

North Lanarkshire Council and NHS Lanarkshire

Working Together Learning Together

Improving Outcomes for Older Adults

A Review of Integrated Day Services
For Older Adults
(Supported by the Joint Improvement Team)

June 2008



With grateful thanks to the people who use our service, to their families and carers, and to the staff and wider stakeholders..... who gave so wholeheartedly of their time, enthusiasm and honest feedback to contribute to this report.

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Introduction

The population of older adults across North Lanarkshire is increasing steadily and is expected to continue to do so over the next few years. Current estimates indicate that there were around 46,102 older adults living here in 2004. By 2010 this number will be nearer 50,122 and in 2014 there are expected to be 54,830 older adults living in our communities.

Although many of these older adults will be in better health than ever before, and will live longer than previous generations, due to issues mainly associated with deprivation and poverty, there will also be a significant number of older adults who are not in good health and who will require specific support from various agencies for lengthy periods of time, in order to remain at home.

During 2007 the National Outcomes Framework for Community Care was developed alongside the restructuring of day services in North Lanarkshire. The framework is built around four high level outcomes for people who use community care services:

- improved health
- improved wellbeing,
- improved social inclusion
- improved independence.

These national priorities are consistent with and have reinforced the underlying aims of our service provision and provide us with the focus for our review.

Day services for older people have undergone significant change across the board in North Lanarkshire, informed by early research undertaken in the Coatbridge locality in particular.

One of the changes involved the development of Sinclair Integrated Day Services for older people in Coatbridge locality in 2006. We have recently undertaken the first evaluation of the Coatbridge facility with a view to rolling this model out across the authority.

This report has been produced to pull information together from a range of processes and sources, and the results will feed into continuing improvement in our services.

The report will cover, the review of services for older people in North Lanarkshire from 2000, and the recent review of Sinclair Integrated Day Services in 2007/8, before going on to consider implications for future developments.

And a little more background

In recent years, day services for older people in North Lanarkshire have undergone a radical review and restructuring. The process of reviewing services by the local authority in partnership with NHS Lanarkshire began in 2000, through an extensive consultation with service users and carers. The results of the consultation were published in the report 'A Home for the Future'.

The findings in this report clearly indicated that older adults in North Lanarkshire wanted to remain in their own home for as long as possible, or in alternative housing.

If this aspiration was to be upheld, access to a range of housing options was needed whilst at the same time a range of sophisticated, flexible services were required within the community if older adults were to be supported to live in their own homes, particularly during periods of ill health.

So what did we want to change... and why?

With regard to policy drivers shaping delivery of services for older people, the NHS and Community Care Act (1990) provided a solid foundation for the development of a range of services that would ensure that, where it was safe and possible to do so, older adults would be supported in their own homes and admission to institutional care settings would be avoided for as long as possible.

More recently, the Joint Future agenda (2000) and the Community Care and Health (Scotland) Act 2002 have enabled new services to be developed jointly between councils and NHS partners.

At the same time, the Disability Discrimination Act (1995) led to significant improvements in access to all public buildings. Scottish Executive Policy initiatives such as Free Personal Care, Free Transport for Older and Disabled People (2006) and Direct Payments paved the way to an increasing range of alternatives to care and traditional support models.

In addition to the results of consultation with users and carers, other drivers to review day services for older people included demographic considerations as well as shifts in relevant national policy.

Consistent with national trends, the population of older adults across North Lanarkshire is increasing steadily and is expected to continue to do so over the next few years (see Introduction)

Some early research was carried out by the Coatbridge Local Care Partnership which identified a need to change how day care services were delivered to older people. The local day care resource had lengthy waiting lists and admissions were arranged with little consultation with the area team.

Local day hospitals, both frail elderly and psychiatric, were also known to be keeping people in the service who were no longer receiving any active rehabilitation and furthermore, waiting lists at day care meant that these people, who were often in poor health, could not access the day service and support they now required.

Therefore there was a pressing need for the Coatbridge Local Care Partnership to prioritise day service development and to ensure that any developing model took into account the strategic drive for joint service development, the needs of the local population and the desire to develop a new and contemporary service that could also promote social inclusion, and minimise the effects of ageing.

At this time, the average waiting times for a placement in the Coatbridge area was around 2 years and to find out more about the circumstances of those on the waiting list a survey was initiated.

40 people were surveyed and were asked the following questions:

- What do you do with your day now?
- What do your friends and family do?
- What would you like to do?
- What stops you doing this?
- Where, in your community, could these activities happen?

Additional information was gathered by a member of Headquarters staff and this process involved discussions with staff in the area team, housing office and day hospital services in the area.

Almost 30% of day service users were coming from sheltered housing complexes, usually for the purposes of social stimulation. Many of these complexes had communal areas that were considerably underused. Further research identified that this situation was replicated across the council area.

The data gathered from individual interviews indicated that the vast majority of people were very lonely and isolated, with almost 80% spending their day alone watching television or reading.

When people were asked what they wanted to do, 100% stated that they wanted to meet others, the majority (80%) expressed a desire to go to local clubs, 60% wanted to go shopping, 30% to the bookies or pub and 10% wanted to access the cinema, or local church.

- Once the researchers started to explore the causes that were preventing people doing the things they wanted to it became clear that very few people had access to information about what was on in their community.
- Others had lost confidence in going to places on their own or in meeting new people
- Some people had significant health needs that resulted in them needing transportation and sometimes support to get out of the house.

Throughout this research although all of those interviewed were on a waiting list for day care – no one asked for a day care service and each person was able to identify other resources in the community where activities in line with their interests could take place.

Following on from these pieces of local research and after an extensive consultation period, the Health and Care Partnership Group agreed the model of Integrated Day Services for older adults and associated eligibility criteria on the 17th June 2005.

The purpose of this review

This review focuses on what has happened following the development and implementation of the Integrated Day Service Model.

The report also hopes to demonstrate how we have begun to improve the outcomes for older adults in the North Lanarkshire Council area.

The outcomes of consultation will support our learning from this work and will inform the roll-out of the model across the North Lanarkshire Council area.

In addition to this, the review will offer a collection of experiences and reflections on joint service provision.

What did we design and how?

Joint working between health and social work services had been a day-to-day feature of practice in the North Lanarkshire Council area over several years. Much of this practice had developed as a result of key people in services sharing the same vision, being open and enthusiastic about opportunities and being willing to work towards the same goal of better care and better outcomes for older people. (c 2001)

Therefore some of the key factors, which are required to take partnership working forward, were already in place. These factors are considered to be:

- Openness
- Mutual trust and respect
- Commitment
- Ability to compromise
- Shared beliefs and values
- Sustained effort

The model of integrated day service was designed to recognise and build on this existing relationship between the partners in care, and further develop beneficial practice, by embracing joint working, and by enhancing the current practice of that time (2004) by making formal links, setting out agreements and through multi-agency support and participation.

This approach is fundamental to and is a foundation of the remit of the Locality Planning Group (see below), which ensures that these essential features of true partnership working continue to underpin practice.

And how did we go about it?

Community mapping

- A local mapping exercise was undertaken initially in the Coatbridge area, and eventually across the North Lanarkshire Council area. This mapping exercise now provides a comprehensive list of what facilities are available in the area, when they are on and how they can be accessed.

Mechanisms have been put in place at a local level to ensure that the information contained in the community map remains up to date. This information is available to staff in social work via public folders and is now available on the NL connect site where it will be widely accessible to those people in the community via libraries and staff in other services via the intranet. (See also - What did we design? The Locality Link Officer)

And what did we design?

The Integrated Day Service Model

Its Essential Features

To achieve an integrated day service that supports older people, recognising that individual needs do change, it is essential that people get the help they need as quickly and simply as possible without unnecessary re-assessment.

It is also essential that skills between the main providers of care and treatment are pooled and shared to enable the service to adjust to these changing needs and respond quickly and appropriately. .

