care inspectorate

Healthcare Improvement Scotland

Services for older people in Argyll and Bute

February 2016

Report of a joint inspection of health and social work services for older people

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Report of a joint inspection

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Contents

Summary of our joint inspection findings

The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services for older people in Argyll and Bute between April and June 2015. The purpose of the joint inspection was to find out how well health and social work services delivered good personal outcomes for older people and their carers. We wanted to find out how well health and social work services worked together to deliver services to older people, which would enable them to be independent, safe, as healthy as possible, and have a good sense of wellbeing. We also wanted to find out how well health and social work services were prepared for the coming legislative changes designed to integrate health and social work services.

Our joint inspection involved meeting over 100 older people and their carers, and around 400 staff from health and social work services. We read 111 older people's health and social work records. We studied a lot of written information about the health and social work services for older people and their carers in Argyll and Bute.

The Argyll and Bute Partnership includes principally Argyll and Bute Council and NHS Highland and is referred to as 'the Partnership' throughout this document. In Argyll and Bute, social work services, most community health, and acute hospital services, were delivered by Argyll and Bute Council and NHS Highland. In addition many specialist health services were delivered by NHS Greater Glasgow and Clyde on behalf of the Argyll and Bute Partnership. These were agreed through a service level agreement.

Quality indicator 1 – Key performance outcomes

The Partnership performed well compared to national trends on preventing avoidable admissions of older people to hospital. Its performance on ensuring the timely discharge from hospital of older people who were medically fit for discharge varied. The balance between hospital and community care was good, with most older people supported at home, compared to the proportion supported in care homes.

There was a positive preventative approach to providing care and support to service users. This helped to reduce the need for admission to hospital, supported discharge from hospital as well as supporting service users to remain at home. Reablement, respite and care at home services were having, in the main, a positive impact in helping older people maximise their quality of life. However, there was room for improvement in the availability of these services.

Enabling choice for service users and their carers was growing with steady progress being made in the offering of self-directed support. Overall, services were delivering good outcomes for service users, helping them to maintain their independence, their ability to manage and live at home or in a homely setting.

Quality indicator 2 – Getting help at the right time

The Partnership's approach focused on outcomes that prevented admission to hospital or to a care home and aimed to decrease social isolation. It aimed to improve wellbeing and health through increased mobility, better self-management and developing support in partnership with individuals and their carers. This approach to earlier intervention and prevention was gathering momentum in some communities. However, staff vacancies meant that delivery of services did not always meet planned support requirements.

The quality and accessibility of anticipatory care planning was improving. However, it was an area requiring further development. The development of the falls prevention was, in part, a success. However, availability of falls prevention services and management of falls was variable across localities and access was not equitable.

Older people and their carers with whom we spoke were generally content with the quality of services they received. The Partnership had worked with the independent sector to increase support to carers and had developed carers' centres in each of the four localities. These were providing valuable services and support to carers. Carers wanted better access to respite care to support them to enable their older relative to stay at home for longer.

Services for people with dementia were generally well delivered. However, some gaps meant that some older people did not always get the diagnostic and post diagnostic support when they needed it. Steady progress was being made in making sure that older people were offered self-directed support. However, the Partnership recognised that assessment processes were cumbersome for both staff and service users and these were under review.

Quality indicator 3 – Impact on staff

Staff were generally well motivated and thought they worked well together to support older people to live in the community. There was evidence of positive attitudes across all staff groups. Some staff advised that they were working to capacity and, as a result, were unable to carry out early intervention work. Pressures in some front line services were being compounded by vacancies and staff absences and this impacted on staff morale.

There was evidence of good multi-disciplinary and multi-agency working, communication and a commitment to providing good standards of care to service users. Although there was evidence of staff consultation activities, staff felt that communication about proposed changes, such as integration of health and social work services, could be improved.

Senior managers recognised that changes were needed to improve dialogue with staff. However, staff told us that communication could be improved to enable staff to feel more engaged.

Generally staff had good access to training but most of this was delivered separately by health and social work services. The Partnership recognised it needed to develop different approaches to deliver training especially in remote areas.

Quality indicator 4 – Impact on the community

The Partnership demonstrated a strong commitment to engagement and consultation with the community and building the capacity of local communities. The Partnership engaged and involved local communities to better meet the health and social care needs of older people. A good range of community supports for older people was already in place.

The Partnership was seeking to work productively with older people, the third and independent sectors to improve engagement and increase awareness of the local community responses to delivering support.

The Partnership had adopted a locality-based approach to design services to meet the needs of the local population. However, the Partnership needed to do more to measure the outcomes of these community supports, to formalise the evaluation of initiatives, and ensure shared learning. The Partnership needed to do more to keep staff updated on the positive work they were undertaking.

Quality indicator 5 – Delivery of key processes

Assessment and care management was generally good. Assessments were carried out, and care and support plans were regularly reviewed. However, there were some areas for development such as the preparation of chronologies. While staff felt confident and supported in managing risk, the preparing and recording of risk assessments and risk management plans needed to improve.

Older people were being involved in decisions about their care and support and were also being well supported to self-manage their condition by Partnership staff.

Work had been done to embed an outcomes approach. New processes were introduced to support the consistent implementation of self-directed support. The options available for service users were limited by availability of provider services in some areas. Further development was needed in areas such as choice and support for carers and independent advocacy.

People who used both health and social work services and their carers were, on the whole, satisfied both with the services they received and the positive outcomes for them that resulted. They highlighted that family members and service users were involved in reviews and in decision making. Some improvements were needed in areas such as respite and care at home.

The Partnership needed to work towards improving the geographical equity of services to make sure that pathways for accessing services are more joined up and effective, for example, the development of a single point of access.

Quality indicator 6 – Policy development and plans to support improvement in service

The Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked the finer details on how they would be achieved. Joint formal strategies and costed action plans for themes such as carers, dementia, telecare and management of assets were needed. The Partnership needed to refresh and articulate its strategic priorities for these areas in the context of health and social care integration timescales.

Using the Change and Integrated Care Funds, the partners had taken a joint approach to the deployment of resources and this was influencing the future shape of health and social work services. Learning from these investments had led to a number of successful service redesigns.

A wide range of performance information was produced, reported and made available for consideration by the Partnership's senior and local management as well as council elected members and NHS board members. A draft joint performance framework linked to national outcomes was being prepared. The Partnership needed to be sure that the framework contained challenging, but achievable targets for service users and their carers.

Many stakeholders, such as the third and independent sectors, were positively engaged with meaningful involvement, in formal planning structures. The Partnership recognised local care market challenges and was beginning to address them. Joint strategic commissioning activity to date had primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners.

However, we saw less evidence of how strategic joint commissioning developments were to be progressed and how these would be led. The Partnership needed to develop its commissioning approach to further shift the balance of care to carry on the progress made so far.

Quality indicator 7 – Management and support of staff

Argyll and Bute Council and NHS Highland were developing joint workforce planning but this was at a very early stage.

Staff recruitment and retention was a challenge in some geographical areas and in some parts of the workforce. This affected the capacity and capability of some services. Although there were few joint posts, there was evidence of new approaches to service delivery through a range of projects and schemes.

Resource allocation and deployment of staff were still largely at an individual agency level. However, there was evidence that frontline staff from health and social work services worked hard to ensure a joined up approach to provide positive outcomes for older people.

Staff development and training were largely specific to each of the partners. Most staff thought there was good access to training appropriate to their post.

On the whole individual supervision arrangements and support were positive. In the partner's own staff surveys the need to improve management support for staff was identified as a key priority. A range of initiatives was in place which showed the Partnership's intentions to address this and other areas including training and development.

Quality indicator 8 – Partnership working

The Partnership was actively planning for health and social care integration. However, it had yet to establish pooled budget arrangements including accounting and reporting frameworks. Separate but effective budget management approaches were in place. However, the shadow Integration Joint Board had yet to have detailed discussions about the scope of the budgets aligned to those services it had agreed to commit to integration. The Partnership needed to progress this area to make sure they delivered the same standard of effective governance that both health and social work services had previously achieved.

There were major challenges of working across separate client information systems. We identified some key information sharing gaps which will need to be addressed as integration moves forward. A joint information technology strategy was awaited.

Good groundwork was in place in relation to health and social care integration. Integration work streams had been established and the senior tier of the new management structure was in place. The Partnership was adopting new ways of collaborative working. These included locality needs assessment, service planning and delivery structures. However, while there were strong links with most stakeholders being forged, more work needed to be done.

Quality indicator 9 – Leadership

NHS Highland and Argyll and Bute Council had a shared vision for services for older people and had an agreed model for integration of health and social work services. They were building working relationships throughout the Partnership. Integration planning was progressing.

A joint management structure was being implemented and a governance structure was being established. Senior managers and staff were working with partners to progress locality commissioning structures. Senior Partnership managers were engaging with other partners such as the third and independent sectors, local communities, service users and carers. They were identifying assets to develop locality commissioning. However, progress was at an early stage.

Leaders needed to communicate better about plans for health and social care integration. More work was needed to make sure that all staff understood the vision and priorities. While we saw evidence of joint working across the Partnership, the management of change needed to become more effective.

Quality indicator 10 – Capacity for improvement

The Partnership had many areas of strength. For example, we noted that staff were well motivated and jointly working together to deliver good outcomes for service users and their carers at a local level. We also found a commitment to realise the potential contribution from within the community to help service users and their carers. Leaders had identified the future challenges in delivering joined up services for service users.

However, we also noted areas for improvement. The Partnership needed to improve services for service users and their carers by reducing the delays in discharging people from hospital. It needed to improve the carers' assessment process, and access to independent advocacy services. This would help enable better access to services for carers and for those that they cared for.

The Partnership needed to develop a better approach to reablement which could demonstrate positive outcomes for service users and their carers. Other areas for future improvement included working towards better geographical equity of services, better care planning, chronologies, risk assessment and management.

Joint workforce planning was needed to support health and social care integration. This would better help support sustainable staff recruitment and retention so that there was sufficient capacity and a suitable skills mix to deliver high quality services for older people and their carers.

Taking forward joint strategic commissioning in cooperation with NHS Greater Glasgow and Clyde and other providers would assist in setting the overall direction of services to deliver good outcomes for services users across Argyll and Bute.

Evaluations and recommendations

We assessed the Argyll and Bute Partnership against nine quality indicators. Based on the findings of this joint inspection, we evaluated the Partnership at the following grades.

Quality indicator	Heading	Evaluation
1	Key performance outcomes	Good
2	Getting help at the right time	Adequate
3	Impact on staff	Adequate
4	Impact on the community	Good
5	Delivery of key processes	Adequate
6	Policy development and plans to support improvement in service	Adequate
7	Management and support of staff	Adequate
8	Partnership working	Adequate
9	Leadership and direction	Adequate

Evaluation criteria

Excellent	Outstanding, sector leading
Very good	Major strengths
Good	Important strengths with some areas for improvement
Adequate	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

No.	Recommendations for improvement
1	The Partnership should put further measures in place that help deliver on the Scottish Government delayed discharge targets to make sure older people return to their own home or a homely setting in which their needs are better met.
2	The Partnership should develop and improve its approach to reablement across Argyll and Bute which could demonstrate positive outcomes for service users and their carers. This should be supported with an outcomes framework capable of producing effective, performance improvement data.
3	The Partnership should work further with the carers' centres to improve how information about carers' needs are shared between carers' centres and social work staff so that carers have better access to services for themselves and those for whom they care.
4	The Partnership should work towards improving the geographical equity of services ensuring that pathways for accessing services are more joined up and effective.
5	The Partnership should ensure that all relevant case records contain accurate chronologies and, where appropriate, have written risk assessment and risk management plans in place so that people's care needs are better assessed and planned for.
6	The Partnership should ensure that plans to support vulnerable older people are updated and training is provided for staff in hospitals and that alternative places of safety are found to ensure that older people can receive the right support at times when they most need it.
7	The Partnership should enable a wider range of client groups to access independent advocacy services. This should ensure the most vulnerable people are supported through complex and challenging life events to express their own views as far as possible.
8	The Partnership should make sure that the future joint strategic commissioning plan gives detail on: • how priorities are to be taken forward and resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • full and detailed costed action plans including plans for investment and disinvestment based on identified future needs, and • expected outcomes.
9	The Partnership should complete and deliver a joint workforce strategy to support health and social care integration. This should include a clear workforce plan to support sustainable recruitment and retention so that there is sufficient capacity and suitable skills mix to deliver high quality services for older people and their carers.
10	The Partnership should update, in cooperation with NHS Greater Glasgow and Clyde, the service specification of their service level agreement to clarify issues such as financial governance and quality assurance measures.

11	The Partnership should update its consultation, engagement and involvement policies and procedures with stakeholders and ensure that these are fully implemented. This should include better engagement on: • its vision and objectives • integration pathways • service redesign • supporting improvement and change management • realising the full potential of the third and independent sectors, and • providing feedback on how the results of consultations have been considered, and the subsequent actions resulting from the views of stakeholders.

Background

Scottish Ministers have requested that the Care Inspectorate and Healthcare Improvement Scotland carry out joint inspections of health and social work services for older people. The Scottish Government expects NHS boards and local authorities to integrate health and social care services from April 2016. This policy aims to ensure the provision of seamless, consistent, efficient and high quality services, which deliver good outcomes[1] for individuals and carers.

At the time of inspection, Partnerships across Scotland were establishing transition arrangements, and each was producing a joint integration plan, including arrangements for older people's services. In addition, Partnerships had to produce a joint strategic commissioning plan. We will scrutinise how prepared Partnerships are for health and social care integration. It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

The purpose of this report is to evaluate the progress that the Argyll and Bute Partnership was making towards joint working, and how that progress was impacting on outcomes for older people who used services and their carers. The Argyll and Bute Partnership includes principally Argyll and Bute Council and NHS Highland and is referred to as 'the Partnership' throughout this document.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (see Appendix 1). Our findings on the Argyll and Bute Partnership's performance against the 10 quality indicators are contained in the 10 separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver very good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector[2] to deliver positive outcomes for service users and their carers.

1 The Scottish Government's overarching outcomes framework for health and care integration is centred on, improving health and wellbeing, independent living, positive experiences, improved quality of life and outcomes for individuals, carers are supported, people are safe, health inequalities are reduced and the health and care workforce are motivated and engaged and resources are used effectively.

2 The Third Sector comprises community groups, voluntary organisations, charities, social enterprises, cooperatives and individual volunteers (Scottish Government definition).

The inspection teams were made up of inspectors and associate inspectors[3] from both the Care Inspectorate, Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors, who were carers, and Healthcare Improvement Scotland's public partners on each of our inspections.

Our inspection process

Phase 1 – Planning and information gathering

The inspection team collates and analyses information requested from the Partnership and any other information about the Partnership sourced by the inspection team before the inspection period starts.

Phase 2 – Scoping and scrutiny

The inspection team looks at a random sample of health and social work records for around 100 people to assess how well the Partnership delivers positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. A staff survey is also carried out.

Phase 3 – Reporting

The Care Inspectorate and Healthcare Improvement Scotland jointly publish a local inspection report. This includes evaluation gradings against the quality indicators, examples of good practice and any recommendations for improvement.

To find out more go to: **www.careinspectorate.com** or **www.healthcareimprovementscotland.org**

The Argyll and Bute context

Argyll and Bute is situated in the west of Scotland and is bounded by the urban areas of Helensburgh and Dunoon along the Clyde, Loch Lomond to the east, the Mull of Kintyre to the south, Atlantic Islands to the west, and the Sound of Mull and Appin to the north.

The area's population of 89,590 is spread across the second largest local authority area, by land mass, in Scotland. It has the third sparsest population density of any Scottish local authority. Nearly 20% of Argyll and Bute's population live on islands. Overall 80% of Argyll and Bute's population live within one kilometre of the coast with 55% of them living in settlements smaller than 3,000 people.

3 Experienced professionals seconded to joint inspection teams.

The changing demographic profile indicates that the proportion of the population of pensionable age will increase by 10% over the next two decades alongside an increase of 73% in the population aged 75 years and over. The ageing population profile in Argyll and Bute brings with it opportunities, with health and social care a prominent employment sector throughout the area. Forty per cent of employee jobs in Argyll and Bute were in 'public administration, education and health'. The care sector offers growth potential for both independent and third sector business. There are challenges too with the traditional working age population reducing.

The Scottish Index of Multiple Deprivation identified 10 data zones in Argyll and Bute as being in the 15% most overall deprived data zones in Scotland. These 10 were all located in towns (Helensburgh, Dunoon, Rothesay, Campbeltown and Oban).

Argyll and Bute is divided into four localities, which are used for service planning. These are Bute and Cowal, Helensburgh and Lomond, Oban, Lorn and the Isles and Mid-Argyll, Kintyre and the Islands.

The Argyll and Bute Partnership has to meet the considerable challenge of delivering health and social work services to remote and island communities. This is against a backdrop of meeting the needs of an ageing population and managing rising expectations of service provision from patients, service users and carers.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Good

The Partnership performed well compared to national trends on preventing avoidable admissions of older people to hospital. Its performance on ensuring the timely discharge from hospital of older people who were medically fit for discharge varied. The balance between hospital and community care was good, with most older people supported at home, compared to the proportion supported in care homes.

There was a positive preventative approach to providing care and support to service users. This helped to reduce the need for admission to hospital, supported discharge from hospital as well as supporting service users to remain at home. Reablement, respite and care at home services were having, in the main, a positive impact in helping older people maximise their quality of life. However, there was room for improvement in the availability of these services.

Enabling choice for service users and their carers was growing with steady progress being made in the offering of self-directed support. Overall services were delivering good outcomes for service users, helping them to maintain their independence, their ability to manage and live at home or in a homely setting.

In this section we look at a range of local and national data to assess the Partnership's performance in respect of key outcomes for older people. For example, over time, we would expect to find that fewer older people had an emergency admission to hospital. Where older people had been admitted to hospital, we would expect to find fewer had their discharge delayed. We also looked at how the Partnership provided services to support older people at home or in a homely setting, and how the Partnership was improving the health and wellbeing outcomes for older people and their carers.

1.1 Improvements in Partnership performance in both healthcare and social care

Emergency admission to hospital

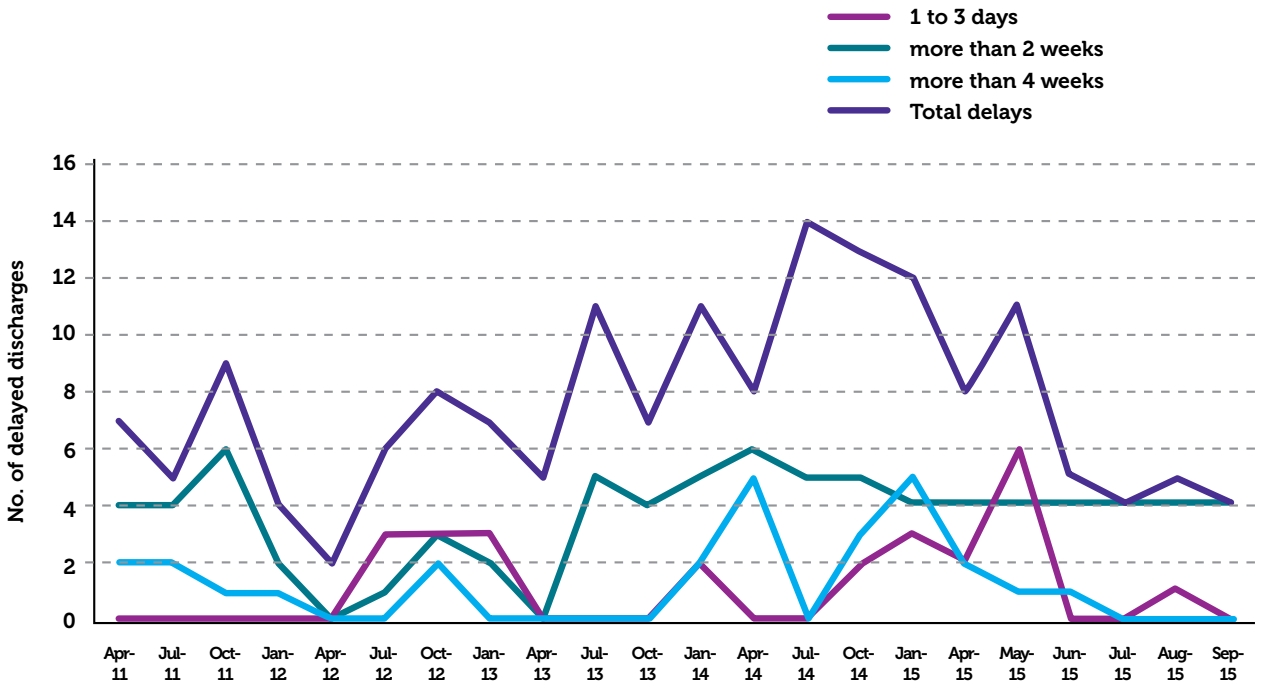
An emergency admission is 'when admission is unpredictable and at short notice because of clinical need'. The Partnership was performing better than the Scotland average in the levels of emergency admissions, multiple emergency admissions and bed days occupied by patients aged 65 years and over for older people subject to an emergency admission.

