Appendix 4
2012/13 Performance scorecard

# Thurrock Council Re-ablement Performance Scorecard
## Re-ablement Funding 2012/13 (£862k)
## March 2013

## Contents



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## Executive Summary

Project spend remains line with agreed budgets

The Rapid Response Assessment Service (RRAS) continues to receive high volumes of referrals (106 in month) indicating that there is a high demand for the service. 79 interventions took place in the month. In 2012/13, there has been a 171% increase in the number of interventions carried out in comparison to 2011/12. 205 referrals were from GP's (15 in 11/12), which demonstrates the significant amount of partnership working that has taken place over the year. Only 3% of interventions resulted in an admission to hospital. Across 8 months of the year (Aug-Mar), 92% of interventions resulted in a GP call being avoided, 59% of individuals avoided residential/nursing care, and a further 39% avoided a home care package.

A new scorecard has been developed for the Joint Re-ablement Team which will be reported on a quarterly basis and captures additional data on service provision and outcomes. In 2012/13, 47% of service users completing a period of re-ablement had a reduction/end in their care package. Additionally, no service users have had an increase in their commissioned hours since transferring from the Joint Re-ablement Team to an external home care provider, which is measured after 30, 60, 90 and 180 days.

The number of delays from hospital attributable to adult social care was 0 for acute and 2 non-acute. There have been no delays in acute in 2012/13 and non-acute has had a total of 46 days delay, which is 30% lower than 2011/12. Both targets have been exceeded and these outcomes demonstrate the clear effectiveness of the team despite there being some significant issues affecting hospital discharges throughout the year.

Whilst not funded from the Re-ablement Funding, the Collins House Interim Bed Service continues to show positive results, with 65% of individuals avoiding residential care in 2012/13 (not including hospital admissions) and 40% returning to the community. New monitoring has commenced over the last three months to record the numbers avoiding residential care and returning to the community out of only those that had re-ablement potential. From January to March, 83% of those with re-ablement potential avoided residential care and 62% returned to the community.

<u>Performance Issues:</u>

There are still some concerns around the reporting for the RRAS, particularly with regards to the recording of carer's assessments (including joint assessments). Work is ongoing to rectify these issues.

The Settling at Home service was previously extended to include referrals from BTUH, in order to raise the level of referrals as these were limited. However, despite this extension the service it appears that the number of referrals continues to be poor. This month there were no referrals, and in the previous month there were only 3 referrals, with only one actual intervention. Another meeting has been held with Papworth Trust regarding this and it has been agreed that from April the service will be extended to all Community Hospitals for Thurrock residents.

# Part One

## Re-ablement Funding - Monthly Performance Update

### Project 1 – Rapid Response Assessment Service (RRAS) - Increased crisis support from social care at the duty stage (formally Duty Pilot)

* NB – the indicators below are out of those people who have reached assessment stage

| Performance Indicator | Target | 2011/ 2012 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Total Number of Referrals | N/A | 397 | - | - | - | - | - | - | - | - | 119 | 145 | 95 | 106 |
| Total number of Assessments | 50 pm | 397 | 55 | 63 | 50 | 73 | 110 | 139 | 98 | 121 | 108 | 111 | 79 | 77 |
| Number of carers assessed | 10 pm | 116 | 16 | 16 | 18 | 14 | 0 | 1 | 1 | 3 | 3 | 1 | 3 | 2 |
| Number of assessments that were referred by GP's | 5pm | 15 | 1 | 2 | 3 | 5 | 23 | 43 | 24 | 15 | 23 | 27 | 25 | 14 |
| Number of people who were admitted to hospital | 1pm or under | 3 (5 months) | 0 | 2 (3%) | 1 (2%) | 0 | 3 (3%) | 8 (6%) | 3 (3%) | 0 | 0 | 2 (2%) | 5 (6%) | 5 (6%) |
| % of GP Calls Avoided | - | - | - | - | - | - | 100% (110) | 84% (117) | 87% (85) | 86% (104) | 91% (98) | 99% (110) | 100% (79) | 97% (75) |

**% of Service Users who Avoided the Following Social Care Services:**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Older Person Residential (Standard) | - | - | - | - | - | - | 28% (31) | 47% (66) | 64% (63) | 64% (78) | 52% (56) | 55% (61) | 53% (42) | 46% (36) |
| Older Person Residential (High Dependency) | - | - | - | - | - | - | 0% | 1% (2) | 0% | 1% (1) | 0% | 0% | 0% | 0% |
| Older Person (Dementia Unit) | - | - | - | - | - | - | 15% (16) | 2% (3) | 3% (3) | 2% (2) | 1% (1) | 2% (2) | 0% | 1% (1) |
| Older Person Nursing | - | - | - | - | - | - | 8% (9) | 9% (13) | 1% (1) | 3% (4) | 2% (2) | 1% (1) | 0% | 0% |
| Older Person Nursing – High Needs | - | - | - | - | - | - | 0% | 1% (1) | 0% | 0% | 0% | 0% | 0% | 0% |
| Collins House Interim Bed | - | - | - | - | - | - | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Homecare Agency | - | - | - | - | - | - | 46% (51) | 38% (53) | 32% (31) | 30% (36) | 44% (48) | 37% (41) | 37% (29) | 48% (38) |
| No Social Care Service Avoided | | | | | | | 3% (3) | 1% (1) | 0% | 0% | 1% (1) | 5% (6) | 10% (8) | 3% (2) |

* Please note – from August a new form of recording was implemented.

**Progress Update**

Overall in 12/13 there has been a 171% increase in the number of interventions carried out in comparison to 11/12. The number of referrals received from GP's h
increase significantly in the year by 190, demonstrating the considerable amount of partnership working that has taken place over the last year.

Overall across the 8 months of the year that recording has taken place, 92% of interventions resulted in a GP call being avoided, and the majority of individuals av
standard residential care (51%) or a home care package (39%). In the whole of 12/13, only 3% of interventions resulted in an admission to hospital.

**Case Studies:**

Case Study 1:
**Patient History:** Mrs A 78 with advanced dementia referred following sudden death of her husband who was main carer
**RRAS:** SW and Nurse visit same day
**Intervention by RRAS:** Unable to establish level of care needed for Mrs A as unknown how much Mr A did for her
**Outcome of assessment:** 24 hour care put in as temporary measure at home to assess what Mrs A care needs in future will be and to maximise safety while this is assessed
**Action following assessment by RRAS:** Temporary 24 hour care
**RRAS follow up**: Nurse practitioner to follow up any health issues

Case Study 2:
**Patient History:** Mrs B referred by GP following self discharge from A and E after fall and UTI
**RRAS**: Joint health and Social Worker:
**Intervention by RRAS:** Full physical, psychological and social assessment (holistic) undertaken – by Health and Social Care. Blood's taken as discussed with G signs taken (BP, pulse, respirations and temperature) – nothing abnormal detected
**Outcome of assessment:** Pt found to have very large weight loss. Care package to start 2 times daily. Blood test abnormal
**Action following assessment by RRAS**: GP to refer for further investigation (malignancy). Pressure relieving equipment ordered. Referred to ICT. Referred to
**RRAS follow up:** Care provided in own home while awaits further investigation

