

Draft Older Peoples Strategy Implementation Plan 2009-2014

Chapter Three THEME PROMOTING A HEALTHY AND ACTIVE OLD AGE

Strategic Aim 1 : To improve support to carers who provide care to older people allowing them to feel valued, supported and key partners in care

Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
1.1 Develop a structure and organisation which recognises the important role of carers and provides an assessment process which meets current and future needs	<p>Agree procedures for area teams to conduct assessments and reviews using revised tools</p> <p>Increase awareness of importance of carers role throughout health and social care and their involvement in care planning</p>	Project Officer Carers Strategy	<p>May 2009</p> <p>ongoing process</p>	<p>CCO Q2 90% of carer's assessments completed to national standard</p> <p>% increase of carers assessments</p> <p>Feedback from carers</p>
1.2 Ensure carers are informed of the services and support available to them in a freely and widely accessible way	<p>Work with health point to ensure signposting to services and healthy advice</p> <p>Carers service commissioned to provide information, advice and support across Moray.</p>	Project Officer Carers Strategy	<p>October 2009</p> <p>April 2009</p>	<p>Feedback from carers</p> <p>Regular monitoring and evaluation of delivery of the contracted services and the demand for service.</p>
1.3 Create a structure of respite that supports carers to maintain their caring role and remain healthy both physically and mentally	<p>Increase respite options in the home and residential settings</p> <p>Review reporting and monitoring procedures</p>	Project Officer Carers Strategy	<p>April 2010</p> <p>Jan 2010</p>	<p>% increase in use of respite to support carers</p> <p>Increase the annual provision of respite care to 64 weeks for all client groups including older people.</p> <p>Feedback from carers</p>
1.4 Maintain the health and wellbeing of carers young and old	Progress the Development of health plans for carers as part of the anticipatory care work which is planned see item 6.2	Project Officer Carers Strategy	Jan 2010	Feedback from carers

Strategic Aim 2 : To promote active ageing by ensuring that older people have access to recreational activity, healthy living advice and can participate in the life of their local community

Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
2.1 Ensure that health and social care staff have the skills to deliver health promotion and a self care approach to older people and provide information and advice	Develop integrated workforce development plan See item 10.1	Training leads health and social care	July 2010	Staff development plans
	Link with Long Term Conditions programme self care work stream	Tracey Gervaise LTC	ongoing	LTC stakeholders group
	Use assistive technology where appropriate e.g.COPD met office	Extended community care teams/Lorna Bernard	Ongoing see item 3.6	Establish baseline from accurate statistics and progress uptake of service Service user evaluation
	Learn from Dufftown self care pilot and roll out to other areas in Moray if appropriate	Jan Short Dufftown Self Care Project	ongoing	Pilot feedback report
	Develop self care/management support systems across moray	Tracey Gervaise LTC programme	Aug 2010	LTC stakeholders group
	Implement recommendations from health point review		Jan 09	Service User feedback
	Develop Health Promotion Programmes for older people e.g. bone health	Tracey Gervaise Health Improvement	See item 4.5	Service User feedback
	Ensure Promotion of mental health and wellbeing in later life	M Perera	See item 6.9	Mental Health redesign programme updates

2.2 Improve and develop local services and facilities to meet the needs of locality areas working with voluntary agencies and older people	Establish clubs, leisure, recreational and support opportunities in each locality area	Area operational managers	March 2010	Locality area health improvement action plans
	Examine ways to provide older people with the information			Service user feedback
	Link with library services		March 2010	
	Establish any transport issues		March 2010	
	Identify gaps in locality areas and ensure older people have access to healthy living advice and recreational activities		July 2010	Locality Report
	Complete Moray library services strategy for services to older people	Library Services Strategy Group	Aug 2009	Strategy group records
Progress implementation		2009-2012	Libraries management team	
2.3 To secure appropriate funding to expand and progress BALL project	Continue development of BALL projects across Moray in Rothes, Elgin and Buckie	Irene Weeden	ongoing process	Feedback from BALL groups
	Costs in place for development	Irene Weeden	July 2009	