There was also a positive reducing trend for emergency, including multiple, admissions of older people and bed days lost to these admissions. However, our staff survey found that there was room for improvement. Less than a third of respondents, agreed that there was a broad range of services available to offer alternatives to hospital provision.

Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. The experience of having their discharge delayed can be very distressing for an older person. An unnecessarily lengthy stay in hospital can result in significant loss of confidence and capacity for self-care. This jeopardises the possibility of the older person returning home to live independently.

Figure 1: Numbers of Argyll and Bute (standard) delayed discharges by length of delay/ performance against Scottish Government targets 2011–2015



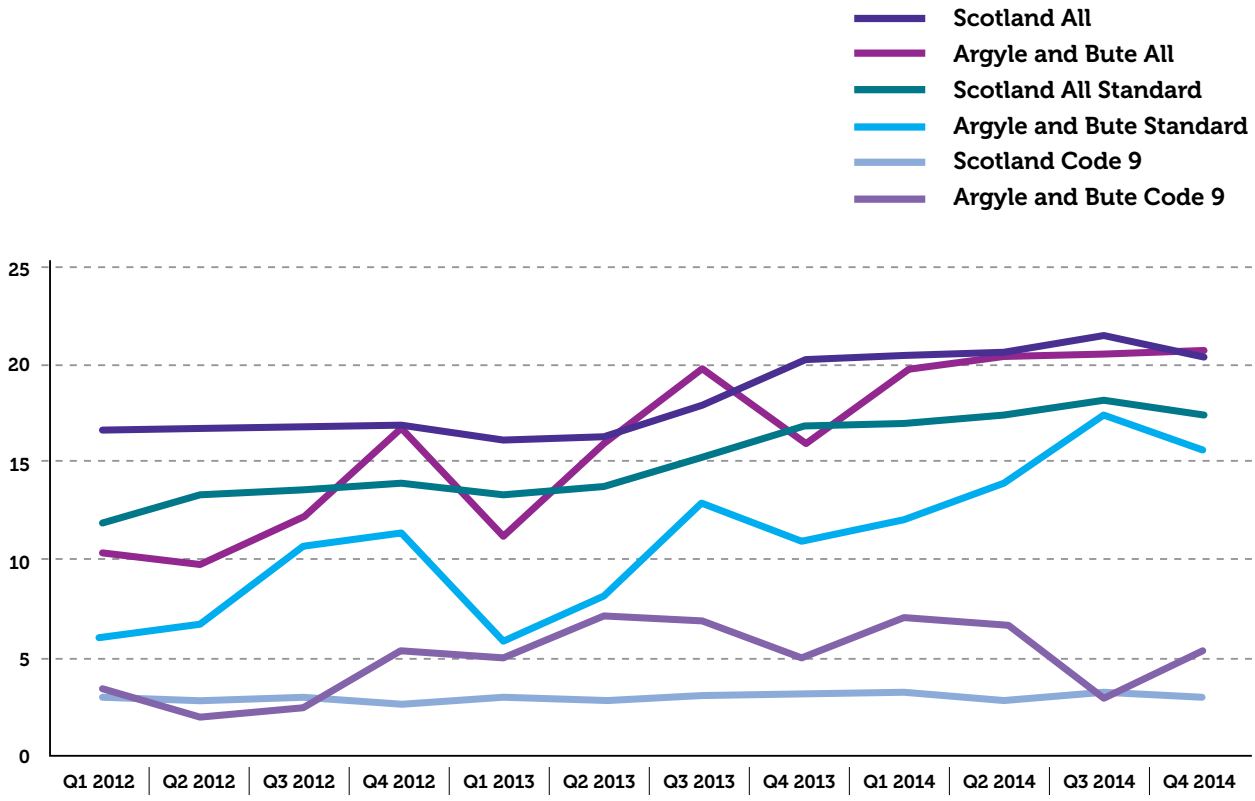
Source: Information Services Division

In April 2015, the Scottish Government strengthened its target for delayed discharges, in that there should be no delayed discharges over two weeks' duration. Before this, the target had been four weeks. There is evidence that the longer an older person spends in hospital when they do not need to be there, the harder it becomes to discharge them home or to an appropriate setting.

There were relatively few delayed discharges recorded by the Partnership. However, figure one shows that, overall the Partnership's performance on preventing delayed discharges against the current and the previous Scottish Government targets was inconsistent.

Figure two shows that, over time, the Partnership lost fewer bed days to all delayed discharges and standard delays, compared to the Scotland average. However, there was a rising trend of beds days lost for both of these indicators.

Figure 2: Numbers of bed days lost to delayed discharge, rate per 1,000 population aged over 65 years, 2012–2014 (Argyll and Bute and Scotland)



Source: Information Services Division

The most common reason for delayed discharge was because of the allocation and completion of community care assessments. Another common reason for delayed discharge was patients who were waiting to go home but were unable to do so because there was no care at home service immediately available.

Frontline health and social work services staff we spoke with mentioned the difficulties with timescales for assessment completion and unavailability of care at home as a causal factor of delayed discharge. Another common reason for delayed discharge was patients who were waiting on a care home place becoming available. Health and social work services staff said that individuals could spend a lengthy period in hospital while they waited for a vacancy in the care home of their choice, in the location of their choice. GPs managed many of the admissions to community hospitals which had a positive impact for patients in continuity of care both as an inpatient and in the community. However, we also noted that community hospitals were sometimes used as a temporary solution when an individual could not return home due to lack of community staff to support them at home.

Bed days lost to code nine[4] delays fluctuated above and below the Scotland average levels. Some of the health and social work services staff we met advised that a few individuals, who lacked capacity, experienced lengthy delays, while powers (in line with the Adult with Incapacity (Scotland) Act 2000) were obtained from a court to move them from the acute bed to a care home. The use of this legislation is important as it supports timely hospital discharges and protects the patients' rights.

Frontline health and social work staff told us there could be insufficient mental health officer capacity to carry out the work necessary to secure welfare guardianship powers from a court. This was a causal factor for some of the lengthiest delays. We heard from frontline staff about patients whose discharge was delayed over six weeks waiting for guardianship orders (code nine). They were unable to use section 13ZA[5], of the Social Work (Scotland) Act 1968, as a guardianship application had already commenced. Some health managers considered that at times Section 13ZA could have been used more effectively to discharge individuals, who lacked capacity, from an acute bed to a permanent place in a care home. Clinical leads were concerned that guardianship orders could take a number of months to complete.

Recommendation for improvement 1

The Partnership should put further measures in place that help deliver on the Scottish Government delayed discharge targets to make sure older people return to their own home or a homely setting in which their needs are better met.

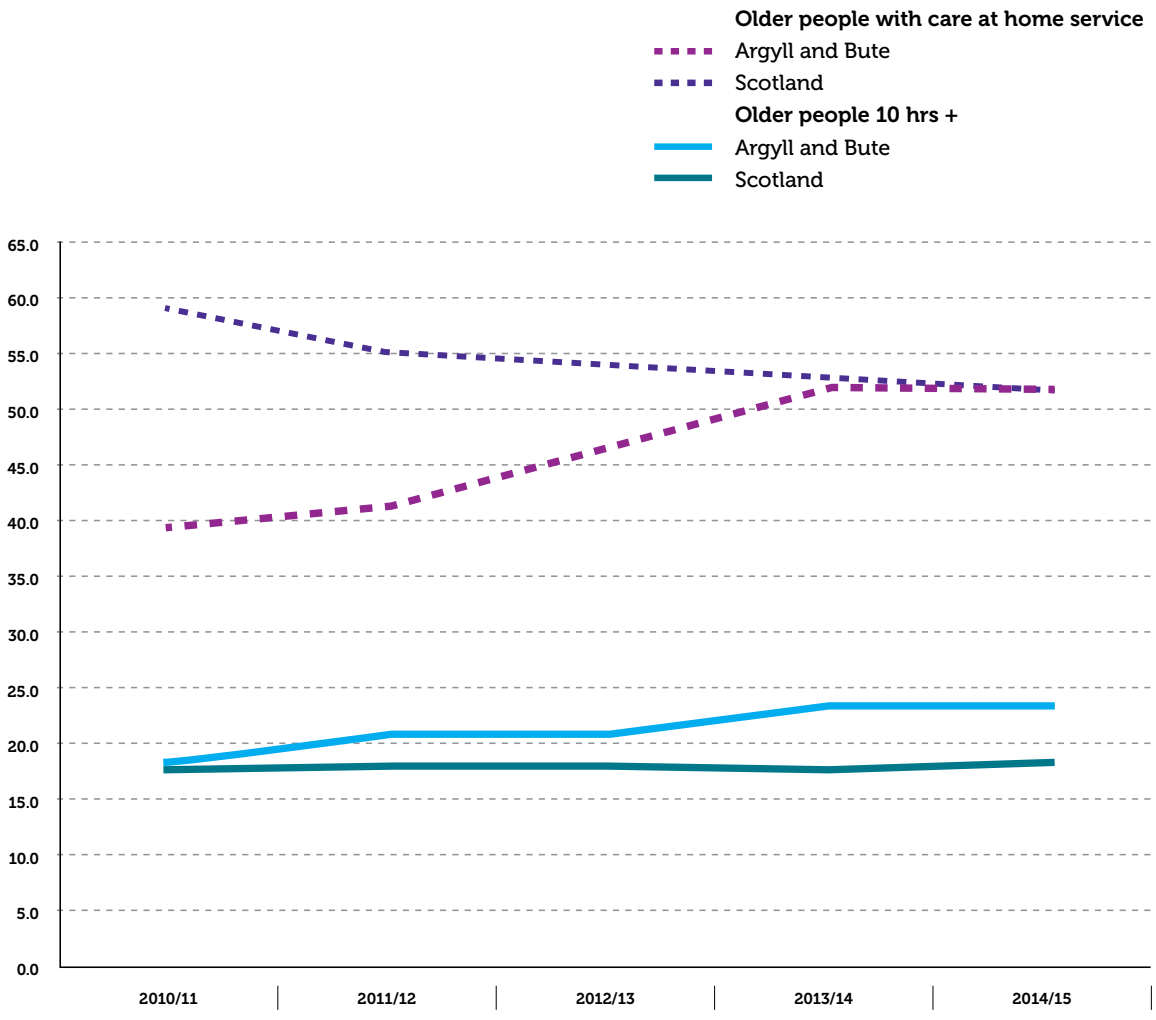
4 Code nine delayed discharges are mainly due to patients who lack capacity and require powers from a court to move them from an acute bed to a care home. Code nine delays can be due to the need to secure a specialist health resource for a patient.
5 Section 13ZA of the Social Work (Scotland) Act 1968 enables the local authority to move compliant individuals who lack capacity.

Provision of care at home services

Care at home is care and support for people in their own home to help them with personal and other essential tasks. It is a key service in supporting older people to remain at home.

Figure three shows the Partnership's performance on overall delivery of care at home services and intensive care at home services to older people. Since 2010, the Partnership delivered care at home services to an increasing number of older people. Since 2011, the Partnership delivered intensive care at home (10 hours plus) to an increasing number of older people too. These improving trends should be viewed against a Scotland average of Partnerships' delivering care at home services to lower levels of older people, and a recent stable Scotland trend for provision of intensive care at home services.

Figure 3: Provision of care at home, 10 hours plus care at home, rate per 1,000 population aged over 65 years, 2010–2015 (Argyll and Bute and Scotland)



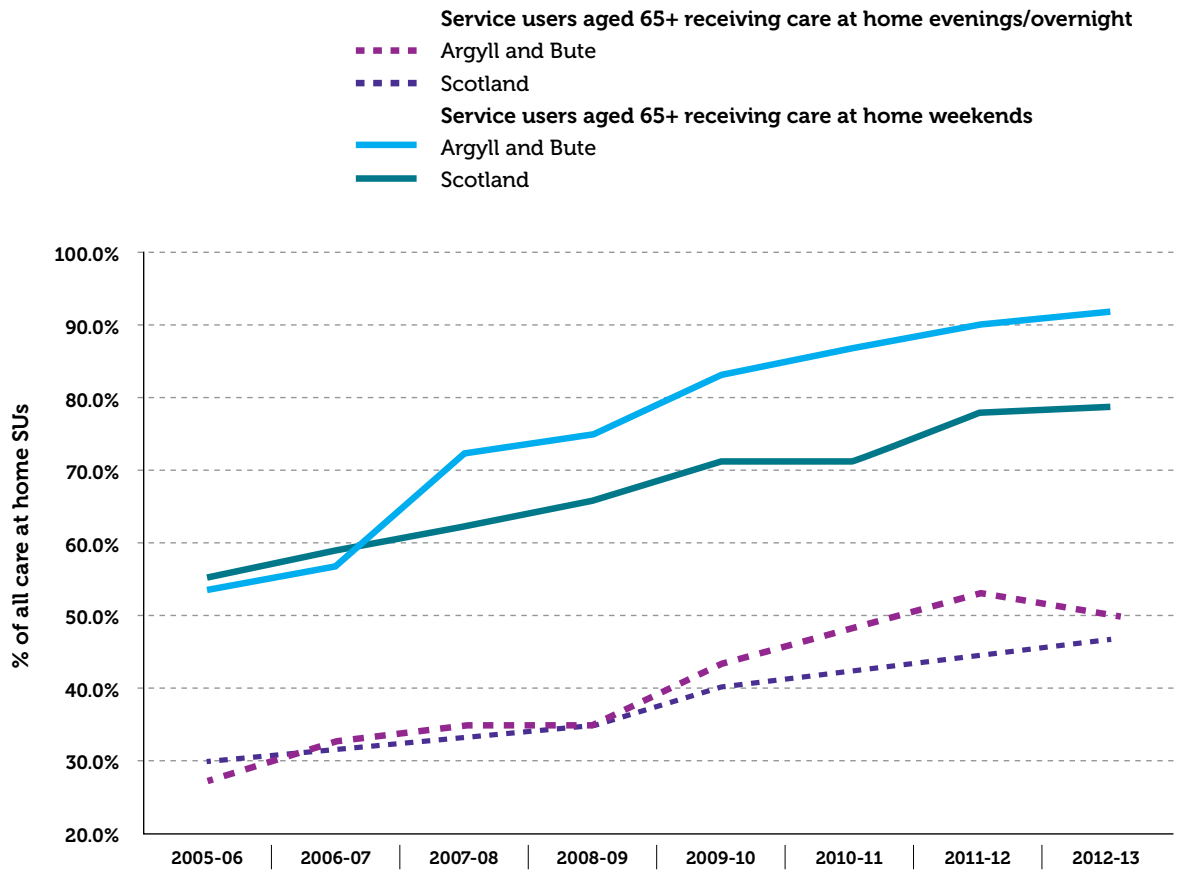
Source: Scottish Government

Unavailability of care at home staff in some locations, (from any sector), was a recurring theme throughout our inspection. Some older people had to wait for the deployment of the care at home staff they required to meet their needs and deliver their desired personal outcomes.

Despite the issues with the availability of care at home staff in some locations, the Partnership was supporting progressively more older people with intensive support needs to live independently at home.

Figure four shows that the Partnership delivered proportionately more 'out-of-hours' care at home services to older people than the Scotland average. Staff, older people and their carers whom we met acknowledged that this provision supported vulnerable older people, with complex medical conditions and complex social care needs, to remain at home.

Figure 4: Service users aged over 65 years receiving evenings/overnight and at weekends care at home as percentage of total 65+ years care at home service users, 2005–2013, (Argyll and Bute and Scotland)



Source: Scottish Government

In summary, the Partnership was performing above the Scotland average in areas such as:

- percentage of care at home service users who were over 65 years
- percentage of care at home service users receiving a service during evenings/overnight
- percentage of care at home service users receiving a service during weekend
- average number of hours received by service users over 65 years receiving free personal care, and
- number of care at home care clients receiving community alarm/telecare.

The Partnership was performing less well, compared to the Scotland average, in areas such as:

- total number of care at home hours per population rate over 65 years
- number of care at home service users receiving personal care as a percentage of all home care clients over 65 years, and
- average care at home unit costs.

Most of the health and social work services staff we met said that there was an adequate level of care at home provision for individuals. However, a few health and social work services staff and families of service users we met with said that there was sometimes insufficient care at home provision to meet the needs of people at the time when the service user wanted the service.

Sometimes the service had difficulties in providing care for people at times when they needed it as they did not have the requisite number of staff, particularly when the person needed two staff for personal care. Staff told us the impact of this was that some people had to wait for the care at home support they needed and the patients' discharge from hospital was delayed.

Care at home managers told us teams often struggled to provide the right level of support for older people when it was needed. As a result, some individuals had their care delivered by more than one service provider. This made it difficult for teams to maintain continuity of care and promote personal choice. Provision was mainly service led, based on time allocation, as compared to user outcomes and the Partnership recognised that this had to change.

Care at home procurement officers told us that they had become, in some instances, care mangers by default. As demand pressure on assessment and care managers, such as social workers was so great, there would have been additional waiting times for a service if they had not intervened. They said they did not have the appropriate training for this impromptu role. The Partnership recognised that new ways of working were required in the care at home sector. It had established a strategic care at home group with the participation of Scottish Care (an independent sector provider representative organisation) and The Institute for Research and Innovation in Social Services (IRISS) to carry out a major review.

We met with a number of service users who were very satisfied with the care at home services they received. They told us that their needs were, in the main, met. We also met carers who were generally satisfied with the amount of care at home that the person they cared for received, even when the care at home support provided was relatively low. In addition, the community meals service helped enable older people to live independently in their own home. The Partnership performed at around the Scotland average level in the delivery of this service.

Reablement and intermediate care

Reablement is the delivery of intensive and specialist care at home support, often combined with intermediate care services such as physiotherapy, occupational therapy and rehabilitation. This is normally delivered for a prescribed period of up to six weeks and it aims to help people regain confidence, and focuses on skills for daily living. It can enable people to live more independently and reduce their need for ongoing services and supports. Reablement services are often delivered with intermediate care services.

Reablement was delivered by the Extended Community Care Teams. These teams helped support older people to return to their own homes when deemed medically fit for hospital discharge. The service was predominantly health-led although we were told that health support workers had generic roles to support services such as community nursing, care at home and occupational therapy. In some of the localities in-reach support was provided by social work staff.

These multidisciplinary teams were very much health focused with limited social work input. Extended Community Care Teams did provide effective reablement to some older people following a hospital admission or a crisis at home. However we found that Extended Community Care Teams were not able to fully deliver on the reablement approach as much of their time was spent delivering care at home services. This significantly restricted their capacity to deliver on reablement.

We concluded that there was a lack of strategic direction for reablement services. Reablement practice and the level of provision duration of each reablement episode varied between localities. Extended Community Care Team staff estimated that 20% of their time was employed in delivering reablement. Differing Extended Community Care Teams estimated that between 60–70% of their capacity was taken up in delivering care at home services particularly when there were delays in social work services deploying care at home services. The remainder was generally allocated to physiotherapy tasks.

Frontline staff and managers felt this was impacting on the teams' capacity to deliver on preventative work. Furthermore, staff told us that the concentration on personal care had prevented them from developing skills in reablement. Very limited information was available on the outputs or outcomes of reablement. The Partnership was unable to provide us with any aggregate activity or outcome data for older people who had a reablement episode. As a result, it was hard to measure the impact reablement activities had on preventing admission to hospital and supporting independence. Some local efforts were under way to gather information.