## Project 2 – Joint Re-ablement Team (Enhanced Re-ablement Capacity of Occupational Therapists to work within the re-ablement team)

| Performance Indicator | Target | 2011/ 2012 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 |
| Number of people completing a period of re-ablement (year to date) | 400 YE | 250 | 17 | 33 | 54 | 73 | 108 | 125 | 144 | 165 | 171 | 182 | 186 |
| % of those completing period of re-ablement which resulted in a reduction/end in care package | 35% | 24% | 12% (2) | 15% (5) | 35% (19) | 36% (26) | 38% (41) | 43% (54) | 44% (64) | 46% (76) | 45% (77) | 42% (77) | 43% (80) |

| Performance Indicator | Target | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Total number of individuals in receipt of JRT service in period | N/A | 69 | 70 | 67 | 96 | 103 | 75 | 92 | 112 | 106 | 142 | 82 | 76 |
| The average length of stay of service users in period (i.e. total number of days stay divided by number of departures) | 42 days | 26 | | | 24 | | | 22 | | | 26 | | |
| Number of referrals received by JRT in period | N/A | 127 | | | 160 | | | 185 | | | 208 | | |
| Number of service users admitted to hospital whilst in the service | N/A | 7 | | | 12 | | | 14 | | | 26 | | |
| Number of current cases in receipt of a service for 6+ weeks | N/A | 3 | | | 12 | | | 17 | | | 19 | | |
| % of service users that had a reduction in their care package from start to end of intervention | N/A | 12% | | | 13% | | | 19% | | | 18% | | |
| Number of service users that have had an increase in their commissioned hours 30 days after transfer to external provider (YTD) | N/A | 0 | | | 0 | | | 0 | | | 0 | | |
| Number of service users that have had an increase in their commissioned hours 60 days after transfer to external provider (YTD) | N/A | 0 | | | 0 | | | 0 | | | 0 | | |
| Number of service users that have had an increase in their commissioned hours 90 days after transfer to external provider (YTD) | N/A | 0 | | | 0 | | | 0 | | | 0 | | |
| Number of service users that have had an increase in their commissioned hours 180 days after transfer to external provider (YTD) | N/A | 0 | | | 0 | | | 0 | | | 0 | | |

### Progress Update

**Update on Staffing:**

Currently in post:

6 coordinators, 24 re-ablement workers, 1 social worker,1 support planner, 1 Physiotherapist, 3 OT's, 1 OT assistant, 1 nurse, 24 care workers. There are plans fo assistant to be put in place with re-ablement money.

Total carers hours are 599 **without** regard for annual leave, sickness absence and training. If this is calculated as allowing 15% for sickness absence, annual leave training, we have 509hours in total.
Care workers continue to do a great deal of overtime.

3 bank workers in place; however they are not currently providing us with adequate or satisfactory cover. Comensura continue not being able to provide adequate and the care workers that they have provided do not want to work the core hours and are very unreliable either cancelling at the last moment and missing visits.

**Care Packages/Capacity:**
The team continue to take all referrals received through the team; although work continues to be slow to transfer there has been an improvement in the transferring packages from re-ablement to an external provider. We continue to hold onto care packages in excess of 6 weeks. These tend to be difficult to handle cases.

The Clinicians continue to complete the re-ablement plans as due to the workload coordinators have not had capacity to take this over yet. We receive 14 and 25 c packages each week.

**Our Capacity:**
Remains problematic as we are still trying to get all mandatory training up to date as well as cover the service, however we are managing this well.

**We currently hold 126 service users in the team and 789 hours.**

## Project 3 – Comprehensive Learning and Development Programme

### Progress Update

There have been no training events in March.

## Project 4 – Funding of Care and Healthtrak

### Progress Update

A meeting has taken place with the Lead Commissioner for the Clinical Commissioning Group (CCG) to discuss the next steps and for Care and Health Trak and the key work streams. A further meeting is scheduled to take place with key staff to agree how to take the project forward.

## Project 5 – Review of Joint Re-ablement Team

### Progress Update

The review of the Joint Re-ablement Team has now been completed.

A more in-depth review is planned to take place in the next financial year.

## Project 6 – Prevention Strategy: Third Sector Support
## a) Settling at Home Pilot

| Performance Indicator | Target | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Number of patients referred to the Settling at Home Scheme | Baseline to be set 12/13 as pilot | - | 3 | 1 | 1 | 2 | 6 | 5 | 5 | 0 | 3 | 0 | 0 |
| % of patients settled at home with no intervention required | Baseline to be set 12/13 as pilot | - | 0% | 0% | N/A | 0% | 0% | 20% (1/5) | 0% | - | - | - | - |
| % of patients settled at home with intervention from Papworth | Baseline to be set 12/13 as pilot | - | 100% | 100% | N/A | 100% | 100% | 80% (4/5) | 100% (5/5) | - | 33% (1/3) | - | - |
| % of patients who required Papworth to call for further help | Baseline to be set 12/13 as pilot | - | 0% | 0% | N/A | 0% | 50% | 0% | 0% | - | 0% | - | - |
| % of patients re-admitted to hospital* | Baseline to be set 12/13 as pilot | - | 0% | 0% | N/A | 0% | 0% | 0% | 0% | - | 0% | - | - |

* Please note that Papworth would not be aware of any re-admittance to hospital once the visit has been carried out.

**Progress Update**

During the month of March we had no referrals for the service.

Papworth had a service meeting with Commissioners on 14th March. It was agreed that although referrals to the service had been very slow since the start of the y service will be extended for another year.

Beccy Carpenter (NHS Foundation Trust) advised she will be meeting shortly with local Community Hospitals where she will discuss the service with the dischar teams, in order to assist patients living in the Thurrock area.

**12/13 Overall:**

There were a total of 26 referrals to the Settling at Home service in the year. 22 of these went on to receive a service (84.6%), and 1 individual did not require an intervention. Three individuals did not receive support from the service despite being referred for the following reasons:

- Individual was discharges from hospital but due to a lack of communication, Papworth Trust had not been informed
- Individual was discharged from hospital late in the day and Papworth Trust can only accept referrals up to 3pm
- Individual was not released from hospital as the walking aids required were not available at the time of the planned discharge

No individuals were re-admitted to hospital at the time of the intervention.

## b) Tender – Expansion of Handyperson Scheme / Development of Befriending Services / Settling at Home Service (if Pilot successful – see above)

**Progress Update**

The tender/s for the expansion of the handyperson scheme, development of befriending services and the settling at home service will be undertaken towards the en financial year, once it is evaluated whether the pilot Settling at Home Service has been successful (see above).

## Project 7 – New Models of Service: Funding for Core Staffing at Elizabeth Gardens (Extra Care)

**Progress Update**

The re-ablement funding will contribute towards the development and expansion of extra care housing to allow for the provision of core staffing as part of the care support offer at Elizabeth Gardens. The new service model is expected to be highly effective in:

- Improving people's sense of independence
- Maintaining health and self control
- Improving individuals' health.

There have been significant build delays in the progress of this project due, therefore it is anticipated that the scheme will not be ready for occupation until May 20

A care provider has now been appointed – Carewatch East London.

Further updates will be provided as necessary.

## Project 8 – Telehealth Project

**Progress Update**

Health to report performance metrics/update

## Project 9 – Falls Car

**Progress Update**

Health to report performance metrics/update

## Project 10 - Increased support for the hospital social work team within the acute hospital (Two temporary social workers)

| Performance Indicator | Target | 2011/ 2012 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr | May | Jun | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

| | | | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 13 | 13 | 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DTOC (Acute) – total number of days delayed in the month that are attributable to Adult Social Care | 10 YE or under | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DTOC (Non-Acute) – total number of days delayed in the month that are attributable to Adult Social Care | 66 YE or under | 66 | 22 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 17 | 0 | 2 |

**Progress Update**

Delays attributable to Adult Social Care in March are 0 for acute and 2 days for non-acute.

Overall in 2012/13, there have been no delays in acute and 46 days delay in non-acute. For non-acute this is 30% lower than 2011/12. This has shown that the ho social work team is very effective in reducing delays.

