**Clackmannanshire Partnership**
**Commentary on joint performance 2007/2008 for the Scottish Government Performance Improvement and Outcomes Division**
**June 2008**

## 1. Analysis of performance during 2007/08 according to the 6 interlocking themes in the national community care outcomes framework, illustrating a whole system understanding.

### THEME 1
### Increasing levels of satisfaction amongst people using community care services

(*National Framework Measure 1-3 and any relevant LITs, plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measures 1-3 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement

**Measure No1 : % of community care service users feeling safe :**

In the broad context of community safety, the Clackmannanshire Community Safety Partnership comprises representation from the Council, NHS Forth Valley, Central Scotland Police, Central Scotland Fire and Rescue Service, Joint Clackmannanshire Community Councils, the Substance Misuse Forum and CVS Clackmannanshire. This partnership is one of the four Community Planning Theme Teams and it has a strategic overview of community safety issues.
Key priorities for the Community Safety Partnership are to address the perception and fear of crime and to provide support for victims.
Health and community care information :

- In the MAISOP survey of 2006-2007, most older people (75-90% bracket) agreed that health and social work services had helped them to feel safer.
- The SWIA survey in the 2007-2008 inspection programme generated a 36% response from service users and almost all (95%) said that social work services had made them feel safer, almost all (93%) said that social work had helped them to lead a more independent life and most (80%) said that social work services helped them to feel part of the community
- Risk assessments are undertaken across community care services. In response to MAISOP and SWIA Inspection recommendations and in preparation for the implementation of the Support and Protection legislation (October 2008), a more rigorous approach to risk is being addressed with partners
- Mobile Emergency Care Systems are installed in 1200 homes around Clackmannanshire and the 24/7 warden service responded to 21,441 calls in 2007-2008.
- Additional enhanced systems (Telecare) are being introduced to MECS, providing a larger menu of alerts and devices to promote independence and safety in the home. A survey of service user satisfaction in 2008-2009 will inform the national Telecare evaluation (2008) and will provide baseline information.
- 222 key safes have been installed to enable access by identified service providers to isolated and disabled people
- Mobile Rapid Support services operate 8 vans over 18 hours a day and carry out 300 check visits each week.

- The OTAGO Falls Programme has been introduced for implementation by health and social services staff who are being trained in reducing risk. The effectiveness of OTAGO is measured through an assessment and monitoring system.
- Visits and talks have been provided to day services users by local Police and Emergency services, to raise issues and build confidence.
- 'People First' and Central Scotland police have set up a protocol for crime reporting on bullying and harassment of people with learning disabilities with a Police link worker.
- The Appropriate Adult Scheme has recruited 6 additional workers to support people with learning disabilities who are victims, perpetrators or witnesses of crime across the Forth Valley area.
- Within Mental Health services, a new referral system has been introduced to ensure that users reach the most appropriate service at the earliest opportunity which in turn reduces the need for care to be transferred. Joint assessments the NHS and Social Work services are carried out where there is any ambiguity. A fast tracking system has been established where any client experiencing distress can access a psychiatric assessment within 72 hours. These developments were initiated by feedback from service users, and as a result they now report a simpler and more efficient system.

**Specific measures and targets which are based on consultations and service user and carer surveys will be developed in 2008-2009**

## Measure No 2 : % users and carers satisfied with their involvement in the design of care packages :

Consultation with service users, and service user involvement in the design of care packages, are integral elements of the assessment, care planning and care management process. The needs, wishes and preferences of service users and their carers are taken into account within any individual care plan.

- Service user agreement is recorded in the Community Care Information System for all assessments of community care needs
- Service user agreement is included in all documentation of District Nursing care plans.
- Care plan reviews which involve service users, carers and multiagency staff groups, are routinely carried out across Adult Care services
- Service users groups and committees are established in a range of local service areas
- A Service User involvement plan is being implemented by the service user network of the integrated mental health service. The user group is supported by a development worker
- Peer support working is being introduced
- At March 2008 Direct Payments were provided to 19 people compared to 22 at March 2007 and 24 at March 2006. The promotion and take-up of Direct Payment options in Clackmannanshire will be addressed in 2008-2009
- From SWIA Inspection surveys, 91% of the 178 service users who responded agreed that they got a good response from social services and that they received help at the time it was most needed. 96% agreed that they were treated with dignity and respect and that they had been given a choice about the type of service they received.
- 57% of carers in the SWIA survey felt consulted and listened to and 56% agreed that they had a say on how things were done
- The MAISOP inspection highlighted, in 77% of the cases examined, that carers had been offered information on the support needs of older people they cared for.
  All the older people surveyed, who had been in hospital over the past two years, said that someone had discussed their discharge arrangements with them and most said their carers were involved in the discussion. However, less than half the carers in the survey said they were involved in planning when the person they cared for was being discharged

from hospital.
- Lochview (NHS Forth Valley hospital-based assessment and treatment for 26 people with learning disabilities) has conducted patient and carer satisfaction surveys and have received positive feedback in all the areas of work that were audited. In addition, the service has been looking at other ways to involve clients more meaningfully at their review meetings.
- In response to carers feedback, carers of people with learning disabilities are involved in the redesign of day services, supported by a dedicated worker from the Princess Royal Trust for Carers and facilitated by the NDT
- Mental Health services have open access to personal notes for all service users, maintaining their current 100% position. Care plans are determined in partnership where objectives are outlined and there is agreement at to when these will be considered