Some frontline health staff expressed concerns about the capacity and capability of private sector care at home service providers to take on reablement tasks. Some frontline social work staff were unclear about how reablement would progress in remote and island community settings when skills were in short supply. Senior managers acknowledged that reablement had not been as much of a success to date as it could have been and that there needed to be a new approach to reablement. The reablement service needed to involve a greater range of providers including cross sector care at home service providers.

This was a significant stress point in the care system in Argyll and Bute. The unavailability of a fully integrated reablement service had led significant resources to be diverted to care at home services. The establishment of a fully integrated reablement service could have led to substantial off setting for demand for care at home services. This could allow a commensurate resource release to help support overall service delivery.

There was a lack of a clear, coherent, jointly agreed approach for how reablement should be developed in each of the four localities. Health and social work services managers acknowledged this was an area for improvement. A draft reablement strategy was in preparation and additional resources were being allocated from the Integrated Care Fund to support its development. The Scottish Government had provided additional resources to Partnerships to support investment in integrated services in the form of an Integrated Care Fund. This fund was not restricted to older people, but extended to include support for all adults with long-term conditions.

Recommendation for improvement 2

The Partnership should develop and improve its approach to reablement across Argyll and Bute, which could demonstrate positive outcomes for service users and their carers. This should be supported with an outcomes framework capable of producing effective, performance improvement data.

Intermediate care can include a wide range of short-term interventions or rehabilitative services which will help promote independence, reduce the amount of time someone might spend in hospital, or help to avoid unnecessary admissions to hospital. Intermediate care can be provided in hospital, people's homes or in services such as a care home or day centre.

Step-up care aims to avoid unnecessary hospital admissions and step-down care aims to support early supported discharge. Senior managers told us that the lack of a formal framework on step-down care presented a challenge. As no permanent step-down beds were available, this had resulted in the transfer of service users from hospital beds to care home beds without the opportunity of rehabilitation in an interim supported setting. The Partnership was working with care home providers in Oban and Dunoon to pilot step-down facilities to help reduce the number of older people waiting in hospital when they were medically fit for discharge.

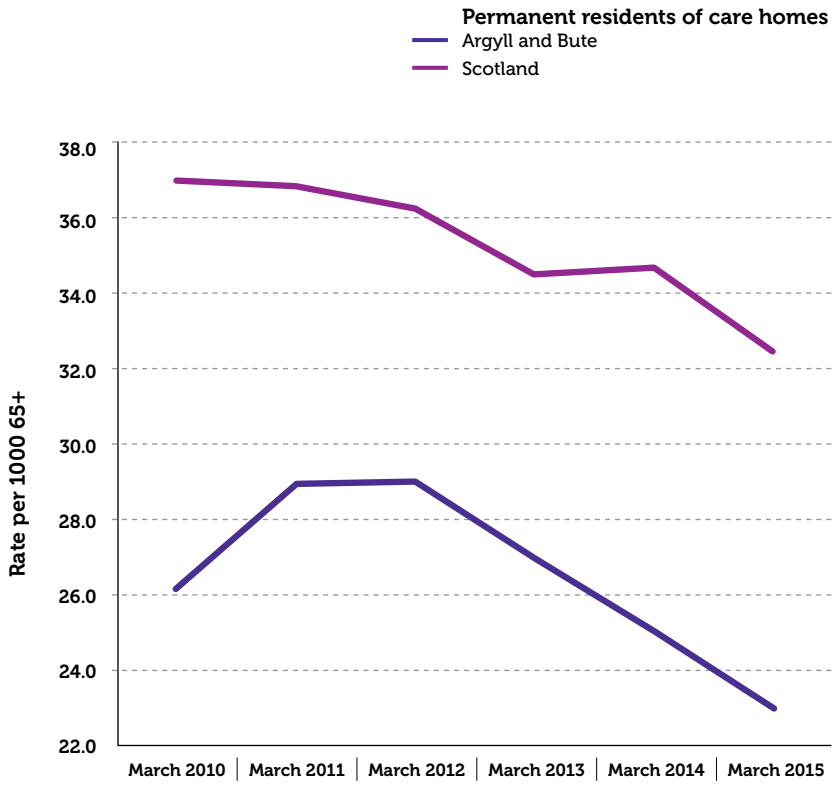
Senior managers advised us that funding had been secured to develop step-up and step-down services. It was anticipated that the service would be commissioned in each locality. A formal framework was expected to be in place by winter 2015. Some health staff told us they saw an opportunity for the Partnership to reduce GP hospital beds once they introduced step-up and step-down beds in care homes. They told us that GP beds were sometimes used in the absence of alternatives. This was counter-productive to enabling older people to improve their wellbeing.

Care home places

Figure five shows that the Partnership placed significantly less older people permanently in care homes than the Scotland average. Statistical evidence showed that the Partnership had the best balance of care of any Partnership area in Scotland. This was due to the relatively low proportion of older people the Partnership placed permanently in care homes and the corresponding relatively high proportion of older people receiving an intensive care at home service.

The Partnership was performing at similar levels regarding the complete length of care home residents' stay (aged over 65 years) on entry compared to the Scotland average. The Partnership should continue to monitor the level of care home provision along with the provision of care at home services to help improve its performance (for example in relation to delayed discharges).

Figure 5: Permanent residents (aged over 65 years) of care homes supported by councils (rate per 1,000 population), 2010–2015, (Argyll and Bute and Scotland)



Source: Scottish Government

Community based social work staff told us they felt under pressure from hospital based staff to meet delayed discharge targets. They felt that sometimes tackling delayed discharge was not fully multi-disciplinary although it should have been. Whilst we observed tensions amongst health and social work staff around delayed discharges, our reading of health and social work services records found that in almost all cases there were no delays in the individual being assessed for key services (96% of cases) or in receiving key services following assessment (92%).

In some cases older people were placed in interim care home placements outside the Argyll and Bute area. We were told, by frontline staff, that sometimes it was agreed with families that this was only until a vacancy came up within the Argyll and Bute area. However, due to hospital discharge pressures this vacancy could be prioritised for a person waiting on discharge from hospital making it harder for the person placed outside Argyll and Bute to return to their home area. There were variations in the way that care home services were accessed across Argyll and Bute. Care home resources were not always available in some locations, due to demand exceeding the number of beds available. However, other causes included that some families wanted a particular care home, or no beds were available in their choice of home.

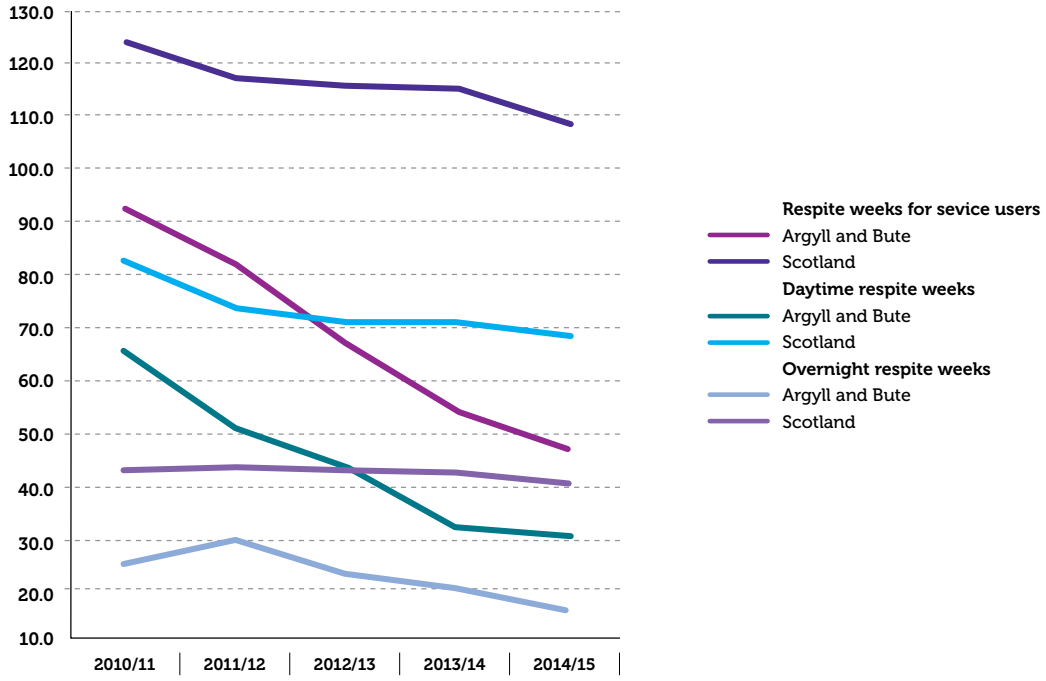
We were told, by frontline staff and managers, that in some instances where a care home was performing poorly, the Partnership had been supportive and provided assistance by having NHS nursing staff directly providing care in those care homes. Whilst this shows the Partnership's commitment to enabling high quality care in a range of settings, the Partnership needed to evaluate the effectiveness of this approach.

Respite care for older people and their carers

Figure six shows that the Partnership's respite provision for older people and their carers was below the Scotland average. There was a significant downward trend in total respite and daytime respite provision for older people. The amount of overnight respite provision had also fallen, but not as sharply as total respite and daytime respite provision. We met a number of carers who cared for older people who said that they benefitted from the respite they and the person they cared for had received.

Some older people and carers told us that respite had not been available to them when they were in crisis. We met a number of carers who cared for older people and older people with dementia, who said it was difficult to obtain respite and that this had a negative impact on their capacity to continue in their caring role.

Figure 6: Respite weeks for service users (rate per 1,000 population aged over 65 years), 2010–2015 (Argyll and Bute and Scotland)



Source: Scottish Government

Social work staff told us that daytime respite was under-used with some day services operating with low levels of occupancy. Some staff said the reason was that referral processes were cumbersome and that the prioritising of need was inconsistent due to differing assessment practices between areas. Another reason given was that day services were now means tested. As a result of these changes to the charging policy, some individuals had chosen to opt out.

Managers told us that residential respite had been limited by bed capacity. However, they felt they were developing more flexible respite at home. Previous commissioning of third sector providers to develop more daytime respite had not been as successful as they had wished. There was a preference, among carers for respite care at home.

The Partnership had recognised the need to review respite care provision and a review was underway. Consultation was taking place with individual carers, carer representatives, carer organisations and the health and social work workforce. The next step was to consult with service providers, service users and other stakeholders. Recommendations for improvement were due in winter 2015. The Partnership needed to use the review to make available more flexible and available forms of respite to meet demand.

Telehealthcare and telecare

Telehealthcare assists the self-management of patients' conditions and may include video-conferencing, remote patients' consultations with healthcare professionals or environmental monitoring devices installed in people's homes. Telecare is equipment and services that support older people's safety and independence in their own home. Examples include community alarms and smoke sensors.

The Partnership provided lower levels of community alarms to older people than the Scotland average. However, compared to Scotland as a whole, it was delivering higher levels of enhanced telecare with approximately 600 enhanced telecare packages. From our review of health and social work services records, there was evidence that telecare, including community alarms, had effectively supported many vulnerable older people to live independently and safely in their own homes.

The majority of referrals to telecare were from occupational therapists for hospital discharges followed by social work referrals. The first six weeks of telecare were free. Very few service users refused to continue with the service.

Community alarms provided a useful reassurance to individuals and their carers that help could be available quickly. However, a requirement that three responders were needed meant that this option was not available to some older people in more remote areas. The council had been innovative by engaging an independent sector provider to enable a response when the required responders were not available. However, this option was not available across all of Argyll and Bute. On occasion, staff had made cross boundary arrangements with neighbouring authorities to cover remote communities where the Partnership did not have an established service.

Performance of regulated services for older people

The Care Inspectorate inspects regulated social care services delivered by local authorities, the voluntary and independent sectors. These services included care homes, housing support services and other support services for older people, for example care at home and day care services.

For each service, the Care Inspectorate awards performance grades on criteria such as the quality of care and support, environment, staff and management and leadership. At the time of inspection, in the main, regulated services were performing well across sectors and provision types.

Overall local authority care homes were performing at 'good' grades in areas such as quality of care and support, environment, staffing and management and leadership. Most, with some exceptions, council care at home and day care services were performing at similar levels. Directly provided housing support services had mostly 'adequate' grades.

On average, third sector care homes were receiving 'adequate' grades in the quality of care and support and environment and 'good' for staffing and management and leadership. Many, with some exceptions, third sector care at home and day care services were performing at 'very good' levels. Third sector housing support services had mostly 'good' grades.

Most independent sector care homes were performing at 'adequate' grades in areas such as quality of care, environment, staffing and management and leadership. With some exceptions, independent sector care at home and day care services were performing at 'good' levels. Independent sector housing support services had mostly 'good' grades.

As a commissioner of services, the Partnership needed to work with regulatory bodies to improve grades particularly in directly provided housing support services, as well as third and independent sector care homes. In the main, in Argyll and Bute, regulated care services delivered good outcomes for service users and their carers. For regulated care services that were not performing well, the Care Inspectorate was working with these services to support the required improvements.

1.2 Improvements in the health, wellbeing and outcomes for people and carers

Outcomes for older people

Outcome-focused assessments and care plans emphasise the desired positive changes the individual wants and the provision of services that are designed to achieve this. Health and social work services delivered a range of positive outcomes for almost all of the individuals who were part of our case record sample. The majority of the service users and carers we met had experienced positive personal outcomes delivered for them by health and social work services. A range of good personal outcomes was being delivered for service users by the Partnership. From our analysis of service users' social work and health records, we concluded that 98% of individuals attained one or more positive personal outcomes. However, it should be noted that 17% had also experienced one or more poor personal outcomes.

We were encouraged to find that 82% of care plans we read were outcome-focused. During our inspection, most service users and their carers told us that, as a result of the health and social work services they received, that they were safer, were living as well as they could be, had good wellbeing and things to do, as well as having friends and relationships. The results of our survey of health and social work services staff (569 staff responded) showed positive results on outcomes. For example:

- 72% agreed that their service works well with other agencies to keep people safe and to protect people from risk of harm
- 68% agreed that their service does everything possible to keep older people at home and in their local communities

- 67% agreed that their service does everything to ensure that older people receive the health care they need when they need it most
- 67% agreed that their service does everything possible to make sure people are supported to live as independently as possible
- 65% agreed that services work well together to ensure that they are successful in helping older people lead as independent a life as possible, and
- 65% agreed that their service works well with its partners in supporting older people and any legally appointed person to be actively involved in the planning of their care.

However, there were less positive staff responses to the questions on services working well together to prevent avoidable hospital admissions with 56% of staff agreeing with this statement. The Partnership had made progress in gathering aggregate data on a number of the national health and wellbeing outcomes[6]. Social work services staff had populated information technology systems with some health and wellbeing outcomes. Social work services staff used the 'Talking Points' framework to gather service users' views on the achievement of these outcomes. The Partnership had plans to extend this data collection to include all national health and wellbeing outcomes. The Partnership's data showed a high proportion of service users reported they felt safe at home, had things to do and greater access to social opportunities and were listened to and were involved in planning their services. A very small proportion of service users reported they experienced stigma or discrimination.

We saw a range of services that helped deliver good personal outcomes in areas such as:

- prevention of admission to hospital
- telecare, and
- care at home.

However, to additionally help deliver good personal outcomes there was room for improvement in areas such as:

- delayed discharges
- reablement, and
- respite.

6 National Health and Wellbeing Outcomes Framework (Scottish Government 2015)

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Adequate

The Partnership's approach focused on outcomes that prevented admission to hospital or to a care home and aimed to decrease social isolation. It aimed to improve wellbeing and health through increased mobility, better self-management and developing support in partnership with individuals and their carers. This approach to earlier intervention and prevention was gathering momentum in some communities. However, staff vacancies meant that delivery of services did not always meet planned support requirements.

The quality and accessibility of anticipatory care planning was improving. However, it was an area requiring further development. The development of the falls prevention was, in part, a success. However, availability of falls prevention services and management of falls was variable across localities and access was not equitable.

Older people and their carers with whom we spoke were generally content with the quality of services they received. The Partnership had worked with the independent sector to increase support to carers and had developed carers' centres in each of the four localities. These were providing valuable services and support to carers. Carers wanted better access to respite care to support them to enable their older relative to stay at home for longer.

Services for people with dementia were generally well delivered. However, some gaps meant that some older people did not always get the diagnostic and post diagnostic support when they needed it. Steady progress was being made in making sure that older people were offered self-directed support. However, the Partnership recognised that assessment processes were cumbersome for both staff and service users and these were under review.

This section looks at whether the Partnership has an integrated approach, at the most appropriate time, to promote and maintain an older person's health, safety, independence and wellbeing. It considers the joint action taken to support an older person's capacity for self-care including those with increased frailty and long-term conditions as well as access and availability of information on care and support.

2.1 The experience of individuals and carers of improved health, wellbeing, care and support

An integrated approach

In the main we found good outcomes were delivered for service users where staff worked together as part of multidisciplinary teams, for example the Extended Community Care Team, and as multi-agency partners. A good range of options was available for older people to help support improved health and wellbeing. A number of self-management groups were in place supported by volunteers. Reshaping Care for Older People[7] implementation groups were taking the delivery of these initiatives forward.

Individuals using telecare and telehealthcare prompts told us about the effectiveness of this approach to help them manage their conditions. Voluntary organisations and volunteers provided good support to people, including befriending. Some service users were able to access support from community groups organised to support self-management of long-term conditions. They told us about the personal benefits they gained from these group activities.

We saw examples of older people being supported to remain in their own homes with appropriate and responsive levels of care and support in place including support to manage long-term conditions. Support from teams such as the Extended Community Care Team helped to support older people to remain at home. In many instances, staff were proud to tell us that older people who wanted to remain in their own home were supported to do that. We were concerned about the longer-term sustainability of the Extended Community Care Teams due to staffing availability. We learned, from Extended Community Care Teams and other frontline staff, of numerous examples of this team having to remain involved with individuals for much longer than needed, due to a lack of available mainstream care at home staff to take over longer-term care packages.

Improving care and support for frail older people

The Partnership had clear processes and protocols in place for admission, transfer and discharge of patients from acute and community hospitals. In the main these processes worked well for individuals. However, a lack of available care at home staff in several locations meant that for some people they had to stay longer in hospital than they needed. This meant that older people who were ready for discharge from hospital were sometimes placed in community hospitals while awaiting for care at home services to be available in the community.

7 Reshaping Care for Older People (Reshaping Care for Older People) is a national policy aimed at balancing care services towards the community .The Change Fund was a Scottish Government resource allocation to health and social work services Partnerships, which aimed to help develop services for older people and their carers using the Reshaping Care for Older People approach.

Older people and their carers told us about good communication between care at home staff and community nursing staff who quickly picked up on changes in an older person's needs. However, communication between care providers when more than one service provider was delivering care and support could be improved. For some individuals, although positive about the quality of care and support they received, they were unaware of how long they would have to wait for assessment for additional care at home services, or in some instances, when equipment would be delivered, or adaptations made, to their home.

Occupational therapy staff told us there were waiting lists for occupational therapy assessments in some areas. No occupational therapists or physiotherapists were available at the weekend to carry out assessments in community hospitals. Instead hospital-based staff referred direct to the Extended Community Care Team. The team's health care workers had been skilled up in assessing older people for equipment and adaptations. Healthcare workers were able to provide emergency equipment to avoid unnecessary admission of the older person to hospital. Acute hospital staff could also make direct referrals to care at home services directly during out-of-hours periods. There were difficulties in Mid-Argyll in the recruitment of occupational therapists and this had caused delays in accessing some services.

Staff told us that delivering some specialist allied health professional services, such as occupational therapy and physiotherapy, was sometimes difficult as some services were delivered by NHS Greater Glasgow and Clyde, not NHS Highland. This had proved a challenge to local teams to sustain sufficient skills to deal with those who cannot access these services, for example, stroke recovery and acquired brain injury.

We found that service users and their carers did not wait for long for the delivery of equipment. However, the Partnership could improve communication on waiting times if there was a delay.

In the main we found appropriate levels of support and a responsive service from the primary care team. However, in some areas there had been long-term vacancies that had remained filled by locum staff. This had led to negative impacts on continuity of care for service users.