Strategic Aim 3 : To deliver an expanded range of housing and care options for older people to be supported at home

Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
3.1 Progress the recommendations of the sheltered housing research and consider: <ul style="list-style-type: none"> The suitability of developing extra care housing within each locality in these facilities where possible How housing support can be available through all tenure types 	Review of sheltered housing within each locality	Sheltered Housing review group Iain Terry	Sept 2009	Report of recommendations from SHRG for each locality area % of users receiving housing support not in sheltered housing facilities

<p>3.2 Link the commissioning of housing support and care in sheltered housing or combine within schemes designated as extra care</p>	<p>Progress trial in two Hanover schemes</p> <p>Investigate opportunities in Moray Council sheltered housing schemes</p>	<p>Margaret Storch</p> <p>Iain Terry/ Sheltered Housing review group</p>	<p>Oct 2009</p> <p>Sept 2009</p>	<p>Report of Hanover pilot</p> <p>Report of recommendations from SHRG for each locality area</p>
<p>3.3 Recognise the importance of the care and repair service within the whole system and its impact when waiting times occur</p>	<p>Map process to identify where improvements can be made</p> <p>Develop standards within service to support prompt response</p>	<p>Derek Davidson</p>	<p>Mar 2010</p>	<p>Waiting times for care and repair service measured against agreed standards</p>
<p>3.4 Progress joint OT store in Moray</p>	<p>Ensure flexible access 24 hours / 7 days a week with links to the minor adaptation service and centralisation of equipment across Moray</p> <p>Establish working group to review systems and processes</p>	<p>Jane Mackie</p> <p>Judy Fairburn</p>	<p>Jan 2011</p>	<p>Action plan of working group</p>
<p>3.5 Increase awareness of assistive technology and the opportunities it gives for older people to Health and social care staff and older people/family/carers</p>	<p>Implement Staff awareness programme</p> <p>Implement public awareness programme</p>	<p>Lorna Bernard</p>	<p>July 2010 ongoing</p>	<p>Establish baseline from accurate statistics and progress uptake of service</p> <p>Service user evaluation</p>
<p>3.6 Progress Tele-healthcare strategy for Moray</p>	<p>Service review by JIT</p> <p>Produce strategy document</p> <p>Commence implementation of Telehealthcare strategy</p>	<p>Lorna Bernard</p>	<p>Oct 2009</p> <p>Nov 2009</p> <p>Jan 2010</p>	<p>Tele-healthcare strategy Group</p>
<p>3.7 Review telemedicine process to include appropriate medical response, specialist assessment and advice for Community Hospitals to make optimum use of telemedicine facilities</p>	<p>Link with emergency centre and community hospitals providing solutions</p> <p>Scope out opportunities for tele-rehabilitation</p>	<p>Lorna Bernard</p> <p>Anne Hill</p>	<p>Dec 2009</p> <p>Jan 2010</p>	<p>Monitor use of telemedicine facilities in community hospitals</p> <p>Scoping report</p>

4.5 Continue to educate staff and public on bone health and reducing falls	Implement training sessions, home hazard checks, Visual assessment, promotion of self care	Anne McKenzie Millie Shepherd	ongoing	Training programme records
	Work with home care and voluntary agencies re hazard checks		ongoing	
	Falls management training		ongoing	Knowledge skills framework in health and employment review and development process in social care
4.6 Improve access to suitable services e.g. strength and balance training, home hazard checks, medication reviews, visual assessment	Ensure accessible services across Moray e.g. strength and balance classes	Anne McKenzie Millie Shepherd	ongoing	User satisfaction evaluation
	Work closely with pharmacy around medication review as part of falls assessment		March 2010	
	Investigate transport solutions		March 2010	
4.7 Improve the nutritional status of dependent older people in Moray moving from a traditional Meals and Wheels service towards an older people's nutritional service	Develop training programme for staff across health and social care re nutrition for older people including care home and sheltered and very sheltered housing staff	Audrey Steele	Ongoing	Training Programme
	Develop nutritional screening tool and practical nutritional and food guidance pack guide for home carers		In progress	Monitor use of tool Guidance pack for home carers
	Liaise with food providers e.g. MOW, lunch clubs to optimise nutrition within meals and progress standardisation of recipes and nutritional standards for Moray		March 2010	Development of Nutritional standards
	Investigate requirement for generic supplements for care home residents		In progress	Clinical Audit
	Provide support for bereaved older people or socially isolated at risk of malnutrition		In progress	Service user feedback
	Support proposal of dedicated dietetics service for mental health patients		In progress	Service user feedback