**Complaints Monitoring :**
10 formal complaints about Social Services in 2006-2007 were dealt with within timescales and all were resolved. There were 6 formal complaints in 2007-2008.
In response to recommendations from Inspections in 2007-2008, a system from monitoring informal complaints is being introduced
The Community Health Partnership Performance Framework monitors complaints and has a target for 70% of complaints received by NHS Forth Valley to be responded to within 20 days. A patient liaison team assists with minimising or eliminating a re-occurrence of events which give rise to complaints. 56 complaints were dealt with across the three NHS FV Community Health Partnerships and the Forth Valley area-wide hosted services in 2007-2008

**MAISOP recommendations for greater involvement of service users and their carers are being taken forward in 2008-2009 and will be applied across care groups**

## Measure No 3 : % service users satisfied with opportunities for social interaction :

The promotion of social interaction and inclusion is a key aim for the Integrated Mental Health Service (IMHS) , community learning disability services and older peoples care services.
- Mental Health services redesigned their community provisions to ensure a more socially inclusive approach. The Community Access Team was established, offering support to employment, education and leisure. The previous service was building based and now all attendees receive support within their own communities and do not need to attend a 'mental health' resource. Thus the previous target of 26.7% community based support has now been increased to 100%.
- Staff in partnership with service users facilitate sessions at local High Schools to raise awareness of mental health issues and also offer sessions to key local employers. Links have been made with both the Muslim and Polish communities as well as distinct initiatives within deprived areas to ensure services are appropriate.
- With the support of local independent advocacy services, service users of learning disability services are involved in a programme of consultation and redesign. 51% of adult day services and activities are currently in community settings and the redesign will continue to shift the balance, with the planned provision of dedicated and integrated spaces in mainstream community facilities.
- The Supported Employment Scheme provides support and training for voluntary work and other employment opportunities. Local Improvement Targets for people with learning disabilities, based on the 'Same as You' returns, show an increase of 6 more people engaged in employment, 10 more people in further education and 26 more people getting alternative day opportunities.
- In 2007-2008, a corporate leisure membership scheme has been established to promote inclusion of people with learning disabilities, physical disabilities and mental health issues. 80 people have signed up and the aim is to increase this level of involvement

- Service users of older peoples day care services view the social element of day care very positively and are involved in the design of the activities programmes through focus groups
- The CLiCK cafe is a community IT resource and Cafe offering a range of facilities for individual and group IT access and training. The cafe employs people with learning disabilities
- A Community Gardening scheme has been set up as part of the Day Services redesign. Performance information will be available in 2008-2009
- The range of support, training and social opportunities available for local carers through the Princess Royal Trust is responsive to carers wishes and needs

**Further consultation with service users and carers is planned in the redesign of services and the further integration of older peoples services, mental health and learning disability services. Some specific measures and targets which are based on service user and carer surveys will be developed in 2008-2009.**

## THEME 2
## Faster access to services or support

*(National Framework Measures 4-6 and any relevant LITs plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measures 4-6 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement

### Measure No 4 : No. of patients waiting more than 6 weeks for discharge to appropriate setting:

**Target : Reduce no of patients delayed by 50% by 2007 and to nil by 2008. Same for short stay cases**

**This target has been met.**

- There has been a good performance record in Clackmannanshire on minimising delays on discharge from hospital. The zero target has been achieved at census dates.
- Generally figures are kept low but there was an increase in demand towards the end of 2007-2008
- A Forth Valley wide inter-agency and multi–disciplinary discharge process group has been set up to analyse the current situation and identify opportunities to improve discharge planning, The aim is to reduce delays and improve patient and carer satisfaction. Clackmannanshire Social Services and the Community Health Partnership are represented on the group and performance information on discharges, delays and reasons for delays are regularly monitored.
- Requests to the Community Care Teams for hospital discharge assessments has increased by 264% since 2004. Hospital discharge requests have been given priority for assessments and key services
- There has been an increasing demand for assessments, services and care home placements for people in the older age bracket (85+). this reflects population trends and the increasing population of older people with care needs who are supported at home

- The shift of responsibility for delayed discharges from the Acute sector to Community Health Partnerships during 2007/08 has enabled the development of the agenda in line with the new 2008/09 Local Delivery Plan targets, the development of Single Outcome Agreements and the delivery against the Joint Commissioning Strategy

**Chart showing Clackmannanshire delayed discharge reporting including all recorded discharges planned within 6 weeks for 2007-2008. Low figures are being maintained.**

| | 3 DELAYED DISCHARGE (all delays incl within 6 wks) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar-07 | Apr-07 | May-07 | Jun-07 | Jul-07 | Aug-07 | Sep-07 | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 |
| **Between 15th of previous month and report month** | | | | | | | | | | | | | |
| 3.1 Number of delayed discharge patients at the start of the period | 0 | 2 | 1 | 3 | 3 | 4 | 5 | 3 | 1 | 0 | 0 | 0 | 5 |
| 3.2 Number of 'new' delayed discharge cases at the end of the period | 2 | 0 | 3 | 2 | 3 | 2 | 3 | 1 | 0 | 0 | 0 | 5 | 6 |
| 3.3 Number of delayed discharge patients at start who were discharged into appropriate settings | 0 | 1 | 1 | 2 | 2 | 1 | 5 | 3 | 1 | 0 | 0 | 0 | 3 |
| 3.4 Number of delayed discharge patients at start who died before being discharged from hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 3.5 Number of delayed discharge patients at end | 2 | 1 | 3 | 3 | 4 | 5 | 3 | 1 | 0 | 0 | 0 | 5 | 7 |
| **At end of period (15th of report month)** | | | | | | | | | | | | | |
| 3.6 Number of people awaiting completion of assessment | 0 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| 3.7 Number of people awaiting funding | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3.8 Number of people awaiting place in a care home | 0 | 0 | 0 | 0 | 4 | 4 | 0 | 1 | 0 | 0 | 0 | 4 | 5 |
| 3.9 Number of people delayed for other reasons | 2 | 1 | 1 | 2 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| 3.10 Total | 2 | 1 | 3 | 3 | 4 | 5 | 3 | 1 | 0 | 0 | 0 | 5 | 7 |
| **No of people beyond 6-week period** | 0 | 0 | 0 | 0 | 3 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |

**To maintain a zero position on delayed discharges will be challenging within existing community care resources and this has promoted a whole system review of resources, including :-**

- **A review of local authority care home bed use**
- **The use of recuperation/ respite and rehabilitation beds in care homes**
- **Joint working on assessment and rehabilitation support through the CARE team and CMHTE in liaison with local authority home care services**
- **Implementation of organisational plans for the new Clackmannanshire Community Hospital which will further enhance local provisions for rehabilitation and palliative care**

## Measure No 5 : No. of people waiting longer than target for assessment, per 000 population :

| | 2007/2008 |
|---|---|
| **Clackmannanshire Community Care** | **Apr-Mar** |
| **Number of Responses within Target Time : all assessments and intake work** | **422** |
| **Number of Responses Outwith Target Time**<br><br>**Rate per 000 population** | **231**<br><br>**6 per 1000** |
| **TOTAL** | **653** |
| **% within target times** | **65%** |

- Priority target times are set for each community care assessment and for all planned reviews of existing care plans. In 2007 2008, 100% of referrals given Priority 1 and 2 were met within target times of 0-5days.

- Due to changes in technological reporting on referral and assessment activity, the baseline target of 95% was not achievable and was therefore adjusted in 2007-2008, to include assessment activity for a broader range of service users including integrated mental health service users. Staff shortages have also had an impact on response times. Overall a 65% performance rate was achieved and this will be the revised baseline for improvement in 2008-2009. This equates to a rate of 6 people per thousand population
- Referrals to the District Nursing teams are assessed within 24 hours of discharge, and pre discharge assessment and planning is completed when necessary
- Mental Health services developed a Single Referral Pathway, a multi-agency gateway to all community MH provision, including NHS, Social Work and voluntary sector partners. Previously there were no clear assessment timeframes or consistency across agencies. Over the past year, since the establishment of the Pathway, 1, 3 and 6 week timeframes for assessment were established, adhered to by all agencies, 84% of these timeframes were met over the first year and systems have since been amended with the intention of improving this figure.

**Measure No 6 : No. of people waiting longer than target time for service, per 000 population :**

- From a baseline of 20 days in 2004-2005, the Local Improvement Target to improve waiting times from community care assessment to first service delivery has been achieved in 2007-2008 with an average waiting time of 5 days
- There are no delays in the provision of key services such as home care, free personal care, meals on wheels and equipment
- There are no delays in the provision of District Nursing care .
- The Local Improvement Target for the Clackmannanshire Equipment Service to maintain above 95% average priority timescales from completion of assessment to delivery of equipment has been achieved at 97% in 2007-2008
- Waiting times for minor and major adaptations are under review in 2008-2009
- Waiting lists for day care, supported employment services and care home placements are regularly reviewed to ensure that priority needs are met

**More specific measures would need to be out in place for a valid indicator on waiting times for the wide range of services that may be provided following assessment.**
**At present the target times based on priorities following assessment are measurable with response times for community care services that need to be out in place promptly to meet essential needs .**
**Community Nursing services are under pressure and the capacity for further expansion is limited. The interface between Acute and Primary Care services is being addressed by the Partnership through work on preventable admissions, anticipatory care, discharge planning and intermediate care.**
**A more comprehensive set of standards on timescales for provision is being jointly considered in a revision of Local Improvement Targets.**

**THEME 3**
**Better support for carers**

*(National Framework Measure 7 and any relevant LITs plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measure 7 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement. More specifically the MAISOP and SWIA inspections have recommended that issues of carer involvement, information, assessment, review and planning are addressed.

**<u>Measure No 7 : % of carers who feel able to continue their role :</u>**

The existing Local Improvement Targets focus on measuring levels of support for carers:

- An average of 28 days respite per person per year has been achieved where this need has been identified for carers From the MAISOP analysis, the number of overnight respite nights provided (rate per thousand of over 65s) was 671.
  This was very positive as the average figure for Scotland was 342. The number of day care places for older people (rate per thousand) was 8.1 against a national average of 8.8. The number of older people attending day care services (rate per thousand) was 21.1 against a national average of 14.3.
- There has been a 2% increase in respite days/nights to support carers of older people in 2007-2008
- More carers (20) have received assertiveness training and Mental Health First Aid training
- The Princess Royal Trust for Carers has funding for a dedicated support worker for carers of people with learning disabilities. In 2007-2008 a Respite Review in 2007 collated the views of carers about support and respite into a report of recommendations which are being picked up in 2008-2009.
- A support service for carers of individuals with mental health problems has continued to develop over the last year with numbers increasing. Carers are offered support, information sessions and access to ASIST and Mental Health First Aid Training. Information on this and other provisions available are offered to all service users at the point of initial assessment, and to relatives where they are actively involved.
- For carers of people with dementia a joint initiative is being developed to provide a rolling programme of training and support following a diagnosis of dementia

**MAISOP Inspection:**
Most carers in the MAISOP survey accepted the services they received and understood the reasons for individual care arrangements which had been made
**SWIA Inspection 2007-2008** :
53% carers who responded to surveys felt valued and supported
57% felt consulted and listened to
56% agreed they had a say on how things were done
69% agreed that services had resulted in an improved quality of life for the people they cared for