The service was designed with the expectation that the following outcomes and benefits of an integrated service would be delivered:

- A smoother journey for the person through services
- A reduction in crises through early intervention and identification
- A person centred approach across the agencies
- A faster response to changing needs
- A reduction in duplication of assessments
- Increased staff confidence
- Designing solutions to changing needs together.

The Aim of the Integrated Day Service

The service aims to provide a comprehensive day service for older people where those who are experiencing difficulty in relation to their physical or mental health needs, can be discretely supported by appropriate professionals and gain quicker access to other services as their needs change.

It was anticipated that as the number of older people steadily increased, this service would target those with more complex care needs and support those with needs that cannot be met in other community settings.

It was envisaged that integrated day services would also play a vital role in supporting carers, preventing social isolation and exclusion and avoiding admission to institutional care settings.

The Objectives of the Integrated Day Service are:

- Specialist assessment, care planning, reviewing and evaluation of people with complex care needs.
- To assist with the planning and delivery of care in the community and the prevention of admission to hospital or institutional settings.
- Delivering specialist forms of treatment in conjunction with the Community Mental Health Team for Older People (CMHT OP) and Allied Health Professionals (AHP)

- Facilitating access to other agencies within the community.
- Facilitating the admission of patients to hospital when necessary.
- Facilitating the resettlement of patients from hospital back to the community.
- Specialist treatment interventions including psychological/behavioural, psychosocial and pharmacological approaches where appropriate.
- The staff within the unit play a key role in the provision of support, education, information and assessment of carers.
- Focused time-limited intervention and support plans, to enable the person to return to their community based support service.
- Promoting mental/physical well being.
- Respite for carers – based on assessed needs of the individual.

The Integrated Day Service Profile

Both Health and Social Work employees form the staff group for the integrated day services for older people, and a Locality Planning Group (multi-disciplinary) is involved in screening all referrals and in ensuring appropriate admission to the service.

The Sinclair Building

The building itself is designed for flexible use, ensuring that staff were skilled and supported to provide discrete support in a range of environments for people with complex care needs, be the needs be physical, mental health issues or a combination of both.

Service dimensions

The integrated day service (IDS) is made up of 25 places at the Sinclair IDS (SIDS) unit based in Coathill Hospital with a small satellite unit based at East Stewart Gardens (ESG) that provides support for an additional 20 people.

Both of these units operate 6 days per week; however both units have sufficient staffing and budgetary costs to enable them to develop a seven day service with one evening opening if there is sufficient local demand.

And what else did we design?

The Locality Link Officer

New posts of Locality Link Officers have been introduced to support the wider changes in service delivery. These posts holders identify alternative resources in the wider community and assist older adults to engage with them. In this way many of the problems of loss of confidence and lack of information can be overcome. Each locality link officer has responsibility for a budget of £15,000 which can be used flexibly to support activities within the wider community and to allow taster sessions of new activities to be set up within various local resources.

And how is the service accessed?

The Locality Planning Group

The Locality Planning Group is integral to joint services provision, including access to the SIDS, as it ensures appropriate allocation of resources and highlights any issues of unmet need to the Local Care Partnership Group in each area.

The membership of the Locality Planning Group for Older Adults is:-

- Integrated Service Manager (SIDS and ESG)
- Senior Charge Nurse (Old Age Psychiatry)
- Senior Social Work Officer
- Charge Nurse (Frail Elderly) Day Hospital
- District Nurse Team Leader
- Locality Link Officer.

The services of Allied Health Professionals are activated through the above key personnel where appropriate

The Integrated Day Service was developed to target those older adults who have complex care needs. By utilising the skills and knowledge of the Locality Planning Group, the IDS was positioned to access a range of specialist supports - offering a much more intensive and flexible service to this group of people and their carers than was possible to deliver before.

But how would we know we are doing better?

The Sinclair Integrated Day Service in Coatbridge opened in April 2006.

Although there were some practical difficulties getting started, this service is now well established and North Lanarkshire Council(NLC) and NHS Lanarkshire (NHSL) sought the support of the Joint Improvement Team (JIT) to undertake a full review of the service to establish what is working well and where adjustments need to be made.

The main focus of this review has been consultation with users, carers, staff and other stakeholders, and the review process sought out and has used innovative tools whose domains have a correlation to the aims and objectives of the Integrated Day Service. (see What did we design and why? Section 3)

How we asked the questions

To be comprehensive, this review needed to elicit the views and perspectives of all those who have a stake in this development i.e. people who use the service, their families and carers, the staff, managers and the employing authorities.

The following pages describe the approaches used to facilitate this process and the outcomes.

Our approach to consultation with service users and carers

The UDSET (User Defined Service Evaluation Toolkit) tool was provided by the Joint Improvement Team and formed the basis of the consultation exercise.

The framework provided enabled a focus on outcomes for both service users and carers.

1 Consultation with service users

As many of the people who use the current service have significant cognitive impairment or some difficulty with communication, a range of methods have been introduced to ensure that all those people who use the service, could participate in its review.

Methods

Individual reviews these were held routinely around 4 weeks after admission to the service, then at regular periods thereafter.

Questionnaires- these are used routinely within the unit at regular interval, they have pictures attached in order to aid communication and to help focus on specific areas.

Service User Meetings- small meetings were organised sometimes only with 2-3 people at any one time and the UDSET framework was used to focus the discussion on the persons experiences of the service.

Creative Meetings 'My Perfect Day'- this method of consultation was used with people who had difficulty in relating to specific questions, in this exercise the interviewer would describe the things that were important to them in terms of achieving their best day, and then the service users would be encouraged to explore what made their day good. This could range from getting up – eating specific things for breakfast, meeting friends etc.

3rd Person Independent Interviews- during these interviews, a member of staff from a neighbouring resource came to the unit as a visitor and asked individual people to give them advice for someone who is considering coming to the service. The person was then empowered to decide what important recommendations they could make by reflecting on their own experience of the service and selecting the things that need improved.

Pictures and photographs were used at many of the discussion opportunities previously mentioned and greatly facilitated communication.

2 Consultation with carers

Again a range of methods were used in order to compile as many views as possible on the service and to facilitate the best time and place for each person to give their view.

Methods

Attendance at Reviews

Carers group Meetings

Questionnaires to Carers

Telephone Interviews

Telephone interviews proved to be one of the most popular methods of consultation, as it provided a more flexible option for carers.

3 Consultation with stakeholders and staff

An event involving all stakeholders took place in the Alona Hotel in Strathclyde Park on the 21st August 2007.

Those who attended were given a series of short presentations that outlined the new service and the key objectives for joint working and measuring performance.

More detail about the responses from this event are included in the Appendices Section.

4 Further consultation with staff – The Integrated Team (SIDS and ESG)

Staff working within the unit were asked to use the Integrated Team Monitoring and Assessment (ITMA) tool to further explore the development of the service.

This tool provides a framework for measuring the success of joint working within an integrated team.

Although the staff required some clarification with regard to specific questions, over all they found the tool useful and this exercise was completed by 27 members of staff.

5 Consultation with External Stakeholders

A small questionnaire was developed and sent to key external stakeholders these included partners involved in planning services, consultant psychiatrists, members of the Locality Planning Group, key individuals leading the strategic direction of service development.

A wider group of external stakeholders was consulted specifically in relation to interagency partnership working, using the Partnership Assessment Tool (PAT2).

Largely due to initial technical difficulties in accessing and using the tool online, responses to this exercise were fewer, with 12 returns. Of the twelve (12) returned, five (5) were excluded because they were not completed fully.

What we found.

1 Service users

40 current users of SIDS were consulted using the UDSET framework in conjunction with a variety of methods to overcome communication difficulties as outlined previously. Key findings on each outcome are reported below.

Quality of Life Outcomes

When reading the commentary below please refer to the following definitions

<i>Almost all</i>	=	<i>over 90%</i>
<i>Most</i>	=	<i>75-90%</i>
<i>Majority</i>	=	<i>50- 74%</i>
<i>Less than half</i>	=	<i>15-49%</i>
<i>Few</i>	=	<i>up to 15%</i>

Safety

Service users said that they felt safe or very safe, most often referring to their home, with one person reporting that they did feel frightened sometimes.