Supporting carers

The Partnership had increased access to support for carers through the development of independent carers' centres in each of the four localities. Carers' centres' staff were proactive in supporting carers to access information, advice and support such as respite. Gaps remained in how carers got information and some were not always aware of the options available to them for their own support and support for the individual they cared for. Some carers told us that they were not supported when they wished to return to education or employment.

Carer support workers, from carers' centres, completed carer assessments. They worked with carers to support them to continue in their caring role. Carers' centres had asked carers how well services had supported them. Of those who responded 87% felt it was worthwhile having a carer assessment and 59% said that there had been positives changes for them as a result.

Increased investment in services for carers had increased the numbers of carer assessments completed. However, better sharing of information about carers' needs between carers' centres and social work services was needed. In many cases, carer assessments remained with the carers' service with little information shared with statutory services.

Recommendation for improvement 3

The Partnership should work further with the carers' centres to improve how information about carers' needs are shared between carers' centres and social work staff so that carers have better access to services for themselves and those for whom they care.

Good communication with carers was important. Our staff survey found that 65% of the respondents agreed that the views of carers were taken into account when planning and providing services to individuals. A majority (57%) of respondents agreed that their service worked well with partners to make sure that older people and their carers were provided with full information about any support, care or treatments they required.

Some carers we met were not always involved or informed about care and support plans for the individual they cared for. This was particularly the case when an individual was due to be discharged from hospital. They were often not involved in discussions about whether they were able to meet care and support needs nor informed or consulted about discharge plans. This was most common when service users were being discharged from hospitals outwith Argyll and Bute.

A few carers we met felt that the services that they had been offered had been inadequate or had been offered at the wrong time. For example, they told us that care at home services were less likely to be available when the service user wanted them. They said that one of the reasons this had happened was due to difficulties with the recruitment of care at home workers and staff rotas. Independent advocacy services availability was reported by carers as limited.

From our case record reading we found that 80% of carers had not been given relevant information or advice on equipment or adaptations. Only one in 10 had attended training organised by health or social work services. However, we noted Macmillan cancer nurses were actively engaged with carers' centres to deliver training to carers.

Access to respite was important to carers and the person they cared for. Some carers we met told us that they could not always get respite near to where they lived or in a place that was familiar to the person they cared for.

This sometimes meant that they felt that the disruption to the older person's usual routine was not helpful to them. The availability of respite care both during the day and in residential services was reducing, and carers were feeling the impact of this. This was particularly so with unplanned respite. They often had to wait a long time for respite or confirmation of a place came to them too late to be able to plan a break. Some carers were beginning to use self-directed support as a way of organising and guaranteeing good quality respite at a time that suited them.

2.2 Prevention, early identification and intervention at the right time

Supporting people with long-term conditions

A challenge for the Partnership was meeting the needs of an increasing number of people living with long-term conditions. Having a better understanding of their long-term conditions helped people understand their symptoms and experiences, and improved their long-term health and wellbeing.

The role of health and social work professionals was to build peoples' self-confidence and their capacity for self-management, and to support them to have more control of their conditions and their lives. The Partnership had invested in community outreach workers to develop community resilience and capacity for self-management. A number of valuable projects were being developed to provide peer and social support to older people and their carers. Some of these projects were being supported long term through reallocation of resources from hospital-based care services.

We found that 97% of the people whose records we read were being supported in some way to self-manage their health condition. This included signposting to other support available in the community. Befriending services were core to a number of these initiatives.

'Living it up' was a website that gave easy access to information about the community groups running in each locality. Although this website covered the whole of Scotland, staff in Argyll and Bute had been proactive in making sure that the local section and local information was up-to-date. The website gave individuals a good range of information about groups and activities that would enable their participation in meaningful activity, help reduce isolation and improve wellbeing.

The Partnership's Joint Improvement Plan had identified that more work was needed to encourage engagement and were developing an action plan to improve self-management programmes for people with long-term conditions. This was reflected in our staff survey where 62% of respondents agreed that the service worked well together to support people's capacity for self-care/self-management.

However 32% of respondents agreed that older people were able to access a range of preventative and enabling services that suited their needs when they needed them.

Service users told us that they found self-management support enabled them to remain well at home. They thought more should be done to increase the number of self-management groups. Many of the service users we spoke with in self-management groups were positive about how they had been signposted to a helpful activity by staff at a time of diagnosis. We noted the enthusiasm of the third sector to engage in joint working to address issues such as long-term conditions.

Self-management services were not always accessible to people living in more remote areas and travel was challenging for people with long-term conditions. The Partnership had commissioned community transport services in some areas but this was not always available. The Partnership should ensure that the impact of a lack of access to transport is included in any planned improvements.

Pharmacists were involved in completing medication reviews as well as assessing an individual's ability to take medication themselves. The Partnership was working with health and social work services staff to address gaps in medication support. Inspectors from the Care Inspectorate had recently made a requirement that the council's care at home service provide medication training to relevant staff. Although a medication policy specifically for care at home staff had been developed, we were unclear when this would be implemented and rolled out across the service. NHS staff were awaiting approval of the medication policy. This would inform the roll out of training to care at home staff including council in-house services.

Implementing Scotland's National Dementia Strategy 2013–2016

At the time of the inspection, key Argyll and Bute strategies, such as the carers' strategy and dementia strategy, were both being refreshed. These included commitments to improving outcomes for service users and their carers. These strategies put individuals and communities at the centre of service planning and delivery. The Partnership was at the early stage of implementing its own draft dementia strategy which was based on Scotland's national dementia strategy.

The local strategy had set targets for improvement by the end of the first year of the plan (March 2016). Outcomes from the draft Argyll and Bute Dementia Strategy were based on the 'Standards of Care for Dementia in Scotland'[8]. It aimed to improve dementia awareness and knowledge, improve community inclusion, deliver early diagnosis and support and promote living well with dementia.[9] There were three locality multi-disciplinary community dementia teams. These usually consisted of a social worker, dementia link worker, community psychiatric nurse, occupational therapist and administrative support in addition to consultant psychiatrist and day care manager. However, due to staff vacancies this was not always the case.

8 Scottish Government Standards of Care for Dementia in Scotland: Action to support the change programme, Scotland's National Dementia Strategy (2011).
9 Dementia Friendly: Draft Argyll and Bute Strategy 2015–2018.

We found that many of the good personal outcomes that had been achieved for individuals had subsequently been adversely impacted by gaps in staffing. Screening for dementia by psychiatric services was supported by active third sector involvement through post diagnostic support workers, NHS community psychiatric nursing services and mental health team occupational therapists. Partnership staff were very positive about the level of support provided post diagnosis. A dementia nurse specialist was also providing support to care home staff to help them manage the stress and distress experienced by individual residents diagnosed with dementia.

However, vacant posts in the community mental health team and long-term absence of consultant support had led to a reduction in the quality of services. This included reduced medication reviews and lack of available support from specialist dementia workers. Access to psychological therapies was described as poor by frontline staff. 'Dementia champions' were training care home staff to help improve understanding of the care of people with dementia. Not all staff trained as 'dementia champions' had previous experience of working with people with dementia. This reduced the potential positive impact of their role.

One hospital in Lochgilphead had a dedicated dementia assessment ward. This meant that some individuals had to travel large distances to receive services. Hospital-based health staff reported that there were communication challenges with social work due to differences in the way that different localities worked. Some frontline staff reported that there was a 'surplus' of residential care home beds and a lack of locally available nursing care and dementia beds. This had led to use of out of area placements. Day care provision levels for older people with a diagnosis of dementia was reported by staff to have geographical services gaps. This was attributed by managers to economies of scale and the diverse nature of the communities. We would encourage the Partnership to ensure that services were designed to meet local need and promoted equity of options in the remote communities.

We noted from statistical evidence that the Partnership performed above the Scotland average in diagnosis of dementia. However, we also noted there had been a decline in performance in recent months due to staff capacity issues. This was with the exception of Helensburgh area. This locality had different arrangements with an older people psychiatry service level agreement with NHS Greater Glasgow and Clyde. This had enabled them to achieve more timely diagnosis and earlier intervention of post diagnostic support.

Community Dementia Teams identified areas such as transport, (support to travel to access services) lack of community-based therapies for people aged over 65 years, staff availability, (for example GP/consultant locums) to deliver diagnosis and clinics, particularly on islands, as problems in service delivery. Several GPs were reluctant to diagnose dementia. This, coupled with the gaps in psychiatric assessment, meant that diagnosis and treatment was beginning to be delayed.

Example of good practice – Community Dementia Teams

These teams were established through effective collaboration between the statutory health and social work services and Alzheimer Scotland. They were delivering care to individuals, families and communities in some of the remotest areas of Scotland.

They provided direct support to those who require the services and also worked with other professionals and organisations to improve the recognition, knowledge, care and support for people affected with dementia. Their work made sure that people's dignity and independence was maintained and that they could remain within their families and their communities for as long as possible.

The specialist flexible service supported individuals and their carers to live well with dementia. This partnership approach was achieved by the development of good working relationships across health and social work at local and strategic levels.

The teams enabled members of each discipline to work together in a flexible way with partnership working that allowed for a sharing of resources, information, knowledge and training giving greater access to all staff in a variety of areas.

Not all GPs were trained in diagnosis of dementia which was carried out by some GPs with others seeking diagnosis from a consultant psycho-geriatrician. These variations meant that accessing services could be delayed due to differing practice depending on where an older person lived. A high turnover of consultants in some areas also hindered access to diagnosis.

Alzheimer Scotland advisors provided practical information and advice. Joint working with Alzheimer Scotland had the potential to deliver positive support to people in the community. Over 100 staff had participated in 'dementia informed' training. We heard about positive initiatives such as Marie Curie's 'Helper Model'. This model trained and supported volunteers in dementia care and the development of 'age friendly' shops and businesses in 'dementia friendly' communities.

Access to assessment and support in island communities was particularly under developed. This meant that post diagnostic support workers were seeing older people at a more advanced stage of dementia. This was reflected in our staff survey where:

- 51% of respondents agreed that the service worked well together to enable people with long-term conditions and those with dementia to remain active
- 41% of respondents agreed that their service did all it can to make sure that older people receive a timely diagnosis of dementia, and
- 37% of respondents agreed that older people were able to timely access post diagnostic support.

We met with some carers of people with dementia. They told us that they did not always feel supported by staff when trying to support their relative at home. Sometimes they were not offered choice of support options and were directed to consider a care home as the best option. When older people with dementia were admitted to hospital, sometimes their families did not feel listened to, even when power of attorney or other powers were in place for them. Consultation on service development included the local service user 'Stirrers Group'. This was a group of local people who represented some service users and commented on services.

Anticipatory care planning

An anticipatory care plan anticipates significant changes in an older person's health and social care needs and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals. Anticipatory care planning is more commonly applied to support those living with a long-term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well.

GPs, community and Macmillan cancer nurses, were increasing the number of anticipatory care plans they completed. However, there were variations in GP practice where some GPs were completing anticipatory care plans while others did not. Some of the health staff we spoke with (such as community nurses) said that these plans had directly prevented a number of older people from experiencing an admission to hospital. This positive approach would be improved if more information from the anticipatory care plans was shared. For example, social work staff could not access anticipatory care plans from the GPs' information technology system. Access to these plans was limited. There was uncertainty among frontline health staff that had the lead officer role. In addition, anticipatory care plans were single agency (health) plans, with very limited contributions from social work services.

We found that anticipatory care plans as an area requiring development. We found few plans when we reviewed individual case records. We heard from health staff that they were often completed without adequate consultation with the service user, their family or care home managers.

We heard from frontline staff that anticipatory care plans were not always consistently completed with different levels of recording in different care sectors. The plans were also part of polypharmacy reviews[10]. Pharmacy staff confirmed that GPs and district nurses made regular referrals to pharmacists when anticipatory care plans were completed. Staff felt that this worked well. However, the process for identifying those needing an anticipatory care plan could be improved. Pharmacists had recognised an opportunity to review the anticipatory care plans alongside poly pharmacy reviews routinely held at discharge from hospital.

10 Polypharmacy – the use of multiple medications.

Unscheduled admissions of older people to hospital can be related to medicines issues. Pharmacists effectively carried out poly-pharmacy reviews for older people who had been prescribed multiple medications and who were at risk of an unscheduled admission to hospital.

Pharmacy technicians were providing valuable support in the community. Referrals were being received from hospital wards, GPs and social workers. The numbers of referrals in all areas was growing. The technicians had established good relationships with care providers across Argyll and Bute.

We were told by frontline staff that anticipatory care plans were routinely completed for people with a terminal illness. However, information from anticipatory care plans was not always accessed at the time it was needed. Some staff were unaware of what criteria leads to an anticipatory care plan 'alert'. Do not resuscitate information was not always accessible by Scottish Ambulance Service. Therefore ambulance crews had no choice but to attempt cardiopulmonary resuscitation with patients who may not have wished to be resuscitated.

Patient key information summaries were not able to be accessed by other staff such as district nurses. These summaries were a way for healthcare professionals to record and share information about people with complex care needs. In some cases, the summaries had no anticipatory care plan 'alert' copies attached.

Palliative and end-of-life care

Support to people at the end of their life was prioritised by all services. This was reported to us by a range of stakeholders including medical consultants, community nurses, physiotherapists, pharmacists, social workers and the Extended Community Care Teams. As part of a 'Delivering Choice' approach the Partnership was operating a 'generalist model' where mainstream nursing were being supported by specialist Macmillan nurses. The Macmillan nursing service was well resourced with multiple practitioners in most localities.

However, access to services in remote areas was difficult. District nurses were usually the lead professional in each locality. They worked closely with the patients and had close working relationships with Macmillan cancer nurses and Marie Curie staff who actively supported district nurses to help coordinate care. Multi-disciplinary 'gold standard' work undertaken by GPs in relation to end of life and palliative care was reported as positive by frontline staff. A dedicated palliative care change plan was being implemented.

There were no permanent dedicated beds available across Argyll and Bute for end of life hospice care. Individual rooms for palliative care patients were made available in hospital funded by Macmillan services. We found a willingness and commitment to ensure that patient wishes and preferences were respected and promoted. Palliative care summaries informed practice across health professionals. This included Macmillan cancer nurses and GPs developing anticipatory care plans and do not resuscitate forms, support and pathways. Some care home providers had concerns that no overarching agreement on the palliative care register was in place and GPs were individually interpreting their approach to this.

Macmillan cancer nurses also provided valued training to care home and care at home staff to help them provide appropriate care and support at the end of a person's life. This helped reduce the need for hospital admissions.

This good partnership working approach between the different sectors had supported people to die at their preferred place. The Macmillan and Marie Curie services had close working relationships with the carers' centres. They had jointly developed training.

Other initiatives included access to support and advice from end of life services within local libraries. Plans were underway to extend availability across Argyll and Bute co-funded through Macmillan Services. This was focused on cancer care but provision could be made for other end of life support. We also learned about Marie Curie's 'Death and Dying' café projects. We heard about good practice in Kintyre where anticipatory care plans and palliative care plans were stored on 'Vision' (an electronic database). This meant that plans could be accessed when people arrived at a hospital's accident and emergency services. However, the Scottish Ambulance Service did not always have access to anticipatory care plans. Overall this had led to a relatively high proportion (93%) of people in Argyll and Bute spending their last six months of life at home or in a community setting. This performance was in the top quartile of Partnerships in Scotland.

However, we met with staff and heard from carers that a few older people with palliative care needs had to wait for care services. This was due to the lack of available care at home staff to support them at home. This was also the case when they needed increased support. We found that it was sometimes difficult to provide care in more remote areas. The Partnership needed to work better to address support needs when care services were not immediately available.

We were concerned that where a social worker or care coordinator was absent for a prolonged period that a service user's changing needs were not addressed timeously. However, the lack of care at home medication administration was not described as a major hurdle to good care for people with palliative care needs with district nursing services providing this service.

Falls prevention and management

Managers told us the falls pathway was one of the significant successes of the Reshaping Care for Older People initiatives. Falls are a major cause of emergency hospital admissions for older people. The falls pathway was a factor in reducing the number of emergency admissions of service users to hospital. This included the work of the falls prevention projects preventing older people falling, and making sure that it they did fall and were uninjured, they would not be admitted to hospital as an unscheduled admission.

Falls prevention programmes had been tested in areas such as Bute and Helensburgh and had proved to be effective. One initiative aimed to ensure that people who fell but were uninjured were not transported to hospital. Instead they were provided with short-term support from the voluntary sector, followed by assessment and reablement and falls prevention classes as required. The service was a community-based model with third sector support.

Plans were underway to develop a standard operating procedure to provide support for people who fell but were uninjured particularly during out of hour's periods. However, no timescale had been agreed to implement this across the Partnership.

We found a few examples where a referral to the falls prevention service may have provided good preventative support but the falls service was not available in all areas. We were told by frontline health staff that falls prevention availability and management was variable across the localities and access was not equitable across Argyll and Bute.

Some service users also told us that getting to falls prevention classes had proved difficult due to a lack of transport. More work was needed to extend the falls prevention approach across Argyll and Bute.

2.3 Access to information about support options including self-directed support (self-directed support)

This section is about how well the Partnership was working to provide information to individuals and their carers about support options, including self-directed support. The Partnership was working hard to improve individuals' and carers' experiences of health and social work services. This was supported by locality Reshaping Care for Older People groups and a supporting multi-agency Programme Board.

A range of websites including Argyll and Bute Council, NHS Highland and the new health and social care partnership integration web page all had a range of information to help individuals consider their options and access services. These websites contained a range of information on how to access support with links to a number of services.

This information showed how to access services, including eligibility criteria, and what to expect from the service. Some information was out of date which the Partnership needed to address.

However, older people and their carers that we met did not always know where to find information about services and supports that may be available for them in their locality. We met several carers and even those from the same locality who often had very differing experiences of how information about support was shared with them or advised about what could be available to them.

The Partnership's focus on integrated working provided a further purposeful approach to supporting individuals and carers to have more control, choice and independence in their own care. It had recently published its 'outline' joint strategic commissioning plan[11] which set out their plans for the future shape of health and social care services.

Self-directed support

Self-directed support includes a range of options for exercising choices in which individuals and their carers can choose the way support is available to them. It includes a range of options for exercising those choices. Since April 2014, Partnerships had a statutory duty to offer the four self-directed options to older people and other adults who need social work services. The self-directed support options are:

- option 1. direct payment
- option 2. the person chooses and directs the available support
- option 3. the local authority arranges the support, and
- option 4. a mix of the above.

The Partnership delivered more direct payments to older people than the Scotland average. Of those individuals who chose direct payments just under half were older people. The level of funding received by them was around 37% of the total self-directed support spend. Both of these figures were above the average for Scotland in 2014.

However, there was a reduction in the number of older people receiving direct payments between 2012 and 2014. Rising numbers of older people were receiving direct payments across Scotland during this time.

We met some service users and carers who were in receipt of direct payments. They said that they valued the choice and control this gave them. However, across all services the proportion of people needing social work support getting to choose how their support needs were met was lower than the Scotland average.

11 Argyll and Bute Health and Social Care Partnership Outline Strategic Plan 2016/17–2019/20.

Social work services frontline staff and managers told us that self-directed support assessment paperwork was lengthy and cumbersome. This had acted, in some instances, as a barrier to self-directed support outcomes-focused approach. There was a lack of third and independent sector service provider capacity (particularly on the islands and remote parts of the mainland) to deliver support to individuals following assessment.

This meant that the ability to select option two (individual chooses the service and the service provider) was constrained. In our staff survey 39% of respondents agreed that their service worked well with partners to promote the implementation of self-directed support.

However, our review of case records found a positive picture with 83% of individuals offered the four self-directed support options. The discussions had taken place with them at either the assessment stage or review stage. Existing service users were offered self-directed support at review meetings.

For the individuals who were offered the self-directed support options 10% chose direct payments. None had chosen to direct the available support. The local authority was arranging the services in 86% of the cases and 4% chose option four, a mixture of the other three options. For the 17% of individuals who should have been offered the self-directed support options, there was no evidence in their social work records that the options were offered.

These findings were compatible with our findings from our discussions with older people, their carers and staff. Many older people were content for the local authority to arrange or continue to arrange the social care services they required. Due to the lack of local provider capacity of social care services in some localities, option two was not always a realistic choice for many older people. Some older people had chosen direct payments, particularly when they needed such care at home services in remote areas.

