CLACKMANNANSHIRE JOINT FUTURE PARTNERSHIP
OLDER PEOPLES SERVICES – Report on the 'Whole System' Framework – May 2006

<table>
<tr><th>Areas for evaluation in JPIAF 10 :</th><th>Information

Joint Performance Information and Assessment Framework</th></tr>
<tr><td>1. Brief Overview of Joint Services</td><td>1.1 Two key developments in 2005-2006 for Clackmannanshire's Older Peoples Services have been a Joint Services Review conducted by the multi-agency local implementation group and also the Forth Valley area-wide work on Joint Commissioning and Capacity Planning which has been supported by the Joint Improvement Team; a local Joint Older Peoples Framework and Joint Commissioning Plan are being produced in 2006-7.

1.2 In 2005, NHS Forth Valley and the three partnership Council areas determined that an examination of the existing care services for older people was required, and that this should take account of social care, health and housing needs and resources. It was agreed that a Commissioning Strategy would be developed for older people's services to would meet current and future needs through:
<u>Building Partnerships</u> involving statutory services and independent and voluntary sector providers, and engaging with user and carer groups;
<u>Understanding and Managing the Market</u> through service mapping, examining capacity within the whole system and incorporating a consideration of costs and available finances;
<u>Encouraging Innovation/Maximising use of Resources</u> following evaluation of existing models to understand what works and an exploration of new models of service to inform service redesign
This work will enable the establishment of a costed 5 year joint Commissioning Plan with new joint commissioning arrangements to implement the agreed commissioning strategy and ensure a process of review is established involving partner organisations, users and carers.

1.3 Joint services that are established and working for older peoples services in Clackmannanshire include assessment and rehabilitation, equipment and adaptations provisions, access to step-up, step-down , day services and respite services. This range of comprehensive provisions assists with meeting national targets and is improving outcomes.</td></tr>
<tr><td>2. Performance on the key sub-indicators and over all (the comparative model) :</td><td>A brief summary of the trends in each of the key indicators
<u>2.1 Emergency and multiple admissions</u>
Throughout 2005/06, Clackmannanshire has maintained a steady position in relation to emergency and multiple admissions. We have seen fewer emergency admissions across Forth Valley and the likelihood of inappropriate admissions is reducing due to the Fast Track responses and joint trends across the area. In the trend summary, the figures relating to emergency and multiple admissions are small, and in the view of clinicians, admissions have not been inappropriate. NHS Forth Valley is addressing chronic disease management in local health care delivery. The Community Health Partnership is undertaking some work to consider safe alternatives to hospital admission and enhanced care arrangements in the development of the new Community Hospital. The current position appears sustainable and work will continue to ensure that admissions are not</td></tr>
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inappropriate.

2.2 Delayed discharges – all

Delayed discharges in Clackmannanshire are within target for 2005/06. We have mainstreamed the Rapid Response Service, ensuring that this achievement can be sustained. There is currently no scope for improvement as we are operating successfully at or beyond targets i.e. 2 people.

Delayed discharge funding has been invested in crisis responses through augmented home care provisions, the Mobile Emergency Care Services (MECS) and in joint assessment and rehabilitation. A reduction in delayed discharges across the Forth Valley area will have priority in the Joint Commissioning Plan.

2.3 Delayed discharges – more than 6 weeks

Discharges are not delayed over 6 weeks unless, on exception, individuals are waiting for specific services that are essential for discharge. Current zero figure for people aged 65+. Targets have therefore been met and exceeded, leaving no scope to improve performance in this area. The Forth Valley area-wide picture is being jointly considered in the joint commissioning work.

2.4 NHS geriatric long-stay bed use

While the long stay bed figure in the trend summary remains at 26, further clarification is required in the current context of NHS Forth Valley re-design. At present 30 beds are designated 'long stay' but they are also used for GORU and palliative care. There are also 18 long stay beds for people with dementia. In the new Community Hospital there will be 45 beds for multiple use; complex care and acute beds will reduce in number from 30 to 25.

2.5 Persons supported in care homes

Although 2005/06 snapshot figures show a minor downward trend, the care home population is relatively static at around 249 people. This is currently not expected to reduce further, largely due to socio-economic factors that cannot be addressed in the short to medium term through service redesign or reconfiguration. 10 more local places are being planned, but at present, our provision of care home places is 32:1000 per head of population, compared with a national figure of 42:1000. Balance of Care priorities across Forth Valley will be negotiated in the Joint Commissioning Plan.