4.8 Ensure the healthy older population has appropriate access to nutritional guidance and advice	Continue liaison with staff from primary care and health promotion regarding nutritional advice for the generally healthy older generation	Audrey Steele	ongoing	Service user feedback
Strategic Aim 5 : Management of long term conditions to ensure optimum independence and promotion of self care				
Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
5.1 To support the management of older people with LTC's and complex needs who are at risk of recurrent admission and institutional care	Link with LTC programme See item 6.2	Tracey Gervaise	2011	T6-To achieve agreed reductions in rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD from 2006/7 to 2010/11
Chapter Four THEME IMPROVING COMMUNITY BASED SERVICES				
Strategic Aim 6 : To Improve integrated health and social care services in the community to ensure high quality, efficient and cost effective services which enable more older people to remain independent and living at home				
Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
6.1 Work towards extended community care team model across moray: find solutions for Elgin / Lossiemouth area	Develop extended community care teams around community hospitals - resource hubs . Involve voluntary and other agencies to provide robust community support. Look at ways to provide an integrated anticipatory and preventative approach in communities which supports self care	Area Operational Managers	Ongoing process	health and social care staff satisfaction service user evaluation T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.
6.2 Area profiling of locality areas to identify <ul style="list-style-type: none"> • Those at high risk • focusing on management of complex care in the frail older person • Existing community support systems in area 	Using local/national tools e.g. SPARRA data, practice data, Health Intelligence and local knowledge: Develop core multidisciplinary teams which meet regularly to develop and introduce advanced/ anticipatory care plans and patient management plans	Area Operational managers Extended community care teams	Nov 2009 Nov 2009	T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05. R3: Reduce the number of people 65+ admitted twice or more as an emergency by 20% (compared against 2004-05) who

	<p>Develop anticipatory/advanced care plans for those at risk of potential health/social crisis and admission/readmission to hospital</p> <p>Target and deliver a proactive case/care management approach to complex cases by appropriate professionals e.g. Care manager, CPN ,DN ,AHP</p> <p>Develop “at risk” registers shared across health and social care - standardise and agree criteria</p> <p>Adjust register accordingly in local areas and agree those requiring case management</p> <p>Develop systems to communicate and share ACP’s across the system</p>	<p>Extended community care teams</p> <p>Locality Anticipatory care group</p> <p>Extended community care teams</p> <p>Tracey Gervaise LTC</p>	<p>Mar 2010</p> <p>Ongoing process</p> <p>Ongoing process as develops</p> <p>Dec 2009</p>	<p>have not had an assessment</p> <p>% of older people with anticipatory care plans</p> <p>No of older people on “risk” register</p> <p>No of people on “risk” register with case manager</p> <p>LTC stakeholders group</p>
<p>Community Care services</p> <p>6.3 Develop capacity to deliver personalised services</p> <ul style="list-style-type: none"> Working with service users and carers as partners Simplifying our bureaucracy Enhancing social work skill and competency Increase the range of services available personalising services Monitor and learn from experience to make further improvements Ensure all roles contribute to improving service user outcomes 	<p>Establish learning needs analysis</p> <p>Develop use of direct payments and consider ways in which it can support re-enablement</p> <p>Ensure Personalised care packages for individuals</p> <p>Promote self directed care and personalisation in community care services</p> <p>Use monitoring and evaluation results to inform further improvements</p> <p>Work closely with service users and carers as partners to ensure positive outcomes for older people</p>	<p>Joyce Lorimer</p> <p>Margaret Stlorach</p> <p>Senior Community Care Officers</p>	<p>Dec 2009</p> <p>ongoing</p> <p>ongoing</p> <p>ongoing</p> <p>ongoing</p> <p>ongoing</p>	<p>employment review and development process in social care</p> <p>Increased uptake and monitoring of direct payments</p> <p>Q1:90% of user assessments completed to national standard.</p> <p>Q3: 90% of care plans reviewed within agreed timescale.</p> <p>Service user evaluation</p> <p>A2: No of people waiting longer than target time (4 weeks) for assessment. (Older People).</p> <p>BC3: To achieve a 1% increase of people 65+ receiving personal care at home over the next five years</p>
<p>6.4 Ensure timely access to flexible home care and carers support</p>	<p>Roll out “Home from Hospital Team” to all areas in Moray.</p> <p>Re-tender external domiciliary care services to increase availability and quality of care</p>	<p>Charles McKerron</p>	<p>May 2009</p> <p>July 2010</p>	<p>Quarterly figures on clients using service</p> <p>Service user satisfaction</p>