Almost all said they felt safe or very safe at the service

Things to do

Almost all responded by saying both that they had interests at home or in the community and that they had plenty to do at they day services.

There were a few negative comments such as 'I hate all that singing' or 'I can't do much'. However, activities like bingo, dominoes, exercise, relaxation, knitting, cards and quizzes rated a positive mention, with some commenting on being able to choose whether or not to join in.

Social contact

When asked about their contact with other people, **most** service users mentioned family as their main social contact out with day care services, with a few mentioning friends. One person described having no social life and missing going out.

Two service users said that they did not enjoy attending SIDS and two were uncertain because they were new to the service and/or didn't know people yet. A large majority made explicitly positive comments about attending day services, including looking forward to attending, making friends, meeting different people.

"My family comment on how they see a big difference in me."

Staying as well as you can be

The majority of interviewees made positive comments on their health experiences ranging from 'keeping alright/not bad' to being 'very well/ fit and well.' A range of specific conditions or events were mentioned like strokes, mobility, hearing, strokes and asthma.

A majority also made positive comments on the link between attending day services and staying well. These included 'gets me out/somewhere to go'; and ' feed you well.'

A few made comments about preferring to spend time on their own or with family or 'not knowing much about this place'.

"I need here, need to know I have somewhere to go."

Living life as you want, where you want

Almost all of those interviewed were happy or very happy with where they live.

More than a third made positive comments on day services, including 'looking forward to attending', 'attending when wanted to', 'really liking/loving to attend' and 'lucky to get here'.

A few made mention of their attendance having a positive impact on their family cares: 'gives daughter a break', 'gives husband time'

Dealing with discrimination

Comments here tended to refer to staff within the services. Although two individuals felt that staff did not treat everyone equally by 'making a fuss of some' and that ' some are treated better' than others, **almost all** made comments on being treated well and equally at day services, with very positive comments made on how they are treated by staff.

"Words could not express how I feel about coming here'

Process Outcomes

Being listened to

"They listen to me and do all the phone calls etc. I only have to say. Sometimes they know me better than myself."

Almost all made positive statements about day service staff listening to them.

Valued and treated with respect

Again, when asked whether they felt valued and treated with respect by staff, **almost all** service users made positive comments about staff – ‘treated the same’; ‘wishes respected here’.

“I’m treated like a queen here’

Choice

There were two negative comments about choice in the service in general. One comment was ‘don’t get choice – do what everyone else does’. The second was ‘plenty choice – take it or leave it’.

Almost all made positive comments about choice at day services, mostly non-specific about ‘good choice’. 40% made comments about food or meals. Although there were more positive than negative comments on the food, this was an issue which provoked mixed views with comments including ‘food is rubbish’, ‘meals questionable’, ‘lacking variety’,

Reliability

With regard to day services, **the majority** of service users made comments relating to travelling to the services, with most of these complimenting the taxi service and being able to depend on being picked up as arranged.

However, one commented ‘taxis do their best – can’t rely on them’, while another stated ‘if they come they come, if they don’t, they don’t’.

“I feel like Julie Andrews”

“My key worker is reliable; she always gets back to me.
They always get back to you even if there is no update.”

Responsiveness

Less than half made service specific comments but all of these were positive and related to staff ‘responsive’, ‘only have to ask’ and ‘sort problems’.

Change Outcomes

Improving skills and confidence

When referring to confidence and skills outwith day services, **less than half** made less than positive statements on this aspect of their experiences. These included ‘never get out’, ‘can’t concentrate’, ‘terrible worrier’ and ‘just get on with it’.

A large majority made positive comment about day services, particularly with reference to improved confidence. These included 'more confident', 'not shy anymore', 'confidence has returned', 'can sing (again) in small groups' 'gives me focus'.

Improved mobility

Less than half commented on problems outwith day services, 'walking not good', 'very poor' and 'falls at home'. One individual commented that he 'wished he could have a day out' with his wife.

Most made positive general comments about mobility at day services, with a few specific comments including 'mobility improved', 'feel safe walking here' and getting assistance from staff.

What we found

2 Carers

33 people took part in individual discussions with a further **27** attending group discussions, making **60** in total. The findings reported below refer to the individual interviews.

Definitions of commentary.

<i>Almost all</i>	=	<i>over 90%</i>
<i>Most</i>	=	<i>75-90%</i>
<i>Majority</i>	=	<i>50- 74%</i>
<i>Less than half</i>	=	<i>15-49%</i>
<i>Few</i>	=	<i>up to 15%</i>

Quality of Life Outcomes

Health and Wellbeing

With regard to their general health and wellbeing, **40%** of carers reported being in reasonable health with 'not bad', and 'fine' being most common. Nearly 22% reported health problems, including 'don't keep very well', 'depression', 'stressed'.

With respect to day services, **most** made comments about the positive impact these had on them as carers. By far the most common comment related to 'time/time for me'. Comments also related to 'emotional support', 'reassurance', 'not worrying.' **Over 25%** reported some kind of positive change including 'don't feel so exhausted', 'don't feel so edgy', 'time to see GP' and 'don't worry so much'.

Having a life of your own

Nearly half of carers who were interviewed reported having satisfactory life experiences at present, from 'great life' to specific interests including gardening, church and friends, while three **(3)** carers worked. Seven **(7)** carers made negative

Comments including 'not having a life', 'not having a holiday' and 'not much chance now'.

When considering what day services contribute, **most** carers commented and **all** made positive comments about having 'time for self', 'not clock watching', 'not under pressure' and time to do things like shopping, housework and meeting friends. Those who work commented that the day service enabled them to keep working or to return to work.

Relationship with cared for person

In general terms **most** carers reported positive relationships with the person they care for, ranging from 'great/fantastic' to good' with 3 adding 'she's my mum' 'it's my duty' and 'my responsibility'.

Significantly, **all** carers made positive comments in relation to the impact of the service on their relationships. These included improved conversations and things to talk about with the cared for person, and the benefit of staff explaining the reasons for behaviour.

Freedom from financial hardship

In general terms, and with two exceptions, **almost all** interviewees reported no issues with their finances or that their income had been maximised.

With respect to day services, six **(6)** believed day services didn't deal with finance/benefits, while one **(1)** stated that the service 'keeps me right'.

Choices in caring including breaks

Most carers believed they were actively involved in making choices, including declining certain services like respite and home care. Specific mention was made of being involved in reviews, meetings and staff keeping carers informed and respecting their views.

Informed/equipped to care

There were fewer comments on this question than many of the others, with a **40%** response rate. Of those who responded, approximately half mentioned equipment like community alarm, hoists and stairlift as making a difference.

Other made general comments like 'don't need much', 'everything we need', 'manage fine'. One carer reported 'finding it more difficult'.

One noted a bathing service was provided by day services then it was stopped. The carer had suggested using a shower but was still awaiting a response.

'Staff have helped me to understand the illness and how to deal with it'

Satisfaction in caring

Again there was a **40%** response rate to this question.

Of those responding, three (**3**) reported 'finding it difficult and stressful' and 'it can be difficult', 'mum in day care 2 days, I still have to look after her rest of time', 'respite care still involves long visits with her'.

Eight people (**8**) commented on their satisfaction with care staff, rather than satisfaction with their own caring, and these comments were all positive. One (**1**) reported having a 'fantastic relationship' with the cared for person.

Treated as a partner

Significantly, **all 33** interviewees made positive comments on this. Specific mention was made of being involved in reviews, meetings, 'staff listening' 'carers meetings', 'always asked my views', 'access to care plan and integrated care plan'.

Process Outcomes

Valued and respected as an expert

All 33 made positive remarks.

Specific comments included 'opinions respected', 'service makes you feel equal', 'staff call me for advice', and 'opinions taken on board. There were a couple of examples where specific difficulties were mentioned – one (**1**) that suggestions were not taken forward and one (**1**) relating to the GP service and difficulty getting appointments

A say in services

Thirty-two (32) of **33** carers make positive remarks. As with the question on being treated as partners, many of the comments related to being involved in reviews and meetings as well as being informed and kept up to date by staff.