A number of engagement events had been held across Argyll and Bute to inform individuals, their carers and staff about self-directed support. This included support from the Scottish Personal Assistants Employer Network (SPAEN) to provide advice to people who wanted to explore direct payments. In the main, many older people and their carers that we met with did not always know where to find information about self-directed support. Few people we met had chosen direct payments. However, of those who had, most had good experiences of having a say in how their support was delivered. We found good examples of person-centred care being delivered in remote areas that met most of the individual's desired outcomes.

The resource allocation system that helped staff and individuals cost their eligible budget helpfully included a weighting for rurality to help realise care supports in more challenging geographic areas. However, we also heard that paperwork to help assess for resources was cumbersome to complete and off-putting to use.

Quality indicator 3 – Impact on staff

Summary

Evaluation – Adequate

Staff were generally well motivated and thought they worked well together to support older people to live in the community. There was evidence of positive attitudes across all staff groups. Some staff advised that they were working to capacity and, as a result, were unable to carry out early intervention work. Pressures in some front line services were being compounded by vacancies and staff absences and this impacted on staff morale.

There was evidence of good multi-disciplinary and multi-agency working, communication and a commitment to providing good standards of care to service users. Although there was evidence of staff consultation activities, staff felt that communication about proposed changes, such as integration of health and social work services, could be improved.

Senior managers recognised that changes were needed to improve dialogue with staff. However, staff told us that communication could be improved to enable staff to feel more engaged.

Generally staff had good access to training but most of this was delivered separately by health and social work services. The Partnership recognised it needed to develop different approaches to deliver training especially in remote areas.

In this section we consider if staff were motivated and committed to delivering high quality services. We also consider if they were well supported, managed and provided with the resources to carry out their work well. We comment on whether staff felt there was good joint working, understood organisational priorities, had good opportunities for organisational development and contributed to change management.

3.1 Staff motivation and support

Motivation

We considered a range of evidence, including documentation submitted by the Partnership (for example training plans), results from recent health and social work staff surveys and a staff survey we conducted as part of the inspection. We met with approximately 400 health and social work services staff over the duration of the joint inspection. This included face-to-face meetings with managers and staff groups in health and social work and other care settings.

Just over 1,500 health and social work staff were asked to complete our survey with 569 responding. This was a 38% response rate. Of those who returned our questionnaire:

- 68% of the respondents were employed by NHS Highland
- 30% were employed by the local authority, and
- a further 2% were employed in 'other' sectors (for example GPs).

Staff they were clear about their roles and responsibilities. On the whole they were enthusiastic and committed to delivering and improving the care, support and treatment for older people and their carers. Responses to our survey showed that staff:

- enjoyed their work (86%)
- felt valued by other practitioners and partners when working as part of a multi-disciplinary or joint team (74%)
- felt well supported in situations where they may face personal risk (73%)
- felt valued by their managers (62%)
- agreed that their workload was managed to enable them to deliver effective outcomes to meet individuals' needs (57%), and
- agreed that there were effective systems for allocation and management across the partners and teams (31%).

There was little difference, in response type, between NHS and local authority staff. However, a slightly higher proportion of NHS staff indicated that they did not know whether they felt valued by managers or were well supported in situations where they faced personal risk. This was generally confirmed in our focus groups with frontline health and social work staff.

Staff morale was generally good. However, in some settings it was mixed and some staff felt they were 'fire-fighting' rather than adopting a planned approach to meet the need and desired outcomes of older people and their carers. We were told this was largely due to sickness/ absence levels, unfilled vacant posts, increased workloads and a high volume of paperwork. Despite these pressures, staff told us they had continued to work hard to ensure they delivered a good service for older people.

Argyll and Bute Council's most recent staff survey and supporting audits indicated low staff morale in some areas. There was a perceived increase in workload and lack of support and communication from managers. The Partnership's action plan for improvement had begun to address these issues. For example, managers had access to training in management and leadership. Assessment documentation was reviewed to try and reduce the volume of paperwork. Most health and social work staff welcomed these developments.

The Partnership had developed a range of communication methods to help engage staff on the key developments of health and social care integration. These included a dedicated website, newsletters, road shows and events. However, some staff groups told us they did not feel engaged or have enough information about integration.

They were uncertain about how this would develop and what it might mean for them and the impact of this on service delivery and service users. Trade unions had also raised concerns about perceived gaps in communication to staff on developments linked to the Partnership. Frontline health and social work staff and some managers raised concerns with us about their perceived uncertainty on the future of directly provided care at home and care home services. We found similar comments in the results of the Partnership's own staff surveys. Improvements in communication, consultation, and reducing workload pressures were highlighted as some of the key areas identified for further improvement.

Senior managers recognised they needed to increase their visibility and improve communication and dialogue with staff. They acknowledged that strengthening workforce engagement was key to implementing positive change and the overall success of the Partnership. Feedback from a series of road shows, led by senior managers, highlighted the need to adopt a less formal approach when engaging with staff. This would encourage more open and frank discussion and contribution. We noted that senior managers were addressing this by reviewing their overall approach to staff engagement. They were considering plans to invest in external consultants to support them improve staff participation and better inform a wider range of staff groups.

Teamwork

There was a long history of informal joint working between health and social work staff at an operational level in Argyll and Bute. This was reported to work particularly well where teams shared offices and close, trusting working relationships had developed over a number of years. Many felt this had helped to prepare them as they moved forward to more formal joint working arrangements. This was less evident for some other staff who felt there was a long way to go before partnership working was fully developed across the localities.

Most staff said they felt valued by their colleagues, partner agencies and line managers. They welcomed integration and saw this as the formalisation of a joint working approach that already existed for most of the health and social work services. Our staff survey results showed that 67% of respondents agreed they had excellent working relationships with other professionals and 75% agreed that joint working was supported and encouraged by managers.

Multi-disciplinary and multi-agency meetings were well established in localities. The meetings provided opportunities for health and social work staff to come together to share information and expertise, and work productively to improve the health and wellbeing of older people.

Example of good practice – Virtual ward meetings

Virtual ward meetings had been established across all of the localities. This was a multi-agency meeting to review the needs of older people living in the community whose condition was causing concern, as well as individuals in hospital whose discharge was delayed. The meetings were led by healthcare staff and were attended by hospital and community social work services staff, community nurses, allied health professionals and ward managers. These meetings were a good example of joint working.

The remote geography of some of the region posed a barrier to effective liaison. However, we noted the wide use of technology to overcome this. We saw positive examples of teleconferencing being used to allow staff across the Partnership to interact. Overall, we were impressed by the collaborative and interagency approach to ensuring the delivery of the best possible care for older people.

When we met with staff it was clear they were genuinely committed to providing and delivering services to support older people to lead purposeful and fulfilling lives, increase opportunities for independence and keep people safe from risk of harm. For example, staff responded positively in our survey with the majority agreeing that services:

- worked well together to ensure they were successful in helping older people lead as independent a life as possible
- worked well to keep people safe and protect them from risk of harm
- did everything possible to keep older people at home and in their local communities, and
- that their workload was managed to enable them to deliver effective outcomes to meet individual needs.

Staff had reservations about whether there was sufficient capacity within their teams to cope with future demand. For example, 26% of staff felt they had sufficient capacity within their team to carry out preventative work. Frontline staff told us the number of referrals of older people with complex care and support needs had increased. We heard about the increasing pressures on social work services staff. Many of them told us they were struggling to cope with increases in workload and high volumes of paperwork. Assessment and care management paperwork was reported to be cumbersome and not directly accessible to healthcare staff. As a result, there was duplication of information and difficulties accessing information.

This could sometimes impact on the approval process and result in a delay in delivering services for older people. We saw some examples of this when we attended scheduled workplace meetings with health and social work services staff.

At times of crisis, services generally worked well together to provide an appropriate level of care and support for vulnerable older people who were at risk. We saw good examples of this when we reviewed the health and social work records of older people. This was confirmed by those service users and their families when we spoke with them.

Learning and development

Health and social work partners had arrangements in place for individual supervision, annual performance appraisal and individual professional development. Staff reported that they were able to gain access to appropriate training, development and supervision in their respective professions, although some thought there was less access to training than previously particularly in remote areas.

In our staff survey 68% of respondents agreed they had good opportunities for training and professional development, and access to effective line management, including regular professional specific supervision. There was little variation between the responses from NHS and local authority staff.

The Partnership's approach to the development of a more strategic approach to joint training was not fully developed. Health and social work services had their own suite of training and development resources. However, staff told us that training was largely delivered separately within their own organisation. Joint training opportunities were limited. Adult support and protection training was an example of joint training and was accessible to healthcare staff and third sector colleagues. However, there was a low uptake of this training from healthcare staff. The Partnership should encourage a more comprehensive approach to delivering joint training for staff, whilst acknowledging the issues around service provider sector and geography.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

The Partnership demonstrated a strong commitment to engagement and consultation with the community and building the capacity of local communities. The Partnership engaged and involved local communities to better meet the health and social care needs of older people.

A good range of community supports for older people were already in place. The Partnership was seeking to work productively with older people, the third and independent sectors to improve engagement and increase awareness of the local community responses to delivering support.

The Partnership had adopted a locality-based approach to design services to meet the needs of the local population. However, the Partnership needed to do more to measure the outcomes of these community supports, to formalise the evaluation of initiatives, and ensure shared learning. The Partnership needed to do more to keep staff updated on the positive work they were undertaking.

4.1 Public confidence in community services and community engagement

In this section we looked at how the Partnership worked to promote positive community capacity and engagement. We looked at evidence that the characteristics of the local communities were understood and that there was evidence of community partnership working.

Engaging with the community

It was clear from meeting with senior managers and council elected members that significant importance was placed on building the capacity of local communities and that engaging them in service changes and developments was a priority.

Involving the public in policy and service development, co-production and community resilience building were themes that ran throughout the Partnership's draft Joint Strategy for Older People 2014, 'Long, healthy, active and happy lives', 'Outline Joint Strategic Commissioning Plan 2016–2020' and 'Joint Health Improvement Plan'.

The Partnership was in the process of updating its communication and engagement approach for involvement with stakeholders about the outline and final joint strategic commissioning plans. These plans were being co-produced by the statutory services and the third and independent sectors. The Partnership had learned from previous communication and engagement activities in the preparation of the Reshaping Care for Older People draft Older Peoples Strategy 2014.

We noted the variety of engagement methods used. These included conversation cafes, events, road shows, one to one conversations and the Public Partnership Forum. The Partnership's commitment to effectively engaging with communities was underpinned by training community representatives and public involvement champions from health, social work services and the third sector. Their role was to provide information for communities and engage them in consultation about integration. However, there was limited uptake of this training by health and social work staff. We saw examples of occasions when older people and carers had participated in engagement activities and events. These included:

- Local consultation in Helensburgh had scoped the local community's interest and preferences for a new befriending programme. The resultant service was then introduced and its delivery was consistent with the community views that had been expressed. Uptake of the service indicated it was positively received.
- Caring Connections Conversation Café had invited members of the public to address representatives from health and social work. The focus of the session was to identify positive experiences people had and areas for improvement.

The Partnership had demonstrated a strong commitment to building community resilience using Reshaping Care for Older People Change Fund. This included the development of community groups which articulated the needs of older people, supported the statutory agencies and enhanced community capacity.

Example of good practice – 'Grey Matters'

'Grey Matters', originating in Helensburgh, was initially set up as a local forum for older people to enable them to have a say in community life. The forum had over 200 members and had a weekly column in a local newspaper. The group had become an influential voice for the community, with clear changes made in response to their concerns. For example the GP appointment system was changed to improve access for older people. The group had shared their success at national events including those run by the Scottish Government's Joint Improvement Team. 'Grey Matters' had since expanded to Oban.

We also asked about community involvement in our staff survey. The results from those who responded were:

- 51% of respondents agreed that there was a strong positive engagement between the partners and local community and voluntary groups
- 46% of respondents agreed that their service recognised and consulted diverse local communities about levels, range, quality and effectiveness of services, and
- 46% of respondents agreed that there were clear joint strategies to promote and expand community involvement and communicate change.

However, 20% disagreed with these statements and around a third indicated that they did not know. From our focus groups with health and social work services and frontline staff, we also found that there was a limited awareness that health and social work services had an important role to play in developing community capacity. The Partnership should better promote the importance of engagement and involvement with local communities and other provider sectors with their staff.

Despite the overall positive sense of engagement with communities, we learned that the impact of community consultation was not always effectively shared with communities. The Partnership needed to ensure stakeholder feedback from the stakeholders is always used as a tool to drive improvement, and that the results of community consultation are always transparent.

Argyll Voluntary Action, part of the third sector interface, had an active role in community consultation activity. They had strong links with the Partnership and were represented on the community planning partnership. Argyll Voluntary Action told us of a significant improvement of the involvement of the third sector over recent years, referring to a more trusting relationship and a sense of moving forward together.

Community initiatives

The Partnership had a clear focus on developing community capacity. Projects, many of which were initiated using the Reshaping Care for Older People Change Fund, had been used as a tool to drive change. Argyll Voluntary Action had conducted a scoping exercise of the needs and preferences of older people to guide service development. They also had an active role in both the securing of funding and delivery of initiatives. The focus was on promoting healthy, active and independent lives for older people living in a homely setting. Examples of these projects included the following:

- the 'Happy Bus' in Kintyre. We heard from older people about the positive impact the service had on helping to reduce social isolation and promoting activities

- 'time banking' was a scheme in which members 'deposited' their time by giving practical help and support to others. They were then able to 'withdraw' their time when they needed something done themselves. This had started in 2003 and had grown in scale and had nearly 3,500 volunteers
- the 'Visiting Friends' project worked in partnership with community health, social work services and support agencies. Its role was primarily as befrienders. It made referrals directly to health and social work services. We heard, from frontline staff, that this resulted in earlier diagnosis of conditions such as dementia and better working with the dementia link workers, and
- the Joint Activity Programme led by Arthritis Care Scotland had trained people with long term conditions to run peer led self-management courses. Following this, generic self-management groups were established which were open to anyone with a long-term condition. Participants reported that they were able to communicate more effectively with health professionals about the services they needed, and when they needed them.

There had been significant investment, not just from the Reshaping Care for Older People Change Fund but also from the council and NHS Highland. We learned about successful projects being 'mainstream' funded following the end of the Change Fund. We heard from services users about the positive impact these projects had on their lives. There was evidence of evaluation of some projects. However, we were unsure whether evaluation was routine and robust across all projects.

We were advised by senior staff that there was an intention to establish better performance reporting systems and provide support as part of the Integrated Care Fund. We heard some critical comments, from service users and carers, about the lack of available community transport provision. Localised initiatives existed (for example, patient travel scheme and volunteers). However, we learned from some service users and carers of the difficulties faced by some older people in accessing services particularly from the more remote communities. Managers told us that the Partnership's vision was to develop locally available and sourced services, rather than invest in large-scale transport schemes.

The Health Improvement Team took a preventative approach to improving health which aimed to enable people to lead longer, healthier lives. The Joint Health Improvement Plan had included older people as one of its main target groups. As part of the plan we saw that activities such as befriending, shopping help, time banking, falls prevention, self-management of long-term conditions and active ageing were prioritised. However, we were unclear about the contributing resources that would be delivered from other partners such as leisure services.

Senior managers and frontline staff told us that a locality-based approach to capacity building and service design had been adopted. We read about the Partnership's ongoing commitment to design and adjust services to meet local need. However, there did not seem to be a strategic approach or overview of locality-based projects which ensured best practice was shared. Staff we spoke to acknowledged that there was a variation and inconsistency in services across Argyll and Bute.

We heard, from senior managers, about the positive impact of community resilience workers. Funding for these posts had been match funded by Argyll Voluntary Action and the Change Fund. The workers worked alongside statutory agency staff, had an interface role and provided awareness of community resources to signpost to. They also supported the third sector in completing grant applications to initiate projects and those seeking funding to expand. We also heard that the community resilience workers were instrumental in developing community capacity locally and were highly visible in local communities.

The Partnership needed to develop an overarching joint community capacity and co-production strategy, including how local services were to be supported, with a measurable action plan that clearly set out the role of community support interventions in delivering the overarching joint strategic commissioning plan.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

Assessment and care management was generally good. Assessments were carried out, and care and support plans were regularly reviewed. However, there were some areas for development such as the preparation of chronologies. While staff felt confident and supported in managing risk, the preparing and recording of risk assessments and risk management plans needed to improve.

Older people were being involved in decisions about their care and support and were also being well supported to self-manage their condition by Partnership staff.

Work had been done to embed an outcomes approach. New processes were introduced to support the consistent implementation of self-directed support. The options available for service users were limited by availability of provider services in some areas. Further development was needed in areas such as choice and support for carers and independent advocacy.

People who used health and social work services and their carers were, on the whole, satisfied both with the services they received and the positive outcomes for them that resulted. They highlighted that that family members and service users were involved in reviews and in decision making. Some improvements were needed in areas such as respite and care at home.

The Partnership needed to work towards improving the geographical equity of services to make sure that pathways for accessing services are more joined up and effective, for example, the development of a single point of access.

This section focuses on the extent to which all staff recognised that an individual is in need of care and support. It considers how well information was shared between partners and was used to make decisions. It looks at the timeliness and effectiveness of the help and support provided, to older people and their carers, in preventing difficulties arising or increasing.

5.1 Access to support

The council had a call centre system for all adult care where referrals were logged and then passed to the relevant area teams. Access to services was through self-referrals, partner agencies and the council's website. A referral was passed to an area team's duty worker to take forward. No screening of calls took place between receiving the enquiry at contact and then passing the referral to duty workers. This meant there was a missed opportunity to screen and triage referrals.

This impacted on busy older people's community care teams. It also added an unnecessary layer in accessing pathways for older people requiring support. Access to NHS services was through a variety of routes such as community health services and GP practices.

A number of joint health and social work services teams existed across Argyll and Bute. They provided differing types of support including mental health and learning disability. Where these teams were established, we found that the NHS services were being accessed directly through traditional referral routes such as GP services while social work services were being accessed through the above described channels. This meant that there was a lack of joined up access pathways for health and social work services even where joint teams were established.

Senior managers described the steps taken to develop a single point of access as being a single agency strategy initially. Once a single point of access could be achieved for health, a multi-agency one may become an option. They said there were no active plans to develop this. We noted this was an important consideration as integration will only increase the need to jointly develop services and the subsequent access arrangements to them. There was no single point of access adopted across the Partnership and this needed to be addressed.

The Partnership had a set of eligibility criteria for accessing services. A set of priorities was in place to allow for the appropriate targeting of services across both health and social work services. Priority was given to older people who had critical or substantial needs. Individuals whose risks were assessed as moderate or low were directed to appropriate third sector organisations including carers' services. However, in our staff survey 28% of respondents agreed that there were joint eligibility criteria for services which were consistently applied. Nearly half (46%) said they did not know.

We found instances, (for example mental health, dementia, sensory impairment, falls prevention, out-of-hours and care at home services), where access to services in remote and island communities was sometimes limited. This was consistently identified as an issue by frontline staff and service users. This finding was supported by our staff survey which recorded that only 23% of respondents agreed that there was a fair geographical coverage of services. Over half (55%) disagreed. In some cases services were delivered after delays of several weeks or months depending on the type of service. An example mentioned by service users was that the sensory impairment team visited certain areas including islands only when there had been sufficient referrals to 'justify' a clinic. This resulted in significant delays.

Recommendation for improvement 4

The Partnership should work towards improving the geographical equity of services ensuring that pathways for accessing services are more joined up and effective.

The Partnership deployed Extended Community Care Teams to provide support for those living in their own home. These teams provided care at home services including aspects of rehabilitation and were managed by a mixture of health and social work professionals. Access to these teams service was by referral from hospital staff, GPs and duty social work as well as through other services such as the out-of-hours service delivered by the independent sector provider Carr Gomm.

The out-of-hours service aimed to deliver a rapid emergency response (for example to telecare calls) as well as planned visits. The overnight support service was reported by staff to be flexible. For example, it allowed a service to restart following a hospital accident and emergency department admission. The Carr Gomm service did not cover all of Argyll and Bute. Senior managers acknowledged this as an issue. We were told by them that plans were in place to remedy this.

