

Multi-agency inspection

Collaborative working across services for older people in Forth Valley

Multi-agency inspection

Collaborative working
across services for older
people in Forth Valley

Acknowledgement

We wish to thank everyone who assisted us during this pilot multi-agency inspection. We received a warm welcome from everyone we met and we are grateful to them for the time and effort they took to assist us. We particularly appreciate the way the local co-ordinators provided us with support and information throughout the inspection.

© Crown copyright 2008

ISBN: 978-1-905501-55-7

Social Work Inspection Agency (SWIA)
Ladywell House
Ladywell Road
Edinburgh
EH12 7TB

Produced for the Social Work Inspection Agency by RR Donnelley B53019 1/08

Published by the Social Work Inspection Agency, January 2008

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

The text pages of this document are printed on recycled paper and are 100% recyclable

CONTENTS

Chapter 1	Introduction	1
Chapter 2	Summary	2
Chapter 3	Scope and methodology of the multi-agency inspection	4
Chapter 4	Context of services for older people in Forth Valley	5
Chapter 5	Overview of Forth Valley-wide issues	9
Chapter 6	Clackmannanshire Council and NHS Forth Valley partnership	27
Chapter 7	Falkirk Council and NHS Forth Valley partnership	63
Chapter 8	Stirling Council and NHS Forth Valley partnership	100
Chapter 9	Joint evaluations and recommendations	140
Appendix 1	Model for the multi-agency inspections of services for older people	145
Appendix 2	Methodology for the multi-agency inspection in Forth Valley	146
Appendix 3	Clackmannanshire Community Health Partnership structure	149
Appendix 4	Clackmannanshire Council Social Work structure	150
Appendix 5	Falkirk Community Health Partnership structure	151
Appendix 6	Falkirk Council Housing and Social Work Services structure	152
Appendix 7	Stirling Community Health Partnership structure	153
Appendix 8	Stirling Council Community Services structure	154
Appendix 9	Tables of NHS data on joint performance	155

Joint evaluations

The multi-agency inspections for community care services have adopted the SWIA six point scale. In this multi-agency inspection of services for older people, the inspection team has provided a joint evaluation for each of the six areas for evaluation, as set out in appendix 1: Model for the multi-agency inspections of services for older people.

The joint evaluations apply to collaborative working between health and social work services within the partnerships. For this reason, they may differ from the evaluations in the SWIA performance inspections. There are no joint evaluations given to a single agency or in chapter 5 which considers the Forth Valley-wide issues.

The joint evaluation scale

Level	Definition	Description
Level 6	Excellent	Excellent or outstanding
Level 5	Very good	Major strengths
Level 4	Good	Important strengths with some areas for improvement
Level 3	Adequate	Strengths just outweigh weaknesses
Level 2	Weak	Important weaknesses
Level 1	Unsatisfactory	Major weaknesses

The report format

We collected a very large amount of information during the inspection. This report cannot do full justice to all that we learnt. Instead it draws out the main themes about collaborative working, backed by a range of selected evidence.

Except where the inspection team is expressing an opinion, the report is written in the past tense. Where we use quotes from individuals, they represent opinions we heard widely expressed, not just one individual's views.

The report uses the following words to describe numbers and proportions in relation to the results from the various surveys:

Almost all = over 90%

Most = 75-90%

Majority = 50-74%

Less than half = 15-49%

Few = up to 15%.

The term 'social work services' covers both social work and social care services, either directly provided by councils or commissioned from the independent sector.

Introduction

This report gives an overview of collaborative working between health and social work services for older people in Forth Valley. It sets out the strengths and areas of good practice as well as identifying areas where improvements are needed.

It covers the second multi-agency inspection of services for older people. The first was undertaken in Tayside in 2006. A follow up inspection will be carried out one year after the publication of the report, both in Tayside and Forth Valley.

In recent years, the NHS in Scotland and councils have responded to significant challenges and changes. There have been substantial improvements in health, social work and social care services which have delivered better outcomes for people and their carers. But demographic changes, people's rising expectations and advances in medical technology are placing greater demands on agencies to continue improving services for older people.

In all public services there is a shift from top-down, target driven performance management to more self-improving systems built around the needs of individuals. Increasingly, collaborative working between health, social work and social care agencies will make a significant contribution to improved services. Multi-agency inspections support this improvement in several ways. For this reason, they were announced by Malcolm Chisholm, then Minister for Communities, in 2006.

There were significant improvements in the way that this second pilot was undertaken. Data helpfully provided by ISD, the national organisation for health statistics, was used. It promoted discussion with health professionals and managers, particularly about how differences in clinical practice, such as emergency admissions for older people, impacted on outcomes for older people. The data provided support for the direction of travel within Forth Valley towards more community based health services.

A core set of published performance indicators was agreed with the partnerships as the basis for the evaluation of outcomes for older people and their carers, because the National Outcomes were not fully in place. The analysis of health and council performance data enabled the inspection team to undertake considerably fewer fieldwork sessions.

We fully appreciate the co-operation and assistance of the four agencies, NHS Forth Valley, Clackmannanshire, Falkirk and Stirling Councils, which have participated in the second pilot inspection of services for older people. In particular we are grateful to patients, service users, carers, staff and managers who played an active role in the inspection process.

Alexis Jay
Chief Inspector
SWIA

David Steel
Chief Executive
NHS QIS

CHAPTER 2

Summary

1. Older people in Forth Valley generally were pleased with the health and social work services they received and the way these services worked together. Carers were less satisfied with the support they received, although this is consistent with the way carers across Scotland feel.
2. There was a very positive culture in Forth Valley between managers and staff at all levels in NHS Forth Valley, Clackmannanshire, Falkirk and Stirling Councils about working together in partnership to help older people and their carers lead as independent lives as possible.
3. Significant successes had been achieved (see Tables 1-6) by the partners in relation to the way that older people were supported in the community and were admitted and discharged from hospital. There were many commendable examples of proactive services such as the Fast Track team in the hospitals and the range and depth of the rehabilitation services.
4. NHS Forth Valley had progressed the development of a new acute hospital in Larbert competently and was fully engaged in developing three new-build community hospitals. Some staff in older people's services said they wished for better engagement in the change processes for community hospitals and senior managers recognised the need to take action on this. The partners agreed that a key priority for them was integrated working, the development of community health services, and ensuring that social work and health services in the community dovetailed together. In order to achieve this, NHS Forth Valley recognised that the role of the Community Health Partnerships (CHPs) in partnership working at the local level would have to be strengthened. The councils also recognised that they would have to play a more active role in CHPs and anticipated doing so with the newly elected members. The councils provided different kinds and levels of services for older people and their carers across Forth Valley.
5. Clackmannanshire social work services were well supported by their elected members, who saw quality services for older people as a priority. They ensured that these services had relatively high levels of funding, higher than the national average and the highest in Forth Valley in 2005-06 per older person. The Head of Community Care Services and the CHP General Manager provided strong and enabling 'can do' joint management. Service commissioning was proactive in response to the needs of older people, and services such as mobile home care were innovative in meeting the needs of older people. Older people and their carers expressed the highest level of satisfaction in Forth Valley. Their belief that outcomes for them from services were very positive was supported by the evidence from an agreed core data set of performance indicators, developed for this multi-agency inspection.

6. Falkirk social work services were also well supported by their elected members who had decided that people should receive home care services without charges. Joint leadership and management of health and social work services in Falkirk were not strong, and we were concerned about the managerial capacity to jointly progress strategic whole systems thinking. This was partly because of recent vacancies and new appointments in the council. Staff said they lacked understanding and involvement in the development of services for older people. Assessment and care management was being undertaken in an unsystematic and uncoordinated way and needed urgent attention. Falkirk Council provided a relatively high level of home care services and generally older people were satisfied with the outcomes for them.
7. At the time of the inspection, Stirling Council viewed social work services for older people as one of its priorities, but not one of its highest priorities. Older people and carers were the least satisfied with the outcomes of services for them. This was supported by the evidence from the agreed core data set of performance indicators. In particular, home care services were provided at a much lower level than in the other partnerships in Forth Valley. Assessment and care management were not being undertaken jointly. There was a very active commitment amongst health and social work staff to health promotion and well being of older people, such as rehabilitation services in council care homes. Joint leadership and management of health and social work services in Stirling were not strong and we were concerned about managerial capacity. However, there was now a clear recognition that improvements were needed and would be implemented.
8. There were some over-arching issues in Forth Valley such as ensuring that there were clear procedures for social work care staff in relation to medication, the need to extend services for older people with mental health problems and dementia services and to improve joint financial planning and reporting.
9. Overall, the main issue for the partnerships was the need to develop a joint strategy for future community health and social work services. They should urgently progress the development of a joint Forth Valley-wide framework for older people's social work and health services in the community. This should be done in conjunction with the on-going work on developing plans for services in the community hospitals.

This framework should set out how it will meet the need for older people's services, particularly community health services and intermediate care services across Forth Valley. It should identify the desired outcomes of these services. It should also ensure that there is more discussion and greater understanding in relation to levels of health funding across the Forth Valley councils. This Forth Valley-wide framework should include a joint commissioning plan, financial plan, joint action plan and time scales.

CHAPTER 3

Scope and methodology of the multi-agency inspection

3.1 Background

The model and methodology for the multi-agency inspection were developed by the National Health Service Quality Improvement Scotland (NHS QIS), the Social Work Inspection Agency (SWIA), and the Care Commission. Each has different ways of working but all have an equal focus in assisting agencies to give people the best and safest care possible.

3.2 The Forth Valley multi-agency inspection of services for older people

The Forth Valley inspection was the second of two pilots designed to test the new model and methodology. It took place between April and September 2007 with the fieldwork being undertaken in the three partnerships in May and June 2007. The inspection team had been able to improve the model and methodology after the first pilot. (See appendix 1 for the model used in these multi-agency inspections.)

3.3 Scope and methodology of the multi-agency inspection

The pilots focused on inter-agency issues and not single agency services. The pilots did not include acute health services except where they impacted on primary health, social work and social care services.

The inspection process included interviews with older people, carers, elected members, managers, and staff, as well as questionnaires, case file reading, self assessment workbooks and advance information.

The methodology for this pilot was significantly improved by the better use of data and statistics. We agreed with the partnerships a core set of published performance indicators as the basis for the evaluation of outcomes for older people and their carers, because the National Outcomes were not fully in place.

Data helpfully provided by ISD, the national organisation for health statistics, was also used. This promoted discussion with health professionals and managers, particularly about how differences in clinical practice, such as emergency admissions for older people, impacted on outcomes for older people. The data provided support for the direction of travel within Forth Valley towards more community based health services.

The report is written in a different way from the report of the first pilot. Chapter 5 contains an overview of issues for all the partnerships. Chapters 6, 7 and 8 are stand-alone chapters for the Clackmannanshire, Falkirk and Stirling partnerships respectively. This means that there is some repetition in each of these chapters. We expect people to read chapter 5 and the relevant chapter for their partnership.

See appendix 2 for the methodology for the multi-agency inspection in Forth Valley.

Context of services for older people in Forth Valley

4.1 NHS Forth Valley

The *Kerr Report*,¹ 2005, presented a comprehensive review of the NHS in Scotland and proposals for the way forward. Following on from this, the Scottish Executive Health Department published *Delivering for Health*² which forms the blueprint for the direction of travel for all NHS Boards in Scotland. It emphasises the need for the modernisation of health services and a shift in the balance of care from hospital based services to services in the community. The NHS Forth Valley Integrated Healthcare Strategy provides the local interpretation of *Delivering for Health* and recognizes the significant progress that has been made across NHS Forth Valley towards shifting the balance of care.

NHS Forth Valley's overall vision is to improve health and healthcare for the people of Forth Valley. To realise this vision, from 2009 acute healthcare services will be provided from a single acute hospital in Larbert. This will be supported by fully integrated and enhanced primary and community services which will be delivered from a variety of settings ranging from community hospitals, to support people in or as close to their own homes as possible. In addition, primary care facilities and services will continue to be modernised, and greater linkages will be created between primary and secondary health services, and services delivered by council and voluntary sector partners.

Two major parts of the infrastructure support for the Strategy have already been approved and construction has commenced for the Larbert acute hospital and Clackmannanshire community hospital. The Alloa hospital will come into full operation in late 2008. The construction of the Larbert hospital will be completed in late 2009 and there will then be a phased commissioning and transfer of services from Falkirk and Stirling over 2010 to 2011. In total there will be four community hospitals supporting the delivery of the Strategy: in Clackmannanshire, Falkirk, Stirling and Bo'ness. There will be capital investment for the Stirling and Falkirk hospitals but the business cases are not at this stage complete so it is unclear whether these will be new build or a mix of rebuild and refurbishment on the existing hospital sites. There will, however, be a new model of care for all four of the community hospitals to support shifting the balance of care.

It is important to recognize that there was a fundamental change to the way that acute services in Forth Valley were delivered from October 2005 to support the changes for Larbert. This meant that a virtual single inpatient hospital was created across the Falkirk and Stirling campuses. This has been a major challenge to the partnerships in delivering care services.

NHS Forth Valley area is located in central Scotland and has a total population of about 286,000. It is coterminous with three council areas: Clackmannanshire, Falkirk and Stirling. Each of the councils has an Extended Local Partnership Agreement with NHS Forth Valley and these underpin the local partnerships referred to throughout this report.

¹ *Kerr Report–National Framework for Service Change in the NHS in Scotland*, Scottish Executive, 2005

² *Delivering for Health*, Scottish Executive, 2005

The three NHS Community Health Partnerships (CHPs) in Forth Valley, Clackmannanshire, Falkirk and Stirling, were established in April 2005. CHPs are responsible for improving the health of their local communities in line with the Integrated Healthcare Strategy. They are doing this by working closely with the public, the voluntary and independent sectors and councils in their area, for example in reducing the number of patients delayed in their discharge from an acute setting. Partnership working has also been developed with patient groups, community groups, social economy partnerships, and regeneration outcome groups.

They will also work towards delivering more and improved services as close to home as is possible, thereby reducing unnecessary admissions to hospital and providing faster access to services. In addition to primary care services, CHPs deliver a range of services to older people including community hospitals and community mental health services of older people such as day hospitals and mental health teams.

We recognise that each of the three CHPs was taking the lead for different services or functions such as joint performance management and that therefore one partnership might appear to be more advanced in some functions than others. We have taken this into account when making joint evaluations.

Within the Clackmannanshire CHP there are 7 practices which employ 38 General Practitioners (GPs). In the Falkirk CHP there are 28 GP practices which employ 101 GPs and in the Stirling CHP there are 22 GP practices which employ 85 GPs. All GP practices provide general medical services under the new GMS contract and are supported by practice nurses and administrative staff.

4.2 Clackmannanshire Council

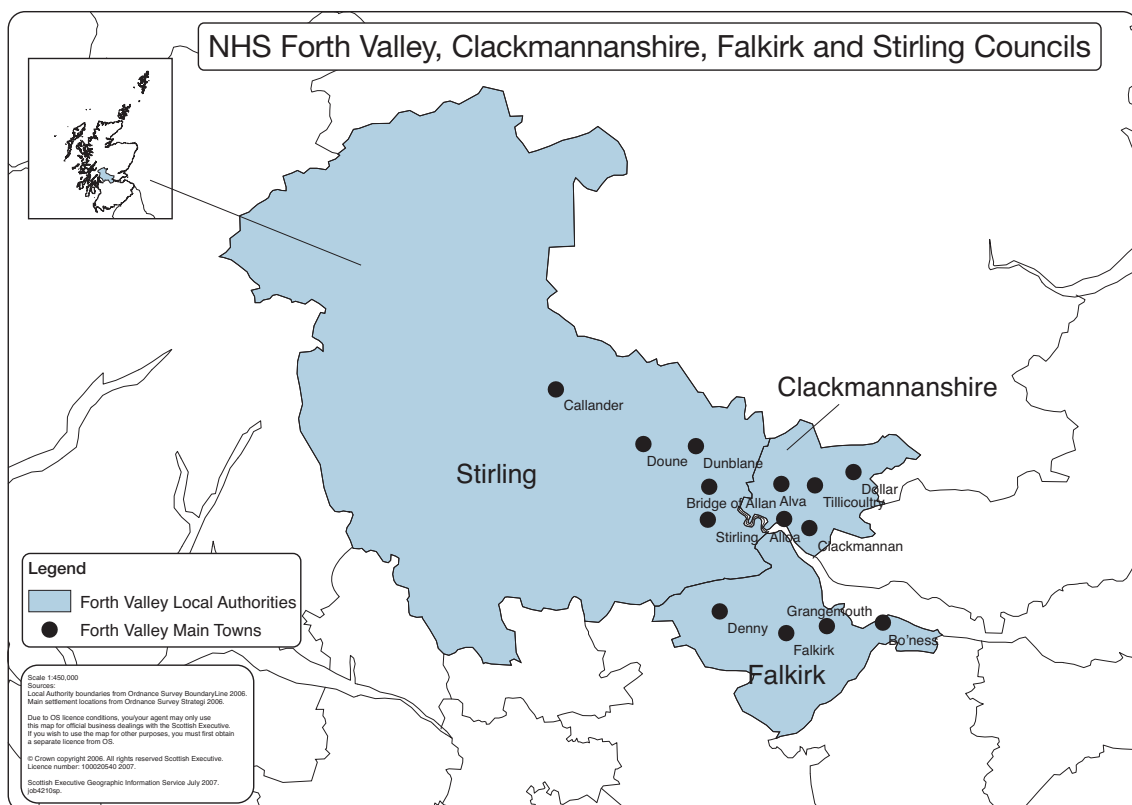
Clackmannanshire Council covers 159 square kilometres and is the smallest mainland authority in population in Scotland – 48,900 people living in a number of towns and villages. Alloa and Sauchie are the main towns with a total population of 18,623.

By 2014, the local population is expected to increase by 0.8%, but with a 28% increase in the older population, which is significantly above the national increase of 17%. It is projected there will be an increase in the older population from 18% to 23% of the total population by 2024. However, as a result of substantial new housing developments in the area it is expected that this figure could be higher. Improved transport links such as the new bridge, the Upper Forth Crossing, and the rail link to Clackmannanshire are also expected to have a positive effect on future population projections.

The Clackmannanshire economy is being restructured and rebuilt following a massive decline in employment in the traditional manufacturing sector, particularly in the textile and brewing industries. Regeneration is a key priority and includes a focus on health and health improvement initiatives in identified areas of significant deprivation and poor health.

Social work services, including adult care assessment, care management and older people's care services, are in the council's Services to People Directorate. The CHP is an integral part of the Community Planning structure. There is council representation in the CHP, where service developments are based on the Extended Local Partnership Agreement, 2004.

Fig 1: Map of NHS Forth Valley, Clackmannanshire, Falkirk and Stirling Councils



4.3 Falkirk Council

Falkirk Council covers 297 square kilometres, and has a growing population of 149,700. This is spread across the towns of Falkirk, Grangemouth, Bo'ness, Denny, Bonnybridge and many small villages in rural and semi-rural locations. These were previously centres of mining activity which has now declined. There is some evidence of deprivation in these areas compounded by relative geographic isolation.

By 2014 the local population is expected to increase by 4.3%, with a 19% increase in the older population, which is just above the national increase of 17%. It is projected there will be an increase in the older population from 19% to 21% of the total population by 2024.

An integrated Housing and Social Work Service within Falkirk Council with a single Director was established in 1999-2000. The Director is not directly responsible for the delivery of NHS services but plays a pivotal role on behalf of the council in developing the co-delivery of health and social care services.

4.4 Stirling Council

Stirling Council area covers 2,187 square kilometres, with a growing population of 87,800. Almost a third of the population lives in rural Stirling where there are about thirty settlements. Around two thirds live in the City of Stirling, Scotland's newest city, and its neighbouring communities of Dunblane and Bridge of Allan. This is the main urban centre and economic driver for the area.

By 2014, the local population is expected to increase by 2.3%, but with a 21% increase in the older population, which is above the national increase of 17%. It is projected there will be an increase in the older population from 19% to 22% of the total population by 2024.

In 1999, the council restructured its social work services into two integrated services. Children's Services includes children's social work and education and Community Services includes community care. The CHP has both council elected member and senior manager representation, and the Director of Community Services has the lead officer role for the council in health improvement issues.

At the time of the inspection, a major fire in Drummond House, one of the council's most important buildings and the centre for the care management and home care services, had required intensive management action to ensure that not only the inspection but also social work services ran as smoothly as possible. We appreciate the work involved in this and are grateful to the managers involved for ensuring that the inspection went ahead.

Appendices 3-8 contain diagrams of the structure of the CHPs and social work services.

Overview of Forth Valley-wide issues

There were several issues which were consistently shared by the three partnerships and they are brought together in this chapter. Where it is appropriate to give more details about a particular partnership, this is done in the following chapters. Chapters 6, 7 and 8 are stand-alone chapters for the Clackmannanshire, Falkirk and Stirling partnerships respectively. This means that there is some repetition in each of these chapters. We expect people to read chapter 5 and the relevant chapter for their partnership.

5.1 Whole systems approach

5.1.1 The situation in Forth Valley

Collaborative working across services for older people in Forth Valley was based on a bedrock of strong commitment by NHS Forth Valley and Clackmannanshire, Falkirk and Stirling Councils to partnership working. We were impressed with the very positive relationships between health and social work staff and managers at all levels in the agencies.

There have been a number of jointly sponsored services such as the Forth Valley Sensory Centre, the Joint Equipment Loan service and the Burnbrae unit for older people with mental health problems who were transferred from Bellsdyke Hospital. Considerable joint work had been undertaken to reduce delayed discharges. In 2003 there were about 55 delayed discharges in the acute sector on a routine basis. In 2007 there had been no delayed discharges in the acute sector for more than six months.

Collaborative working reflected two main influences. The first was major strategic change in the provision of acute and post-acute care by NHS Forth Valley; the second the considerable disparity in the development and provision of relevant services by the three partnerships: Clackmannanshire, Falkirk and Stirling. The latter had resulted in different levels and types of services for older people that depend on collaborative working. This was confirmed both by our observations and by the detailed comparative data on service use and outcomes provided by ISD, the organisation which collates information on the NHS in Scotland (see below).

We acknowledge that these differences reflect local democracy, choices about local priorities and consequently differing approaches, but we endorse service users and carers views that the differences are too wide and that there is not a consistent enough approach across the partnerships.

5.1.2 Shifting the balance of care between acute and primary care

A major reconfiguration of NHS acute and post-acute care was under way, and will culminate in the single-site provision of acute care in the new-build PFI hospital on the Larbert site in 2009. The two district general hospitals, at Stirling and Falkirk, had already undergone significant service change in anticipation of this, with acute admissions almost exclusively channelled to Stirling and the increasing use of the Falkirk Royal Infirmary for planned care.

This process appeared to have been well managed, with prior consultation and service modelling and a high degree of public acceptance. There was a growing emphasis on alternatives to admission, and improved interface between community and acute health services.

In addition to the new acute hospital, and complementing its services, there will be four community hospitals, in Clackmannanshire, Stirling, Falkirk and Bo'ness. These will provide some in-patient services such as post-acute rehabilitation. They will also provide a base for community and outreach health and in some cases social work services.

The progress towards these four community hospitals engendered optimism that, when complete, the new hospitals will together realise the ideals of the *Kerr Report* and *Delivering for Health*. These reports set out the way forward for the NHS in Scotland – centralisation of acute services backed up by augmented local provision, in order to achieve the goal of safe and effective care as near people's homes as possible. There was satisfaction that the NHS Forth Valley strategy had anticipated the recommendations of the Kerr Report.

In particular, geriatrician leadership in Forth Valley had contributed significantly to the strategy, and had done so on the basis of a record of sustained and energetic service provision and service development. Health care services for older people in Forth Valley were active and innovative, closely involved in both acute inpatient care and community initiatives, and able to demonstrate from service data and from audit some impressive achievements over recent years.

In specific terms, the significant achievements by NHS Forth Valley and the partnerships can be identified in several ways:

- rates of admission of older patients had remained static despite ageing of the population
- inappropriate admissions from care home settings had been minimised by service developments, such as in palliative care
- community rehabilitation services had evolved to reduce avoidable use of acute care
- multiple emergency admission rates of older people remained creditably low
- there were no delayed discharges in acute beds at the time of the inspection.

5.1.3 Service use and outcomes: insights from ISD data

A significant step forward was made in the second pilot by using national health data to analyse the local situation before the inspection began. In the course of the first MAISOP pilot in Tayside, the potential value of ISD data in illustrating the impact of collaborative working on service use and outcomes was noted, and a relatively simple analysis revealed interesting differences between the three Tayside partnerships. In advance of the second pilot in Forth Valley, and in discussion with ISD and representatives from Forth Valley, a more extended analysis was requested, and again proved to be of considerable interest.

For our purposes we focused on trend data from the three partnership areas for older people, along with Forth Valley and Scottish average data, covering:

- total bed days for acute admissions (Table 1)
- delayed discharges (Table 2)
- acute emergency admissions (Table 3, in appendix 9)
- multiple (2+) acute emergency admissions (Table 4, in appendix 9)
- length of stay for emergency admissions (Table 5, in appendix 9)
- standardised mortality rate (Table 6, in appendix 9).

Such data, though not entirely conclusive, undoubtedly informs any discussion of the adequacy of collaborative services for older people. Overall the data demonstrated the positive outcomes for the services which NHS Forth Valley and the councils were achieving.

From Table 1 we drew the conclusion that bed-day data, reflecting both numbers of admissions and their duration, can be used as a broad measure of the shift in the balance of care, with lesser use of acute provision indicating improving community services. The Forth Valley partnerships performed better than the Scottish average.

Delayed discharge is a major national concern both organisationally and in personal, patient-focused terms. The potential influence of good collaborative services on delayed discharge rates is therefore of particular importance. It is however complex. Lower rates may reflect the successful avoidance of admission to hospital of the frailest (those most at risk of delayed discharge) and also the effect of better collaborative services in maximising the possibility of their return home once admitted. There was clear evidence that the Forth Valley rates for delayed discharges are improving (Table 2). The delayed discharge census at June 2007 showed that, in relation to delayed discharges of more than 6 weeks, Clackmannanshire had no delayed discharges, Falkirk had 16, a reduction of five from April, and Stirling had six, the same as the previous month.

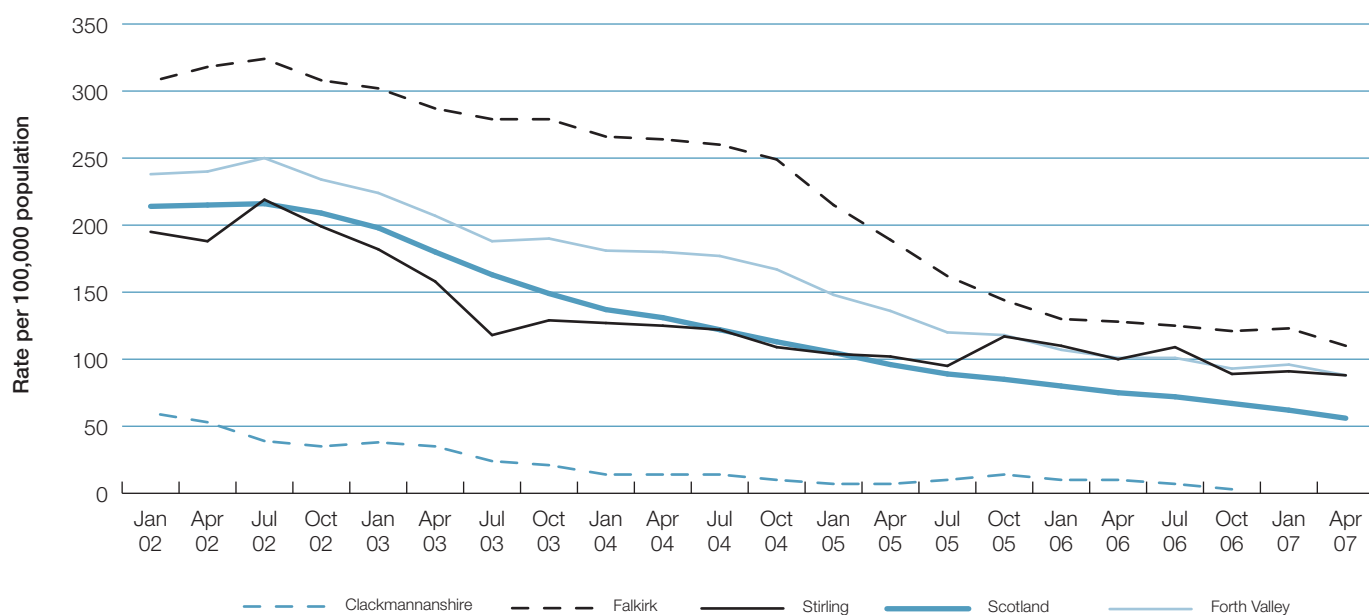
The Forth Valley partnerships performed better than the Scottish average in relation to the following important key indicators for joint working. We concluded that lower acute admission rates, especially for people over 75 years, can be seen as demonstrating the successful avoidance of unnecessary admissions (Table 3 in appendix 9). We also concluded that lower repeat admission rates, especially among the over 75 years, reflected degrees of success at managing sub-acute illness at home, with the avoidance of unnecessary admission (Table 4 in appendix 9). Further details on emergency admissions nationally is available at <http://www.isdscotland.org/isd/3914.html>

We concluded that a shorter length of stay was more likely when readily accessible community support and rehabilitation services for older people being discharged from hospital were available (Table 5 in appendix 9).

Table 1. Bed days for all emergency admissions for older people aged 75+ for Clackmannanshire, Falkirk, Stirling, NHS Forth Valley and Scotland



Table 2. Delayed discharge over 6 weeks: older people aged 65+ ready for discharge in Clackmannanshire, Falkirk, Stirling, NHS Forth Valley and Scotland



The standardised mortality rate data for people over 75 years (Table 6 in appendix 9) was included for completeness and should be interpreted with caution in relation to any discussion of health and social care service provision and use. However, in general terms it appeared to show that the lesser use of inpatient services in Clackmannanshire, reflecting the shift locally in the balance of care, was not, over the period studied, associated with any consistently adverse mortality, and indeed the opposite may be the case.

As part of the fieldwork, most of the ISD data was shown at meetings with both health and social work officials, at Forth Valley level and in the partnerships. It was consistently received with interest and enthusiasm. Such data, broken down by council area as well as by NHS Board, offers hitherto unavailable insights into the use of acute health services by older people and the very old within and across an NHS Board area. As a quantitative assessment of whole-system performance of health and social care for older people, it provides a potentially powerful high level means of evaluating such services. In the hands of managers, clinicians and other practitioners involved in the provision of care, it can contribute to the analysis and improvement of local performance in all Scottish partnerships.

5.1.4 The three local partnerships

It became clear in the course of the inspection that the three partnerships differed greatly in the significant challenges of size and geography. They also differed greatly in the volume, quality and accessibility of the services they provided for older people, as well as in terms of culture and organisation. Some of this was to be expected in terms of responses to the challenges of size and geography. What became of increasing interest, as the inspection and subsequent analysis proceeded, was how well the evidence obtained in the fieldwork phase correlated with the detailed quantitative comparative information which was available from ISD. We came to the conclusion that the diversity of services provided across the three partnerships was not acceptable to older people and carers.

Clackmannanshire partnership

Compact in size and with the smallest population, this partnership area was socially mixed with significant post-industrial problems and also growing numbers in commuter communities, with greater affluence and better health. Its relatively small scale had facilitated simplified management systems in both health and social work services and real collaboration between the two agencies. The partnership was widely regarded as ‘can-do with excellent community services’ and included a progressive CHP that appeared to work well. Collaborative services appeared accessible and effective – and this was supported by the comparative ISD data.

Falkirk partnership

With a large population and relatively high levels of deprivation in a post-industrial society, the Falkirk partnership appeared to face particular challenges. Although historically it enjoyed some advantages in terms of community service initiatives for older people, there were concerns locally about the partnership and provision of some social work elements of collaborative services. There was a tradition of high-volume council residential care, which was under review. The Care Commission had concerns about the quality of some independent sector care home provision. Rehabilitation services at home were relatively integrated and appeared to work well. As ISD data demonstrated, progress on delayed discharges (Table 2) had been the object of considerable concern, and considerable reductions had been achieved. However, the Falkirk partnership remained above the Scottish average of delayed discharges. The development of the CHP appeared to be as yet tentative: with a history of low participation from elected members, some concern about commitment on the part of GPs, and a general impression of an organisation yet to demonstrate its full potential.

Stirling partnership

The Stirling partnership area was relatively prosperous, though pockets of deprivation existed. Historically it had been relatively well resourced in terms of ease of access to acute care, reflecting the high level of provision of acute services at Stirling Royal Infirmary. In sharp contrast, care provision for older people at home was poor, with assessments slow and the provision of packages of care for patients leaving hospital often seen locally as inadequate. We were advised many individuals paid for their own care, both at home and in care homes, although they would normally also receive free personal care payments. For others, and in particular for those in rural areas in need of care at home, services were limited. CHP development was also seen as emergent rather than advanced in terms of partnership working.

5.1.5 The future shape of services in Forth Valley

It is noteworthy that significant successes have been achieved (see Tables 1-6) in a situation in which there are considerable differences in the way that the councils function. The relatively unitary organisation of health services, particularly hospital-based services, in Forth Valley was in contrast with the arrangements for the provision of social work services. For a variety of reasons, geographical, historical, demographic and political, considerable disparities in them persisted.

The development of collaborative services therefore involved complex negotiations between NHS Forth Valley and the social work services. Without shared standards and procedures, the partnerships did not provide the same levels of services across Forth Valley. This was surprising because the managers in the partnerships consistently told us about the strength of joint working and the benefits of their collaborative culture.

In addition there had been a tendency on the part of the three councils to allow NHS Forth Valley to become the driving partner in the development of new services. The councils were not rigorously thinking through for themselves what services, both community health services and social work, were needed for older people. They could therefore not participate in joint discussions in a robust way, with a clear view of what the balance of health and social work services should be in their own area.

For example, the levels of community health services should be a key consideration for the councils. The Joint Commissioning Plan, 2006, stated that the level of community nursing and community psychiatry nursing was lower and the level of continuing care beds provided by NHS Forth Valley was higher than comparable NHS Boards in Scotland. We were also informed by nursing staff in Forth Valley that they felt constantly under pressure, because of lower levels of staff and because the focus of managers was on acute services. We suggest that this issue should be fully considered by the partnerships, since the ability to support older people in the community will depend on robust community nursing services.

The CHPs were at an early stage of development in terms of partnership working. The key role of the CHP in leading the Health and Wellbeing element of the Community Plan was noted in Falkirk and in Clackmannanshire, and was being reviewed in Stirling.

Both council and health senior managers confirmed that the CHPs had not yet reached their full potential in jointly driving developments of services locally or in involving councils as effectively as had been anticipated. We were told by many staff that this was because the focus of senior managers in NHS Forth Valley had been on the major developments around the new hospitals. Senior health managers said that this was not so – a dedicated team from acute services had taken forward the Larbert hospital project. However, some council senior managers also said that they had not been as fully involved in setting the agenda for CHPs as they now recognised they should have been, sometimes because of the size of their remit and the limitations around managerial capacity in small councils.

We urge senior managers to take steps to remedy this, particularly in the light of the number of newly elected members who will be able to take an active part in influencing the way forward for services for older people. The Chief Executive of NHS Forth Valley confirmed that the partnerships were considering how to strengthen the role and remit of the CHPs and the CHP Committees, in order to promote partnership working at the local level.

In the light of all the evidence, we recommend that the NHS Board and the three councils must urgently conclude the work they have begun on agreeing the shape of future community health and social work services for older people in Forth Valley.

Recommendation: Forth Valley-wide number 1

NHS Forth Valley and the three councils should develop a joint Forth Valley-wide framework for older people's social work and health services in the community within a year from the publication of this report. This should be done at the same time as the ongoing work on developing plans for services in the community hospitals.

This framework should set out how it will meet the need for older people's services, particularly community health services and intermediate care services across Forth Valley. It should identify the desired outcomes for older people and their carers. It should also ensure that there is equity in relation to levels of health funding across the Forth Valley councils. This Forth Valley-wide framework should include a joint action plan, financial plan, time scales and commissioning plan.

Senior managers should ensure there is sufficient strategic planning and management capacity to undertake developing and implementing this framework and, if necessary, augment the existing capacity, which could be done in a variety of ways.

5.1.6 Financial resources

Each of the three partnerships had different levels of funding for older people's services. This appeared to be one of the reasons why services differed in level, range and quality in each of the partnerships.

Fig 2: Gross spend by councils on services per adult aged 65 and over, in 2005-06*

Clackmannanshire	Falkirk	Stirling	Scotland
£1586	£1483	£1373	£1504

* Figures worked out by SWIA on the basis of published data.

Fig 3: Net amount spent on services for older people within the three councils, 2006-07*

Year of funding	Clackmannanshire Council	Falkirk Council	Stirling Council
2006-07	£8.0 million	£27.0 million	£16.4 million

* POBE figures sourced from the three councils. These figures represent the net value of spend at the year end, not the gross amount. Not all councils were able to provide us with forward projections of gross budgets established at the start of 2006-07. Published data on gross spend was not available.

Separate resource transfer agreements and joint funding arrangements were reached between each council and NHS Forth Valley. Health managers thought that health funding of services reflected levels of need in partnership areas. Some social work managers said that they considered the allocation of resources across all three council areas to be transparent, but that the allocations themselves were not always equitable (see Fig 4).

Clackmannanshire staff were very concerned that there might be less health funding in future for their services because many of the shared problems, such as delayed discharges, had been successfully handled. This was largely because of the priority that the council gave to assisting older people, and was reflected in the high level and creative development of services.

Fig 4: Budgets for older people's services in NHS Forth Valley by CHP area, 2006-07*

Source of funding	Clackmannanshire CHP	Falkirk CHP	Stirling CHP
NHS Forth Valley (spend per older person)	£3.7 million (£498)	£13.8 million (£584)	£8.2 million (£574)

* Sourced from NHS Forth Valley.

All the partnerships faced the issues of providing services for increasing numbers of older people. In addition, advances in medical technology and people's rising expectations place greater demands on agencies to continue improving services for older people. NHS Boards are required to manage health services tightly and effectively and NHS Forth Valley clearly did so.

However, there is increasing emphasis within the NHS in Scotland to maximise the resources being made available and to promote community health services. The three local partnerships were clear that they faced financial pressures in relation to services for older people. Moreover, councils and health boards face a number of nationally determined priorities such as delivery of waiting time targets.

