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Section 1
Introduction
Section 1: Introduction

1.1 This strategy is about change. We wish to create a vision for the future of services for older people. It will promote health and well-being, maximise independence, develop long-term living options and allow people with complex needs to be supported in the community.

1.2 Health and social care services, however, are only a small part of the support that older people value and only a small part of the experience of growing older.

1.3 The strategy describes how services for older people will be developed over the next five years and it provides a vision of how all our services will work together to support older people in maintaining better health and well-being.

1.4 Older people are citizens with important roles in supporting families and within communities. We recognise that older people are also the biggest providers of support to other older people.

1.5 In preparing this strategy we asked our staff, local people and organisations that represent older people’s interests, to tell us what was important to them about their needs and how we could improve services. They told us that they would like services to be more flexible and better organised so that older people could be supported to remain independent, for as long as possible. They also told us that when older people became frail and ill, they needed specialist care, as far as possible, at home.

1.6 The strategy describes how we will develop new approaches in the way we deliver services for older people and new forms of care and treatment. Advances in technology provide us with opportunities to deliver more effective services in different ways and in different settings.

1.7 We are developing a separate strategic plan for services for people with dementia and older people with mental health conditions. Both strategies will complement each other.

1.8 In developing this strategy we have engaged with the Northern Board and agreed that the strategy will provide the Trust’s direction for health and social services for older people.

1.9 In the first years of this strategy there will be major change in the way health and social services, as well as other public bodies, in Northern Ireland are organised. The changes to be made by the Review of Public Administration (RPA) and Developing Better Services will affect how and where services are provided to the population. For health and social services, a Health and Social Services Authority and Local Commissioning Groups have replaced the four Health and Social Services Boards. The number of Trusts has reduced to five. The amalgamation of the three Trusts in the Northern area into the Northern HSS Trust provides us with the opportunity to organise, manage and deliver services that are cost effective and truly centred on the needs of older people.

1.10 We have taken a view on what is achievable and affordable. Further work will be required to develop a detailed implementation plan with targets and timescales. We recognise that it will take longer than five years to fully meet all our aspirations, however this strategy provides a framework within which a lot can be achieved in modernising and developing services for older people and their carers.

1.11 The purpose of the strategy is:

- to provide a clear direction for services for older people;
- to make sure that services provided to the older people are efficient and effective, based on the assessed individual needs;
- to make sure that older people retain control over their lives by providing support, in their own homes, for as long as it is needed;
- to inform the planning of services and support provided by other agencies and organisations;
- to recognise and address the needs of those who are or feel excluded, including older people who live in poverty and black and minority ethnic groups; (Ref. 1)
- to challenge negative attitudes towards ageing;
- to recognise that carers provide the greater amount of support to older people and respond to carers needs as individuals; (Ref. 1)
- to commit to involving older people and their carers in planning, reviewing and monitoring services; and
- to make sure we have the right number of skilled, properly trained and qualified staff to provide services.

1.12 Older people are a highly diverse population with different experiences of growing older, different lifestyles, different beliefs, different attitudes and different approaches to ageing. And we know that older people may need varying levels of support at different times. Therefore, the strategy describes a range of support and services, appropriate to individual needs, circumstances and environments.
Section 2
Our values and principles
Section 2: Our values and principles

2.1 Mission Statement
“To provide for all, the quality of service we expect for our families and ourselves.”

2.2 Core Values
The Northern Health and Social Care Trust is committed to the following core values:

Patient/Client Centred
Patients’ and clients’ interests will be at the centre of all decision making processes. We will strive to make services more responsive to those who use them.

Engagement
A culture of engagement with patients, clients, carers and their nominated representatives will be fostered.

Open and Honest
We will be responsive to the needs of patients and clients. Our staff will be open and honest in their dealings with the public and with each other.

Respect for Others
The views of staff will be listened to, valued and taken into consideration.

Team Working
We are committed to team working both uni-professional and multi-disciplinary.

Professionalism
Staff will be expected to take responsibility, account for their actions and adhere to their respective professional codes of practice.

Excellence
The Trust will improve the quality of services and achieve best value.

Striving for Improvement
We will strive to improve performance continuously and end unsafe or inappropriate practice.

High Performance
The Trust will maintain a focus on outcomes and a drive for results. The Trust will use its resources to best effect to deliver services that are safe and fit for purpose.

2.3 In developing this strategy we have established the following principles, based on the Trust’s vision and values:

- we will make sure that older people are never discriminated against in accessing health and social services as a result of their age;
- we are committed to promoting positive images of ageing and making sure that older people and their carers have a stronger voice in the planning of services;
- we will respect the wishes of the individual by providing services that make sure older people are treated as individuals and receive appropriate and timely intervention, which meets their needs as individuals, regardless of health and social services boundaries.

Supportive Organisation
Staff will be encouraged to support one another in the discharge of their duties. We will foster a supportive working environment in which staff will be able to give of their best.

Innovation
We will promote good practice and will be at the leading edge of reform, modernisation and innovation in service delivery.
Section 3
The context in which we work
Section 3: The context in which we work

3.1 We must modernise and reform services to make sure that the individual is always at the centre of what we do. We must make sure that resources are focused on delivering services that are flexible, responsive, and efficient and represent good value for money.

3.2 The strategy is designed to meet the key priorities of our commissioners, the Northern Health and Social Services Board. And, the implementation of RPA - the Health and Social Services Authority and Local Commissioning Groups.

3.3 The Strategy was developed in consultation with a wide range of stakeholders. The first stage of consultation involved engaging with representative groups and individuals and staff through a range of workshops to test the initial themes of the strategy. At this stage questionnaires were also issued to all residential and nursing home providers as well as GP practices. Service user and team questionnaires sought the views of users and carers. Once the draft strategy was developed, a workshop was held with Trust Board and it was approved for formal consultation. The formal 12-week consultation process included a second round of workshops with staff and representative groups and individuals to gather views on the draft document. The consultation process detailed above has enabled the Trust to create and maintain links with local people, our partners and staff, to help us provide better services for older people living in the Northern Trust area.

3.4 In addition to extensive consultation with users of services and staff, the strategy has been informed, influenced and shaped by legislation, regulation and policy detailed in Appendix 1.

3.5 This is an ambitious agenda for improving services and quality of life for older people. The focus is on enabling older people to remain as active and independent for as long as possible and putting services in place that can effectively respond to their acute and chronic needs. Choice is a constant theme throughout and is at the heart of the Government’s public service reform agenda.

Section 4
The changing needs of the population
Section 4: The changing needs of the population

4.1 It is important in responding to the needs of an increasingly ageing population that we must focus our limited resources on those in greatest need.

4.2 Northern Ireland is an ageing society. Age Concern NI (Ref. 15) estimates that there will be a 47.8% increase in the 60 to 74 year olds and a 56.7% increase in the over 75 year population by 2023.

4.3 At the last Census (Ref. 16) in 2005 mid year estimates, the number of people aged 65 and over living in the Local Council areas within the Northern Trust was over 61,000. It is estimated that by 2015 the number of people over 65 in the Trust area will increase by 25%. This presents a significant challenge to the Trust in developing services at a time of increasing demand, but with limited resources.

4.4 In addition we are mindful of and welcome the changing nature of our society. We are becoming a more culturally and ethnically diverse community and our services, along with others, will respond so that we provide appropriate culturally sensitive services and support.

4.5 Recent Department for Social Development (DSD) figures indicate that 31,421 people from 120 countries applied for National Insurance numbers between April 2003 and June 2005. Many migrants to Northern Ireland will remain and grow older here. We will take account of this when planning services.