6.5 Embed the concept of personalisation and enablement into all home care activity	Pilot the use of an enabling and re-abling role in Keith and Speyside to support individuals to achieve care tasks independently and minimise the amount of care required	Charles McKerron	Nov 2009	BC2: To achieve a 30% increase of people 65+ with intensive needs receiving care at home by 2008
	Develop assessment and care planning which will support this model	Anne McKenzie	Nov 2009	BC1: To shift the balance of care from institutional to 'home based' care. (Older People) by investing 1% from institutional care to home care annually until 2011
	Progress Moray home care development plan	Home Care Development group	ongoing	Home Care Development Plan
6.6 Ensure there is sufficient carers in each area to meet growing demand on the service	Increase service in all areas to meet growing demand	Charles McKerron	ongoing	T8-Increase the level of older people with complex care needs receiving care at home. Monitor the capacity quarterly
6.7 Integrate HFH Team with other Community Support teams in Elgin/Lossiemouth areas	Ensure integrated working with other community support teams e.g. Community care assistants, Spynie Therapy Team as part of the community rehabilitation and response team	Charles McKerron	Feb 2010	T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.
6.8 Redesign day services around the needs of older people and expected outcomes	Examine the role of day services in anticipatory care/prevention and intermediate care	Sarah Omand Anne McKenzie	Ongoing process	Service user Forum and evaluation Audit of client outcomes achieved
	Develop a system for quality assurance monitoring outcomes for older people.	Sarah Omand	Ongoing process	Service Quality questionnaire
	Review job description for care assistant day care staff to include rehabilitative model	Sarah Omand	July 2009	
	Pilot potential of Nintendo wii for physical, mental and social wellbeing	Sarah Omand	June 2009	Service user feedback
	Upgrade day service buildings	Sarah Omand	Ongoing process	
6.9 Increase the provision of specialist dementia care or alternatives and	Progress adult mental health redesign programme	Mike Perera	ongoing	Older Adult Redesign Steering Group Initial workshop held to consult and share