In the light of this, it is important that clear joint plans for future services are developed. We noted that joint service plans and financial plans for older people's services had still to be developed. During our fieldwork in late May and June 2007, the 2007-08 aligned budgets had still not been identified and agreed by the agencies. Budgets were mainly incrementally rather than strategically driven, although they were adjusted for specific developments and initiatives. Much more joint work was therefore required to align budgets with services.

As operational service plans had still to be refined and agreed, budgets were managed largely on a 'bottom line' basis and inter-budget adjustments were made during the financial year. The robustness of the budgets was therefore suspect but this was, to an extent, understandable in view of the fact that the service planning process had to be further progressed. In general, budgets did not always appear to reflect the planned operations. This can only be properly addressed when the joint strategy for older people's services is progressed and the financial plans are appropriately linked. This needs to be urgently progressed as part of recommendation Forth Valley-wide number 1.

There was also a distinct absence of joint medium term financial planning. All three partnerships were unable to produce joint financial plans for the following two years 2008-09 and 2009-10. Medium term joint financial plans are essential to the process of forward planning and they should be prepared and agreed, based upon policies and objectives in force at the time of preparation. Thereafter, they can be adjusted accordingly, on a rolling basis, if required.

Furthermore, we found that the financial monitoring reports submitted to the CHP committees included only NHS Forth Valley financial information and that the appropriate council data was not included. Relevant health financial data was also not included in council reports. Therefore, the decision making committees within the council and the CHP were not being provided with the full financial information about their partners' services.

Recommendation: Forth Valley-wide number 2

All partnerships should prepare medium term (three year) joint financial plans and review them on a rolling basis in order to inform the process of forward planning of services for older people.

Recommendation: Forth Valley-wide number 3

All partnerships should improve the joint financial management processes, particularly around aligning budgets for services for older people, and publish joint financial reports on services for older people. The financial reports submitted to CHPs and councils should include appropriate financial data from NHS Forth Valley and the councils.

5.2 Person centred care

5.2.1 Single shared assessments and care planning

The staff of the Forth Valley partnerships were committed to collaborative working but were struggling to cope with the demands made on them by the incompatibility of health and social work IT systems, particularly in relation to single shared assessments (SSAs). They were waiting for the Scottish Government to issue the new technology in early 2008 which would enable the different systems to interface properly. Once fully integrated IT systems are in place, they will bring about significant improvements to inter-agency working. In view of the national situation, we have not made a recommendation about urgently progressing this work as it will be more cost-effective and time-effective to make changes when the new technology is available.

However, we were very concerned about the poor quality of written care plans and the fact that they were not regularly shared with service users. Part of the problem arises from the nature of the IT systems which do not encourage staff to enter either SSAs or care plans as a single entry. During the file reading exercise we had to search across the IT systems for parts of the care plans. They often appeared to consist only of a list of services, rather than being a carefully thought through statement of the needs of the individual older person, the outcomes desired and the way that the needs would be met, together with time frames, identification of responsible members of health and social work staff and services. A plan for home care inputs was often regarded as an adequate care plan.

We deal with this issue more fully in the following chapters, but make a recommendation here for all three partnerships.

Recommendation: Forth Valley-wide number 4

All partnerships should ensure that every older person receives a copy of their own assessment and care plan. Care plans should clearly set out the needs of each older person, the way these needs will be met, the desired outcomes, timeframes, and responsible members of staff.

A national group, the Assessment and Review Co-ordinating Group (ARCG) is developing national minimum information standards for assessments, care plans and reviews. Once these are finalised, partnerships should adopt these at the earliest possible date.

5.2.2 Support for carers

Support for carers was recognised by all three partnerships as being a crucial element in sustaining older people at home. The way in which the partnerships assessed and provided support differed considerably and is dealt with in the relevant chapters.

At a Forth Valley-wide level, we heard very good reports about the role of GPs in identifying carers and offering them health checks. We think this is commendable and were pleased to hear that this service will continue, despite some concerns that funding might be withdrawn. Positive comments were made about some GPs in Falkirk, who recognised the contribution of carers and signposted them to services. The Quality and Outcomes Framework (QOF) supporting the GMS contract for GPs had a strand about identifying carers and this had been implemented across Forth Valley.

The carers survey and discussions with carers revealed that some carers felt that hospital staff were often brusque with them, did not give them as much information as they would have liked and did not respect their role or their knowledge of the older person they cared for. Several carers felt that carers received a very poor reception from ward staff in the acute sector, when the person they cared for was admitted to hospital.

Recommendation: NHS Forth Valley number 1

At a time of major changes within NHS Forth Valley, managers should assist health staff to communicate more effectively with carers especially about the transitional arrangements for hospital admissions and transfers between hospitals. This should include health staff positively acknowledging the role of carers of older people.

We recognise that the issue of carers assessment is a complex one. We heard positive reports from Stirling carers about the way that the Stirling PRT Carers Centre had developed a carers assessment form, which had been agreed jointly by Stirling Council and NHS Forth Valley. Clackmannanshire Council had promoted the use of carers assessment and had recently completed over 200.

We were also told that many carers and staff generally did not understand the rationale for carers assessments or believe that they would make a difference. But we also noted from the carers surveys the evidence that carers assessments did make a difference. We therefore make a recommendation about this.

Recommendation: Forth Valley-wide number 5

Carers assessments should be promoted and evidence of improved service delivery and outcomes as a result of these assessments should be collected and shared with carers.

A national group, the Assessment and Review Co-ordinating Group (ARCG) is developing national minimum information standards for carers assessments. Once these are finalised, partnerships should adopt these at the earliest possible date.

5.2.3 Preventative and self care services

The emphasis in current health and social work thinking, as set out in *Delivering for Health and Changing Lives*³, stresses the importance of early stage, preventative services for older people. Current thinking also stresses the importance of self care, particularly for people with long term conditions. All the Forth Valley partnerships were aware of the need for services which promote well being and self care. The councils were, however, being faced with difficult decisions about their ability to fund and provide early stage, preventative services because of the increasing demands on their budgets. They were committed to continuing to provide these services but managers acknowledged that it might not be possible to do so.

NHS Forth Valley had initiated an anticipatory care project in each partnership to identify patients with long term conditions (LTC) and to support them effectively in the community through case management. A CHP-led group on long term conditions had been established, with a remit which included establishing a preventative framework and models of care.

³ *Changing Lives: Report of the 21st Century Social Work Review*, Scottish Executive, 2006

5.3 Delivery and management of services

5.3.1 The interface between health and social work staff

We noted the positive way in which front line health and social work staff generally worked together in Forth Valley.

Good practice example: NHS Fast Track team

The Fast Track team carried out immediate assessments in A&E to support decisions to admit or discharge a patient. It consisted of four senior therapists (OTs and physiotherapists) and two therapy assistants. There were strong links between them, social work staff and the NHS Forth Valley discharge co-ordinator. The Delayed Discharge Steering Group had provided the impetus and funding for the team which had been developed over the last 18 months. The team was widely considered to be very effective.

However, community nursing staff in Forth Valley told us that they felt under constant pressure and that they thought that their staffing numbers were low. They said:

'We are just getting on with the job, but the resources are not keeping pace with the number of older people. We don't think that older people are a priority any more in Forth Valley. We see more and more people with dementia. Acute services get the best deal. We work very hard but get very little recognition from senior staff.'

These concerns were borne out in the NHS Forth Valley staff survey. We acknowledge that, at the time of the inspection, there were significant changes taking place in the NHS Forth Valley, for example, the development of the new acute hospital and community hospitals, together with national changes in the roles of community nurses and health visitors.

We think that the issue of levels and resources dedicated to community health services such as community nurses needs to be addressed as part of the progressive development of the Healthcare Strategy. We cover this issue in Forth Valley-wide recommendation 1, and we also make a recommendation here specifically in relation to NHS staff in all the partnerships.

Recommendation: NHS Forth Valley number 2

Bearing in mind the current level and range of organisational change underway within NHS Forth Valley, health managers should take steps to assist staff understand and be involved in the development of services for older people, for example through a communication strategy.

5.3.2 Medication

Regular and consistent handling of medication for people at home is a litmus test of multi-agency collaboration, because it is essential if people are to be supported to stay in their own homes. There were differences about the way that the three partnerships approached the role of home care staff in prompting and/or giving medication.

There were problems with some pharmacists who were unwilling to fill more than a certain number of small plastic containers for pills or fill them for more or less than a specified number of pills. More problematic was the situation when people needed more than prompting. Staff from Alzheimer Scotland, who supported 60 families and a further 43 carers, said that medication for people with dementia in the community *'is a nightmare'*. Two of the three councils' policy was that home care and social care staff were not allowed to administer medication. This can put additional pressures on community nurses who may have to undertake many visits to ensure regular medication. However, some staff told us that they do not always follow council policy and do administer medication.

Clackmannanshire Council has developed arrangements with independent providers for their staff to administer medication. This is done following training by health staff and with appropriate supervision. It has led to a better service for older people, as well as being more responsive and cost-effective. We think that a Forth Valley-wide approach should be taken to this issue to ensure that a consistent approach is taken to the administration of medication in relation to home care services.

Recommendation: Forth Valley-wide number 6

All partnerships should ensure that there are Forth Valley-wide policies and procedures for prompting and administering medication, such as drugs and creams, for older people receiving home care services. Managers should ensure that these are clear and are consistently implemented across the three partnerships.

5.3.3 Dementia and mental health services

Older people with mental health problems and dementia problems whose needs cut across all health and social work boundaries have in general received, until recently, relatively little attention and insufficient new resources to meet their needs. At carers meetings, we heard that lack of information, care and support for people at the point of diagnosis was a particular issue.

The partnerships acknowledged that community based services for older people with functional mental health illnesses were not well developed. They anticipated that this would be addressed together with the major redesign of specialist Old Age Psychiatry services in the near future.

There were a number of services for older people with dementia, some of which were very positive, such as the Joint Dementia Initiative, (although it appeared that while this had been set up as a Forth Valley-wide service, it was utilised mainly by people from Falkirk). The effectiveness of nursing assistants in the Community Mental Health Team for the elderly, CMHT(E), in supporting people with dementia at home was often highlighted.

Good practice example: Liaison service for people with dementia in care homes

The psychiatric liaison service set up as a pilot in January 2006 involved dedicated nursing staff liaising with care home staff. It has had significant success in supporting staff in care homes, with the result that older people with dementia can continue living in care homes. There has also been a noteworthy elimination of admissions from care homes (in the pilot) to acute old age psychiatry beds. This approach is also being extended to patients in care homes with palliative care needs.

We urge managers to keep the need to develop more services high on the agenda, particularly in light of the increasing numbers of older people, (see recommendation Forth Valley-wide: number 1). The work being undertaken with Stirling University in the Dementia Project on improving pathways of care across services such as health, council, voluntary and independent sectors, as well as others such as police and churches should play a crucial part in this. It was supporting important work around raising awareness, and training and education of staff.

Recommendation: Forth Valley-wide number 7

All partnerships should ensure that appropriate mental health services for people over 65 years and services for people with dementia are proactively developed. These should build on the work of the Dementia Project and include appropriate information and support at the point of diagnosis.

5.3.4 NHS Forth Valley out of hours services

Concerns were raised with us about the inflexibility and unresponsiveness of NHS 24, the national out of hours service. Independent providers of care homes, users and carers said that NHS 24 often took a number of hours to get back to them. They were angry that there was an expectation that elderly people, who were often ill and confused, were expected to come to the telephone to explain their symptoms to the staff at the NHS 24 centre. Older people found this distressing and were unable to do this, particularly if they had dementia. Staff in care homes, who were often nurses, and relatives or carers of older people felt this was unreasonable when they could have done this.

Concerns were also raised with us about the out of hours service which employed doctors who did not know individuals or their case histories, unlike their own GPs. Staff believed this was leading to an increased level of hospital admissions. They also believed that the expectation that older people should attend GP out of hours centres at night was unrealistic, especially when the individuals were elderly, or in the winter months. This was particularly so for patients in Clackmannanshire after 12 midnight, when they had to travel to Stirling. Providers told us they had not reported these issues to the CHPs because they were not aware they could do so.

We were not able to ascertain how widespread these issues were for older people. We were informed that a survey on these services had recently been carried out and had not revealed this issue. NHS Forth Valley senior managers told us that the level of need in Clackmannanshire did not justify a fuller service. Issues around NHS 24 and the out of hours service had only been raised with them in a few cases, and they committed themselves to examining whether there was a more general problem.

5.3.5 Joint developments

We heard about many examples of the way in which staff, both directly and through joint working, worked hard to assist older people and their carers have as independent and enjoyable a life style as possible. For example, older people and their carers were very positive about the tissue viability clinic, saying that *'the staff are very responsive and there when people needed them most'*. Care home providers were also very positive about this service.

There was good joint working between health and social work in supporting people at the end of their lives in care homes and in the community. This was being led by one clinician and was reinforced by the NHS LES agreement that GP practices should review patients periodically, ensure medication was reviewed and make sure care plans recorded basic details.

There were a number of positive examples of collaborative services in Forth Valley. They include:

- Liverpool palliative care pathway work
- Forth Valley Advocacy
- Joint Dementia Initiative
- Forth Valley Sensory Centre
- Gold Standards Framework in palliative care.

We describe many examples throughout the report.

Good practice example: Forth Valley Sensory Centre

This new purpose built centre provided a range of services, both joint and single-agency, including a multi-disciplinary and multi-agency team providing a range of services. The Sensory Centre had been developed as a partnership across the statutory and voluntary sectors and with significant involvement of service users. It was operated as a company limited by guarantee with charitable status.

Services included assessment and care management to Falkirk and Stirling residents and straightforward assessments for Clackmannanshire residents. Falkirk employed a social care officer for deaf people providing services to all the councils. Individuals could access interpreter services from the centre as well as obtain guidance about equipment from a technician.

There were weekly low vision and audiology clinics with social work staff in attendance. For people with visual impairments there were weekly clinics where they could be tested and registered on the same day and given equipment prior to leaving if appropriate. The unit had a sessional consultant ophthalmologist who took referrals from other consultants across Forth Valley. Other team members included a RNIB full time member of staff and three rehabilitation workers for guide dogs for the blind.

So within the one setting, older people could have access to a wide range of advice, guidance and services. During the fieldwork we met five people using day care provision who spoke very positively of the experience, with one person saying *'it is the best service I have ever had'*.

Clackmannanshire Council and NHS Forth Valley partnership

This chapter, together with chapter 5, covers all the issues for the Clackmannanshire partnership. It follows the model as set out in appendix 1.

6.1 Person centred care

There were well established processes for assessment, care management and treatment in social work and health services. Clackmannanshire Council had developed its own community care IT system, and made access to it possible for health colleagues, pending the e-Care solution from the Scottish Government. Staff in social work and community health services had constructive working relationships with colleagues and focused on delivering person centred care to older people and their carers. The experience of people receiving services was generally taken into account when delivering services. Enabling well being and self care was being undertaken proactively. There were a number of mechanisms to ensure access to services, such as a wide range of leaflets. The partnership's performance was evaluated as very good.

6.1.1 Assessment and care management

Jointly agreed and documented assessment processes

Clackmannanshire Council had developed its own community care information IT system in-house. It had arranged for NHS Forth Valley colleagues to have direct access to the system through computers placed by the council in GP surgeries and other health board settings. The council had taken this enterprising step in order to promote joint working, and in particular to promote the undertaking of single shared assessments (SSAs) by health colleagues. Whilst some community nurses were not positive about the IT system, others, including community psychiatric nursing (CPN) staff, found it easy to use. Clackmannanshire managers acknowledged that although it was sometimes difficult for some health colleagues to access the system, they believed that it had been a worthwhile step to take. We endorse this. However, we note that while health staff could and did access the IT system to gain information, they did not regularly carry out SSAs.

The partnership managers said that they were waiting for the e-Care solution from the Scottish Government which was due in 2008. The use of an integrated IT system will undoubtedly make joint working easier and more productive. Clackmannanshire was rigorously using the Indicator of Relative Need (IoRN), a national tool to measure dependency levels, when assessing older people aged over 65 years.

There was a jointly agreed and documented assessment process. All the council files were held electronically. The IT system ensured that service user consent to share information was sought, and service user agreement to the identified needs and care plan was recorded. The SSA format included a pathway for older people with cognitive impairment or mental health needs. Clackmannanshire had an arrangement with the Department of Work and Pensions (DWP) for them to undertake the financial assessments on cases. The effectiveness of the assessment processes was monitored on a casework basis and evaluated through a multi-agency joint implementation group.

Both health and social care staff spoke very positively of their working relationships and the fact that health staff had straightforward access to social work resources. Staff felt that things would continue to improve once both community nurses and social workers are co-located in the new community hospital.

Clackmannanshire had recently set up a new intake team to make best use of resources. Some users and carers felt that the new duty team had adversely affected the service they received, depending on who was on duty that day. Managers acknowledged that the new system would take time to establish itself.

From our file reading we found that assessments of community care needs were on most files. All the council files contained some record of a community assessment. There was evidence of multi-agency working in most cases and in three quarters of applicable cases there were clearly stated roles and responsibilities for each agency.

The staff survey showed that the majority of respondents agreed that SSAs were undertaken by the relevant professionals, although we were told that health staff often asked social work staff to enter the assessment onto the IT system, to save time. Social work staff did so as an interim measure and to promote joint working, and this accounted for the apparently low level of SSAs completed by health professionals. Managers thought that the situation would improve once the new IT system, provided by the Scottish Government, was available. We considered that further management action would be required to ensure that the work practices of health professionals were successfully modernised to make best use of investment in new joint systems.

The service users survey showed that only 20% had seen a written assessment of their needs whilst 80% had not. Since there was no identified place on the IT system where SSAs could be recorded as an entity (and this was so for all three partnerships), it would be difficult to share them with older people. We comment on this in more detail in chapter 5 and make a Forth Valley-wide recommendation.

Assessment of cultural and ethnic needs

The Clackmannanshire partnership said there were culturally sensitive assessment systems in place to identify and assess the needs of groups and individuals who have particular needs or preferences. Whilst the partners appreciated that the numbers of black and ethnic minority older people were small in Clackmannanshire, they acknowledged that more work needed to be done to look at services that would respond to the future needs of a more diverse and ageing population.

Needs of carers are identified and assessed

There was evidence of positive joint working in relation to carers needs in Clackmannanshire. This included collaboration with the Princess Royal Trust (PRT) Carers Centre and the NHS scheme for GPs to identify carers. Council staff had recently undertaken 200 carers assessments, and they were clear that their approach to all assessments was holistic. There were carers support groups in place and the Clackmannanshire carers strategy and NHS Forth Valley-wide carer information strategy outlined action plans for further developments.

Less than half of the carers in the survey had been informed of their right to carers assessment, mostly by a social worker or a Carers Centre representative. Only 20% had had their needs assessed. When the person they cared for was admitted to hospital, most of the carers were not informed of their right to a carer's assessment.

Of those who had had a carers assessment, most (six out of eight respondents) said that the assessment had helped them a lot, or had partly helped them. Only one out of seven respondents had received a copy of their assessment. As a result of the carers assessment, six out of seven respondents had received support services for themselves, whilst seven out of eight respondents had received additional services for the person they cared for. These figures demonstrate the value of carers assessments.

During the fieldwork we heard from carers who had been active in trying to promote carers assessments. They found that some carers were reluctant to agree to a carers assessment because they thought that the quality of these was variable, depending on the abilities and commitment of the individual worker. But some carers whom we met said that they had benefited from carers assessments, for example by learning that they were entitled to a flu jab and receiving acknowledgement from their GP and other NHS staff that they were carers. We thought that it would reassure carers if there was more information about the benefits of carers assessments.

From the file reading, in 77% of applicable cases the carers in Clackmannanshire council files had been offered information on the support needs of the older person. This was significantly higher than in the other council files.

Prevention of inappropriate admission to hospital

In order to prevent inappropriate hospital admission, NHS Forth Valley had set up the hospital based Fast Track team, which offered immediate assessments by occupational therapists (OTs) and physiotherapists in A&E. There was a range of other services, such as rehabilitation at home, the mobile emergency care service, step up and step down services, and rapid response service which could provide intensive home support. Referrals were made to specialist services as appropriate.

The majority of staff in the survey agreed that multi-agency services were successful in preventing inappropriate hospital admissions, although less than half of health staff agreed.

Screening and initial assessment for unscheduled or planned hospital care

For older people being admitted for unscheduled or planned hospital care, a prompt initial screening and initial assessment should be completed within agreed timescales. This should include a review of both health and social care needs. There was a range of services available to Clackmannanshire residents, for example the Fast Track team. The council did not have social workers located in the two hospitals in Falkirk and Stirling but would ensure that staff were available to undertake any assessments whenever required.

About half of the service users in the survey had been admitted to hospital within the last two years. They said that overall the results in relation to admission to hospital were fairly positive.

From the file reading, about one third of older people had been admitted to hospital during the last 12 months. Most of those who had been admitted to hospital had been admitted once only. Most of the admissions were unplanned.

Jointly agreed care planning processes

There should be jointly agreed care planning processes which document goals and outcomes agreed with the older person and record whether these were achieved. There were sound care planning systems and good inter-agency working relationships between professionals in Clackmannanshire. But although there was a section for care plans within the community care IT system (for detailed information of what services were provided, by whom, and how often), this was not used routinely by staff. This would facilitate information sharing with older people or colleagues.

Care management functions were normally undertaken by the community care teams, although health professionals would lead when appropriate, for example community nurses in palliative care or members of the community mental health team for the elderly, CMHT(E), particularly if there had been CPN involvement. A dementia care pathway was being applied by CMHT(E) colleagues, and the effectiveness of nursing assistants within the team was highlighted, recognising the impact they had in supporting people with dementia at home. Staff also spoke about the positive use of the care programme approach (CPA) in mental health with formalised meetings every two weeks. Health and council staff said that joint processes for complex cases included joint visits, discussion and information sharing.

Two thirds of staff in the staff survey said that care or treatment plans were regularly reviewed on a multi-agency basis. Council managers were very clear that all cases were reviewed on a single agency basis and they were proud of their 100% track record on this. Service users and carers were involved as a matter of routine.

Of the service users in the survey, 46% of users had been given a clear plan of the services they receive (compared to Falkirk 56% and Stirling 33%). Only one of the eight people we interviewed said that they had a copy of their care plan. However, from the file reading there was evidence that the views of individuals were taken into account in around 90% of cases.

We were concerned about the recording of care planning in Clackmannanshire. We make a Forth Valley-wide recommendation about care planning in chapter 5.

Discharge planning

The partnership had no delayed discharges. Delayed discharges were not an issue in Clackmannanshire for a number of reasons, such as the high priority given to community care assessments for hospital discharge. People in hospital were allocated immediately and assessments normally commenced within 24-48 hours. Staff also told us that their good relationships were the key to their success. Discharges, transfers and/or significant changes of accommodation were clearly being planned in partnership with older people, their carers and other agencies and arrangements put in place to meet assessed health and social care needs.

Discharge protocols and a prompt referral system were in place. The NHS unified case record had a trigger list for referral to colleagues and external agencies. Pre-discharge home visits were being arranged when necessary. There were also daily patient reviews by a multi-disciplinary team and discharge co-ordinators. Discharge co-ordinators monitored discharges, referrals and delays. Case conferences were held if required.

There was a joint Forth Valley leaflet called *Moving from hospital to care home*, which emphasised choice but also highlighted that people might have to go into another home until their choice became available. Within Clackmannanshire, OTs could access equipment and basic home care services to enable safe discharge from hospital. In Clackmannanshire no one normally entered a care home unless there had been a comprehensive assessment completed whilst the older person was at home. Social work staff would visit within 24 hours of the patient being discharged from hospital if it was a priority. Once a person was in a care home, social work staff preferred not to move them to NHS continuing care beds when their needs increased, if it was possible to support them in the care home.

The majority of staff thought that multi-agency discharge arrangements met the needs of older people. Clackmannanshire staff were the most positive in Forth Valley about this aspect. However, they had some concerns about the move to the new acute hospital. Transport was a Forth Valley-wide issue but particularly so in Clackmannanshire, and the need to improve the transport network alongside changes in the functions of the two hospitals in Falkirk and Stirling was identified. The transitional arrangements for health professionals meant that new relationships had to be developed. Some staff thought that communication was more difficult between the two hospitals and that discharge planning was not as good as it had been, although they recognised it would improve in time.

Less than half of the carers in the survey said they were involved in planning when the person they cared for was discharged from hospital. A third were asked prior to discharge if they were willing and able to provide care. A third of the carers said that the person they cared for had received an assessment of their needs prior to being discharged from hospital, with one third feeling that they had sufficient information on services and support available prior to discharge from hospital. The majority of carers in the survey said that they received specific information on medicine and treatment prior to discharge, mostly from hospital staff.

Most users who responded to our survey said that the help they needed was in place at the time they were ready to leave hospital.

Assessment of the ability of older people to manage their own medication

Clackmannanshire Council had a medication policy and procedures for all services, including residential and day care settings. The council, its major independent home care provider (the Independent Living Service), and health staff had worked in partnership to train care staff to provide enhanced personal care, including the administration of some medication, under community nursing supervision. This was proving extremely cost-effective and time-effective. Tools to ensure safe medication, such as dosette boxes and SMART technology, were being used by staff. There were plans to establish a partnership group to develop a protocol for the self-administration of medicines.

The majority of staff in the survey said that there was effective assessment of the ability of older people to manage their own medications safely regardless of setting.

Older people are provided with full information about their condition

There were methods in place to ensure that older people were provided with full information about their condition and any treatment or care they required, and their right to consent to treatment. As well as accessing information via GPs and community nurses, there were specialist nursing links and links to voluntary agencies that supported people. Community care staff also provided information through the assessment process.

There were advocacy leaflets and partnership funding of an Alzheimer Scotland information officer post, with the organisation providing a full range of information on the condition as well as a phone information line.

Almost all the older people we interviewed during the fieldwork said that information about their condition was available and provided when they needed it. The majority of carers in the survey said they had received specific information on treatments and medicines prior to the person they cared for being discharged from hospital, mostly from hospital staff.

Accessing personal information

Older people should be informed about how to access their personal information, and about their rights to determine how their personal information is shared and protected. NHS Forth Valley and Clackmannanshire Council participated in the Forth Valley data sharing partnership with the other council partners, police and fire service. The Forth Valley information sharing protocols, November 2006, provided thorough guidance. The leaflet on *Sharing information and giving consent: a guide for service users* was helpful.

NHS Forth Valley provided new patients with a helpful leaflet called *Confidentiality and your health records*. Dedicated offices in NHS Forth Valley and Clackmannanshire Council dealt with data protection queries. Staff across the partnership attended mandatory training in data protection and confidentiality, which covered patient consent and information sharing.

Over two thirds of staff in the survey thought that older people, and with their consent, carers were informed about how the older person's personal information was recorded and used, how to access their personal information and about their rights to determine how their information was shared and protected.

However, older people and carers told us they were not routinely informed about how to access their personal information, and about their rights to determine how their personal information was shared and protected. We think more emphasis should be put on this issue by managers because it appears that, while procedures and training are sound, they are not being followed through by staff when working with older people.

6.1.2 Experience of people and carers when receiving services

Systems to obtain feedback from people who use services

The Clackmannanshire partnership used many systems to obtain feedback about the experience of people when accessing and using health and social work services. We heard from a range of older people during the fieldwork about their level of satisfaction with the services they received and the way they were encouraged to feed this back to staff. GP practices were required to undertake patient surveys to meet the requirement of the patient experience indicators in the QOF.

NHS Forth Valley complaint and patients' relation service and the council's complaints systems were avenues for feedback and 64% of service users said they would feel comfortable about making a complaint if they were unhappy about the service they received from health or social work, with 38% knowing who to contact to do this.

Although council and NHS managers recognised that there was a need to develop more systems to allow services users to feedback their views, the partnership already used proactive methods of seeking feedback. A health and well being survey had been conducted through the CLACKS 1000 consultation group. The reporting on the rehabilitation at home service had also provided positive feedback from service users and carers. As a result of service user feedback systems, Clackmannanshire had made improvements to their services. For example, reports on Ludgate House and Menstrie House had influenced the development of specialised lounges which provided person centred care for people with dementia and sensory impairments.

Systems to obtain feedback from carers

A carers forum was established in Clackmannanshire, supported by the council and NHS Forth Valley. Feedback was gained from this group, individual carers and other carers groups such as the carers strategy group, which had developed the strategy with the involvement of carers. Carers events had also been organised by carers with the support from NHS Forth Valley and the council. For example, the theme of an event in March 2007 was carers health and well being. The staff survey showed that over two thirds of staff agreed that systems were in place to obtain feedback from carers.

Some carers from Clackmannanshire whom we met during the fieldwork told us about their positive experiences of being involved in discharge discussions from hospital. However the experience of others was less positive. They described not being kept informed or that whilst the individual they cared for was in hospital, information could be given to them but it could change within a few hours. Carers were then left feeling powerless and that they were unable to influence what happened in hospital. Most said that they did not know who to approach in the ward to get information. We make a Forth Valley-wide recommendation about this in chapter 5.

Older people are enabled and supported to make decisions

There was good evidence that older people were regularly encouraged as part of the care planning process to be involved in making decisions in their own care. Older people were also enabled to contribute meaningfully through the review process and this was a reflection of the person centred approach in Clackmannanshire.

Forth Valley traditionally had a very positive approach to advocacy and invested considerable resources in advocacy services. It had the highest percentage spend per head of population in 2003-04 in Scotland. The council had a service level agreement for a worker (30 hours) whose remit was to work with older people. Advocacy workers prioritised those with dementia and those with communications difficulties.

Good practice example: Advocacy one stop shop in Alloa

There had been recent co-location of three advocacy groups within the same building in Alloa, and this was seen to be a very helpful move. The Advocacy Centre had also recently been involved in a redesign of services for older people.

All the older people and carers we interviewed confirmed that they had been consulted regarding their care plan, and in fact two had refused some services that they did not feel they required. Most staff in the survey agreed that older people are enabled and supported to make decisions throughout their care or treatment, although NHS staff were more likely to disagree.

Direct payments constitute another way of enabling and promoting choice to people who require services. All the councils had information leaflets and procedures in place to promote direct payments, but take up was still relatively low. Although one reason cited was that older people did not want to have the responsibility for the administration of these, we believe much could still be done to improve the take up. In 2007, Clackmannanshire had 32 service users (all care groups) using direct payments, Falkirk had 61 and Stirling had 37. These figures need to be considered in relation to the size of the population.

6.1.3 Enabling well being and self care

Agencies collaborate to promote and maintain health and independence

The Joint Health Improvement Plan (JHIP) made links across all agencies promoting health and well being initiatives and set out the strategic direction. A health and well being survey had been conducted through the CLACKS 1000 consultation group, which covered a broad range of topics including physical activity and healthy eating.

We were impressed by the enthusiasm and commitment of the public health, leisure and recreation staff we met in Clackmannanshire. We were told about a range of activities to support older people to retain or improve their health and independence. There was a clear link to health improvement, with staff in public health and the council's leisure and recreation services working jointly on the enabling and well being agenda. They provided a range of services including keep fit, a self help project called Braveheart (for people who have had or are at risk of heart attacks), anticipatory care, and falls prevention.

There were plans to build on these initiatives and to develop others. For example it was proposed to develop an outreach health service to community based initiatives. Staff acknowledged some of the barriers to taking forward some of the initiatives, such as funding and finding suitable premises, but they stressed the positive working relationships between themselves, and that resources and information were willingly shared.

Joint action to support older people's capacity for self care and self management

The current focus in the NHS in Scotland on action to support people with long term conditions in order to increase their capacity for self care and self management was still in the early stages in Forth Valley, but an anticipatory care project linking to men's health initiatives was being initiated.

We heard of a range of joint working between Clackmannanshire and NHS Forth Valley to support older people's capacity, such as the hospital based CARE team (which included home care staff trained in rehabilitation) providing ongoing follow up at home. Work on the Liverpool care pathway for terminally ill and people requiring palliative care was well underway through community nursing, Crossroads and independent home care providers.

6.1.4 Access to services

Information is available to older people, carers and the public on services

There was a good range of information and leaflets for older people in Clackmannanshire which was updated annually. It was provided by the NHS, the council, voluntary organisations and care providers. NHS Forth Valley, the council and the local carers organisation had produced a local strategy for carers, with action plans, which linked into the NHS carer information strategy.

There was a range of council leaflets, for example on home care and the mobile emergency care service, which provided helpful information including eligibility criteria and the complaints procedure. Clackmannanshire had several leaflets specifically targeted for older people's services and these contained clear and relevant information. It was surprising these were not on the council's website, which had an easily accessible section devoted to older people.

The NHS Forth Valley internet site provided information and advice to enquirers and complainants. The Forth Valley partnership leaflet called *Moving from hospital to a care home* was clearly written and easy to understand although it was only in English, with no signposting to other formats or languages. Health and social work services sought to ensure there were no barriers to accessing services, for example telephone interpreting and face to face interpreting services were available across all NHS Forth Valley and council services. There had been an increase in the uptake of these services due to training and awareness activity.

Most staff in the survey believed that comprehensive information was readily available to older people, carers and the public on health and social work services, although less than half of the staff thought information was provided in all relevant languages and formats. We would agree with the staff view of the current situation, but recognise that it is a response to the low numbers of black and ethnic minority people living locally.

Systems to determine eligibility and priority

There were systems in place to determine eligibility and priority for health and social work services and these appeared transparent, fair and equitable. Criteria were set out in some of the leaflets and policy statements, for example eligibility criteria for community care assessments, and eligibility criteria for Ludgate House day care service and the Whin resource centre. Criteria were agreed and monitored by the Joint Implementation Group and the CHP. The SSA eligibility criteria had a priority system and gave priority to hospital discharges. As part of the augmented home care rapid support service, there were jointly developed eligibility criteria to ensure consistency of access.

Access to specialist services

There was a range of more specialised services in place in Clackmannanshire so that older people could have access as necessary to specialist services and were cared for in a manner that reflects their individual needs. There were specialist services for older people with sensory impairments, those who had dementia and those who were physically frail and isolated. There was an acknowledged lack of resources for those with mental health functional difficulties. Deaf blind guide communication could be provided to support individuals accessing services via the Forth Valley sign language interpretation service.

The Forth Valley Sensory Centre could be accessed by Clackmannanshire patients in need of low vision or audiology clinics. Although social work staff and posts were funded by Stirling and Falkirk, they undertook simple assessments for Clackmannanshire patients, but older people did not have access to the full range of services provided by the centre. Managers explained that people were reluctant to travel to the centre. The difficulty in recruiting staff hindered the planned delivery of these services locally.

The CMHT(E), day hospital and community rehabilitation service all had both open referral and GP referral systems in place. NHS Forth Valley disability service received referrals from in-patient and community sources. Community assessments were carried out by the disability adviser with referral to the appropriate local authority. The continence advisory team provided a service to people of all ages across Forth Valley. Alzheimer Scotland provided a good range of services for people with dementia and their families.

The older people we interviewed felt that their requirements were met and that they were treated with respect by the variety of service providers when accessing specialist services. They described the help they received as either excellent or very good.

Multi-disciplinary rehabilitation for older people

There was good access to multi-disciplinary rehabilitation for older people who required it, such as the rehabilitation services that were being provided both within hospitals and an individual's home environment depending on each individual's need. Staff worked across GORU (geriatric orthopaedic rehabilitation unit) and the CARE (community assessment and rehabilitation for elderly people) team. These services provided continuity of care, avoiding duplication of assessment and treatment. The CARE team had been proactive in the training and development of rehabilitation assistants, both health and social care, and provided 24/7 rehabilitation services.

Essential equipment is delivered to older people within agreed timescales

Essential and urgently required equipment was delivered to older people within agreed timescales. There were no delays in providing standard stock equipment with minimal delays on other items. Community care and health services staff could request equipment which was provided free of charge directly from the Clackmannanshire equipment store. Clackmannanshire had a resource centre which allowed people to see and test out equipment.

Public and private sector adaptations were overseen by the housing based occupational therapist. While minor adaptations were prompt, Clackmannanshire acknowledged that waiting times varied for major works.

Most older people and carers and staff said people received the required equipment and that it was delivered on time.

6.2 Key outcomes for older people and their carers

Positive outcomes for older people and their carers form a key indicator of effective collaboration between agencies. The evidence demonstrated that services for older people and their carers in Clackmannanshire assisted them to live as independently as possible, especially because of the high level and range of home care services. Most older people and carers said they were satisfied with their services. Most older people believed that health and social work staff worked together to ensure positive outcomes for them. For example, they said that health and social work staff responded quickly to significant changes in their situation. Over a number of questions, the service user survey was the most positive of the three partnerships' surveys. The partnership's performance was evaluated as very good.

We evaluated outcomes for people who use services and their carers by considering a range of information, including service user and carer surveys, interviews, focus groups, and evidence from file reading. We also agreed with the partnerships a core set of published performance data, such as levels of delayed discharges and amount of home care hours provided by the councils. Some of this information was proxy for the more robust National Outcome measures which are being developed.

Core data set for evaluating outcomes for older people and their carers

We used exactly the same performance indicators for 2005-06 for the three partnerships on four key areas relating to outcomes for people and carers, as set out below.

Overall, Clackmannanshire performed very well on most of the indicators, for example it provided high levels of home care service relative to long term residential care.

1. *Supporting more people at home as an alternative to residential and nursing care. This is often known as the balance of care between home based care and NHS continuing care beds and care homes.*

In March 2006 there were 219 older people in care homes. This was a rate per thousand of people over 65 of 29.5. The rate for Scotland overall was 39.8. This rate was the lowest of the three partnerships, which, when set against a high level of home care, indicates a positive balance of care. There were 3.4 (rate per thousand) occupied NHS continuing care beds in Clackmannanshire. The average figure for Scotland was 2.7.

There were 76.8 (rate per thousand of over 65s) 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. Moreover, 30.6% of home care service users received care in the evenings and or overnight. 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 this service and the council ranked 8 out of 31 councils in Scotland.

Twenty three (rate per thousand of over 65s) home care service users in Clackmannanshire received more than 10 hours home care. 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.

2. *Assisting people to lead independent lives through reducing inappropriate hospital admissions, reducing time spent inappropriately in hospital and enabling supported and faster discharges from hospital.*

There were no delayed discharges of over 6 weeks in March 2006, much to the partnership's credit.

3. *Ensuring people receive an improved quality of care through faster access to services and better quality services.*

The average time taken to provide a community care service from first identification of need to first service provision was 14 days. The average figure for Scotland was 20 days.

4. *Better involvement of and support for carers.*

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.