2.6 Persons with more than 10 hours home care weekly

There is a growing need to provide individuals with 10+ hours plus of home care per week. A reconfiguration of provisions is targeting those in need whilst retaining a ceiling for cost-effective support, which can meet needs at home. This is resulting in an increase in referrals to other services. In support of this, independence training and joint rehabilitation initiatives are being developed as part of a package of measures aimed at reducing home care hours to each individual as appropriate. Other support services include:

- 'Deli-bag' scheme provides a snack meal in addition to a hot midday meal
- housing support offering a range of support for independent living
- day care and home support for frail elderly and people with dementia
- rehab at home, respite care/short breaks and carer respite

From the experience of measuring and reporting levels and balance of care in 2005/06, it seems 20+ hours would be a more meaningful measure of levels of intensive care need than 10+ hours.

2.7 Single Shared Assessments

Service providers and practitioners are anticipating that Forth Valley E-care outcomes and solutions will be available in 2006-2007. The system currently in use is CCIS (Community Care Information System). While this offers joint access

	to some services, joint outputs are still not fully recorded via this system. The roll-out of single shared assessment by all agencies continues to progress. In terms of output, there are no waiting times for services, or for equipment and minor adaptations, which we believe has been achieved partly through the use of single shared assessments. The IoRN and ICADs data is integrated into the CCIS reporting system and is now more accessible to health practitioners. It has been used to show the balance of care against identified need. **2.8 'Benchmarking' with immediate comparators** Clackmannanshire shows a positive bias with benchmarked comparators. This has been explored in detail through the Joint Commissioning Database in terms of populations, resources and services and will further aid the Joint Commissioning Plan.
3. Demonstrating a holistic approach :	***Partnerships should demonstrate their understanding of the causes and effects within each indicator and the inter-relationship between indicators and on service provision. Balance of care is a key element. That should include:*** **3.1 Emergency and multiple admissions - a proxy for inappropriate admissions.** The Clackmannanshire Older Peoples Services Group have examined the data on emergency and multiple admissions: acute hospital admissions are generally considered by clinicians to have been necessary. There have been no 'social' admissions and an emergency care home bed, which is directly accessible by GPs has provided an alternative to admission. The trend in the take up of step-up and step-down services will be monitored against admissions data. The Community Hospital (2007) will provide a local facility and more flexible bed use, offering alternatives to hospital admission. **3.2 Delayed discharges - a combination of both systems and services that is a measure of joint working in a key priority area.** Hospital Discharges are given a high priority for community care assessments and provisions. There is no waiting list for assessments and/or services. Delayed discharges remain extremely low in number; a joint approach ensures that, through the provision of a range of prompt services, people receive appropriate levels of service to prevent admission and support discharges. **3.3 Service levels - a measure of the partnership's total joint investment for people with more intensive care needs (the kind of person who may emerge as an inappropriate admission or a delayed discharge).** The Care and Rehabilitation for the Elderly (CARE) team has a joined-up approach to providing appropriate levels of service to people with more intensive care needs, linking into acute, primary care and community based services. Primary Care have a significant role in ensuring that appropriate resources are accessed early enough to prevent an inappropriate admission, for example GP access to emergency respite. District nurses are providing high levels of care and are able to provide this quickly to support people who may be at risk of inappropriate admission or delayed discharge. In the development plans for the new Community hospital, a local response may include planned admissions for people with intensive care needs or long term conditions and this is anticipated to reduce the incidence of emergency multiple admissions. The Community Care Assessment and Care Management Teams have no waiting time on prioritised assessments.

