Trust’s plans for the achievement of these priorities.

The Trust has developed the following principles for the planning and delivery of services to older people:

- Providing safe, effective and efficient services within available resources
- Having a highly skilled, supported, flexible and motivated workforce to ensure quality service delivery
- Promoting the health and wellbeing of older people and their carers
- Promoting and maintaining independence, choice and control
- Care for older people in their own homes and communities for as long as possible
- Empowering and supporting older people to manage their long term conditions
- Working with older people and others to agree and meet the care needs of the individual
- Ensuring that older people have access to a range of information, support and services
• Providing choice and support to enable older people to live their life in the way they want to

• Maximising the opportunities presented by advances in technology, through the use of telecare and telehealth

• Working in partnership with the community and voluntary sector to maximise effectiveness and efficiency in how resources are used and address the wider wellbeing needs of older people

• Where older people need an episode of hospital care, to provide timely access to high quality services that will effectively assess their needs, offer timely diagnosis and treatment and ensure timely discharge with appropriate community support where needed

• Recognising the vital contribution that carers make and supporting them to continue in their caring role

• Commissioning or providing a range of alternative accommodation that is safe, high quality with a homely environment when long term care needs cannot be met in the person’s own home

• Continually reviewing care needs with the recognition that older people may at times need more or less care to support changing needs.

The above principles are reflected within the Trust’s plans to deliver services to older people through a whole systems approach. This has been illustrated within the following model.
The Trust’s Model to support older people in ‘living their life to the full’

This model is integral within the Trust’s strategic vision and in the planning, development and delivery of a continuum of care for older people.

The Trust’s key priorities within this continuum of care have been set out under the following sections: -

- Keeping yourself well;
- Having the right information;
- Supporting older people to remain in their own home; and
- Supporting older people when they are no longer able to live in their own home.
Chapter 3: Keeping Yourself Well

It is important to maintain health and wellbeing by having a healthy lifestyle such as keeping physically active, eating a balanced diet, looking after your mental wellbeing and maintaining contact with others. It is recognised that independence can be improved by better self care and management of long term conditions such as diabetes or arthritis.

The Trust works together with other services across the community, voluntary and private sectors to plan, develop, and deliver services aimed at promoting wellbeing.

There are significant benefits to be gained by older people who actively participate in community life. Volunteering, mentoring and other inter-generational programmes can help promote wellbeing and maintain social contact and support. The Trust will work closely with other partners to ensure that older people have access to a range of services to address their wider social needs such as access to an appropriate level of income, housing, and a range of leisure activities, local community programmes and initiatives that are targeted specifically for older people. It will ensure that services are delivered to meet the various needs of older people within available resources.

There are a range of services and structures currently in place across the Southern area which address the health and wellbeing of older people both within Trust teams and through communities and partner organisations. Many of these providers are supported by the Promoting Wellbeing Team through training, capacity building and targeted
Mechanisms have been established to enable referral or signposting to these services where appropriate need is identified. A range of service level agreements and small grant schemes are in place to facilitate local development and delivery of this work. The Southern Investing for Health Partnership of which the Trust is a member further supports this work and our proximity with the border has opened opportunities to access European Funding and co-working with CAWT.
Chapter 4: Having the Right Information

General Information Needs

The majority of older people wish to remain as independent as possible for as long as possible and they want to be able to access the right services, at the right time and for the length of time they need them. However, many older people, their families and carers are unaware of the range of information, support and services available to them in their own communities.

In order to address this, the Trust is in the process of developing a new access and information service which will be established during the 2011 year to offer advice and information on the range of services available to older people. There will be one point of contact for older people which will mean they will be provided with a service that is readily accessible and responsive to meet their individual needs. It is planned to develop a detailed local Directory of Services which will enable the Trust to signpost older people or their family to the most appropriate service. These services may be provided by the Trust or by organisations who work with the Trust. The Trust continues to build upon existing relationships with other agencies to facilitate the development of appropriate support. The Trust has recently agreed a social partnering strategy: “Trust in Community”, which seeks to maximise the impact of partnership working with community, statutory and voluntary organisations and will directly target vulnerable older people and develop innovative approaches to address their ongoing needs.
The Trust plans to involve older people in defining the type of information that may be needed and how it can be accessed. We are also keen to develop opportunities for older people to gain information themselves, by using libraries, the internet or other local sources. It is recognised that people may have a range of information needs, such as that associated with specific health conditions, care, treatment or the availability of local community and social activity programmes.