This evidence demonstrated that Clackmannanshire provided very positive outcomes for older people and their carers.

The views of older people on outcomes

Most older people and carers, for example those we interviewed, said they were satisfied with their services, and that the quality of the help they got was excellent or good. One person said about the help they received: *'I was discharged from hospital a few days ago and need more help than before. My daughter visits every day and my son also stays nearby. The district nurse visits every day to change my dressing and home carers come in twice a day to help me get dressed and remind me to take my tablets. I also get an injection every three months from the district nurse.'*

All the older people interviewed said the services they got helped them to feel safe. One person said about their mobile alarm system: *'I would never be without it. I put it under my pillow at night. I wear the pendant all the time and I feel much safer having this service.'* Most of the older people we interviewed said they received equipment when they needed it. One was not satisfied and said: *'There was too long a delay getting a bath seat. I could not have a bath. My daughter worried about me slipping.'* Some thought that the charges they had to pay were not fair. One said: *'I decided not to have a shopping service due to the charge.'*

All the older people we interviewed who had been in hospital over the last two years said that someone had discussed their discharge arrangements with them. Most also said their carers were also involved in the discussions. They all said they were treated with respect by council staff, NHS community staff and hospital staff.

Most people in the survey agreed that health and social work services staff had helped them feel safer. The majority of people agreed that NHS and social work services staff had helped them lead a more independent life. Half of the respondents agreed that health and social work services staff had helped them feel a part of their community. Some said that services could not really achieve this, rather than seeing it as a failure of the services.

In the survey, older people in Clackmannanshire were generally more positive than the other two areas on questions relating to the range and quality of services. Most were particularly positive that a good range of services was available to them, and that services were of a good quality. Most also thought that the help they needed was in place at the time they were ready to leave hospital. Clackmannanshire service users were strongly positive on receiving help at the time they needed it, and on NHS and social work staff responding quickly when there was an important change in their circumstances.

Views of carers on outcomes for older people

In our survey, carers in Clackmannanshire were more positive than the two other areas about social work staff providing them with practical support, health professionals and social work staff working together to provide them with practical support, and about health professionals and social work responding promptly when there was a crisis.

We met with carers in a range of situations during the fieldwork. Although they all had positive things to say about Clackmannanshire services, those carers who were long term carers of an older person who needed a high level of support were less positive. They said that they needed more support from their GPs and that they had experienced difficulties in accessing respite. (This was in contrast to staff we met who told us that GPs and community nurses could make direct referrals for respite services and that there was no waiting lists for them.) They had mixed views about some services, for example, when there were problems with the transport arrangements for the people they cared for. On the whole, however, they seemed to accept the services they received or to understand the reasons for individual care arrangements which had been made.

Views of staff on outcomes for older people

Staff questionnaires showed that staff thought that positive outcomes in relation to independence, developing skills, isolation, and safety were being achieved.

Almost all respondents agreed that multi-agency services were successful in helping older people live as independent a life as possible. Most staff thought that multi-agency services were successful in helping older people to develop their skills and abilities to the full. Most respondents agreed that multi-agency services were successful in helping older people lead less isolated lives. Most respondents agreed that multi-agency services did everything possible to keep older people safe. The majority of staff agreed that multi-agency services were successful in preventing inappropriate hospital admissions. The majority of Clackmannanshire council staff thought that multi-agency discharge arrangements met the needs of older people.

Evidence from file reading

The scrutiny of case files (50) revealed that the council was least likely to have improvements in an individual's circumstances attributed to effective collaboration and multi-agency working. We consider that this is worthy of further scrutiny and joint action. There was evidence that the objectives in the care or treatment plan had been, or were in the process of being achieved in all files read. (The average for all Forth Valley files read was 93%.)

We found there was effective joint working on the ground in Clackmannanshire that in the main delivered very good outcomes for service users.

6.3 Whole systems approach

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.

Joint strategic planning and commissioning needed to be developed and 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.

6.3.1 Range and quality of community based services

A whole systems approach to delivering services

Health and social work staff and managers in Clackmannanshire demonstrated a very positive approach to whole systems thinking for services for older people. Senior managers within social work services and the CHP had a shared agenda to develop and promote whole systems working. The General Manager for the CHP and the council's Community Care Manager worked closely together, and were pro-active in seeking opportunities to develop whole systems initiatives. The partnership had a strong track record in promoting the fast delivery of joint services for older people. This was evidenced in strong performance on key indicators, as well as in a range of joint initiatives. Plans were well advanced for co-location of health and social care services within the new community hospital. At all levels there was confidence that this would facilitate greater integration of services.

We saw many examples of good joint working and well co-ordinated services during the inspection. Collaboration between GPs, community nurses and social work staff at the front line operational level was very good. For example, social work staff were fully engaged with the local Managed Clinical Network in palliative care, which had wide representation from health, social work and voluntary care providers. There was a strong emphasis on delivering integrated care at points of crisis and there was an extensive mobile service which delivered integrated crisis care across the council area. Joint rehabilitation had been developed in people's own homes and in a local resource centre. Some of these services are described more fully below.

In the staff survey, most (71%) Clackmannanshire social work staff agreed that a whole systems approach was taken to joint working. Fewer staff (13%) disagreed with this statement than in the other two councils or in the Forth Valley-wide health service responses.

Broad range of quality services

In chapter 5, we described the reconfiguration of NHS services in Forth Valley, designed to bring about fundamental shifts from acute to primary care and community health services, in line with the national policy. Alongside this, the balance of long term care provision across Forth Valley needed to shift more towards intensive care at home.

These shifts were already well implemented in Clackmannanshire. Delayed discharges had been eliminated, and Clackmannanshire was well below Scottish and Forth Valley rates for emergency admissions of older people over 65 and for bed days for patients with two or more emergency admissions. Success was attributed by the partnership to step-up, step-down, rehabilitation and respite care initiatives. We also heard that the partnership had been successful in the early development of a support worker model for community in-reach and rehabilitation, and anticipated full development of the model in time for the opening of the new community hospital in 2009.

Good practice example: Mobile rapid support service

Clackmannanshire Council's contract for a mobile home care service which provided rapid support had been very successful. It had expanded from two to eight mobile units deployed to provide task focused interventions in people's homes between the hours of 7am and 11pm, seven days per week. The service was delivered in partnership with a private home care provider contracted by the council, with community nurses supervising and training home carers in the delivery of health related tasks. These included administration of medication, assistance with personal care and wound dressings, catheter care and monitoring of pressure areas.

Care workers also carried out assisted visits with community nurses, freeing up time which otherwise would have been required from a second nurse. We heard that the rapid support service complemented mainstream home care services, which were also purchased from the independent sector. It helped to ensure speedy discharges from hospital and increasingly prevented unplanned admissions to hospital. There had been considerable benefits for older people. The council also estimated that there had been significant savings for both itself and NHS Forth Valley in staff costs.

In looking at the balance of care we use some of the data already considered in the previous section on outcomes for individuals and their carers but consider the trends in service usage here. In the two years to March 2007, Clackmannanshire's care home placements rose by 15%. Relative to its population, its use of care homes was slightly below and converging towards the national average. In March 2007, it had the highest care home placement rate for partnerships in Forth Valley. The rate of older people receiving intensive home care was above the Scottish average and the average for other partnerships in Forth Valley. In March 2007, 19.9 older people per thousand were receiving intensive home care, compared to rates of 18.5 and 7.1 for Falkirk and Stirling respectively.

We found a very good range of joint and integrated services for older people in Clackmannanshire. Emergency respite care home places and one palliative care bed were purchased by the council without financial support from NHS Forth Valley, and enhanced home care support was readily available in Clackmannanshire. GPs and community nurses made direct referrals for respite and rehabilitation services, and the hospital discharge co-ordinator made direct arrangements for step-down rehabilitation when people were leaving hospital.

Good practice example: Ludgate House

This resource centre provided a range of services, such as day care service, home care, respite and the mobile emergency community services (MECS). It was a former council care home which closed in 2001 and was re-established as a resource centre. It operated 7 days a week and provided a focal point for older people's care services in Clackmannanshire. Other professionals were able to make referrals directly, for example A&E at Stirling Royal Hospital could fast track referrals for respite. The joint rehabilitation service operated from Ludgate House, with the OTs and physiotherapists in the CARE team providing a centre based service and also training home care staff to deliver rehabilitation services at home. Specialist dementia day care was provided. Older people said that this service alleviated their loneliness and they enjoyed attending.

We noted that the mobile rapid support service had expanded fourfold since its inception. However, there had been no increase in NHS funding to support the development of the scheme, despite the strong focus on delivery of health care to support rapid hospital discharge and prevention of emergency admissions. We considered that the level of NHS funding for community services required review if the ongoing shift from acute to community health and care services was to be sustainable in the longer term.

Provision for people with enduring or relapsing mental illness who were beyond retirement age was identified as a need. Relatively small numbers meant that developing a suitable service for this group required agreement at Forth Valley level to jointly commission a specialist service. We make a Forth Valley-wide recommendation about this in chapter 5.

Palliative care at home was also identified as a growing need. The social work service currently funded one respite place for palliative care. This was in recognition of a pressing need which could not be met within existing NHS resources. It was hoped that once the new community hospital was opened, there would be more flexibility to improve services to people who required palliative care in their own homes.

Providers also raised the issue of shortages of podiatry cover; however we heard from managers that the podiatry service had been reviewed and was being targeted at those most in need, rather than available to everyone. This had not been popular, although waiting times had dramatically reduced for those now eligible.

Service commissioning

The Clackmannanshire partnership had signed up to the Forth Valley-wide Joint Commissioning Statement of Intent. The draft Joint Commissioning Framework was accepted in so far as it set the direction for travel, but required further work and refinement before it would provide a full strategy for joint commissioning. The balance between service commissioning at Forth Valley and individual partnership level had still to be worked out.

Senior health and social work managers in Clackmannanshire were outward looking and positive. They were keen to work co-operatively at Forth Valley level where specialist services were required, or where added value could be achieved through combining scarce commissioning resources. The Clackmannanshire partnership described its approach to service commissioning as 'bottom up'. By this it meant that experience gained through assessing and meeting local needs was the principal mechanism for identifying gaps and expanding services or developing new services.

This approach to commissioning ensured flexibility and responsiveness to local needs. It appeared to work well because Clackmannanshire was a small area, with strong operational links between health, social work staff and local providers.

Whilst there were clear benefits from the approach adopted in Clackmannanshire, we considered that service commissioning would be greatly assisted if the partnership developed written local commissioning strategies for older people and people with dementia. These should make appropriate links with emerging Forth Valley-wide joint commissioning plans. Local service commissioning needed to be supported by the development of clear financial frameworks, both Forth Valley-wide and for the local partnership. This would allow local joint commissioning to proceed on a more strategic footing.

6.3.2 Planning, policy development and partnerships

Strategic planning is informed by a whole systems approach

At all levels in Clackmannanshire, there was a very strong sense of a shared vision for older people's services, informed by a whole systems approach. However, this was not set out in comprehensive, joint plans for older people's services. In December 2005, the partnership had produced a statement entitled *Better Outcomes for Older People – Joint Services Review* but this was a joint position statement rather than a strategic plan. The Community Care Plan 2005-08 was very general and did not contain SMART objectives, action points and timescales for older people's services. The JPIAF provided a framework for objectives and targets but it required further work to translate it into a comprehensive strategic plan which could inform local commissioning strategies.

We recognised that as a small partnership, Clackmannanshire had real capacity issues in relation to committing resources to strategic planning and commissioning of services. Nevertheless, we considered that many of the building blocks were already in place, and there would be considerable benefit in allocating some resources to produce and consult on a joint strategic plan for the future of older people's services in Clackmannanshire.

The intention behind the recent reconfiguration of planning structures in Forth Valley was to streamline Forth Valley-wide strategic planning, and ensure that the majority of planning took place at CHP level. Joint planning in Clackmannanshire was overseen by a multi-agency Joint Partnership Group (formerly known as the Joint Future Management Group). There was an Older People's Strategy Group and local implementation groups, including a very active working group taking forward plans for the new community hospitals. The CHP's Public Partnership Forum (PPF) brought together a range of stakeholders, including the voluntary sector. There was a carers strategy group and a housing strategy group, both of which brought together a range of stakeholders and gave them the opportunity to participate in and influence joint planning.

Implementation of joint vision, policies and strategy

The Clackmannanshire partners considered that partnership working had been effective in agreeing a joint vision for older people's services, in agreeing joint plans, including financial plans for managing delayed discharges, and in reaching agreement to develop joint commissioning plans. Partnership groups had worked on governance, finance, delayed discharges, performance, staff and training. This was evidenced at operational level in prompt and crisis responses, reduced waiting times, joint rehabilitation services, and enhanced home care, housing support and respite.

There was, however, some mixed evidence about how successfully the joint vision, policies and strategies were implemented. Staff and managers in Clackmannanshire were overwhelmingly positive about delivering speedy and responsive services for older people. In our focus groups for front line and middle managers, council managers were very positive about the value of the CHP in improving older people's services and outcomes. They were less clear about the different elements of the joint planning structure and how these contributed to better outcomes.

In the staff survey there was less confidence and clarity about the implementation of the joint vision, policies and strategy. Less than half of respondents agreed that the vision for older people's services was set out in comprehensive, joint plans with strategic objectives, measurable targets and timescales. Less than half agreed that there were effective partnerships which focused on delivering key policies and plans for older people and included all relevant stakeholders. These responses were close to the average for Forth Valley.

These findings confirmed our view that the production of written plans and commissioning strategies for older people's services in Clackmannanshire would assist staff and managers to understand and be confident about the links between strategic objectives and operational performance.

6.3.3 Financial and resources management

Financial planning

Clackmannanshire Council's budgeted resources for all community care services were £11.6 million for 2006-07. (We were not provided with figures for older people's services.) The NHS Forth Valley budget was £3.7 million for the Clackmannanshire area. The council's gross spend per adult over 65 was £1586 in 2005-06. This was above the national average of £1504. It reflected the priority given by the council to ensuring that older people have as independent and fulfilled lives as possible. The level of funding was reflected in the high quality of services for older people in Clackmannanshire.

As was the case in the other two partnerships, financial plans were prepared by each partner individually and were not yet driven by policies and service plans agreed by the partners. Therefore, the annual budgets were largely incrementally driven. In addition, the officers that we met advised us that they were aware that much work was needed to align services and budgets. At the time of our inspection, almost two months into the financial year, the aligned budgets had not been identified and agreed for 2007-08 and there were no joint financial plans available for 2008-09 and 2009-10.

Financial management

As was the case with the other two partnerships in Forth Valley, budgets were aligned rather than pooled, and therefore each partner was responsible for its own financial control. The financial monitoring reports submitted to the CHP Committee included only NHS Forth Valley financial information. Therefore the committee did not receive the full financial data for all older people's services within its area. NHS Forth Valley managers advised us that the financial reports submitted to the CHP Committee were in an agreed format to facilitate understanding of the respective CHP's position and, in summary form, of the other two CHPs and NHS Forth Valley as a whole.

However, we are of the opinion that there is room for improvement in the clarity and accuracy of the financial reports submitted to the Clackmannanshire CHP Committee. The content of the reports should be reviewed to ensure that the financial information provided is robust, complete and commensurate with the committee's role and remit. NHS Forth Valley accepted that the reporting needed to improve and there was enthusiasm to expand and encapsulate the appropriate information from all the partners.

Each partner produced its own budgetary control information for its own officers on a monthly basis. Budget variance reports were generally produced within 7 working days of each period end and monthly meetings were held with service managers to discuss the budgetary control information. Cost centres were set up where older people's services costs could readily be coded, but analysis work was necessary where these costs could not be readily identified within a particular cost centre. Officers advised us that, while most of the expenditure on older people's services was identifiable, some of it was estimated.

Clackmannanshire Council had recently introduced a Social Services Purchasing Budget Carry Forward Scheme whereby year-end pressures were removed as from 2006-07 and control was to be exercised over 3 year rolling periods with no preset carry over. Whilst we appreciate the reasoning behind this scheme, we thought that the undue flexibility offered by the scheme could result in a weakening, rather than a strengthening of budgetary control, unless the scheme was closely monitored. Senior managers assured us they were aware of this issue and were operating on a basis that they would not have a larger than 2% variance in any year. They were clear that the council's policy was in effect a vote of confidence in their ability to manage the budgets flexibly and effectively.

There has been no significant capital expenditure in recent years. Any capital expenditure requirements were dealt with by using the partners' corporate methodology.

We make Forth Valley-wide recommendations about financial planning and management in chapter 5.

6.4 Delivery and management of services

The partnership managers worked closely together to deliver services in a collaborative way, through formal systems and close joint working. Systems for the risk management of vulnerable adults were in place. The management and support of staff was very positive with managers agreed on the importance of giving consistent messages. Performance management and continuous improvement were embedded in the way staff and managers approached service delivery and development. The partnership's performance was evaluated as very good.

6.4.1 Joint operational management

The approach taken in the Clackmannanshire partnership was for health and social work services to work positively together rather than to move rapidly towards integrated services or teams, although they had early stage developments such as the integrated community mental health service. There was very positive collaboration between health and social work operational managers which resulted in effective management of services and resources across the whole system. The Joint Partnership Group of service managers had agreed the prioritisation of services for older people with a focus on prompt and responsive services. This was ensured through clear eligibility criteria used in well established systems of referral, assessment, service delivery and care management with good collaboration between service and team managers in health and social work.

The joint commitment to delivering co-ordinated services was demonstrated through a number of projects, such as ensuring there were social work computers in health centres for health staff to access social work records. The social work computer system meant that any manager or member of staff, whether health or social work, could immediately access real-time social work information about any individual case. The value of this was undermined by the limited use of NHS staff of this system. The council's rigorous system of reviewing cases also meant that managers were very alert to any inter-agency issues which might have arisen.

There were joint services such as the successful rehabilitation at home service which included OTs, physiotherapists and home care staff trained in rehabilitation. Palliative care at home was well progressed through the Liverpool care pathway which was being implemented by council, health, voluntary and private providers working together. More people with palliative care needs were being jointly supported at home. However, NHS community resources were severely overstretched and had not kept pace with the changing trend for more people to be supported through palliative care in the community. Ludgate House provided impressive examples of how health and social work staff worked together, for example staff from A&E in Stirling Royal Infirmary could fast track referrals for respite, especially during problematic times such as Christmas and the New Year.

The Joint Implementation Group, which met monthly, had a range of representatives including a geriatrician and operational health and social work managers. We attended a meeting of the group and observed that the members were responsive in jointly handling issues both at the strategic and day to day levels. The Joint Partnership Group had identified in its review in February 2007 that it would take forward the integration agenda, for example for integrated older people's teams. It had also identified the need to combine itself and the CHP Committee into a single management group.

Joint handling of work had been facilitated by co-location in Sauchie Hospital, the old community hospital, which had been closed. There would be co-location of health and social work staff in the new community hospital which was being built, and plans were well advanced for this. There was good collaboration and joint working in this transitional phase. Staff thought that the co-location would further enhance joint working.

Health staff, including clinicians who were involved with patients from Clackmannanshire, had a clear understanding that the council would not normally fund care home places for people being discharged from hospital without an assessment at home first being undertaken. However, the transitional arrangements for the development of the new acute hospital in Larbert had meant a change in medical staff. Council managers were aware that they would have to work with these clinicians to enable them to understand the council's approach to hospital discharge. This meant that clinicians should not suggest care homes to an older person and their family when the older person could be supported at home with the range of services which the council was able to provide.

Concerns were raised with us by individuals, staff and providers about the NHS out of hours service in Clackmannanshire, particularly about the fact that that the service only operates until midnight, and about the inflexibility and unresponsiveness of NHS 24. We deal with this issue at more length in chapter 5. On the whole, managers felt that the services that were provided in Clackmannanshire, such as emergency respite services that could be accessed by GPs, MECS, and the widespread and immediate response of the mobile home care service, meant that there was not a significant issue about the NHS out of hours service.

Waiting lists for services

There were no waiting lists for community care assessments, community nursing services, provision of equipment, or home support services. The joint loan equipment service had proved a major step forward in eliminating waiting times through a flexible and 'can do' approach to sharing budgets for equipment, storage and ordering arrangements, as well as developing clear priority categories. The figures for 2006-07 show that 82% of Priority 1 users obtain equipment within 24 hours, 91% of Priority 2 receive equipment the next day and 96% of Priority 3 receive equipment within one week. Waiting lists for day care and adaptations to homes were regularly reviewed by social work managers.

In 2006, the average time taken to provide a community care service from first identification of need to first service provision was 14 days. The average figure for Scotland was 20 days.

The flexible use of places at Ludgate House, where GPs had direct access, also demonstrated a joint approach to day to day use of resources. There was a proactive response in both health and social work towards minimising delay, for example at health centres, extra sessions had been arranged to tackle waiting times for blood tests.

Health and social work services scrutinised and reported on some waiting lists more intensively than others. For example, in relation to delayed discharges (although the partnership did not have any), the Forth Valley Delayed Discharge Steering Group monitored reports at its monthly meetings. The Clackmannanshire Adult Care Bulletin was produced twice a year, and set out the key areas of services delivery, as measured by key performance indicators. It was a useful performance report including data on carer assessments, intensive home care packages and the number of homes with the MECS service.

The Older People's Day Service Review in June 2006 was a comprehensive overview, and it jointly addressed the issue of waiting lists for day services for older people with particular needs, by setting out actions for a reconfiguration of day services.

Joint mechanisms for operational management

There were no formal mechanisms for joint operational management such as screening and prioritising referrals, managing caseloads and allocating resources on a day to day basis in line with the partnership's agreed priorities. However, there was a very strong joint commitment to ensuring positive outcomes for older people and this was demonstrated in the priority given to hospital discharges and prompt provision of services. Service managers and team leaders took responsibility for their areas of service, such as the assessment process undertaken by the community care teams. Local decisions and allocations were overseen by the Joint Implementation Group and at a higher level by the Joint Partnership Group and the CHP.

The Delayed Discharge Steering Group had given considerable impetus to the issue of delayed discharges across Forth Valley, for example £1.8 million had been allocated for a variety of projects or service developments which the group was monitoring. Clackmannanshire Council was concerned that because it had handled delayed discharges well, by inputting considerable council resources, it would in effect be penalised financially if either its level of funding from NHS Forth Valley was lowered, or other councils were to receive more financial assistance from NHS Forth Valley in the future.

6.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Inter-agency arrangements for the protection of adults at risk should be in place. These should include an inter-agency policy and procedure for the reporting and management of abuse of vulnerable older people. Staff generally should be aware of these and be confident in using them.

Arrangements

A Forth Valley Steering Group and a comprehensive Forth Valley Adult Protection policy and framework were in place for the protection of adults at risk. There were local customised arrangements within Clackmannanshire.

Joint training for managers and some staff took place in May 2006 on a Forth Valley-wide basis, involving the three councils, police and health. Training for staff was being rolled out across Forth Valley and sessions had been run locally. Adults with Incapacity legislation was applied as appropriate, as were the duties of the new Mental Health Act. We appreciate that a jointly accessible community care IT reporting system had been set up by the council to facilitate the immediate exchange of information.

Accountability for risk management

The accountability for risk management and monitoring of risk assessments was undertaken through multi-disciplinary protection of vulnerable adults (POVA) case conferences, supervision, assessment, as well as care programme approach (CPA), care management processes and case file audits.

Deciding on the appropriate balance between risk management and the right of people to make their own decisions is a complex process. Clackmannanshire worked through the implementation of their single shared assessment process and person centred care planning to ensure there was a balance between an individual's self determination and risk management. A risk management policy was being developed.

There appeared to be a mixed level of awareness about adult protection issues in Forth Valley. Risk management of adults at risk was not presented to us by staff or managers as a significant issue, for example no one said that managers were regularly scrutinising practice in relation to this issue or talked about the use of independent advocates. Some staff were concerned that training for them had not been made available sooner.

Case file reading showed that there were up to date risk assessments in 45% of all the applicable cases in Forth Valley. There was more likely to be an up to date risk assessment in health files than in council files – over two thirds in Clackmannanshire CHP but only 27% in Clackmannanshire Council files. There was evidence that multi-agency partners' views had informed the risk assessment in the majority of applicable cases. There was an up to date risk management plan or equivalent in most of the applicable cases, including 100% of the council's files, which is very commendable.

6.4.3 Management and support of staff

Joint training and staff development

Many joint development and training opportunities had been set up as part of the Joint Future programme and these were being further developed, such as the partnership development programme which was open to all staff employed by the council and NHS Forth Valley. The updated Joint Future Training Plan for 2006-07 set out all the joint training and development activity undertaken or planned, such as that for SSA and care management, adults with incapacity, and the new Mental Health Act. The Management Certificate programme was open to health and social work managers, such as those in integrated teams and community care managers. Some staff were not aware of this joint plan or the opportunities in it.

Managers said that all community nursing staff and social work staff had supervision, professional support and opportunities for development, which are identified through regular development reviews. They also had personal development plans.

The surveys of Clackmannanshire Council and all health staff showed that the majority agreed that they were given time to undertake professional development and that their team regularly evaluated its work and took appropriate action for improvement. There was less agreement about the annual appraisal or staff review system with 57% of council staff, but only 32% of health staff, agreeing it helped them improve the way they did their work.

During fieldwork, we were continually informed by health and social work staff and managers that there were many opportunities for joint and single agency training and staff development, for example for palliative care and vulnerable adults training. This was notably also the case in our discussion with private and voluntary sector providers. For example, the council had set up training for private home care providers, which involved training by health staff, so that they could undertake enhanced personal care tasks. This enabled the providers to offer a better service to older people and reduced the workload of community nursing staff, as well as costs to the council. Several carers had had assertiveness training.

Health and social work staff were able to access information they required to carry out their duties and responsibilities through formal information sharing arrangements such as team meetings, locality meetings, and websites. Relevant information about individual patients and service users, such as minutes of care planning meetings and reviews, was also circulated. There was also single agency information. For example, NHS Forth Valley had a comprehensive discharge manual for staff which included guidance on the role of the discharge co-ordinator, the discharge planning pathway, assessment of ability of an older person's ability to take their medication, rehabilitation services, and policy on choice of care home.

Effective communication between staff

The Clackmannanshire partnership said that communication between health and social work staff took place primarily through informal channels. The Head of Service said: *'We are a small council so we can talk quickly and easily to our partners and make things happen very quickly'*. The CHP General Manager said: *'We have experience of joint working in the integrated mental health service to build on. And we try to ensure that, as the senior managers, we have a common message for our staff.'*

However, there were also many formal channels such as the Older People's Implementation Group, Delayed Discharge Steering Group, CHP meetings, Forth Valley Sensory Centre Board, and Housing Strategy Core Group meetings. These were effectively used. There was joint training, for example for the single shared assessment process. Joint rehabilitation training for home care providers by CARE staff was shifting the culture of dependency towards the promotion and maintenance of independence. A more joined up approach to palliative care was being promoted by health professionals and the independent sector providers through the Liverpool care pathway. Care home staff were being trained by the podiatry service in basic foot care.

There was clearly positive and responsive communication between front line social work and health staff. This was also true for relationships between health and social work managers at all levels in the Clackmannanshire partnership. Staff said they were kept informed by managers about service issues and new developments. However, the staff survey showed that only about half of all social work and health staff thought that there were policies, developed in partnership with other agencies, which guided, monitored and improved the way that staff communicated and engaged with each other and older people, carers and the public.

Staff support and morale

There was a largely positive picture in relation to staff support and morale. The survey of social work staff demonstrated that they were positive about the services they provided, the capacity for improvement and the leadership provided by senior managers. Staff in the health service survey, which covered all NHS Forth Valley staff, were less positive.

For example, just under half of all staff agreed that the quality of service offered to older people by multi-agency services had improved over the last year but the NHS staff were less positive (only 16% of them agreed). NHS staff also gave less positive responses to the questions about feeling valued by managers (65% of Clackmannanshire council staff and 39% of NHS Forth Valley staff), receiving feedback about the quality of their work (62% and 32%), the annual appraisal system (57% and 32%) and policies on communication and engagement (64% and 38%).

Staff in Clackmannanshire Council were the most positive in Forth Valley about the way that managers across health and social work provided joint leadership and direction for older people's services, with 62% agreeing with this, as well as 44% of health staff. About 52% of council staff and 30% of health staff agreed there was well managed joint leadership of change which contributed to improved outcomes for older people and their carers.

Both health and social work staff were positive about many aspects of joint working such as information for the public, guidance on eligibility for council services, that assessments were person centred, that older people were supported to make their own decisions and there was sound access to advocacy. In particular, Clackmannanshire staff were positive about the role of multi-agency services in ensuring better outcomes for older people. These included successfully enabling people to live more independently and safely and ensuring that multi-agency discharge arrangements met the needs of older people. Staff were also positive about the robustness of financial systems.

During discussions with us, both health and social work staff were very positive about the services they provided and the way they worked together. However, health staff told us that they felt under constant pressure and that they thought that their staffing numbers were low. Community nursing services were described as over stretched. These concerns were borne out in the NHS Forth Valley staff survey. It was hoped that this would be addressed within the context of developing the new community hospital, although the national review of community nursing had raised major issues which might take some time to resolve.

We acknowledge that, at the time of the inspection, there were significant changes taking place in the NHS Forth Valley, for example, the development of the new acute hospital and community hospitals, together with the national changes in the roles of community nurses and health visitors. We think that the issue of levels of resources dedicated to community health services, such as community nurses, needs to be addressed as part of the progressive development of the Healthcare Strategy. We make a recommendation about this in chapter 5.

6.4.4 Performance management and continuous improvement

Joint performance reporting

This is undertaken through the Scottish Government reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). It contains annual returns by partnerships on performance indicators based around four national outcomes. These are underpinned by Local Improvement Targets (LITS), which are set by the partners themselves to measure progress and improvement.

The Scottish Government rated the partnership's performance in 2005-06 as making good progress.

1. The Scottish Government rated the partnership on single shared assessments (JPIAF 6) as making steady progress.
2. It judged that steady progress was being made in cross-agency access to services (JPIAF 8).
3. The whole system working indicator (JPIAF 10) was evaluated as above average on the comparative model, and making good progress on understanding the holistic approach. The balance of care was positive and continued to move in the right direction.

4. For JPIAF 11, the progress on the existing local improvement targets (LITS) was rated as falling well short, but the new targets were evaluated as sufficient. In particular information was lacking on rapid response, reducing emergency and admissions intensive home care, (but it was acknowledged that the council used a different way to collate its figures compared to the national way). However, the partnership was close to meeting its targets on single shared assessments and more than met its targets on delayed discharges.

NHS Forth Valley had a positive approach to the use of performance data, for example in developing the business case for the new acute hospital. The CHP was developing a local Performance Management Framework which will include national, Board and local priorities and outcomes. The Clackmannanshire CHP General Manager had led on the performance management system for the three CHPs on behalf of NHS Forth Valley. A commendable and detailed paper was presented to the CHP Committee in March 2007. It included general outcomes around shifting the balance of care, management of long term conditions, anticipatory care and specific outcomes and targets for multiple emergency admissions.

The council had a Service Plan 2006-09 which included services for older people. It used the Balanced Scorecard approach and set out targets, performance anticipated and achieved in areas such as community care responses within target times. It was however a fairly high level document, covering a wide range of education, children's, criminal justice, housing, and other services.

Use of joint performance management information

The partnership was confident in its use of performance information and that they could demonstrate positive outcomes and targets met. Joint performance management information such as numbers and types of delayed discharges and the provision of equipment was shared at the Joint Implementation Group for Older People. It was also formally reported to the CHP. This ensured that the focus was kept on high priority needs.

The NHS Forth Valley Chief Executive was particularly positive about the use of performance information to drive improvements in services. We saw a powerful and comprehensive presentation on information about emergency admissions at a Forth Valley-wide meeting, which was considering how the partners could work together to improve the delayed discharge situation. We fully endorse this approach.

However, the staff survey showed that only 48% of staff thought that multi-agency services for older people performed well against service targets. Half of staff thought that services performed well against national and local indicators and benchmarks. High proportions of respondents ticked the "neither agree nor disagree" option. This is an area that requires further scrutiny and joint action.

Our impression was that managers, while conscious of performance management information, did not promote the use of it widely. Some middle managers told us that they believed that better performance management information would help them, as they had serious doubts about the validity of some of the JPIAF indicators. The Joint Partnership Group had identified in its review in February 2007 that joint performance measures needed to be urgently progressed. However, the partnership was proud of some of its performance measures, such as 95% of SSAs are undertaken within the target times.

Continuous improvement

The partnership used joint performance information to assist it to focus on continuous improvement in some areas, for example in relation to waiting times for assessment, the delivery of care packages and other services.

There were no formal joint complaints procedures or systems but integrated teams had procedure manuals with guidance on handling complaints. There were no examples of formal complaints that had needed to be jointly addressed. Staff told us they did not know of any examples of complaints being used to review service quality. However, there was a number of ways in which individuals could make known their concerns.

The Carers Strategy Group acted as a joint consultative group. Council day and residential services had service user forums. The CHP Public Participation Forum in Clackmannanshire responded to issues about the CHP which were raised with it. The Joint Implementation Group for older people addressed cross-cutting issues and was the forum for jointly sharing concerns and feedback from individuals, as well as learning from these. We observed a meeting of this group and noted its positive approach.

There were several examples of successful improvements in health and care services in the last two years, such as the joint rehabilitation service which had enhanced the skills of home care staff. There had been a significant improvement in the services offered by Ludgate House, which included respite, crisis and rehabilitation services that were closely monitored and were used to capacity. Another example was the enhanced mobile emergency care service (MECS) where the MECS and community care teams jointly monitored call outs. The provision of the rapid support mobile home care service purchased from an independent home care provider had had a considerable impact on supporting older people at home.

There were several examples of positive developments in joint services for older people including people with dementia. Alzheimer Scotland had purchased a property for home based day care, and adapted it with a housing improvement grant. There was joint development of services for example the work being undertaken on integrated care pathways through the Dementia Project, a Scottish Government funded project. Work was also being undertaken on telecare/telemedicine developments using Scottish Government funding.

There were several existing standards for services which were single agency standards with partnership elements, such as the ISO Quality Standards in residential and day care services, national assessments and care management standards, Clinical Effectiveness Standards and the requirements for Supporting People services. There were some joint standards such as delivery times for equipment from the joint equipment loan service.

Benchmarking has been well used by NHS Forth Valley, for example as part of its point prevalence studies in relation to the development of its acute and community hospitals. A number of these have been undertaken, such as those on rehabilitation pathways and one undertaken on the characteristics and needs of most patients in NHS Forth Valley beds. These studies have been used to inform healthcare strategy decisions and strategic capacity planning. They have also demonstrated key internal changes in the balance of care, over time.

The work which was undertaken in conjunction with the national Joint Improvement Team (JIT) on joint commissioning involved considerable benchmarking for both health and social work services across Scotland. This was to be continued in the development of the joint commissioning plan in 2007.

Culturally sensitive services

The NHS Forth Valley-wide group called 'Fair for All' had three council representatives as well as community group representatives. This group supported the Central Scotland Chinese Association Big Lottery application to secure funding for support and advocacy on behalf of isolated groups including older Chinese people.

Equality and diversity training was delivered to NHS Forth Valley staff and it included information about access to interpreting services for people with a sensory impairment or people with limited proficiency in English. Equality and Diversity Impact Assessments have been undertaken by NHS Forth Valley for a wide range of services such as A&E, the complaints procedure and food and nutrition in hospital.

The council was also promoting culturally sensitive services through a number of mechanisms such as person centred care, training and the move towards personalisation of services by developing individualised care packages. However, we were not made aware of any specific service developments for older people which were led by the council. Our impression was that the low level of ethnic minority groups had generally led to a low level of staff awareness of culturally sensitive services and the need for them.

6.5 Leadership and direction

There was a clear vision of the outcomes for older people at all levels in the organisation. The council strongly supported services for older people and the senior managers demonstrated a positive ‘can do’ style of leadership, maximising the benefits of the small size of both the council and the CHP. Communication with staff was effective as the senior managers stressed the importance of consistent messages. The management of change was handled well and there was sound managerial practice at all levels. The partnership’s performance was evaluated as very good.

The Clackmannanshire partnership had developed a clear vision of services for older people. The Chief Executive of NHS Forth Valley said the four national Joint Future outcomes were the basis for its work with older people:

- supporting more people at home
- reducing inappropriate hospital admissions
- faster access to services and
- better involvement and support of carers.

From this starting point, the partnership has a strong track record of providing joint services for older people, or health and social work services which complemented each other. Its integrated mental health service was an early stage development. The successes of this approach were notable – for example, no delayed discharges from acute wards and no waiting lists for most services. It has used the opportunity presented by the building of the new community hospital to look at how it can improve services, for example by co-locating social work staff.

Joint projects have included e-Care information sharing within the context of the national project. The council has made available its own database and computers in GP surgeries so that health professionals such as community nurses can have access to information regarding older people as service users. While access to the system was not perfect, the council’s actions illustrated its willingness to act proactively in order to promote collaborative working.

There are many aspects of positive performance, both joint and single agency. Single shared assessments (SSAs) were being undertaken within a clear protocol that urgent priority 1 cases would be assessed on the same day, and Clackmannanshire had set in place a new duty system to speed up assessments. It was also able to ensure that all reviews would be regularly completed.

Private and voluntary providers considered that the partnership valued older people and that it was committed to seeking innovative services in response to local and changing needs. In Community Planning activities in Clackmannanshire, there was an emphasis on how people and communities should be genuinely engaged in decisions made about public services.

Clackmannanshire CHP was viewed positively by health and social work staff as an energetic and positive organisation. This view has been strengthened through the joint approach to working together on future services to be provided in the new community hospital. The CHP was regarded by the council as having a strong focus on older people's services. The new leader of Clackmannanshire Council chaired the Clackmannanshire Alliance, which was the Community Planning partnership. There were two elected members on the CHP Committee. We observed strong joint operational leadership between senior managers in the council and the CHP General Manager, for example, in actively promoting collaborative or innovative ways of working.

There were joint agreements regarding the extent of CHP responsibilities and the governance arrangements as overseen by the CHP Committee. There were also leadership development programmes which were initiated jointly with the council but led by NHS Forth Valley.

Good practice example: Joint leadership and maximising resources in a small organisation

The Head of Community Care and the CHP General Manager worked together effectively and proactively. They were prepared to consider innovative solutions, and in doing so, they minimised the difficulties they were faced with. This was notable in the two organisations – the CHP and council – which were small and lacked capacity, in terms of numbers of staff and managers, but not in managerial competencies.