**We will continue to work with the Princess Royal Trust for Carers and other partners to identify carers and to ascertain carer needs, wishes and preferences**
**Education is ongoing across all Community Nursing and Practice teams related to the NHS Forth Valley Carers strategy, raising awareness of carers rights and health needs**

**A Clackmannanshire Carers Charter agreed in 2008 has set out the key objectives against which we will revise our local Improvement targets and measures**

**The NHS Carer Information Strategy will be implemented jointly with partners; priorities for funding over the next 3 years have been identified. Phase 1 due in 2008-2009 will include a hospital-based carers project, providing training and support and improving links with community services for carers identified in the health system.**

## THEME 4
## Improving the quality of assessment and care planning

*(National Framework Measures 8-10 and any relevant LITs plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measures 8-10 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement
The Forth Valley Data Sharing Partnership is confident that e-Care will be linked to the national store for a pilot project in 2008 and rolled out in 2009

### Measure No 8 : % of user assessments completed to national standard :

- All (100%) Community Care Assessments comply with the national standard
- Community Nursing (NMC) assessment standards are applied to all community nursing assessment activity
- Further development of Single Shared Assessment is awaiting the National E-care solution From the 866 Intake Assessments Completed in 2007-2008, 261 were Single Shared Assessments = 30%
- There is further work to be done on the Integration of housing/health/social care needs assessments for the development of more coordinated care planning and for the implementation of the particular needs housing action plan.

### Measure No 9 : % of carers' assessments completed to national standard :

- Carers assessments are recorded on the Community Care Information System
  From a baseline of 120, the Local Improvement target of a 5% increase in the number of carers assessments recorded in 2007-2008 has been achieved at 167
- In response to recommendations from the MAISOP report, a Carers Assessment working group is reviewing the local approach to carers assessments which will inform a Forth Valley area-wide review and link with the implementation of the NHS Carer Information Strategy
- Further development of Single Shared Assessment is planned

### Measure no 10 : % of care plans reviewed within agreed timescale :

- A review system is established in the Community Care Information System
- Performance information is regularly monitored
- 64 % community care planned reviews were completed within timescales
- All service users in day care and respite care services have care plans which conform to ISO and Care Commission standards and are subject to regular review

**The chart below shows the nature of reviews which are monitored on the Community Care System :**

| Clackmannanshire Community Care Reviews | Target | | |
|---|---|---|---|
| Assessment Type | in time | outwith time | Grand Total |
| Care Home Review | 98 | 147 | 245 |
| Community Assessment and Referral Team Review | 242 | 23 | 265 |
| Intake Review | 130 | 34 | 164 |
| Learning Disability Review | 9 | 17 | 26 |
| Mental Health Review | 7 | 23 | 30 |
| Review Planned | 1416 | 1524 | 2940 |
| Review Unplanned | 1496 | 31 | 1527 |
| Worker Review | 206 | 261 | 467 |
| Grand Total | 3604 | 2060 | 5664 |

**64%** **Reviews within timescale**
**36%** **Reviews outwith timescale**

**The aim is to complete all reviews within timescale. This is subject to available staffing and resources. Performance will continue to be monitored with anticipated improvement in 2008-2009.**

## THEME 5
## Increasing pro-active work with people at risk of admission to hospital

*(National Framework Measures 11-13 and any relevant LITs plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measures 11-13 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement

**Measure No 11 : No of emergency bed days in acute specialties for people 65+, per 100,000 pop**.

**Target : Reduce emergency in patient days by 10% by 2008, against 2004-05**

**Performance has been maintained and this Target has been almost met at 9.9%**

| *Source ISD data :* | 2004/05 | 2005/06 | 2006/07 | % change |
|---|---|---|---|---|
| Clackmannanshire | 19,195 | 18,825 | 17,463 | - 9.9% |

- As part of the Integrated Healthcare Strategy implementation, acute hospital services across NHS Forth Valley were significantly reconfigured through Transitional Arrangements between October 2005 and March 2006. All emergency receiving and major trauma in-patient activity was centralised on one site.

This service change has supported a focussed approach to emergency care and co-ordinated management of inpatient capacity and discharge. Since the change was implemented there has been a constant reduction in the number of 65+ emergency bed days.

- In addition there are a number of activities underway across NHS Forth Valley focussing on shifting the balance of care and on the key aims of the management of Long Term Conditions. A Primary and Community Care Services Development Plan has been agreed with partners to focus on the key priorities of co-ordinated care, workforce development, developing 24/7 services and the promotion of self care
- The relocation of provisions in the new Community Hospital will have an impact on admissions rates and will be monitored.
- Emergency in-patient bed days are reducing in line with target

**Measure no 12 : No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100, 000 pop.**

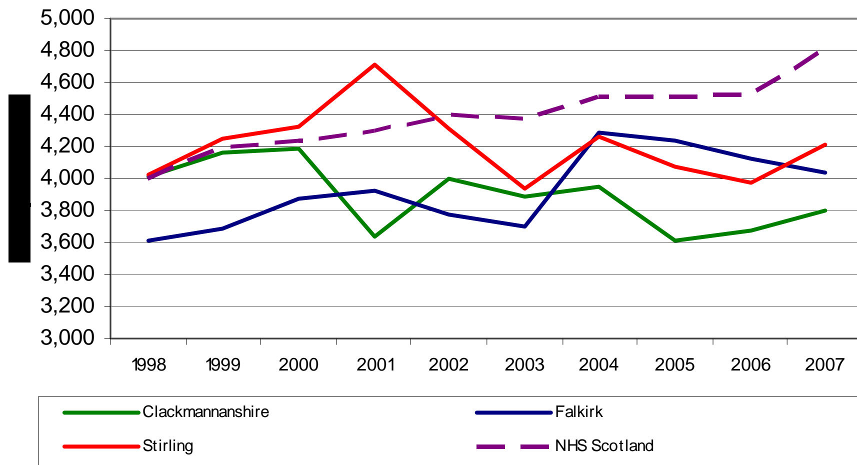
**Target : Reduce No. by 20% compared to 2004/05**