## Social Care Funding Additional Indicator - Continuing Health Care (CHC)

| Performance Indicator | Target | 2011/ 2012 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Number of CHC's completed with social care professional involvement | N/A – 98-100% target to be reported on by Health | 217 | 23 | 40 | 18 | 30 | 57 | 51 | 55 | 64 | 26 | 39 | 29 | 25 |
| Number of DST's with social care professional involvement | N/A – 98/100% target to be reported on by Health | 101 | 20 | 14 | 14 | 11 | 7 | 2 | 10 | 10 | 4 | 6 | 6 | 4 |

**Progress Update**

**12/13 Overall:**

There were a total of 457 CHC's completed in the year, which is a 110.6% increase from the last financial year.

There were a total of 108 DST's completed in the year, which is a 6.9% increase from the last financial year.

## Cross-Cutting Indicators

| Performance Indicator | Projects Indicator Linked To | Target | 2011/ 2012 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 |
| Number of placements in permanent residential care 65+ at month end | 1, 2, 4 | Reduction | 409 | 406 | 408 | 399 | 405 | 418 | 415 | 412 | 411 | 408 | 402 | 411 |
| Number of placements in permanent nursing care 65+ at month end | 1, 2, 4 | Reduction | 33 | 32 | 32 | 32 | 30 | 26 | 25 | 26 | 27 | 26 | 28 | 27 |
| % of clients receiving self-directed support | All | 60% | 40% | 37.9 % | 38.1 % | 38.2 % | 38% | 39.3 % | 38.4 % | 61.5 % | 61.6 % | 61.5 % | 60% | 59.4 % |
| % of service users who feel safe and secure (as per annual survey) | All | 86% or higher | 86%* | - | - | 83% | - | - | - | - | - | - | - | - |

# Part Two

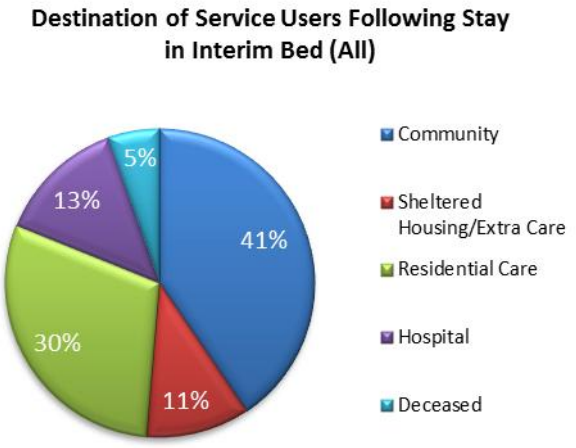
## Other Early Intervention / Prevention Services

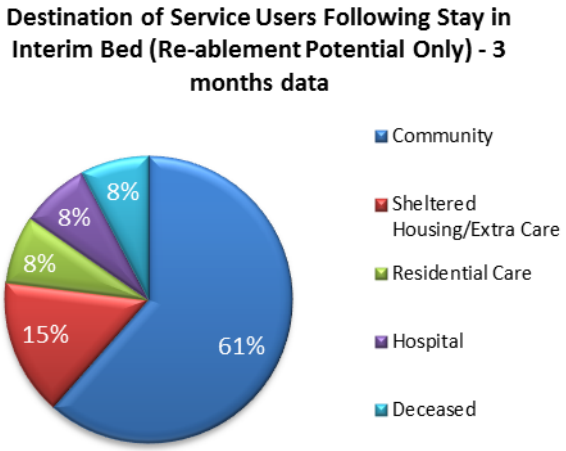
Thurrock Council is piloting various other schemes delivering early intervention/prevention. These are not funded through the re-ablement funding.

## Collins House Interim Beds (Social Care Funding)

| Performance Indicator | Target | 2011/ 12 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Occupancy rate per month (YTD) | 65% | 88% | 86% | 90% (88%) | 96% (92%) | 77% (87%) | 84% (87%) | 89% (87%) | 77% (85%) | 62% (82%) | 90% (84%) | 90% (84%) | 86% (84%) | 83% |
| Average length of stay per month (YTD) | 42 days | 39 | 64 | 15 (52) | 48 (50) | 123 (64) | 47 (59) | 47 (57) | 88 (64) | 39 (61) | 31 (59) | 29 (52) | 56 (53) | 41 |
| % of service users who avoided residential care upon discharge (per month) | N/A | 67% (18/ 27) | 67% (4/6) | 100% (2/2) | 25% (1/4) | 67% (2/3) | 25% (1/4)* | 83% (5/6) | 67% (4/6) | 60% (3/5) | 100% (2/2) | 78% (7/9) | 67% (6/9) | 50% (2/4) |
| % of service users who avoided residential care upon discharge (year to date) | 60% | 67% (18/ 27) | 67% (4/6) | 75% (6/8) | 58% (7/12) | 60% (9/15) | 53% (10/ 19) | 60% (15/ 25) | 61% (19/ 31) | 61% (22/ 36) | 63% (24/ 38) | 66% (31/ 47) | 66% (37/ 56) | 65% (39/ 60) |
| % of service users who avoided residential care upon discharge who were assessed as having re-ablement potential (per month) | N/A | - | - | - | - | - | - | - | - | - | - | 83% (5/6) | 75% (3/4) | 100% (2/2) |
| % of service users returned to community upon discharge (per month) | N/A | 56% (15/ 27) | 50% (3/6) | 100% (2/2) | 0% (0/5) | 33% (1/3) | 25% (1/4)* | 67% (4/6) | 22% (2/9) | 50% (3/6) | 67% (2/3) | 46% (6/13) | 40% (4/10) | 40% (2/5) |
| % of service users returned to community upon discharge (year to date) | 50% | 56% (15/ 27) | 50% (3/6) | 63% (5/8) | 38% (5/13) | 40% (6/15) | 37% (7/19) | 44% (11/ 25) | 38% (13/ 34) | 40% (16/ 40) | 42% (18/ 43) | 43% (24/ 56) | 42% (28/ 56) | 41% (30/ 74) |
| % of service users returned to community upon discharge who were assessed as having re-ablement potential (per month) | N/A | - | - | - | - | - | - | - | - | - | - | 67% (4/6) | 40% (2/5) | 100% (2/2) |

NB – For the % avoided residential care, figures do not include those who leave the service that are admitted to hospital or are deceased. For the % returned home, figures include all discharges (including those admitted to hospital or deceased).




**Progress Update**

Two beds in Collins House were decommissioned as interim beds on the 20/03/13 and 25/03/13, therefore there are 12 beds currently being used as interim beds. T interim beds are still in high demand however there has been an increase in demand for permanent beds, and there are capacity issues due to increased workload th interim beds generate.

Occupancy rate has dropped slightly again this month from 86 % to 83%. This is mainly due to the turnover rate; however some beds have been vacant for a num days before the next let.

Average length of stay has reduced this month to 41 days, which is within the 42 day target. 2/5 individuals who left the service in the month went over the 42 da

Of the 5 Individuals left the service in the quarter:

- 2 returned to the community (both were assessed as having re-ablement potential)
- 2 moved to residential care (neither of these were assessed as having re-ablement potential)
- 1 admitted to hospital who later passed away passed away (this person was assessed as not having re-ablement potential)

**2012/13 Overall:**

The Average Occupancy Rate for the year was 84%, which is above the 65% target but is slightly under last year's figure (88%). However, the numbers of beds u interim have doubled since last year which has affected the figures due to a higher turnover.

The Average Length of Stay in the interim beds over the year was 52 days, which is 10 days over the target. However, some not all individuals using the interim b have re-ablement potential and therefore can stay in the beds longer whilst an appropriate placement is sought. In particular there can be waiting lists for sheltered care housing and sometimes for particular residential care homes.