Communication within health and social work services at the operational level was described as *'very straightforward'*. This was attributed in part to the flat organisational structure within the council and its close links to the CHP, as well as to the positive style of the senior managers in both health and social work. Their aim was always to have a *'common message'*.

Forth Valley-wide joint performance management systems were under development and the CHP General Manager had been given the lead across NHS Forth Valley to develop performance management and monitoring. This was being achieved, initially through the development of a local performance framework with joint indicators and joint targets. There was a clear indication from the Chief Executive of NHS Forth Valley of a willingness to move towards greater reliance on shared data in order to improve performance management. We welcome this.

Clackmannanshire Council has continued to demonstrate its high commitment to older people in its *per capita* spend, which was higher than the national average. The viability of this level of funding to maintain current levels of services had also been reported to committee. The intention was to move to a three-year budget cycle, which is an indication of the confidence held by the council in the managerial strengths of its senior managers. The degree of flexibility delegated to the Chief Social Work Officer will enable prompt and effective responses to expressed local needs. Within the context of the strong focus on the new community hospital, services for older people at home have seen significant investment by the council, largely through outsourced services such as home care and crisis care. It was also notable that the council had gone ahead in purchasing some palliative respite care on its own, in order to meet the needs of older people, since current health provision was inadequate.

The Clackmannanshire partnership had capitalised on one of its key strengths. Its size – there are only 7 GP practices – permitted easy dialogue between staff in health and social work services. This was underpinned by joint arrangements such as the resource centre at Ludgate House to which GPs can refer older people for respite, day care or rehabilitation services. The success of the partnership has more to do with practical on the ground solutions being sought jointly rather than a focus on structures.

Overall, the Clackmannanshire partnership impressed as dynamic in its aspirations and performance for services for older people. It responded to changing needs in a flexible, ‘can do’ manner with less of a consideration of budgetary or organisational constraints, and more of a focus on improving services in order to ensure the outcomes that older people and their carers wanted. These included enabling older people to be supported to remain at home or to return as speedily as possible from hospital to their own homes. In the areas of joint working such as delayed discharges, reduction in levels of emergency admissions, increase in rehabilitation services and flexible home care services, the partnership was achieving significant results.

6.6 Capacity for improvement

We found that significant achievements had been made to improving outcomes and experiences of people using services. Senior managers recognised the importance of quality assurance and performance management. The joint leadership in the partnership was very good with a proactive and responsive style which focused on getting things done. The partnership's capacity for improvement was evaluated as very good.

The evaluation of capacity for improvement is based on three key factors:

- demonstrable improvements in outcomes for people who use services and their experiences,
- quality assurance and performance management, and
- effectiveness of leadership at all levels in health and social work services.

The local partnership had a number of positive factors which will support it in continuing to improve outcomes for older people and carers in Clackmannanshire. The elected members gave high priority and funding to services for older people. There was a strong track record of collaborative working between staff and managers in delivering good outcomes to older people and their carers. There were a number of responsive services such as Ludgate House and the mobile home care service.

A commitment to improving quality assurance ran through health and social work services and the CHP had led the way on implementing robust systems of performance management, and social work services were closely involved with this in relation to the elements concerned with joint working.

There were stable and strong leadership at the senior and middle manager levels of the council and CHP, who were able to maximise the benefits of being a small partnership, while minimising the difficulties such as limited managerial capacity in a number of ways, for example by adopting a flexible and joined-up approach to communication.

Falkirk Council and NHS Forth Valley partnership

This chapter, together with chapter 5, covers all the issues for the Falkirk partnership. It follows the model as set out in appendix 1.

7.1 Person centred care

There was not consistent use of the processes for assessments and care management in social work services, with particular weaknesses in the recording of them and in the allocation of resources. The experience of people and carers receiving services needed to be taken into account more fully when delivering or developing services. There was a strong focus on jointly enabling well being and self care in the Falkirk partnership. Information about services was variable and needed to be improved. The partnership's performance was evaluated as weak.

7.1.1 Assessment and care management

Jointly agreed and documented assessment process

Multi-disciplinary assessments should be undertaken in line with a jointly agreed and documented assessment process, and in partnership with other agencies where required. In the last two years, Falkirk Council had worked very hard to re-invigorate the use of single shared assessments (SSAs) across the Falkirk partnership. This was evidenced in the NHS Forth Valley and Falkirk Council SSA training packs.

The SSA process included the collection of data for the IoRN, a national tool for assessing the dependency levels of individuals. Falkirk expected the SSA process to be developed following the implementation of the e-Care information sharing infrastructure which is being led by the Scottish Government and due to be introduced in early 2008. The use of an integrated IT system will undoubtedly make joint working easier and more productive.

Community nurses used a separate form for SSAs which was designed and developed by the partnership. The acute health sector had unified patient case records, with SSA documentation being used in some areas. All new assessments completed by the Falkirk geriatric service were multi-disciplinary, with good liaison and joint working between community psychiatric nurses (CPNs) and social work staff. However, there were problems with the fact that if community nurses or CPNs undertook assessments, they had to go to social work managers for prioritising and processing and then for funding approval, which could take a further 4-5 weeks.

Staff were in principle committed to joint working. But during file reading we became aware of significant problems with the way in which SSAs are being undertaken in the Falkirk partnership. There was not consistent use of the SSA and care management processes by social work services or health staff. Each of the seven community care teams appeared to undertake their own version of the SSA. One front line manager commented:

'There are as many systems and processes as there are teams and workers in Falkirk.'

Some front line staff said that Falkirk had developed four types of SSA recording in paper format, with no version control. We saw several different versions during file reading. There was no electronic sharing of SSAs and staff were unaware of when this might be introduced. Staff felt there was a need to standardise forms and processes. Some nurses complained that the processes for them to access services differed across the council. Front line fieldwork staff told us that because of the situation, service users and carers might experience duplication of assessment and some delay in accessing services.

A range of staff we met during the fieldwork felt that the situation regarding SSAs in Falkirk was difficult due to several factors including the lack of leadership from senior and middle managers, both in health and social work services. Although the staff survey showed that two thirds of respondents thought that SSAs were undertaken by the relevant professionals, we were told that nurses were reluctant to complete SSAs because of the volume of work involved. In fact, social workers thought nurses were encouraging their patients to self refer.

Some providers said that their experience of multi-disciplinary assessments was variable, particularly assessments for people with dementia living at home.

The file reading showed that assessments of community care needs were on most of the files and there was also evidence of multi-agency working in the majority of cases. Each agency had clearly stated roles and responsibilities in the majority of applicable cases.

The service user survey showed that only 24% of older people had seen a written assessment of their needs and 76% had not.

We were very concerned about the quality and recording of assessments in Falkirk and comment further on this in chapter 5.

Assessment of cultural and ethnic needs

Culturally sensitive systems should be in place to identify and assess the needs of groups and individuals within the population who have particular needs or preferences. Council staff said they could obtain literature available on request in different community languages and formats, but were not aware of anyone doing so.

There was not a strong emphasis in the partnership on the issue of cultural and ethnic needs and it would be helpful if partnership managers could promote good practice in this area.

Needs of carers are identified and assessed

Falkirk and NHS Forth Valley carers strategy and action plan 2007-08 was in draft form. This document was inclusive in addressing carers' participation and addressing issues such as promotion of direct payments. The carers' information pack provided general information about assessments and a range of services including information on short breaks and day care services.

In the Forth Valley area as a whole, less than half of the carers in the survey had been informed of their right to carers assessments. In most cases they had been informed by a social worker or a Carers Centre representative. Only 20% had had their needs assessed. Of those who had had a carers assessment, most said that it had helped them a lot, or had partly helped them. Only one third had received a copy of their assessment. As a result of the carers assessment, half had received support services for themselves, whilst 60% had received additional services for the person they cared for. We thought that it would reassure carers if there was more information about the outcomes of carers assessments.

From the file reading, in just over half of applicable cases carers had been offered information on the support needs of the older person. The carer had been offered an assessment which was declined in 16% of cases. There was an assessment of the carers needs on file in only 17% of applicable cases. However, there was other evidence that carers needs had been identified more often than actual carers assessments were on files.

We met a range of carers during the fieldwork. Carers cited mixed experiences of working with Falkirk and NHS Forth Valley staff. Some carers were very involved and happy with the care package put in place, whilst others were much less positive. All the carers in a focus group had experienced difficulty in finding out about and accessing services and getting information at the point of diagnosis. Several carers cited poor experiences with ward staff in the acute hospitals but they felt that GPs were more approachable and aware of carers issues.

Prevention of inappropriate admission to hospital

The partnership identified a range of services that had been put into place to reduce inappropriate admissions to hospital, in line with the current policy drivers in community care. There were several examples of joint services or collaborative working, such as step up and step down services, crisis care, and rehabilitation at home through FALGO, the Falkirk geriatric outreach team.

FALGO consisted of health professionals – occupational therapists (OTs) and physiotherapists – who also trained the social work support workers in the team to provide aspects of rehabilitation in the community. These services had been successful in preventing admission and supporting hospital discharge whilst reducing dependency on long term care packages. This service was valued by users, carers and staff. The support workers who previously worked in the mainstream home carer service felt very positive about the rehabilitation approach. Community nurses, CPNs and social workers all agreed that the team's work supported older people to live at home.

The majority of staff in the survey agreed that multi-agency services were successful in preventing inappropriate hospital admissions but less than half of NHS staff agreed.

Screening and initial assessment for unscheduled or planned hospital care

For older people being admitted for unscheduled or planned hospital care, a prompt initial screening and initial assessment should be completed within agreed timescales, including a review of health and social care needs. The NHS Forth Valley Fast Track team, which included OTs and physiotherapists, carried out immediate assessments in A&E to support decisions to admit or provide alternatives. The success of this team and other initiatives described in this report can be seen in Table 4 which shows that the level of unscheduled admissions in Forth Valley has remained relatively steady, compared to a rising rate in Scotland as a whole.

About half of the older people in the survey had been admitted to hospital within the last two years, and overall they thought the results of being admitted were fairly positive. A few said that their hospital stay could have been prevented if they had had better support at home.

From the file reading, about one third of older people had been admitted to hospital during the last 12 months. Most of those who had been admitted to hospital during the last 12 months had been admitted once only, but 7 individuals had been admitted twice or more. Overall in Forth Valley, one fifth of the admissions were planned admissions, but none of the admissions in Falkirk Council files or the acute files were planned.

Jointly agreed care planning processes

There should be jointly agreed care planning processes which document goals and outcomes agreed with the older person and record whether these were achieved. Falkirk Council managers told us that individual professional groups and teams had their own methods of completing care plans. The IT system did not facilitate the completion or recording of comprehensive care plans and there was no agreement about recording them in one place on the system. Some of the documents we saw which were called care plans were home care plans, as opposed to full care plans. In the file reading, Falkirk Council had the highest proportion of unsatisfactory or weak care plans.

However, one team manager told us that she had agreed with her team members that they would record full care plans in one place on the computer system. We appreciated her initiative and found the team's care plans easy to read and well constructed.

Care management functions were normally undertaken by the community care teams, although health professionals would lead when appropriate. Just over half of the service users in the survey had been given a care plan. However, from the file reading there was evidence that the views of individuals were taken into account in around 90% of cases. Two thirds of staff in the survey agreed that care or treatment plans were regularly reviewed on a multi-agency basis, although we did not find evidence of this during the file reading.

We were very concerned about the consistency and effectiveness of the way that care plans were undertaken and recorded in Falkirk and we make fuller comments and a recommendation about this in chapter 5.

Discharge planning

Falkirk partnership had a higher level of delayed discharges than the other two partnerships so we were particularly interested in their discharge planning. Discharges, transfers and/or significant changes of accommodation should be planned in partnership with older people, their carers and other agencies as required and arrangements put in place to meet assessed health and social care needs.

A range of joint initiatives had been put in place, including the rapid response team, crisis care, and FALGO which undertook rehabilitation in the community. Other examples included the home care liaison service in the Falkirk hospital social work team and the mobile emergency care service (MECS). The Forth Valley partnership leaflet *Moving from hospital to care home* was a concise and clear leaflet which emphasised choice but also highlighted that people would have to go into another care home if their first choice was unavailable. It made it clear that people could not stay in hospital if they did not need treatment.

However, we heard from a range of front line managers and staff about the difficulties in discharge planning, particularly with the council's IT system. They described it as not being fit for purpose or user friendly, and that it was difficult to share copies of assessments and care plans with older people or colleagues. Multi-disciplinary meetings could be convened to address discharge planning arrangements in complex cases, but some professionals felt this should happen more often.

Less than half of the staff in the survey agreed that multi-agency discharge arrangements met the needs of older people. Falkirk staff were marginally more negative in their response than other Forth Valley staff.

Falkirk Council hospital social work team had been 60% understaffed for about five months – two members of staff in this small team were on long term sick leave. Although other staff within the council undertook assessment work during this period, managers told us this factor had impacted on the delayed discharge figures, although it would not explain the long standing issue. There appeared to be an understanding between hospital social work and health professionals about not moving older people from hospital to a care home while there were sufficient beds in hospital locally and while the first choice care home had no available places.

We think that both health and social work managers need to examine these issues in more detail as part of their drive to reduce delayed discharges.

In Forth Valley as a whole, the majority of carers of older people in the survey said they had received specific information on treatment and information prior to discharge, mostly from hospital staff. About half of the carers in the survey said that the person they cared for had received an assessment of their needs prior to being discharged from hospital, with only a third feeling that they had sufficient information on services and support available prior to discharge from hospital. About half of the carers in the survey said they were involved in planning when the person they cared for was discharged from hospital, and about a third were asked prior to discharge if they were willing and able to provide care.

Assessment of the ability of older people to manage their medication safely

In all settings there should be effective assessment of the ability of older people to manage their own medications safely, with provision made for those in need of support, supervision and monitoring in relation to administration of medicines.

The Falkirk partnership said that there was a range of effective systems in place such as monitored dosage systems for use by council staff and a medication prompting service in Grangemouth. The documentation used by the FALGO therapists included a pharmacy screening tool to determine the need for input by the team's pharmacist. Family members where appropriate monitored medication in liaison with hospital and community pharmacists. Care homes used a service user self-medication assessment procedure.

Falkirk Council had a draft policy for its home care staff for dealing with the administration of medicine. Just over half of staff in the survey said that there was effective assessment of the ability of older people to manage their own medication safely regardless of setting. However, we were told that there were inconsistencies in the way that home care staff in older people's own homes handle medication issues. We make a recommendation about this in chapter 5.

Older people are provided with full information about their condition

Falkirk partnership identified a range of ways by which older people were provided with information about their condition and any treatment or care they require, and their right to consent to treatment. These included nursing staff in community and in-patient settings providing information verbally and in written form. There were advocacy leaflets and partnership funding of an Alzheimer Scotland information officer post, with the organisation providing a full range of information on the condition as well as a phone information line.

In Forth Valley as a whole, the majority of carers of older people in the survey said they had received specific information on treatment and information prior to discharge, mostly from hospital staff.

Accessing personal information

Older people should be informed about how to access their personal information, and about their rights to determine how their personal information is shared and protected. NHS Forth Valley and Falkirk Council participated in the Forth Valley data sharing partnership with the other council partners, police and fire service. The Forth Valley information sharing protocols, November 2006, provided thorough guidance.

The NHS Forth Valley staff also provided new patients with a helpful leaflet entitled *Confidentiality and your health records*. Dedicated offices in NHS Forth Valley dealt with data protection queries, and all staff attended mandatory training in data protection and confidentiality, which covered patient consent and information sharing.

Two thirds of staff in the survey agreed that older people, and with their consent, carers were informed about how the older person's personal information was recorded and used, how to access their personal information and about their rights to determine how their information is shared and protected.

However, older people and carers told us they were not routinely informed about how to access their personal information, and about their rights to determine how their personal information was shared and protected. The council's IT system was constructed in such a way that staff did not need to indicate whether they had asked older people about this in SSAs and automatically assumed that they had not been asked. It would have been better if it had flagged up the need to staff to do so.

We think more emphasis should be put on this issue by managers because it appeared that while procedures and training were sound, they were not being followed through by staff when working with older people.

7.1.2 Experience of people and carers when receiving services

Systems to obtain feedback from people who use services and carers

The partnership used a variety of ways to obtain feedback about the experience of people when accessing and using health and social care services. In 2005, an evaluation of the epilepsy monitoring service was very positive. This service provided fall monitors and offered early assistance and medical intervention when necessary, predominantly for older people with epilepsy and younger single parents. Other examples included the home care users' forum, satisfaction surveys, housing with care consultation process, the Sensory Centre users group, older people's forum and the Joint Improvement Team's (JIT) commissioning workshop. The evaluation of the mobile emergency care service (MECS) was positive with users and carers seeing this as providing a major source of relief from anxiety for carers. The need for the improvement of information leaflets was identified from the evaluation.

NHS Forth Valley and the council had formal complaint systems and 55% of service users said they would feel comfortable about making a complaint if they were unhappy about the service they received from health or social work services, with 35% knowing who to contact to do this.

The Princess Royal Trust (PRT) Carers Centre in Falkirk provided an impressive range of activities which included lunch clubs, a mental health group, men and women's groups and a quarterly newsletter. It was able to ensure that carers views were fed back to the council through carer groups and an area consultative forum.

The staff survey showed that the majority of respondents agreed that systems were in place to obtain feedback from carers. Falkirk had made commendable improvements to services as a result of feedback, such as more Carers Centre activities, review of carers' assessments, and development of short breaks offering more variety for older people and their carers.

We recognise the many ways that the partnership used to obtain feedback about the experience of people when using health and social work services. The partnership managers were clear that they needed to do more, proactively and systematically, to obtain the views of older people and to use them to improve services. Falkirk would benefit from looking at how this information might be assimilated and improvements made as a result of the feedback.

Older people are enabled and supported to make decisions

Forth Valley traditionally had a very positive approach to advocacy and had invested considerable resources in this service. NHS Forth Valley had a five year service level agreement with Forth Valley Advocacy to provide independent advocacy to people with mental health problems and older people. Falkirk Council had its own service level agreement with Forth Valley Advocacy, but it did not fund an advocacy worker specifically for older people, despite the NHS advocacy worker receiving the highest number of referrals involving transitions from Falkirk Royal Infirmary. We found no evidence to suggest that Falkirk had any plans to develop advocacy services for older people in Falkirk. There were no befriending services in Falkirk for older people, for example through Age Concern.

All the older people we interviewed said they were supported to make decisions throughout their care experience. Most staff in the survey agreed that older people are enabled and supported to make decisions throughout their care treatment, although NHS staff were more likely to disagree.

Direct payments constitute another way of enabling and promoting choice for people who require services. All the councils had information leaflets and procedures in place to promote direct payments, but take up was still relatively low. Although one reason cited was that older people did not want to have the responsibility for the administration of these, we believe much could still be done to improve the take up. In 2007, Clackmannanshire had 32 service users (all care groups) using Direct Payments, Falkirk had 61 and Stirling had 37. These figures need to be considered in relation to the size of the population.

7.1.3 Enabling well being and self care

Agencies collaborate to promote and maintain health and independence

Falkirk partnership had a wide range of initiatives to promote older people's health and well being. These included the falls prevention scheme, exercise classes, the taxi contract, garden aid, rehabilitation at home, palliative care and Liverpool care pathway training, dementia care pathways, and the sign language interpreting service. Falkirk CHP had the responsibility for leading and delivering the Health Improvement theme of the Community Plan.

During the fieldwork we met a very broad range of enthusiastic staff from health and social work settings who were very motivated to assist older people remain well or improve their health and well being. Home care staff had received training to do enhanced tasks such as catheter care. Falkirk produced a 'winter warm pack'.

Good practice example: Falls prevention schemes

The mobile emergency care service (MECS) worked with 6,000 older people in Falkirk, providing a community alarm system. As part of the falls prevention programme, MECS alerted health and social work staff if an older person had had two or more falls in the last six months and referred them to the Falkirk geriatric outreach service (FALGO). The older person would be assessed and provided with support. The length of the FALGO programme depended on the older person's specific needs. The OTAGO system, developed in New Zealand, involved training staff in sheltered housing to provide a programme of exercises. This also reduced falls and improved older people's mobility, as part of the falls prevention scheme. It was a joint initiative supported by NHS Forth Valley and Falkirk Council.

Joint action to support older people's capacity for self care and self management

The current focus in the NHS on action to support people with long term conditions in order to increase their capacity for self care and self management was still in the early stages in Forth Valley, but an anticipatory care pilot was being initiated.

Falkirk provided a list which included FALGO, the joint loan equipment service, Windsor day hospital, memory clinics, the Simple Solutions Catalogue, and promotion of the Liverpool care pathway for palliative care. Two thirds of people who accessed the rehabilitation at home service finished the time-limited input without needing ongoing care. This was a positive result, although only 12 people could receive the service at any one time.

7.1.4 Access to services

Information for older people, carers and the public about services

The Falkirk partnership used a range of methods, including web sites, public information leaflets, the care home directory, locality meetings, local newspaper and radio, advocacy services by which information was made available to older people, carers and the public on services provided by the NHS, the local authority, voluntary organisations and care providers. Whilst Falkirk Council had a section within its website devoted to older people, there were no leaflets or links in this to signpost people to services.

There were leaflets on home care and the mobile emergency care service which provided basic information including complaints procedure and eligibility criteria. Some of the providers considered that older people or their carers received good information from social work services or acute hospitals about the range of care and service options open to them when the decision was taken to arrange a care home place. Older people and families in contact with Alzheimer Scotland were given detailed information directly or through signposting to other services.

Managers told us that they were aware that there was a need to improve access to information about services. Most staff in the survey believed that information was available to older people, carers and the public on services provided by the NHS and the council.

Most of the carers we met had experienced difficulty in finding out about and accessing services, or getting information at the point of diagnosis. Carers had a mixed range of experience. Sometimes they had excellent support, but on other occasions they were left feeling frustrated at the lack of support provided both by health and social work. Several carers had poor experiences with ward staff in the hospitals. All said that their GPs were more approachable and aware of carers' issues.

The discrepancy between what staff perceived to be easily available information and what service users and carers told us leads us to suggest that managers, in line with what they had indicated to us, should ensure that information about services is made more accessible.

Comprehensive information should be available in all relevant languages and formats. The Falkirk partnership said that interpretation and translation services were available and that across NHS Forth Valley support existed for the provision of materials to be produced in alternative formats. Translation of information for minority ethnic languages was accessed via a multi-agency contractual agreement with a local company. Translation of information into large print, Braille, audio tape or disc could be accessed via the NHS Forth Valley disability service. NHS Forth Valley provided interpretation and translation flow charts to each department and the procedure was highlighted as part of new staff induction training.

Less than half of staff in the survey agreed that comprehensive information was provided in all relevant languages and formats. Most information leaflets were written only in English with no signposting to other languages or formats, which would have been helpful. Both organisations thought it was appropriate to provide information when needed, rather than try to provide a wide range of leaflets because of the low numbers of minority groups.

Systems to determine eligibility and priority

In view of the fact that there were no charges for home care services in Falkirk, we were interested to see what impact this would have on assessment for and provision of home care. We were advised by staff that more people now accepted home care, where before they would have refused it if payment was required. The need for clear criteria for a service which is in high demand is critical, if decisions are to be made equitably. In health and social work services generally there should be systems to determine eligibility and priority which are transparent, fair and equitable.

Falkirk Council managers provided us with some documents about determining eligibility and priority for services such as home care, assessment and care management as well as jointly agreed criteria for FALGO and hospital discharges. We deal in other sections with the fact that there appeared to be marked discrepancies between the way in which the seven community care teams each carried out assessments and care planning functions. Managers said that they monitored waiting times and the resource panel decisions in attempting to provide some consistency across Falkirk to care packages but no figures were provided at this level of detail.

These issues should be urgently addressed by managers. We make a Forth Valley-wide recommendation about this in chapter 5.

Health and social work services sought to ensure that there were no barriers to accessing services, for example Falkirk Council and Department for Work and Pensions (DWP) were working together to ensure older people had easy access to relevant benefits and services, whilst also trying to reduce duplicate use of forms. The sensory service provided interpretation and translation services for people with sensory impairment or limited English proficiency. Telephone interpreting service and face to face interpreting services were available across all services.

Access to specialist services

A range of specialist services was available to older people living in the Falkirk area so that they could be cared for in a manner that reflected their individual needs. During the fieldwork we visited Burnbrae Home, a council care home which had a day care unit and three units for frail older people. Following a partnership project a five bedded unit for older people who have severe and enduring mental illness was developed. Each person within the specialist mental health residential unit was allocated a CPN. This was welcomed by staff since they thought there was a lack of resources generally for older people with mental health difficulties. Alzheimer Scotland provided a range of specialist services, advocacy, and information to those with dementia and their families.

The Sensory Centre was very effective in making sure that older people with sensory impairment had access to specialist services, such as the deaf blind guide communicators who were could support individuals accessing services via the sign language interpretation service. NHS Forth Valley disability service received referrals from in-patient and community sources and the continence advisory service provided advice and information across Forth Valley. The CMHT(E), the day hospital and community rehabilitation service all had both an open referral and GP referral systems in place.

The people we met during the fieldwork who were able to comment on specialist services said that they were happy with these services.

Multi-disciplinary rehabilitation for older people

There was good access to multi-disciplinary rehabilitation for older people who required it. A range of rehabilitation services were being provided within both hospital settings and an individual's home environment, depending on each individual's need. Staff worked well across GORU (geriatric orthopaedic rehabilitation unit) and the FALGO team, which provided rehabilitation at home. This provided continuity of care and avoided duplication of assessment and treatment.

The FALGO team members provided community assessment and rehabilitation for older people 7 days a week. The service was seen by all staff as a good example of joint working, like the CARE service in Stirling and Clackmannanshire, with significant results in supporting recovery and promoting independence.

Essential equipment is delivered to older people within agreed timescales

The joint loan equipment service had been established since 1987 and was a partnership between Falkirk and Stirling, managed on behalf of the partnership by Falkirk Council. It provided social work and nursing equipment. The Falkirk partnership offered good training for staff to use the equipment. There were liaison nurses in each locality to assist the training of social work staff. Community nurses and OT staff in acute services could access some council funded equipment through the joint arrangements. There was a 'satellite store' in Falkirk to enable speedy delivery of standard pieces of equipment at the time of initial assessments.

The Dundas Disability Living Centre provided advice and information about independent living. Public and private sector adaptations were overseen by the housing officers who reported to the same Director as social work services. We therefore noted with surprise (from the file reading and from discussions with older people) that there were lengthy waits for major adaptations.

The majority of staff thought that essential and urgent equipment was delivered to older people within agreed timescales.

7.2 Key Outcomes for older people and their carers

Positive outcomes for older people and their carers form a key indicator of effective collaboration between agencies. The evidence in Falkirk in relation to outcomes for older people and their carers was mixed. Most older people said they were satisfied with their services, but carers were less happy. The availability of home care and the fact that services were free contributed greatly to the fact that people and their carers regarded services in a positive light. We think that the outcomes for older people in Falkirk and their carers were, on the whole, good. The partnership's performance was evaluated as good.

We evaluated outcomes for people who use services and their carers by considering a range of information, including service user and carer surveys, interviews, focus groups, and evidence from file reading. We also agreed with the partnerships a core set of published performance data, such as levels of delayed discharges and amount of home care hours provided by the councils. Some of this information was proxy for the more robust set of National Outcome measures which is being developed.

Core data set for evaluating outcomes for older people and carers

We used exactly the same performance indicators for 2005-06 for the three partnerships on four key areas relating to outcomes for people and carers, as set out below.

Overall, Falkirk performed well on the level of home care service provided, but performed poorly on some of the other core performance indicators, such as delayed discharges.

1. *Supporting more people at home as an alternative to residential and nursing care. This is often known as the balance of care between home based care and long term care, including NHS continuing care beds and care homes.*

Long term care in Falkirk was consistent with the pattern in Scotland. In March 2006 there were 807 older people in care homes. This represents a rate per thousand of people over 65 years of 34.2. The average for Scotland was 39.8. There are 4.3 (rate per thousand) occupied NHS continuing care beds in Falkirk. The average figure for Scotland was 2.7.

The level of home care was good. There were 79.2 (rate per thousand of over 65s) who received home care in Falkirk. The average figure for Scotland was 68.2. The total hours of home care provided (rate per thousand of over 65s) was 566. Falkirk ranked 10 out of 30 councils in Scotland. Moreover, 25.6% of home care service users received care in the evenings and or overnight. Falkirk ranked 17 out of 31 councils in Scotland on this. In relation to home care at the weekends, 55.7% of over 65s received this service. Falkirk ranked 16 out of 31 councils in Scotland.

Eighteen (rate per thousand of over 65s) home care service users in Falkirk received more than 10 hours home care. The average figure was 17 for Scotland. Intensive home care as a percentage of long term care was 33% in Falkirk. The target figure for Scotland was 30%. In relation to older people receiving less than 10 hours home care per week, the rate per thousand was 62.3, against the national figure of 51.3.

2. Assisting people to lead independent lives through reducing inappropriate hospital admissions, reducing time spent inappropriately in hospital and enabling supported and faster discharges from hospital.

There were 28 delayed discharges of over 6 weeks in March 2006, and this figure had been reduced to 18 by May 2007, much to the partnership's credit.

3. Ensuring people receive an improved quality of care through faster access to services and better quality services.

The average time taken to provide a community care service from first identification of need to first service provision was 16 days in Falkirk. The average figure for Scotland was 20 days.

4. Better involvement of and support for carers.

The number of overnight respite nights provided (rate per thousand of over 65s) was 394.5. This was positive as the average figure for Scotland was 342. The number of day care places for older people (rate per thousand) was 4.4 against a national average of 8.8. The number of older people (rate per thousand) attending day services was 13.5 against a national average of 14.3.

The views of older people on outcomes

The evidence in Falkirk in relation to outcomes for older people and their carers was that they were satisfied with their services. However, some people had concerns about some aspects of the services, particularly staff attitudes in hospitals and care homes. Most of the responses from the Falkirk interviewees were positive, although some did not feel that the help they got made them feel part of the community. Their view was that services could not really achieve this rather than a perceived failure in services. None of the Falkirk older people was charged for any services, because home care services were free to service users in Falkirk.

All of the people we interviewed said that council staff and NHS community and hospital staff treated them with respect. All said they would be comfortable making a complaint if they needed to do this.

The service user survey showed that the majority of older people agreed that NHS and social work services staff had helped them feel safe, to lead a more independent life and to feel a part of their community. They were positive about the quality of services, that they received help at the time they needed it, and that NHS and work staff responded quickly when there was an important change in their situation, and that the help they needed was in place at the time they were ready to leave hospital. Respondents to the survey in Falkirk were more positive than in Stirling but less positive than people in Clackmannanshire when asked about access to information about the range of services that might help them, whether services were well organised and co-ordinated, and whether there was a good range of services available to them.

Views of carers on outcomes for older people

Carers were, on the whole, less satisfied than service users in Falkirk, although this is consistent with the situation across Scotland. Many of the carers we met said they felt side-lined, or worse, by staff in hospitals. There was strong agreement that the personality of the assigned social worker was crucial. Some carers said services ‘closed ranks when you complained’. Advocacy services were in some cases perceived as ‘threatening and military’ and some GPs receptionists as unhelpful.

Views of staff on outcomes for older people

Council staff from the Falkirk partnership believed that their effective joint working delivered good outcomes for vulnerable older people. Staff questionnaires showed that staff thought that positive outcomes in relation to independence, developing skills, isolation, and safety were being achieved. Most staff agreed that multi-agency services were successful in helping older people live as independent a life as possible, keep older people safe and lead less isolated lives. The majority thought that multi-agency services are successful in helping older people to develop their skills and abilities to the full.

The majority of respondents agreed that multi-agency services are successful in preventing inappropriate hospital admissions.

Evidence from file reading

Our scrutiny of records revealed in Forth Valley overall that in 71% of cases, the individual’s circumstances had generally improved in the period under scrutiny. The lowest figure was in Falkirk CHP at 46%. The figure for Falkirk Council files was 75%.

We think that the outcomes for older people in Falkirk and their carers were, on the whole, good. The availability of home care and the fact that services were free contributed to the fact that people and their carers regarded services in a positive light.

7.3 Whole systems approach

There were some examples of good collaborative working at project level, but in the main older people's services were led and managed by single agencies. Sustained effort was needed on key whole systems indicators such as reducing repeat emergency admissions and delayed discharges. Rates of older people receiving home care and intensive home care were above average and the balance of intensive home care was good, and met the national target. There were some issues around availability of care home provision. A whole systems approach to joint strategic planning and service commissioning was needed 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. The partnership's performance was evaluated as adequate.

7.3.1 Range and quality of community based services

A whole systems approach to delivering services

In Falkirk, we did not find a well developed whole systems approach to delivering services for older people. Our discussions with front line and middle managers suggested that whole systems thinking was not yet well embedded at key levels within health and social work. We found some examples of good collaborative practice, and these are commented on more fully below.

Falkirk Council did not charge for home care services. There were mixed views amongst staff about whether this was helpful to older people or not. Some staff said that so few people used to pay, it had cost more to collect charges than was gained from doing so. Others thought there were significant downsides, for example income was forgone, and that demand increased. Staff said that some older people, who would previously not have paid for home care, now accepted it. This issue is not an easy one, but did not appear directly relevant to collaborative working as Falkirk Council provided a high level of home care.

In the staff survey, the majority (68%) of social work staff agreed that a whole systems approach was taken to joint working. This response was average in terms of the three councils.

Broad range of quality services

In chapter 5, we described the reconfiguration of NHS services in Forth Valley, designed to bring about fundamental shifts from acute to primary and community health care, in line with the national policy. Alongside this, the balance of long term health and social care provision needs to shift more towards intensive care services in the community and at home.

Prior to 2005, delayed discharges (over 6 weeks) were running at a high level in Falkirk. The position improved markedly during 2005. However, the downward trend levelled off more recently. The partnership failed to meet its local improvement target to reduce delays by 50% by March 2007. Taking account of the size of the older population, the rate of delayed discharges in Falkirk was above the Scottish average and, over time, was showing a less steady downward trend. Falkirk's rate of two or more emergency admissions for patients over 65 years was higher than the other two partnerships in Forth Valley, but below the Scottish rate. It was also below the Scottish rate for bed days for patients with two or more emergency admissions, and showing a downward trend. This success was attributed by the partnership to step-up, step-down, rehabilitation and respite care initiatives.

Overall, reducing the level of delayed discharges requires further sustained effort, particularly at the whole system level.

Recommendation: Falkirk partnership number 1

Building on the improvements achieved to date, the Falkirk partnership should take proactive steps to improve its level of delayed discharges. This would include better long range planning, for example by factoring in significant issues such as availability of care home places.

In looking at the balance of care, we use some of the data already covered in the previous section on outcomes for older people and their carers, but here we consider the trends in service provision. In March 2006, Falkirk outperformed the Scottish and Forth Valley averages for the rate of older people receiving home care, and intensive home care. It also met the national target of 30% of all long term care delivered in the form of intensive home care.

Falkirk had below average usage of care homes. The most recent JPIAF return showed that for March 2007, there was an increase in numbers receiving intensive home care (up 10%), increased placements in care homes (up 11%) and an increased number of residents in NHS continuing care (up 11%). Over the last two years, intensive home care as a proportion of all long term care remained the same.

In Falkirk, older people's services were in the main led and delivered by a single agency, rather than jointly. We heard that there were good operational links between front line health and social work services for older people, and some examples of joint services. The Falkirk geriatric outreach service (FALGO) had a social work component in the rehabilitation support workers, and we heard that the service had strong links with GP practices, community nurses and social work teams. The aims of the service were to prevent unnecessary hospital admission and to continue rehabilitation after discharge.

Social work services delivered a range of in-house home care services, and also purchased around 1500 hours per week from local voluntary and private home care agencies. In addition to practical help, the council's home care service also provided extended personal care, including stoma and catheter care, rehabilitation at home following hospital discharge, and rapid response/crisis care 24/7. We heard positive comments from front line health and social work staff about the quality of rehabilitation, rapid response and crisis care services. An example of good practice was seen in the employment of an activities therapist in Ivy Bank, an independent care home, so that people had a range of well organised activities. Another was the council's memory impairment prompting service in Grangemouth.

Falkirk acknowledged gaps in service provision which included meals on wheels and shopping service, both of which had limited availability. There were particular issues about the quality of home care services for older people with dementia. We were told by staff that Falkirk's home care policy had changed some time before. They said this meant that specialist home care provided by voluntary organisations for people with dementia could only be accessed by going through the council's home care service. The council service attempted to meet the person's needs first, and only when this failed was a referral made to the specialist dementia service. Providers told us that this change had resulted in a serious deterioration in the quality of home care for people with dementia, who were perceived as getting a very poor service. Managers assured us that home care services for people with dementia could be accessed directly through local community care teams depending on the person's needs. We considered that quality and access arrangements for dementia home care provision required further review at an early stage.

There was a range of local day care provision and the Joint Dementia Initiative which provided day care and short breaks services in people's own homes. This was a Forth Valley joint project managed by Falkirk Council. It was also planning a day service for people with dementia in one of the council's redesigned care homes.

There were strengths in partnership working with housing in Falkirk, and a strong emphasis on developing a range of housing with care options to meet the needs of older people. There were partnerships with housing associations and Falkirk's own housing with care services were being redesigned and expanded. However, during fieldwork and file reading we became aware that there were very considerable delays for major adaptations.

Falkirk Council had engaged in a programme of redesigning and upgrading its six care homes. This resulted in changing two homes from frail elderly to a specific care home for people who have dementia and the other unit specifically for people who have severe and enduring mental illness. Redesign of one home into a very sheltered care partnership project with a housing association was under consideration. We received comment from one senior clinician that further consideration of care home provision was required in Falkirk, as there were insufficient places for people who required nursing care, and this contributed to delayed discharges.

We met with a group of providers, who between them cared for a large number of older people living in care homes or receiving specialist home care and day care. They all considered that the services they provided were highly valued by staff in health and social work. Very positive comments were made about an NHS Forth Valley pilot scheme to provide direct CPN support to five care homes, including two in Falkirk. This had been very effective in reducing emergency hospital admissions of people with dementia. We also heard very positive comments about the service provided to people in care homes by the tissue viability specialist nurse. It was described as ‘*excellent*’.

Care home providers were highly critical of specialist health services for people in care homes. They considered that care home residents had variable and generally very poor access to specialist health care services and were treated less favourably than older people living in other settings. Examples given to us included physiotherapy ceasing as soon as an older person was admitted to a care home; the NHS not providing specialist mattresses; and care home residents having to rely on communal wheelchairs which were unsuited to their needs. Broken hearing aids were replaced by the NHS if people lived in their own homes, but not if they lived in a care home. Providers also considered that some older people with dementia might have avoided care home admissions or transfers if appropriate steps had been to review and manage medication whilst they were in hospital settings.