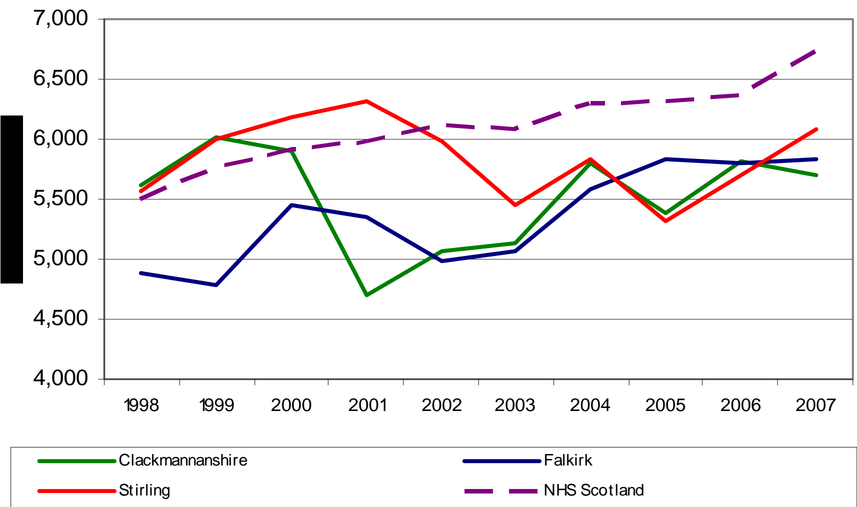
**Position is being maintained and is in line with national performance on this target**

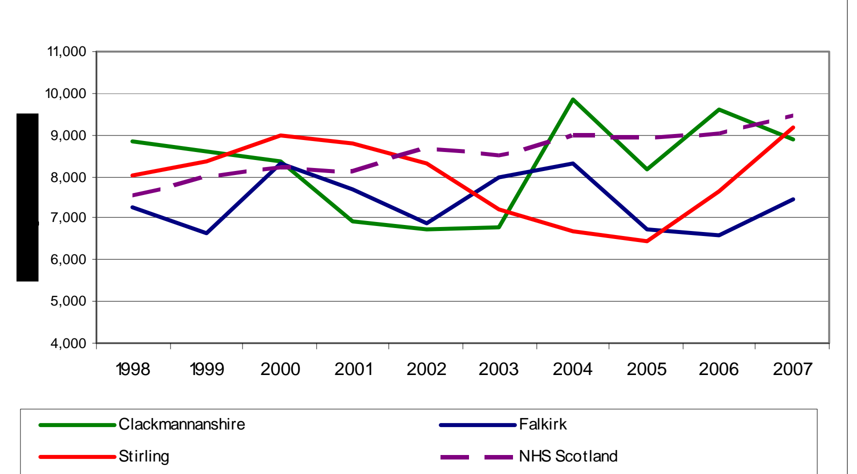
| *Source ISD Data* | 2004/05 | 2005/06 | 2006/07 | 2007/08 | % change 2004-2007 |
|---|---|---|---|---|---|
| Clackmannanshire | 36 | 37 | 38 | - | **0.5%** |

- Across NHS Forth Valley work is undertaken through the Unscheduled Care Collaborative and the Out of Hospital Care Project; this supports work on preventable admissions and addresses the interface between Acute and Primary Care services.
- As part of Forth Valley's Integrated Healthcare Strategy, work is progressing to provide Primary Care and Community Hospitals supporting whole systems working, ensuring a shift in the balance of care and action on areas such as chronic/complex disease management and long term condition management within health services.
- A Long Term Conditions Management Self Assessment Tool has been implemented with the aim to facilitate systematic approaches to the provision of services for those with one or more long term conditions, as close to home as possible.
- Arrangements are set up to ensure that appropriate tests are available to avoid admission where possible. These include the provision of the 6-day ambulatory care service on both hospital sites, the 6-day ECG service, and exercise-testing,
- SPARRA data is being used for a pilot anticipatory care project in Clackmannanshire. This will involve joint casework reviews and monitored care plans of treatment and intervention for a sample of people in the high risk group

**The Older Peoples Implementation Group is now able to use ISD and SPARRA data at a local level for joint performance measurement and planning and trends will be further examined. The chart below shows trends by age group across Forth Valley.**


Emergency Readmissions Aged 65+ by CHP
Rate per 100,000 population
5,000
4,800
4,600
4,400
4,200
4,000
3,800
3,600
3,400
3,200
3,000
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Clackmannanshire
Falkirk
Stirling
NHS Scotland


Emergency Readmissions Aged 75+ by CHP
Rate per 100,000 population
7,000
6,500
6,000
5,500
5,000
4,500
4,000
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Clackmannanshire
Falkirk
Stirling
NHS Scotland


Emergency Readmissions Aged 85+ by CHP
Rate per 100,000 population
11,000
10,000
9,000
8,000
7,000
6,000
5,000
4,000
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Clackmannanshire
Falkirk
Stirling
NHS Scotland

**Measure no 13 : No of people 65+ admitted twice or more as an emergency who have not had an assessment, per 100, 000 population.**

| *Source ISD data July-Sept 2007* | Social Care Assessments recorded | SSA | Health | No assessment |
|---|---|---|---|---|
| Clackmannanshire Total : 146 people | 106 | (32) | **146 63community nursing assessments** | 40 people not known to Social Services |