Responsive to changing needs

Almost all made positive comments. Specific comments related to *paid carers* being responsive to changes – ‘have good knowledge’, ‘trained in care’, ‘equipped to care’, ‘very alert to needs’,

Although two (**2**) carers made comments on current challenges, ‘I am finding it increasingly difficult’, ‘mum is getting confused’ **almost all** made positive comments about services, including ‘flexibility’, ‘informative staff’, ‘staff communicate well/approachable’,

Meaningful relationship with staff

Again, **all 33** made positive comments. Specific remarks included ‘positive relationships’ and staff were variously described as ‘very open’, ‘available’, ‘informative’, ‘friendly’ and sensitive.

Accessible and available

Most made positive comments, with reference to having quick access to day services.

What we found.

3 Consultations with stakeholders

The initial survey to stakeholders yielded a **70%** return.

Of those that responded **100%** agreed that information provided around the development of this service had been well communicated and all parties were kept well informed of the development as well as the review process now underway.

All of the respondents also noted that access to services appeared to be quicker, the range of access to services was extensive and in general the outcomes for individuals who attended appeared to be significantly improved.

The role of Locality Link Officer was also seen to be a crucial element in the development of this service.

In relation to the difficulties and challenges to be overcome, **20%** noted some professional barriers still in place and raised concern that in relation to mental health needs the current staffing may be insufficient.

Some concern was also noted with regard to supporting people with complex care needs who required to use specialist equipment, e.g. Scalemobiles and Stairmatics to get them out of their house and into the day service.

In these situations the level of staff support was exceptionally high and if more people with this level of need were to attend, more staff would be required or alternative forms of transport/ housing options would need to be put in place.

With regard to plans for roll out, **50%** expressed some concern with regard to the cultural challenge that lay ahead and suggested a need for a “powerful coalition” to be put in place to ensure full implementation.

All agreed that the model should be rolled out across the authority.

In summarising the advantages and disadvantages of the service, there was **general agreement** that the service was a significant improvement on previous models, that joint training and sharing skills and knowledge had improved not only the service for those who used it, but had influenced the success of the care management pilot in Coatbridge.

However there may be **more clarity required** in terms of what the service hopes to achieve and how people with complex physical care needs can be supported in the longer term.

4 Consultation with The Integrated Team (SIDS and ESG)

Using ITMA

STAGE 1 - PREPARATION

The Integrated Team Monitoring and Assessment (ITMA) tool was used to provide information on one of the key aspects of the service review process by exploring how well the integrated team is working.

The tool was distributed along with guidance notes to all staff within the Sinclair Integrated Day Service, incorporating East Stewart Gardens.

Guidance notes were developed following a pilot run of the questionnaire in December 2007. Small group feedback sessions following this pilot run were held and the staff intimated that they would find some definition, elaboration, and clarity around terms and statements helpful to ensure consistency of reflection and comment.

The ITMA tool was sent out for completion in January 2008 with guidance notes and the results obtained as below.

The skill mix within the team, including temporary staff, is as follows:

Admin Officers	2
Unit Manager	1
Integrated Service Manager	1
Senior Care Workers	5
Registered Mental Health Nurse	1
Health Support Worker	1
Care Workers	15
Locality Link Officer	1

Total Staff 27

As noted above the questionnaire was first distributed to all staff in December 2007, but without guidance notes. Twenty (20) questionnaires were returned (74%).

However following the development of guidance notes to accompany the questionnaire which gave clarity and consistency to some of the terminology contained in the questions, twenty two (22) questionnaires were returned in January 2008 (81%), an increase of 9% on the return.

STAGE 2 - GATHERING DATA

Staff were asked to respond to 30 statements by reflecting on their experiences and selecting from a range of possible responses. The statements were divided into 5 Principles with 6 statements in each.

The response for each Principle is detailed below. For each Principle the range of scores is shown along with the number of respondents who felt that each particular score reflected their own views and feelings.

An ITMA interpretation for each score is also shown. Staff were asked to comment on each Principle and some comments have been included to illustrate positive responses balanced out by comments that give some detail around perceived issues and concerns

Principle 1: Purpose and Mission

For Principle 1 *Clear Purpose and Mission*, individual scores ranged from 15 – 24. The average score was 20 and the most frequent score was 17.

SCORE	INTERPRETATION
B: 16-20	There is some measure of agreement about mission and purpose but not everyone is clear

Staff comments which support the scores suggest that:

- there is an excellent support network
- a better provision of service is being provided
- the team are committed to supporting people at home

- there is flexibility and access to resources
- staff are helpful and supportive
- the reasons for the team's creation and function are not always understood
- there were not enough team building exercises

Principle 2: Ownership and Trust

For Principle 2 *Securing Ownership and Trust*, individual scores ranged from 12 – 23. The average score was 18 and the most frequent score was 18.

SCORE	INTERPRETATION
B: 16-20	There is some degree of ownership and trust but this is not universal across the team

Staff comments which support the scores on Principle 2 suggest that:

- staff feel that their contributions are equally respected and valued
- staff are enthusiastic and supportive
- there is a lack of commitment from other professionals
- staff absences have a detrimental effect on the ability to rely on each other

Principle 3: Operational Arrangements

For Principle 3 *Robust Working Arrangements*, individual scores ranged from 11 – 24. The average score was 18 and the most frequent score was 18.

SCORE	INTERPRETATION
B: 16-20	Operational arrangements are partially developed but incomplete

Staff comments which support the scores suggest that:

- ring fenced places have health documentation only and information is shared on a 'need to know' basis
- clear instruction is given every morning
- 'health' use different records
- team members are willing to work on tasks not normally seen as within their remit depending on what the task is (this was commented on more than once)
- PIMS and SWIS need to be better linked
- a ratio of 1:7 (*) is insufficient to achieve the team's objectives

Note

(*) NB The ratio of 1:7 as indicated above relates to the ratio of staff to client only and does not refer to (for example) ratio of health to social care staff or skill mix within the team.

Principle 4: Learning and Review

For Principle 4 *Learning and Review*, individual scores ranged from 16 – 21. The average score was 19 and the most frequent scores were 17, 18 and 23.

SCORE	INTERPRETATION
B: 16-20	There is some agreement upon what to achieve and some limited support for team development

Staff comments which support the scores suggest that:

- the team are always looking to improve and take on board suggestions of others
- the team know they are working successfully due to the feedback at carer's meetings
- due to the variety of new staff, the service is focusing on stability before moving forward (*)

Note

(*) It is interesting to note this particular comment as both organisations have been undergoing significant organisational change and clearly this has had a perceived impact on the team. Resulting changes in personnel possibly have held back the potential development of stability within the team impacting on team members' ability to make the desired personal commitment and investment in on-going development and change.

Principle 5: External Links and Support

For Principle 5 *External Links and Support*, individual scores ranged from 13 – 24. The average score was 18 and the most frequent score was 18.

SCORE	INTERPRETATION
B: 16-20	The team is supported in its role by the partner agencies but this is limited in some important respects

Staff comments which support the scores against Principle 5 suggest that:

- there is a problem with ‘types’ of transport
- staff don’t know whether there are clear and realistic timetable for the team to achieve it’s aims and objectives

Note

NB Some staff have commented on the psychological and emotional impact of looking after people with very complex needs and particular reference has been made to the emotional impact on staff of working with people at the end stages of life.

This illustrates that the service is indeed targeting people who might previously have not been able to be sustained at home due to increasing dependency etc. but it also highlights the requirement to reflect on the team’s need for support with this aspect of care provision.

STAGE 3 – ANALYSIS AND INTERPRETATION OF DATA

In order to form an overall view of the significance of the ITMA scores, individual scores were aggregated to provide an actual score for the Team.