Issues which were raised during the inspection about the range and quality of services in Falkirk and service gaps included:

- insufficient care home places for people who required nursing care
- although the crisis care services was viewed as excellent by front line staff, there was not enough overnight care at home - more people could be sustained at home if overnight services were available
- there was a need to develop and expand access to rehabilitation at home to strengthen the bridge between hospital and home
- voluntary sector providers and carers highlighted a lack of information and signposting to services for people with dementia, at the point of initial diagnosis. This was felt to be a major gap.

Service commissioning

The Falkirk partnership had signed up to the Forth Valley-wide Joint Commissioning Statement of Intent. The draft Joint Commissioning Framework was accepted in so far as it set out the direction for travel but in advance of this progressing, there was little activity on joint service commissioning at Falkirk level.

Falkirk Council's approach to commissioning of care and support services had been one of meeting demand based on individuals' needs assessments, largely through care managers in social work teams holding devolved budgets. This allowed individuals' needs to be addressed in a focused way, but has meant that there has not been a clearly documented strategic approach to commissioning. The council moved towards this when it appointed four link officers, including one for older people, at the beginning of 2007. It intended, in the next one to two years, to rationalise home care services, review contracting arrangements and in years three to five, consider radical service reconfiguration.

The Falkirk partnership appeared to be at a very early stage of development in terms of whole systems thinking around commissioning. Its intention was to move to more strategic commissioning with a particular focus on partnerships between Falkirk Council, NHS Forth Valley and the two neighbouring councils. However, little practical progress had been made towards this goal and in the main the redesign and commissioning of services for older people was being carried out separately within services, rather than taking a whole systems approach. We consider that the development work to be done around the new community hospital might also provide a catalyst to moving forward a whole systems approach. We urge that every effort should be made to take advantage of this opportunity to move forward jointly on whole systems working and closer integration of services, where this is required.

7.3.2 Planning, policy development and partnerships

Strategic planning is informed by a whole systems approach

As with service commissioning, there was not a strong sense that strategic planning was well informed by a whole systems approach. A strong shared vision for older people's services had not yet been developed and communicated.

There was no written, joint strategic plan for older people's services or people with dementia. Falkirk Housing and Social Work Services produced a service performance plan and a community care services management plan, but so far as older people's services were concerned, these did not reflect whole systems working with NHS Forth Valley. The plans stated a commitment to carrying out reviews of elements of older people's services, rather than presenting a jointly agreed action plan, with SMART objectives, action points and timescales. The JPIAF provided a framework for joint objectives and targets but a considerable amount of further work was needed to translate the JPIAF targets into a comprehensive strategic plan for older people which could inform local commissioning strategies.

We have commented in chapter 5 on the recent reconfiguration of the Forth Valley-wide planning structures, which was intended to ensure that the majority of planning took place at CHP level. At Falkirk CHP level, there was a local implementation group which was taking forward work on *Better Outcomes for Older People*.⁴ However, in the absence of clear strategic plans, partnership working was focused around individual projects rather than more strategically. We observed a very active and lively CHP Public Partnership Forum, and considered that this could provide a vehicle for engaging a wide group of stakeholders in future joint planning for older people's services.

We considered that the development of whole systems working in Falkirk would be greatly assisted by the production of a written strategic plan for older people's services, including older people with dementia, supported by consultation with all relevant stakeholders.

Implementation of joint vision, policies and strategy

Apart from those managers directly engaged in the joint planning structure at Forth Valley-wide or Falkirk level, there was not a great deal of awareness of the joint vision for older people's services, or joint policies and strategies.

In our focus groups with front line managers and front line staff, there was a general lack of awareness of the outcomes of joint planning. Providers also showed a lack of awareness of strategic objectives, such as shifting the balance of care, and had not been involved in discussions about how this was to be achieved, although they clearly had an important contribution to make.

Less than half the staff we surveyed in Falkirk (39%) felt that the vision for older people's services was set out in comprehensive, joint strategic plans, strategic objectives and measurable targets and outcomes. Less than half of staff surveyed in Falkirk (45%) considered that there were effective partnerships which focused on delivering key policies and plans for older people and included all relevant stakeholders. In both cases, the level of agreement was marginally lower than the average in Forth Valley.

The Falkirk staff survey findings confirmed our view that the production of written plans and local commissioning strategies for older people would assist staff, managers and other stakeholders to understand and have confidence in the strategic direction for the service and the performance required to deliver this.

⁴ *Better Outcomes for Older People*; Scottish Executive, 2004

Recommendation: Falkirk partnership number 2

The Falkirk partnership should urgently collaborate on implementing a whole systems approach to older people's services within all levels of the council and the CHP. It should consider local needs and produce a local plan which dovetails with the wider Forth Valley-wide strategy. The local plan should include a joint action plan, financial plan, timescales and commissioning plan, and should set out how the partnership will meet the need for health and social work services in the community. It should also set and monitor timescales for delivering tangible results.

7.3.3 Financial and resources management

Financial planning

Falkirk Council's budgeted resources were £40.1 million for all community care services for 2006-07. (We were not provided with figures for older people's services.) The NHS Forth Valley budget was £13.8 million for the Falkirk area. Falkirk Council's budget per adult over 65 years was £1483 in 2005-06, compared to the national average of £1504.

The construction of each year's budget appeared to be mainly historically and incrementally driven rather than through specific links to current policies and objectives. However, officers advised us that budgetary adjustments were made for specific developments and initiatives and that work was continuing to align services and budgets. At the time of our inspection, the aligned budgets had not been identified and agreed for 2007-08 and there were no joint financial plans available for 2008-09 and 2009-10.

Financial management

As was the case with the other two partnerships in Forth Valley, budgets were aligned rather than pooled, and therefore each partner was responsible for its own financial control. The financial monitoring reports submitted to the CHP Committee included only NHS Forth Valley financial information. Therefore the committee did not receive the full financial data for all older people's services within its area. NHS Forth Valley managers advised us that the financial reports submitted to the CHP Committee were in an agreed format to facilitate understanding of the respective CHP's position and, in summary form, of the other two CHPs and NHS Forth Valley as a whole.

However, we are of the opinion that there is room for improvement in the clarity and accuracy of the financial reports submitted to the CHP Committee. The content of the reports should be reviewed to ensure that the financial information provided is robust, complete and commensurate with the committee's role and remit. NHS Forth Valley accepted that the reporting needed to improve and there was enthusiasm to expand and encapsulate the appropriate information from all the partners.

Each partner produced its own budgetary control information for its own officers on a monthly basis. Budget variance reports were generally produced within three weeks of each period end. The Community Care Finance Group met six-weekly and all community care service managers, the service manager for commissioning and contracting and finance representatives attended in order to discuss budgetary and other financial issues.

Cost centres were set up where older people's services costs could readily be coded, but analysis work was necessary where these costs could not be readily identified within a particular cost centre. The council operated a generic community care constructed budget where resources were allocated to subject area as opposed to client age group.

We were advised that partnership capital expenditure was minimal and we did not view any capital plans for the partnership. Any capital expenditure requirements were dealt with by using the partners' corporate methodology.

We make recommendations about financial planning and management in chapter 5.

7.4 Delivery and management of services

The effectiveness of day to day planning and resource management between health and social work varied very considerably within the local social work services. There was little joint management activity. Procedures for risk management of vulnerable adults were in place. The partnership's management and support of staff needed urgent investment to ensure that staff were more fully involved in knowing about and deciding on the direction of travel. Performance management and continuous improvement showed some strengths. The partnership's performance was evaluated as adequate.

7.4.1 Joint operational management

There should be collaboration between health and social work operational managers in order to ensure the effective management of services and resources across the whole system of care. In Falkirk, there was the Joint Future Management Group, whose membership included the General Manager of Falkirk CHP and Head of Service from Falkirk Council, who were joint chairs. Agenda items covered issues such as the telecare bid, JPIAF reporting, and e-Cart (electronic-Community Assessment and Reporting Tool) updates, rather than day to day operational issues.

Good practice example: Kinglass Centre, Bo'ness

This joint centre for social work and health services, built in 2002, promoted positive joint operational management. Professionals were located within the one building with some shared facilities such as a conference room, small library and kitchen facilities. Professionals held monthly multi-agency meetings and staff talked positively of the advantage of co-location in building networks and relationships. There were patient representatives at operational management meetings. The chair of this meeting, who was a patient, was also a member of the Scottish Health Council. We were told during our visit that the centre was increasingly being used by other services, e.g. the Citizens Advice Bureau (CAB). All the staff confirmed their commitment to doing as much as they could locally to improve services.

The inspection self assessment workbook gave a limited list of joint managerial activity in relation to day to day service delivery, such as GP practice meetings. It also contained examples of joint activity such as joint interviewing for joint posts, job swaps and joint training, although these are not directly relevant to operational management. There were locality meetings for sharing information and experience. Falkirk Council had a comprehensive and up to date (January 2007) loose-leaf document with guidance and procedures in relation to housing matters for people with disabilities.

More significantly, the allocation of rapid response and rehabilitation at home services was undertaken jointly through joint resource panels. The rehabilitation at home service had a joint budget with a single manager. However, service responses and waiting times for services varied greatly between the seven social work area teams in Falkirk. We heard many different reports, both internal and external to social work services, that the area teams were virtually autonomous and did not work to shared procedures. This resulted in services for older people being patchy, depending on where they lived.

We were not convinced that there were consistently strong managerial and staff links between the agencies in relation to day to day planning of services, case allocation and joint planning for the care of individuals.

Waiting lists for services

There were no waiting lists for home care, community nursing and standard items of equipment. We met a member of the social work team in Falkirk Royal Infirmary who arranged straightforward care packages for people leaving hospital and were impressed with the efficiency and person centred way in which she negotiated these, so that people could leave hospital as soon as possible.

There were waiting lists for assessments and services accessed through the community care teams. There were also waiting lists for respite care, day care, and the mobile emergency care service (except for Priority 1).

However, in 2006, the average time taken to provide a community care service from first identification of need to first service provision was 16 days. The average figure for Scotland was 20 days. From the file reading, we noted that 33% of older people were on waiting lists. This figure was the highest in Forth Valley, where the average was 16%.

Health and social work services scrutinised and reported on some waiting lists more intensively than others. For example, in relation to delayed discharges, the Forth Valley Delayed Discharge Steering Group monitored reports at its monthly meetings. These reports detailed the reasons, such as awaiting community care assessments, care home placements or care at home packages. At a meeting of the group which we attended, we saw the senior health manager, the General Manager, Medicine and Rehabilitation Unit, work very constructively and positively towards enabling action to be taken to reduce delayed discharges.

Waiting lists were also reported to the Best Value and Audit Forum. The Housing and Social Work Service Performance Plan, 2006-09 set out a list of priorities for best value or service reviews including home care and joint dementia services, as well as assessment and care management.

Joint mechanisms for operational management

There was a limited number of mechanisms for jointly managing workloads and allocation of services in line with the partnership's agreed priorities. A resource panel met weekly and agreed priorities for allocation of available resources, such as care home places. The joint equipment store had clear priority systems for providing equipment. The community care teams and integrated teams monitored the waiting lists through team management and supervision of individual workers.

In April 2006, there were 47 delayed discharges but this level had been significantly reduced by May 2007 when it stood at 18. We were told that the level of delayed discharges had a number of causes, such as capacity in Falkirk Royal Infirmary, reluctance of consultants and social work staff to insist on older people having to move to a care home which was not their first choice and the limitations on care home places. This was due to a number of factors such as the Care Commission's concerns with some of the independent sector homes and the up-grading of some of Falkirk Council's own homes, both of which had reduced the total capacity of care homes in Falkirk.

The Delayed Discharge Steering Group had given considerable impetus to the issue of delayed discharges across Forth Valley, for example £1.8 million had been allocated for a variety of projects or service developments which the group was monitoring. Although there had been some difficulty in evidencing that the projects had impacted on admissions, the group had agreed that the projects were to continue.

The level of delayed discharges in Falkirk had been reducing but we think that more robust or innovative actions should be taken by the council to reduce the level. This is covered in the whole systems approach section of this chapter.

Nevertheless we think that the partnership was taking some very positive steps to improve the efficiency and effectiveness of its single-agency approach to providing services to older people. The Falkirk Crisis Care Service had been established with funding of £167,000 from Falkirk CHP. It provided an augmented home care service through the 24/7 home care team at Denny, with a link to the home care liaison officer at Falkirk Royal Infirmary.

7.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Multi-disciplinary arrangements for the protection of adults at risk should be in place. These should include a fully implemented inter-agency policy and procedure for the reporting and management of abuse of vulnerable older people. Staff generally should be aware of these and confident in using them.

Arrangements

The Forth Valley Vulnerable Adults Steering Group, which met quarterly, and a comprehensive Forth Valley adult protection policy and framework were in place. There were local customised procedures within Falkirk and a system for preventing financial abuse was being developed.

Joint training for managers and some practitioners took place in May 2006 on a Forth Valley-wide basis, involving the three councils, police and health. Training for staff was being rolled out across Forth Valley. It would also be reinforced by the council's on-going care management training.

Accountability for risk management

The accountability for risk management and monitoring of risk assessments was undertaken through multi-disciplinary protection of vulnerable adults (POVA) case conferences, supervision, assessment, the care programme approach (CPA), care management processes and case file audits.

Deciding on the appropriate balance between risk management and the right of people to make their own decisions is a complex process. Falkirk worked through the implementation of their single shared assessment process and their person centred care planning to ensure there was a balance between an individual's self determination and risk management.

There appeared to be a mixed level of awareness about adult protection issues in Forth Valley. Some staff in Falkirk were very concerned that training for them had not been made available sooner, and they told us that they lacked confidence about handling vulnerable adult cases.

Case file reading showed that there were up to date risk assessments in 45% of the applicable cases in Falkirk CHP, and in 39% of the applicable cases in Falkirk Council. In all Forth Valley partnerships there was more likely to be an up to date risk assessment in health files than in council files. There was evidence that multi-agency partners' views had informed the risk assessment in the majority of applicable cases. There was an up to date risk management plan or equivalent on file in the majority of applicable cases in Falkirk Council, and in most applicable cases in Falkirk CHP.

7.4.3 Management and support of staff

Joint training and staff development

There were many joint development and training opportunities which had been set up as part of the Joint Future programme and these were being further developed, such as the partnership development programme which was open to all staff employed by the council and NHS Forth Valley. The Management Certificate programme was also open to managers, such as those of integrated teams and community care managers. The Housing and Social Work Services – Training and Workforce Development Plan 2007-2009 set out all the joint training and development activity undertaken or planned, such as that for SSA and care management training, adults with incapacity, and the mental health and dementia awareness training.

Managers said all community nursing staff and social work staff have supervision, professional support and opportunities for development, which are identified through regular development reviews. They also have personal development plans.

The surveys of Falkirk council and all health staff showed that the majority agreed that they were given time to undertake professional development and that their team regularly evaluated its work and took appropriate action for improvement. There was less agreement about the annual appraisal or staff review system with only 39% of council staff and 32% of health staff agreeing it helped them improve the way they did their work.

Health and social work staff were able to access information they required to carry out their duties and responsibilities through formal information sharing arrangements such as team meetings, locality meetings, and websites. Relevant information about individual patients and service users, such as minutes of care planning meetings and reviews, was also circulated. There was also single agency information. For example, NHS Forth Valley had a comprehensive discharge manual for staff which included guidance on the role of the discharge co-ordinator, the discharge planning pathway, assessment of ability of an older person's ability to take their medication, rehabilitation services, and policy on choice of care home.

Effective communication between staff

The Falkirk partnership saw communication between health and social work staff taking place mainly through formal channels and groups such as Extended Management Team meetings for housing and social work, the Delayed Discharge Steering Group, CHP meetings, Forth Valley Sensory Centre Board, locality meetings and trade union meetings. There was also joint training, for example for the SSA process. Managers told us that better outcomes for older people resulted from these formal methods of communication. They were able to evidence the impact of some improved information giving systems, for example through increased uptake of Direct Payments and a reduced and more appropriate waiting list for housing with care. We were advised by many of the staff whom we saw that communication between staff on the front line was good.

However, staff said that there were significant issues about how well they were kept informed by managers about service issues and new developments, since staff did not necessarily participate in many of the formal groups. They also said that communication from managers tended to be predominantly by e-mails sent to all staff or newsletters and that often these were seen as irrelevant. Managers did not describe a dynamic process of communication with or between staff in discussions with us.

There was a consensus that generally working relationships between social work staff and GPs were improving but there were still pockets within Falkirk where this was not the case, for example of a GP who would *'not let social workers over the door'*.

The staff survey showed that only about half of respondents in Falkirk council and 38% of NHS Forth Valley respondents thought that there were policies, developed in partnership with other agencies which guide, which monitored and improved the way that staff communicated and engaged with each other and older people, carers and the public.

Staff support and morale

There appeared to be a significant problem in relation to staff support and morale. The survey of social work staff demonstrated that social work staff had positive views about the services they provided, but much less so in relation to the capacity for improvement and the leadership provided by senior managers. Staff in the health service survey, which covered all NHS Forth Valley staff, were less positive (although this was the consistent picture for health staff across Forth Valley).

For example, only 38% of Falkirk staff and 16% of NHS Forth Valley staff agreed that the quality of service offered to older people by multi-agency services had improved over the last year. Health staff also gave more negative responses to the questions about feeling valued by managers (54% of Falkirk council staff and 39% of health staff), receiving feedback about the quality of their work (60% and 32%), annual appraisal system (39% and 32%) and policies on communication and engagement (50% and 38%).

Both health and social work staff were positive about many aspects of joint working such as information for the public, guidance on eligibility for council services, that assessments were person centred and there was sound access to advocacy. In particular, staff were positive about the role of multi-agency services in successfully enabling people to live more independently and safely. Staff were less positive on several other statements. Around a quarter of Falkirk Council staff and a third of health staff said that there was clarity within staff groups about the key principles and aims of joint working. Similar percentages thought that there was well managed joint leadership of change. Almost half of council and health staff disagreed that financial and resource management systems were robust.

Most of the council staff whom we spoke to were not positive about middle and senior managers. They said *'We don't get much leadership or support – there seems to be a black hole.'* They said there was strong peer support and that was crucial in the light of the fact that managers seemed to have lost the capacity to understand the difficulties of not being able to provide sufficient services to older people and their carers. They told us an independent review of community care team operations had been undertaken and the report presented to the senior managers in February 2007, but it had not been shared with them by the time of the fieldwork in May 2007. They understood that it reflected their critical views of the situation. We asked to see it, as it was clearly a positive step to take, but were told that it was not appropriate for us to do so as it had not yet been shared with staff. In view of what staff had told us, we think that the handling of this document, to which many staff contributed, is disappointing.

We acknowledge that, at the time of the inspection, there were significant changes taking place in the NHS Forth Valley, for example, the development of the new acute hospital and community hospitals, together with changes in the role of community nurses and health visitors. There were also significant issues for council staff with the introduction of Single Status and equal pay whereby large numbers of staff had had major changes to their status and remuneration.

We think that the senior managers in both Falkirk Council and NHS Forth Valley should consider the messages from the staff surveys and the fieldwork and take action to support staff more effectively and proactively. We make a recommendation about health staff in chapter 5.

Recommendation: Falkirk Council number 1

Falkirk Council should take urgent steps to improve the understanding and involvement of managers and staff in older people's services, particularly in the light of the changes underway in relation to Single Status and equal pay issues. It should consider developing and implementing a communication strategy about the way forward for services for older people.

7.4.4 Performance management and continuous improvement

Joint performance reporting

This is undertaken through the Scottish Government reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). This contains annual returns by partnerships on performance indicators based around four national outcomes. These are underpinned by Local Improvement Targets (LITS), which are set by the partners themselves to measure progress and improvement.

The Scottish Government rated the partnership's performance in 2005-06 as making steady progress.

1. The Scottish Government stated that improvement was required in the progress of the partnership on single shared assessments (JPIAF 6).
2. It judged that steady progress was being made in cross-agency access to services (JPIAF 8).
3. The whole system working indicator (JPIAF 10) was evaluated as average on the comparative model, and making steady progress on understanding the holistic approach. The balance of care was moving in the right direction regarding home care but was still too dependent on NHS long stay beds and care homes.
4. For JPIAF 11, the progress on the existing local improvement targets (LITS) was rated meeting or close to meeting the targets and the new targets were evaluated as sufficient. The partnership was close to meeting its targets on delayed discharges and single shared assessments, and was more than meeting its targets for rapid response services and intensive home care.

The CHP was developing a local Performance Management Framework which will include national, Board and local priorities and outcomes. These will include general outcomes around shifting the balance of care, management of long term conditions, anticipatory care and specific targets such as reducing multiple emergency admissions.

The council had a Service Performance Plan 2006-09 for Housing and Social Work Services which included services for older people. It was a fairly high level document with some performance information directly relevant to older people's services, such as hospital discharge performance and the rapid response service. It gave positive results for extending home care services, community care alarms, assessments and provision of OT equipment. There were quarterly reports on this plan and they were comprehensive, offering contextual narrative, for example about the lack of care home places, and data such as reductions in the number of bed days lost.

Use of joint performance management information

The partnership managers were confident about the use of performance information and that they could demonstrate positive outcomes and targets met. The council has a range of reporting mechanisms such as six monthly returns on home care. Joint performance management information such as numbers and types of delayed discharges and the provision of equipment were regularly shared at many joint groups such as the Joint Loan Equipment Service Group and the CHP Community Planning Group. The CHP was responsible for delivering, on behalf of Falkirk Council, the Health Improvement theme as part of the Community Planning process. This had ensured that both council and health performance issues were reported to both organisations simultaneously.

The Chief Executive of NHS Forth Valley was particularly focused on the use of performance information, such as SPARRA health data, to drive improvements in services. We saw a powerful and comprehensive presentation on information about emergency admissions at a Forth Valley-wide meeting, which was considering how the partners could work together to improve the delayed discharge situation. We fully endorse this approach.

However, the staff survey showed that only 37% of staff thought that multi-agency services for older people performed well against service targets. Less than one third of staff thought that services performed well against national and local indicators and benchmarks. High proportions of respondents ticked the 'neither agree nor disagree' option. Our impression was that managers, while conscious of performance management information, did not promote the use of it widely.

Continuous improvement

The partnership used joint performance information to assist it to focus on continuous improvement, for example in relation to waiting times for assessment, the delivery of care packages and other services. An example of this was the statistical evidence provided for the Crisis Care Team in December 2006, which demonstrated that 61 people had used the services in December, with 26 referrals to support and facilitate early discharge, 33 to prevent hospital admission and 2 were referrals from A&E. At the end of the period of crisis care, 39 cases (63%) were taken on by social work, 12 people were admitted to hospital, 3 recovered, 3 were admitted to respite and one person went on to the rehabilitation pilot.

There were no formal joint complaints procedures or systems. However, there were several ways in which individuals could make known their concerns, such as through the Carers Centre, the Sensory Centre users group and relatives' groups associated with the Joint Dementia Initiative.

Good practice example: Public Partnership Forum in Falkirk

The NHS Public Partnership Forum (PPF) in Falkirk responded to issues about the CHP which were raised with it, such as questions about the new acute hospital. We attended a lively and positive meeting where we saw this in action. There were also detailed presentations about local dental services and how the public representatives on the PPF represented local views at the CHP Committee meetings.

There were examples of joint developments which had led to successful improvements in health and care services, such the mobile emergency care service (MECS) where all service inputs were jointly recorded by MECS and community care teams, and then monitored by the service manager. This approach was particularly proactive in assisting older people to obtain help if they had a number of falls. This service also undertook epilepsy monitoring. The Burnbrae project facilitated the discharge of patients from Bellsdyke Hospital to a specialist unit in the care home. The psychiatric liaison nurse and clinics in care homes as well as Torwoodhall, a specialist care home, were further examples of service developments.

There are several examples of developments in services for older people with dementia, such as the work being undertaken in the Dementia Collaborative on integrated care pathways. The health and social work training course for people with dementia underpinned the partnership's proactive approach to dementia services.

The Falkirk partnership did not specify any locally developed standards which it was using but said it would be developing a joint commissioning strategy which would underpin the development of locally based standards.

Benchmarking had been effectively used by NHS Forth Valley as part of its point prevalence studies in relation to its acute and community hospitals. A number of these had been undertaken, such as those on rehabilitation pathways and on the characteristics and needs of most patients in NHS Forth Valley beds. These studies have been used to inform healthcare strategy decisions and strategic capacity planning. They have also demonstrated key internal changes in the balance of care, over time.

The work on joint commissioning which was undertaken in conjunction with the national Joint Improvement Team (JIT) involved considerable benchmarking of both health and social work services across Scotland. This was to be continued in the development of the joint commissioning plan in 2007.

Culturally sensitive services

The NHS Forth Valley-wide group called 'Fair for All' had three council representatives as well as community group representatives. This group worked to promote culturally sensitive services, for example it supported the Central Scotland Chinese Association Big Lottery application to secure funding for support and advocacy on behalf of isolated groups including older Chinese people.

Equality and diversity training was being delivered to NHS Forth Valley staff and it included information about access to interpreting services for people with a sensory impairment or people with limited proficiency in English. Equality and Diversity Impact Assessments have been undertaken by NHS Forth Valley for a wide range of services such as A&E, the complaints procedure and food and nutrition in hospital. Falkirk Council's race equality scheme, set out in a comprehensive document covering 2006-09, undertook to assess all new policies introduced by the council using its Impact Assessment Toolkit.

The council was also promoting culturally sensitive services through a number of mechanisms such as person centred care, training and the move towards personalisation of services by developing individualised care packages. However we were not made aware of any specific service developments for older people which were led by the council. It appeared that the low level of ethnic minority groups had generally led to a low level of staff awareness of culturally sensitive services and the need for them.

7.5 Leadership and direction

There were many services which ensured good outcomes for older people and carers. A clearer vision of the future of community services was required and agreement on which services needed to be commissioned. There was commitment amongst front line staff, both health and social work, but there was low morale, partly because of the major change agendas for both organisations. However, managers recognised that they needed to take a more active part in improving the involvement and understanding of staff about the future of services for older people. The partnership's performance was evaluated as adequate.

Leadership at the chief executive level in both the council and NHS Board was positive and willing to embrace the necessary changes to bring about improvements in services and outcomes for older people. The Chief Executive of NHS Forth Valley presented a very clear vision about the way forward for the Board. She confirmed that the Healthcare Strategy was based on key principles such as using integrated approaches wherever that would be helpful and best value. She confirmed that it was essential not to become overly focused on the new acute hospital but also to ensure the development of community hospitals and energised primary care services.

There was a strong commitment to the CHP in Falkirk. The Director of Housing and Social Work was a member of the CHP Committee and it was anticipated that, following the elections, a new elected member to the CHP would be nominated. Elected members and social work managers considered that CHP meetings could be difficult – with large numbers of people, and often with agendas reflecting health rather than shared social work and health issues. The Chief Executive of NHS Forth Valley confirmed that the Board was considering how to promote more effective partnership working at CHP level.

The joint reporting to the CHP Committee and the council was not detailed enough to ensure that all members were able to engage in informed decision making. For example, the Chair of Falkirk CHP confirmed that there had not been joint reporting to the partnership of delayed discharges and numbers of acute beds occupied. During the fieldwork senior managers confirmed that information now available from ISD would form the basis of improved joint monitoring of performance and budgets. We welcome the proposed use of national and local statistics by both the CHP and council.

Falkirk Council had brought together social work and housing services in order to promote better joint working, and there were signs of this happening, although in the file reading we noted a significant problem in the long waits for adaptations to housing for people with disabilities. Falkirk Council's gross spend on services for older people was just below the national average in 2005-06. The level of home care services provided was good and there were no waiting times for home care. The council had good retention of home care workers and there was an emphasis on training staff in order to provide extended home care.

We did not observe strong joint operational leadership between senior managers in the council and the CHP, for example, in actively promoting collaborative or innovative ways of working. The managerial capacity within social work services was raised with us many times. There was a clear indication that attention to the range of operational demands was preventing senior managers from devoting sufficient time to strategic planning. However, vacancies at senior manager levels were in the process of being filled. Some re-designation of responsibility to allow greater focus on planning was under consideration. Nevertheless we consider that it is important for senior managers in the council to ensure that they increase the level of managerial capacity to deal with strategic and operational issues. This could be done by a variety of ways such as mentoring.

There has been some positive joint working and achievements within the Falkirk partnership on key issues, such as reducing the level of delayed discharges. The focus in the partnership had moved, quite rightly, onto the prevention of unnecessary admissions. A wide range of services had been created including the NHS Fast Track service in both Stirling and Falkirk hospitals, MECS, the prevention of falls service and rehabilitation at home. More were being developed, such as telecare. The partnership recognised the need to develop more intermediate care services.

Joint leadership of change has been patchy. The SSA process was not jointly owned or undertaken as a joint process, staff apparently having decided to use separate forms and methods of inputting completed assessments onto the IT system. Relationships between senior professionals such as geriatricians and managers were described as good, but more could be done, with increased managerial capacity in the council, to energise joint strategic and operational leadership. The strategic direction both from the NHS Board and the early work of the CHP had been heavily influenced by the health agenda, such as the development of the new acute hospital and, to date, the planning of the community hospital and locality community health services had been more limited.

The council was coping with major change issues, such as the redesign of its six care homes for older people which had reduced capacity. This had happened at the same time as actions taken in response to Care Commission recommendations, and had led to an overall reduced capacity in residential care places in Falkirk. We were concerned about the lack of whole systems thinking which had not anticipated that these changes would have a knock on effect on the level of delayed discharges.

The Falkirk partnership managers appeared to regard the major opportunities for communication with very diverse staff groups as being mainly formal channels. Although there was much joint engagement between the key managers of the CHP and the council, who said *'we are constantly in the same meetings'*, there was a strongly held view by staff that there was poor communication with them. They believed there was no joint vision of services or that it had not been communicated adequately. Staff said that senior managers had not been proactive in communicating any progress on joint initiatives. Evidence from the staff surveys and discussions with staff led us to believe that these were widely held beliefs.

We are aware of the significant changes underway in the council, such as Single Status and equal pay arrangements, and the impact this was having upon staff morale. We make a recommendation about NHS Forth Valley staff in chapter 5 and about social work staff earlier in this chapter. The Director of Housing and Social Work acknowledged this was an area which required much greater attention so that council staff could become more aware of and enthusiastic about the pace and direction of collaborative working.

7.6 Capacity for improvement

We found that there were generally good outcomes for older people using services and carers. There had been distinct improvements in some outcomes, such as the level of delayed discharges. However, there were serious concerns about the absence of a shared approach to SSAs and care planning. Whole systems approach to services was not widely evidenced. Quality assurance was not high on the agenda in the Falkirk partnership. Joint performance management was being led, on behalf of all three partnerships by Clackmannanshire partnership, and was therefore not as well developed as in that partnership. The joint leadership of the Falkirk partnership was not as strong or as motivated about promoting collaborative management of services as it could have been. The partnership's capacity for improvement was evaluated as adequate.

The evaluation of capacity for improvement is based on three key factors:

- demonstrable improvements in outcomes for people who use services and their experiences,
- quality assurance and performance management, and
- effectiveness of leadership at all levels in health and social work services.

There are several factors which will underpin and support the improvement of outcomes for older people. Both health and social work staff were motivated to work together to support older people living at home as independently as possible. There was some good collaborative working to support this aim, and some positive single-agency services, especially the high level of home care. We were concerned about the limited collaborative working between front line staff in relation to assessment and care management. This existed for a number of reasons such as the apparent lack of strong joint leadership on this issue.

The partnership needed to utilise a whole systems approach more effectively in relation to commissioning services. It has made significant progress in reducing the level of delayed discharges. It now needs to continue the work on deciding which services, such as intermediate services, would help it to completely reduce this level. Work was being undertaken on the CHP performance management framework. Joint performance management was being led, on behalf of all three partnerships by the Clackmannanshire partnership, and was therefore not as well developed in Falkirk as in that partnership. Social work services had begun to develop a performance management culture. Both partners still had work to do to ensure that a performance culture was embedded at all levels.

The leadership in managing change had been good at the NHS Forth Valley-wide level, such as the development of the new acute hospital. But both health and social work staff in Falkirk told us they were unhappy at not being more involved in the development of services. Health staff said they were concerned about the level of community nursing services, because of the impact on their workloads, and the focus on the acute hospital. Council staff said they were unhappy for a number of reasons such as the fact that an independent report on community care teams, undertaken at the start of the year, had not yet been shared with them. Some of their issues were not surprising in view of the high level of changes in the council and the Forth Valley-wide situation, such as Single Status and the development of the new hospital. Managers told us they were committed to taking steps to reduce the level of staff concerns.

CHAPTER 8

Stirling Council and NHS Forth Valley partnership

This chapter, together with chapter 5, covers all the issues for the Stirling partnership. It follows the model as set out in appendix 1.

8.1 Person centred care

Stirling was working to improve the joint process for assessment and care management but there were weaknesses in the processes at all stages, including the allocation of resources for care packages. There was a strong focus generally on enabling well being and self care in the Stirling partnership and there were positive initiatives to promote health and well being in later life. The experience of people receiving services needed to be taken into account more fully when delivering and developing services. The range of methods to ensure information about services, such as leaflets, needed to be improved. The partnership's performance was evaluated as adequate.

8.1.1 Assessment and care management

Jointly agreed and documented assessment processes

Multi-disciplinary assessments should be undertaken following a jointly agreed and documented assessment process, and in partnership with other agencies where required. In Stirling the single shared assessment (SSA) process underwent a substantial review in 2006, and an action plan was agreed to improve the process. The Stirling SSA Strategic Implementation Group Action Plan 2006-09 was specific, measurable, attainable, realistic and had a time frame attached to it explaining in detail what had to be in place to work towards a single shared assessment process.

An innovative pilot to promote and extend the use of SSAs by health and other staff in order to access more services was about to be implemented in one of the rural areas of Stirling. Stirling expected the extent and scope of SSAs to develop following the implementation of the e-Care information sharing infrastructure, which is being led by the Scottish Government and is due to be delivered in early 2008. IoRN (a national tool for assessing the dependency levels of individuals) data was not being gathered in the Stirling partnership, which was awaiting IT development capacity to include this. Stirling managers thought that the situation would improve once the new IT system was available.

The acute health sector had unified patient case records, with SSA documentation being used in some areas. The unified case record had a trigger list for involving internal colleagues and external agencies. There was a range of guidance notes, forms and documentations to support joint working. A full SSA process had been agreed for two services, mobile emergency care service (MECS) and rapid response.

During file reading, we found that assessments of community care needs were on most, but not all files. There was evidence of multi-agency working in most cases and in two thirds of applicable cases there were clearly stated roles and responsibilities for each agency. However, many of the assessments were for services rather than being a comprehensive assessment of individuals' needs.

Our staff survey showed that just over half of respondents thought that SSAs were undertaken by the relevant professionals. In discussions with us, social work staff made it clear that they thought that the Action Plan was at an early stage of implementation with much activity still to be done in making sure staff were informed and fully involved in its implementation. They also said that health staff did not like undertaking SSAs, because of the volume of paperwork involved. Some Stirling managers told us that the local SSA group appeared not to have been very effective of late. Social work and health staff were continuing to use different forms to collect information, with little effort appearing to be made to share information and thus reduce the number of times people had a full assessment completed.

Stirling social work staff were committed to the SSA process in enabling people to live independently and to working together to achieve this. However, difficulties arose in the division of assessment and resourcing roles. Field work staff completed assessments and all proposed care plans were scrutinised in order to complete a 'sizing' exercise and decide on the level and kind of service to be provided. In exceptional circumstances, care plans went to a resource panel for a decision to make on the level and kind of service provided. This process created time delays which social work staff, users and carers described as frustrating.

Our service user survey showed that only 23% of older people had seen a written assessment of their needs whilst 77% had not. Representatives of the private and voluntary providers felt that generally it took a considerable length of time for an assessment to begin, unless the case was urgent.

We found limited evidence during the file reading and fieldwork of joint working in undertaking or sharing assessments between health and social work or the use of a single SSA format agreed by health and social work. We were concerned about the quality of assessments. We comment on this and make a Forth Valley-wide recommendation in chapter 5.

Assessment of cultural and ethnic needs

Culturally sensitive systems should be in place to identify and assess the needs of groups and individuals who have particular needs or preferences within the population. Stirling told us that their assessment process fully included the minority preferences and needs of individuals. Partners had diversity training programmes and IT based training packages including race equality and diversity. The council's Community Services employed an ethnic minority advisor who worked across all council services but also worked closely with care management and health staff, both for individual referrals and assessments and for specialist general advice. Staff also had access to the council's Language Line.

Needs of carers are identified and assessed

The Stirling carers strategy had been jointly developed following a full consultation exercise with carers, which was managed by the Stirling partnership for carers. This document, called *Together We Care 2006-2009* was a user friendly document and had a clear action plan. Together the council, NHS Forth Valley and Carers Centre had also developed a new way forward for carers assessments.

Good practice example: Carers assessments

A new agreement was in place with the Stirling PRT Carers Centre to undertake assessments on behalf of the council. The assessment form had been jointly developed by the Carers Centre, the council and NHS Forth Valley and assessments were recorded onto the council's system. Carers liked this system. Community nursing services used a 'carers views' form to encourage the identification of their needs. A full training programme about carers needs had been put in place by the PRT Carers Centre for council staff.

Less than half of carers in the survey had been informed of their right to carers assessments. In most cases they had been informed by a social worker or a Carers Centre representative. Only 26% had had their needs assessed. Of those who had had a carers assessment, most said that the assessment had helped them a lot, or had partly helped them. Five out of eight respondents had received a copy of their assessment. As a result of the carers assessment, two out of eight respondents had received support services for themselves, whilst three out of eight respondents had received additional services for the person they cared for. These figures show the value of carers assessments.

In the file reading, about half of the cases had a carer and were therefore considered applicable cases. In just over half of these applicable cases, the carers in Stirling had been offered information on the support needs of the older person they cared for. There was an assessment of the carers needs on file in only 7% of applicable cases. However, there was other evidence on files that carers needs had been identified more often than an actual carers assessment was undertaken.

We met with some carers who expressed concern about accessing information and services. They felt it was *'trial and error'* with some professionals providing relevant information and others not. They thought that there were long delays both in undertaking assessments and starting services. For example, they said there was a waiting list for the day care service. However, managers informed us that, of people waiting, the majority had alternative services in place such as home care and respite. We set out carers views more fully in the next section of this chapter.