- From the information provided from ISD sources, all community care assessments recorded in the 6 months either side of the reporting period were counted. Of the 106 assessments counted in Community Care Information System, 32 were Single Shared Assessments
- From the Health Services analysis of the ISD information provided, all patients had received a health assessment. 63 were known to Community Nursing services. The commonest cause for re-admission appeared to be an acute exacerbation of a pre-existing condition requiring medical treatment in an acute setting. In a few cases early discharge from an acute area appeared to have been premature, resulting in a re-admission. However it was not always possible to ascertain whether the wishes of the patient/family for discharge had influenced the date of discharge.
- Discharge planning is undertaken early on admission. This includes liaison with community care and health care workers as appropriate.
- The Long Term Conditions Action Group will be undertaking some focused work in 2008-2009 around High Risk patients identified from SPARRA data with the view to implement improvements and reduce readmissions.

**THEME 6**
**Moving services closer to patients/people who use services**

*(National Framework Measures 14-16 and any relevant LITs plus information from any inspection or regulation activity.)*

Work is ongoing across the Clackmannanshire Partnership to improve joint systems and processes for measuring and monitoring performance for Measures 14-16 and to record and report accordingly. This is influenced by the emerging Community Health Partnership Performance Framework and the integration of measures which inform the Single Outcome Agreement

**Measure No 14 : Shift in balance of care from institutional to 'home based' care :**

- From service/placement information based on the Joint Future Whole System model, there has not been a marked shift in the overall balance of care in Clackmannanshire in 2007-2008. The continuing aim is to maintain or improve the balance in favour of supporting people in their own homes.
- The Local Improvement Target of more than 50% expenditure on community care services vs. expenditure on care home placements has been achieved at 55% vs. 45%.

- High levels of home care services are provided relative to long term residential care; the rate per 1000 care home places purchased by Clackmannanshire is comparable with the rest of Scotland. In the two years to March 2007, Clackmannanshire's care home placements rose by 15%.
- From Audit Scotland returns, at March 2006 there were 257 people aged 65+ in care home placements (34 rate per 1000 population), increasing to 264 (35 per 10000 population) at March 2007 and decreasing at March 2008 to 244 ( 33 rate per 100 population). These figures include the use of residential respite care beds. Overall, figures are being maintained at a lower rate than the Scottish average and are considered to be appropriate to meet locally identified need.
- A positive balance of care is indicated by the number of care home/continuing care placements set against the high level of home care. There were 3.4 (rate per thousand) occupied NHS continuing care beds in Clackmannanshire. The average figure for Scotland was 2.7. This balance is changing with Community Hospital development as the designation of beds is being adjusted to provide fewer continuing care beds and more rehabilitation and palliative care beds. Nationally reported figures will be adjusted accordingly in the balance of care model.
- 5 more care home placements have been made available for older people in 2007-2008

**The multi-agency approach to supporting people at home and shifting balance of care also includes community nursing, CARE team, CMHTE, day services, respite care, joint rehabilitation, step-up and step-down services. Joint performance measures are being revised for inclusion the Community Health Partnership Performance Framework for 2008-2009**

**In mental health services, the Intensive Home Treatment Team has responded to an increased number of referrals (146 2006-2007 to 236 in 2007-2008)and there is ongoing work in the Forth Valley NHS Re-design programme to address acute mental health service needs and focus a reduction in admissions with community-based treatment and recovery initiatives.**

## Measure No 15 : % of people 65+ with intensive needs receiving care at home :

**Target : 30% get care at home by 2008**

**This target has been met at 39.5% in 2007-2008**

- In March 2007, there were 76.8 (rate per thousand of people aged 65+ years) people who received home care in Clackmannanshire. The average figure for Scotland was 68.2. The total hours of home care provided (rate per thousand of over 65s) was 538. Clackmannanshire ranked 11 out of 30 councils in Scotland. 30.6% of home care service users received care in the evenings and or overnight and Clackmannanshire ranked 9 out of 31 councils in Scotland on this. In relation to home care at the weekends, 62.6% of over 65s received services at weekends and Clackmannanshire ranked 8 out of 31 councils in Scotland.
- In March 2007 19.9 older people per thousand were receiving intensive home care which compared favourably with other authorities
- MAISOP reported home care service users in Clackmannanshire receiving more than 10 hours home care at 23 per 1000 people aged 65+. The average figure for Scotland was 17. Intensive home care as a percentage of long term care was 33% in Clackmannanshire. The target figure for Scotland was 30%. In relation to the number of older people receiving less than 10 hours home care per week (rate per thousand), the figure was 57.4 against the national average of 51.3.

- At March 2008, the percentage has increased to 39.5%

**The chart below is a breakdown of quarterly indicators of the balance of care in 2007-2008**

| | At 30 Jun | At 30 Sep | At 31 Dec | At 31 Mar |
|---|---|---|---|---|
| Older people (65+) receiving intensive home care (10+ hours) **Source**: *quarterly community care return* | 228 | 182 | 178 | 172 |
| Older people 65+ receiving long term care (Including 26 hospital long stay beds) **Source**: *quarterly cc return* | 282 | 275 | 320 | 237 |
| Long Stay Hospital Beds | 26 | 26 | 26 | 26 |
| **TOTAL LONG TERM CARE** | **536** | **483** | **524** | **435** |
| Older people 65+ receiving Intensive Home Care as a % of all older people receiving Long Term Care | 42.5% | 37.7% | 34.0% | **39.5%** |