Table 1: Northern Health & Social Care Trust - over 65 population 2005 - 2015

<table>
<thead>
<tr>
<th></th>
<th>2005 M</th>
<th>2005 F</th>
<th>2015 M</th>
<th>2015 F</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>2,498</td>
<td>3,204</td>
<td>5,702</td>
<td>4,213</td>
<td>7,913 39%</td>
</tr>
<tr>
<td>Ballymena</td>
<td>3,965</td>
<td>5,333</td>
<td>9,298</td>
<td>6,481</td>
<td>11,346 22%</td>
</tr>
<tr>
<td>Magherafelt</td>
<td>2,163</td>
<td>2,702</td>
<td>4,865</td>
<td>3,269</td>
<td>5,972 23%</td>
</tr>
<tr>
<td>Cookstown</td>
<td>1,792</td>
<td>2,318</td>
<td>4,110</td>
<td>2,951</td>
<td>5,315 29%</td>
</tr>
<tr>
<td>Larne</td>
<td>2,030</td>
<td>2,739</td>
<td>4,769</td>
<td>3,423</td>
<td>6,031 26%</td>
</tr>
<tr>
<td>Carrickfergus</td>
<td>2,294</td>
<td>3,204</td>
<td>5,498</td>
<td>3,845</td>
<td>7,263 32%</td>
</tr>
<tr>
<td>Newtownabbey</td>
<td>5,099</td>
<td>7,001</td>
<td>12,100</td>
<td>8,136</td>
<td>14,383 19%</td>
</tr>
<tr>
<td>Moyle</td>
<td>1,105</td>
<td>1,447</td>
<td>2,552</td>
<td>1,888</td>
<td>2,751 8%</td>
</tr>
<tr>
<td>Ballymoney</td>
<td>1,744</td>
<td>2,285</td>
<td>4,029</td>
<td>2,980</td>
<td>5,270 31%</td>
</tr>
<tr>
<td>Coleraine</td>
<td>3,686</td>
<td>5,081</td>
<td>8,767</td>
<td>6,314</td>
<td>11,031 26%</td>
</tr>
<tr>
<td>Overall total</td>
<td>26,376</td>
<td>35,314</td>
<td>61,690</td>
<td>43,175</td>
<td>77,275 25%</td>
</tr>
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</table>

4.6 Although, on average, females live longer than males, a greater proportion of a female’s lifespan is lived in ill health - 15% compared with 12% (Ref. 17).

4.7 Conditions that account for most disease in the United Kingdom are primarily related to older age (Ref. 18). In addition, the largest concentration of health and social care provision and costs occur in the last year of a person’s life. As people grow older, so expenditure on their health and social care increases. For example, currently there are approximately 3,843 people receiving a range of homecare services. This gives an indication of the level of need and service provision within the Trust.
Section 5
How services are funded
Section 5: How services are funded

5.1 In 2004/05 the Northern Area Trusts spent about £100 million of its total budget on services for older people. In implementing this strategy we must make sure that the considerable resources already expended on services for older people are used in ways that result in the greatest benefits for older people.

5.2 Our commitment is to use all the resources available to us, to develop and deliver responsive and flexible services for older people when they need them and for as long as they need them.

5.3 The Table below reflects the cost of caring for people at different ages. It shows a large increase of cost at over 65.

Table 4: Allocation of funding by population

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<tbody>
<tr>
<td></td>
<td>%</td>
<td>£m</td>
<td>%</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>EHSSB</td>
<td>40.83%</td>
<td>£1,015m</td>
<td>39.91%</td>
<td>£992m</td>
<td>£23m more</td>
</tr>
<tr>
<td>NHSSB</td>
<td>23.93%</td>
<td>£595m</td>
<td>24.27%</td>
<td>£603m</td>
<td>£8m less</td>
</tr>
<tr>
<td>SHSSB</td>
<td>18.33%</td>
<td>£456m</td>
<td>18.65%</td>
<td>£464m</td>
<td>£8m less</td>
</tr>
<tr>
<td>WHSSB</td>
<td>16.91%</td>
<td>£421m</td>
<td>17.17%</td>
<td>£427m</td>
<td>£6m less</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>£2,487m</td>
<td>100%</td>
<td>£2,487m</td>
<td></td>
</tr>
</tbody>
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5.4 The funding we receive for services for older people is below the Northern Ireland average. Overall, capitation in the Northern Health and Social Services Board (NHSSB) area is £8 million under the Northern Ireland average - see Table 4.

5.5 We will work with commissioners to make sure that the Northern HSS Trust is allocated an appropriate share of resources in keeping with the size and needs of the population of older people.
Section 6
Changing the way we work
Section 6: Changing the way we work

6.1 Putting service users first is the core element of this strategy. We will change the way we deliver services by placing the service user at the heart of what we do. We want to make it easier for older people to get the service they need by making it quicker and simpler for them to contact us. We also need to make sure that we put more resources into frontline services and eliminate waiting lists.

**How we will achieve this**
- We will improve the way we work to deliver services that, as far as is possible, meet individual need and provide choice.
- We will become more efficient in managing and delivering services and eliminating waiting lists.

6.2 We must work together to develop a single path into the range of local services available for older people. We know that inter-disciplinary teams can be one of the best ways of making sure that a person’s needs are met quickly and effectively. We will also make sure that staff are supported, individually or in teams, to work closely together and across boundaries to meet individuals’ needs.

6.3 We will further develop integrated working between health and social care professionals in the support and management of the wide range of medical conditions that affect older people.

**How we will achieve this**
- We will continue to develop acute services for people who have had a stroke and those with chronic conditions.

6.4 We need to work more closely with others to develop a broader range of services. Building greater trust and sharing information is essential for this to happen. We must promote better links within our own services to make sure we operate as one organisation.

**How we will achieve this**
- We will engage with other agencies to develop a shared vision and maximise the potential of all available resources.

6.5 As well as the services we provide, staff will know what else is available and who can help. They will work with others to get the right support or services for people. We want to support carers, family, friends and neighbours in supporting older people, particularly those who live alone.

Section 7
Making services more accessible
Section 7: Making services more accessible

7.1 Older people may have difficulty getting the services they need when there is limited information available, particularly when it is unclear how to access services, what different organisations do and how they relate to each other. We will work to remove the barriers to access and simplify the cumbersome and complicated ways in which services are organised and provided.

7.2 We know that we need to improve access to and information about services available to older people by providing a central information and referral point where people can receive information, advice and be referred on to appropriate services. Information should be easy to read and in languages other than English and available through the Internet and by telephone.

How we will achieve this
- We will establish an accessible central information and referral system, operated by trained staff. We will also provide advice on where to get information on a range of matters such as services, benefits and accommodation.
- We will work with primary care colleagues, including general practitioners, to make sure that information is easily accessible.

7.3 We know that the current referral and assessment process can be cumbersome and confusing. A range of professionals working independently of each other can often assess individuals who need help. We will change our practice so that people will not have to provide the same information to more than one care professional. Those involved in assessing need and providing services will share this information, but only as necessary for the treatment and support of the individual.

How we will achieve this
- We will review and analyse the current process involved in assessment and service delivery to identify improvements and changes that need to be made.
- We will work with the University of Ulster and the Department of Health and Social Services and Public Safety in developing a single assessment process.
- We will introduce a Person-Centred Community Information system to support the assessment and provision of care.
- We will develop clear processes and closer integration with Primary Care Services.
- We will develop the Trust’s Information Communication Technology (ICT) infrastructure.

7.4 Health and Care Centres will be developed, by 2017, as part of Developing Better Services. These will support staff by providing them with better accommodation and as a base for assessment, treatment and joint primary care and community services.

Section 8
Moving forward
Section 8: Moving forward

8.1 Because of the diversity of older people’s needs, we describe how we can move forward under three inter-related and overlapping themes.

- **Promoting positive ageing** - to reflect and promote a positive view of ageing, the potential for older people to maintain independence and enjoy good health and quality of life.

- **Living independently with support** - to enable older people to continue to live in their own homes.

- **Living with complex needs** - to make sure that older people maintain dignity and security when they have complex health and social care needs and chronic medical conditions.

### Promoting positive ageing

8.2 Older people’s lives are about more than health and well-being. Transport, housing, leisure facilities, money, companionship and community are all important. We recognise that many older people live active and fulfilling lives involving leisure, learning and work in their communities.

8.3 Changes in lifestyle, even in later life, can bring benefits - longer life, increased levels of functioning, and an improved sense of well-being.

8.4 Older people should have the choice to live independently in their own homes with access to a full range of services. They should also be able to influence the decisions which affect their own lives and communities. An enormous range of activities, interventions and services help to promote independence and prevent or delay ill health and frailty. During consultation, older people told us that better access to health and social care services, transport, community safety and housing repairs and maintenance were of most concern.

### Promoting health and well-being

8.5 Promoting health and well-being for older people is a key component of this strategy and will promote initiatives such as encouraging exercise, improving diet and lifestyle. However, promoting the health and well-being of older people involves all of society, and not just health and social services.

8.6 The increasing numbers of active older people creates opportunities for voluntary work. Volunteering by older people benefits both the individual and the organisation to which they offer their services.

#### How we will achieve this

- We will work with other organisations, including the voluntary sector, to make sure that information on recreation and learning, social activities and volunteering is available for, and easily accessed by, older people to promote independence.

- We will support the development of neighbourhood and community groups in urban and rural areas and work with local Councils in the development of their community plans.

- We will encourage older people to explore their full potential as volunteers within the voluntary sector and work with them to provide appropriate training and support.