When an older person is assessed as needing extra help to maintain their independence the Trust will offer help and support, including information on the ways in which the individual’s needs could be met.

Older people will often have their needs met from within their own resources or with help from their family or the local community. The Trust recognises the need for carers to have access to good quality information about the help and services available so they have the means to provide care. The Trust is committed to building capacity within local communities by providing training and support and, where appropriate, resource to community and partner organisations to enable them to address the needs of older people within their communities.

**Help in an emergency**

The Trust has established processes that help us identify older people known to community care services who are perceived as being at risk and, where appropriate, we ensure that necessary supports are put in place to help avoid the need for crisis intervention.

We recognise the importance of older people having an understanding of what an emergency is, that they have access to information and know who to contact in an emergency.

When a crisis situation does arise, the Trust works with a range of professionals to ensure they can give support quickly to meet the needs
of the individual. If the older person is currently in receipt of Trust services they will find contact details for use in an emergency situation are available within their care plan. They will be made aware that contacts provided are for use in urgent situations and where their needs can wait they may be directed to appropriate daytime services.

The Trust currently offers the following out of hours services:

- **Out of Hours Emergency Social Work Service**
  This service operates from early evening overnight and all day during weekends and bank/public holidays. The service is provided by qualified and experienced social workers for emergencies only. This may be because of a situation which causes the individual or their family distress and upset. This can include domestic violence or mental health problems.

- **Unscheduled Mental Health Services**
  These services are accessed via GPs or members of the Trust Mental Health Teams. Emergency referrals for urgent assessment, immediate crisis management or home treatment assessment are made through a central referral point.

- **Domiciliary Care**
  The Trust Domiciliary Care Service and independent providers have on call services and can restart care services in unsocial hours, during Mon-Fri until 10.30pm and on Saturdays and Sundays.

- **District Nursing**
  The District Nursing service provides an out of hours service Saturday, Sunday and Bank Holidays as well as a Twilight Nursing Service which operates each evening. Referrals are made from a wide range of services including patients, carers, GPs and Trust Professional staff. The District Nursing service provides a range
of nursing needs to people within their own homes, such as support to patients and families with palliative care needs. The service is supported by Marie Curie nursing to meet the needs of patients at home with end of life care needs.

• **GP Out of Hours**
  GP Out of Hours may be contacted when an individual is ill and cannot wait to see their own GP during normal surgery hours. This service operates at Craigavon, Armagh, Newry, Dungannon and Kilkeel at night and weekends and can only be accessed in the first instance by phone. This service cannot treat injuries such as cuts, abrasions or broken bones.

• **Minor Injuries Units in South Tyrone Hospital, Dungannon and Mullinure Hospital, Armagh**
  The Minor Injury Unit in Dungannon is led by Emergency Nurse Practitioners supported by nursing/auxiliary staff and is operational 9am-9pm seven days a week. There is access to x-ray facilities.

  The Minor Injury Unit at Mullinure is a nurse led service which operates from 5pm to 9am Mondays-Fridays and 24 hours on Saturdays, Sundays and Bank Holidays. This service operates at all times when the Armagh Community Hospital minor injuries unit is closed. There is no x-ray facility at Mullinure.

• **Accident and Emergency services in Craigavon Area Hospital and Daisy Hill Hospital**
  Accident and Emergency services are open all year round 24 hours a day.
Chapter 5: Supporting older people to remain in their own home

An older person may have suffered ill health at home or even had to spend some time in hospital. This may have been because they have had a stroke, hip fracture, heart condition or other medical or surgical need that could not have been met within their home. The Trust is keen to help older people with their continued independence. As soon as they come into hospital, staff will work with the individual to start to plan for them going home or to Lurgan or South Tyrone Hospitals for a period of rehabilitation first.

The Trust continues to develop its links with GPs and other agencies to ensure that alternatives to hospital admission are more widely available. This has included the establishment of a one stop assessment centre for older people which will be developed further as part of the review of day hospitals. The development of intermediate care and domiciliary care services, as well as improved assessment and a range of care in the community for people with long term conditions, support older people who require hospital treatment to be discharged safely back into their community with appropriate support and effective rehabilitation. This has contributed to a reduction in delayed discharges from hospital. As older people spend less time in hospital the Trust will continue to review its requirements to ensure resources are best directed to meet needs within the community setting.