	3.4 The level/percentage of home care - a proxy for the totality of community based services for people with more intensive care needs) as a key part of the balance of care. As stated previously, it is felt that 10+ hours of home care are not necessarily the indicator of intensive care needs; in the balance of care, people deemed to be at risk are also in receipt of a wider possible range of other services. Compared to benchmarked partnership areas, Clackmannanshire provides a high level of home care support in a partnership network of health, social services, housing and voluntary sector provisions which support people in their own homes. In terms of a balance of community care expenditure, we continue to focus the greater proportion of resources on supporting people at home **3.5 Single Shared Assessments - a further proxy for joint working that are pivotal to changing the balance of care etc.** As previously reported, the Single Shared Assessment data does not yet reflect the extent, or the effectiveness, of the good joint working practice that is established in older peoples' services. There is improved communication about needs and faster access to agreed services, using an interim system. Technological solutions are awaited with Forth Valley e-Care. (see notes attached to JPIAF 6 SSA submission and direct access to identified services outlined in JPIAF 8)
4. Translating the results of performance with an understanding of the holistic approach and its application.	***The partners should describe how these key issues are brought together with others as described below. Looking at that in more detail, partners should demonstrate what the key drivers of current performance are………*** 4.1 A joint approach to community care planning and provisions for older people is well-established in Clackmannanshire; it has been founded on good relationships which pre-date the Joint Future Agenda and has been formalised in a joint services framework which is overseen by a local multi-agency group. The current key drivers are **Population, Policy, Resources** and the **"Balance of Care"** …. the work being undertaken with the Joint Improvement Team will assist with the development of a Joint Commissioning Plan in a detailed planning framework which is addressing the future needs of an increasing population. ***What are the pressure points in the system, and how do they plan to address them……..*** Pressure points include : 4.2 Managing tight community care resources and being cost-effective..for example, we have put in place measures to reduce the home care time on meal preparation and free up hours to provide more personal care, the meals on wheels services have been reconfigured and we are also working with the Supporting People Team to set up a Mobile Warden Scheme. 4.3 Transitional arrangements in NHS Forth Valley Redesign – Forth Valley NHS redesign is reconfiguring acute and long stay provisions on new sites – the planned Clackmannanshire Community Hospital will provide a range of local inpatient, outpatient and community based services and a joint base for health and social services, prompting earlier discharges from acute care with flexible local bed use, including palliative care and long stay beds and a network of alternative care arrangements. 4.4 An increasing older population : the partnership is planning to respond to anticipated increases in demand in the Joint Commissioning Plan. Across Forth Valley there will be an 8.2% increase in the population over 65 and a 9% increase in the population over 75 in the five-year period 2005 to 2010. Over the same period there will be a 20.2% increase in the population aged 85 or over.

	This indicates a potential need for growth of community health and social care services of 10% to 15% (i.e. one to two per cent per year over the period) to maintain the rate of existing services and is the baseline of the Joint Commissioning Plan. 4.5 Recruitment issues..there is a low availability of ward staff and home care staff in a small local pool….consideration is being given to joint investment in recruitment and advertising and a joint training initiative with private care home providers. ***How do services and systems combine to improve results? For example, how are admissions affected by demography/ health, by GPs' referral patterns, by the availability of intermediate care/step up/step down services and by out of hours services?……..*** 4.6 The Clackmannanshire Joint Services Framework sets out the services that are in place and work jointly for older people – the multi-agency group has been considering the inter-relationships of acute, primary and community care services. The CARE team is a good example of joint working to prevent admissions and supports discharges. Home care workers are trained to promote independence. Step-up, step-down and 24-hour response services are in place including Mobile Emergency Care (MECS), fast-track A&E and rapid response services. Arrangements between MECS and registered social landlord housing providers enable an out-of-hours response services and access to rapid response services. The Joint Commissioning work has also put this into the context of health trends and demographics to inform the Joint Commissioning Plan which will be taken forward in 2006-2007. ***What arrangements and strategies are in place for other 'manageables', in particular around falls prevention and long term conditions management. Within this analysis, partnerships should also refer to the part played by service provision generally, and by the voluntary and independent sectors……..*** 4.7 There is a joint approach to risk assessment with local guidance on falls prevention and responses; there are good links through the MECS system and direct referrals to secondary services A Falls Group is run at the Day Hospital and the Specific Standardised Falls Assessment is applied….Lifting and Manual Handling training is available across all agencies (health , social services and the independent sector) in shared facilities. The Clackmannanshire Equipment Service (CES) is directly accessible for the prompt provision of health and social services equipment. With regard to long term conditions and in response to recommendations in the Kerr report, acute services are looking at the 'expert patient' model. There are also district nurses with particular skills and expertise in long-term conditions and they provide community based support and training to other staff and agencies as appropriate. The inter-relationship of indicators…….. ***How are delayed discharges influenced by the flow from admissions ?*** 4.8 Delayed discharge figures are kept low through fast track screening and therapy services in A&E, direct referrals , prioritisation of referrals, no waiting time for assessment, rapid response for planned discharges and the prompt availability of home support. No waiting list for care home places and the use of an emergency care home bed. The Community Hospital Development Plan and Joint Commissioning plan will address issues around alternative care options. ***How effective are inter-agency systems ?***