## Measure No 16 : % of people 65+ receiving personal care at home :

- At 31st March 2008, **82%** of people aged 65+ in receipt of home care services were receiving assistance with personal care needs. The charts below show trends and a breakdown of home care services

| Clackmannanshire | |
|---|---|
| Total service users 65+ receiving home care as at 31 March 2008 | 590 |
| Total service users 65+ receiving personal care as at 31 March 2008 | 483 |
| **% service users 65+ in receipt of personal care at home Apr-Mar** | **82%** |
| ***Source:*** *H1 return* | |

| **Home Care Services for people aged 65+ years** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|
| Number of people receiving personal care | 399 | 447 | 469 | 483 |
| Number receiving help with domestic and other tasks | 362 | 365 | 234 | 187 |
| Housing Support | 121 | 77 | 66 | 106 |
| **% RECEIVING PERSONAL CARE** | **67%** | **78%** | **82%** | 82% |
| **% RECEIVING DOMESTIC AND OTHER TASKS** | **61%** | **64%** | **41%** | **32%** |
| **% RECEIVING HOUSING SUPPORT** | **20%** | **13%** | **12%** | **18%** |

| **Number of people receiving the following hours of home care (65+ years) :** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|
| Less than 4 hours | | | | 234 |
| Between 4 - 10 hours per week | 128 | 203 | 188 | 184 |
| 10 hours or more | 170 | 137 | 154 | 172 |
| **Total people Aged 65+ years** | | | | 590 |
| **Population 65+** | | | **7423** | **7423** |
| **Rate per 1000 population (65+) receiving 10 hours or more** | | | **20.7** | **23.2** |

| SCOTLAND | YEAR AT 31 MARCH | | |
|---|---|---|---|
| | 2005 | 2006 | 2007 |
| More than 10 Hours | 25% | 26% | 28% |
| Between 4 and 10 Hours | 30% | 29% | 30% |
| Less than 4 Hours | 45% | 45% | 42% |

| CLACKMANNANSHIRE | YEAR AT 31 MARCH | | |
|---|---|---|---|
| | 2005 | 2006 | 2007 |
| More than 10 Hours | 30% | 26% | 28% |
| Between 4 and 10 Hours | 33% | 36% | 35% |
| Less than 4 Hours | 37% | 37% | 37% |

- Home care services are provided by in-house and independent providers and include a range of tasks and activities including domestic and personal care tasks, shopping services, bathing service, medication prompts, meal preparation, Rapid Support check visits.
- Services are provided promptly following assessment. Priority is given to hospital discharges and essential needs for services based on identified needs and risks.
- Care plans are reviewed regularly
- Trend information 2005-2008 shows a increase in the number of people receiving between 4 and 10 hours a week. The number of people receiving 10+ hours of home care has not increased significantly
- Rates of home care provision are similar to the Scottish average

**The Clackmannanshire Older Peoples Implementation Group will continue to consider the levels of demand for assessments and services and the availability of resources and provisions for older people. Home care service provision needs is considered in the context of a wider range of provisions such as day care, meals, respite, community nursing and joint rehabilitation.**
**Local Improvement indicators, measures and targets are under review.**

## 2. How the partnership's understanding of its whole system has influenced performance at a strategic level and in specific actions.

| **How performance against the 6 themes has interacted in 2007/08, and intentions for action resulting from this.** |
| --- |
| **Overview of the Forth Valley strategic approach to partnership working** :<br>The Forth Valley Joint Adult Strategic Planning group comprises senior officers from the Forth Valley area ( NHS Forth Valley, Stirling, Clackmannanshire and Falkirk Councils) and oversees the strategic planning, monitoring and reporting arrangements of the three Community Health Partnership areas.<br><br>The NHS Forth Valley Integrated Healthcare Strategy[1] sets out a number of strategic objectives that are dependent on the development of Primary and Community Care Services. These include:<br>a) The modernisation of primary and community care services;<br>b) Shifting the balance of care "away from reactive episodic care in acute settings to team-based anticipatory care closer to peoples homes";<br>c) Development of anticipatory care;<br>d) The need to reduce avoidable admission/readmission to hospital;<br>e) Promotion of self care and the effective management of long term conditions in the community; and<br>f) Addressing health inequalities.<br><br>The recently established multi-agency MAISOP Implementation Group also has representation from all four strategic partners, and has responsibility to oversee the implementation and monitoring of the MAISOP Action Plan, reporting to the Joint Adult Strategic Planning Group. A Commissioning Strategy is being developed across services for older people.<br><br>The Older People's Mental Health Reference Group continues with the redesign of mental health services for people over 65 years – 'Moving forward', the redesign of old age psychiatry services in Forth Valley". A dementia care programme, lead by Stirling University and involving a wide range of partners, was completed in 2008 and further recommendations for improving care and developing services will be taken forward<br><br>The Forth Valley Delayed Discharges Steering Group meets on a monthly basis to review the delayed discharge position and to monitor progress. All partners recognise the challenge and are committed to the minimisation of delayed and prolonged stays in hospital. The Local Implementation Group addresses the impact of delayed discharge targets through the holistic aspects of admissions, community support, prevention, rehabilitation and community care provision.<br><br>NHS Forth Valley redesign is ongoing with the significant development of a new District Hospital. The interface of acute and primary care services is shifting towards a balance in favour of locally responsive and community-based services.<br>Community Hospitals are being built, including the Clackmannanshire Community Hospital in Sauchie which is due for completion in December 2008. This will provide a |

range of inpatient, outpatient, community health and community care services. Community health services and the social services community care teams will be co-located in the Clackmannanshire Community Hospital.