development of the level and quality of day opportunities available for people with dementia				views on proposed community team structures, staffing etc. A further workshop is to be held late August/early September
6.10 Move from a traditional meals on wheels service towards an older people and nutritional service	See item 4.6 Encompass other ways of helping older people to improve their nutritional status Working in partnership with dietitians and local organisations	Audrey Steele Senior Community care Officers	ongoing	Service user satisfaction
Pharmacy 6.11 Continue to identify where work can be progressed in supporting and providing pharmaceutical care for people with long term conditions and complex needs	Provide pharmaceutical care for older people e.g. regular medication review Link with LTC programme Link with screening programme	Sandy Thomson	Ongoing as other programmes develop	Records of LTC programme and screening programme
Strategic Aim 7 : To improve 24 hour response services for older people reducing unnecessary admissions to hospital, residential and nursing care				
Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
7.1 Provide rehabilitation services locally with a strong community focus	Ensure AHP's represented in all planning and development of services at the earliest stage e.g. review of the virtual medical ward/medical pathway Refocus therapy team to over 65's and people with LTC's Re-establish links to Dr Grays Hospital Pilot integration of Elgin and Lossiemouth therapy team with other existing support teams to provide one 24/7 community rehabilitation and support team in the Elgin/Lossiemouth area Consider Roll out of model to community hospital areas if appropriate	Anne McKenzie Anne McKenzie Anne McKenzie Sandra Gracie Anne McKenzie	Ongoing process Mar 2010 Mar 2010 Sept 2010	Monitoring of services R2:No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000 T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05. Report of pilot
7.2 Ensure rehabilitation service is accessible to those that use services, including direct access when essential	Investigate single point of contact/access Ensure a systematic approach to delivering	Anne McKenzie	Mar 2010	Service user satisfaction

	<p>rehabilitation to individuals promoting independence and self management</p> <p>Ensure rehabilitation services cater for the distinct phases of care and identify models to enable seamless transitions</p> <p>Identify transport issues and feed into Grampian transport group</p>		<p>Mar2010</p> <p>Mar 2010</p> <p>Mar 2010</p>	<p>Grampian transport group</p>
7.3 Ensure health and social care professionals critically review the use of the current staff resource through services redesign and skill mix review when implementing the rehabilitation framework	<p>Link with rehabilitation co-ordinator</p>	<p>Area Operational Managers</p> <p>Anne McKenzie</p>	<p>Ongoing process</p>	<p>Rehabilitation action plan</p>
Adult Mental Health 7.4 Progress review and redesign programme to provide a service which is community based, supports a preventative and anticipatory approach and meets the needs of the community	<p>Promote mental health and wellbeing in later life</p> <p>Complete review and redesign programme in Adult mental Health</p> <p>Raise awareness of the population about the prevention of dementia</p>	<p>Adult Mental Health review and redesign team</p>	<p>As per adult Mental health review and redesign programme plan</p>	<p>T9 Each NHS board will achieve improvements in the early diagnosis and management of patients with dementia Service user evaluation</p>
<p>Strategic Aim 8 : To develop intermediate care facilities within the home and close to home preventing unnecessary admissions to hospital, facilitating early hospital discharge and preventing premature admission to residential and nursing care</p>				
Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
8.1 Commission Intermediate Care beds for the Elgin/Lossiemouth locality closer to home	<p>Secure contract in Elgin for beds in Nursing Home</p>	<p>Elena Geddes</p>	<p>May 09</p>	<p>Monitor bed usage</p>
8.2 To develop a menu of Intermediate Care services across Moray	<p>Review the role of community hospitals in intermediate care see item9.9</p> <p>Develop intensive re-ablement for patients over 65 attending A&E</p> <p>Support the development of an enhanced home care service</p>	<p>Jamie Hogg/ Anne McKenzie Elena Geddes</p> <p>Elena Geddes</p>	<p>Nov 2009</p> <p>April 2011</p> <p>Ongoing process</p>	<p>Report of review</p> <p>T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.</p>