	4.9 Health, Housing and social care agencies are involved in the Clackmannanshire Joint Services Framework and there is a general view that services for older people are well coordinated in this small partnership area. There is good joint working between Hospital Discharge Liaison staff, Community Nursing, CARE Team, Ludgate House, MECS, CMHTE and the Community Care Assessment and Care Management Teams Inter-agency technological systems need improvement; information-sharing will be facilitated by the Forth Valley e-care system when introduced. A new Acute Hospital is planned and the Community Hospital is being developed in partnership to enhance local services, with the Community Health Partnership. ***Are levels of services appropriate ?*** 4.10 All available community care resources are invested in providing the best possible services and are being used to the maximum…the 'levels of service' issue is being addressed in the Forth Valley Joint Commissioning work with the Joint Improvement Team : an unprecedented amount of local joint information has been put into a joint database alongside national and benchmarked data for analysis. The other factor for further exploration is that of the views of service users and their carers on whether service outcomes are improving; this will be taken up through the Joint Services Framework and Community Engagement . Plans for the new Community Hospital are being developed with partners and with public consultation through the Public Participation Forum and the Community Forum. ***What specific responses are available e.g. step up and step down services including rehabilitation?*** ➢ GORU…geriatric orthopaedic rehabilitation unit ➢ Fast Track and Rapid Response Services ➢ CARE team….care assessment and rehabilitation for the elderly ➢ CMHTE…community mental health team for the elderly ➢ Rehab at Home….CARE team in conjunction with trained home carers ➢ Ludgate Resource Centre Respite and day services for assessment and rehabilitation and support to maintain people at home ➢ Planned and rolling respite for service users and their carers ➢ An emergency bed in a local care home The above services are available to **all** people aged 65+ who live in the Clackmannanshire Area. ***A number of partnerships cite having services that are not counted in the model (eg community hospitals) but are central to delivery, as part of the whole system. The partnership should report them here as part of demonstrating its holistic approach – but they will not count in the model itself.*** ➢ A comprehensive MECS system with enhanced alarms and 24 hour responses ➢ Flexible day care and respite services over 7 days ➢ Time-to-Share and day care at home services for people with dementia through the Joint Dementia Initiative and Alzheimers Society ➢ Supporting People team – Mobile Warden services being developed ➢ A joint project to deliver health service equipment through the CES (Clackmannanshire Equipment Service) has resulted in a more prompt and effective service which is jointly accessible ➢ The Community Hospital Development Plan for a range of provisions and

	flexible use of 45 beds and community-based initiatives ➢ The Community Health Partnership is taking forward the Health Improvement Agenda with a joint team. ***In addition, partnerships should illustrate how their development of joint services under the Joint Services Framework, Better Outcomes for Older People, is improving outcomes in their area.*** 4.11 ' Better Outcomes' has provided a focus for discussion and debate in a well established partnership of service providers and agencies working with older people. A joint framework of services has been developed and has highlighted good practice and also future needs. Further work, to check whether service delivery and outcomes are improving, is planned in consultation with services users and their carers. The Joint Commissioning Plan will further shape services and outcomes. Joint Future progress is reported in the Community Health Partnership and to eth Public Partnership Forum. ***Partners should show how their approach fits into or alongside their wider performance assessment arrangements……*** 4.12 The Performance Framework submitted as JPIAF 11 sets out the key outcome areas and local measures for improvement targets and is still in development. Performance is also measured in the context of wider performance reporting arrangements in Clackmannanshire Council's Corporate Plan, and the NHS Forth Valley Strategic Health Plan. In taking forward the next stage of the Healthcare Strategy, further Primary Care development and Community Hospital development are seen as critical to delivery. ***Partnerships should set out concisely their view of their current baseline (i.e: where they are at currently) and where they would wish to be in the medium to longer term……*** 4.13 The work of the National Joint Improvement Team will inform next steps considering: • Capacity across the system in the non acute setting • What is required in terms of capacity • What models of service will address the need • Data analysis to inform model of care development NHS Forth Valley is working with the three Council partnership areas to address the balance of care. Plans within Forth Valley are developing against 'Delivering for Health' key actions around Intensive Case Management, which is considered to be a key driver to meet this target to realise a shift in the balance of care. Targets on emergency re-admissions are being set and action on areas such as chronic disease management within health services; work to achieve this target will be reflected in Community Health Partnership priorities. 4.14 The key principle in community care is to support people as far as possible in their own homes, with due consideration of the economic and social drivers that influence the availability of resources. It is felt that a reasonable balance has been working in Clackmannanshire to meet identified needs and provide services. This has been maintained over the past few years on a minimum 50:50 resource split in favour of community care provisions against expenditure on care home places. There are no waiting lists for services such as home care and equipment. 10 more care home places are planned. Home adaptations and day care are under review, along with a review of