65% of service users avoided residential care in the year (not including those admitted to hospital or deceased). This is exceeding the 60% target, and over the las months (Jan-Mar) 83% of those assessed as having re-ablement potential avoided residential care.

41% of service users avoided returned to the community in the year (including all departures from the service), which is slightly below the 50% target. However, last 3 months (Jan-Mar), 62% of those assessed as having re-ablement potential returned to the community.

## Interim & Respite Extra Care Flats / STAR Flats

From March 13 we began recording refusals to the Interim, Respite and STAR Extra Care flats due to the beds being occupied. This will help to determine demand for the services.

In March 13 there was 1 refusal.

**Interim Extra Care Flat:**

The Interim Extra Care flat is located in an extra care scheme and provides short term support to individuals who:

- may potentially need extra care to facilitate decision making regarding their extra care need
- are adjusting to a new condition or disability, suffering a loss of confidence, but have the potential to return home
- are awaiting adaptations/repairs to their home
- need emergency accommodation who are not eligible for residential care but cannot return home

**Progress Update**

The current resident has been staying in the interim flat since October. There has been no move on in the period. The current resident moved into the interim flat emergency placement and is being provided with re-ablement whilst clearance and work is done on her existing property. Decision to be made as to whether the s user wants to return home or move into extra care housing.

To date one individual has left the service (since reporting started in September 12). The individual had a reduction in level of service and avoided residential care moved to sheltered housing following the support in the interim bed. They came to this service from residential care.

**Respite Extra Care Flat:**

In addition the Respite Extra Care Flat Pilot is due to commence in November. This flat also resides in an extra care scheme and will provide a respite facility that is not in a residential care setting. This service provides similar support to the Interim Flat and can provide planned regular respite to prevent carer breakdown.

**Progress Update**

The respite extra care flat is now operational and the first service user moved in on the 21st February. This was an emergency placement.

**STAR Flats (Kynoch Court and Piggs Corner):**

We also have in existence two STAR flats for short term assessment and rehabilitation in two of our sheltered accommodation sites. These are for service users to use following a spell of ill-health or discharge from hospital. Service users receive both Social Care and Health input.

**Progress Update**

There has been two service users move on from the STAR flats in March. One service user was admitted in January and stayed a total of 43 days. They were adm the service following an admission to hospital and were unable to return to their high rise flat due to mobility issues. The service user also has a mild learning disa and was risk of self neglect and isolation. Following re-ablement they moved to Extra Care Housing where they continue to receive support. The second service u referred to the STAR flats following repeated admissions to hospital. However, they only remained in the service for 1 day and refused support. They returned to home in Gaitskell House where they receive support from the re-ablement team.

8 individuals have moved through the STAR flats in the year (from September when recording started). The average length of stay is 51 days. The outcomes for individuals are:

- 3 returned to live in the community. One of these did not require any support whilst in the service; the placement was due to a need for emergency accommodation due to concerns of domestic violence. One individual originally lived in residential care, and the third individual refused support and r back to their home in a Sheltered Housing Service where they continue to receive support.
- 1 moved to Extra Care Housing
- 3 moved to residential care.
- 1 passed away in hospital.

Performance monitoring of the Interim and Respite Extra Care flats, and the STAR flats is being put in place at present and it is planned that more robust monitoring will be available in the future.

## Mental Health Support - Increased Support to Intermediate Care Service (ICT) within the OPMH Team (Social Care Funding)

Funding has been provided to increase support in the Intermediate Care Service within the OPMH Team. The aims and objectives of the post are to:

- Provide re-ablement and a wide range of high quality community care services to people with mental health needs
- Help/ enable individuals with mental health needs requiring rehabilitation to maximise their independence, avoid hospital admission or enable early discharge.
- Be a member of the multi-disciplinary Older People's Community Mental Health Team and will work in close co-operation with hospital and community care based professionals.
- Ensure that an integrated service is provided to their clients and that a good inter-disciplinary working environment is maintained.
- Provide a service to people with mental health needs to enable them to achieve their full re-ablement potential as identified in their care plan/support plan.
- Have a shared responsibility for the maintenance of high quality standards of care within the team.
- There will be a requirement to contribute to the duty rota and to work weekends.

| Performance Indicator | Target | 2011/ 12 | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Apr 12 | May 12 | Jun 12 | July 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 |
| Number of Referrals in month | N/A | - | - | - | - | - | - | - | - | - | - | 5 | 3 | 5 |
| Number of service users supported in month | N/A | - | - | - | - | - | - | - | - | - | - | 11 | 12 | 12 |
| Number of service users on waiting list in month | N/A | - | - | - | - | - | - | - | - | - | - | 4 | 2 | 0 |

### Progress Update

**Case Studies Demonstrating Outcomes of Service:**

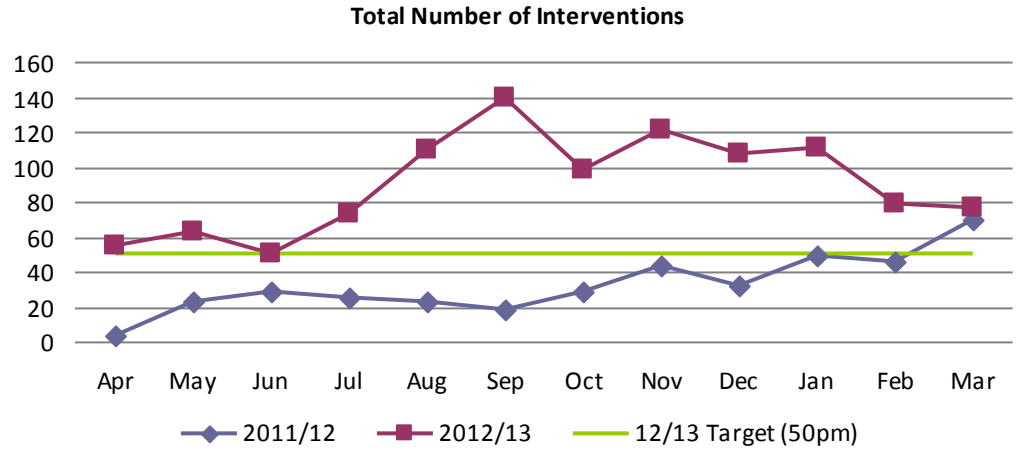
Mr X was referred to ICT by his Consultant after he attended the out patients department, he was reported to have presented at the appointment looking unwashed being dirty and unkempt. Mr X has a diagnosis of Alzheimer's disease, diabetes and takes medication for his thyroid. The District nurses were also visiting to check his wound following a skin graft operation, and change his dressing.

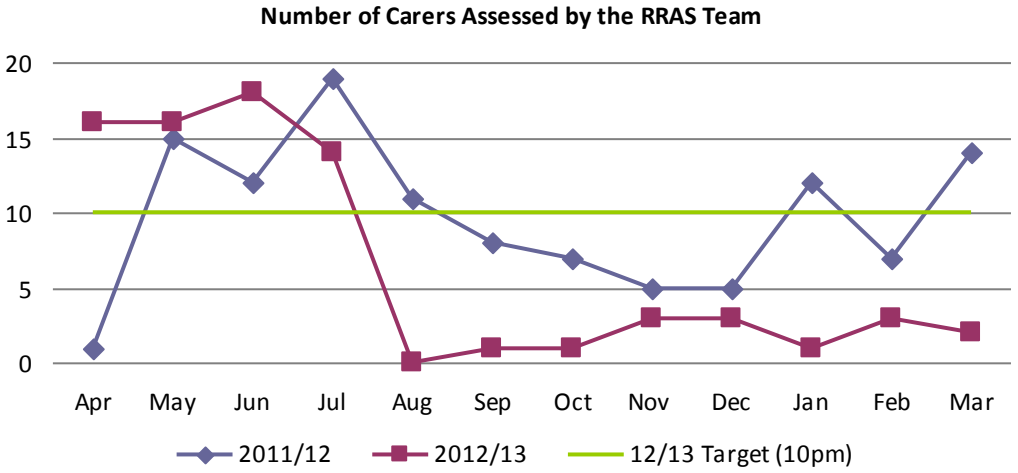
Despite having home care services in place Mr X was reported to be refusing support from carers, forgetting to eat, drink or take his medication. The ICT staff supported Mr X with getting washed dressed, taking his medication and with ensuring that he had a meal. Mr X was able to engage with the ICT staff an were able to assist him with getting washed and dressed. Following several weeks of working with Mr X a review meeting was held and the case was transferred b the home care provider.