The work of the Extended Community Care Team was being diverted, in many cases, to supporting staffing shortfalls in staffing in care at home services. Many staff including senior managers expressed frustration that they were not able to support people in the community earlier in order to prevent short-term needs becoming longer.

A prominent issue was the difficulty in recruitment to care at home services. Care at home support was provided by the council (in some locations), as well as third and independent sector providers. The supply of staff was constrained by the lack of suitable job applicants. Other reasons included travelling time, level of skills and training of staff to undertake a reablement approach and the use of 'zero hours' contracts in the directly provided care at home service. We were told by some frontline staff that delays in arranging care at home services following assessment were the most common reason for not receiving services at the right time. However, not all areas experienced the same level of accessibility of services.

5.2 Assessing need, planning for individuals and delivering care and support

The Partnership was carrying out work to refine and improve the assessment and care management processes. It had recently carried out work to better focus on individual outcomes for older people, as well as giving staff tools to offer self-directed support options in their assessments. We attended some hospital multi-disciplinary meetings which identified priorities for patients and helped ensure that service users experienced a smooth discharge from hospital along with the allocation of resources which were required to meet their needs.

However, in a few cases, older people experienced problems when being discharged from hospitals in the NHS Greater Glasgow and Clyde area. In these instances staff told us that they had received little notice of when the older people were to be discharged. This meant that packages of support could not be planned in advance. The way medical records were shared across NHS boundaries could be improved and patients did not always access timely rehabilitation as a consequence. They also said that community care assessments on leaving hospital were not always carried out in a NHS Greater Glasgow and Clyde hospital.

This meant that some older people would be moved from a NHS Greater Glasgow and Clyde area hospital to an Argyll and Bute hospital for assessment rather than returning home. In other cases, assessments carried out in NHS Greater Glasgow and Clyde by health staff had overestimated the care needs required, putting pressure on resources which could not be redressed until the social work service could reassess in Argyll and Bute. In both scenarios the outcomes for the older people involved were poor. This lack of coordinated planning and support for discharge should be addressed by health and social work managers.

Where care assessment was carried out in Argyll and Bute we found evidence from individuals' case records that supported a generally positive picture of assessment and care management. From the health and social work services records we read, 95% of people had a needs assessment completed. In 68% of those assessments, it was clear that a range of professionals had contributed to the assessment. Early intervention and prevention options had been considered in 73% of cases. We evaluated 69% of the assessments we read as good or better. In 2% of the assessments, we evaluated them as weak and needing improvement. The remainder were evaluated as adequate.

Chronologies set out key life events that can influence the care and support offered to individuals. They are a useful tool in assessment and practice which promote engagement with service users. An accurate chronology has sufficient detail but is not a substitute for file recording. They should be reviewed and relevant to the individual's circumstances. The majority of relevant records we read (65%) contained a chronology. However, two-fifths of those chronologies we read were of not of an acceptable standard. This was an area of work where the Partnership needed to improve its performance. The Partnership needed to ensure that all relevant case records contained accurate chronologies so that older people's care needs are better assessed and that the services they receive are better planned and delivered to meet individual need.

Recommendation for improvement 5

The Partnership should ensure that all relevant case records contain accurate chronologies and, where appropriate, have written risk assessment and risk management plans in place so that people's care needs are better assessed and planned for.

All assessments we read had taken account of the individual's needs and almost all had taken account of the individual's choices (98%), with 82% outcome-focused. Staff generally obtained agreement to share information across agencies. Most files (88%) included clear evidence that health, social work and other services had shared relevant information.

We noted that overall the Partnership performed better, than the Scotland average, for the time from referral to completion of assessment. However, it performed less well, compared to the Scotland average, from the time taken from assessment to the delivery of services (January–March 2015). From our staff survey:

- 66% of respondents agreed that individual care plans identified health and social care needs and the role of relevant staff
- 58% of respondents agreed that care plans were regularly reviewed, signed and implemented
- 35% of respondents agree that key professionals worked together to inform a single, user friendly assessment, and
- 34% of respondents agreed that joint teams responded within agreed organisational timescales.

Managers and frontline staff we spoke with across health and social work services, as well as the majority of older people using services, felt that clients received a good service and had good outcomes. This was supported by our review of individuals' case records. We evaluated that nearly all had achieved an improvement in their circumstances and that personal outcomes were achieved in almost all cases. Generally those individuals and their carers that we met with who expressed dissatisfaction noted that poor communication and a lack of clarity in the care plan as the main difficulties.

Frontline social work staff told us that paperwork for completing care plans and assessments was onerous. They said that there were often delays in completing assessments and care plans as the length of paperwork made it difficult to get the assessment process completed in the required 28 days. Health staff told us that care plans were generally slow to be reviewed by social workers when people were admitted to hospital.

Some of the records contained a 'Personal Outcome Plan'. These were designed to cover all aspects of the assessment, care planning and review processes. We found that assessments and reviews carried out using this approach were clearly linked to national health and wellbeing outcomes and focused on the individual. However, social work services staff told us that the processes were cumbersome and the introduction of the Personal Outcome Planning system had led to increased staff time spent in administrative tasks. This meant that less time was available to spend with service users.

In April 2014, the Partnership had commissioned a review of the assessment and care management processes and documentation. This review resulted in the development of a universal adult assessment tool. This was intended to facilitate the introduction of self-directed support and better person-centred planning. The universal adult assessment tool was being introduced in phases. Phase one for social work services staff was introduced in May 2015. Phase two, including healthcare staff, was planned for autumn 2015. Interim guidance had been issued to staff to address self-directed support implementation using the previous personal outcome plan system until the universal adult assessment tool was embedded.

The introduction of the universal adult assessment tool was at an early stage and not all staff had used the new format. Managers told us that the new system would take time to bed in and that the staff would initially have a greater amount of information to enter in to the new system.

It was expected that this would reduce significantly in the longer term. Universal adult assessment tool team leader 'champions' would be responsible for cascading training within their locality. At the time of the inspection work, on phase two was in its early stages with a number of tasks to be completed.

Phase two was expected to incorporate the 'supported assessment questionnaire and resource allocation system'. The universal adult assessment tool also contained risk assessment and risk management sections. From our review of health and social work case records we found that:

- in almost all cases there was evidence that the service actively sought and took into account, the individual's views at assessment (99%), care plan (94%), and review stage (97%)
- in almost all cases (93%) the health and social care support was subject to regular review, and
- just over half of all cases had a comprehensive care and support plan (51%), while for 40% the care and support plan was not comprehensive. The remaining 9% did not have a plan.

5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks

Well structured governance arrangements were in place for adult support and protection. The adult protection committee had an overview of adult protection procedures and used the 'West of Scotland' guidance to inform practice. There were four locality adult protection development forums. The development of these forums had been inconsistent. The chair and other members of the adult protection committee had recently committed to attend the forums to drive forward improvements. We attended a meeting of the adult protection committee. We saw how the independent chair challenged partner agencies to achieve more effective involvement in the adult protection agenda using detailed performance data. This supported improvement work.

We noted that stakeholder attendance at the adult protection committee was not always consistent. There were some difficulties in securing all the information required to inform the committee of user views. This hindered future planning. A chief officers group held an overview of public protection and routinely received performance reports from the adult protection committee. The adult protection committee chair was satisfied that chief officers were providing the necessary oversight.

Adult support and protection awareness training was described as excellent by some staff. Frontline staff told us that training had taken place across professions and agencies although there could be long periods between training sessions. They thought there should be more regular 'refresher' training. We were told that not all health staff who were offered awareness training attended. GPs' attendance was reported as mixed. Partner agencies and providers received a good level of training with the adult protection committee monitoring attendance.

Referrals were monitored by the adult protection committee, local forums and area team managers. Most referrals were received from Police Scotland. The adult protection committee was monitoring the rate at which cases resulted in a referral. Screening of referrals was carried out by social work. The Partnership aimed to meet the guidance target of five working days from referral to completed inquiry. This was monitored by the adult protection committee. The proportion meeting the target was low. We were told that the adult protection committee planned to explore the reasons for this.

The Partnership had a programme of adult support and protection self-evaluation. Recent self-evaluation file audits have been conducted with multi-agency involvement. This had resulted in improved practice within social work services. Team leaders audited 10% of instances where a referral was not raised and audited one of their team's cases a month. Results from this self-audit were due to be reported in winter 2015. The adult protection committee sought to build on this by learning from case studies from significant case reviews case studies. Attendance at case conferences was routinely monitored by the adult protection committee.

The completion and availability of comprehensive risk assessments and risk management plans are integral to the effective support and protection of adults at risk of harm. Our review of health and social work services records looked at risk assessment and risk management practice. The findings of this were variable and in some aspects concerning. We found that operational practice was not always consistent with the Partnership's own procedures and best practice. For example, in the files with adult protection type risks identified, (current or potential issues regarding adult protection or protection of the public), we found that:

- 60% had a risk assessment on file
- the timing of the most recent risk assessment was in keeping with the needs of the individual (100%)
- multi-agency partners' views had informed the protection risk assessment (89%)

- 66% of risk assessments were rated as 'very good' or 'good' with 22% rated as 'adequate' and 11% rated as 'weak'
- 40% had an up-to-date risk management/protection plan and in all cases these were up-to-date
- half of the risk management plans were rated as 'very good' or 'good', while the other half were rated as 'adequate'. No plans were rated as 'weak' or 'unsatisfactory', and
- 13% had not dealt with risks adequately.

Whilst some caution needs to be exercised with these findings, given the small sample size of adult protection type cases, there was room for improvement. A range of social work staff and managers told us that staff were completing risk assessments where these were needed. However, we found from our case record reading these were not always formally recorded in the service user's case record.

In the files with adult non-protection type risks identified (such as a frail older person at risk of falling and sustaining an injury) our case record findings indicated that for those cases where non-protection type risks existed:

- 78% had a risk assessment on file
- the timing of the most recent risk assessment was in keeping with the needs of the individual (84%)
- 20% had no evidence that multi-agency partners' views had informed the risk assessment
- 89% of risk assessments were rated by us 'good' or 'adequate'
- less than half had a risk management plan (47%)
- 90% of risk management plans were up-to-date, and
- 83% of cases had all risk concerns dealt with adequately.

A range of risk assessment frameworks were being used. During our review of case records we found that assessment of risk was included in the Partnership's assessment templates. However, not all assessments recorded risk in the same way and this meant that there were variations in risk assessment. This was more commonly found in lower level risks such as non-protection risk.

Not all risk assessments were shared routinely. In our staff survey we found that 64% of respondents agreed that there was a range of risk assessment tools which they could use. Around two-thirds (66%) of respondents agreed that there was clear guidance and processes in place to support all staff in assessing and managing risk. The Partnership aimed to adopt a standardised approach to risk identification with coordination of care by a lead professional. The lead professional role needed further development.

Health and social work staff told us they felt confident in dealing with adult support and protection. A large-scale investigation of adult support and protection issues, in a particular care home, was underway at the time of inspection. Staff told us they were confident in participating in the investigation even though this was the first investigation of this type that the local authority had undertaken for some time.

However, some of the challenges experienced by staff in providing support to vulnerable older people included a lack of infrastructure in place to manage some adult support and protection activities. This included difficulties in accessing out-of-hours services. For example, in some localities, the place of safety during the out-of-hours period for a patient who was held under mental health legislation was in an accident and emergency department, community hospital or police cells. On occasions patients had been admitted to a ward or local nursing home temporarily with extra staffing for support until additional services became available.

Access to mental health services was variable particularly out-of-hours with limited access to community psychiatric nursing and acute admission. We heard that this had led to older people being detained in inappropriate settings. No dedicated facility for those with dementia and challenging behaviour was available in some localities. Admissions to hospital in Lochgilphead, to allow access for diagnosis, could be delayed due to transport issues.

Some transport services only worked on weekdays. Staff told us that Police Scotland were helpful in holding vulnerable people safely and providing transport when no other option was available. However, these arrangements had the potential to undermine the outcomes and rights provided to older people under mental health legislation.

Managers told us that a contingency plan was in place for mental health response but this needed to be updated. Senior managers commented that the modernisation of mental health services had resulted in a reduction in beds, and an increase in community based care. During acute periods of illness the community hospitals were increasingly providing short-term support for individuals with mental illness until a safe transfer could be made. Some senior health managers recognised that staff did not yet have the skills and confidence to deliver the best care in community hospitals to meet these particular needs.

Recommendation for improvement 6

The Partnership should ensure that plans to support vulnerable older people are updated and training is provided for staff in hospitals and that alternative places of safety are found to ensure that older people can receive the right support at times when they most need it.

5.4 Involvement of individuals and carers in directing their own support

Self-Directed support

Self-directed support lead officers told us that good progress had been made in offering support to individuals and carers in taking up and managing their support. The council had taken positive steps and were working with Carr Gomm and Argyll Voluntary Action to engage with individuals and providers to explain and articulate self-directed support options.

The Partnership had updated its self-directed support policy and procedures in April 2015. Assessment procedures were developed to help enable a consistent approach, to streamline paperwork and enable health staff to complete assessments at a later stage. The resource allocation system had yet to be embedded into the new documentation. This was under development.

The range of providers was limited in some areas. Staff noted that this could be particularly challenging for island and remote communities where there may be just one service user requiring services. We were told about an initiative with Scottish Care and the Institute of Research and Social Sciences which aimed to identify more service providers across each of the locality areas with a target minimum of three service providers for each area.

Although this work was at an early stage, the Partnership anticipated that existing service providers could work differently to provide flexible services more efficiently through collaboration. Existing service providers displayed what services they provided on the council website. The Partnership was building a resource directory to include community activities with the aim of providing a web based self-service directory.

Carers

Support to carers was promoted by a network of carers' centres working alongside health and social work services. We met with the carers' centre network who told us of their involvement in strategic planning events. Members of the network were also members of the strategic planning groups and were actively contributing to the development of the joint strategic commissioning plan and the development of service plans in the context of anticipated legislative changes in support of carers. Network members told us they felt actively involved in the planning of future services for carers.

We attended a drop-in session for carers in Lochgilphead. We met staff and volunteers who were motivated and committed to helping others access support services. We were told about the activities within the carers' centres which encouraged new and existing carers to access support services.

Staff from the carers' centres, including outreach workers, were responsible for completing carer assessments. They identified a tension between carers' autonomy to direct their own care through carers' centre activities and accessing support through statutory services by carer assessment. The Chief Social Work Officer had met with carers' groups with the aim of helping them take a lead with carer assessments. One of the challenges highlighted was that carers needed consent to report back details on the carer assessments and that there were concerns raised by carers regarding confidentiality and data protection.

Carers' centre staff were working with carers to allow them to be confident on what could be shared. Some social work and health staff thought that carer assessments should be shared automatically, as a default, unless the carer indicated otherwise.

Of the health and social work services case records we read, half of service users had a carer who provided a substantial amount of care. Of these, we found that carer assessments were offered in 80% of cases (20% had not). Where the offer of an assessment had been accepted, a completed assessment was evident in two-thirds of cases. Where an assessment had been completed, we found that service users and carers had mostly led to improved outcomes for the carer and the person they cared for. In 80% of cases there was evidence of support for the carer to allow them to continue in their role based on their assessed need. However, there was limited evidence of carer emergency plans.

Assessment was offered on first contact. We were told that the carers' centres were proactively supporting carers by using some of their own budgets to access respite for them. Carer assessments included contingency planning, however, these plans were not always available alongside other plans such as anticipatory care plans. The uptake of carer assessments that were offered was high. Staff believed was this was due to them having time to spend discussing the assessment with the carer. The Partnership needed to find more joined up ways of sharing and making use of the carers' centres personal outcome data to develop support services.

Independent advocacy

Referrals for independent advocacy services were mostly linked to statutory mental health and adults with incapacity work with few referrals from older people. Good referral links were made with some staff within health and social work. The independent advocacy service (Argyll and Lomond Independent Advocacy) had an open referral policy. However, the service level agreement it had with the Partnership had, until recently, mostly limited the service to mental health and learning disability referrals. This had the effect of restricting access to other older people needing help. Staff from the independent advocacy service told us there had been limited referrals for adult support and protection and self-directed support. This was despite access to independent advocacy, being part of the adult support and protection and self-directed support implementation plans.

Advocacy services had provided support to older people to articulate their views and wishes in some cases. This had included support to challenge decisions of adult support and protection processes, care plans and housing services. During our review of health and social work service records we looked at the provision of independent advocacy services. We found that in half of the cases where independent support or advocacy should have been offered, those individuals did not receive it. Of those individuals who had received advocacy support, it helped to articulate their views in half of the respective cases.

Carers' advocacy was provided informally by staff at carers' centres. They would also redirect carers to Argyll and Lomond Independent Advocacy for older people, mental health and learning disability service users and their carers. Social work staff told us they had few difficulties in accessing advocacy when they referred to the service. Service users living in island communities told us that they had some difficulties accessing the service. The Partnership needed to ensure availability of advocacy support for older people as well as people subject to adult protection and support procedures. At the time of the inspection, the Partnership was re-negotiating the service specification with Argyll and Lomond Independent Advocacy, to help to improve availability across older people services.

Recommendation for improvement 7

The Partnership should enable a wider range of client groups to access independent advocacy services. This should ensure the most vulnerable people are supported through complex and challenging life events to express their own views as far as possible.

Quality indicator 6 – Policy development and plans to support improvement in service

Summary

Evaluation – Adequate

The Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked the finer detail on how they would be achieved. Joint formal strategies and costed action plans for themes such as carers, dementia, telecare and management of assets were needed. The Partnership needed to refresh and articulate its strategic priorities for these areas in the context of health and social care integration timescales.

Using the Change and Integrated Care Funds, the partners had taken a joint approach to the deployment of resources and this was influencing the future shape of health and social work services. Learning from these investments had led to a number of successful service redesigns.

A wide range of performance information was produced, reported and made available for consideration by the Partnership's senior and local management as well as council elected members and NHS board members. A draft joint performance framework linked to national outcomes was being prepared. The Partnership needed to be sure that the framework contained challenging, but achievable targets for service users and their carers.

Many stakeholders, such as the third and independent sectors were positively engaged with meaningful involvement, in formal planning structures. The Partnership recognised local care market challenges and was beginning to address them. Joint strategic commissioning activity to date had primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners.

However, we saw less evidence of how strategic joint commissioning developments were to be progressed and how these would be led. The Partnership needed to develop its commissioning approach to further shift the balance of care to carry on the progress made so far.

This section comments on the organisational and strategic management across the Partnership, and the extent to which the strategies and plans reflected its vision of the service. It also considers how purposefully the Partnership involved individuals and carers in service development. It also covers quality of services and how quality management drove improvement.

6.1 Operational and strategic planning arrangements

The community planning partnership had set out the joint vision for Argyll and Bute in its single outcome agreement 2013–2023. This identified that 'people live active, healthier and independent lives' as one of its main themes. This had been taken forward by the Health and Social Care Partnership. Informed by the agreement, the plans for services for older people were set out in the Partnership's draft Joint Strategy for Older People 2014, 'Long, healthy, active and happy lives', and consultative 'Outline' Joint Strategic Commissioning Plan 2016–2020 alongside NHS Highland's Local Development Plan 2015/16.

These plans gave a clear view of the direction of travel, but lacked some of the finer details on how they would be achieved. This limited their use as delivery management and accountability tools. They were not always fully costed in detail and delivery timescales were not always clearly identified. They did signal areas for future disinvestment and investment with some corresponding financial figures attached.

The strategic planning sub-group of the community planning Health and Social Care Partnership was taking forward the preparation of a joint strategic commissioning plan. An additional group focused on the planning and delivery of services for carers.

The draft Joint Strategy for Older People 2014 was circulated widely for consultation. It contained overviews of health and social work needs analysis, the strategic direction and identified strategic priorities. It also set out an implementation plan and some financial information. It highlighted areas for future disinvestment and investment including hospital sites. A finalised plan was not produced following consultation.

Geography posed challenges to delivering services. Senior officers told us that the commissioning of services took account of local circumstances. The Partnership was working towards developing a locality-based approach for the planning and delivery of services in the four locality areas. This would incorporate the seven Reshaping Care for Older People localities. This was at an early stage. Progress was inconsistent across the localities. As locality plans developed, the Partnership needed to set out a quality assurance framework for localities and detail how they would consistently measure local performance in addition to that already carried out.