8.7 Promoting good mental health will also be a focus for services. We will improve services for older people with mental health conditions, by working more closely within the Trust and with primary care, including general practitioners.
8.8 Healthy eating promotes good physical and mental health. Being either over weight or under weight can have a detrimental effect on an older person’s health and well-being. Healthy eating can reduce illness, falls and fractures and can also address specific disease risks such as cardiovascular disease, stroke, diabetes and osteoporosis. Advice on diet will take into account the older person’s culture and preferences (Ref. 19).

**How we will achieve this**
- We will provide training and information to key staff who deliver services for older people to develop their knowledge to promote healthy and active living and to identify potential risks to health and well-being.
- We will develop services, including the provision of equipment, to support older people with sensory impairment.

8.9 Good oral health is important for the health and well-being of older people, particularly those with chronic and complex health conditions. Problems with teeth gums and dentures can significantly affect the overall well-being of an older person and their ability to age positively. Greater emphasis is now put on developing policies in oral health promotion and oral disease prevention. ‘Oral health promotion must be a role for all involved in the care and support of older people’ (Ref. 20).

**How we will achieve this**
- We will provide training and information to key staff who deliver services for older people to develop their knowledge to promote healthy and active living and to identify potential risks to health and well-being.
- We will work with the Investing for Health Partnership and other initiatives to give people information and support on how to look after themselves.
- We will provide information on oral health more widely to older people and carers, through staff who support and are in contact with older people.
- We will improve the availability of oral health promotion and explore ways of enhancing community dentistry services.

8.10 Capacity to function well relies on mobility. Many older people experience foot and gait problems, which can prevent or reduce their mobility and independence. Increasing age, accompanied by the increasing incidence of chronic diseases, frequently lead to significant complications in foot health. The provision of podiatry services must be a priority. Whilst a significant private podiatry provision exists, it is important that poorer people can access a podiatry service (Ref. 21).

**How we will achieve this**
- We will focus on the development of the Trust’s podiatry service to make sure that those who need this service have better access.

8.11 Hearing loss and visual impairment can increase sharply with age. Mild hearing loss reduces the ability to take part in conversation and so can impact dramatically on an individual’s social life. This can lead to loneliness and isolation. Poor vision can restrict mobility and affect daily living and also lead to isolation.

**Challenging poverty**

8.12 Low income, poor housing and social isolation make it less likely that people will enjoy good health in their older years. These problems can be worse for those in rural areas. Poverty is the greatest risk factor for health and many older people in the Trust area are living in poverty. There are a number of schemes and initiatives to address poverty amongst older people such as Investing for Health and Health Action Zones (Ref. 22).

8.13 For older people, high heating costs can lead to poverty and ill health. Increasing the income of older people leads to better diet and warmer homes, which is likely to improve health and well-being.

**How we will achieve this**
- We will work closely with representative groups, other statutory organisations and the independent sector to address poverty amongst older people.
- We will encourage or direct people to organisations that can assist them in getting the financial benefits and advice to which they are entitled.

**Housing and support**

8.14 During consultation, older people felt strongly that they want to remain in their own home for as long as possible. They told us that they are particularly concerned about personal and community safety and are anxious about crime against older people in their homes.

**How we will achieve this**
- We will work with other organisations to improve home safety and security.
- We will link with local community initiatives, including community safety partnerships that promote safety and security in the home and in the community.
8.15 Housing and the availability of support, to live at home, are often crucial factors in informing the choices older people have to make when they face illness or increased frailty. We are committed to working closely with the Housing Executive (NIHE) and the independent sector to stimulate appropriate and suitable housing and support for older people.

8.16 Working with local communities, voluntary organisations, housing providers and the NIHE will create the environment and support to help people remain in their own homes or alternative accommodation. This can be done with local support, as well as the appropriate use of technology, so that people can be as independent as possible with peace of mind.

8.17 It is crucially important to acknowledge the effect that stress, social isolation, changing family structures and bereavement of a partner, can have on an individual. The availability of help from family and communities, as well as skilled support from social workers for older people, can help deal with these issues and must continue to be addressed.

The relative risks of alcohol consumption become greater as people get older. Sometimes bereavement and isolation can increase the misuse of alcohol and other substances.

How we will achieve this
- We will promote the use of technology in supporting people at home and explore funding opportunities.
- We will work with the Housing Executive to determine the accommodation needs of older people to make sure that adequate provision is developed within the Trust area.
- We will explore ways of influencing housing providers to build or adapt homes that will be suitable for older people when they become frail or ill.
- We will work with the Supporting People Partnership to make sure that housing and support are available to older people to meet their current and future needs to help people remain at home.
- We will work with communities, voluntary organisations and Northern Ireland Housing Executive to assist older people in being as independent as possible and to minimise risks within the home.
- We will improve our equipment service so that people can obtain equipment when they need it, and we will explore opportunities for people to hire or purchase appropriate equipment.
- We will continue to promote social work intervention with older people and their carers.
- We will make appropriate services available to older people with alcohol and substance misuse problems.

8.18 Many older people feel isolated in their own homes. Tackling this isolation is essential to promoting mental health and well-being among older people. Improved access to community based leisure facilities will allow older people to enjoy physical and social activity (Ref. 23).

8.19 Some older people may be concerned about running their homes independently, particularly in relation to housework, laundry, gardening, home maintenance and repairs. During consultation, older people stated that support with these tasks is central to being able to live at home.

Social and emotional support

How we will achieve this
- We will work with the statutory and voluntary organisations and community groups to make these services more widely available.
- We will establish a community development approach that reflects the potential within local communities to galvanise older people, communities and carers to recognise and promote opportunities for an active ageing population.
- We will fund organisations through grant aid and other means on the basis of criteria developed on the principles and actions detailed in this strategy.

Falls prevention

8.20 About 1600 people fracture their hips each year in Northern Ireland and the majority of these are over 65 (Ref. 24). It is anticipated that as the population ages, the number of older people with hip fractures will increase. The regional Home Accident Strategy (Ref. 25) and Northern Area Investing for Health Home Accident Prevention Steering Group provide guidance on falls prevention.

Poor housing design contributes to accidents in the home. Removal of hazards in the home may help to reduce injury and death from accidents. There are a number of factors, both personal and environmental, that can increase the risk of an older person falling. We need to establish better ways of identifying those at risk of falls and provide practical advice and support to make sure that fewer people suffer falls.

How we will achieve this
- We will establish a collaborative project to find ways of preventing falls.
- We will further develop our processes for identifying risk for older people and provide advice, information and practical interventions that will help reduce the risk of a fall.
- We will further develop Home Safety Schemes across the Trust.
Living independently with support

8.24 Older people have told us that it is important that more choice should be provided to enable them to retain control over their lives. This theme describes the issues and the necessary actions and responses required to address this.

Domiciliary support and supported living

8.25 Following the implementation of ‘People First’ in 1993, the care management approach enabled an increase in domiciliary care for older people with complex needs. This meant that more people were able to stay at home for longer where admission to residential or nursing care would have been considered earlier. However, the demand for residential and nursing home care has continued to increase. Today there are 1,016 Northern Trust residents in residential care and 1,735 in nursing home care.

8.26 In Northern Ireland 58% of residential and nursing home residents are cared for in nursing homes compared to 37% in England, 49% in Scotland, 40% in Wales and 36% in the Republic of Ireland. This demonstrates a high reliance on the most expensive form of care (Ref. 27). These facts raise important questions about the effectiveness of assessment, the availability of rehabilitation and the range of crucial core support services in making decisions about admission to care homes.

8.27 We are concerned at the increase in the number of older people being admitted in crisis and in emergencies to nursing home care. We aim to improve and enhance our domiciliary services to provide support for older people with complex needs and provide a safe and effective alternative to residential/nursing care.

Transport

8.22 During consultation older people stressed that a lack of mobility can prevent them from participating in social activities. This can lead to low morale, depression and loneliness.

8.23 A large number of older people are dependent on public transport. Community transport provides a valuable service for those with no access to personal or public means transport. Transport provides an essential link to friends, family and the wider community - a vital lifeline to maintaining independence (Ref. 26).

How we will achieve this

- We will work with other agencies, to review funding arrangements of voluntary and community transport arrangements and to develop transport initiatives such as Shop Mobility, Dial-A-Ride and door-to-door transport schemes.
- We will work with other agencies to promote appropriate levels of accessible public transport.

Continence management

8.21 Incontinence, whenever it occurs, can be a distressing condition, which greatly undermines quality of life, impinging on the independence and dignity of the individual. It can lead to social isolation, affecting both physical and mental health. It is vital that those who are incontinent are given support to regain continence, where possible. A high quality comprehensive continence service is an essential part of services for older people.

How we will achieve this

- We will establish a joint Trust and primary care forum with our primary care colleagues to ensure effective continence management and wider availability of continence products.