	Implement early supported discharge intermediate care model	Elena Geddes	April 2011	R2:No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000
Palliative and Terminal Care 8.3 Develop palliative and terminal care strategy to include the need of the growing older population and their needs Acknowledging end of life care for frail elderly	Develop palliative care strategy document Pilot electronic palliative care summary in Moray	Jane Mackie Gordon Pringle	Jan 2010 June 2008	Moray Strategic Palliative Care Group report of pilot
8.4 Commission palliative care bed for Elgin/Lossiemouth population	Secure palliative care bed	Elena Geddes	May 2009	Monitor bed usage
8.5 Increase in usage of Marie Curie Service	Link with Marie Curie around end of life care for the frail elderly and supported discharge	Jenny Williams	April 2010	Monitor use of MC service Service user evaluation
8.6 Develop palliative care specialism	Progress work of palliative care group Develop rapid discharge pathway from hospital	Palliative care working group	Dec 2010	To achieve 100% success rate for people who wish to die in their own homes by 2010 compared to 2004-05 (or an alternative non-hospital setting). (Determine baseline).
Chapter Five THEME IMPROVING HOSPITAL AND RESIDENTIAL CARE				
Strategic Aim 9 : Ensure a seamless patient pathway through hospitals in Moray which meet standards of care for older people and ensure that the value of every move is beneficial to enabling them to return to maximum independence as close to home as possible				
Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
9.1 Provide improved access to medical and nursing advice out of hours to older people in Moray	Roll out booklet "important information for older people" a resource provided by NHS 24 and help the aged Link with NHS 24 and OOHRS services Adopt an anticipatory approach	Sandra Gracie Caroline Paterson	Nov 2009 Nov 2009	Service user feedback T10: To support shifting the balance of care NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.

<p>9.2 Acknowledge the national shortage of geriatricians and endeavour to recruit when possible in order to provide a comprehensive geriatric assessment services within a supporting infrastructure</p>	<p>Progress locum support in the interim</p> <p>Investigate other solutions for providing a comprehensive geriatric assessment e.g. physicians assistant, assessment tools</p> <p>Work towards early involvement of geriatrician and a comprehensive geriatric assessment in AMU</p>	<p>Jamie Hogg</p>	<p>ongoing</p>	<p>Moray Management Group</p>
<p>9.3 Progress 18 week whole journey standard from GP referral to access to hospital services</p>	<p>Progress planned care programme</p>	<p>Issie Graham</p> <p>Planned care group</p>	<p>Mar 2010- dec2011</p>	<p>A10-Delliver 18 weeks referral to treatment from 31December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting to admission for an inpatient or day case treatment from March 2010.</p>
<p>9.4 Progress the development of the pre-assessment unit</p>	<p>Incorporate older people's needs into the discharge plan</p> <p>Consider providing an outreach pre assessment service to other locality areas</p>	<p>Issie Graham</p> <p>Planned care group</p>	<p>Sept 2009</p> <p>Ongoing process</p>	<p>service user evaluation</p> <p>Project development reports</p>
<p>9.5 Reduce the average length of stay for older people by 10%</p>	<p>Revisit roll out of discharge policy and procedure to all professionals and ward areas, monitor and evaluate</p> <p>Commence work on admission/transfer policy</p>	<p>Caroline Paterson/Pat Catto</p> <p>Community Hospital managers</p>	<p>Oct 2009</p>	<p>Monitor and audit discharge as per discharge protocol</p>
<p>9.6 Roll out of national recording system for delayed discharges and monitoring of the patients journey</p>	<p>Complete Edison training</p> <p>Roll out system to community hospitals</p> <p>Investigate benefits of roll out to DGH to record the total patient journey</p>	<p>Elena Geddes</p>	<p>June 2009</p> <p>Mar 2010</p>	<p>Edison system when implemented</p> <p>Feedback from users</p>