Some providers said that the needs of carers were not taken into account and there was a lack of information and support for carers. However, we recognise that carers could directly access support services funded by the council, such as the Carers Centre, Crossroads Town and Townbreak which also undertook assessment and screening.

Prevention of inappropriate admission to hospital

Stirling identified a range of joint initiatives that have been put in place over the last two years (involving social work services, NHS primary care and acute hospitals) to reduce hospital admissions, including the following:

- The CARE service which provided rehabilitation at home (for approximately four weeks), step up and step down rehabilitation in rural and city areas in council care homes, including three care home beds available for crisis situations which were fully used.
- Continued development of the rapid response service which will result in services being available at home from approximately 6.45 am to 11 pm. This service will facilitate early supported discharge. The crisis care service offered up to 72 hours service and was used for people who had a short term acute illness which had led to deterioration in ability.
- A considerable amount of work had been undertaken by the falls prevention group, which had not met regularly but had just been reconvened.

Most council staff in the survey agreed that multi-agency services were successful in preventing inappropriate hospital admissions, although less than half of health staff agreed.

Screening and initial assessment for unscheduled or planned hospital care

For older people being admitted for unscheduled or planned hospital care, a prompt initial screening and initial assessment should be completed within agreed timescales. This should include a review of both health and social care needs.

A comprehensive assessment process had been developed as part of the new rapid response protocols. This allowed for a full assessment to be completed at the point of admission to hospital either to prevent unscheduled hospital admission or facilitate quick supportive discharge. The Fast Track team in the hospitals was widely considered to be very effective.

The file reading showed that most of those who had been admitted to hospital during the last 12 months had been admitted once only. The majority of admissions were unplanned.

Overall the service users in our survey thought the results in relation to their admission to hospital were fairly positive, although a lower proportion of users in Stirling said that the help they needed was in place at the time they were ready to leave hospital compared to respondents in the other council areas. As with the other partnerships, a few said that their hospital stay could have been prevented if they had had better support at home.

Jointly agreed care planning processes

There should be jointly agreed care planning processes which document goals and outcomes agreed with each older person and record whether these were achieved. Care plans were not kept on the electronic system in Stirling. There had been a major fire in the council building, which was the centre for all the operational care management and home care functions, shortly before the inspection, so there were no care plans on the paper files for us to inspect as part of the file reading exercise. Following the fieldwork we asked to see some care plans which had been completed after the fire.

Stirling managers told us that care planning which clearly set out the desired outcomes for older people was at an early developmental stage. However, they said that the new rapid response service had clearly agreed protocols and documentation to support goal setting and outcome measures.

We found little evidence of any systematic completion and/or sharing of care plans with service users or carers. Only one third of users in the survey had been given a clear plan of the services they receive, which was lower than for the two other partnerships. Of the eight older people we interviewed during the fieldwork, only two had a copy of their care plan, and two others recalled signing their care plan but had not been given a copy. Some of the documents we saw which were called care plans were home care plans, as opposed to full care plans.

Less than half of staff responding to the staff survey said that care or treatment plans were regularly reviewed on a multi-agency basis. We saw little evidence of reviews having taken place regularly. We were concerned about the effectiveness of care planning in Stirling and we make fuller comments and a recommendation about this in chapter 5.

Discharge planning

Discharges, transfers and/or significant changes of accommodation should be planned in partnership with older people, their carers and other agencies as required and arrangements put in place to meet assessed health and social care needs.

The partnership managers said that professionals worked well in partnership to complete assessments of people who were to be discharged. Social workers, residential staff and ward staff and therapists contributed to the identification of individuals who could be maintained and supported at home or transferred for rehabilitation in care homes with additional rehabilitation from the CARE team.

Therapists from the CARE team arranged the deployment of some equipment and council OTs handled home adaptations. Formal weekly review meetings, which included professionals, older people and carers, ensured arrangements were put in place that matched assessed needs. Although we were told that discharge planning meetings and case conferences took place, these did not seem to happen on a routine basis.

As part of the review of care management services, a full review of hospital social worker services had been completed. Specific hospital based services were to be established from April 2007, with the expectation these would provide stronger support for discharge and transfer planning. The council's care managers took the lead for the majority of cases with complex care arrangements for older people being discharged from hospital. Health colleagues led where professionals were more actively involved, for example, from CMHT(E).

Although most (79%) service users in the Forth Valley surveys said the help they needed was in place at the time they were ready to leave hospital, those in Stirling were less positive (67%).

Less than half of carers from our survey said they were involved in planning when the person they cared for was discharged from hospital, and a third were asked prior to discharge if they were willing and able to provide care. Most carers of older people in the survey said that they had received specific information on treatment and medicine prior to discharge, mostly from hospital staff. Less than half of the carers said that the person they cared for had received assessments of their needs prior to being discharged from hospital with one third feeling that they had sufficient information on services and support available prior to discharge from hospital.

Less than half the staff in the survey thought that multi-agency discharge arrangements met the needs of older people. In support of that, we found that in practice multi-agency discharge planning varied considerably.

Assessment of the ability of older people to manage their medication safely

In all settings there should be effective assessment of the ability of older people to manage their own medication safely, with provision made for those in need of support, supervision and monitoring in relation to administration of medicines. The approach to the ability of older people to manage their medication in Stirling appeared to be patchy. There was some good guidance and practice such as a guide to the council policies and procedures and a self-medication assessment tool for people who could self-medicate. The documentation used by the CARE team therapists included a pharmacy screening tool, which was used to determine the need for input by the team's pharmacist.

Medication procedures and self medication procedures existed within care home settings. There were medication guidelines for home support services, care managers, and health partners making it clear that home care staff should only give verbal prompts without having to check that the older person has taken their medication.

In-patient nursing staff and CMHT(E) nursing staff worked with families and carers to identify tools to support older people to self-medicate, for example dosette boxes. A community pharmacist, as a member of the Development and Implementation Group for older people's services, had a remit to explore the issue of medication management and prompting in community based services. There were plans to establish a partnership group to develop a protocol for the self-administration of medicines.

The majority of staff in the survey said that there was effective assessment of the ability of older people to manage their own medication safely regardless of setting. However, in the fieldwork staff told us there was considerable uncertainty about the extent to which staff could prompt or administer medication and there was inconsistency in what staff actually did. We make a recommendation about this in chapter 5 in the section on medication.

Older people are provided with full information about their condition

Stirling partnership identified a range of ways in which older people were provided with information about their condition and any treatment or care they required, and their right to consent to treatment. These included nursing staff in community and in-patient settings providing information verbally and in written form. Community care staff also provided information through the assessment process.

There were advocacy leaflets and partnership funding of an Alzheimer Scotland information officer post, with the organisation providing a full range of information on the condition as well as a phone information line.

Of the people interviewed during the fieldwork, most said they had been consulted about their care and, where appropriate, their carers had been as well. Most of carers in the survey said they had received specific information on treatments and medicines prior to the person they cared for being discharged from hospital, mostly from hospital staff.

Accessing personal information

Older people should be informed about how to access their personal information, and about their rights to determine how their personal information is shared and protected. NHS Forth Valley and Stirling Council participated in the Forth Valley data sharing partnership with the other council partners, police and fire service. The Forth Valley information sharing protocols, November 2006, provided thorough guidance. The leaflet on *Sharing information and giving consent; a guide for service users* was helpful. The NHS Forth Valley staff also provided all new patients with a helpful leaflet *Confidentiality and your health records*. In addition, the NHS Forth Valley carers information strategy contained advice on this issue.

Two thirds of staff in the survey thought that older people, and with their consent, carers were informed about how the older person's personal information was recorded and used, how to access their personal information and about their rights to determine how their information was shared and protected. Staff across the partnership attended mandatory training in data protection and confidentiality, which covered consent and information sharing.

However, older people and carers told us they were not routinely informed about how to access their personal information, and about their rights to determine how their personal information is shared and protected. We think more emphasis should be put on this issue by managers because it appears that while procedures and training are sound they are not being followed through by staff when working with older people.

8.1.2. Experience of older people and carers when accessing and using services

Systems to obtain feedback from people who use services

Systems should be in place in to obtain feedback about the experience of people when accessing and using health and social care services. The partnership gave us some examples, such as Stirling Council's survey in 1999 as part of its review of its care homes. It also carried out surveys on shopping and housing services, in particular 30 individual older people's reviews for Supporting People services. The majority of these individuals expressed positive views about the services they received. Two older people were members of the Development and Implementation Group for older people's services and shared their views on experiences of using both health and social work services.

Feedback had shown a high level of satisfaction with rehabilitation at home services. GP practices were required to undertake patient surveys to meet the requirement of the patient experience indicators in the QOF. There was a jointly agreed job description for an older people's development worker post, for which joint funding was being sought. The post holder was expected to focus on engagement of older people.

The council's talkback system and complaints procedure provided general opportunities for older people and carer feedback. There was a joint protocol for the investigation of multi-agency complaints drawn up between Stirling and NHS Forth Valley, which also had a complaint and patient relations service. Half of users in the survey said they would feel comfortable about making a complaint if they were unhappy about the service they received from health or social work services, but only one quarter knew who to contact to do this.

The partnership managers were clear that they could not rely on current processes and complaints procedures and needed to obtain the views of older people receiving services more proactively and systematically.

Systems to obtain feedback from carers

There were many ways that the partnership used to obtain feedback. There was a Partnership for Carers group which was chaired by the PRT Carers Centre and involved the council and NHS Forth Valley. The group had a monitoring role in the implementation of the carers strategy as well as providing a forum for constructive dialogue between carers and statutory agencies. The Stirling partnership Strategy for Carers, called 'Together We Care 2006-2009', was a well written and user friendly document informed by positive consultation. The Centre, whilst undertaking carers' assessments, could also provide feedback to the partnership.

As a result of carers feedback the council's residential and day services had opened a rural care initiative in the Callander health centre, as a joint venture with health, and was actively seeking to expand the provision further to meet local needs.

NHS Forth Valley and the council had formal complaints systems and could be contacted by carers to express their views about their experiences of accessing health services and the standard of services received. The staff survey showed that two thirds agreed that systems are in place to obtain feedback from carers.

However, managers told us they were clear they needed to obtain the views of carers about services more proactively and systematically.

Older people are enabled and supported to make decisions

Forth Valley traditionally had a very positive approach to advocacy and invested considerable resources in advocacy services. It had the highest percentage spend per head of population on independent advocacy in Scotland in 2003-04. In response to Scottish Government guidance and implementation of the new Mental Health Act, the councils and NHS Forth Valley had acted both independently and in partnership to commission independent advocacy services. NHS Forth Valley had a five year service level agreement with Forth Valley Advocacy to provide independent advocacy to mental health and older people. Stirling Council funded one post in Forth Valley Advocacy specifically for an older people's worker.

Advocacy workers prioritised those with dementia or communication difficulties. Older people had the option of accessing a professional advocacy worker or they could be partnered with a volunteer advocate. Almost all staff in the survey thought that older people were enabled and supported to make decisions throughout their care or treatment, although NHS staff were more likely to disagree. All the older people we interviewed said they were supported to make decisions throughout their care experience.

Direct Payments constitute another way of enabling and promoting choice to people who require services. All the councils had information leaflets and procedures in place to promote Direct Payments, but take up was still relatively low. Although one reason cited was that older people did not want to have the responsibility for the administration of these, we believe much could still be done to improve the take up. In 2007, Clackmannanshire had 32 service users (all care groups) using Direct Payments, Falkirk had 61 and Stirling had 37. These figures need to be considered in relation to the size of the population.

8.1.3. Enabling well being and self care

Agencies collaborate to promote and maintain health and independence

The Joint Health Improvement Plan (JHIP), 2004-2008, for Stirling CHP provided partners with the strategic direction for promoting health and well being in later life. Older people had participated in the development of this plan. The work involved in promoting healthy ageing had received international recognition at a recent WHO conference. This approach was well embedded in the Community Planning structure, with the Health and Wellbeing Group leading on the delivery of key health improvement actions.

The life expectancy and healthy life expectancy for men and women in Stirling is above the Forth Valley and Scottish averages, both at birth and at 65 years. On average, women in Stirling are expected to have about two more years more of healthy life (10.4 years), compared to the Scottish average of 8.8 years, while men in Stirling are expected to have about three (9.5 years) more compared to the Scottish average of 7.6 years. This figure is related to a number of factors such as relative affluence of the local population, as well as health and social work services.

We met with a wide range of representatives involved in promoting health and well being within the older people population in Stirling and were impressed their positive approach and certainty about the value of their work. There was a range of initiatives including:

- ‘Walk around Stirling’ funded a co-ordinator providing volunteer-led walks which successfully involved approximately 150 people, largely older people, who regularly walked each week.
- ‘Moving about’ training was being delivered to care home staff and day care centre staff to provide activity programmes for frail older people.
- A retired volunteer was providing a handy person service to older people across Stirling with priority given to home safety issues. The intention was to link this development with the telecare developments and the falls prevention programme (which involved persuading older people not to wear ‘sloppy slippers’).
- The Sensory Centre provided direct support to people with sensory impairments in Falkirk and Stirling. We met 10 profoundly deaf older people from across Forth Valley who spoke positively of meeting every week as a group and communicating in their first language, BSL.

Joint action to support older people’s capacity for self care and self management

The current focus in the NHS in Scotland on action to support people with long term conditions in order to increase their capacity for self care and self management was still in the early stages in Forth Valley, but an anticipatory care pilot was being initiated.

Partnership services included the CARE team and the joint loan equipment service (JLES). NHS Forth Valley community nursing and the council were considering improved methods of meeting the needs of those who were terminally ill, in particular improving palliative and end of life care. Some staff were to be offered Liverpool care pathway training to support this way of working.

8.1.4 Access to services

Information for older people, carers and the public about services

The partnership informed us that there was a good range of information for older people, carers and the public on services provided by the NHS, the local authority, voluntary organisations and care providers. We found that it was patchy and needed to be reviewed and improved.

There were no council leaflets setting out all services for older people. There was a range of information on specific services, for example leaflets on home care, rapid response service and residential care, which provided basic information, including eligibility criteria. A Forth Valley partnership leaflet *Moving from hospital to a care home* was clearly written and easy to understand, although it was only in English with no signposting to other formats or languages.

There was a range of joint directories of services, community care directory and mental health directories, which were developed involving service users. The Community Care Directory of Services, 2005-06, whilst thorough, did not dedicate specific sections to older people. The council had a section devoted to older people within their website, but it was not easy to find.

There were a number of general advocacy leaflets. The partnership funded an Alzheimer Scotland information officer post and the organisation provided a full range of information about dementia services as well as a telephone information line. Some providers thought there was little information available about access to services.

In the service user survey, only 31% of users said that they found it easy to obtain clear information and 39% disagreed. (The Forth Valley figure was 49%). Almost all carers responding to the survey were not informed of their right to a carers assessment when the person they cared for was admitted to hospital.

Comprehensive information should be provided in all relevant languages and formats and Stirling Council had a contract with a local company to provide interpretation and translation services as well as the translation of information for minority ethnic languages. Within NHS Forth Valley, interpretation and translation flow charts were provided to each department and the relevant procedures were highlighted as part of new staff induction training.

Information leaflets were written in English with signposting to other languages or formats, which was helpful. Both organisations thought it was appropriate to access interpretation and translation facilities when needed, rather than to try to provide a wide range of leaflets in minority languages because of the low numbers of minority groups. Two thirds of Stirling staff in the staff survey answered positively when asked if they felt comprehensive information was provided in all relevant languages and formats.

Most staff in the survey believed that information was available to older people, carers and the public on services provided by NHS Forth Valley and the council. This was in marked contrast to responses from service users and carers. The discrepancy between what staff perceived to be easily available information and what service users and carers told us, as well as our own experience in trying to obtain information about services for older people, leads us to suggest that information must be made more accessible.

Systems to determine eligibility and priority

In health and social care there should be systems to determine eligibility and priority which are transparent, fair and equitable. It is commendable that Stirling Council had published eligibility criteria for assessments which were applied to new referrals and gave priority to hospital discharges. There were jointly developed eligibility criteria for the rapid response and rehabilitation at home models to ensure consistency of access.

Whilst these systems for determining eligibility and priority were transparent and fair staff said that they had concerns about their implementation. They said there was a lack of consistency between front line staff and their area manager, or when it was involved, the resource panel, in using these criteria. Staff said that this could result in disparity between recommendations made and resources allocated. Senior managers informed us that *'some staff may have viewed all of their cases as a priority, while their area manager may have reached a different view'*. We think that Stirling needs to consider the issue of the implementation of their eligibility criteria with a degree of urgency.

The council also had difficulties in making sure that social care was delivered equitably between rural and urban areas, as home care could be particularly difficult to access in rural areas.

Managers told us that there was a range of creative solutions and flexible and joint working within the rural areas to meet local needs. Home support services and MECS ensured access to all areas in poor weather via the use of four wheel drive vehicles.

Good practice example: Killin Community Trust

The Killin Community Trust had emerged from social work services working with the community with the determined aim of maintaining the small local care home when it was put up for sale. The Falls of Dochart Care Home was bought by a Community Trust, with assistance from the council on fund raising plus finance from social work and health, and managerial support from the council's care provision manager. It continues to provide an important 'hub' for residential and respite services in the heart of this rural community.

Health and social work services sought to ensure there were no barriers to accessing health and social care services. The three ethnic minority lunch clubs (for the Chinese, Indian, and Pakistani communities) were primarily for older people but also provided services to any socially excluded members of these communities. The sensory impairment service provided interpretation and translation services for people with sensory impairments or limited English proficiency. Telephone interpreting service and face to face interpreting services were available across all services.

Access to specialist services

There were several specialist services available to older people in the Stirling partnership so that they could be cared for in a manner that reflected their individual needs. These included the Forth Valley-wide arrangements for deaf blind communicators who were available to support individuals via the sign language interpretation service. Other examples included the provision of advocacy services and provision of specialist information and support services from Alzheimer Scotland.

The NHS Forth Valley continence advisory service provided advice and information across Forth Valley. It was available through the community care and health mainstream processes, although during the fieldwork some social care staff and carers we met were confused about how to access this service. Stirling Council residential and day services also ensured a continence service advisor worked with service users who required the service.

Emergency referrals to the NHS disability service were seen within three working days. There was a waiting list of up to eight weeks for non-urgent referrals, although telephone or letter contact might take place to provide support. The CMHT(E), the day hospital and community rehabilitation service all had both open referral and GP referral systems in place.

The people we interviewed during the fieldwork felt that their requirements were met and they were treated with respect when accessing the specialist services.

Multi-disciplinary rehabilitation for older people

There was good access to multi-disciplinary rehabilitation for older people who required it. A range of rehabilitation services were being provided in hospital settings and in individuals' homes, depending on needs. Staff worked well across the GORU (geriatric orthopaedic rehabilitation unit) and the CARE (community assessment and rehabilitation for elderly people) team. This provided continuity of care and avoided duplication of assessment and treatment.

Good practice example: Rehabilitation service in Stirling Council care homes

The service was developed by utilising health funding for the building of the rehabilitation and respite suite in Strathendrick care home. Social work services funded the revenue costs of the staff and equipment and NHS Forth Valley funded the specialist staff. The service had three beds for rehabilitation in two units, Strathendrick and Allan Lodge. The units worked closely together to ensure best use of resources. Immediately on admission, detailed care plans were drawn up identifying goals to be achieved.

Developments made since the rehabilitation service was established included the introduction of rehabilitation units in Falkirk and Clackmannanshire as well, thus confirming the need for the service and the value of having a co-ordinated and focused approach to rehabilitation.

Essential equipment is delivered to older people within agreed timescales

Essential and urgently required equipment was generally available and delivered to older people within agreed timescales. The JLES had been established since 1987 as a partnership between NHS Forth Valley and the council. Although initially each agency had funded appropriate equipment separately, access to equipment had been extended to include a wider range of staff with agreed competencies, since implementation of the Joint Future recommendations relating to SSA. OT staff in acute services and community nurses could access some council funded equipment through the joint arrangements. Stirling Council also operated a local 'buffer store' of equipment to enable speedy delivery of standard pieces of equipment at the time of initial assessments.

Emergency and out of hours delivery of essential equipment was available to prevent inappropriate hospital admission. Impressive work had been undertaken by the NHS head occupational therapist over the last five years to manage and monitor the waiting lists for specialist items of equipment. Clinical guidelines, protocols and priority tools had been developed to support the appropriate assessment for provision of equipment.

The majority of staff agreed that people received the required equipment and that it was delivered on time.

8.2 Key outcomes for older people and their carers

Positive outcomes for older people and their carers form a key indicator of effective collaboration between agencies. The evidence in Stirling in relation to outcomes for older people and their carers was mixed. Some older people and carers said they were satisfied with their services. Most had concerns about aspects of the services they received, and did not believe that they always ensured positive outcomes for older people. For example, they said that health and social work staff did not always respond quickly to significant changes in their situation, and that the help they got did not always help them to remain at home. The service users survey was the least positive of the three partnerships' surveys. The partnership's performance was evaluated as weak.

We evaluated outcomes for people who use services and their carers by considering a range of information, including service user and carer surveys, interviews, focus groups, and evidence from file reading. We also agreed with the partnerships a core set of published performance data, such as levels of delayed discharges and amount of home care hours provided by the councils. Some of this information was proxy for the more robust set of National Outcome measures which is being developed.

Core data set for evaluating outcomes for older people and carers

We used exactly the same performance indicators for 2005-06 for the three partnerships on four key areas relating to outcomes for people and carers, as set out below.

Overall, Stirling performed very poorly on the level of home care service provided and therefore on the balance of care. It also performed poorly on some of the other core performance indicators, but it performed well on the level of respite for carers and day care services.

- 1. Supporting more people at home as an alternative to residential and nursing care. This is often known as the balance of care between home based care and long term care, including NHS continuing care beds and care homes.*

Long term residential care in Stirling was consistent with the pattern in Scotland. In March 2006 there were 571 older people in care homes. This represents a rate per thousand of people over 65 years of 40.0. The average for Scotland was 39.8. There are 3.3 (rate per thousand) occupied NHS continuing care beds in Stirling. The average figure for Scotland was 2.7.

However, the level of home care is problematic. There were 49.7 (rate per thousand of over 65s) who received home care in Stirling. The average figure for Scotland was 68.2. The total hours of home care provided (rate per thousand of over 65s) was 284. Stirling ranked 29 out of 30 councils in Scotland. Moreover, 22.7% of home care service users got care in the evenings and or overnight. Stirling ranked 21 out of 31 councils in Scotland on this. In relation to home care at the weekends, 54.9% of over 65s received this service. Stirling ranked 17 out of 31 councils in Scotland.

Seven (rate per thousand of over 65s) home care service users in Stirling received more than 10 hours home care. The average figure was 17 for Scotland. Intensive home care as a percentage of all long term care was 18% in Stirling. The average figure for Scotland was 30%. In relation to older people receiving less than 10 hours home care per week, the rate for Stirling was 39.1, while the national average was 51.3.

- 2. Assisting people to lead independent lives through reducing inappropriate hospital admissions, reducing time spent inappropriately in hospital and enabling supported and faster discharges from hospital.*

There were 12 delayed discharges of over 6 weeks in March 2006, and this figure had been reduced to six by May 2007, much to the partnership's credit.

- 3. Ensuring people receive an improved quality of care through faster access to services and better quality services.*

The average time taken to provide a community care service from first identification of need to first service provision was 26 days in Stirling. The average figure for Scotland was 20 days.

4. *Better involvement of and support for carers.*

The number of overnight respite nights provided (rate per thousand of over 65s) was 457. This was very positive as the average figure for Scotland was 342. The rate for day care places for older people in Stirling was also positive – 19.3 against a national average of 8.8. The number of older people attending day care services (rate per thousand of over 65s) was 21.7 against a Scottish average of 14.3.

The views of older people on outcomes for themselves

The evidence in Stirling in relation to outcomes for older people and their carers was mixed. Many of the older people and carers, for example those we interviewed, said they were satisfied with their services, and that the quality of the help they got was excellent or good. However, most people had concerns about some aspects of the services. These included their belief that health and social work staff did not respond quickly to significant changes in their situation, that the help they received did not always help them to remain at home, and that they did not think the charges they had to pay were fair. (We recognise that Stirling followed the CoSLA charging policy.)

Several concerns were expressed to us about the setting up of large care packages. For example, one person who had very severe disabilities told us that he was promised more care before he was discharged from hospital than he actually received. He needed two members of staff at any time help him transfer. Stirling Council had a policy, based on a committee decision, of normally allowing around 25 hours of home care per week, except in exceptional cases, for example where an alternative care arrangement, such as a care home placement is not available. He was told that he could only get a maximum of twelve and a half hours care per week since two workers were needed at the same time. He said that the care manager who did the initial assessment recommended more care hours, but this was rejected. The restriction placed a considerable burden on his wife, although she said that eventually they had 'grown accustomed' to the care arrangements. Moreover, the individual could not obtain day care locally as Stirling Council had no centres for people who needed to use a hoist. We comment on the allocation of services later in the report.

Everyone we interviewed said both they and their carers were involved in the arrangements for their hospital discharge, although one individual said that not all of the services were in place when she was discharged: *'It was quite frightening to go through an experience like this at a very horrendous time. We got nothing on paper. It was not clear who was responsible for what. We had no one point of contact. We should have had something in writing.'*

However, some of the people we interviewed said that the help they received helped them to feel part of the community. One of them was very positive about the benefit he got from mainstream services such as free travel. He said: *'I travel all over Scotland in my disability scooter. I get free travel. Meals on wheels did not suit as I had to be at home to get the food.'*

All of the people we interviewed said they were treated with respect by council staff and NHS community staff. Some people said they were not treated with respect by hospital staff. Half of the people we interviewed said they would be comfortable making a complaint.

The service user questionnaires showed that the way that people felt about services was in line with the other partnerships, but they were much less positive about some key aspects of services. For example, only about half agreed when asked if health and social work services staff had helped them feel safer and able to lead a more independent life. When asked if health and social work staff had helped service users to feel that they were a part of their community – again respondents in Stirling were least positive, with only 37% agreeing.

Respondents were less positive than in the other two council areas about whether the help they needed was in place at the time they were ready to leave hospital. Responses in Stirling were negative about whether it was easy to get clear information on the range of services available to help them (31% agreed but 39% disagreed). Older people were notably less positive than in the other two areas with under half agreeing that services provided by the health and social work staff were well organised and co-ordinated, or that health and social work staff responded quickly when there was an important change in their circumstances. Only about 60% said they received help at the time they needed it.

Views of carers on outcomes for older people

Carers were, on the whole, less satisfied than service users in Stirling, and also less satisfied than carers in the other two partnerships. In the survey of carers, carers in Stirling responded negatively to statements about social work staff providing them with practical support, and about health and social work staff working together to provide them with practical support. They were also less positive than other respondents about health and social work services responding promptly when there was a crisis. However, carers in Stirling were more positive than other carers about health professionals providing them with practical support.

Carers were forthright in expressing their views about services in a meeting with us. They were very positive about the support they got from the Stirling PRT Carers Centre. Many had had a carers self assessment undertaken with Carers Centre staff, using a template developed jointly by the Carers Centre and council staff. They said this type of carers assessment had been very helpful to them. One said: *'The Carers Centre has been invaluable. Things started to happen after I got a carers assessment. Before that I got passed from pillar to post.'*

Most of the carers felt that services in Stirling were not as good as in other areas. One said: *'You can get in Falkirk when you can't get in Stirling. They all get the same funding and they all have the same duty of care. If it's Stirling you will not get anything.'*

The carers said there was difficulty getting a home care service in Stirling, especially in rural parts of the council. Another concern, which we heard from a number of sources, was that service users had to accept services at unreasonable times of day to suit the needs of the service provider. Some carers also said there were problems in obtaining services such as respite or equipment.

Carers said that they believed that the problems lay at senior and middle manager level. One said: *'It's not the front line staff; it's the people above who are sitting on things. They have a fixation about budgets. I was able to bypass the blockage. Not all of the people have the energy to do this. It's quite a battle to get results.'*

We thought that the views held by this group of carers reflected the issues identified for the Stirling partnership, such as problems in obtaining home care, as well as delays and limitations on services.

Views of staff on outcomes for older people

Staff questionnaires showed that staff thought that positive outcomes in relation to independence, developing skills, isolation, and safety were being achieved. Most respondents agreed that multi-agency services were successful, in keeping older people safe, in helping them to lead less isolated lives and in helping older people to develop their skills and abilities to the full. Almost all thought that multi-agency services are successful in helping older people live as independent a life as possible. Most respondents agreed that multi-agency services are successful in preventing inappropriate hospital admissions.

Evidence from file reading

The council case files showed that the objectives set out in the care or treatment plans had been or were in the process of being achieved in 76% of cases – the average figure for Forth Valley overall was 93%.

In view of all the evidence, we make a recommendation that Stirling Council must review the way that services are provided and take steps to improve outcomes for service users and carers.

Recommendation: Stirling Council number 1

Stirling Council should take steps to improve the outcomes for older people and the low levels of satisfaction with services held by service users, carers and colleagues in other organisations. It should take steps to improve its services especially home care services and the care management process.

8.3 Whole systems approach

The partnership's understanding of the whole systems approach was not well developed in Stirling. There was not a high level of services to support people in their own homes, although there were examples of integrated services which had developed largely as part of early supported discharges. Joint strategic planning and commissioning needed to be developed and this needed to take place at the level of the partnership, as well as Forth Valley wide.

Improvements had been made on delayed discharges, but performance on other indicators was mixed. Repeat emergency admissions were low, but performance against the national target for intensive home care was poor. Systems were not yet in place for fully aligned budgets or joint financial management of older people's services. The partnership's performance was evaluated as weak.

8.3.1 Range and quality of community based services

A whole system approach to delivering services

The partnership's understanding of the whole systems approach was not well developed. The 2005-06 JPIAF evaluation statement found the partnership's performance on the comparative whole systems indicator to be below average. The partnership showed extensive slippage on services between years, which impacted on the already low levels of services at the year end. It was performing well on repeat emergency admissions, but less so on discharges. Its balance of care was very dependent on care homes and to a lesser extent on long stay beds. The partnership was found to be making steady progress on its understanding of the holistic approach. It provided a very limited analysis of the drivers of individual indicators and their interaction, and the direction of travel was not very clear, giving a sense of being static. Local improvement targets were reasonable but did not really impact on the balance of care.

Our discussions with front line and middle managers suggested that whole systems thinking was not yet well embedded at key levels within health and social work. We found some examples of good collaborative practice, and these are commented on more fully below.

In the staff survey, more than half (62%) agreed that a whole systems approach was taken to services for older people. This was marginally lower than the response for the other two councils or for NHS staff across Forth Valley.

Broad range of quality services

There was not a high level of services to support people in their own homes, although there were some examples of integrated services which had developed largely as part of early supported discharges.

In chapter 5, we described the reconfiguration of NHS services in Forth Valley, designed to bring about fundamental shifts from acute to primary care and community health services, in line with the national policy. Alongside this, the balance of long term care provision, including NHS continuing care beds, required to shift more towards intensive care at home.

Delayed discharges (over six weeks) peaked in Stirling at July 2002, when the numbers of delayed discharges reached 30. This was followed by a marked improvement to July 2003, when discharges fell to 16. The partnership failed to achieve its local improvement targets on delayed discharges in March 2006. However, in the latest JPIAF submission, for March 2007, delayed discharges (over 6 weeks) had been reduced to six. The rate of delayed discharges in Stirling was above the Scottish average in January 2005, but has shown a steady downward trend in line with the rest of Scotland.

Stirling's rate of two or more emergency admissions for patients aged over 65 was at the Forth Valley average, and below the Scottish rate. Bed days for patients with two or more emergency admissions, were also below the Scottish rate, and fluctuating just under the Forth Valley average. This success was attributed by the partnership to step-up, step-down, rehabilitation and respite care initiatives.

In looking at the balance of care we use some of the data already considered in the previous section for outcomes for individuals and their carers, but here we consider the trends in service provision. Stirling compared unfavourably with its neighbouring authorities and with Scotland in terms of overall rates of home care for older people, as well as intensive home care. In March 2006, 49.7 per thousand older people received a home care service, compared with a rate of 68.2 for Scotland. The rate of people receiving intensive home care (7 per thousand) was less than half the rate for Scotland (17 per thousand). Provision of intensive care (10+ hours per week) barely increased in the two years prior to the inspection, and stood at 18% of all long term care. This was approximately half the national target of 30%.

We were concerned that in Stirling, levels of home care and care home placements were decreasing, against a backcloth of significant increases in very frail older people and people with dementia and reducing hospital provision. For example, the total home care hours, provided as a rate per 1,000 population of older people aged over 65 years dropped from 350.4 in 2003-04 to 291.8 in 2004-05 and again in 2005-06 to 281.4, and in 2006-07 improved to 354.3, a marginal increase. The most recent JPIAF return by the partnership to the Scottish Government showed that for March 2007, placements in care homes reduced by 5% and the number receiving intensive home care was almost static.

Recommendation: Stirling Council number 2

Stirling Council should urgently improve the level and range of home care services as well as its balance of care between care home places and home care for older people, in order to provide better outcomes to older people.

However, we noted that Stirling had developed a mobile personal care service in 2002. It began with the bathing service which helped facilitate early discharge from individuals as older people did not have to wait for bathing equipment to be in place prior to discharge. Mobile personal care which covered all of the council area, operating from 6.30 a.m to 11.30 p.m, had been in place since 2005.

In Stirling, the evidence we received in the fieldwork from front line staff and managers, senior medical clinicians, service users, carers and providers, suggested that social work, health and housing services were generally disjointed and communicated poorly with each other, rather than operating jointly to achieve a whole systems approach. Community care services were perceived as very thin on the ground, with shortages and waiting lists for most services, and particular problems of coverage in rural areas. This was a consistent theme, well reflected in the words of one senior health professional: *'If you need a care home place in Stirling, you might be lucky, but if you need care services at home, you can forget it. Older people in Stirling get a very bad deal.'*

The evidence from the staff survey was however more positive, for example about half of all staff agreed that the quality of service offered to older people by multi-agency services had improved over the last year. Stirling Council staff were more positive (62%) and all NHS staff least positive (only 16% agreed.)

We found evidence of some joint and integrated services in the form of individual projects. These included rapid response services and joint rehabilitation delivered from two redesigned local authority care homes. The hospital based CARE team provided an outreach rehabilitation services for people in their own homes and in community settings, and had close links with GP practices, community nurses, and social work teams.

The rapid response service had initially focused on early supported discharges but had been restructured to broaden the focus to include prevention of admission. The restructured service was due to be relaunched in June 2007. Other partnership projects under development included health care staff directly accessing social care resources in the rural area, and step-up/step-down rehabilitation in two council care homes. An initial review of dementia services had been undertaken, although further work on this was not scheduled to take place until 2008.

Over the last four years there had been a significant increase in the number of day care resources in Stirling, three of which were jointly set up by health and social work. About 220 people per week received a service. Day centre provision in the grounds of Strathendrick care home, established four years ago, was a joint venture. A support group instigated by carers was run from 3-5 pm one day a month within the centre. Stirling Council residential and day services had introduced a carer's support group offering support to families and carers of people with dementia who attended day care. There was also a stroke carer's support group.

Service commissioning

The Stirling partnership had signed up to the Forth Valley-wide Joint Commissioning Statement of Intent. The draft Joint Commissioning Framework was accepted in so far as it set the direction for travel, but required further work and refinement before it would provide a full strategy for joint commissioning. The balance between service commissioning at Forth Valley and individual partnership levels had still to be worked out.

Managers identified the need to reconfigure some existing services in order to achieve a greater balance of care and indicated that the provision of sheltered/more supportive styles of housing for older people would be a significant challenge. Stirling had a comparatively low level of extra care housing. There was, however, a sense that little would move forward in Stirling in advance of a Forth Valley-wide strategy being concluded.

We considered that in parallel with work on a Forth Valley-wide joint commissioning strategy, it was imperative that the Stirling partnership demonstrated leadership in tackling service commissioning for the Stirling area. Early and vigorous action was needed to identify redesign and service development priorities and to accelerate the pace and direction of change in order to improve the balance of care for older people. The partnership should agree clear local priorities, targets and timescales for change in older people's service, and harmonise these with the emerging Forth Valley-wide strategy.

We have noted in chapter 5 that the overarching financial plan for older people's services in Forth Valley needs to be set out. NHS Forth Valley and Stirling Council also needed to develop a joint local financial plan for older people's services. As with Clackmannanshire and Falkirk, this needed to take account of the Forth Valley-wide financial framework. In Stirling's case, it also needed to specifically address whether sufficient council resources were available to support an appropriate and equitable range and quality of care for older people and people with dementia.

We heard that Stirling had a higher proportion of older people who paid for their home care service or care home place (although they might also be eligible for free personal care payments as well), but we did not consider that this diminished the council's responsibility to ensure an adequate level of provision for its older citizens, delivered in partnership with the NHS and other agencies.

In discussion with senior managers in the council, it was apparent that the social work services need to resolve practical issues around specifying services and contracting these from the independent sector, such as the use of block contracts. In these areas, they appeared to be much less well advanced than neighbouring councils, and many other parts of Scotland. This is a significant concern, given the scale of the commissioning challenges the council faced.

The group of providers we met considered that services were not always suitably planned and co-ordinated between agencies. Examples included allocating a day care resource without corresponding practical arrangements being put in place, for example sufficient assistance with dressing, or transport arrangements. Providers also commented that Stirling had a low uptake of direct payments and in some cases, potential claimants were actively discouraged by council staff. Providers said that access to urban services was easier than rural services and they cross-subsidised rural clients by providing services in both areas at the same price, despite the differential in costs to them.

8.3.2 Planning, policy development and partnerships

Strategic planning is informed by a whole systems approach

As with service commissioning, there was not a strong sense that strategic planning was well informed by a whole systems approach. Within Stirling, a strong shared vision of a whole systems approach to older people's services was not apparent at all levels in the partnership. There were no recent joint strategic plans for older people which set out the vision or joint objectives, and we did not find evidence of joint action to set SMART objectives, action plans and timescales. An action plan for *Better Outcomes for Older People*⁵ had been produced, but this was a joint position statement rather than a strategic plan.

We recognise that Stirling is a relatively small partnership and had capacity issues in relation to committing resources to strategic planning and commissioning of services. Nevertheless, we consider that this is an essential next stage if the partnership is to begin to address the many challenges it faces in implementing national policy and improving community health and care services for older people.