How we will achieve this

- We will work with providers of residential and nursing home care to review the range of options available and develop alternatives to residential/nursing care, where appropriate.
- We will also review the role of statutory residential care and, as appropriate, develop alternative forms of support and care for older people.
Domiciliary support

8.29 The promotion and wider availability of domiciliary based services, supported accommodation and the full range of services outlined throughout this strategy, will reduce reliance on residential and nursing care and help people remain at home or in accommodation which better meets their needs and choice. Apart from providing personal care, good domiciliary support can identify potential health problems, raise morale and encourage independence.

Better and more flexible domiciliary service is the first step to providing support for older people to live independently at home and to achieve successful recovery following a stay in hospital. It is important that domiciliary services are available seven days a week and delivered by skilled, well-trained domiciliary support workers.

How we will achieve this
- We will develop homecare services to be available over 24 hours.
- We will develop the availability of domiciliary care for short-term crisis.

8.30 Cook-chill meals are currently provided, following a needs assessment, to those who are unable to prepare food due to frailty, disability, incapacity or ill health. The domiciliary meals service delivers about 6,000 meals each week to older people in the Northern Trust area. Most recipients report a high level of satisfaction with this service (Ref. 28). During consultation, staff told us that cook-chill meals did not suit everyone.

How we will achieve this
- We will make sure that older people receive good quality, nutritionally balanced meals.
- Where cook-chill meals are not appropriate, we will explore alternatives with the individuals involved.

8.31 Too many people are admitted to hospital in crisis and too many people will have to stay in hospital for too long. Many people are admitted to residential and nursing homes when, with the right services provided at the right time, they could return home earlier. The emphasis placed on reducing delayed discharges from hospital has resulted in attention and resources being focused on getting people out of hospital, but it is also necessary to provide adequate support for people to live independent lives.

How we will achieve this
- We will provide, in partnership with the voluntary, community sector and families, a range of support services for older people who prefer to continue living in their own homes but need some support during the day and at night.
- We will make sure that the available resources are provided to best effect to those who have the greatest assessed need.

Day activity and support

8.32 Day centre services help people remain at home, through relieving social isolation, providing basic personal care and offering respite to carers. This function needs to be clarified and we need to consider new approaches to day care provision. We will further develop our day centre services to provide assessment, therapy, and rehabilitation and re-enablement. We are aware that we must offer a range of opportunities to promote ordinary living through developing and maintaining links with existing community services.

How we will achieve this
- We will continue to develop day activity and support services with a focus on rehabilitation, re-enablement and respite.
- We will explore opportunities for more individual support either within an individual’s home, or social and recreational activities in local communities.

The benefits of technology

8.33 The use of assistive technology such as visual aids, fall detectors and ‘telecare’ systems to monitor movement, can help to keep people safer, improve their lives and allow them to maintain or regain their independence. Helping people to remain independent, in their own homes, with the support of assistive technology can often be an economical alternative to providing nursing and residential care. The Trust and other statutory organisations cannot be the sole providers of assistive technology and many people may choose to buy their own equipment.

How we will achieve this
- We will work with other agencies, including the Housing Executive and Supporting People Partnership to make sure that assistive technology is made available.

Rehabilitation

8.34 It is important that those who are at risk of developing serious health problems are identified early to avoid crisis and admission to hospital or residential/nursing care.

8.35 To maximise independence and enable people to continue or resume living at home, we will increase our focus on community based rehabilitation services to prevent admissions to and facilitate early discharge from hospital.

How we will achieve this
- We will develop rehabilitation services to help people retain or return to independence.
Intermediate care

8.36 Intermediate care is short-term intervention and is for people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to hospital or residential and nursing home care. It involves active therapy, treatment or opportunity for recovery and is aimed at maximising independence and enabling people to return to or stay at home.

8.37 Intermediate care should form an integrated range of services linking health promotion, preventative services, primary care, community health services, social care, support for carers and acute hospital care.

8.38 Individual services may provide excellent support, however older people still find it difficult to access services or move between them. A proactive, integrated approach to hospital discharge can make sure that older people are able to move as quickly as possible to an environment that is appropriate for their needs. A short period of intensive rehabilitation and treatment should be available for people who would otherwise face an unnecessarily prolonged stay in hospital or inappropriate admission to hospital or residential/nursing care.

How we will achieve this
- We will develop integrated, intermediate care services to make sure people move as quickly as possible to an environment that is appropriate for their needs.

Direct Payments

8.39 Direct Payments have been developed so that older people can have greater choice and control over their lives. Instead of providing services directly, we can make payments to individuals, who can purchase the services they require from appropriate service providers, other than the Trust.

8.40 The management of Direct Payments can be cumbersome and difficult to manage. There is a need to make sure that service users are fully informed about the potential of Direct Payments, and provided with good quality information and support. Trust staff must promote the benefits of Direct Payments.

How we will achieve this
- We will make our staff fully informed of the benefits of Direct Payments, and provide potential users with good quality information and support.
- We will make sure that older people are given the opportunity of using Direct Payments for support.
- We will explore the possibility of Direct Payments being used for the provision of equipment.
- We will review the funding available for Direct Payments.

The role of carers

8.41 Many older people are able to live independently at home because of the invaluable support they receive from family and friends. Older people may be both a carer and have others caring for them, often without direct involvement of outside agencies. The significant role that carers play in providing support to older people, especially as more people are being supported at home, must be better recognised and acknowledged. The support to carers is limited and needs further development. Carers have told us that they need timely and practical services, support and information to help them in their role as carers. The needs of carers, as individuals in their own right must be addressed through proper assessment and provision of support and services.

How we will achieve this
- We will make progress towards implementing the recommendations of ‘Caring for Carers’.
- We will work with carers and voluntary agencies to meet carers’ individual needs.
- We will invite carers to be actively involved in an older people’s consultation forum.
- We will further develop the carers’ training programme.
- We will make sure that carers are involved in the process of assessment and we will assess their needs as both carers and individuals.
- We will work in partnership with voluntary organisations to further develop carer support groups.
Respite care

8.42 Carers often describe respite as a lifeline in enabling family members to continue their caring role. The provision of accessible and flexible respite services was identified as a priority during consultation. Respite support can help older people to overcome change in circumstances or provide ongoing support to their carer. We need to do more to allow service users and their carers to plan the periods of respite in advance. This will help provide continuity of support and make sure that, as far as possible, service users and their carers can have peace of mind in the knowledge that regular short breaks are guaranteed.

How we will achieve this
- We will seek the means of accessing funding and work with the voluntary, community and private sector to expand respite to include more flexible services that can be provided in the home.

Vulnerable older people

8.43 Some older people may need protection from physical, emotional or financial abuse or mistreatment. Isolation and fear contribute to these problems remaining hidden. It is essential that all agencies work to raise awareness of the needs of vulnerable older people (Ref. 29).

How we will achieve this
- We will develop training and support for staff to raise awareness of mistreatment and abuse of older people.
- We will further develop working arrangements with other agencies to make sure that older people are protected.

Older disabled people

8.44 People with a physical, sensory or learning disability may have access to more specialist services when they are younger which may not always be available as they grow older because of the way services are currently structured.

How we will achieve this
- We will make sure that people receive the appropriate support to meet all their health and social care needs and circumstances.

Living with complex needs

8.45 As people grow older, they are more likely to suffer chronic medical conditions, become frail and experience difficulties in daily living. This theme sets out the services and supports for older people who have more complex needs and chronic medical conditions.

8.46 Those aged 65 and over constitute about a sixth of the population, but occupy almost two thirds of hospital beds (Ref. 30). The prevalence of longstanding illness, disability or infirmity increases from 15% of those aged under 5 to 72% for those aged 75 and over (Ref. 31).

8.47 We are developing a model of integrated services for older people - designed to make sure that a combination of acute nursing care at home, rehabilitation, intermediate and domiciliary care are available to help people remain at home and enable prompt discharge from acute hospital care.

8.48 Service users with chronic diseases need not be mere recipients of care but key decision makers in the treatment process. By making sure that knowledge of their condition is developed, they can work in partnership with health and social care providers and voluntary organisations and have greater control over their lives (Ref. 32).

8.49 For some individuals and their families, home may be a better place to end their lives. It is important that people’s wishes take precedence at this time, wherever possible. A full range of palliative care services will be available.

How we will achieve this
- We will continue to develop the integrated care model.
- We will work with primary care and voluntary organisations to develop and facilitate self-management programmes with the aim of reducing the severity of symptoms and improving confidence.
- We will make provision for palliative care for people at home, if that is their wish, in partnership with the voluntary and independent sector.