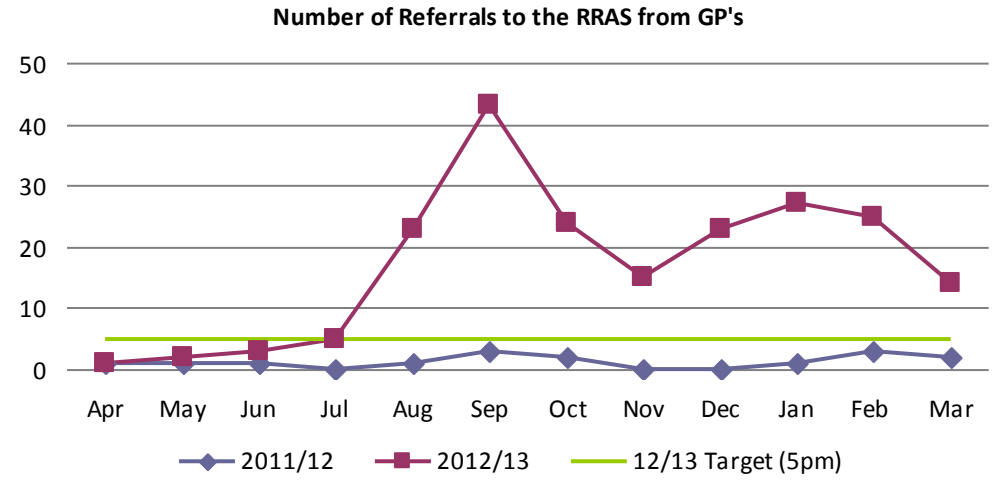
# Part Three

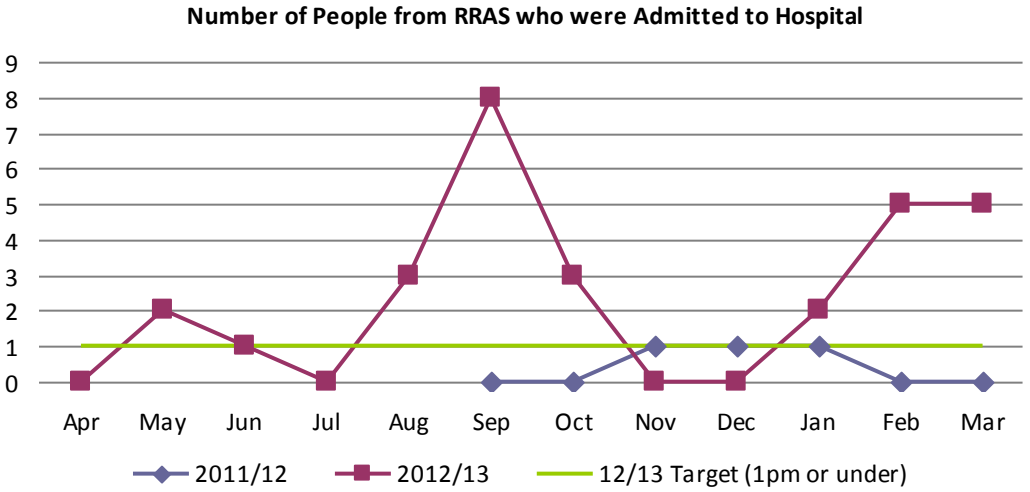
## Performance Comparison – Re-ablement Funding

### Project 1 – Rapid Response & Admission Avoidance Team (RR&AA) - Increased crisis support from social care at the duty stage (formally Duty Pilot)

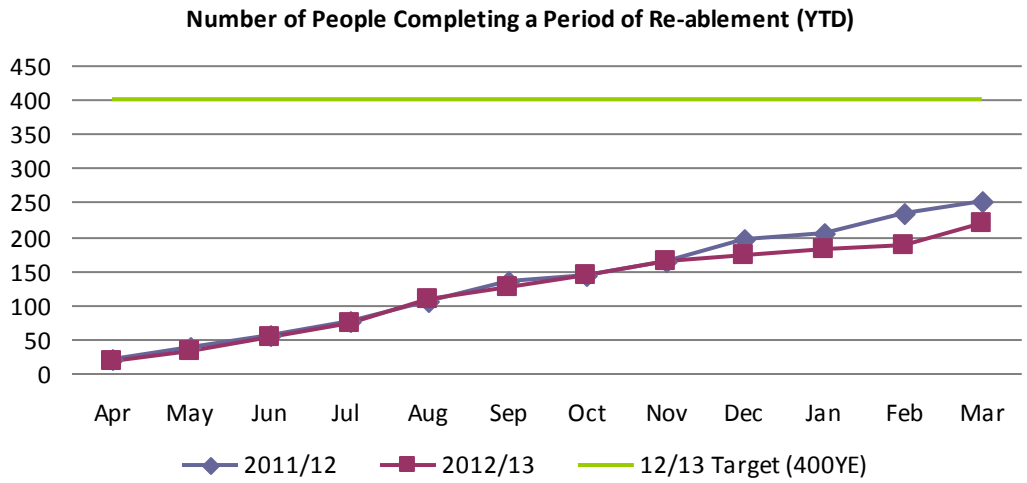

Total Number of Interventions
160
140
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
12/13 Target (50pm)

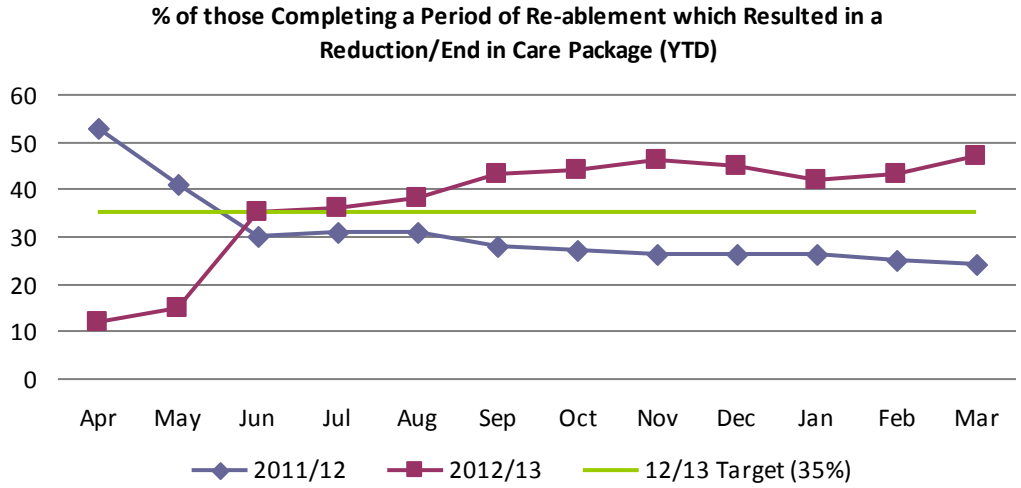

Number of Carers Assessed by the RRAS Team
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
12/13 Target (10pm)