Sometimes older people will develop health and social care needs which will impact on the quality of their lives. When this happens, the Trust will talk to the individual, their family, carers and others about their needs, how those needs could be met and whether Trust services will be necessary to help meet ongoing
recovery needs. For example, an older person may need help at home because they have a health condition which has affected their ability to be independent. The older person’s circumstances may have changed and help from family and friends is no longer enough to allow them to live safely and independently at home.

While the Trust continues to target services at those most in need it recognises that older people may have a range of varied needs which may be met by other organisations or agencies.

**In order to support older people to remain in their own home we will:**

- **Provide you with a reablement service**
  We know that with a focused phase of appropriate support a lot of older people can be helped to regain their independence. We are now in the process of developing a new reablement team which, over the next two years, will build on services already provided by the intermediate care team and which will provide up to 6 weeks support to people at home. This may be necessary because the older person has experienced deteriorating health or following a spell in hospital. The service will work with the individual to help them regain independence, recover skills and confidence for daily living. It will provide them with support and encouragement to re-learn skills and learn new skills so that they are able to undertake the daily tasks of living themselves, such as getting dressed and undressed, using the stairs, washing, preparing meals.

For older people undergoing reablement, ongoing review of progress against their reablement plan will be an integral part of the process. To do this effectively, we will be working in partnership with the individual and their family to agree the support they need to help them return to their previous level of independence.
• **Agree with the individual the support that they need**

We are now establishing 7 Integrated Care Teams working across the Trust. This will mean that district nurses, care managers, social workers and occupational therapists will be working together to ensure a more joined up approach to care delivery so that they can more appropriately meet the needs of individuals.

A member of the Integrated Care Team will undertake an assessment of the older person’s needs as the first step towards getting them the help and support they need. This assessment will indicate which needs are most important and will also highlight the risk for the individual if they don’t get the help they need. Then depending on the professional contact required, a decision will be made about the member of the team who will act as the individual’s keyworker.

We will meet with the individual to identify what they need, ensure a shared understanding of the level and range of their needs and arrange for the appropriate help to be provided. As part of the process we will help older people to make best uses of the supports available to them including support from families, informal carers and wider communities.

If Trust services are needed, the team will involve the older person in the development of a care and support plan. This will set out how the individual’s needs will be met and agree how their services will be monitored and reviewed. The services which the Trust may provide include:

- Palliative care and end of life services
- Memory Services Team
- Specialist Services
- Intermediate Care Services
Mrs A had a stroke and after 7 days in hospital she was able to safely return home. The Trust has an Early Supported Discharge Stroke Team in the community and so she was able to continue her multidisciplinary rehabilitation programme at home.

This meant she participated in 12 weeks intensive rehabilitation in her own home environment as opposed to remaining in hospital for this. With the help and support of her family and the Team, she was able to make a start at getting back to doing the things that were important to her before the stroke.

- **Organise care and support**
  The Trust will have a process for organising care where this has been agreed. This may be following discharge from hospital, during a period of ill health at home, as the individual's needs change or where they need support for end of life care and bereavement.

  The Trust has plans to put in place a dedicated team of specially trained administrative staff to focus on streamlining and managing the processes associated with arranging care packages within domiciliary care, day care and residential and nursing services.

  This team will put together a package of support for older people based on their individual assessed need. This may include services from private, community or voluntary organisations. It may involve the older
person having an individual budget to organise their own care with whom they choose, or alternatively the Trust may organise care on their behalf or put the individual in contact with specialist services or supports in their local community. The Trust will be able to advise older people and their carers on how to access support for information on a range of benefits including direct payments.

A greater number of older people are having their support needs met in their own home. The trend of reduced need for long term care is a direct result of increased investment in community services, offering higher levels of care to support older people to remain in their own homes. We are continuing to develop our domiciliary care services to ensure they are more flexible and responsive. To help the Trust ensure that individuals who are most in need receive the support they require, the Trust assesses individuals for access to services against a range of sub-eligibility criteria. If an individual is assessed as having a critical or substantial eligible need, services will be commissioned to meet that need.