Clackmannanshire Alliance, Community Planning and the Community Health Partnership:
The Clackmannanshire Alliance is taking forward key priorities with all community planning partners and these are set out in the Single Outcome Agreement.
The Community Health Partnership is well established with a Public Participation Forum and ensuring that the health and community care agenda is integrated.
All partners across Forth Valley jointly commissioned research into integrated models of community health partnerships; the outputs of this work are informing local discussions at CHP level on the future of joint working.

The Forth Valley Data Sharing Partnership has signed off an Information Sharing protocol and is aiming to pilot systems in 2008-2009

**Local interaction on interlocking themes :**

The partnership is generally performing well on outcomes.
From the MAISOP Evaluation of Whole System working for peoples aged 65+, the partnership's understanding of the whole systems approach was very good, and there was a strong emphasis on the fast delivery of joint services for older people. Performance on delayed discharges was excellent, and it performed well on other indicators, including preventing repeat emergency admissions and intensive home care. There was a wide range of health and social work services, and a collaborative approach was taken to joint planning with a continued investment in the 'resource centre' model of services for older people.

MAISOP recommended that joint strategic planning and commissioning needed to be developed and that this needed to take place at the level of the partnership, as well as Forth Valley wide. Systems were not yet in place for fully aligned budgets or joint financial management of older people's services, although at operational level the partners worked collaboratively to make best use of the resources jointly available to them. The partnership's performance was evaluated as good. Work is already underway to address the issue of resource management across the three partnerships in Forth Valley through 'MAISOP' action planning for older peoples services.

Across all care groups, the Community Health Partnership oversees the health and community care agenda and how the six themes relate to each other in terms of planning, performance measurement and improved outcomes. The Community Health Partnership is coordinating a development programme of joint working and the new Community Hospital will be a catalyst for this. A key objective for the Partnership is to improve our knowledge and information management systems and to refine the local framework of performance management, by connecting the strands which run through the Single Outcome Agreement and all other Plans.

**Overview of the 6 community care themes**

**Increasing levels of satisfaction amongst people using community care services**

Service users and their carers are consulted across health and community care services; providing good quality services to ensure satisfaction amongst people using services is integral to provision. Feedback from MAISOP and SWIA surveys has mainly been positive. The Partnership is picking up issues from inspection and regulation activity and is developing action plans to address these. More specific surveys will be jointly developed. In 2008-2009, a telecare survey will be carried out; further surveys are planned, including user involvement in the development of mental health services and learning disability service redesign.

**Faster access to services or support**

The Partnership performs well on key targets such as delayed discharge with a proactive approach to maintaining performance. Response times are monitored and steps being taken in specific service areas where there are delays (e.g. adaptations), to improve provision.

**Better support for carers**

MAISOP recommendations are being taken forward and these will have an impact on all carers, in terms of improving information, assessment processes, consultation and involvement. networks The NHS Carer Information Strategy is being implemented with funding directed at improving awareness of carers in the health system, identifying carer support needs and improving community links.

**Improving the quality of assessment and care planning**

The national technological solution and the implementation of the Forth Valley e-Care programme are awaited. These will build on current joint initiatives for single shared assessment, the utilisation of shared assessment tools, the shared recording of needs and the development of shared care plans.

**Increasing pro-active work with people at risk of admission to hospital**

Anticipatory care programmes using SPARRA data will build on current initiatives and inform further service developments for older people. The Intensive Home Treatment Team and Single Referral Pathway are proactive initiatives in place to address the balance of care in mental health services.

**Moving services closer to patients/people who use services**

The Clackmannanshire Community Health Partnership and all Community Planning partners are committed to a balance of care in favour of supporting people in their homes and local communities.
A workforce planning exercise has been undertaken by the Community Health Partnership, the aim of which is to promote more joint working across community hospital primary care and social care services.

**Summary of Key Action Plans**

| ACTION | Timescales |
| --- | --- |
| **Revision of local performance and improvement targets by October 2008** | **Revised performance measures for 2008-2009** |
| **Community Health Partnership Performance Framework : review of joint targets** | **Review joint targets in the framework** |
| **Integration of performance frameworks in line with the Single Outcome Agreement and Local Delivery Plan** | **SOA review 2009** |
| **MAISOP Action Plans** :<br>Financial Strategic Framework and Reporting<br>Joint Commissioning Framework and Plan<br>Assessments and Care Plan Review<br>Carer Involvement<br>Medication Policies and Practice<br>Mental Health and Dementia Care | March 2009<br>These action plans address whole system issues in response to recommendation and involve all relevant partners |
| **SWIA Action Plans arising from recommendations** | Report due September 2008 |
| **Community Hospital operational plans**<br>Hospital will open in Sauchie in December 2008 and will enhance joint working and the interface between health and community care providers | Evaluation of progress March 2009 |
| **Primary and Community Care Development Implementation Plan**<br>Coordinated Care<br>Workforce development<br>Developing a 24/7 service<br>Self Care<br>Location of services / shifting the balance | Short, medium and longer plans are set out in the development plan |
| **Implementation of the Particular Needs Housing Action Plan**<br>Focus on the housing needs of older people<br><br>Developing housing options for people with learning disabilities | Particular needs housing assessments being developed into action plans with all relevant partners in 2008-2009-2010 |

**Some specific project work towards community care outcomes in 2008-2009 :**

- Service user and Carer consultation
- E-Care implementation
- Anticipatory care pilot : SPARRA data is being utilised to conduct joint case reviews on a selection of patients in the higher risk categories
- Development of a delayed discharge initiative to provide care home places for recuperation and rehabilitation
- Evaluation of MECS and telecare
- Adaptations review : setting standards and timescales
- Self-directed support / Direct Payments : investigate promotion and take-up