ITMA SECTION	MAXIMUM SCORE	ACTUAL SCORE
Section 1: Purpose and Mission	24	20
Section 2: Ownership and Trust	24	18
Section 3: Working Arrangements	24	18
Section 4: Accountability, Learning and Review	24	19
Section 5: External Links and Support	24	18
TOTAL SCORE	Maximum = 120	Actual = 93

The aggregate IMTA score is **93**. That indicates a team that is developing well but is in need of some further support as indicated in the Interpretation table below.

SCORE	INTERPRETATION
80-104	A team that is developing well but is in need of some further support

The ITMA tool has proved useful as a foundation for the development of an action plan to take forward integrated team working and practice building on the identified need and stage of growth.

See next page

The tool will be used in further reviews to demonstrate and chart progress in team development and integrated working.

STAGE 4 – ACTION PLANNING FOR OUTCOMES OF ITMA EXERCISE

Principle	What needs to improve	Suggested action	Taken by
1	There is some measure of agreement about mission and purpose but not everyone is clear	<ul style="list-style-type: none"> • Share outcome of Review process with team • Identify development needs of new and existing staff • Develop agenda to take forward team building 	Training department Organisational development NHS Lanarkshire and North Lanarkshire Council)
2	There is some degree of ownership and trust but this is not universal across the team	<ul style="list-style-type: none"> • Distribute Review outcomes to wider stakeholder network • Ensure locality distribution of Review outcomes • Relates to requirement to offer team building opportunities 	Fiona Taylor (NLC) Sandra Shafii (NHSL)
3	Operational arrangements are partially developed but incomplete	<ul style="list-style-type: none"> • Complete work on development of operational policy • Report progress to Human Resource Organisational and Development Group • Arrange for formal signing of Partnership Agreement 	Fiona Taylor (NLC) Sandra Shafii (NHSL)
4	There is some agreement upon what to achieve and some limited support for team development	<ul style="list-style-type: none"> • Identify team training and development needs using personal and team development plans 	Audrey Brogan (SIDS)
5	The team is supported in its role by the partner agencies but this is limited in some important respects	<ul style="list-style-type: none"> • Roll out of service model across North Lanarkshire will increase opportunity for the team to benefit from peer support and shared experience and reduce the feelings of isolation and “aleness” often felt by those who are pioneering in the delivery of new services. 	Fiona Taylor (NLC) Fiona Gairns (NHSL) Eleanor Wilson (NHSL)

What we found

5 The wider stakeholder group

Using the PAT 2 – SIDS

In addition to the ITMA tool, the recently updated Partnership Assessment Tool – PAT2 – was used as part of the evaluation, to gather views from a broader range of stakeholders on how the partnership is working. The tool was distributed along with guidance, in March 2007, to all stakeholders who had attended the consultation event in August 2007.

In practice, the returns from PAT2 were limited in number, largely due to IT difficulties. Although the tool was sent to 37 stakeholders overall, several people reported IT glitches with accessing and using the tool. Of 12 tools which were finally returned, five (5) were inadmissible due to not having been fully completed. Given these limitations, the results will be referred to in brief.

Individuals were asked to respond to and comment on five principles. In summary, the limited results from the PAT2 exercise confirmed the broad findings of the ITMA, identifying that partnership working is progressing well in the locality, with some scope for further improvement.

Comments relating to the PAT2 reflected that while there is consistent local commitment to supporting integrated working, and that outcomes for individuals using the service are very good, limited resistance is still evident from some team members.

While communication with all staff groups and grades was viewed positively, there was a continued need to ensure that all partners are kept up to date and that staff have a shared understanding of the principles and values of the service.

Practical recommendations were made about staffing arrangements. These included a suggestion that staff should be selected via interview rather than being redeployed into the joint service, in order to improve trust and ownership.

Further, governance could be enhanced by streamlining employment conditions and reviewing staffing levels, particularly given the unanticipated complex care management role of staff.

In relation to monitoring, measuring and learning, there was a view that the existing review system in the service is working well in allowing reflection on the appropriateness of supports and responding to people's changing needs.

(See the results of using UDSET for consultation with carers ref. positive comments made about the review system)

While feedback from users and carers is positive, it remains a challenge to identify the extent to which the service is preventing admissions and maintaining people at home.

The Action Plan developed in response to the ITMA would also support the points raised by the PAT2, particularly the proposals for staff training and better information sharing.

In addition, the suggestions relating to staffing arrangements arising from PAT2, will be fed back, along with the wider progress report, to the appropriate Joint Services Human Resource forum for further consideration.

How are we measured?

In addition to the tools and techniques used above, the service is also subject to routine internal and external monitoring and review processes.

As a joint service, the Integrated Day Service is performance managed through reporting on HEAT (Scottish Government Health Directorate) targets, the Delivering for Mental Health Targets and Commitments (DfMH), the Local Improvement Targets (LITS) and financial monitoring by both NHSL and NLC.

Standards of care also have to meet the appropriate NHS Quality Improvement Scotland Standards, and also demonstrate SIGN and Nice guidelines in practice.

The service is also subject to visits from external review bodies such as the Care Commission, Mental Welfare Commission, and Social Work Inspection Agency.

In its first year of service provision, SIDS featured in the NHSL Accountability Review 2006.

Ongoing monitoring against the LITS and reporting against the other performance management frameworks (as above) will in due course provide information around how the service is impacting favourably against these targets.

However it is early days to begin to conclusively draw clear and unequivocal association between the service coming on stream and the fact of a noticeable reduction in numbers of people waiting for care home in the Coatbridge locality.

Attached as an appendix is a table that offers some ideas around how the service has moved forward using some facts and figures that begin to show features of positive performance.

See Appendix – Service Provision Pen Pictures

Financial Information

Always of great importance in public service is demonstrating financial probity and value for money.

It has proved difficult for the purposes of this review to untangle the funding and associated costs of the previous services (day care service, psychiatric day hospital which covered more than the Coatbridge locality and provided out-patient services as well as day assessment and treatment) and make direct comparisons with the unit costs of the new integrated day service to analyse this aspect of service reflection and review. It should also be noted that health and social work financial systems are not readily compatible.

However this review process has highlighted the importance of maintaining joint service financial information systems in the future to ensure that (if and when required) the information about service costs etc can be readily accessed, comprehensive and are robust.

However, it is believed that the outcomes from stakeholder consultation (the main component of the review process) have demonstrated that bringing together health and social care provision definitely produces better care outcomes.

Featured below are some potential areas of interest; however more detail can be requested from NLC and NHSL if desired.

Employee Costs	£254,838 (SIDS)
Property Costs	£ 37,358 (SIDS)
Administration Costs	£ 3,535 (SIDS)
Supplies	£ 66,645 (SIDS)

Transport Costs – originally estimated at **£77,300**, experience has shown that these are considerably less than anticipated however, the current service does not, as yet, have sufficient demand to provide support in the evening and on Sundays. It is anticipated that over the next few months this underspend in transport costs will gradually be eroded.

Modes of transport include:

- the use of adapted taxis,
- the mini bus in previous use by the service is now being replaced with a people carrier and the service will continue to have access to a flexible adapted car.

Unit Occupancy

Since the service opened the numbers of those who attend has steadily increased and SIDS are now providing support for around 58 people each week (as at end May 2008) supported between 1 – 6 days (average 2/3 days of support per week). 25 people are supported each week at ESG.

Current Staffing Structure

Sinclair Integrated Day Service

*Integrated Service Manager x 1 (37hours)
Senior Social Care Workers x3 (37hours x 1, 37 hours x 1, 11.25 hours x 1)
Registered Mental Nurses x1 (37.5hours) plus sessional support from CMHT
Social Care Workers (37hours x 4, 22.5 hours x 3)
Mental Health Support Worker x 1 (37.5 hours)
*Administration support. x 1 (35 hours)

The satellite unit at East Stewart Gardens has

Day Care Manager x 1 (35 hours)

Senior social care workers x 3 (37 hours x 2 and 11.25 x 1)

Social care workers x 6 (37 hours x 2, 35 hours x 1 and 27.5 hours x 3)

Administration support x 1 (20 hours)

****The posts of integrated service co-ordinator and admin worker are joint posts with each agency paying 50% of salary costs.***

Some Role Outlines

Role of Integrated Service Manager

The Integrated Service Manager manages all staff (health and social work) within the unit and has overall responsibility for budgets, building etc.