Number of Referrals to the RRAS from GP's
50
40
30
20
10
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2011/12
2012/13
12/13 Target (5pm)

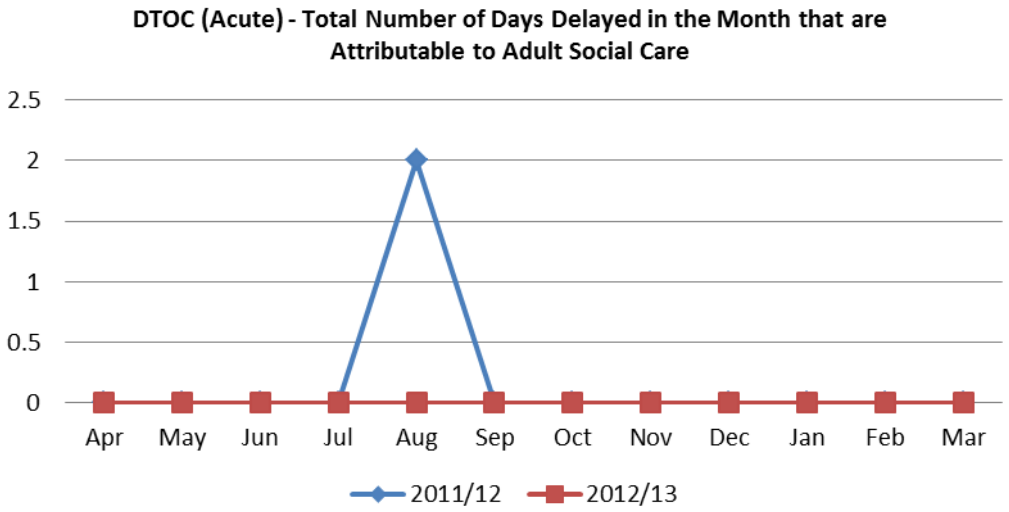

Number of People from RRAS who were Admitted to Hospital
9
8
7
6
5
4
3
2
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2011/12
2012/13
12/13 Target (1pm or under)

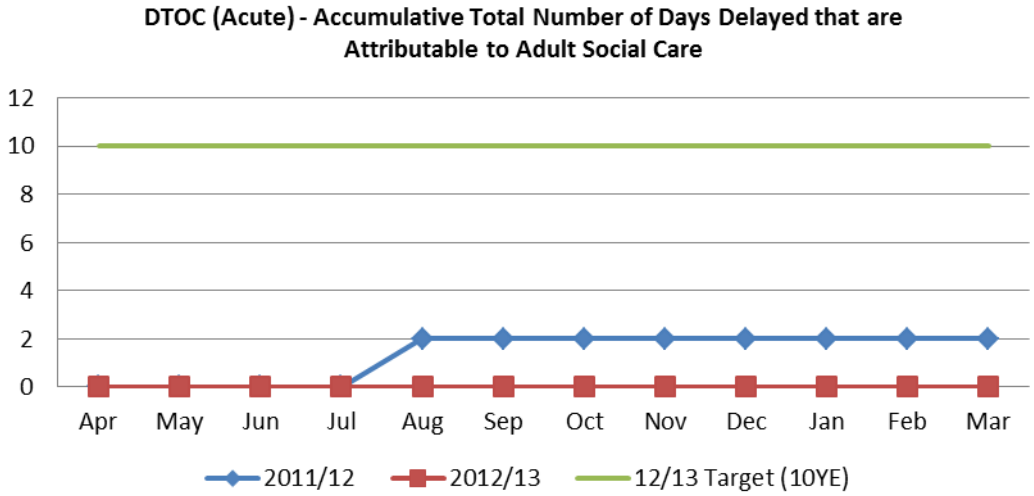
## Project 2 – Joint Re-ablement Team (Enhanced Re-ablement Capacity of Occupational Therapists to work within the re-ablement team)

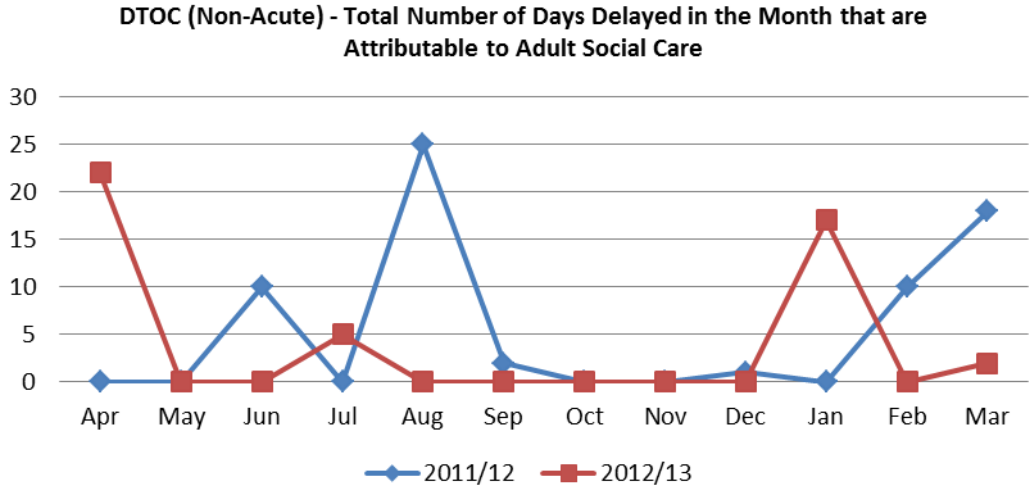


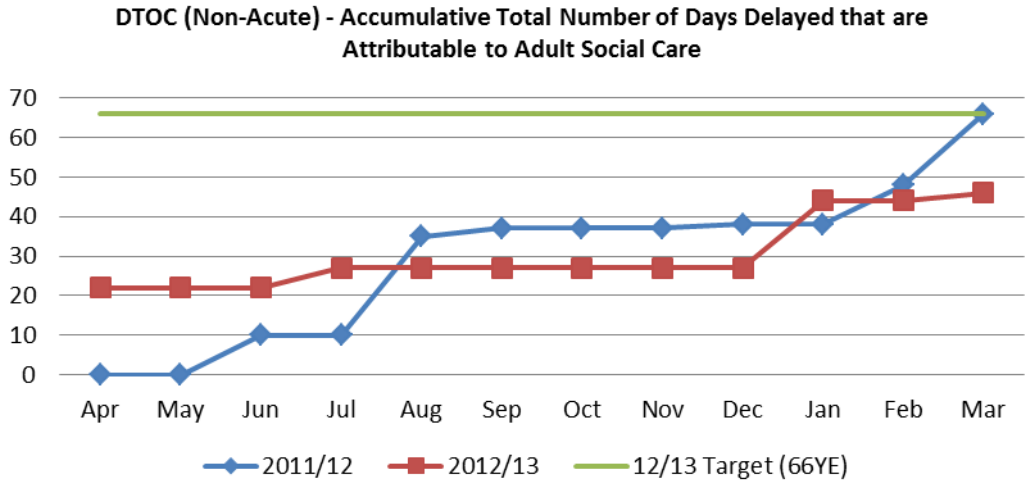




**Project 10 - Increased support for the hospital social work team within the acute hospital (Two temporary social workers)**