The Trust continues to provide improved access to early assessment, diagnosis, treatment and rehabilitation services through a range of initiatives including the development of Integrated Clinical Assessment and Treatment service (ICATs), specialist support for people with long term conditions, community stroke rehabilitation teams and one stop rapid access assessment clinics within Mullinure, South Tyrone and Lurgan Hospitals. The Trust works in partnership with voluntary organisations to provide programmes such as ‘Challenging Your Conditions’ to help older people better manage their conditions.
The Trust’s day hospitals in Lurgan, Mullinure and South Tyrone Hospitals provide a rehabilitation service to older people living in their homes. This is crucial in enabling people to reach their full potential for independence and contributes to the prevention of hospital admission and the reduction in reliance on community services. We are further developing services that could prevent people having to stay in hospital for treatment, for example IV therapy and blood transfusion services.

The Trust provides a range of day care services in localities across the Trust to support older people. The Trust intends to further modernise these services to ensure that there is a greater emphasis on re-enablement, maintenance and support for people with memory loss.

The Trust supports the introduction of new technologies in health and social care. We have introduced new technology which helps to better monitor people with Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disorder (COPD) and Stroke. The Trust recognises the potential that this will have to greatly improve the quality of people’s lives and cost efficiency of service provision. Remote tele-health monitoring is a clinical practice that involves remotely monitoring patients from home. This will allow people to manage their own health problems and be in a better position to seek help earlier. This will reduce the need for unplanned hospital admissions and help people to stay well.

It enables the patient to have greater control of their lives while having their condition monitored at home by the specialist health care team. Specialist practitioners are able to see patient’s results such as; oxygen levels, pulse, blood pressure, blood glucose and temperature on a regular basis and commence early treatment when required. This helps to avoid repeat attendances at clinics, visits to the GP, unnecessary admissions to hospital or attendances to Out of Hours services.
Mr Saunders has chronic obstructive airways disease (COPD). He used to be in and out of hospital several times every winter with chest infections. He has now been provided with telemonitoring equipment as part of his case management approach by the specialist COPD team. He monitors his own temperature, pulse and oxygen levels on a daily basis in his own home, with the results being transmitted and made available on an electronic system accessed by the specialist team at their computer. This has enabled him to become aware of his own health and recognise early signs of a chest infection, and also provides timely access to information by the specialist COPD team, to ensure early treatment of his condition. This has reduced Mr Saunders reliance on hospital, GP and out of hours services. He has a better quality of life as he has more control over his condition.

We will be working with the individual and their family as they progress through the various stages of their care with recognition that at times they may require more or less care in order to maintain their independence and as their circumstances change.

- **Ensure that the care and support provided is appropriate to meet individual need**

  To continually assess if the support provided to the individual is right for them the Trust has built monitoring and review processes into each stage of their care. This simply means that the Trust will regularly check with the individual, their family and carers to see if the support they are getting really matches their current needs and make sure that necessary changes are made when required. This will ensure that, as an individual’s health and circumstances change, they are discharged from a service or alternatively directed to the services that best meet their needs.
If an individual’s condition improves they may no longer need the same level of support and so services may be reduced or ceased. Likewise if their condition changes and their needs increase, they may be reviewed as needing Trust services in the future. In this way we are able to ensure that the people who most need our services can receive them.

The Trust has processes in place to deal with any issues that individuals may have during the review, monitoring and development of their care plan. For example, if an individual does not agree with the assessment of their care needs they should in the first instance discuss this with their Care Manager, Social Worker or Community Nurse. If the individual remains unhappy after this discussion, the member of staff will advise them on how to appeal the decision.

- **Advice on other housing solutions**

  Having adequate and appropriate housing can assist the ability of older people to continue living at home. The Trust has been working in partnership with the Housing Executive and Housing Associations to increase the local provision and range of supported housing available to older people. We continue to work with a range of bodies, including private providers, to influence the development of housing solutions which will provide older people with their ‘own front door’ and offer them the support and security necessary to help them stay in their home for all of their life. One such example is plans for the development of 12 new units of housing for older people in Kilkeel.
Chapter 6: Supporting older people when they are no longer able to live in their own home

Residential & Nursing Home Care

If the older person is no longer able to remain in their own home, we will work with them, their family and carers to choose a suitable available residential or nursing home. If the home the individual wants does not have a vacancy they may move somewhere else that is suitable until there is a vacancy. The Trust is working with nursing homes to support them in managing the care of people with more complex needs.