Continuity and choice

8.50 For people with complex needs, co-ordinated multi-disciplinary assessment is essential, to make sure their full needs are met. Well-trained staff will put together appropriate packages of care to meet complex needs. These services should be regularly reviewed and adjusted, as necessary, to make sure that support is comprehensive. An individual is enabled to do as much for themselves as possible, thereby maximising their opportunity for independence.
8.51 For some people, increasing frailty, ill health or other high dependency needs means that living independently at home is not possible. For them, transfer to residential or nursing home may be the next stage.

8.52 The decision to move into long-term care, the choices open to people and the quality of the care they receive, should only be made in the right environment and after sufficient time for planning and assessment has been allowed.

How we will achieve this

- We will make sure that permanent decisions about future long-term care are not taken at a time of crisis either in acute hospital or in temporary residential or nursing home care.

8.53 The development of domiciliary services, specialist rehabilitation and acute nursing care will provide choices for older people when their needs point to higher levels of support and care. In time, as people are provided with higher levels and more specialised forms of care and treatment in their own homes, the reliance on residential care, as a permanent move from home, will reduce. In our consultation with older people, they told us that as far as possible they wish to remain at home rather than be admitted to any form of permanent residential or nursing care (Ref. 33).

How we will achieve this

- We will further develop our services so that they become more integrated, focus on the individual and their needs and are provided, where possible, in the person’s own home.

8.54 The residential homes owned and run by the Trust provide high levels of quality care and many are regarded as part of their local communities. However, statutory residential care is often more expensive than private residential care (Ref. 34). As alternative forms of support and accommodation become available for older people, including those with complex needs, we need to consider the future of our statutory residential homes. Releasing some of this capital and revenue would allow us to invest in innovative and more cost effective models of care including developing domiciliary services and supported living.

Integrated Support and Care

8.55 However, during consultation, both staff and service users emphasised the need to continue to have access to residential and nursing home care, where alternative forms of support are not appropriate or available. We will consider alternatives to statutory residential care and develop, in consultation with residents, carers, staff and communities, plans for the provision of care.

How we will achieve this

- We will make sure that a continuum of care, including care at home, supported living and residential care, is available to meet the diverse needs of older people with complex needs.

8.56 We recognise that the voluntary and private sector have a vital role to play in the provision of well planned, high quality and responsive residential and nursing home services which will meet the future needs of those who still require this form of care (Ref. 35).

8.57 We aim to make sure that all our services work together in providing complementary services that are of direct benefit to service users and their carers. For those older people with chronic illness and complex needs, effective joint working between Trust staff and primary care, from referral to the provision of services, is an absolute necessity (Ref. 36).

8.58 The need for intensive support at home arises for many reasons. Short-term help may be needed after discharge from hospital or to avoid hospital admission. Rehabilitation services may be required for longer. Chronic illness may result in the need for help with daily living tasks and activities. Different family circumstances give rise to the need for different types and variety of help. It is essential that we develop a wider range of services to extend the continuum of support available to older people with complex needs (Ref. 37).

8.59 The Trust’s district nursing service is already changing with the emphasis on looking after people with more complex health conditions, requiring high levels of clinical skills, knowledge and experience.

8.60 The establishment of multi-professional rapid response teams can prevent unnecessary admission to hospital or residential/nursing care. It can also achieve a safe discharge from hospital, by providing assessment and appropriate support. Teams must work collaboratively with primary care, including GPs, medical and nursing and allied health professional staff to arrange for appropriate support to be made available when needed.
How we will achieve this
- We will continue to develop intermediate care services - supported by the Community Rehabilitation Service - to bridge the gap between Acute Hospital and Community Care.
- We will develop an intensive rapid response home support service.
- We will provide services that manage, and reduce risk factors of conditions such as, cardiovascular disease, dementia and degenerative disorders including loss of sight and hearing.
- We will further develop proposals for a range of services including specialist wound management, specialist cardiac services, diabetes services and a community splinting service.
Section 9: Delivering the strategy

9.1 A five-year framework of action will support the strategy and implementation will not happen overnight. And, the process must reflect service user, carer and local needs as well as regional and national aims and must accommodate ongoing change.

How we will achieve this

- We will work together with staff to establish an action plan to implement the strategy within a realistic timeframe.
- We will develop a wide range of standards that we will implement and monitor to improve the quality of services for older people.
- We will establish robust monitoring arrangements to make sure that we deliver on this strategy. As this strategy is taken forward, it is important that it is continually reviewed and updated.
- We will engage with older people, representative groups and carers to establish an effective forum to assist in the implementation and review of this strategy.
- We will make sure that the right number of staff with the right skills and experience are in place to implement this strategy and make services better for older people.

9.2 There are clear aims and challenges to address in this strategy. Some will build on existing services and initiatives; others will change the direction of services. Essentially, there are a number of areas where the strategy will break new ground. All are important and will require time and commitment to be achieved.

9.3 This strategy will be supported by an implementation plan with clear objectives and measurable outcomes.

How we will achieve this

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<tbody>
<tr>
<td>We will support the development of neighbourhood and community groups in urban and rural areas and work with local Councils in the development of their community plans.</td>
<td>End March 2009</td>
<td>Director of Strategic Planning and Performance Management</td>
</tr>
<tr>
<td>We will improve access to dietetic services and the use of nutritional screening of vulnerable older people to identify with nutritional problems.</td>
<td>Tool complete Pilot ongoing</td>
<td>Head of Dietetic Services Project Manager (SAT)</td>
</tr>
<tr>
<td>We will provide training and information to key staff who deliver services for older people, to develop their knowledge to promote healthy and active living and to identify potential risks to health and well being.</td>
<td>Ongoing as part of Annual Training Cycle</td>
<td>Director Educare Assistant Director Social Services Training</td>
</tr>
<tr>
<td>We will provide information on oral health more widely to older people and carers, through staff who support and are in contact with older people.</td>
<td>Achieved Pilot progressed, evaluated by December 2008</td>
<td>Clinical Director of Dental Services Assistant Director Social Services Training</td>
</tr>
<tr>
<td>How we will achieve this</td>
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<tr>
<td>We will work with other agencies, including the Housing Executive and Supporting People Partnership to make sure that assistive technology is made available.</td>
<td>Making sure that in meeting needs assistive technology is considered as an option during the assessment process. Identifying a source of funding for assistive technology.</td>
<td>March 2009</td>
</tr>
<tr>
<td>We will promote the use of assistive technology in supporting people at home and explore funding opportunities.</td>
<td>Develop a plan to increase the use of assistive technology in the Trust.</td>
<td>March 2009</td>
</tr>
<tr>
<td>We will work with the Housing Executive to determine the accommodation needs of older people to make sure that adequate provision is developed within the Trust area.</td>
<td>Further develop Supporting People Group and establish a Supporting People Co-ordinator post. Establish multi-disciplinary planning group for older people.</td>
<td>Achieved</td>
</tr>
<tr>
<td>We will encourage or direct people to organisations that can assist them in getting the financial benefits and advice.</td>
<td>We will explore ways of influencing housing providers to build or adapt homes that will be suitable for older people when they become frail or ill.</td>
<td>March 2009</td>
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### Promote positive ageing

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<tr>
<td>We will improve the availability of oral health promotion and explore ways of enhancing community dentistry services.</td>
<td>Establish a local implementation plan to take forward the national oral health strategy in relation to older people.</td>
<td>December 2008</td>
<td>Clinical Director of Dental Services, Senior Community Dentist</td>
</tr>
<tr>
<td>We will focus on the developments of the Trust’s podiatry service to make sure that those who need this service have better access.</td>
<td>Establish a local implementation plan to make sure older people have access to podiatry services.</td>
<td>Achieved</td>
<td>Podiatry Services Manager</td>
</tr>
<tr>
<td>We will develop services, including the provision of equipment, to support older people with sensory impairment.</td>
<td>Develop a process that will improve access to and provision of equipment to older people.</td>
<td>October 2008</td>
<td>Director Mental Health and Disability Services, Assistant Director, Physical Disability</td>
</tr>
<tr>
<td>We will work closely with representative groups, other statutory organisations and the independent sector to address poverty amongst older people. We will work with other organisations to improve home safety and security. We will link with local community initiatives, including community safety partnerships that promote safety and security in the home and in the community.</td>
<td>The model to work with Councils and others on the development of Community Plans and the development of the community development business case will support this objective.</td>
<td>End March 2009</td>
<td>Director of Strategic Planning and Performance Management, Head of Health Improvement and Community Development</td>
</tr>
<tr>
<td>We will work with benefits agencies and CAB to make sure information and services are accessible.</td>
<td>We will work with other agencies, including the Housing Executive and Supporting People Partnership to make sure that assistive technology is made available.</td>
<td>Achieved/ongoing</td>
<td>All operational directorates</td>
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<td>March 2009</td>
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</tr>
<tr>
<td>We will promote the use of assistive technology in supporting people at home and explore funding opportunities.</td>
<td>Develop a plan to increase the use of assistive technology in the Trust.</td>
<td>March 2009</td>
<td>Deputy Director, Emergency, Primary Care and Older People’s Services, OT Services Manager</td>
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<td>We will work with the Housing Executive to determine the accommodation needs of older people to make sure that adequate provision is developed within the Trust area.</td>
<td>Further develop Supporting People Group and establish a Supporting People Co-ordinator post. Establish multi-disciplinary planning group for older people.</td>
<td>Achieved</td>
<td>Assistant Director, Strategic Planning and Performance Management, Deputy Director, Emergency, Primary Care and Older People’s Services, Assistant Directors within Emergency, Primary Care and Older People’s Services, Assistant Director, Mental Health and Disability Services</td>
</tr>
<tr>
<td>We will encourage or direct people to organisations that can assist them in getting the financial benefits and advice.</td>
<td>We will explore ways of influencing housing providers to build or adapt homes that will be suitable for older people when they become frail or ill.</td>
<td>March 2009</td>
<td>Assistant Director, Planning and Performance</td>
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<td>Achieved</td>
<td>Assistant Director, Strategic Planning and Performance Management, Deputy Director, Emergency, Primary Care and Older People’s Services, Assistant Directors within Emergency, Primary Care and Older People’s Services, Assistant Director, Mental Health and Disability Services</td>
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### Promote Positive Ageing