The integrated service manager plays a key role in the development of the network of community resources that are available in the locality. Without this network the service would stagnate and be less effective.

This includes.

- Identifying gaps within the resources in the locality.
- Meeting with providers to develop services
- Providing training for sheltered housing wardens and other staff who provide a range of day opportunities for older people in the Coatbridge area.
- Line managing the locality link officer and assisting her to problem solve for local groups.
- Ensuring that the practical problems that affect older people in terms of accessing their community are heard at the right level via regular quarterly reports.
- Ensuring consistence of communication throughout the network so that people who are experiencing difficulty are quickly identified and brought back to the locality planning group if required.
- Promoting the health , well-being and social inclusion of older people throughout the locality. ,

The integrated service manager currently chairs the Locality Planning Group

With regard to this role she plays a crucial part in:

- Ensuring the assessments that are received by the group of a high standard.
- That group members are clear about their purpose and role within the group
- That assessors are clear about the process decision making within the group.

- That regular reports are prepared to strategic groups in order to monitor performance
- That gaps in service provision are identified and addressed where ever possible
- That staff development and training needs are met on a multi agency basis where ever possible.
- That where it is safe and possible to do so, that older people are supported to remain in their own homes.
- Continuously developing a better quality of service within the locality
- Ensuring quicker access to services
- Supporting carers in their caring role.

The admin officer is responsible for supporting staff from both health and social work agencies and uses the computerised systems of both agencies to fulfil her role.

Staffing costs within the service have remained similar, however health (nursing) staff who were employed in the original psychiatric day hospital (this covered both Airdrie and Coatbridge localities) were split equally between the two areas.

SIDS has 1 full time Band 6 Registered Mental (Health) Nurse (RMN) and a Health Support Worker Band 3 on each shift. Professional support for the RMN comes from a Senior Charge Nurse on the Coathill Hospital site.

In the first phase of this development it was thought that one full time RMN would be sufficient however this has now been increased by adding additional flexible support from the locality Community Mental Health Team (CMHT) for Older Adults.

This allows the RMN input to be utilised effectively between the main unit and the satellite at East Stewart Gardens, i.e. managing the planned and unplanned absences, undertaking some outreach work and covering all the necessary clinics and therapy sessions.

The Senior Social Care Worker and Social Care Worker posts from social work were largely transferred from the aforementioned day service and the budget for staffing transferred along with them.

What have we shared?

Over the last two years (since the service opened its doors in April 2006), we have been asked to present on our experiences and describe our service at a variety of events. We have also been visited by a wide range of interested groups.

We have delivered 15 presentations to various groups and teams from our local Coatbridge area community team and local service providers, through to presentations at events sponsored by the Joint Improvement Team, Stirling University Dementia Services, and at events in the Argyll and Clyde area and Edinburgh City Council.

In this period we have received visits from 20 groups drawn from local authority and health board personnel (including NHS Lanarkshire and North Lanarkshire Council, but also from other local authority areas such as East Renfrewshire Council, Glasgow City Council and West and East Lothian Councils) and the service featured in the NHS Accountability Review in 2006.

We have also enjoyed receiving a visit from health and social care managers from Norway!

The visiting groups represented teams and service such as community mental health teams for older people, early supported discharge teams, day service staff groups, social work area team staff, ward staff day hospital staff, senior officers from social work services, Carers Together, Alzheimer's Scotland and sheltered housing wardens (for example).

All groups and teams have expressed interest in our work and how the service has been developed and its wider service and community context.

What have we learned?

Whilst we continue to learn from the experience of integrating health and social care provision, the unit sits within a defined township or locality and is a component of the potential pool of support and care within that community.

Of equal importance is the on-going and aligned development of the wider community network.

Expanding and developing the community network

A considerable amount of development work has been undertaken with colleagues in housing, particularly with sheltered housing wardens. Many of the local wardens now provide a range of activities for people living in complexes and in many instances, for isolated older adults living locally.

Phased development of a community arts programme has enabled many of the wardens and tenants to try out new activities and to get involved in things they may not have previously tried.

The planned introduction of activity libraries has led to an increase in activity and easier access to a wide range of activities to further enhance this service and to ensure ease of access to a wide range of alternative activities in each locality.

Some additional funding has been provided by social work services to develop lunch clubs in areas where demand is particularly high.

Remodelling of Alzheimer's Action on Dementia Day services

A service review on the day services provided by Alzheimer's action on dementia was undertaken simultaneously by staff in North Lanarkshire Council SW Headquarters.

Up until this point, this service had provided a fairly traditional day service for people with Dementia in three localities in the NLC area, namely Wishaw, Motherwell and Bellshill.

As experiences of the new model of integrated day services began to emerge these reviews were tied together in order to ensure that these developing services would compliment each other and prevent any unnecessary duplication.

As the integrated model would incorporate a range of highly skilled staff from health and social work agencies, the need for a specialist day service for people with dementia to sit along side this was not evident. Therefore the service was completely reconfigured to provide individualised support for people with dementia in their own community.

The main purpose of this new service is, to do activities with the person, as opposed to doing things for them. This new service was then rolled out to all 6 localities and, at the time of writing, provides approximately 100hours of flexible support to each locality. Access to this is again controlled and monitored via Locality Planning Groups.

And some further reflections

Care management / care co-ordination

The issue of care management has become a significant factor in terms of staff time. It was originally anticipated that although some of the people who were being supported within the service could be care managed by the staff working there, a significant amount would continue to have their care managed by a social worker at the area team. However over the past year, this has proved not to be the case.

For staff this has meant that an increasing amount of their time has been taken up ordering a wide range of equipment, arranging respite, organising and recording reviews on computer systems, negotiating home support packages and meeting with families. Whilst in many situations this challenge is relished by staff and is deemed to be appropriate, the extent to this role has had a significant impact was underestimated and staffing ratios will need to be reconsidered if this aspect of support continues.

With the introduction of care management for community nursing staff it is now perhaps an opportunity to draft guidelines on whom and when an external care manager should be allocated and it may be necessary to reconsider staffing ratios if the majority of these tasks remain within the service.

Integrated care records.

During the first year of this service we have introduced an integrated care record for all service users, these records are usually held within the premises and all staff who work with the person fill in their observations and comments on this single record.

However as some of the service users, have their main support at home provided by the councils home support service, these workers to have been trained using the integrated care record and the service users bring these in with them each day.

At the time of evaluation there are 10 people who are now using this system, discussions with staff have revealed that this system of communication has greatly improved the service being provided. Home support staff regularly call the unit and seek expert advice if they are finding difficulties at home. Similarly the staff within the unit can gain a good understanding of the person's wellbeing by seeing the information with regard to support at home that has been recorded by the dedicated staff team.

Host agency

At the present time the manager of the unit (Integrated Service Coordinator) is employed by social work services and line managed by the Service Development Manager employed by NHS Lanarkshire.

This has been particularly beneficial in terms of getting the right balance and connections between the various linked health services and on site staff and also in terms of overcoming some of the practical problems re catering, cleaning and property issues given that the Sinclair Integrated Day Service is based on a health site.

However a significant part of the service costs are met by social work services and the service itself links people back into the community therefore the role of the Integrated Services Co-ordinator is one of developing a community network of options within the locality and therefore this post has responsibility for the management of the Locality Link Officer.

What is there still to do?

Some challenges for the future.

Although there has been much progress in the development of services for older adults across the council area, there is still a considerable amount of obstacles to overcome. And the next few years will lead to the further redevelopment of a range of opportunities for older adults in partnership with a range of agencies.

Transport

The introduction by the Scottish Executive of free travel for older adults has meant that many older adults who were unable to afford the costs of public transport can now use it regularly and many of our active citizens have taken up this initiative.