The Partnership had recently agreed an ambitious one-year Joint Improvement Plan which set out a range of priority actions based on the Care Inspectorate's strategic inspection quality indicator framework. The plan had a strong social work focus. However, it would have benefitted from a more developed integrated health and social work perspective. There was a need to cross-refer to other strategic planning processes such those involved in the delivery of NHS Highland Local Delivery Plan, Strategy for Older People and 'Outline' Strategic Plan alongside existing and developing performance frameworks.

At the time of inspection, the Partnership was following national policy frameworks for carers, dementia and telecare. However, we were not clear if there were local formal costed strategies and action plans for these themes. The Partnership needed to refresh and articulate its formal strategic priorities for these areas in the context of health and social care integration timescales.

A clear joint approach to the joint management of assets such as premises was needed too. For example, during the inspection we noted that the role of some day care services was under review. The partnership needed to ensure that there was an ongoing, balanced and sustainable local demand for the services being invested in.

The Partnership had carried out a joint strategic needs assessment for older people in May 2013. Senior staff told us that they thought enough relevant existing analysis was available to support the existing strategic direction.

6.2 Partnership development of a range of early intervention and support services

Across health and social work services, services were being developed that helped to support older people to remain independently at home. This included the promotion of reablement, care at home and telecare. The delivery of this approach was inconsistent across localities. However, the development of reablement services was at a relatively early stage when compared to some other areas of Scotland. The tiered eligibility model for accessing services formed the basis of the approach to early intervention and prevention. This aimed to provide an incremental delivery of care and support.

Through the Change and Integrated Care Funds, the partners had taken a joint approach to the deployment of resources to support improved outcomes for older people. This funding had been used to test different working models. This was starting to inform the future shape of how health and social work services would be delivered. Learning from Change Fund investments had led to service redesign in areas such as:

- falls prevention and management
- reablement
- equipment, adaptations and telehealthcare
- community resilience
- palliative and end of life care
- carers support
- dementia support, and
- self-directed support.

The Partnership's Change Fund expenditure was profiled towards preventative and anticipatory care and proactive care and support at home. Some projects had a clear health promotion and prevention approach. More work was needed to set out how change would be implemented using the approaches that had been tested.

The Partnership was at an early stage of developing step-up (for example avoiding unnecessary hospital admissions) and step-down services (for example to support early supported discharge, capacity and associated procedures). The Partnership had recognised that respite services were in need of refocusing and development. At the time of inspection a review of respite services was underway and the findings were awaited in winter 2015.

6.3 Quality assurance, self-evaluation and improvement

A range of performance information was produced, reported and made available for consideration by the Partnership's senior and local management as well as council elected members, NHS board members and area committees.

Performance information based on national and local indicators formed the basis of the approach. A Health and Social Care Partnership bi-monthly performance report was available at locality level. It included areas such as emergency admissions, multiple admissions and the balance of care. The report also showed action taken to remedy poor performance and future improvement actions planned.

The council had a range of performance information through its 'Pyramid' performance management system. Performance across localities was inconsistent. The Partnership's own targets were not being met in areas such as delayed discharges, proportion of service users receiving care in institutional and community settings, timescales for carers assessments, unallocated work and staff absenteeism. The indicators tended to focus on input/output measures. The Partnership was aware of which areas required improvement.

The Reshaping Care for Older People performance management group had access to detailed information for most of the Reshaping Care for Older People work streams. However, some work streams did not have performance management information and some had measures in development. Again these were mostly focused on output measures monitoring. There was a need to incorporate more personal outcomes-based information more widely. The Partnership had made progress in gathering aggregate data on a number of the national health and wellbeing outcomes. Social work services staff had populated information technology systems with some health and wellbeing outcomes. They used the 'Talking Points' framework to gather service users' views on the achievement of these outcomes. The Partnership had plans to extend this data collection to include all national health and wellbeing outcomes.

NHS Highland had established the 'Highland Quality Approach'. This was an overarching method to improve services across priority areas. These included person centred care, safe care, primary care, unscheduled and emergency care, integrated care, care for multiple and chronic illnesses, health inequalities, prevention, workforce, innovation, efficiency and productivity. Its objectives were to:

- provide quality care at all times
- support people and communities to maximise their own health
- develop precision driven services so that when people need care they experience timely, focused, effective services, that minimised duration and frequency of contact, and
- ensure that every health pound spent delivers maximum health gain.

A range of improvement projects were underway employing 'rapid improvement' workshops and 'kaizen' continual improvement methodologies. This was led by a dedicated quality improvement hub team. It was intended that these improvement tools and techniques would be cascaded through the organisation over a three-year period. However, we were unclear how evidence was gathered to demonstrate what impact the improvement activity had achieved in the Argyll and Bute area.

A draft joint performance framework linked to national outcomes was being prepared. This was at an early stage. This would help partners to identify areas where performance was improving or required improvement. Joint performance measures would be based on national and local indicators. This covered areas such as 'reshaping care for older people', reablement, carers, telecare, long-term care, adult support and protection, and national NHS 'HEAT'[12] targets. It was intended that the performance framework would focus, in due course, on personal outcomes as well as input/output indicators. Outcome-focused and qualitative measures were still to be agreed and rolled out across all externally commissioned services also. The Partnership needed to be sure that the joint performance framework contained challenging, but achievable targets. The Partnership intended to assimilate elements of the Highland Quality Approach with the council's own performance improvement tools (for example the public sector improvement framework). However this work was at a very early stage as was the intention to incorporate more health information into 'Pyramid'.

The Partnership had carried out a series of 'thematic' self-evaluation exercises on issues such as Reshaping Care for Older People, self-directed support, adult care key processes, adults at risk, self-evaluation, joint performance scorecard and work with NHS Scotland's Information Services Division. These had helped to identify future areas for improvement.

12 Health improvement, efficiency, access to services and treatment (HEAT) targets are an internal NHS performance management system that supports national outcomes. NHS Boards are accountable to the Scottish Government for achieving HEAT targets.

We were advised by senior managers that an ambitious programme of file audit and review in social work services was planned but had not yet commenced. File audit was already in place for adult support and protection cases. However, this approach needed to be expanded to other care areas to help improve and assure practice. In addition from the case records we read, we saw evidence of first line management scrutiny of files with 60% of records scrutinised by line managers. This particular approach was not so well developed in health services. The Partnership had a very detailed strategic risk management register which identified possible risks and mitigating actions. Examples of direct service user feedback included surveys for care home and day care users.

However, we were unsure if these questionnaires were available across all services and all sectors. Satisfaction levels with social work services were just above the Scotland average at 57%. NHS Scotland carried out an annual survey of patient experiences.[13] In NHS Highland this showed levels of satisfaction broadly comparable with the Scotland average.

Results from our staff survey showed that informing and receiving feedback on performance required some improvement as:

- 67% agreed that their service regularly evaluated its work and took appropriate action for improvement
- 59% agreed that the service had measures in place to ensure the quality of the services they deliver
- 55% agreed that their service had measures in place to ensure they monitor the impact of care and support, and
- 41% agreed that the quality of services offered to older people jointly by partner's staff had improved in the previous year.

NHS Highland complaints response times and recordings were a matter of concern to NHS Highland. The Partnership intended to use the Highland Quality Approach as one means of improving services and expected these improving services would lead to fewer complaints. There were separate governance systems for complaints across health and social work services. To make the process more joint, the clinical and care governance group were working on this.

The Partnership was also considering how they could jointly share learning on adverse incident reporting. Performance data on adverse events and high-level themes and trend information was being captured for the purposes of improvement work. NHS Highland was using this information to carry out 'hot spot' improvement work in the required areas of service and practice.

Health and social work services managers and staff recognised that they needed to do more to evidence the positive outcomes and impacts of some of the supports delivered to service users and their carers.

13 Scottish Inpatient Patient Experience Survey.

6.4 Involving individuals who use services, carers and other stakeholders

NHS Highland and Argyll and Bute Council had policies for engaging with people who were using their services as well as with other stakeholders, including staff and external providers. Council elected and NHS board members and senior managers needed to better engage and communicate with staff and other stakeholders on future direction and implementing change. This was evidenced in our staff survey where:

- 51% agreed the vision for older people's services was set out in comprehensive joint strategic plans, strategic objectives with measurable targets and timescales
- 37% agreed that priorities set at Partnership, team and unit levels reflected jointly agreed plans
- 36% agreed views of older people and their carers who use services were taken into account fully when planning services at a strategic level, and
- 33% agreed views of staff were taken into account fully when planning services at a strategic level.

We found that senior managers felt involved in development and improvement activity. However, frontline staff were less positive and not as clear.

Overall, third and independent sector providers were generally content about the level of support they were given by the Partnership to improve their performance. They commented positively on the opportunities to contribute to strategic planning agendas. Ongoing consultation and engagement with service providers was a recurring and positive theme. This was helping to ensure that service providers were better engaged in reshaping how they provided services. However, an area that required improvement was the ongoing input from primary care services such as GPs. These practitioners needed to be more closely involved in strategic planning.

Local authority housing staff reported that they were encouraged to participate in joint planning at strategic and operational forums and they welcomed this. They were members of Reshaping Care for Older People groups and Change Fund monies had been invested in housing related projects. However, they advised they would like closer involvement with health and social care integration related planning.

Housing services invited social work and health partners to the local 'Strategic Housing Forum' alongside housing associations to discuss future investment decisions. A recent bespoke 'special needs' housing needs and demand assessment had been produced. This aimed to better identify the housing related services for older people. This would build on the work that 'Care and Repair' services delivered in areas such as adaptations and telecare. The council's local housing strategy had identified a major theme as 'supporting people to live independently'. The council's strategic housing investment plan had set aside capital investment for housing for particular needs including older people. Recent capital investment had included 'progressive care' and 'extra-care housing' and additional units were planned.

Senior managers told us that they had learned from issues arising from recent bed number reductions across Argyll and Bute, where the Scottish Health Council had advised, that, during consultation, the community had not been properly engaged or understood what was taking place. Future hospital/ward closures could not go ahead until the Partnership could demonstrate that it had adequately engaged and consulted and that a modelling process had been carried out.

From our meetings with council elected members, NHS board members and senior managers, it was evident, that they recognised the need to develop community capacity. They placed significance on the role that local communities and community organisations could play in providing support to older people.

They acknowledged that current service configurations for the care of older people were not sustainable. However, we saw less evidence of how the Partnership measured the impact of the outcomes achieved by the various community support services. Managers suggested that there was unrealised potential, to deliver services, in the third sector.

6.5 Commissioning arrangements

Joint strategic commissioning means all the activities involved in the partnership jointly assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

The Scottish Government expected health and social care partnerships to produce joint commissioning strategies for older people's services during 2013. Informed by Scottish Government guidance, these aimed to provide jointly assessed and forecasted needs, desired outcomes, and plan the nature, range and quality of future services. This plan should focus upon delivering improved outcomes for users and carers through better aligning investment with what the evidence tells about the needs of service users in local communities. In 2014, additional Scottish Government guidance advised that these plans were to be developed further to include detailed financial planning and extend to all adult groups. This joint strategic commissioning plan should be published by April 2016.

The Partnership recognised that there were challenges in local supply and capacity in areas such as care homes, care at homes and self-directed support market segments. 'Market testing' exercises had been undertaken in care home and care at home services. A care at home framework had been established to try to improve the quality and reliability of service delivery. However, this had been only partially successful. A strategic partnership with care at home providers, Scottish Care and The Institute for Research and Innovation in Social Services (IRISS) was looking to agree future care at home priorities. The Partnership had aspirations to provide a similar framework for directly provided services. They recognised that these services needed the same requirements as externally commissioned services.

Supply and quality was an issue in the care home sector. This was evidenced by the substantial number of service users (estimated at 35 or more by senior managers at the time of inspection) who were in 'out of area' placements outwith Argyll and Bute.

The Partnership recognised that they were providing a 'centre-based' model of day care. There were issues of under occupancy. This service delivery model should be reassessed to enable a greater choice of more flexible options for service users and their carers.

The council had contract supplier management and procurement procedures. These included contract monitoring, contract compliance and service review. Commissioning officers advised that externally commissioned services had quality assurance measures in place as part of contractual compliance procedures. Meetings were planned with all service providers every three months.

An Audit Scotland report published in May 2015[14] had made recommendations on improving procurement procedures in Argyll and Bute. Senior managers and commissioning officers advised us that they had learned from the report and would review and update their procedures accordingly.

The Partnership's preparations for locality commissioning were underway. Locality-based coordinators had a budget to develop services. Projects from local groups, to provide community based solutions, were encouraged. We heard from senior managers that learning from small scale local commissioning would help inform the approach to wider strategic commissioning.

Joint strategic commissioning activity to date had primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners. However, we saw less in terms of how strategic joint commissioning developments were to be progressed and how these would be led. The partnership needed to develop its commissioning approach to further shift the balance of care.

To further articulate its strategic intentions, and in line with Scottish Government guidance, the partnership should produce a 'SMART' (specific, measurable, achievable, realistic and time-bound) joint strategic commissioning plan by April 2016. The Partnership intended to formally consult on its draft joint strategic commissioning plan in the autumn of 2015.

14 Audit Scotland: Review of the commissioning process undertaken on behalf of the Argyll and Bute Alcohol and Drugs Partnership (May 2015).

Recommendation for improvement 8

The Partnership should make sure that the future joint strategic commissioning plan gives detail on:

- how priorities are to be taken forward and resourced
- how joint organisational development planning to support this is to be taken forward
- how consultation, engagement and involvement are to be maintained
- full and detailed costed action plans including plans for investment and disinvestment based on identified future needs, and
- expected outcomes.

Quality indicator 7 – Management and support of staff

Summary

Evaluation – Adequate

Argyll and Bute Council and NHS Highland were developing joint workforce planning but this was at a very early stage.

Staff recruitment and retention was a challenge in some geographical areas and in some parts of the workforce. This affected the capacity and capability of some services. Although there were few joint posts, there was evidence of new approaches to service delivery through a range of projects and schemes.

Resource allocation and deployment of staff were still largely at an individual agency level. However, there was evidence that frontline staff from health and social work services worked hard to ensure a joined up approach to provide positive outcomes for older people.

Staff development and training were largely specific to each of the partners. Most staff thought there was good access to training appropriate to their posts.

On the whole individual supervision arrangements and support were positive. In the partner's own staff surveys the need to improve management support for staff was identified as a key priority. A range of initiatives was in place which showed the Partnership's intentions to address this and other areas including training and development.

This section comments on how staff were supported and managed within the workforce. It also looked at how staff were supported to learn and develop in their roles and in the context of a changing culture, how the Partnership approached joint workforce planning and deployment of staff.

7.1 Recruitment and retention

We read a range of documentation provided by Argyll and Bute Council and NHS Highland. This included policies, procedures and strategies for safer recruitment, retention and the management and support of staff. Although the documents were specific to each agency, they were robust and fit for purpose.

Joint health and social work service planning was at an early stage particularly with moving to a locality and commissioning approach. Four commissioning localities had been identified and work was underway to look at the organisational development of the workforce. The Partnership had commissioned Scottish Care, to gather information about the skills profiles of staff working in older people's services across all sectors. Learning and development needs were collated to identify the different levels of skills and knowledge to inform the joint workforce strategy. However, this was still under development.

The Partnership's intentions were to reshape staffing models and skills mix in localities to meet the future need and demand of services for older people. In order to achieve the Partnership's strategic aspirations, it needed to fully identify the future needs in terms of staffing resources and skill mix/levels. Senior officers told us that the development of an integrated workforce plan was in preparation.

In our interviews and focus groups with a range of frontline staff and managers, we learned about the ongoing challenge of recruitment and retention in areas such as medical consultants, GPs, care at home, allied health professionals, social workers and community nurses. This had affected the delivery of services and delayed the development of some Change Fund projects. There was a particularly high turnover of staff in care at home services. Third and independent sector providers also reported difficulties with recruitment of nursing and social care posts. They also said this was more challenging in remote areas. Senior leaders and managers recognised that recruitment and retention was a significant constraining issue for the Partnership.

Most job descriptions and profiles were specific to each of the partners. Staff we met with confirmed they were clear about their roles and responsibilities. Although recruitment processes were separate, the Partnership had begun to look at a more joint and strategic approach to recruitment. A joint human resource group had been set up to provide expertise on the new management structure. It would also input to the development of job descriptions and role profiles for new integrated posts. The Partnership had established a workforce planning group involving Scottish Care and Social Work Scotland. This group would work with care at home providers to consider different approaches to support recruitment and retention, service mapping, training and conditions of service. However, we found limited evidence of its impact during our inspection.

The council had been working for a number of years to modernise their care at home services. This included tendering for services from the independent sector in an attempt to expand the range of care options available. However, recruitment across all sectors remained a challenge. In localities, where there was a lack of third or independent sector supply the council was the sole or main provider of care at home services. Most council care at home staff had 'zero hour' contracts.

This had led to staff turnover and a number of individuals were reported to have left the council for other service providers. We heard that this had led to occasions where care at home services were unavailable for service users or that the community nursing service had filled the gap. This in turn had affected their own capacity. The Partnership was negotiating with trade unions representing council care at home staff to try to resolve terms and conditions issues.

Heads of human resources from health and social work confirmed that recruitment was an ongoing issue. Recruitment campaigns, local advertising and other approaches including media broadcasts had taken place to try to attract people to work in the area. The council had established a working group, supported by the Institute of Research and Social Sciences to develop staff retention and to help develop social care as a career.

This group were also looking into the development of a 'training passport' to allow the training received by a staff member in one service provider to be transferrable to another. This would help speed up the recruitment process and avoid delays in staff commencing employment.

The Partnership had considered a range of approaches to make health and social work jobs more attractive career options. We heard about some positive developments that were underway such as:

- sharing staff across different care sectors to embed a multi-disciplinary working approach, and to move away from staff only carrying out tasks associated with their roles, and
- building 'grow your own' schemes as well as modern apprenticeships, staff using open university and distance learning materials to support their career progression and links with local colleges to develop career pathways for younger people.

Example of good practice – Health and Social Care Academy

To address some of the recruitment difficulties, the Partnership had developed a 'Health and Social Care Academy'. Argyll Voluntary Action, a third sector partner, had established links with Argyll College in a positive drive to develop more vocational and care courses to encourage young people to engage in health and social care career pathways. This had extended to the introduction of modern apprentice schemes. In local schools senior pupils were enabled to gain experience of working in a health or social care environment as part of the school curriculum.

Sickness and unplanned absence could have an impact on service delivery. We were advised that Argyll and Bute Council's adult care services had an average absentee rate of 17.5 days per full-time employee equivalent, (in 2014/15). This was above the council average and above target. NHS Highland (Argyll and Bute) had an absentee rate 4.72% (in 2014/15) which was above target. Both social work and health services had strategies in place to reduce absence levels. Absence information was reported regularly and monitored. This needed to continue to help deliver on targets.

Recommendation for improvement 9

The Partnership should complete and deliver a joint workforce strategy to support health and social care integration. This should include a clear workforce plan to support sustainable recruitment and retention so that there is sufficient capacity and suitable skills mix to deliver high quality services for older people and their carers.

7.2 Deployment, joint working and team work

We found that resource allocation and deployment of staff were still largely at an individual agency level. From our review of social work services and health records, we found positive aspects of joint working. In most cases, there was evidence of multi-agency working and that services worked together, for example, to provide care at times of crisis. There was evidence that multi-agency partners' views informed individuals' assessments and risk assessments. There was evidence of multi-agency working in 91% of cases. In 88% of assessments health, social work and other services were sharing information and recording it.

Frontline staff as well as NHS and social work services managers reported good working relationships with colleagues across the services. They said that an increased focus on outcomes was evolving as a result. GPs told us that they had good links and felt well supported by medicine for the elderly specialists. We saw a few examples where teams shared offices or were co-located in the same building but they did not always see themselves as working in integrated teams. They were, in effect, aligned teams although there was mutual trust and respect for each other in their respective roles.

Senior managers told us that the Scottish Government were supporting them to look at a flexible workforce model for integrated care. It was keen for the Partnership to develop test sites to pilot new models in remote areas. Plans were underway to review a model of integrated care that developed in the Netherlands. We also heard that a joint community nursing and care model was being tested on the islands and the Kintyre peninsula.