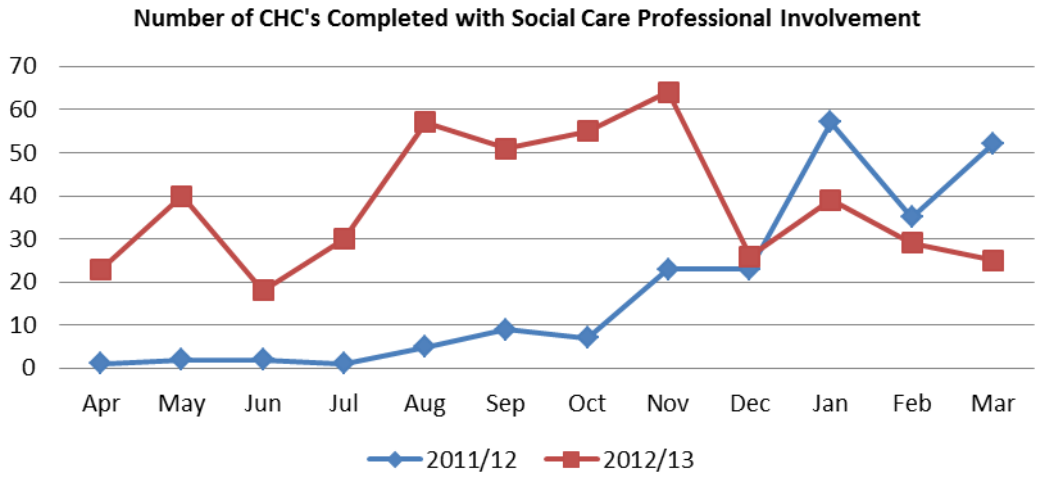

DTOC (Acute) - Total Number of Days Delayed in the Month that are Attributable to Adult Social Care
2.5
2
1.5
1
0.5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13

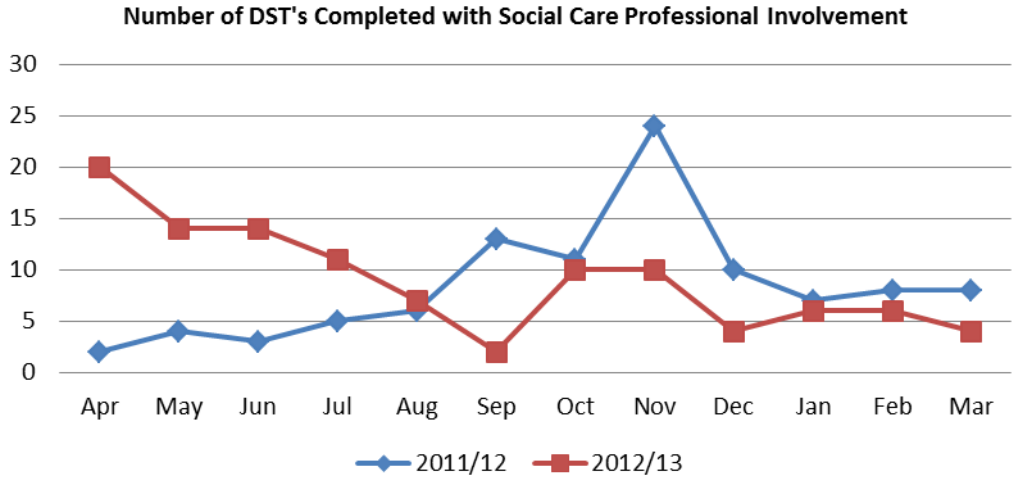

DTOC (Acute) - Accumulative Total Number of Days Delayed that are Attributable to Adult Social Care
12
10
8
6
4
2
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
12/13 Target (10YE)


DTOC (Non-Acute) - Total Number of Days Delayed in the Month that are Attributable to Adult Social Care
30
25
20
15
10
5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2011/12
2012/13

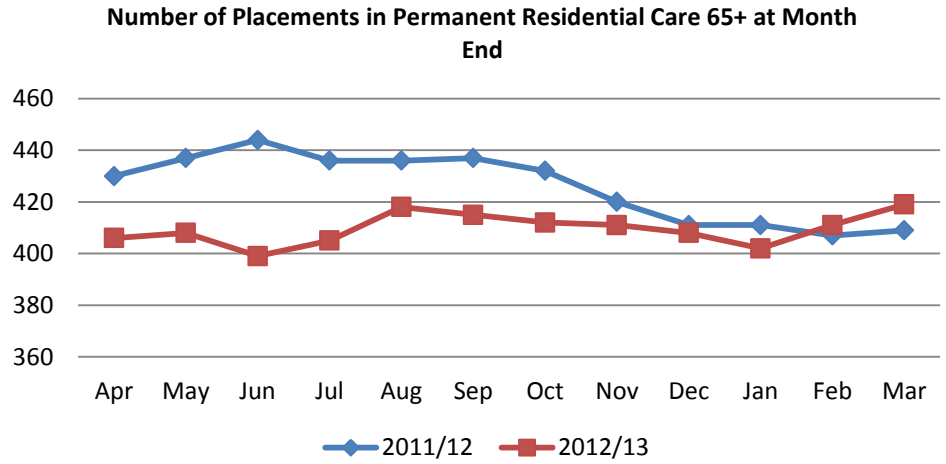

DTOC (Non-Acute) - Accumulative Total Number of Days Delayed that are Attributable to Adult Social Care
70
60
50
40
30
20
10
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2011/12
2012/13
12/13 Target (66YE)

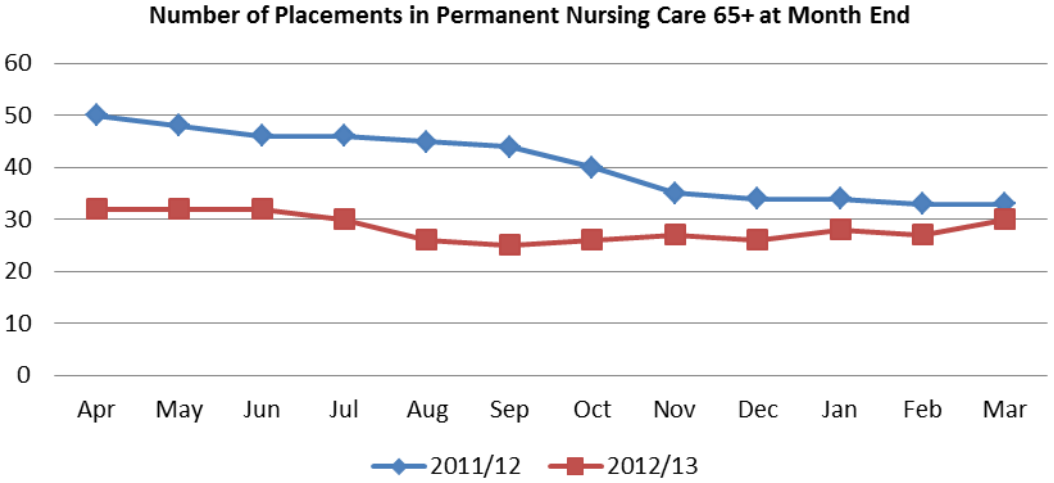
## Social Care Funding Additional Indicator - Continuing Health Care (CHC)