However for those older adults who need support to get out of their homes or who cannot travel with ease, there are several transport issues that remain to be overcome. Our challenge over the coming year then will be to address some of the problems around transport and assistance, both in relation to those who have complex care needs and attend the integrated day services and require a range of transport options. And also for those other people many of whom live in isolated or unsafe communities and require safer and more flexible transport solutions to those currently available.

Further developing the community network

Volunteers

With a growing number of *well* older adults living in our communities there will be opportunities to engage some of these people in voluntary work at a local level. Some work has been initiated within the council area in considering how this service can be developed and there is already a considerable demand from some of the staff and volunteers providing alternative activities in community halls and sheltered housing complexes for additional support.

Community services

The Disability Discrimination Act has led to the refurbishment of many community facilities in terms of access, but some require further investment in relation to the fabric of the building and with regard to egress via fire exits. A range of more appropriate seating has been provided to ensure older adults are comfortable when taking part in activities but a wider and more appropriate range of activities is required.

Life long learning

Closer links with community education in terms of information and access to educational programme is essential if the further development of the community network and the options available within it are to be realised. New ways of breaking down the barriers that exist between older and younger citizens is also being considered at present and some early work has begun with local schools to encourage intergenerational activities to take place.

Leisure and recreation

Some contact has been made with leisure services, but this too needs further developed, it is hoped that in the longer term direct links will be made into keep fit activity and wellbeing classes within local swimming facilities can be further enhanced.

Lunch clubs

As the population grows there is likely to be an increased demand on places where older adults can go for company and a meal. Further investment may be required in lunch clubs, or similar facilities in key areas and more imaginative ways of providing good quality food need explored.

Community planning partners

Further work is required to be undertaken with community planning partners in order to ensure that streets are safer for older adults to walk in. This includes frequently sanding pavements in the winter, repairing street lighting, providing adequate park benches for people to sit in and ensuring that key facilities, like swimming pools, consider the needs of older people.

Developing barrier free homes

The development of this service and more specifically the introduction of Locality Link Officers and Locality Planning Groups has highlighted the need for greater co-ordination of expertise when it comes to the design of housing and adaptations to housing.

Many of the people being referred to the Locality Planning Group were those individuals who simply could not get out of their house without support. These barriers were sometimes created as a result of new PVC doors being fitted that had a ridge that people could not step over.

For others it was because people had recently been allocated housing that, although of superior quality, included external stairs that now meant that they could not get out without assistance. Some people had broken paths to negotiate and others needed practical support to lock or unlock their doors.

Assistive technology

As the majority of people who attend the Sinclair Integrated Day Service have their care managed by staff within the unit, it has been relatively easy to promote the use of assistive technology to those who use the service and as the needs of these people increase an increasing range of technology support systems are likely to be introduced.

North Lanarkshire Council has a distinct advantage in this area as we have our own dedicated 24hour response team and can provide a range of planned and unplanned supports.

However in the longer term as the number of people with complex care needs continues to grow we will need to further develop the existing response service, seeking to reduce response times and ensuring more individualised response mechanisms for these individuals if we are to prevent admissions to long term care.

To date much of the development work in this area has been focussed on supporting people in their own homes, however this service will now need to develop to consider how people with more complex care needs can be supported when they are accessing resources in the community, and this may involve the development of a neighbourhood network response system to ensure locally based response systems.

Informing future practice

It is hoped that the learning from this service review can be built into the wider infrastructure within the department as a model of good practice.

Some of the possibilities around this include the further development of the Social Work Information System (SWIS) – here it may be possible for the review section to be amended to reflect UDSET tool. This would then be regularly used as a system of measuring outcomes within 4 weeks of the person starting, 6 months after and then at the end of each year.

Carers' consultation groups, across the council, could take advantage of building the UDSET tool into the carer's assessment and using it as a focus for carers' meetings and telephone/ individual interviews.

The ITMA tool could be used at 6 monthly staff development session across a range of joint services and with the recent development of the department's Quality Assurance Team these tools could be linked into the performance process and focus on the development on qualitative data sampling and monitoring across services.

The Health and Care Partnership group has recently given approval for the PAT tool used in this exercise, used as a method of assessing the progress of joint working across a range of services across the council area.

And in conclusion.....

Much work has already been done with regard to developing day services for older people. The integrated day service now targets those with more complex needs, can offer more flexible support packages than was previously possible and can ensure quicker access to a range of other services for those in greatest need.

Wherever possible the aim of this service is to rehabilitate and re-engage the person with their own community.

However the staffing level of support staff within the resource may need to be considered in relation to the extensive nature of the care management role.

The evolving community network now provides a range of alternatives to day care for our growing population of older adults and mechanisms and ideas for further improving and developing this network are still emerging.

Working in partnership with service users, carers and other service providers across the council has led to the development of new and innovative models of support that is already producing promising results in terms of keeping people out of long term care and to provide vital support to their carers. Staff across different agencies are developing new skills and working together more effectively than was possible in the past.

We need to further develop our joint operational policies and procedures, building on the common ground, and developing joint solutions to everyday operational challenges.

We need to continue to advocate for more joined up organisational responses to human resource issues and organisational procedures to support the everyday work at direct service level.

Although much work remains to be done, we believe that the foundations of our integrated day service are built on solid research, consultation and participation.

The findings of this review and learning from the experience will support the planned roll out of this model across the North Lanarkshire Council area.

However achieving success in implementing or rolling out this model means going beyond mere replication of the structure, roles, resources and processes.

The review team have been struck by the crucial impact that positive leadership, shared value base and attitude, enthusiasm, humanity, caring and “can-do” approach has had on the undoubted success of this model of integrated service provision.

It took also took vision

- **Vision to create the idea**
- **Vision to further develop the idea into a service reality**
- **Vision of service users who had aspirations beyond “day care”**
- **Vision, mutual respect and willingness to find solutions to problems of any nature**
- **Vision to continue to grow and develop**

This model of support, built on whole system working, will go on to further evolve and to influence other service developments as the needs of the population change over the coming years.

APPENDICES

Consultation with service users and carers - UDSET

The User Defined Service Evaluation toolkit (UDSET) formed the basis of the consultation with service users and carers. At the heart of the UDSET approach are two frameworks of the outcomes important to service users and their carers. Developed alongside the National Outcomes Framework, the toolkit has been developed to enable health and social care partnerships to gather data to determine whether they are delivering good outcomes to service users and carers. The outcomes frameworks have been adapted from a ten-year programme of research on user and carer outcomes at the University of York, and subsequent research commissioned by the Dept of Health on outcomes of partnership working at the University of Glasgow. Researchers from the DH Project have worked with the JIT since 2006 on developing the UDSET. The outcomes frameworks are summarised below:

Service user outcome framework

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence and skills
Having things to do	Having a say	Improved mobility
Seeing people	Treated with respect	Reduced symptoms
Staying as well as you can be	Treated as an individual	
Living where you want / as you want	Responsiveness	
Dealing with stigma/discrimination	Reliability	

Carer outcome framework

Quality of life for the carer	Managing the caring role	Process
Maintaining health and well-being	Choices in caring, including the limits of caring	Valued/respected and expertise recognised
A life of their own	Feeling informed/skilled/equipped	Having a say in services
Positive relationship with the person cared for	Satisfaction in caring	Flexible and responsive to changing needs
Freedom from financial hardship	Partnership with services	Positive/meaningful relationship with practitioners
		Accessible, available and free at the point of need

Findings from stakeholder event – 21 August 2007

Are the aims and objectives for this service the right ones?

- Very appropriate and responsive to changing needs - good and still valid
 - Delivering a person centred service
 - No mention of treatment
 - Loosely worded in terms of measuring outcomes

What is working well?

- Partnerships and relationships
- Quicker access to assessment review and care
- Integrated Care management - smooth journey
- More support to families
- Improved joint working and communication - links everything
- Targeted to most in need - rapid response
- Supports people to move on - clear pathways - LLO work well - very necessary

What are the Challenges?