Monitoring and reassessment continues to be at the cornerstone of all service provision. A Care Home Resource Team will be established during 2011/12 to support older people living in care homes and the staff who provide their care. This will be done by carrying out annual reviews, ensuring contract compliance and providing for the education and training of staff.
### Chapter 7: Outcomes for Older People

The Trust’s Strategy for Older Person’s Services aims to deliver the following outcomes for older people:

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<th>Outcome</th>
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<td>Provide older people with more choice and control over their lives and how their needs are managed.</td>
<td>➢ All patients receiving a new care package at home will be provided with a copy of their individual care plan to enable them to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements. &lt;br&gt; ➢ Increasing the numbers of people who are accessing direct payments. &lt;br&gt; ➢ Development of supported housing units, this will include working with the Housing Executive to progress the development of 12 units in Kilkeel. &lt;br&gt; ➢ Increasing the numbers of people managing long term conditions using remote telemonitoring.</td>
<td>December 2010 &lt;br&gt; March 2011 &lt;br&gt; March 2013 &lt;br&gt; March 2012</td>
</tr>
<tr>
<td>Outcome</td>
<td>Success Measure</td>
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| Promote a greater quality of life and not just quality of care by facilitating inclusion within the wider community, supporting opportunities for social contact and helping older people to make healthy choices. | - Establishment of a Care Home Resource Team.  
- Increased uptake of targeted programmes and services by older people in line with the Promoting Wellbeing Strategic Action Plan.  
- Improvement in social inclusion and quality of life indices (validated indicators to be agreed).  
- Measurement of levels of independence of those availing of the Trust’s new reablement service. | March 2012   
March 2012   
March 2013   
April 2013 |
| Support carers to continue in their caring role.                                                                                         | - Increase in dementia respite places.  
- Implementation of carers strategy which will involve the Trust’s Carers Coordinator providing support for carers networks and groups across the Trust.  
- Involvement of carers in service development and delivery. This will be monitored by the Trust Carers Reference Group.                                                                                               | March 2011   
March 2011   
March 2011 |
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<th>Outcome</th>
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<td>Support the majority of older people to live independently in their own home.</td>
<td>➢ Establishment of a multi-disciplinary palliative care service.</td>
<td>March 2011</td>
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<td>➢ Establishment of Reablement Teams across the Trust.</td>
<td>April 2013</td>
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<td></td>
<td>➢ Increase in the numbers of older people who are supported to live independently and who report satisfaction with their quality of life.</td>
<td>April 2013</td>
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<td>Provide for a single and easily accessible point of access and clear referral processes to services.</td>
<td>➢ A single point of access and single access strategy for referral management to be in place.</td>
<td>April 2011</td>
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<td></td>
<td>➢ Feedback from patients using the Trust's Access &amp; Information Centre and providers of services.</td>
<td>April 2012</td>
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<tr>
<td>Outcome</td>
<td>Success Measure</td>
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| Provide for improved integration of hospital and community services for older people to prevent unnecessary hospital admission and support timely discharge, enabling people to return home earlier. | - Establishment of integrated care teams for adults and older people to provide co-ordinated person centred care.  
- Establishment of Reablement Teams across the Trust.                                                                                                                                                                                                                                           | March 2011  
April 2013 |
| Provide a range of rehabilitation services in the community setting.                                                                                                                                                                                               | - Development of one stop assessment clinics in non-acute hospitals.  
- Modernising day care services and other local alternatives, working with partner agencies to ensure that people’s needs can be met closer to their home.  
- Review of day hospitals in Lurgan, Mullinure and South Tyrone Hospitals and development of new services  
- Establishment of Reablement Teams across the Trust.                                                                                                                                                                                                 | June 2010  
January 2011  
March 2012  
April 2013 |
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<th>Outcome</th>
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| Improve the integration of services and ensure clear pathways for older people with long term conditions. | ➢ Establishment of Community Stroke Teams.  
➢ Care pathways to be implemented for Falls, Enteral Feeding and Diabetes services.  
➢ Development of case management for people with chronic diseases.  
➢ Implementation of remote telemonitoring and monitoring for people with COPD, chronic heart failure and diabetes. | September 2010  
March 2011  
March 2011  
March 2011 |
| Provide for skills and competencies within Teams to meet the needs of older people through the development of services and new ways of working. | ➢ Establishment of integrated care teams for adults and older people to provide co-ordinated person centred care.  
➢ Implementation of Staff Health & Wellbeing Strategy.  
➢ Increase in number of staff, at all levels, receiving KSF and PDP development  
➢ Increase in number of care workers who are trained to NVQ3. | March 2011  
March 2011  
March 2011  
April 2013 |