We were told by managers that partnership working was effective at Forth Valley level in agreeing a joint vision for older people's services, agreeing joint plans for managing delayed discharges, and reaching agreement to develop joint commissioning plans. We have noted earlier in the report that the intention behind the recent reconfiguration of planning structures in Forth Valley was to streamline Forth Valley-wide planning and ensure that the majority of planning at CHP level.

Partnership working at local authority and CHP level was considered to have been most effective in agreeing joint local improvement targets (LITS) and in putting in place local services such as rapid response and joint rehabilitation services.

5 *Better Outcomes for Older People*; Scottish Executive, 2004

The current local planning structure in Stirling was the Development and Implementation Group for older people's services. We observed this group to be well attended, bringing together a range of planning and operation managers from the local authority, the CHP lead nurse and clinical nurse manager, together with representatives of service users and the voluntary sector. Our observation of a meeting of this group suggested that it came together mainly for discussion and information sharing rather than to drive forward a strategic agenda.

Senior council managers told us that a Stirling geographical data mapping workshop had been held with Forth Valley GIS (Geographical Information Services) to explore how geographical data mapping can enhance future planning and reporting issues. Regular management information is presented to the JLES Management Group to inform operational and strategic decision making.

Managers in the Stirling partnership considered that there was good involvement with voluntary and provider organisations. The Stirling carers strategy had been jointly developed following a full consultation exercise with carers, which was managed by the Stirling partnership for carers. This document, called 'Together we care 2006-2009', was a user friendly document and had a clear action plan. However, some comments made by stakeholders, other than carers, suggested that generally involvement was patchy.

The CHP's Public Partnership Forum (PPF) brought together a range of stakeholders, including the voluntary sector. There was a carers strategy group and a housing strategy group, both of which brought together a range of stakeholders and gave them the opportunity to participate in and influence joint planning.

Implementation of joint vision, policies and strategies

In the staff survey, exactly half the staff felt that the vision for older people's services was set out in comprehensive, joint strategic plans, strategic objectives and measurable outcomes. This was higher than the response for the other two councils and for NHS Forth Valley staff. A similarly positive response was obtained when staff were asked if there were effective partnerships which focused on delivering key policies and plans for older people and included all relevant stakeholders. Here only 2% (1 member of staff) disagreed – much fewer than in the other councils or NHS Forth Valley.

We also received information about the North West locality group within the CHP structure. Older people had been identified as a priority for this group during 2006-07, and minutes of meetings showed evidence of whole systems thinking and good local joint working on the older people's agenda on a range of issues, including palliative care, dementia, rapid response, access to services and the interface between partners and the acute hospital. This group involved social work staff, GPs and primary care staff.

During fieldwork, front line managers and staff were not clear about whether there was any overarching shared vision for older people's services. They did not think that there was a coherent set of joint plans in the form of a strategy for older people, objectives and timescales beyond the performance indicators set out in the JPIAF.

We think that the production of written plans and local commissioning strategies for older people would assist staff, managers and other stakeholders to understand and have confidence in the strategic direction for the service and the performance required to deliver this.

Recommendation: Stirling partnership number 1

The Stirling partnership should urgently collaborate on implementing a whole systems approach to older people's services within all levels of the council and the CHP. It should consider local needs and produce a local plan which dovetails with the wider Forth Valley-wide strategy. The local plan should include a joint action plan, financial plan, timescales and commissioning plan, and should set out how the partnership will meet the need for health and social work services in the community. It should also set and monitor timescales for delivering tangible results.

8.3.3 Financial and resources management

Financial planning

Stirling Council's budgeted resources for community care services were £20.0 million for 2006-07. (We were not provided with figures for older people's services.) The NHS Forth Valley budget was £8.2 million for the Stirling area. The council spent £1373 per adult over 65 in 2005-06 which was less than the average figure of £1504 for Scotland.

As was the case in the other two partnerships, financial plans were prepared by each partner individually and were not yet driven by policies and service plans agreed by the partners. Therefore, the annual budgets were largely incrementally driven. In addition, the officers that we met advised us that they were aware that much work was needed to align services and budgets. At the time of our inspection, almost two months into the financial year, the aligned budgets had not been identified and agreed for 2007-08 and there were no joint financial plans available for 2008-09 and 2009-10.

Financial management

As was the case with the other two partnerships in Forth Valley, budgets were aligned rather than pooled, and therefore each partner was responsible for its own financial control. The financial monitoring reports submitted to the CHP Committee included only NHS Forth Valley financial information. Therefore the committee did not receive the full financial data for all older people's services within its area. NHS Forth Valley managers advised us that the financial reports submitted to the CHP Committee were in an agreed format to facilitate understanding of the respective CHP's position and, in summary form, of the other two CHPs and NHS Forth Valley as a whole.

However, we are of the opinion that there is room for improvement in the clarity and accuracy of the financial reports submitted to the CHP Committee. The content of the reports should be reviewed to ensure that the financial information provided is robust, complete and commensurate with the committee's role and remit. NHS Forth Valley accepted that the reporting needed to improve and there was enthusiasm to expand and encapsulate the appropriate information from all the partners.

Each partner produced its own budgetary control information for its own officers on a monthly basis and regular meetings were held between managers and budget holders to discuss budgetary control issues. Cost centres were set up where older people's services costs could readily be coded, but analysis work was necessary where these costs could not be readily identified within a particular cost centre.

The partnership had no capital budget of its own. Capital requirements were minimal and had to be bid for to the council and to NHS Forth Valley under their normal capital planning procedures. Although the partners operated separate capital plans, joint discussions were held in advance of the capital plans being finalised.

We make recommendations about financial planning and management in chapter 5.

8.4 Delivery and management of services

Day to day planning and resource management were adequately undertaken and monitored at a local level. Staff found the decision making processes for care packages difficult to use to get the best results for older people as they found them cumbersome and unresponsive. Procedures for the risk management of vulnerable adults were in place. Management and support of staff relied on formal channels for conveying information and staff did not feel committed to or involved in decision making about the future direction of travel for services. Joint performance management and continuous improvement was not yet systematically used. The partnership's performance was evaluated as adequate.

8.4.1 Joint operational management

There were some activities in both service delivery and service developments where managers had opportunities to agree service models, and pilots. For example, there was a Joint Future Management Team but it appeared to focus on strategic issues rather than day to day jointly managing operational issues.

There were examples of joint operational management and delivery of services, for example in relation to day care services in Callander and the jointly funded rehabilitation services at Strathendrick and Allan Lodge. Funding from the council was used to support Crossroads West Stirlingshire to ensure it had sufficient funds for health staff to access services. There was direct access for staff of up to £500 of service for an individual from Care and Repair. Palliative care both in hospital and in the community was also effective and much appreciated by families. The CMHT(E) supported people with dementia well, particularly where there was limited community support available. Referrals to the team were increasing instead of people being admitted to hospital as had happened in the past.

There was limited collaboration between health and social work operational managers. They did not present to us as working effectively together in responding to the challenges facing the partnership. This meant that effective management of services and resources across the whole system of care was not as effective as it could have been. Managers and services seemed largely to operate in parallel rather than in a joint way. There was a notable exception to this.

The SSA Group in Stirling was taking forward a pilot in West Stirlingshire whereby community nurses would have access to MECS, occupational therapy, rapid response service, up to 12 hours home care per week, day care and designated rehabilitation care home beds, for people over 65 years through the completion of one agreed assessment form.

Waiting lists for services

We were concerned about the long waiting lists for services and assessments. In 2005-06, numbers on waiting lists for complex assessments were 95, for standard assessments 68, for care home placements 21, and for home support services 30. We were also advised that the waiting times for services could be considerable - about 8 weeks. JPIAF returns for waiting times for single shared assessments showed that the time intervals between initial contact and start of service as an average of 22 days for older people without dementia, with 45% of people waiting over 28 days. For older people with dementia, time intervals were much longer. In the cases read during the file reading, 16% of people were waiting for services in Forth Valley overall, but in Stirling 27% were waiting.

In 2006, the average time taken to provide a community care service from first identification of need to first service provision was 26 days. The average figure for Scotland was 20 days. Many health professionals considered that older people received a poorer service from Stirling Council than elsewhere in Forth Valley, especially for home care. A community nurse said: *'Staff, patients and carers are all suffering in Stirling unless a care home is the answer and even that involves long delays.'*

Health and social work services scrutinised and reported on some waiting lists more intensively than others. For example, in relation to delayed discharges, reports were produced monthly, detailing the reasons for waiting times, such as waiting for care home places, home support services and completion of community care assessments. The Forth Valley Delayed Discharge Steering Group monitored these reports at its monthly meetings. At a meeting of the group which we attended, we saw the senior health manager, the General Manager, Medicine and Rehabilitation Unit, work very constructively and positively towards enabling action to be taken to reduce delayed discharges. Waiting lists and pressures in community health services are reported to the CHP and through it, to the NHS Board. Service volume and pressures in relation to waiting lists for community care services were reported to the council committees.

Joint mechanisms for operational management

There were a limited number of mechanisms for jointly managing workloads and allocation of services and resources in line with the partnership's agreed priorities.

For example, the Joint Home Support Resource Panel met weekly and agreed priorities for allocation of available resources, such as rehabilitation at home and home care. The discharge liaison co-ordinator attended the panel meetings to participate in the allocation of resources. We were told by staff that this panel was overly bureaucratic and was, in effect, used as a delaying tactic to ration scarce resources. Senior managers said that applications to the panel were often inappropriate or poorly completed. We think that more attention should be given to providing a feedback loop to staff, if this is the case.

The Delayed Discharge Steering Group had given considerable impetus to the issue of delayed discharges across Forth Valley, for example £1.8 million had been allocated for a variety of projects or service developments which the group was monitoring. Although there had been some difficulty in specifically evidencing that the projects had impacted on admissions and discharges, the group had agreed that the projects were to continue.

In April 2006, there were 20 delayed discharges (seven above target) over six weeks. Of these 15 were awaiting assessments and five were awaiting placement. In Stirling the reasons for delayed discharges continued to be a combination of waiting for community care assessments and care home placements. However, the council was taking steps to improve its efficiency effectiveness of providing services to older people. By June 2007, the partnership had six delayed discharges.

At the time of the fieldwork, the council had just implemented a restructuring of the community care teams into short term and long term teams in order to address the waiting lists for community care assessments. There was a high proportion of OTs (about 60%) in the short term team in order to ensure rapid and effective throughput of the high volume of requests for equipment. The long term team would undertake care management with individuals needing complex care packages. It was anticipated that this new arrangement would be successful in reducing the waiting lists for assessments and services. The council had also restructured its rapid response service in order to improve its capacity to respond to urgent need in order to prevent inappropriate admission and to support early discharge from hospital.

There is, however, a major issue about how effectively the council can support joint working when it has real difficulties sourcing enough home care services, either from its own in-house service or through independent providers. The commissioning issue is covered in the section covering the whole systems approach. In relation to the impact this limitation has on operational practices, Stirling Council had a policy that care packages should not exceed 25 hours per week, unless there was an assessed need for a higher level of care. There are two issues here.

One is that, as mentioned earlier in this chapter, we were told by senior managers that some staff were applying for inappropriately high levels of care packages. We note that there was no feedback loop to staff and their assessments were not being reviewed in relation to their appropriateness. Secondly, we were told by staff, service users and carers that if one older person needed two staff members for handling and lifting in their home, then the number of home care hours proposed in the assessment would be routinely halved. This would usually mean that someone assessed as needing 24 hours per week would receive 12 hours. We were told by managers that that this is not so, as this would be unacceptable practice because it could place frail older people at risk. Nevertheless, senior managers should take immediate steps to improve general understanding of the process. We make a recommendation, Forth Valley-wide number 5, about care planning in chapter 5 which covers this issue.

8.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Inter-disciplinary arrangements for the protection of adults at risk should be in place. These should include a fully implemented inter-agency policy and procedure for the reporting and management of abuse of vulnerable older people. Staff generally should be aware of these and confident in using them.

Arrangements

The Forth Valley Vulnerable Adults Steering Group met quarterly, and a comprehensive Forth Valley adult protection policy and framework were in place. There were local customised procedures within Stirling and a system for preventing financial abuse was being developed.

Joint training for managers and some practitioners took place in May 2006 on a Forth Valley-wide basis, involving the three councils, police and health. Training for staff was being rolled out across Forth Valley. It would be reinforced by the council's on-going care management training. Other arrangements included the 'Message in a bottle scheme' and quarterly statistical reports on adults at risk.

Accountability for risk management

The accountability for risk management and monitoring of risk assessments was undertaken through multi-disciplinary protection of vulnerable adults (POVA) case conferences, supervision, assessment, the care programme approach (CPA), care management processes and case file audits.

Deciding on the appropriate balance between risk management and the right of people to make their own decisions is a complex process. Stirling worked through their person centred care planning to ensure there was a balance between an individual's self determination and risk management.

There appeared to be a mixed level of awareness about adult protection issues in Forth Valley. One service user told us that she had been inappropriately accommodated in a care home for one year for her safety, following Stirling's adult abuse procedure, because housing services were unable to offer her alternative accommodation. Some staff in Stirling were concerned that training for them had not been made available sooner, and they told us that they lacked confidence about handling vulnerable adult cases.

Case file reading showed that there were up to date risk assessments in 48% of the applicable cases in Stirling CHP, and in 28% of the applicable cases in Stirling Council. There was evidence that multi-agency partners' views had informed the risk assessment in the majority of the CHP cases, but in less than half of the council cases. There was an up to date risk management plan or equivalent on file in all the applicable Stirling CHP cases but in only 67% of Stirling Council's applicable cases.

8.4.3 Management and support of staff

Joint training and staff development

There were many joint development and training opportunities which had been set up as part of the Joint Future programme and these were being further developed, such as the partnership development programme which was open to all staff employed by the council and NHS Forth Valley. The Management Certificate programme was also open to managers, such as those of integrated teams and community care managers. The updated Joint Future Training Plan for 2006-07 set out all the joint training and development activity undertaken or planned, including that for SSA and care management, adults with incapacity, and the Mental Health Care and Treatment Act, 2002.

Managers said that all community nursing staff and social work staff had supervision, professional support and opportunities for development, which were identified through regular development reviews. They also had personal development plans.

The surveys of Stirling Council and all health staff showed that the majority agreed that they were given time to undertake professional development and that their team regularly evaluated its work and took appropriate action for improvement. There was less agreement about the annual appraisal or staff review system with 48% of Stirling Council staff, but only 32% of Forth Valley health staff, agreeing it helped them improve the way they did their work. We note that the council did not have an agreed appraisal system and that this might have affected the response of staff. Our expectation is that all managers should be carrying out annual appraisals or performance reviews, in line with good practice and to assist in professional development.

Health and social work staff were able to access information they required to carry out their duties and responsibilities through formal information sharing arrangements such as team meetings, locality meetings, and websites. Relevant information about individual patients and service users, such as minutes of care planning meetings and reviews, was also circulated. There was also single agency information. For example, NHS Forth Valley had a comprehensive discharge manual for staff which included guidance on the role of the discharge co-ordinator, the discharge planning pathway, assessment of ability of an older person's ability to take their medication, rehabilitation services, and policy on choice of care home.

Effective communication between staff

Stirling partnership managers saw communication between health and social work staff taking place mainly through formal channels and groups such as the North West Forth Valley Locality Partnership, the Delayed Discharge Steering Group, CHP meetings, Forth Valley Sensory Centre Board, the resource panel and trade union meetings. There was also joint training, for example for the single shared assessment process. Formal awareness sessions were planned as part of the roll out of the telecare bid, and joint work had taken place on new developments such as the restructuring of the rapid response service and housing for older people.

Managers thought that better outcomes for older people resulted from these methods of communication. They had not developed clear strategies for improving communication between health and social work staff, largely because they did not perceive there to be any reasons for doing so. We were advised by many of the staff whom we saw that communication between staff on the front line was good.

However, staff also said that there were significant issues about how well they were kept informed by managers about service issues and new developments, since staff did not necessarily participate in many of the formal groups. The staff survey showed that just over half of Stirling council respondents but only 38% of NHS Forth Valley respondents thought that there were policies, developed in partnership with other agencies which guide, monitor and improve the way that staff communicate and engage with each other and older people, carers and the public.

Staff support and morale

There appeared to be a mixed picture in relation to staff support and morale. The survey of social work staff demonstrated that social work staff were positive about the services they provided, the capacity for improvement and the leadership provided by senior managers. Staff in the health service survey, which covered all NHS Forth Valley staff, were much less positive.

For example, under half of all staff agreed that the quality of service offered to older people by multi-agency services had improved over the last year but Stirling staff were most positive (62%) and all NHS staff least positive (only 16% agreed). NHS staff also gave negative responses to the questions about feeling valued by managers (54% of Stirling council staff and 39% of NHS staff), receiving feedback about the quality of their work (64% and 32%), annual appraisal system (48% and 32%) and policies on communication and engagement (55% and 38%). They were also less positive than council staff on several other statements, such as joint leadership of change (45% and 30%).

Both health and social work staff were positive about many aspects of joint working such as information for the public, guidance on eligibility for council services, that assessments were person centred and there was sound access to advocacy. In particular, staff were positive about the role of multi-agency services in successfully enabling people to live more independently and safely.

During the fieldwork, we gained the impression that the situation was more mixed than demonstrated in the staff survey. We were told by many people that the morale of social work staff in Stirling had been low for a long time. This was said to be for a number of reasons such as the perceived bureaucracy in getting care packages approved and the unresponsive style of the senior managers. However, although managers were concerned that staff had been displaced from their usual workplace in Drummond House because of the very serious fire there, staff did not tell us this was a problem.

The council had just implemented a restructuring of the community care teams into short term and long term teams in order to address the waiting lists for community care assessments. Staff in the community care teams seemed largely happy with the new arrangements, stating that the responsible manager understood their issues, had taken time to think through the changes and to involve them. Another positive factor quoted to us was the strong peer support amongst front line social work staff.

We acknowledge that, at the time of the inspection, there were significant changes taking place in NHS Forth Valley, for example, the development of the new acute hospital and community hospitals, together with changes in the role of community nurses and health visitors.

We think that the senior managers should consider these messages and take action to support staff more proactively. We make a recommendation about health staff in chapter 5.

8.4.4 Performance management and continuous improvement

Joint performance reporting

This is undertaken through the Scottish Government's reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). This contains annual returns by partnerships on performance indicators based on four national outcomes. They are underpinned by Local Improvement Targets (LITS), which are set by the partners themselves to measure progress and improvement.

The Scottish Government rated the partnership's performance in 2005-06 as requiring improvement.

1. The Scottish Government stated that improvement was required in the progress of the partnership on single shared assessments (JPIAF 6).
2. It judged that steady progress was being made in cross-agency access to services (JPIAF 8).
3. The whole system working indicator (JPIAF 10) was evaluated as below average on the comparative model, but making steady progress on understanding the holistic approach. Their balance of care was very dependent on care homes and to a lesser extent on NHS long stays beds.
4. For JPIAF 11, the progress on the existing LITS was rated as falling well short, and the new targets were evaluated as insufficient. In particular, information was lacking on SSA, rapid response services, and reducing emergency admissions. The intensive home care was well below the local target of 28.8%. However, the partnership was close to meeting its target on delayed discharges. It also more than met its target to provide respite to older people in their own homes, in order to support carers.

Although the lead in Forth Valley for developing a joint performance management framework lay with Clackmannanshire, the CHP was developing a local Performance Management Framework. This will cover national, Board and local priorities and outcomes, including general outcomes around shifting the balance of care, management of long term conditions, anticipatory care and specific outcomes such as targets for multiple emergency admissions. A paper by the Stirling CHP General Manager on the development of performance management system of the CHP's services was presented to the CHP Committee in March 2007.

Use of joint performance management information

The NHS Forth Valley Chief Executive was very focused on the use of performance information, such as SPARRA health data, to drive improvements in services. We saw a powerful and comprehensive presentation on information about emergency admissions at a Forth Valley-wide meeting, which was considering how the partners could work together to improve the delayed discharge situation. We fully endorse this approach.

However, the staff survey showed that only 37% of staff thought that multi-agency services for older people performed well against service targets. Only a third of staff thought that services performed well against national and local indicators and benchmarks. High proportions of respondents ticked the 'neither agree nor disagree' option. Our impression was that managers, while conscious of performance management information, did not promote the understanding or use of it with staff.

Continuous improvement

The partnership said it was positive in its use of performance information and that they could demonstrate positive outcomes and targets met, such as waiting times for assessment, the delivery of care packages and other services. However, joint performance management appeared to be focused on the JPIAF indicators and LITS, rather than on driving continuous improvement at all levels. For example, Stirling had not set itself a standard or targets for completion of assessments following the introduction of the new community care teams which were designed to speed up the completion of assessments.

There was a helpful joint protocol for the investigation of complaints, which was agreed by NHS Forth Valley and Stirling Council, dated 2004. Staff told us they did not know of any examples of complaints being used to review service quality. However, there was a number of ways in which individuals could make known their concerns, for example through the Carers Centre (which was jointly funded), the Joint Dementia Initiative, and advocacy services.

There were several existing standards for services which were single agency standards with partnership elements, such as the ISO Quality Standards in residential and day care standards, national assessment and care management standards, Clinical Effectiveness Standards and Supporting People services. There were a few joint standards such as that a joint assessment should be carried out by the care home rehabilitation service within 24 hours.

There were several examples of joint developments which have led to successful improvements in health and care services in the last two years, such as the rehabilitation in care homes service, which allowed speedy discharge from hospital and a period of structured rehabilitation provided jointly by social care and health therapy staff. A joint development group was in place to take forward development of the telecare/telemedicine services across the area, with Scottish Government funding to support the purchase of the hardware.

Other examples were the joint services for older people with dementia. Alzheimer Scotland provided specialist day care at weekends in rural areas. There was a dementia liaison nurse who assisted staff in care homes to understand how to best work with older people with dementia. There was joint development of services through the Dementia Collaborative, for example the work being undertaken on integrated care pathways.

Benchmarking has been used effectively by NHS Forth Valley, for example, as part of its point prevalence studies in relation to its acute and community hospitals. A number of these have been undertaken, such as those on rehabilitation pathways and on the characteristics and needs of most patients in NHS Forth Valley beds. These studies have been used to inform healthcare strategy decisions and strategic capacity planning. They have also demonstrated key internal changes in the balance of care, over time.

The council did not appear to use benchmarking regularly as part of the process of continuous improvement, but the work which was undertaken in conjunction with the national Joint Improvement Team (JIT) on joint commissioning involved considerable benchmarking for both health and social work services across Scotland. This was to be continued in the development of the joint commissioning plan in 2007.

Culturally sensitive services

The NHS Forth Valley-wide group called 'Fair for All' had three council representatives as well as community group representatives. This group supported the Central Scotland Chinese Association Big Lottery application to secure funding for support and advocacy on behalf of isolated groups including older Chinese people.

Equality and diversity training was being delivered to NHS Forth Valley staff and it included information about access to interpreting services for people with a sensory impairment or people with limited proficiency in English. Equality and Diversity Impact Assessments have been undertaken by NHS Forth Valley for a wide range of services such as A&E, the complaints procedure and food and nutrition in hospital.

The council delivered its own diversity training programme to staff, covering areas such as stereotyping in relation to age, gender, race and sexual orientation. Training also covers cross-cultural communication and access to professional interpreting and translation services to support people with a sensory impairment or people for whom English is not their first language.

Funding had been made available to three specific minority lunch clubs (Chinese, Indian and Pakistani communities). These were primarily for older people but will also provide a service to any member of these communities. It has also been agreed that they can be used by the partnership to publicise services, provide information or consult on specific service developments. These were helpful services but it appeared that the low level of ethnic minority groups had generally led to a low level of staff awareness of culturally sensitive services and the need for them.

8.5 Leadership and direction

Relationships between managers and staff at all levels across health and social work services were positive and there were some good services. The relatively low level of home care services was a key factor affecting the partnership's outcomes for older people and their carers. Services for older people were being provided by committed front line staff but opportunities to extend the balance of care towards greater home support was lacking in the partnership's strategic plans for older people's services. The funding for older people was relatively the lowest in Forth Valley in 2005-06. The partnership's performance was evaluated as adequate.

The Stirling partnership has not yet developed a clear joint vision of services for older people. Although the shift of focus from acute to primary health care was clearly set out in the Healthcare Strategy, the new acute hospital at Larbert had taken up considerable managerial time and effort to date, and there had been much less discussion about community health services. Managers felt this was changing, however, with a stronger relationship forming between some NHS Board and council senior managers.

Our impression was that the driving of developments remained at NHS Board level, rather than at the CHP level. We recognise that the role and remit of CHPs are evolving nationally, in different directions and at a different pace. The Chief Executive of NHS Forth Valley acknowledged that the Board was considering how to strengthen the role and remit of the CHPs and the CHP Committees, in order to promote partnership working at the local level. We did not observe strong joint operational leadership between senior managers in the council and the CHP, for example, in actively promoting collaborative or innovative ways of working.

Middle managers in the partnership were not clear about a joint vision, and expressed some frustration about timescales for concluding on new service models. For example, senior council managers talked about setting an objective of supporting older people to remain independent and in their own homes for longer – the average age on admission to residential care was 79 years and they would like to increase this to an average of 81 years. There were however no identified targets or actions identified in order to achieve this.

The council had a very strong track record of promoting healthy life styles, such as 'Walk around Stirling'. The Chief Executive stressed the importance of looking widely at all the factors and services, such as transport, which impacted on the quality of life for older people.

However, the performance data showed that Stirling performed poorly on the provision of specific services to enable people to be supported at home. Stirling Council home care was below the national average and the *per capita* spend on services for older people was the lowest across the Forth Valley in 2005-06. The council had prepared a report on the community care housing needs assessment of tenants and also those residing in residential care homes. There was recognition within the 36 broad recommendations of the importance of holding discussions with housing services in Stirling and separately with Communities Scotland in order to progress towards improved provision. However, the detailed housing needs assessment did not however appear to have been translated into effective planning in conjunction with Communities Scotland to develop extra care housing to enable people to remain within their own homes.

We recognise that the council faced a number of corporate challenges, including responding to Audit Scotland's Best Value Review and other inspections. It had therefore to balance the needs of older people against other competing corporate demands, such as road improvements. Nevertheless, we think that it should take action on the level and quality of services for older people.

Senior managers were aware that the council had not made a strong contribution to the development or functioning of the CHP. This was attributed to the relatively small size of the council (with only 22 elected members) and the range of responsibilities held by elected members. The changes following the elections (14 new members) presented both challenges such as informing members about the issues and opportunities to develop a more proactive way forward for services for older people.

The council has reported to Committee over several years about delayed hospital discharges and levels of home care provision. Against a background of competing demands for services across the council, it was not clear that the long standing difficulties in improving waiting times and approval of care packages for older people had been addressed by the council. However, during the financial year 2006-07, the council's Service Policy and Performance Committee received reports concerning the increasing pressures on home care services, equipment and adaptations, which were causing a budget deficit of £100,000. This was offset in part by a number of staff vacancies which were causing waiting lists for assessments and care packages to grow, thus making it difficult to reduce the numbers of those experiencing delayed discharge from hospital.

Senior managers in the council repeatedly described the difficulties which they had encountered in recruiting home carers, but did not appear to have taken proactive steps to engage with the independent or voluntary providers to commission services from them, particularly for the more remote rural areas. The partnership was committed to jointly agreeing plans for commissioning services, and had started in 2006 scoping its requirements through the work with the national Joint Improvement Team (JIT) to achieve this.

However, it had not yet progressed this work, and remained unspecific about the current and projected levels of need and services, particularly in relation to the balance of care. Managers in the council demonstrated a tendency to be unclear in their analysis of need – they said that they were *'awash with data'* – and to be uncertain about the way forward, for example in using contracting processes more effectively. The planning processes seemed protracted, and to be affected more by the extent of current demands than in the shaping of future services. There were, as yet, no sound strategic plans.

There was considerable frustration amongst clinicians within hospital services who had concluded over time that delayed discharges in Stirling had become accepted as a fact of life by the council, with no sense of appreciation about the poor outcomes for patients when discharge from hospital was delayed. As we have noted, significant progress has been made recently in reducing delayed discharges and it remained to be seen whether this could be sustained.

Representatives from the voluntary and private providers stated that the difficulties in providing services were not always taken into account at senior levels within the council. They quoted the example of the higher costs of providing services, especially home care, in rural parts of the Stirling area. Such view points had contributed to a belief that partnership approaches should be improved.

There had been some positive joint initiatives looking at the way forward for services in Stirling, such as a stakeholders' day called 'Patient focus - Public involvement' and also a joint CHP seminar with Stirling University on the needs of older people with dementia. However, health and social work staff were clear that there was a need for increased information sharing and discussion between managers and staff. They expressed a need for senior and middle managers to ensure that staff at all levels could be empowered and involved in problem solving of the very considerable challenges for services for older people which lay ahead.

Overall, it appeared that older people in Stirling were not able to access social work services as easily or as equitably in comparison with other areas in Forth Valley, or across Scotland. Nevertheless the partnership has achieved some improvements in areas of joint working, such as an increase in rehabilitation services, a reduction in the level of emergency admissions for older patients and the length of stay in acute hospitals, as well as the level of delayed discharges.

8.6 Capacity for improvement

Stirling partnership had made improvements to outcomes for older people and their carers such as a reduction in the number of delayed discharges. However, the partnership's performance was adversely affected by the low level and quality of some of the single-agency service provision such as home care. Although there was a strong focus on quality assurance and performance management in the health services, this was not seen in social work services. The joint leadership had not been as proactive or as innovative as it could have been. The partnership's capacity for improvement was evaluated as adequate.

The evaluation of capacity for improvement is based on three key factors:

- demonstrable improvements in outcomes for people who use services and their experiences,
- quality assurance and performance management, and
- effectiveness of leadership at all levels in health and social work services.

Both health and social work staff were highly motivated to work together to provide the best possible outcomes that were valued by older people and their carers. The partnership had made improvements to some of these outcomes, such as a reduction in the level of emergency admissions for older patients and the length of stay in acute hospitals, an increase in rehabilitation, as well as the level of delayed discharges. However, these improvements were in danger of not being maintained because of the council's approach to the provision of single-agency services, for example, the council's level of funding was relatively the lowest in Forth Valley. There was, at the start of the inspection, little recognition of the impact of this approach on improving the outcomes for older people through collaborative working. However, a determination to improve services emerged as the inspection progressed. Both the Chief Executive and the Director of Community Services stressed to the inspection team that they would ensure that services for older people were given significantly more attention, in order to improve outcomes for older people.

Although there was a strong focus on quality assurance and performance management in the health services, this was not seen in social work services. For example, community care teams had been restructured to improve the speed at which services were provided, which was very positive. But senior managers were not able to give us an idea of what was being targeted for improving times to undertake assessments. There was an absence of recognition of the importance of whole systems thinking in improving services. It was essential that the partnership undertook its own scoping work on what was required in a whole systems approach to commissioning complementary health and social work services.

The joint leadership was not as proactive or as innovative as it could have been, and the issue of limited managerial capacity across the partnership was frequently raised with us. This is a very significant issue for this partnership. In order that real improvements can be implemented and sustained, the partnership will need to consider urgently how it strengthens leadership and management of services, both separately within the council and the CHP, and jointly within the partnership. One way of doing this would be to consider how Stirling partnership managers could work more collaboratively with those in the other Forth Valley partnerships. It would be helpful to share, on a national and Forth Valley-wide basis, ideas about how to develop and commission services more creatively as well as empowering staff more effectively.

CHAPTER 9

Joint evaluations and recommendations

9.1 Joint evaluations for the Clackmannanshire partnership

Area for joint evaluation	Joint evaluation
Person centred care	very good
Key outcomes for individuals and their carers	very good
Whole systems approach	good
Delivery and management of services	very good
Leadership and direction	very good
Capacity for improvement	very good

9.2 Joint evaluations for the Falkirk partnership

Area for joint evaluation	Joint evaluation
Person centred care	weak
Key outcomes for individuals and their carers	good
Whole systems approach	adequate
Delivery and management of services	adequate
Leadership and direction	adequate
Capacity for improvement	adequate

9.3 Joint evaluations for the Stirling partnership

Area for joint evaluation	Joint evaluation
Person centred care	adequate
Key outcomes for individuals and their carers	weak
Whole systems approach	weak
Delivery and management of services	adequate
Leadership and direction	adequate
Capacity for improvement	adequate

9.4 Recommendations

9.4.1 Recommendations – Forth Valley-wide

1. Recommendation: Forth Valley-wide number 1

NHS Forth Valley and the three councils should develop a joint Forth Valley-wide framework for older people's social work and health services in the community within a year from the publication of this report. This should be done at the same time as the ongoing work on developing plans for services in the community hospitals.

This framework should set out how it will meet the need for older people's services, particularly community health services and intermediate care services across Forth Valley. It should identify the desired outcomes for older people and their carers. It should also ensure that there is equity in relation to levels of health funding across the Forth Valley councils. This Forth Valley-wide framework should include a joint action plan, financial plan, time scales and commissioning plan.

Senior managers should ensure there is sufficient strategic planning and management capacity to undertake developing and implementing this framework and, if necessary, augment the existing capacity, which could be done in a variety of ways.

2. Recommendation: Forth Valley-wide number 2

All partnerships should prepare medium term (three year) joint financial plans and review them on a rolling basis in order to inform the process of forward planning of services for older people.

3. Recommendation: Forth Valley-wide number 3

All partnerships should improve the joint financial management processes, particularly around aligning budgets for services for older people, and publish joint financial reports on services for older people. The financial reports submitted to CHPs and councils should include appropriate financial data from NHS Forth Valley and the councils.

4. Recommendation: Forth Valley-wide number 4

All partnerships should ensure that every older person receives a copy of their own assessment and care plan. Care plans should clearly set out the needs of each older person, the way these needs will be met, the desired outcomes, timeframes, and responsible members of staff.

5. Recommendation: Forth Valley-wide number 5

Carers assessments should be promoted and evidence of improved service delivery and outcomes as a result of these assessments should be collected and shared with carers.

6. Recommendation: Forth Valley-wide number 6

All partnerships should ensure that there are Forth Valley-wide policies and procedures for prompting and administering medication, such as drugs and creams, for older people receiving home care services. Managers should ensure that these are clear and are consistently implemented across the three partnerships.

7. Recommendation: Forth Valley-wide number 7

All partnerships should ensure that appropriate mental health services for people over 65 years and services for people with dementia are proactively developed. These should build on the work of the Dementia Project and include appropriate information and support at the point of diagnosis.

9.4.2 Recommendations specifically for NHS Forth Valley

8. Recommendation: NHS Forth Valley number 1

At a time of major changes within NHS Forth Valley, managers should assist health staff to communicate more effectively with carers especially about the transitional arrangements for hospital admissions and transfers between hospitals. This should include health staff positively acknowledging the role of carers of older people.

9. Recommendation: NHS Forth Valley number 2

Bearing in mind the current level and range of organisational change underway within NHS Forth Valley, health managers should take steps to assist staff understand and be involved in the development of services for older people, for example through a communication strategy.

9.4.3 Recommendations specifically for the Falkirk partnership

10. Recommendation: Falkirk partnership number 1

Building on the improvements achieved to date, the Falkirk partnership should take proactive steps to improve its level of delayed discharges. This would include better long range planning, for example by factoring in significant issues such as availability of care home places.

11. Recommendation: Falkirk partnership number 2

The Falkirk partnership should urgently collaborate on implementing a whole systems approach to older people's services within all levels of the council and the CHP. It should consider local needs and produce a local plan which dovetails with the wider Forth Valley-wide strategy. The local plan should include a joint action plan, financial plan, timescales and commissioning plan, and should set out how the partnership will meet the need for health and social work services in the community. It should also set and monitor timescales for delivering tangible results.

9.4.4 Recommendations specifically for Falkirk Council

12. Recommendation: Falkirk Council number 1

Falkirk Council should take urgent steps to improve the understanding and involvement of managers and staff in older people's services, particularly in the light of the changes underway in relation to Single Status and equal pay issues. It should consider developing and implementing a communication strategy about the way forward for services for older people.

9.4.5 Recommendations specifically for the Stirling partnership

13. Recommendation: Stirling partnership number 1

The Stirling partnership should urgently collaborate on implementing a whole systems approach to older people's services within all levels of the council and the CHP. It should consider local needs and produce a local plan which dovetails with the wider Forth Valley-wide strategy. The local plan should include a joint action plan, financial plan, timescales and commissioning plan, and should set out how the partnership will meet the need for health and social work services in the community. It should also set and monitor timescales for delivering tangible results.

9.4.6 Recommendations specifically for Stirling Council

14. Recommendation: Stirling Council number 1

Stirling Council should take steps to improve the outcomes for older people and the low levels of satisfaction with services held by service users, carers and colleagues in other organisations. It should take steps to improve its services especially home care services and the care management process.

15. Recommendation: Stirling Council number 2

Stirling Council should urgently improve the level and range of home care services as well as its balance of care between care home places and home care for older people, in order to provide better outcomes to older people.

Model for the multi-agency inspections of services for older people

<p>Are our services person centred?</p>	<p>1. Person Centred Care</p> <p>Assessment, Care Management and Treatment</p> <p>Experience of older people and carers when receiving services</p> <p>Enabling well being and self care</p> <p>Access to services</p>
<p>What key outcomes have we achieved?</p>	<p>2. Key Outcomes for Older People</p> <p>Outcomes for older people and carers</p>
<p>Do we take a whole systems approach to services?</p>	<p>3. Whole Systems Approach</p> <p>Range and quality of community based services</p> <p>Planning, policy development and partnerships</p> <p>Financial and resources management</p>
<p>How good is our delivery and management of services?</p>	<p>4. Delivery and Management of Services</p> <p>Day to day planning and resource allocation</p> <p>Risk management and accountability</p> <p>Management and support of staff</p> <p>Performance management and continuous improvement</p>
<p>How good is our leadership?</p>	<p>5. Leadership and Direction</p> <p>Leadership of people and change</p>
<p>What is our capacity for improvement?</p>	<p>6. Capacity for improvement</p> <p>Evaluation based on the evidence of the 5 other areas for evaluation</p>

Appendix 2

Methodology for the multi-agency inspection in Forth Valley

The multi-agency inspection methodology was devised by a Task Group, comprised of representatives from NHS QIS, SWIA and the Care Commission. The group built upon:

- NHS QIS draft standards for services for older people and the peer review process
- SWIA's performance inspection model and methodology
- The National Care Standards and the Care Commission's inspection and regulatory processes.