<p>9.7 Improve the flow of patients through DGH to meet national standard of maximum waiting time of four hours</p>	<p>Implement findings from medical pathway review</p> <p>Record and Monitor amount of decanting and progress steps to eliminate “decanting of older people”</p> <p>Ensure discharge planning commences on admission</p> <p>Ensure expected date of discharge agreed with patient and relatives within 24 hours</p>	<p>Caroline Paterson</p> <p>Alison Smart</p> <p>Alison Smart</p> <p>Alison Smart</p>	<p>Nov 2009</p> <p>Ongoing process</p> <p>June 2009-08-03</p> <p>Ongoing process</p>	<p>National standard of maximum waiting time in A&E 4 hours</p> <p>Reduction on number of older people decanted</p> <p>Discharge planning commences in AMAU</p> <p>Regular discharge audit as per discharge protocol</p> <p>Record of delayed discharges</p>
<p>9.8 Clarify the role of 23 hour beds in DGH</p>	<p>Agree criteria for use of 23 hour bed</p>	<p>Medical Pathway review group Jamie Hogg</p>	<p>Dec 2009</p>	<p>Report of medical pathway review group</p>
<p>9.9 Revisit the role of the virtual medical ward and care home network within the context of a projected growth in the elderly population and specific outcomes and value of transfer for individual</p> <p>Review the role of community Hospitals within the context of projected growth within each locality and the needs of the local population</p>	<p>Review older peoples pathway</p> <p>Review medical pathway</p> <p>Examine alternatives for Elgin/Losiemouth population</p> <p>Agree the role of community hospitals for the future e.g. intermediate care and rehabilitation, outreach service, assessment, resource hub</p> <p>Consider possibility of elgin/Losiemouth community resource hub</p>	<p>Jamie Hogg</p> <p>Elaine Brown</p>	<p>Ongoing</p> <p>Complete by Mar 2010</p>	<p>Report and recommendations</p>
<p>9.10 Continue working towards meeting agreed standards of care in Moray hospitals</p>	<p>Monitor QIS standards of care for older people in acute services</p> <p>Progress action plan for above and update every 6 months</p> <p>Progress and monitor Community Hospitals standards of care</p>	<p>Issie Graham Liz Tait</p> <p>Community Hospital managers Louise Black</p>	<p>Ongoing process</p> <p>Ongoing process</p>	<p>QIS standards for older people in acute care action plan reports</p> <p>Community Hospital Action plan reports</p>

<p>Care Homes</p> <p>9.11 Ensure that older people in care homes have appropriate access to both primary and specialist health care service</p>	<p>Set up support mechanisms where appropriate e.g. DN allocation to care home</p> <p>Forge links with Community rehab and support team</p> <p>Improve admission /discharge pathway from hospital for care home clients</p> <p>Develop anticipatory care plans</p> <p>Share training resources</p>	<p>Jane Mackie</p> <p>Care Home Owners partnership group</p>	<p>Ongoing process</p>	<p>Care Home User feedback</p> <p>% of acute admissions from nursing home</p> <p>Care Home Owners Meeting records</p>
<p>9.12 Through the provision of improved and increased community based services limit the need for moving to a care home</p>	<p>See item 6.1-6.11</p>	<p>Jane Mackie</p>	<p>2009-2011</p>	<p>BC1: To shift the balance of care from institutional to 'home based' care. (Older People) by investing 1% from institutional care to home care annually until 2011</p>
<p>9.13 To work with the independent sector providers to increase the quality of care homes including increased availability of single rooms and enhancing opportunities for social activities</p>	<p>Link standards of care to national contract</p> <p>Ensure high standard of care which meets the national care standards</p> <p>Offer training opportunities</p>	<p>Jane Mackie</p>	<p>Ongoing process</p>	<p>Audit against national care standards for care homes</p> <p>Care home users feedback</p> <p>Care Commission</p>
<p>Chapter Six THEME MAKING THE STRATEGY WORK</p>				
<p>Strategic Aim 10 : Develop a workforce where there is no ageism and the staff have the skills that meet older peoples needs, understand the needs of older people and foster an enabling and rehabilitative approach</p>				
<p>Priorities for Improvement</p>	<p>Action to be taken</p>	<p>Lead</p>	<p>Timescale</p>	<p>Keeping Track</p>
<p>10.1 Progress an integrated workforce development strategy to progress older peoples strategy</p>	<p>Develop a confident and competent workforce</p> <p>Establish group to take forward workforce issues from workshop</p> <p>Implement recommendations from workforce development workshop</p> <p>Establish learning needs analysis</p>	<p>Linda Mckerron</p> <p>Joyce Lorimer</p> <p>Workforce development group</p>	<p>Ongoing over next 5 years</p>	<p>Workforce development group records</p> <p>Older peoples integrated workforce plan</p> <p>Staff development plans</p>