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<tr>
<td>We will work with the Supporting People Partnership to ensure that housing and support are available to older people, to meet their current and future needs to help people remain at home.</td>
<td>Multi-disciplinary planning group and Supporting People Co-ordinator to work with the Partnership to develop a plan to support this objective.</td>
<td>March 2009 Assistant Director Planning and Performance</td>
</tr>
<tr>
<td>We will work with communities, voluntary organisations and Housing Executive to assist older people in being as independent as possible and to minimise risks within the home.</td>
<td>The model to work with Councils and others on the development of Community Plans and the development of the community development business case will support this objective.</td>
<td>End December 2008 Director of Strategic Planning and Performance Management Director Medical and Governance</td>
</tr>
<tr>
<td>We will improve our equipment service so that people can obtain equipment when they need it, and we will explore opportunities for people to hire or purchase appropriate equipment.</td>
<td>Make sure that this objective is integral to the Community Equipment Plan</td>
<td>Ongoing Head of Community Equipment Service</td>
</tr>
<tr>
<td>We will continue to promote social work intervention with older people and their carers.</td>
<td>Social work needs must be identified as part of the assessment process</td>
<td>Ongoing Executive Director Social Work</td>
</tr>
<tr>
<td>We will make appropriate services available to older people with alcohol and substance misuse problems.</td>
<td>Extend addiction services to over 65s.</td>
<td>2010 Director Mental Health and Disability Services</td>
</tr>
<tr>
<td>We will work with the statutory and voluntary organisations and community groups to make these services more widely available.</td>
<td>Extend addiction services to over 65s.</td>
<td>2010 Director Mental Health and Disability Services</td>
</tr>
</tbody>
</table>

#### Responsible

- Assistant Director Planning and Performance
- Director of Strategic Planning and Performance Management
- Director Medical and Governance
- Head of Community Equipment Service
- Executive Director Social Work

### Develop Business Case to establish Community Development Team, to support and facilitate links with the voluntary and community sector in the delivery of services and supports for older people.

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<tr>
<td>We will establish a community development approach that reflects the potential within local communities to galvanise older people, communities and carers to recognise and promote opportunities for an active ageing population.</td>
<td>Develop business case to establish Community Development Team, to support and facilitate links with the voluntary and community sector in the delivery of services and supports for older people.</td>
<td>Business case by December 2008 Review of existing resource by March 2008 Head of Health Improvement and Community Development Director Emergency, Primary Care and Older People’s Services Deputy Director Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td>We will fund organisations through grant aid and other means, on the basis of criteria developed on the principles and actions detailed in this strategy.</td>
<td>We will work with Commissioners to establish clear processes for support of voluntary organisations, including grant aid.</td>
<td>March 2009 Assistant Director Planning and Performance</td>
</tr>
<tr>
<td>We will establish a collaborative project to find ways of preventing falls.</td>
<td>Implement Falls Prevention Strategy</td>
<td>March 2009 Assistant Director Intermediate Care, Rehabilitation and Community Support Services</td>
</tr>
<tr>
<td>We will further develop our processes for identifying risk for older people and provide advice, information and practical interventions that will help reduce the risk of a fall.</td>
<td>Implement Falls Prevention Strategy</td>
<td>March 2009 Assistant Director Intermediate Care, Rehabilitation and Community Support Services</td>
</tr>
<tr>
<td>We will further develop Home Safety Schemes across the Trust.</td>
<td>Implement Falls Prevention Strategy</td>
<td>March 2009 Assistant Director Intermediate Care, Rehabilitation and Community Support Services</td>
</tr>
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#### Responsible

- Assistant Director Planning and Performance
- Director of Strategic Planning and Performance Management
- Director Medical and Governance
- Head of Community Equipment Service
- Executive Director Social Work
- Director Mental Health and Disability Services
- Director Emergency, Primary Care and Older People’s Services
- Deputy Director Emergency, Primary Care and Older People’s Services
- Assistant Director Intermediate Care, Rehabilitation and Community Support Services

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## Promote positive ageing

<table>
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<tr>
<th>How we will achieve this</th>
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</thead>
<tbody>
<tr>
<td>We will establish a joint Trust and primary care forum with our primary care colleagues, to ensure effective continence management and wider availability of continence products.</td>
<td>Set up a group to review current continence service and produce recommendations for future provision</td>
<td>End December 2007</td>
<td>Assistant Director Emergency, Primary Care and Older People’s Services, Community General Manager for Specialist Nursing Services</td>
</tr>
<tr>
<td>We will work with other agencies, to review funding arrangements of voluntary and community transport arrangements and to develop transport initiatives such as Shop mobility, Dial-A-Ride and door-to-door transport schemes.</td>
<td>Identify Trust lead to work with Commissioners to develop a protocol for funding and commissioning transport initiatives</td>
<td>Achieved</td>
<td>Assistant Director Emergency, Primary Care and Older People’s Services, Community General Manager for Specialist Nursing Services</td>
</tr>
<tr>
<td>We will work with other agencies to promote appropriate levels of accessible public transport.</td>
<td>Identify Trust lead to work with commissioners to develop a protocol for funding and commissioning transport initiatives</td>
<td>End December 2007</td>
<td>Director of Strategic Planning and Performance Management, Director Emergency, Primary Care and Older People’s Services, Director Mental Health and Disability Services</td>
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## Living independently with support

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<tr>
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<tbody>
<tr>
<td>We will work with providers of residential and nursing home care to review the range of options available and develop alternatives to residential/nursing care where appropriate.</td>
<td>Work with commissioners to: Evaluate the current availability and location of residential and nursing home care throughout the Trust area</td>
<td>March 2008</td>
<td>Director Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td>We will also review the role of statutory residential care and as appropriate, develop alternative forms of support, and care for older people.</td>
<td>Evaluate current provision of sheltered housing and supported living schemes Identify projected need for accommodation and develop plans for future accommodation and support needs for older people</td>
<td>May 2009</td>
<td>Assistant Director Planning and Performance</td>
</tr>
<tr>
<td>We will develop homecare services to be available over 24 hours.</td>
<td>Work with commissioners to develop a business case for further developing home care services: • available over 24 hours; and • in an emergency</td>
<td>December 2007</td>
<td>Assistant Director Intermediate Care Rehabilitation and Community Support Services, Head of Domiciliary Care Services</td>
</tr>
<tr>
<td>We will develop the availability of domiciliary care for short-term crisis.</td>
<td>Work with commissioners to develop a business case for further developing home care services: • available over 24 hours; and • in an emergency</td>
<td>October 2009</td>
<td>Director of Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>March 2008</td>
<td>Assistant Director Intermediate Care Rehabilitation and Community Support Services</td>
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## Living independently with support