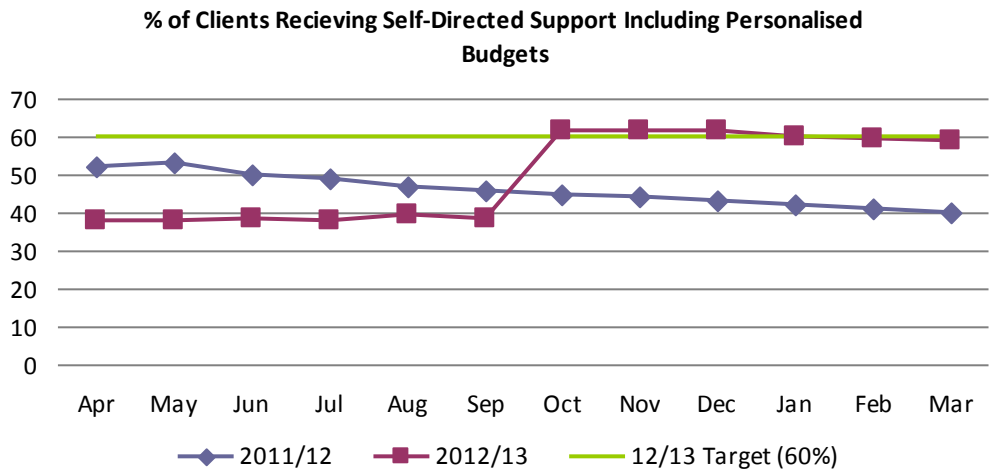


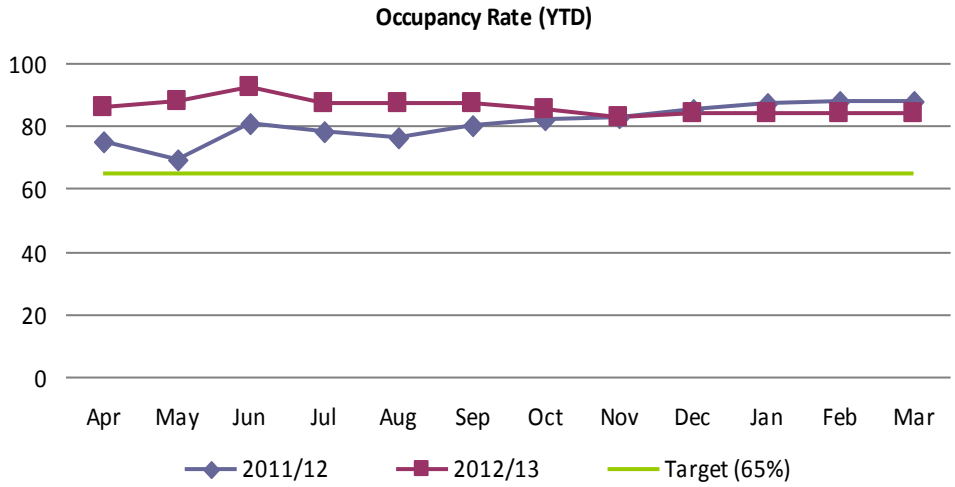
## Cross Cutting Indicators

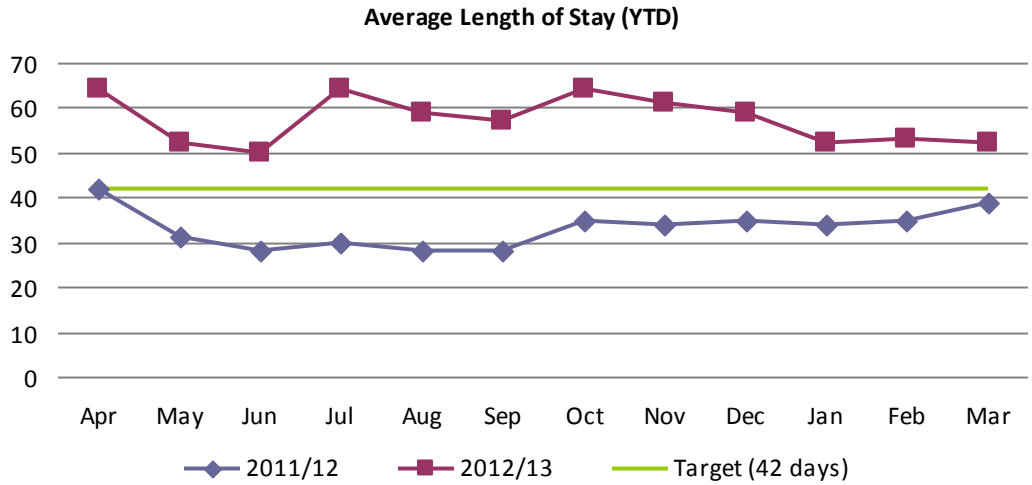

Number of Placements in Permanent Residential Care 65+ at Month End
460
440
420
400
380
360
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13

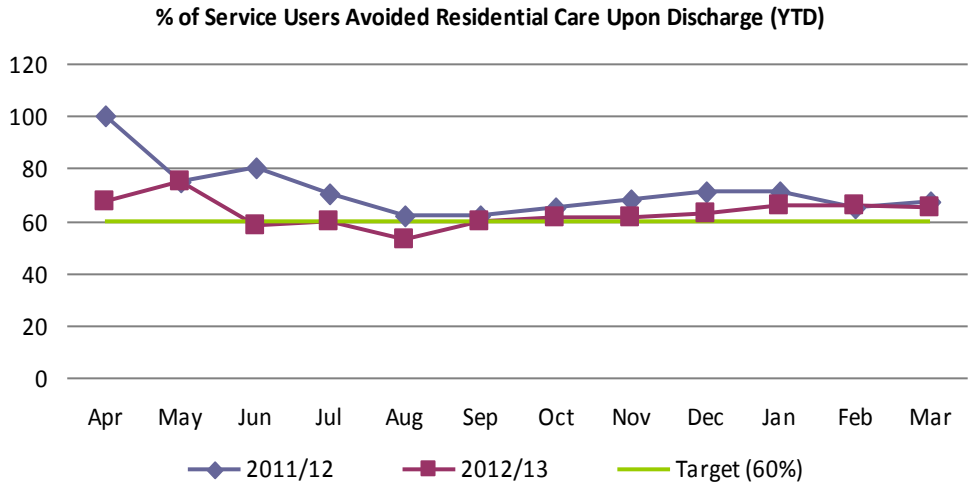

Number of Placements in Permanent Nursing Care 65+ at Month End
60
50
40
30
20
10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13

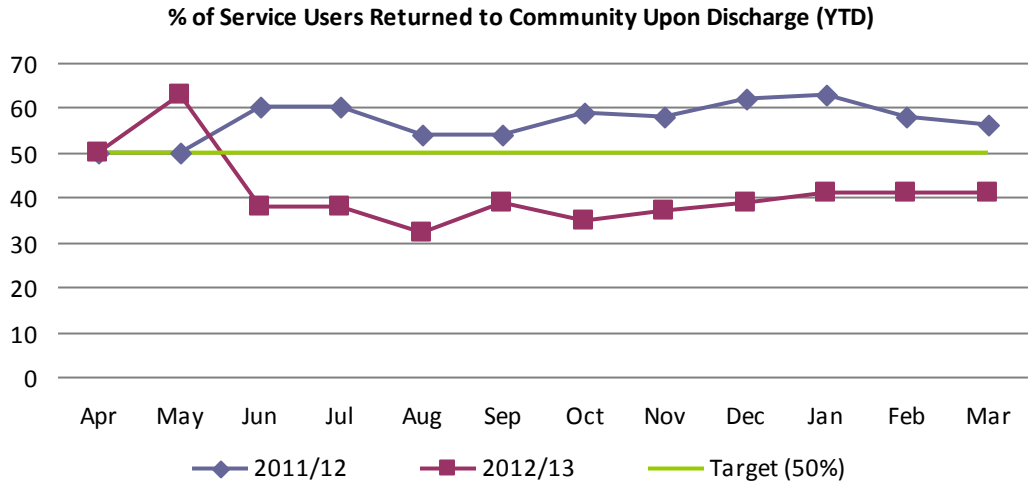



## Collins House Interim Beds


Occupancy Rate (YTD)
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
Target (65%)


Average Length of Stay (YTD)
70
60
50
40
30
20
10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
Target (42 days)


% of Service Users Avoided Residential Care Upon Discharge (YTD)
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
Target (60%)


% of Service Users Returned to Community Upon Discharge (YTD)
70
60
50
40
30
20
10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2011/12
2012/13
Target (50%)