	<p>Maximise skills of workforce across health and social care</p> <p>Develop community nursing role</p> <p>Develop new roles where required</p> <p>Examine the multi-agency capability framework for supporting staff across intermediate care services</p> <p>Link with Long term Condition training needs analysis</p> <p>Link with rehabilitation framework</p> <p>Include voluntary and independent sector</p>			
10.2 To develop the role and management of home care	<p>Review all job descriptions</p> <p>Review all roles</p> <p>Develop and implement an extended hours contact system and emergency contact system</p> <p>All home carers will be trained to support individuals to achieve care tasks independently – enabling role</p> <p>Develop the skills of care organisers in risk assessment and risk management and communication and listening skills</p> <p>Develop “Managing challenging behaviour” policy and review “lone working policy”</p>	<p>Charles McKerron</p> <p>Jacqui Short</p> <p>Charles McKerron</p> <p>Charles McKerron</p> <p>Jacqui Short</p>	<p>July 2009</p> <p>Nov 2009</p> <p>Nov 2009</p> <p>Aug 2009</p> <p>Nov 2009</p>	<p>Staff development plans and training records</p>
10.3 Ensure health and social care staff including care homes and voluntary services have the skills to meet the needs of older people and provide a proactive and anticipatory approach to care	<p>Consider joint training initiatives</p> <p>Consider job shadowing for understanding of other roles</p> <p>Establish where AHP, Nurse led discharge would be appropriate and develop</p>	<p>Workforce development group</p>	<p>Aug 2010</p>	<p>Staff development plans</p> <p>Service user feedback group</p>

Strategic Aim 11 : Improved information and advice about the services and facilities for both staff and users/carers

Priorities for Improvement	Action to be taken	Lead	Timescale	Keeping Track
11.1 Progress and develop communication plan and update throughout implementation	Engage with older people and their carers Establish an Older peoples reference group which will oversee the monitoring and delivery of the strategy	S Gracie and Anne Griffith	Ongoing	Communication plan Older Peoples reference group
11.2 Determine ways to involve older people in developing, improving and reviewing services	Through patient participation groups, community forums and service user groups	S Gracie and Anne Griffith	Ongoing	Feedback from new nursing documentation Annual service package review
11.3 Ensure older people gain easy access to Information and advice	Investigate single point of access to older people for information and advice Clearly market information and advice at the older population Signpost older people to key services and request feedback for ideas for improvement Develop leaflets re services Designing better services team looking at website use for self referral processes Examine possibility of dedicated older peoples website/resource	S Gracie S Gracie S Gracie S Gracie DBS team DBS team	Ongoing process May 2009 ongoing ongoing	Service User Feedback Service User Feedback Service User Feedback Service leaflets and service user feedback DBS recommendations DBS recommendations
11.4 Progress information sharing protocol in Moray	Agree information sharing protocol to allow health and social care staff working together to access both health and social care systems	Sandy Riddell Andrew Fowlie	Mar 2010	Information sharing document

11.5 Ensure practitioners and providers in health and social care are better informed about current and evolving roles and expertise within rehabilitation services	Provide regular updates around rehabilitation for staff	Anne McKenzie	Ongoing process	Staff feedback
11.6 Ensure staff across health and social care are aware of services available to support older people in the community	<p>Incorporate services available into local induction programme</p> <p>Update staff regularly on progress of Older Peoples Strategy implementation</p>	<p>Induction Group</p> <p>Sandra Gracie</p>	<p>Aug 2010</p> <p>ongoing</p>	<p>Staff feedback</p> <p>Staff updates</p>
11.7 Ensure a whole systems approach to transport, to provide opportunities for older people	<p>Link with Grampian transport group</p> <p>Examine solutions for local transport issues</p>	Sandra Gracie	Jan 2010	Service user feedback/ complaints