The multi-agency inspection of services for older people (MAISOP) model and methodology were endorsed by the national Strategic Group for Multi-agency Community Care Inspections in 2006.

The aims of the multi-agency inspection were to:

- examine the effectiveness of collaborative working between health, social work and social care services in delivering better outcomes for older people
- make recommendations on improving collaborative working in order to improve the care and treatment of older people
- develop a more proportionate and whole systems approach to review, inspection, and regulation
- test out the effectiveness and sustainability of the model and methodology for the multi-agency inspection of services for older people (MAISOP).

See appendix 1: Model for the multi-agency inspections of services for older people.

The development of the detailed inspection process was undertaken by staff within SWIA and other inspectors. A multi-agency team was brought together by the Task Group and included:

- SWIA Deputy Chief Inspector, full time and sessional inspectors
- Three NHS QIS peer reviewers: a GP, a consultant in the health care of older people and an OT manager from another NHS Board
- Associate inspectors from two other councils
- Carer inspector
- Statisticians, project manager and administrative staff.

The methodology included:

- analysing the self evaluation workbooks and advance information submitted by the partnerships
- service user, carer, staff and stakeholder questionnaires
- structured interviews with service users and carers

- a fieldwork programme including focus groups, interviews, and meetings with stakeholders such as voluntary and private providers
- case file reading of health and social work files, undertaken jointly by inspectors and local staff, as part of the process of encouraging continuous improvement within the inspection process. Case files were randomly selected and it would have been better to focus on those files which demonstrated a high level of joint working.

Use of health data

The pilot inspection was notable for its pioneering use of ISD data. In the course of the first MAISOP pilot in Tayside, the potential value of ISD data in illustrating the impact of collaborative working on service use and outcomes was noted, and a relatively simple analysis revealed interesting differences between the three Tayside partnerships. In advance of the second pilot in Forth Valley, and in discussion with ISD and representatives from Forth Valley, a more extended analysis was requested, and again proved to be of considerable interest.

As part of the Forth Valley fieldwork, the data was shown at meetings with both health and social work officials, at Forth Valley level and in the partnerships, and was consistently received with interest and enthusiasm. Such data offers hitherto unavailable insights into the use of acute health services by older people and the very old within and across a Health Board area, and – as a quantitative assessment of whole-system performance of health and social care for older people – provides a potentially powerful high level means of evaluating such services. In the hands of managers, clinicians and other practitioners involved in the provision of care, it allows the analysis and improvement of local performance.

Structured interviews with older people

We thought that it was essential to speak to older people directly in order to obtain their views about services and the outcomes for the services they receive. In total 26 interviews were undertaken across the three partnership areas. Some of the older people interviewed were identified from the file reading exercise and the remainder were chosen from a list of older people drawn up by the councils where it was known that both health and social care services were involved. We appreciate that this was a small number of interviews but it was an essential step in developing the new methodology for the multi-agency inspections. The interviews provided high quality data about older people's views and experiences, rather than statistical data.

Core performance indicators for outcomes for people and carers

We agreed with the Forth Valley partnerships to use a set of indicators which formed a core data set with which to evaluate the outcomes for people who use services and their carers. We did this because the new National Outcome indicators are not yet fully in place. The indicators we used are largely proxy indicators for outcomes, for example the comparative level of home care provided by councils. However, we sought information on outcomes in various ways, for example many of the questions asked in the interviews and in the survey were about outcomes for people who use services and their carers.

Use of financial information

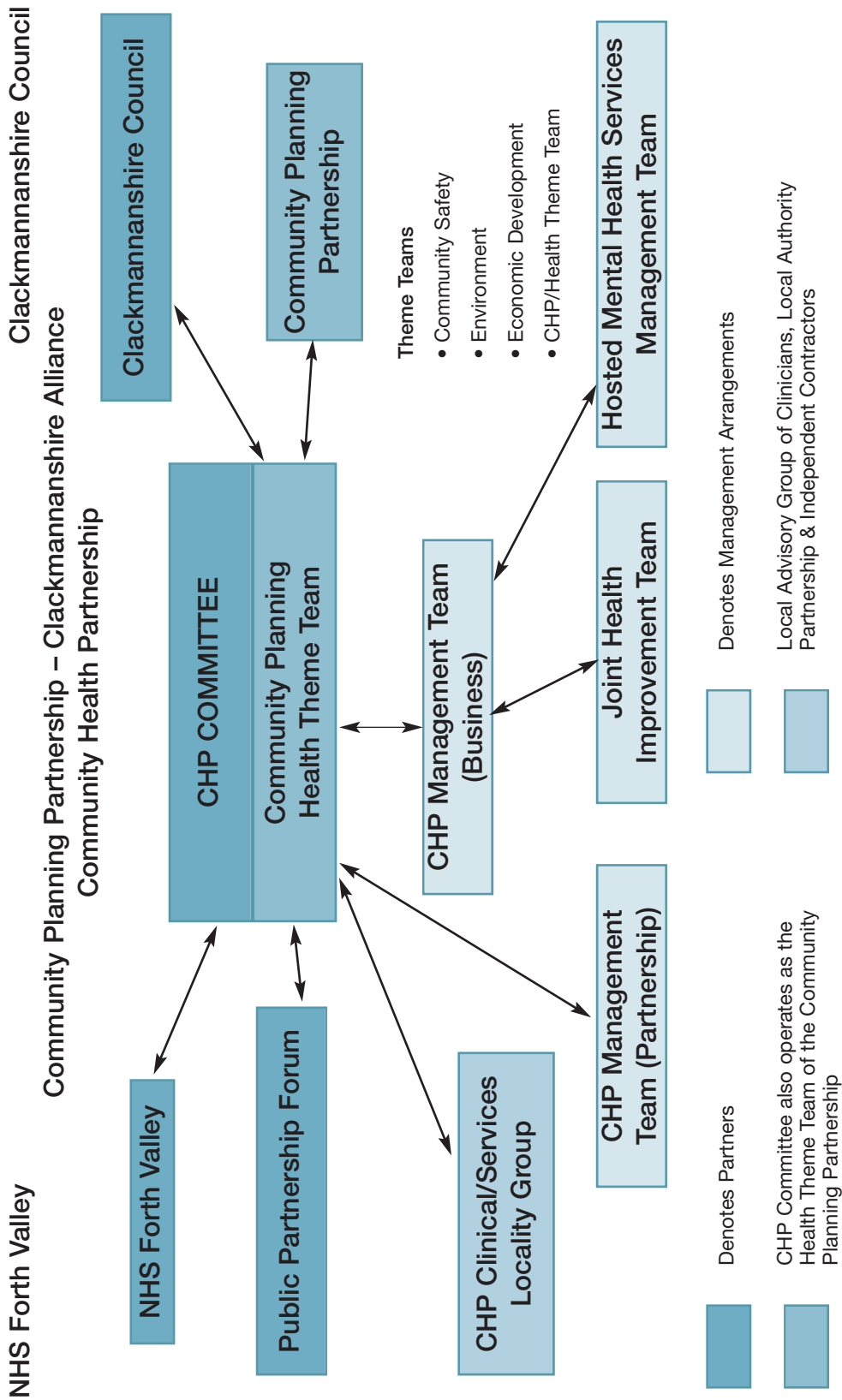
It is difficult to assess what budgets and costs were applicable specifically to older people's services. Financial monitoring reports normally included all CHP figures covering not only older people's services, but also other CHP services. Costs relating to older people's services were not always specifically identified and there were differences in accounting for these services in the three councils. The financial data in this report should therefore be treated with a degree of caution, as it does not necessarily refer only to older people's services.

Conclusion

We built on the experience of the first pilot inspection and considerably improved the methodology for the second pilot. We plan to use both the pilots to assist us to make future inspections more proportionate, for example with more analysis of published data being undertaken before the fieldwork phase.

Clackmannanshire Community Health Partnership structure

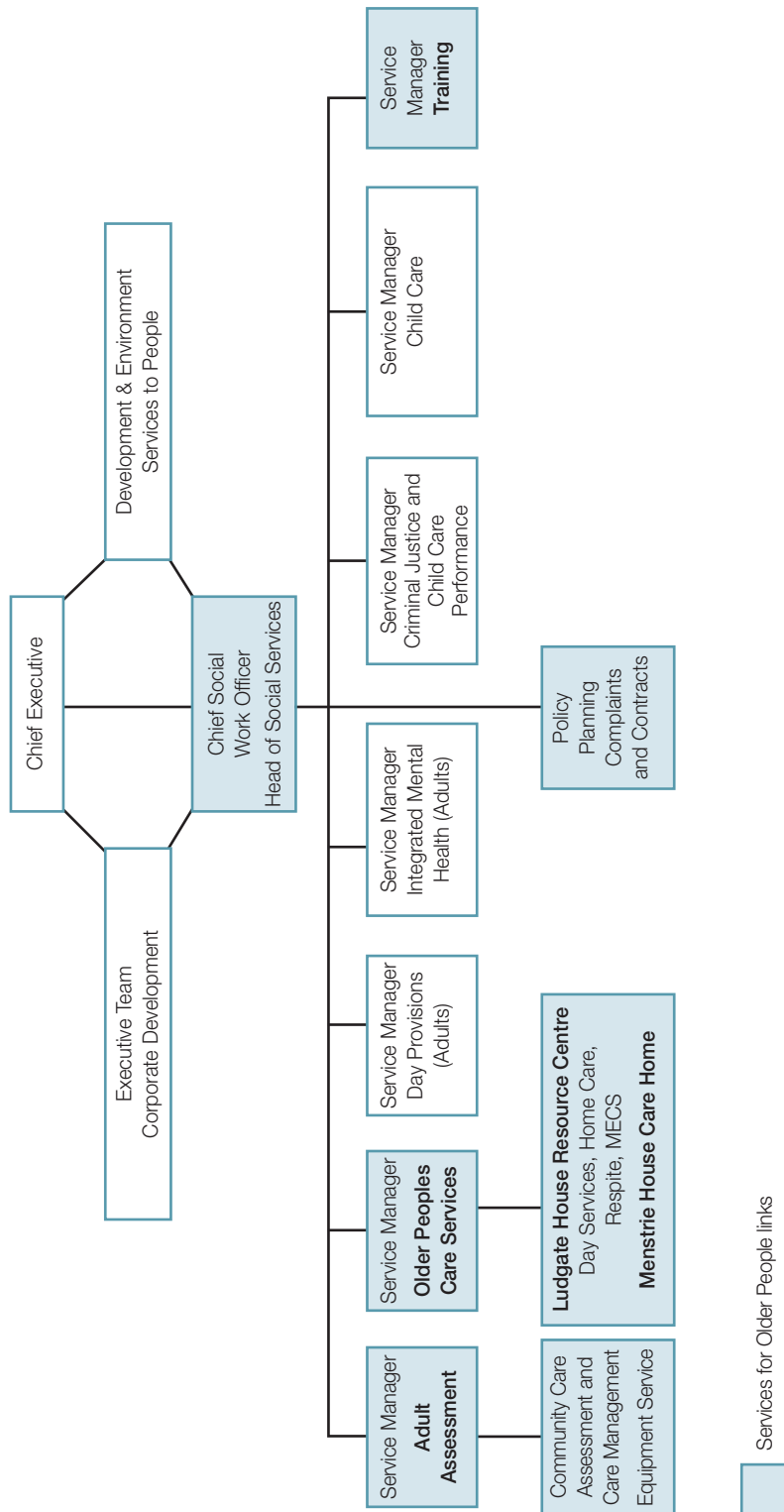
(supplied by CHP)



Appendix 4

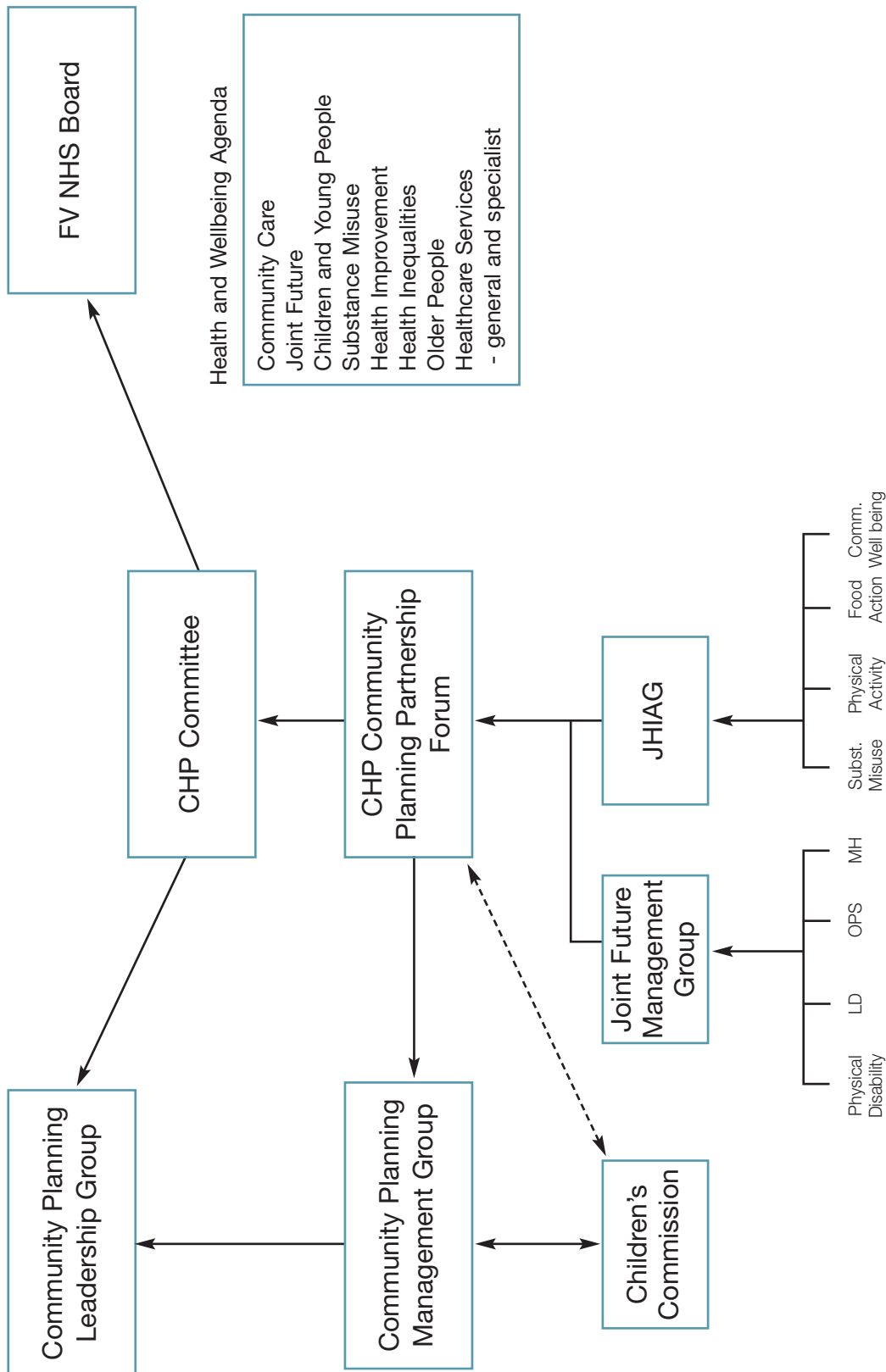
Clackmannanshire Council Social Work structure

(supplied by council)



Falkirk Community Health Partnership structure

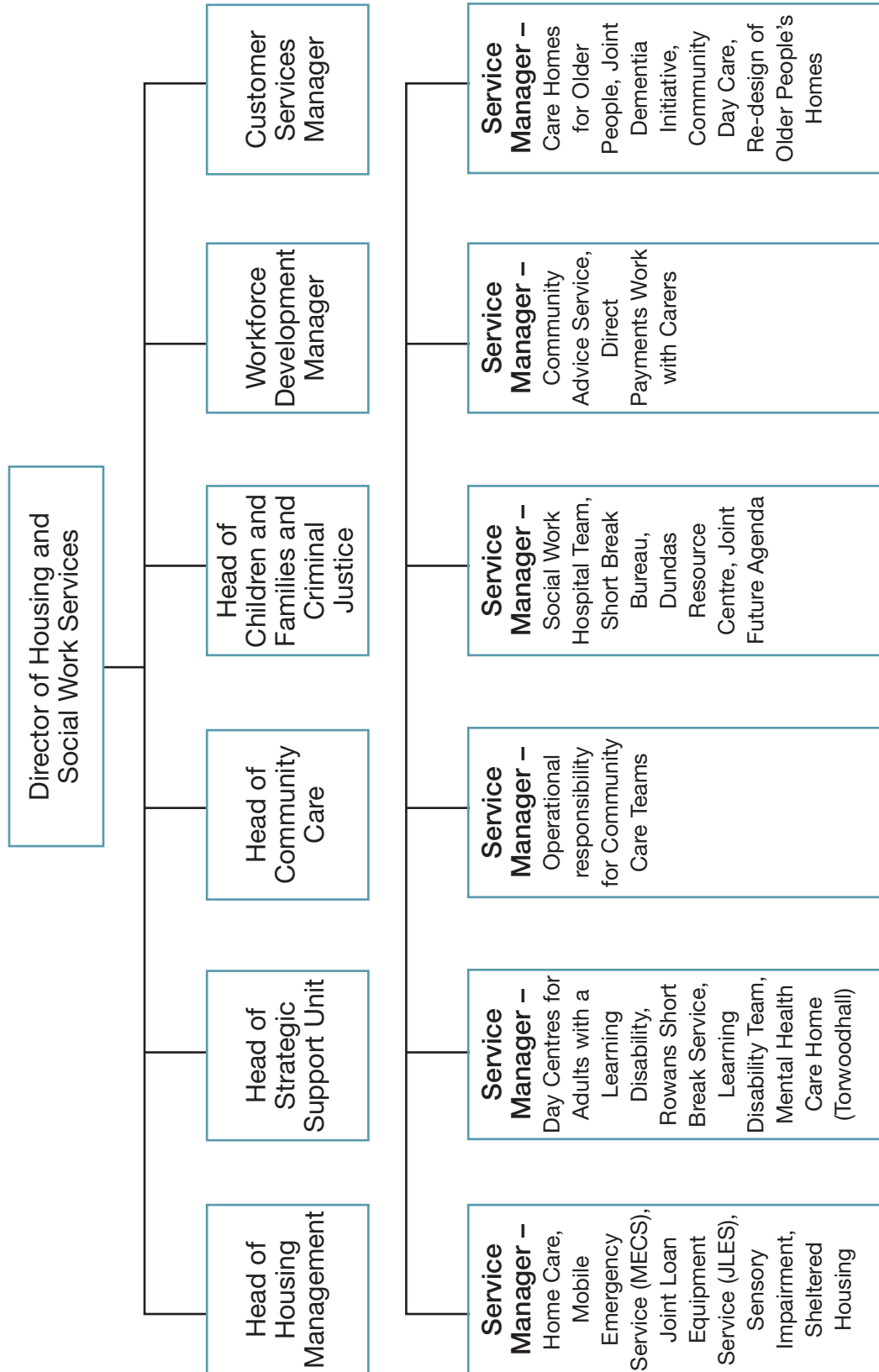
(supplied by CHP)



Appendix 6

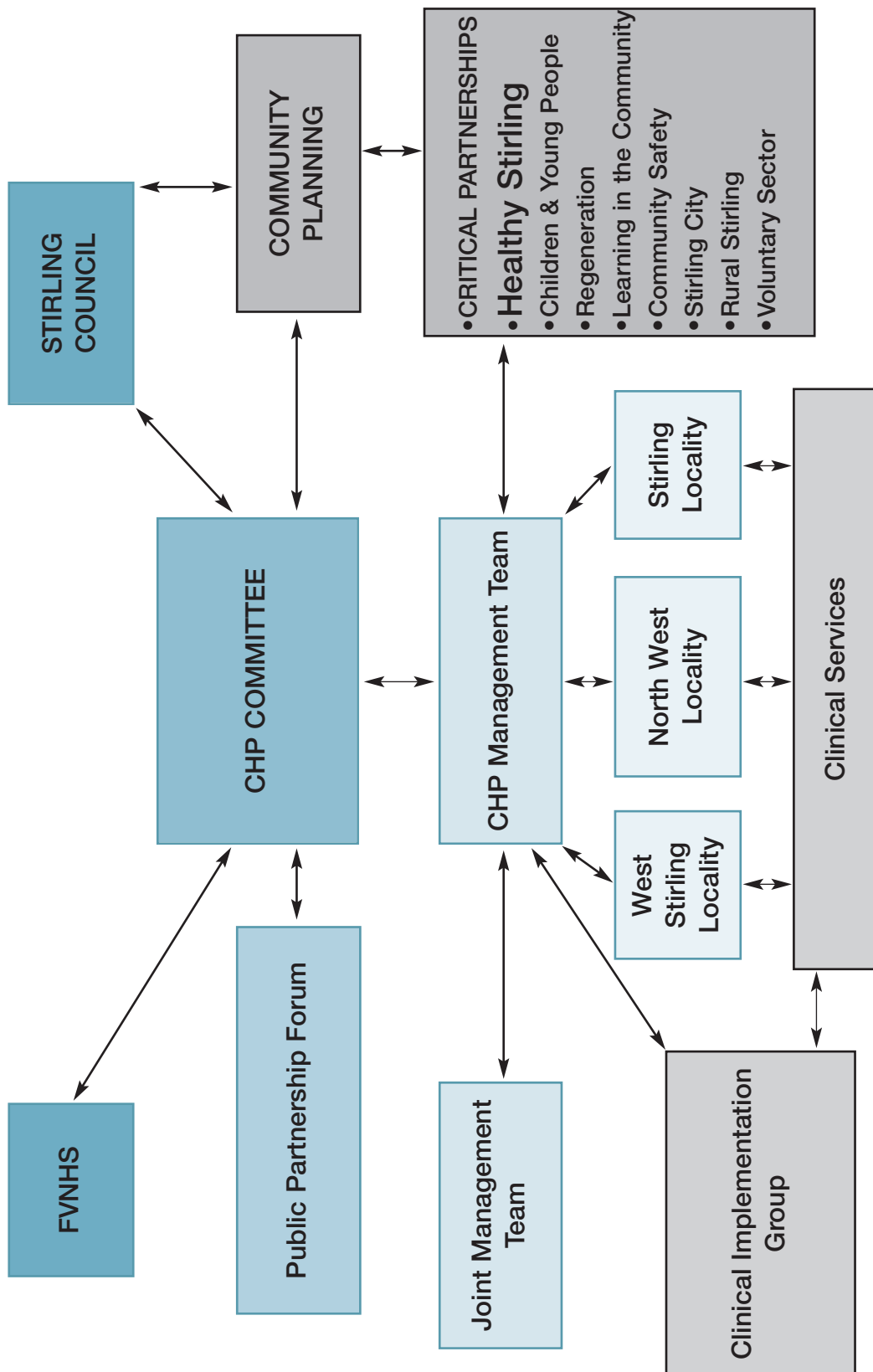
Falkirk Council Housing and Social Work Services structure

(supplied by council)



Stirling Community Health Partnership structure

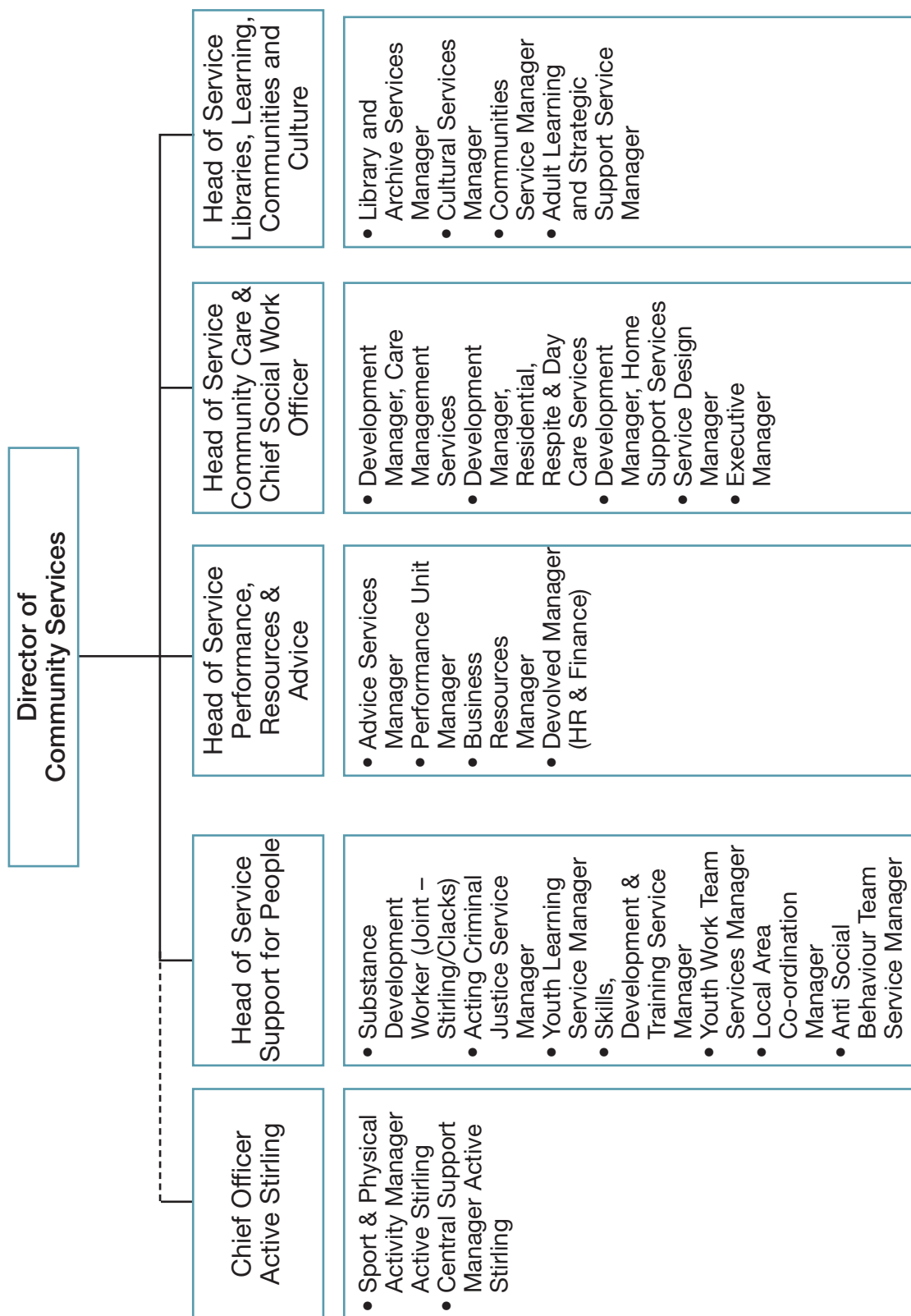
(supplied by CHP)



Appendix 8

Stirling Council Community Services structure

(supplied by council)



Tables of NHS data on joint performance

Table 3. Emergency admissions for older people aged 75+ in Clackmannanshire, Falkirk, Stirling, NHS Forth Valley and Scotland

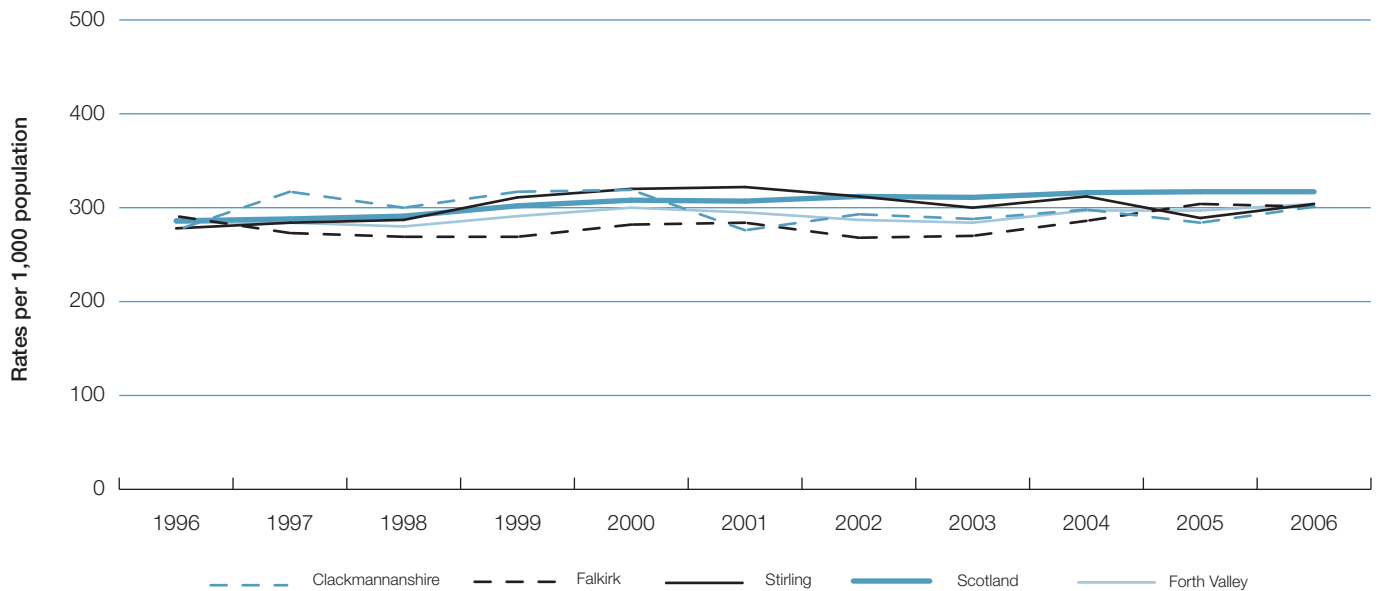
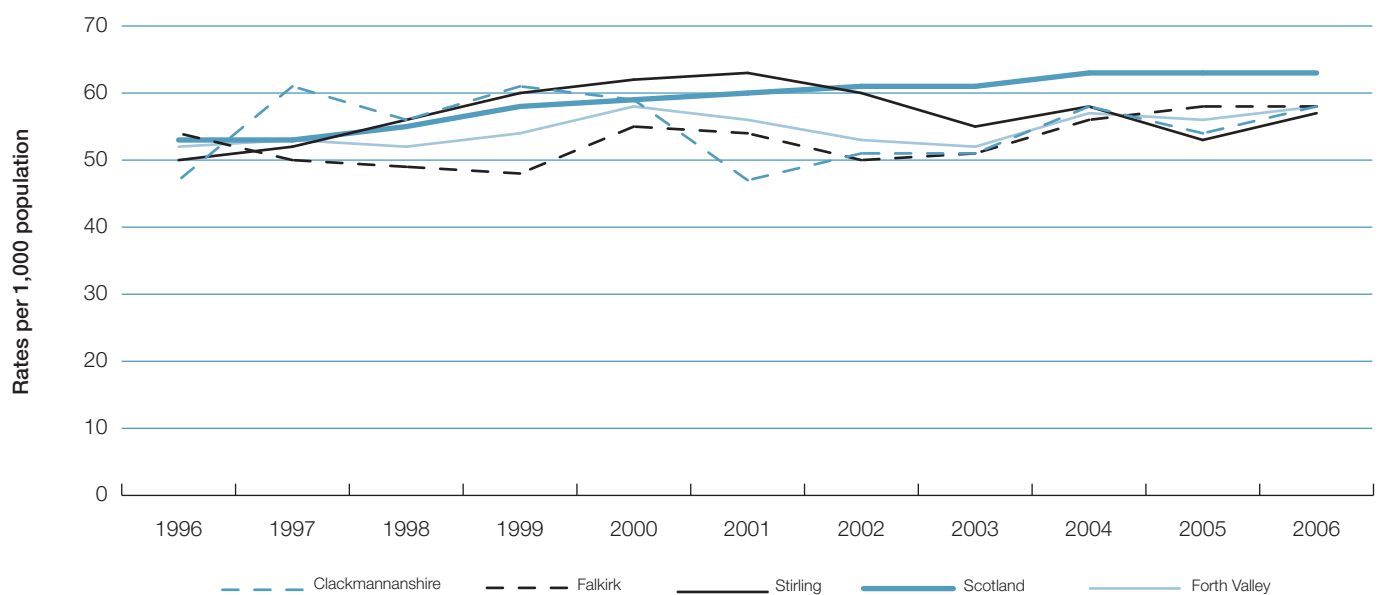


Table 4. Multiple 2+ emergency admissions for older people aged 75+ in Clackmannanshire, Falkirk, Stirling, NHS Forth Valley and Scotland



Appendix 9

Table 5. Average length of stay for 2+ emergency admissions for older people aged 75+ in Clackmannanshire, Falkirk, Stirling, NHS Forth Valley and Scotland

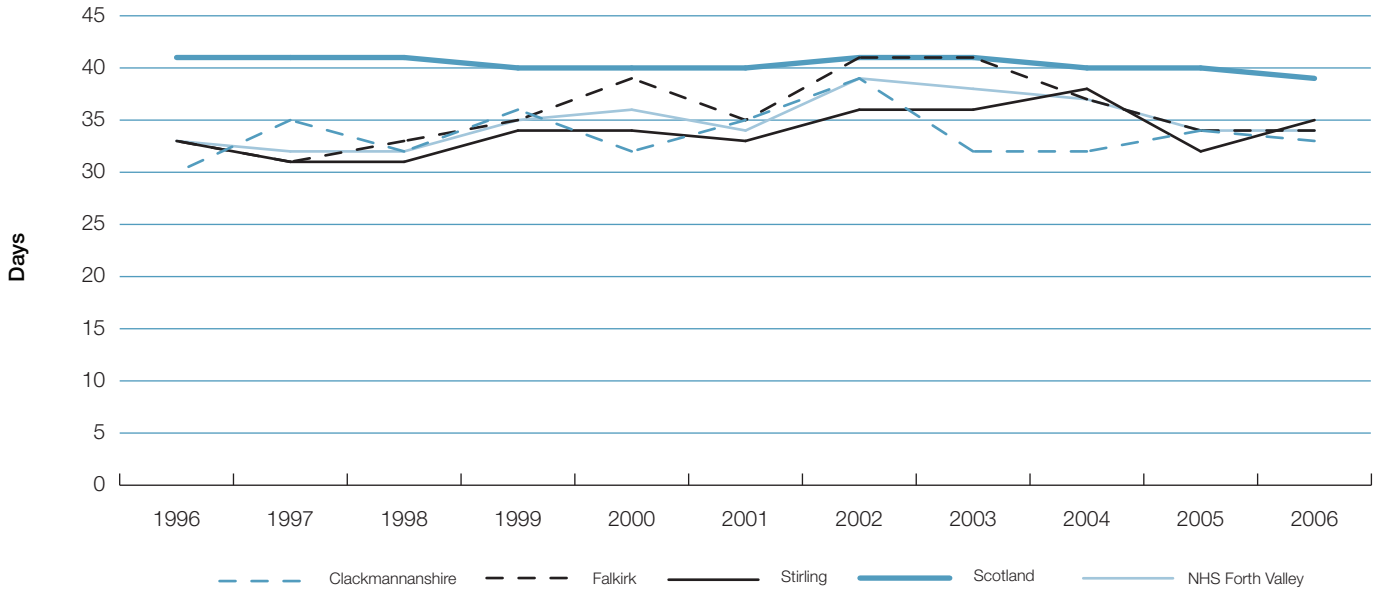
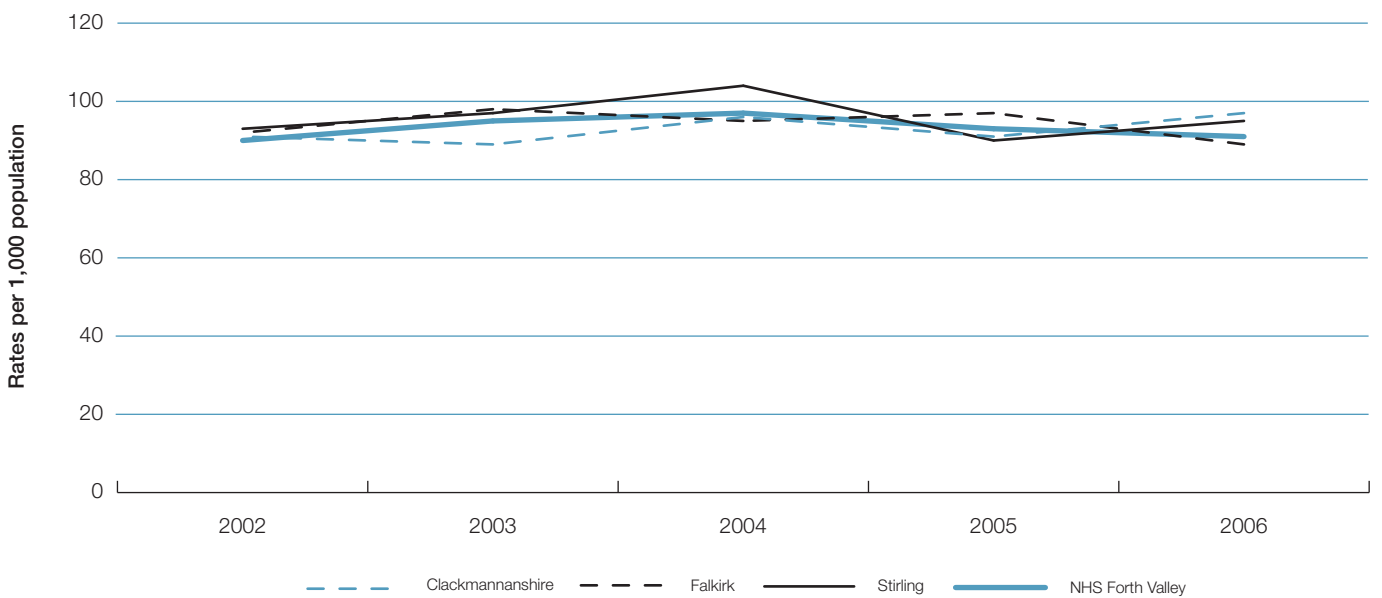


Table 6. Standardised mortality rates: people aged 75+ in Clackmannanshire, Falkirk, Stirling and NHS Forth Valley,



© Crown copyright 2008

Alternative formats may be available on request from the Social Work Inspection Agency. An electronic version is available along with our contact details on the SWIA website at swia.gov.uk

RR Donnelley B53019 01/08

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

Telephone orders and enquiries
0131 622 8283 or 0131 622 8258

Fax orders
0131 557 8149

Email orders
business.edinburgh@blackwell.co.uk

ISBN 978-1-905501-55-7



9 781905 501557