	changing needs in the older population, including the day care and support needs of people with learning disabilities and functional mental illness. The Joint Commissioning data shows a Forth Valley area-wide picture and in the medium to longer-term this will be used to set revised standards in the Joint Commissioning Plan The vision for the new Community Hospital is of co-location of health and social services and flexible use of a local resource with inpatient, outpatient and community health and social care services. ***They should describe broadly how their joint strategies and plans (e.g. care group strategies, balance of care studies, etc), drive change and address local issues/weaknesses/interrelationships between indicators that require practical action(s). The result should be partners' broad direction of travel.*** Forth Valley Older Peoples' Strategic Framework :Joint Improvement Team working with the three partnerships across Forth Valley on a Joint Commissioning Plan Clackmannanshire Older People Joint Services Framework : will be informed by above in taking forward joint service developments Community Health Partnership : setting out local planning framework for all services Delivering for Health Plan : NHS Forth Valley redesign, New Acute Hospital, Community Hospital, and Community Health Partnerships. Health Improvement Plan. The Unscheduled Care Collaborative and the Out of Hospital Care Project support the work at the interface of Acute and Primary Care considering preventable admissions. Palliative Care Strategy: setting out a joint approach and agreements on service levels and the range of support available for people with palliative care needs, terminal illness and end-stage care Joint Community Care Services Plan : pulls together key community care priorities, including joint assessment and rehabilitation, joint training, joint home care provisions, day care for people with dementia and mental health issues, more care home places and a range of housing support. Local Housing Strategy : A Particular Needs Assessment for Older People has highlighted a need for additional housing provision planned in 2007 Supporting People Strategy : Supporting People Team and contracted support hours for home support to keep people in their own homes ***From that analysis partners should identify their specific practical actions to deliver better joint services and better outcomes, indicating, for example, timescales and funding commitments to achieve actual change on the ground in the medium term. This summary should translate into their, Local Improvement Targets (LITs) recorded in JPIAF 11.*** **4.15 Summary** **Across the Forth Valley area, the Joint Improvement Team has been working with NHS Forth Valley, Clackmannanshire, Stirling and Falkirk Councils on the capacity planning exercise, with a view to commissioning relevant services to further reduce delayed discharges and to effect a balance of care across all services and sectors.** **The Community Hospital is the major investment in developing enhanced community-based services and is due for implementation in 2007** **The additional challenge of building a new Acute Hospital with fewer beds than at present, and the redesign of community hospitals to provide care and alternative settings, will have an impact on planning for older peoples' services.**

	The work of the JIT has assisted partnerships and the Older Peoples Strategy Group in taking a Whole Systems approach to setting out a longer term vision and this work is still in progress. **Summary of Key Development Areas in the Joint Commissioning Strategy May 2006** : **1.** Analysis of population factors for the planning model **2.** Accounting for carers' needs in the planning model **3.** Monitoring waiting lists for services and delayed discharge, quantifying the scale and nature of services required to respond to these issues over the next five years **4.** Modelling care at home services and costs in a local 'what works?' survey including further workforce data for analysis **5.** Visits to see alternative models of community health and social care provision. **6.** Decisions on the Change Strategy to be adopted in Clackmannanshire, Falkirk and Stirling and across the whole of Forth Valley **7.** Firm plans for commissioning should be concluded for the next five years, with an annual review to extend those plans as funding becomes clear

Further details, data, analysis and proposals are contained within the Forth Valley Joint Commissioning Strategy for Older Peoples Services (First Draft : May 2006)