- Extension of access to evenings and weekends
- Physical access - in and out of people's own homes. Transport
- Improving communication with users and carers and potential users and carers
- Geography
- Accessing all agencies
- Build on trust - mutual respect and commitment
- Less reliance on beds - need range of skilled staff and interventions - what service now
- Link to housing - access - and link to LPG
- low number of RMN staff
- Earlier intervention
- Better highlighting of needs by referrer
- better awareness of pathways - hospital discharge
- Better communication - more sharing of information - one system
- More health improvement - physical and mental
- Challenge of roll out

What needs to happen now?

- Update /review objectives - fit for purpose now and looking ahead - outcomes etc
- Evaluate service - to inform planning level and roll out (after review and existing support); outcomes; use of UDSET - identify gaps and solutions. Identify Information required. Specialist
- Develop outreach and capacity - prioritisation plan

- Carers' assessments - UDSET? Partnership group to consider
- Use structures such as Locality Planning Groups –to consider how model may be implemented locally and agree the key elements.
- Each locality needs to note what supports etc are available locally as facilities etc available will vary
- Evaluate benefits etc. of single (*i.e. integrated*) management
- Review skill mix with regard to the mental health component of the workforce etc - now and future
- Integrated IT requirements to support the service (Single Shared Assessment and wider issues)
- Facilities aspect - model(s) link to intended objectives
- Recommendations from review and action plan
- Review of existing health and social care day services - what aspects of Sinclair IDS can be adapted
- Review transport
- Communication and marketing of service
- Identify Pathway for older people - wider than Sinclair
- Identify service gaps e.g. overnight support in own home
- Emotional support to all carers
- Continuous review process being introduced

References for PAT 2 and ITMA

www.integratedcarenetwork.gov.uk
www.readiness-tools.com

Service Provision Pen Picture as at March 2007

1. Flexible ad hoc support to service users, mainly as additional respite for, or to support carers.
2. Social Work Staff continue to work between ESG and SIDS.
3. Service is offered on Monday to Friday at SIDS, and Monday to Saturday at ESG.
4. To provide support on public holidays, service at ESG and SIDS is joined up and delivered from the SIDS base building.
5. Carers' support meetings mainly attended by ESG carers with a few from SIDS
6. Service users transferred back from SJM (another day care service) over last few months.
7. Still are separate review processes for home support and day services.
8. Support from Early Supported Discharge, Glenaffrick (over 65 frail elderly) Day Hospital, Falls Service, Speech and Language Therapy remains direct referral.
9. Support from Glenaffrick Day Hospital.
10. Carers pampering sessions started at SIDS.
11. Joint SW and NHSL groups for service users in afternoon, many service users reluctant to participate if group is health and wellbeing focussed.
12. Open day held for professionals and carers.
13. Some referrals – problems with access due to stairs and needs of person. Staff training to commence re use of Stairmatic.
14. In-house training delivered by CMHT re Mental Health. Numerous in-house training events looked at topics such as amended admission procedures, ALT in-house session, sensory awareness, adult protection and ongoing support with SWIS.
15. Social work staff now have access to SWIS in building, staff learning how to record care plans, case notes.
16. Timeliness of Single Shared Assessments (SSA) problematic re being accessed on SWIS.
17. Quality of SSAs problematic at Locality Planning Group.
18. Care management by care staff being embraced with support from SSCw's and managers, still a number of cases being managed by social work area team.
19. Respite being arranged at social work area team level.
20. No waiting time for placements (from completion of assessment to accessing service provision).
21. Separate transport to and from the service. "Core" and "floating" placements use taxis, "ring fenced" (i.e. mental health only) placements use minibus.
22. Still some staff reluctant to fully integrated working arrangements between SW and NHSL staff
23. NHSL staff managed by Charge Nurse at this time.
24. Large numbers of people supported by the service are noted to have greater mental health needs than physical health needs.
25. Locality Link Officer (LLO) working between two localities.
26. March 06 – March 07 LLO supported 38 people (22 from SIDS)
27. March 07 – March 08 the LLO supported 56 people (24 from SIDS).
28. Issues with Dial-A-Bus as the service was not able to go between townships, making it inflexible for older people's needs.
29. Ad hoc support from CMHT for Older Adults for registered nurse cover.
30. Podiatry support is health centre- and home visit- based.
31. No pharmacy support to service in place.
32. Ongoing complaints from service users about the meal service, particularly around choice and quality of food, including poor cakes and home baking for afternoon tea.
33. Groupwork review arranged to be more needs focussed.
34. CMHT for Older Adults transfer all cases/discharge to SIDS once client has moved to floating / core place.

Service Provision Pen Picture as at March 2008

1. Carers more aware of ad-hoc support available.
2. Service users aware of, and positive around, their overall health needs and how the service can support these, i.e. physiotherapy, medication reviews, mental health reviews.
3. Service users more open to discussing with case manager other aspects of their support needs apart from social needs. I.e. finance, physical health, diet, medication, mobility, home support, equipment.
4. All staff work between both (SIDS and ESG) services.
5. Service provision is 6 days each week for both units and open to moving to 7 day service provision.
6. Carers support meetings are well attended by carers of those who use both SIDS and ESG.
7. Support from related services such as Glenaffrick Day Hospital, Falls Service, CMHT for Older Adults, Speech and Language Therapy and home support is very well established, most referrals are appropriate and communication between services is routine.
8. SSAs mainly include appropriate information for day services. More SSAs coming through Locality Planning Group.
9. Social work staff more confident in using SWIS.
10. All cases open to SIDS on SWIS, all review minutes recorded, all equipment ordered.
11. Care management by SIDS and ESG staff around 95% of occupancy.
12. Respite arranged by Day Service Care Manager routinely.
13. No waiting times for placements remains a feature of the service.
14. Gap in service remains for those who require support to leave and enter their homes and link to community groups.
15. Support to sheltered housing wardens via in-house training and more communication regarding tenants who use day services.
16. 5 service users from core places – long term at SIDS have days linked back to community groups.
17. Transport now discrete and arranged dependent on the persons transport needs and proximity to others.
18. Service managed by one co-ordinator (including health and social work staff).
19. Dedicated health staff to service to give better consistency.
20. Dedicated community pharmacy support for advice and guidance.
21. Agreement in place to offer podiatry support at SIDS for those who require it - once podiatry staff in place.
22. Locality Link Officer (LLO) dedicated to Coatbridge Locality
23. Increasing community groups and lunch groups initiated by LLO and supported by her and integrated day service.
24. Dial-A-Bus service slightly more flexible in supporting people to get to and from groups, as facilitated by LLO.
25. Groupwork needs-focussed as well as social groups offered.
26. Working arrangements for staff more integrated, staff flexible in their roles to meet service user needs.
27. Some agreement in place regarding transfer of care management from CMHT for Older Adults, driven by what is best for service user.
28. Stairmatic and Scalamobile used to support people to get to day service who otherwise would be isolated at home.
29. Integrated Care Record now travels with service user.
30. Welcome pack devised by service users with staff support.
31. Meal service reviewed regularly, with some changes to better suit service users preferences, home baking now provided by NLC at SIDS.

- 32. Increase in number of people supported with complex physical health needs.
- 33. Single review of all services, review managed by SIDS/ESG Care Manager.
- 34. Staff time increasing to support personal care needs of service users.

Some Service Activity Data – April 2007 to March 2008

activity	Figures
Admissions To SIDS	90
Discharges To community without other supports	1
Discharges To community with support from other services (e.g. Community Mental Health Team Older Adults, Home Support)	31
Discharges Service user to unwell to attend	4
Discharges Admissions to Long Term Care / Care Homes Admissions To NHS Continuing Care	15 3
Deaths	19
Discharges With reduced support from SIDS	5

Supports to Integrated Day Service:

From March 2007 to February 2008

- 75 hours from Locality Link Officer
- 20 hours from Dietetics
- 80 hours from Physiotherapy at Glenaffrick Day Hospital
- 18 hours for Occupational Therapy at Glenaffrick Day Hospital
- 63 hours from Community Podiatry
- 80 hours from Community Mental Health Team for Older Adults.