### How we will achieve this

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<tr>
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<tbody>
<tr>
<td>We will make sure that older people receive good quality, nutritionally balanced meals.</td>
<td>March 09</td>
<td>Director of Elective and Acute Services Head of Dietetic Services</td>
</tr>
<tr>
<td>Continue to work with people to meet individual needs.</td>
<td>July 08</td>
<td>Assistant Director Intermediate Care Rehabilitation and Community Support Services</td>
</tr>
<tr>
<td>Explore the possibility of providing cooked chilled meals across the Trust area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where cook chill meals are not appropriate, we will explore alternatives, with the individuals involved.</td>
<td>March 09</td>
<td>Assistant Director Intermediate Care Rehabilitation and Community Support Services</td>
</tr>
<tr>
<td>Continue to work with people to meet individual needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To map the range of voluntary and community groups who currently provide and have the potential to provide support services to older people in the community.</td>
<td>Business case by October 2008</td>
<td>Head of Community Development Services Director of Emergency, Primary Care and Older People’s Services Director Strategic Planning and Performance Management. Director of Mental Health and Disability Services</td>
</tr>
<tr>
<td>Identify the range of support services and resources required in meeting the needs of older people.</td>
<td>Review of existing resource by March 2008</td>
<td></td>
</tr>
<tr>
<td>Engage with the voluntary and community sector to determine which support and services should be provided by the voluntary and community sector.</td>
<td></td>
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</table>

### Action required

- Develop and maintain a directory of available services based on directory of services East Antrim model.
- Develop a range of locally based services.
- Make sure the eligibility criteria is embedded in the review process.
- Pilot the Single Assessment process.
- Develop a strategy for day support services for older people informed by the recommendations of the regional review of day care services.
- Evaluate current rehabilitation and re-enablement services and utilise examples of best practice to make recommendations for the future development of and access to services.

### Timescale

- November 2009
- November 2009
- November 2007
- March 08
- September 2008
- June 2008

### Responsible

- Head of Health Improvement and Community Development Services
- Operational Directors
- Director of Emergency, Primary Care and Older People’s Services
- Commissioners
- Assistant Director Primary Care and Older People’s Services
- Assistant Director Intermediate Care, Rehabilitation and Community Support Services
- Director of Strategic Planning and Performance Management
- Deputy Director Emergency, Primary Care and Older People’s Services
- Director Mental Health and Disability Services
## Living independently with support

### How we will achieve this

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<tr>
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<tbody>
<tr>
<td>We will develop integrated intermediate care services to make sure people move as quickly as possible to an environment that is appropriate for their needs.</td>
<td>Evaluate the current range of intermediate care services and utilise examples of best practice to make recommendations for the future development of and access to services.</td>
<td>June 2008</td>
</tr>
<tr>
<td>We will make sure our staff are fully informed of the benefits of Direct Payments and provide potential users with good quality information and support.</td>
<td>Further promote awareness of direct payments with staff and older people. Identify ring fenced recurring resources for the funding of direct payments. Make sure that independent advice and support is available.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>We will make sure that older people are given the opportunity of using Direct Payments for support. We will explore the possibility of Direct Payments being used for the provision of equipment. We will review the funding availability for Direct Payments.</td>
<td>Develop implementation plan.</td>
<td>January 08</td>
</tr>
<tr>
<td>We will make progress towards implementing the recommendations of ‘Caring for Carers’</td>
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### Living independently with support

### How we will achieve this

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<tbody>
<tr>
<td>We will work with carers and voluntary agencies to meet carers’ individual needs.</td>
<td>Ensure we are carrying out carers’ assessments Identify resource to meet carers’ needs Map the range of voluntary and community support available for carers Identify with carers and representative organisations the opportunities for carers’ support.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>We will make sure that carers are involved in the process of assessment and we will assess their needs as both carers and individuals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We will invite carers to be actively involved in an Older People’s Consultation Forum.</td>
<td>Establish forum</td>
<td>March 2008</td>
</tr>
<tr>
<td>We will further develop the carers’ training programme.</td>
<td>Review of training and standard of training Expand programme Identify resource</td>
<td>Ongoing</td>
</tr>
<tr>
<td>We will work in partnership with voluntary organisations to further develop carer support groups.</td>
<td>Make sure that the development of carers’ support groups are integral to the Carers’ Strategy</td>
<td>Ongoing</td>
</tr>
<tr>
<td>We will seek the means of accessing funding, and work with the voluntary, community and private sector to expand respite to include more flexible services that can be provided in the home.</td>
<td>Examine models of good practice and establish a plan for the further development of flexible respite services.</td>
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### Living independently with support

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</table>
| We will develop training and support for staff to raise awareness of mistreatment and abuse of older people. | Complete training needs analysis across all relevant staff and develop a range of comprehensive and accessible training and awareness programmes. | Ongoing   | Director Emergency, Primary Care and Older People’s Services  
Director Mental Health and Disability Services  
Director Elective and Acute Services  
Training providers |
| We will further develop working arrangements with other agencies to make sure that older people are protected. | Ensure that there is widespread knowledge and implementation of the regional policy on the Protection of Vulnerable Adults. | Ongoing   | Executive Director Social Work  
Senior Management Team |

### Living with complex needs

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</table>
| We will continue to develop the Integrated Care Model.                                  | Develop a structure that will support the Integrated Person Centred Care Model, including ICEP, to include locally managed with professional accountability. | 31 March 2009 | Director Emergency, Primary Care and Older People’s Services  
Assistant Directors  
Deputy Director |
| We will work with primary care and voluntary organisations to develop and facilitate self-management programmes with the aim of reducing the severity of symptoms and improving confidence. | Work with primary care and voluntary organisations to establish a project to make sure that expert patient and self-management programmes are further developed. | 31 May 2009 | Director Emergency, Primary Care and Older People’s Services  
Assistant Director Primary Care and Older People’s Services  
Head of Health Improvement and Community Development |
| We will make provision for palliative care for people at home, if that is their wish, in partnership with the voluntary and independent sector. | Review current provision of palliative care services and develop an action plan to further develop responsive and flexible palliative care services | January 2009 | Deputy Director Emergency, Primary Care and Older People’s Services  
Assistant Director of Medicine and Unscheduled Care Services  
Head of Health Improvement and Community Development |
<p>| We will continue with the review of the Care Management System with the aim of developing a better process, which puts the older service user at the centre of integrated assessment. | Establish a Care Management Board to review current care management systems and make recommendations for the future of care management | September 2008 | SMT as delegated |</p>
<table>
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<tbody>
<tr>
<td>We will make sure that permanent decisions about future long-term care are not taken at a time of crisis either in acute hospital or in temporary residential or nursing home care.</td>
<td>Further develop appropriate support at home or in alternative accommodation to make sure people make long-term decisions in a suitable environment. Provide appropriate information so that informed decisions can be made.</td>
<td>October 2009</td>
<td>Director Emergency, Primary Care and Older People’s Services, Director Elective and Acute Services, Director Mental Health and Disability Services</td>
</tr>
<tr>
<td>We will make sure that a continuum of care, including care at home, supported living and residential care, is available to meet the diverse needs of older people with complex needs.</td>
<td>Engage with Commissioners to identify adequate resources for the range of services to meet the needs of older people.</td>
<td>Ongoing</td>
<td>Director Emergency, Primary Care and Older People’s Services, Director Mental Health and Disability Services</td>
</tr>
<tr>
<td>We will continue to develop Intermediate Care Services - supported by the Community Rehabilitation Service - to bridge the gap between Acute Hospital and Community Care.</td>
<td>Review current interface arrangements between acute, primary and community care and further develop a range of intermediate care services.</td>
<td>31 March 2008</td>
<td>Deputy Director Emergency, Primary Care and Older People’s Services, Assistant Director of Intermediate Care, Rehabilitation and Community Support Services</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>We will provide services that manage and reduce risk factors of conditions such as cardiovascular disease, dementia and degenerative disorders including loss of sight and hearing.</td>
<td>Review current provision of services that manage and reduce risk factors of conditions such as cardiovascular disease, dementia and degenerative disorders including loss of sight and hearing and make sure there is equity of service.</td>
<td>31 May 2009</td>
<td>Director Emergency, Primary Care and Older People’s Services, Director Mental Health and Disability Services</td>
</tr>
<tr>
<td>We will further develop proposals for a range of services including, specialist wound management, specialist cardiac services, diabetes services and a community splinting service.</td>
<td>Review current provision of services including: specialist wound management, specialist cardiac services, diabetes services and a community splinting service and make sure there is equity of service.</td>
<td>31 March 2008</td>
<td>Director Emergency, Primary Care and Older People’s Services, Assistant Directors within Emergency, Primary Care and Older People’s Services, Director Medicine and Governance</td>
</tr>
<tr>
<td>We will work together with staff to establish an action plan to implement the strategy within a realistic timeframe.</td>
<td>Establish Strategy Implementation Group</td>
<td>31 December 2007</td>
<td>Director, Emergency, Primary Care and Older People’s Services, Assistant Director Primary Care and Older People’s Services</td>
</tr>
</tbody>
</table>
## Living with complex needs

<table>
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<tbody>
<tr>
<td>We will develop a wide range of standards that we will implement and monitor to improve the quality of service for older people.</td>
<td>Make sure that appropriate standards are identified and implemented in respect of the implementation of this Strategy.</td>
<td>Ongoing</td>
<td>Director Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td>We will establish robust monitoring arrangements to make sure that we deliver on this Strategy. As this Strategy is taken forward, it is important that it is continually reviewed and updated.</td>
<td>Establish Older People’s Panel to monitor and make recommendations on the implementation of the Strategy. Implement a robust performance review process.</td>
<td>31 March 2008</td>
<td>Director Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td>We will engage with older people, representative groups and carers to establish an effective forum to assist in the implementation and review of this Strategy.</td>
<td>Establish and support Older People’s Panel</td>
<td>31 March 2008</td>
<td>Director Emergency, Primary Care and Older People’s Services</td>
</tr>
<tr>
<td>We will make sure that the right number of staff with the right skills and experience are in place to implement this Strategy and make services better for older people.</td>
<td>Develop workforce plan to support this Strategy</td>
<td>Ongoing</td>
<td>Director Emergency, Primary Care and Older People’s Services</td>
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### Glossary
Glossary

Mental Health Strategy
A major reform and modernisation programme in the Homefirst mental health service commenced in 2002. The Strategy for Mental Health Services for Older People - 'Adding life to years' will dovetail closely with the Trust’s Strategy for Older People’s Services to ensure that the needs of residents in the Northern Area are met in a flexible and comprehensive manner.

Northern Board
The Northern Health and Social Services Board is responsible for assessing, planning, securing and monitoring health and social care for the 430,500 people who live within its area.

Northern Health and Social Care Trust
Provides acute and hospital-based services on eight sites and a wide range of community-based social services and support to people at home. The Trust provides services to the areas formerly covered by Homefirst, Causeway and United Hospitals Trusts.

RPA
The Review of Public Administration represents a real opportunity to revitalise public services in Northern Ireland, to replace current structures with a new, more accountable public sector. It is a comprehensive examination of the arrangements for the administration and delivery of public services in Northern Ireland. It covers over 150 bodies, including the 26 district councils, the Health and Social Services Boards and Trusts, the five Education and Library Boards and about 100 other public bodies.

DSD
The Department for Social Development is one of eleven Government Departments established under the Northern Ireland Act 1998. The Department comprises of two core groups, the Resources, Housing and Social Security Group (RHSSG) and the Urban Regeneration and Community Development Group (URCDG), and two Executive Agencies, the Social Security Agency (SSA) and the Child Support Agency (CSA).

Developing Better Services
Developing Better Services is changing the way in which health care services are provided to patients throughout Northern Ireland. These changes are taking place at local, sub-regional and regional levels and are reflected both in where and how these services are being provided.

Under DBS, the Department of Health is developing a model of health care which will provide high quality, safe, accessible services for the patient, wherever he or she may live. DBS is a modernisation programme which puts the patient first. It is based on the belief that the people of Northern Ireland deserve the best possible health care system - one which is safe, effective and efficient within the limit of available resources.

Primary care
These services include general practice, provided by Generalist Medical Practitioners (GPs), which offers first contact accessible care. GPs have a responsibility for its practice population and their services are activated by patient choice. At its heart is the family GP and the Primary Care Team; Nurses, Managers, Midwives, Health Visitors, Social Workers and Allied Health professionals. However, primary care does not stop here. Pharmacists, Dentists and Optometrists provide essential services within the Primary Care domain.

Care management
Care Management refers to the total concept for providing care in the community and comprises the key functions of case finding, screening, assessing need, care planning and implementation, and co-ordinating, monitoring and reviewing services.

Domiciliary care
This encompasses the range of services put in place to support the person in their own home, from intensive care/assisted living scheme to home help service, meals services, etc.

Residential care
This refers to care that takes place in either statutory residential homes or voluntary and private residential care homes. They are defined in Article 10 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. They are staffed 24 hours a day, providing board and general personal care to the residents. Such premises are provided for those who require ongoing care and supervision in the circumstances where nursing care would normally be inappropriate.

Nursing home care
This refers to care which takes place in nursing homes. These are as defined in Article 11 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. They are residential facilities providing nursing care 24 hours per day.

Delayed discharges
A Delayed Discharge is any Care Managed patient or patients awaiting a Care Management Assessment remaining in hospital after the date they are deemed medically fit for discharge.

ICEP
The Integrated Care of the Elderly Project was established in June 2005 as part of the reform and modernisation agenda to develop and implement an integrated model of care to support older people in the community. The Project is specifically targeted at avoiding unnecessary hospital admission, facilitate prompt discharge from hospital and reduce the need for residential and nursing home care.
References
References


Health Needs of Minority Ethnic Groups in Northern Ireland

VFM Report - Mental Health Services for Older People
DHSSPS, (2003/04)


Valuing Carers: A Strategy for Carers in Northern Ireland
DHSSPS, (2002)


5. Ageing in an Inclusive Society - Promoting the Social Inclusion of Older People

DHSS&PS, (2002)


10. Best Practice - Best Care: A Framework for setting standards, delivering services and improving monitoring and regulation in the HPSS.


12. Caring for People Beyond Tomorrow - Primary Health and Social Care: A Strategic Framework
DHSSPS, (2005)


15. Age Concern NI http://www.ageconcernni.org


21. Homefirst Community Health and Social Services Trust, Podiatry Strategy 2005 - 2010


24. NI Medical Review Issue Number 1477 – 4976 (November 2004)

The Assessment and Prevention of Falls in Northern Ireland
www.nice.org


http://www.ehssb.n-i.nhs.uk

28. Annual Satisfaction Survey of Homefirst’s Cook Chill Meals Service

Appendix 1

   http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf


34. Towards a Strategy for Elderly People’s Services, South and East Belfast Trust


Appendix 1

Health and Personal Social Services (NI) Order 1972 (Ref. 2) – the statutory duty to provide services.

People First: Community Care in Northern Ireland in the 1990s (Ref. 3) - provides the policy focus for actions designed to make sure that all service users have access to high quality and responsive care in the setting most appropriate to their needs.

Review of Community Care First Report 2002 (Ref. 4) – recommended the following:

- enabling people to live in their own homes;
- spreading best practice;
- developing service to provide practical support to carers;
- care management processes and tools;
- promoting the development of a flourishing independent sector alongside good quality public services;
- accountability of agencies; and
- funding structure for community care.

Ageing in an Inclusive Society 2005 (Ref. 5) - sets out the actions government departments will take to promote the inclusion of older people. It describes the need for integrated programmes on health and nutrition, consumer protection, housing, family support, social security income, employment and education.

A Healthier Future: A Twenty Year Vision for Health and Well Being in Northern Ireland 2005 - 2025 (Ref. 6) - the regional strategy for health and well-being and presents a vision of how Health and Social Services will develop in Northern Ireland over the next 20 years which highlights the importance of protecting and promoting a “full life” for carers and details the following main themes.

- Investing for health and well-being
- Involving people - caring communities
- Responsive combined services
- Teams which deliver
- Improving quality

Disability Discrimination (NI) Act 2002 (Ref. 7) - makes it a legal duty to make goods and services accessible to people with a disability.

Caring for Carers 2006 (Ref. 8) - addresses the support that carers want and need to allow them to continue caring and to give them access to the same opportunities as the rest of society.

The Carers and Direct Payments Act 2005 (Ref. 9) - gives carers a right to an assessment. It makes it possible for carers to receive services and for carers as well as service users to be considered for receipt of direct payments as an alternative to direct service provision. It also places a requirement on Trusts to identify carers and provides them with information on services available.

Best Practice - Best Care 2001 (Ref. 10) - sets out a framework to raise the quality of services provided to the community and tackle issues of poor performance across the Health & Personal Social Services. It aims to provide a high quality system of Health and Social Care, which is easy and convenient to use, is responsive to people’s needs and provides a service that instils confidence in those who use it.

Developing Better Services 2002 (Ref. 11) – outlines the opportunities to plan and build new facilities of a high standard and purpose, designed to improve and modernise a wide range of health and social care services.

Caring for People Beyond Tomorrow - Primary Health and Social Care - A Strategic Framework 2005 (Ref. 12) - sets out a long term vision and policy position and action plan to guide the development and delivery of primary care services.

Ringing the Changes, NHSSB 2003 (Ref. 13) - sets out the Northern Health & Social Services Board’s vision of care and support for older people in the Northern Board area.

The Review of Public Administration (RPA) 2005 (Ref. 14) - sets out the Government’s plans to reform and modernise the public sector in Northern Ireland and sets the agenda for a more efficient and cost effective public service.