7.3 Training development and support

From our staff survey, we noted that three-quarters of respondents agreed that joint working was supported and encouraged by managers. A clear majority agreed that they had good opportunities for training and professional development. This was broadly consistent with both partners own staff survey results. Frontline health and social work services staff we met with were positive about training opportunities.

NHS Highland and Argyll and Bute Council had arrangements for individual supervision, appraisal and professional development. We read a range of documents and training plans from health and social work. This included a suite of statutory, mandatory and core training. It was clear there was a good variety of training available to ensure staff maintained their skills, knowledge and accountability in their respective professions. However, much of this was single agency. Formal joint ongoing staff training was limited to topics such adult support and protection.

Throughout the Partnership, there was an expectation that supervision for staff should be in place. However, in our discussions with organisational development staff, we were told that supervision on an individual basis was not always achieved.

We noted that over half (56%) of case records we read recorded decisions and discussions from supervision. Similarly 60% of cases had been read by line managers. Frontline staff told us they felt supported by immediate line managers but had limited contact with middle, and senior management.

The integration 'Organisational Development Plan' was under review and a lead officer had been appointed to support this process. An integration organisational development group had been set up to develop and consult on a joint workforce plan.

Self-directed support training had been rolled out to all social work staff so they were clear about their role. Basic awareness training about the values and ethos of the legislation had taken place for a limited number of health staff. However, we were told that more in depth training was planned to target a wider audience. This would include NHS and third sector partners.

Alzheimer Scotland was supporting the roll out of the 'Promoting Excellence' framework to deliver on dementia training for staff across the Partnership. This was reported to be at an early stage of development. Independent sector providers told us there was a wide range of dementia training available from the council and external sources. We were told that a network to support dementia 'ambassadors' and dementia 'champions' had been set up to develop and share learning. This would strengthen and support and leadership for staff providing care for individuals and the carers of those with dementia.

Example of good practice – Caring Connections Network

Financed through the Reshaping Care for Older People Change Fund, this course for health, social work and third sector staff aimed to change delivery of care and change practice. It sought to equip workers with new ways of planning and developing services through community asset building approaches and focus on person-centred care. It promoted an enabling model of health and social care and allowed staff to work with more awareness of service user and carers' requirements and wishes.

The course helped staff to find what can be done to make sure that service users were being listened to, inspiring and motivating people who provided and received care, bringing person-centred care to life in each health and care setting and helped people talk about their practice or experience of care and support.

We found there was a good but informal network of training from health professionals who had supported social work services staff working in care homes and in the community. This support extended to local authority services and the third and independent sectors. Themes included input on palliative and end of life care and anticipatory care plans.

Many courses were now available online or involving a distance learning element. It was reported, by frontline staff, to be more difficult to organise more specialised training as the numbers were not sufficient due to the dispersed nature of staff. Some difficulties were highlighted about the lack of available trainers to enable staff to attend refresher courses in moving and handling. That led to delays of up to six months in some instances. Argyll and Bute Council had continued to fund Scottish Vocational Qualifications when internal staff moved to another service provider.

Health and social work staff told us they felt they had good opportunities for training. However, this was less so for staff working in remote areas as we were told that most of the training was organised on the mainland. Staff reported it was difficult for them to attend because there was limited capacity in their teams to provide cover. The Partnership acknowledged these difficulties and was considering different approaches including investment in more online course and distance learning opportunities. Independent care at home service providers reported an improvement in access to training.

The Partnership had recruited a 'Releasing Time to Care' facilitator post to help develop more integrated teams. This would be re-visited at end of 2015/16.

The Partnership had established an action learning set of managers from the health, social work services, third and independent sectors. This was part of a national leadership programme to develop partnership working with support from external facilitators through NHS for Education for Scotland and Scottish Social Services Council. We heard about the Partnership working with a range of organisations, such as the Scottish Government's Joint Improvement Team and external consultants to learn and implement good practice. For example, a leadership development programme for senior managers across sectors had proved popular. Senior managers spoke positively about the benefits of this training and the opportunities it had created for them to work together in partnership to improve and develop services for older people.

Quality indicator 8 – Partnership working

Summary

Evaluation – Adequate

The Partnership was actively planning for health and social care integration. However, it had yet to establish pooled budget arrangements including accounting and reporting frameworks. Separate but effective budget management approaches were in place. However, the shadow Integration Joint Board had yet to have detailed discussions about the scope of the budgets aligned to those services it had agreed to commit to integration. The Partnership needed to progress this area to make sure they delivered the same standard of effective governance that both health and social work services had previously achieved.

There were major challenges of working across separate client information systems. We identified some key information sharing gaps which will need to be addressed as integration moves forward. A joint information strategy was awaited.

Good groundwork was in place in relation to health and social care integration. Integration work streams had been established and the senior tier of the new management structure was in place. The Partnership was adopting new ways of collaborative working. These included locality needs assessment, service planning and delivery structures. However, while there were strong links with most stakeholders being forged more work needed to be done.

This section comments on how finances and resources were managed across the Partnership and whether there was a whole systems approach. It also considers whether areas such as business support and information technology supported the delivery of outcomes for individuals and respective members of the Partnership.

8.1 Management of resources

As with many areas of Scotland, the Partnership was not at the stage of jointly pooling budgets. Financial management responsibilities remained separate with NHS Highland and the council until integration commencement in April 2016. Health and social work services partners were working collaboratively towards a shared approach to planning and budget management. Indicative budgets had been produced to support the 'outline' joint strategic commissioning plan.

The combined 2015/16 budget was £250.7 million. This represented a 1% and a 2% reduction on the 2014/15 social work and health budgets respectively, matched by savings within services included for integration. The achievement of these savings plans would be challenging and presented a risk to service delivery.

Despite agreeing the scope of services to be delegated and the indicative combined budget, we noted that at the time of our inspection the shadow Integration Joint Board had yet to discuss the overall detailed integration budgets.

At the time of the inspection, the Partnership had yet to establish joint accounting control measures, decide how the joint budget would be synchronised and develop a joint financial reporting framework. Although the Integration Joint Board would receive agreed budgets from both health and social work services it was unclear whether or not it would have a parent or partner relationship with existing bodies. The Partnership had established an integration financial work stream to oversee this work. This work stream would benefit from the appointment of a Joint Chief Finance Officer post. This had been established but not yet appointed.

Financial performance of Argyll and Bute Council

The council had reviewed their funding levels going forward as part of their 'service choices' exercise. It had identified that there was a growing budget gap resulting from anticipated increased inflationary cost pressures and central government funding. At May 2015, the total budget gap for the period covering 2016/17 to 2020/21 was estimated to be between £21.7 and £26.0 million taking in to account best and worst case scenarios. This gap was projected to be between £7.8 and £8.8 million by 2016/17, the first full year of operational Integration Joint Board responsibilities.

The challenge for the council and Integration Joint Board was that this position will require significant recurring savings year on year. This would be against an identified need for a 3% uplift in the older people's budget to meet the demographic challenges and projected impact on service demand. The council held financial reserves but at the time of our inspection had no plans to assign these to the Integration Joint Board.

The council adult care budget, including community care services for older people in 2014/15 was £43.4 million. Within this budget there was an under spend in the same reporting period of £0.2 million. A £1.3 million over spend in care at home services was offset mainly as a result of cost reductions made across learning disability, and mental health services and Change Fund disinvestment funds. Change Fund disinvestment fund were non-recurring. Removing this amount resulted in an over spend of £0.3 million. The main pressures on the adult care budget included the growth in the number of service users and the increasing complexity of new care packages.

Community care services met their efficiency savings target of £1.4 million with £0.6 million of this amount coming from vacancy savings. A similar target was set for 2015/16. This was against the backdrop of high agency costs required to maintain service delivery offsetting the positive aspects of this target being met.

A revised charging policy was being implemented. At the inspection we were advised by managers that this had no significant impact on take up of services. The non-residential element of this policy collected £0.7 million per year. However, there was a risk that existing levels of revenue could not be maintained in the longer term.

The Partnership needed to continue to monitor the impact of this policy both in terms of whether it prohibited service uptake and to ensure its ability to generate maximum income was being refreshed where appropriate.

Performance management of former Argyll and Bute Community Health Partnership (CHP)

NHS Highland's operational implementation plan (2015–25) relied on an achievement of planned recurring savings averaging at around 2% of funding each year. This totalled £161.7 million over the 10 year period to meet immediate cost pressures and planned investments.

Argyll and Bute CHP reported that it had an annual budget under spend in 2014-15 of £0.685 million. It had met its efficiency savings target of £3.4 million despite setting budgets based on establishments plus 25% for turnover including vacancies, sickness and absence cover with inpatient services particularly challenging. In addition, there were cost pressures associated with the high number of locums required to cover vacant senior clinician posts. We did not anticipate any reduction in these pressures in the short term.

NHS Highland faced challenges on the sustainability of its three year rolling service level agreement with NHS Greater Glasgow and Clyde. We were told that approximately 25% of the former CHP's total budget was allocated for this agreement for cross boundary services arrangements. Contributory factors to difficult budget monitoring were GPs referrals for specialist treatments such as cardiology, orthopaedics and ophthalmology services in NHS Greater Glasgow and Clyde. While access to these treatments was viewed as necessary to meet patients' assessed needs the Partnership did not have the level of service specification in the agreement that they would have wished (for example quality control measures). There were no immediate plans to address this issue. Senior managers told us that this issue was one of the major challenges for the Integration Joint Board to take account of. This issue was a significant risk that could adversely affect the Partnership's financial sustainability if not focused upon.

Recommendation for improvement 10

The Partnership should update, in cooperation with NHS Greater Glasgow and Clyde, the service specification of their service level agreement to clarify issues such as financial governance and quality assurance measures.

The Partnership had agreed that the Integration Joint Board would not yet have any direct capital budget. However, the joint strategic commissioning plan should articulate any revenue support to relevant capital projects.

It should also set out separately and jointly planned capital projects which contribute to the Integration Joint Board's objectives. This would help ensure that capital investment had a joint focus.

Change Fund/Integrated Care Fund

The council and NHS Highland had worked closely with the third and independent sectors to plan and deliver a range of services as part of the Reshaping Care for Older People agenda.[15] This was continuing with the Integrated Care Fund.

Since 2011/12 the Scottish Government had provided funding to the Partnership through the Change Fund as 'bridging finance' to enable the redesign of services towards early intervention and support. By March 2015 the Partnership had received £7.3 million in funding. We noted that a significant proportion was channelled to services supporting carers, those with dementia, end of life care and the third sector.

Partners had used the Change Fund and other tests of change to inform some of their investment and disinvestment decisions, and this had created an environment to make step changes to services in the future. These provided a basis to set the future direction that was shared with all key stakeholders.

Carried forward by locality Reshaping Care for Older People implementation groups, the work was led by a dedicated project manager who provided regular progress reports to a multi-agency Programme Board providing oversight. The projects were reviewed regularly and investment/disinvestment options were considered by the Programme Board based on an outcomes approach. This approach was to be emulated through investment from the Scottish Government's Integrated Care Fund of which the Partnership received £1.8 million per year up till 2017/18.

A sizeable proportion of this fund had been allocated to each locality with support from the health and social work commissioning staff to assist in developing locality commissioning. Central to investment decisions was the need for localities to use the funding to enable sustainable disinvestment/investment plans. This work would be complemented by £0.5 million technology enabled care funding in 2015/16.

8.2 Information systems

Integrated data sharing arrangements are a challenge throughout Scotland. Argyll and Bute was part of the Highland Data Sharing Partnership. Its aim was twofold. Firstly, it provided guidance to staff about what, when and how to share information. Secondly, it prioritised the developments of procedures which would support the practitioners across the different services and enable them to undertake effective integrated working. The Partnership recognised that the information sharing protocol needed to reviewed and refreshed.

15 Scottish Government Reshaping Care for Older People: A Programme for Change 2011–2021.

As with many Partnerships in Scotland there was very limited evidence that progress had been made in delivering a coherent joint information technology approach that supported effective information sharing at both an individual practitioner and strategic levels. We were told that health staff access to the social work 'Carefirst' information technology system was very limited and that social work staff had similar access problems with health information technology systems such as 'MiDIS' and 'Vision'.

Information sharing in support of joint working was not straight forward. Both health and social work staff told us that information was difficult to share as information technology systems did not enable access to information from other agencies in most instances. Staff maintained effective contact using email and alternative formal and informal networks such as meetings and regular contact to support joint working. This was evident in our staff survey where 34% agreed that information systems supported front line staff to communicate effectively with partner organisations. Despite the lack of supporting information technology systems, we found that staff were being proactive and communicating effectively with each other to the benefit of the older people they were working with. From our review of case records we found that records were largely single agency. Few showed evidence of relevant multi-agency electronic information sharing. However, in 68% of records information from partners informed the assessment. This showed that there was good communication between frontline staff.

Information technology system gaps identified included human resources, referral, assessment, care planning and out-of-hours services. Improvements in information technology systems were planned for service monitoring in areas such as care homes, care at home, respite and day care services. We were told about difficulties communicating between frontline health services staff, as they used different information technology systems. Communication between primary care and secondary healthcare services with social work services was also inconsistent.

An example of the impact the difficulty in sharing information had included the risks to avoiding hospital admissions and supporting discharges. We were told that the out-of-hours support services had limited access to 'Carefirst' and healthcare patient records for the older people referred to them for night time support.

The Partnership planned to place the universal adult assessment tool form on the 'MiDIS' system. This would mean that healthcare staff could access the information held in the assessment. Staff told us that this would be available on 'MIDIS' on a read-only basis and would restrict healthcare staff from being able to enter information on the assessment forms alongside social work services staff. Some staff told us that they had shared information electronically in the past. However, clinical governance difficulties and problems with information technology systems had prevented further development of joint assessment tools that could be shared. Joint work being considered by the integration clinical and care governance work stream around shared electronic risk registers. Information systems provided frontline staff with a tool to monitor their own workload and performance. The capacity for social work services staff to record and measure outcomes had been embedded in the universal adult assessment tool.

At the time of the inspection, this assessment tool was being rolled out. It was anticipated that aggregated outcomes information would inform performance reports. Staff told that this had some difficulties. We noted that the Partnership was working with the Scottish Government's joint improvement team to help resolve these issues. This was reflected in our staff survey where 31% of staff told us that there was a coherent strategy to gather and use data to improve outcomes.

The Argyll and Bute Health and Social Care Data Integration and Intelligence Project was a thematic review project linked to national work commissioned by the Scottish Government. Its aim was to work with NHS Scotland's Information Services Division (ISD) to develop an information and intelligence framework to support services delegated to health and social care integration. The Partnership recognised the importance of this approach to developing more intelligent and sophisticated approaches to its strategic planning, commissioning, investment, disinvestment and service redesign modelling. A test platform had been set up allowing the Partnership to send wide-ranging social care data sets to ISD for analysis alongside health data. This would allow the Partnership to consider cost and quality issues more thoroughly. However, while this work was progressing, the Partnership still had work to do to ensure this was ready for health and social care integration. In particular, further work was needed on evaluating test systems, running pre-defined tests and familiarising themselves with the test platform ahead of going live.

Senior officers told us that work was being carried out to enable 'Pyramid', the council's performance management system, to be shared with health partners. The information management and technical integration work stream was responsible for overseeing this work. Much of this work was an early stage of development.

8.3 Partnership arrangements

The Public Bodies (Joint Working) Scotland Act 2014 requires NHS boards and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions.

Compliance with integration delivery principles[16]

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) Scotland Act 2014 to review and evaluate if the planning, organisation or coordination of social services, services provided under the health service and services provided by an independent health care service is complying with the integration delivery principles.

Health and social work services had a well-established history of partnership working. Partnership working was established through community planning structures and integration arrangements were building on this.

16 Section 31 of the Public Bodies (Joint Working) Scotland Act 2014 states in summary: high quality integrated, effective, efficient, and preventative services should improve service users' wellbeing, take account of their particular needs and characteristics, where they live (locality), their rights and dignity, keep them safe, involve them and engage with their communities.

Much of the groundwork was in place such as the shadow Integration Joint Board and an integration 'body corporate' model scheme approved by the Scottish Government. This was the delegation of functions and resources by NHS boards and local authorities to a body corporate. This would be managed by an Integration Joint Board with an appointed chief officer who would be jointly accountable to both chief executives.

A high level 'outline joint strategic commissioning plan' was being consulted upon. The joint chief officer and the senior tiers of the management structure had been appointed. Integration delivery work streams were constituted and making progress. A joint health and social care mangers meeting was well established.

Membership of the shadow Integration Joint Board was being finalised with the appointment of stakeholders such as public, third and independent sector and senior clinical representatives. A clinical and care governance group had been established to progress joint governance.

A communication and engagement group, steered by the third and independent sectors, was involved with public consultation support from both health and social work services communications services. However, more work was needed as 40% of the respondents to our staff survey agreed that there were effective partnerships which focussed on delivering key policies and plans for older people and included relevant stakeholders. Developing governance arrangements included the setting up of the Argyll and Bute governance committee. This was a subcommittee of NHS Highland Board and provided high-level governance of modernisation and redesign across both health and social work services. As well as reporting to NHS Highland, it had appointed two council elected members and a council officer to ensure a joint approach. We also noted that the council's community services committee also had an integration monitoring role with the Integration Joint Board.

Example of good practice – Progressive Care

Two 'progressive care' centres were established on the islands of Jura and Mull. These were developed to meet the needs of individuals with high levels of care needs. As there were no care homes on either island, service users had their needs met, in their own homes, by a range of community-based staff. Significant levels of capital funding were required. This was delivered by a combination of the council (social work and housing including the strategic housing fund), NHS Highland, housing associations and the local community. Revenue support was reported by the Partnership as sustainable as the unit costs of progressive care were consistent with care home costs.

The Partnership needed to build on existing individual models of governance and agree joint financial accounting and reporting frameworks for when the Integration Joint Board assumed full responsibility in April 2016. There would be significant challenges ahead for the Partnership. The impact of current and future savings and efficiencies targets for both partners needed to be considered jointly.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Adequate

NHS Highland and Argyll and Bute Council had a shared vision for services for older people and had an agreed model for integration of health and social work services. They were building working relationships throughout the Partnership. Integration planning was progressing.

A joint management structure was being implemented and governance structure was being established. Senior managers and staff were working with partners to progress locality commissioning structures.

Senior Partnership managers were engaging with other partners such as the third and independent sectors, local communities, service users and carers. They were identifying assets to develop locality commissioning. However, progress was at an early stage.

Leaders needed to communicate better about plans for health and social care integration. More work was needed to make sure that all staff understood the vision and priorities. While we saw evidence of joint working across the Partnership, the management of change needed to become more effective.

This section comments on the quality of leadership and the contribution of corporate leadership to drive the vision, culture and communication with the workforce and wider population. It also considered the effectiveness of the leadership around strategic and cultural change and improvement.

9.1 Vision, values and culture across the partnership

The Partnership had a shared vision for services for older people. This was set out in a range of strategic plans. Leaders of health and social work services had identified many of the future challenges in delivering joined-up services for older people. They had an agreed model for integration and were building working relationships throughout the Partnership. A series of detailed integration work streams were progressing. Work stream and planning group papers showed a wide-ranging commitment to service improvement activity. Integration planning was well prepared and progressing.

The Partnership's 'integration scheme' had been approved by the Scottish Government. A shadow Integration Joint Board, with suitable representation, was being established. Its key aim was to provide joint direction and recommendations to both parent organisations (Argyll and Bute Council and NHS Highland). A strategic risk register was in place and was being monitored.

The Partnership needed to take steps to promote ownership of its vision, and the practicalities of integration. For example, from our staff survey, less than half said that there was a clear vision for older people's services with a shared understanding of the priorities. We asked staff if the vision for older people's services was set out in comprehensive joint strategic plans, alongside strategic objectives with measurable targets and timescales. Just over a half agreed with the statement. Nevertheless, across the Partnership, staff were committed to delivering joint services.

9.2 Leadership of strategy and direction

We attended meetings with shadow Integration Joint Board members and the leader of the council, NHS Highland and council committees. There was evidence of positive working relationship between NHS non-executive and council elected members, with agreement about the way forward on integration. Shadow Integration Joint Board members needed further support from senior officers to improve their capability to fulfill their roles.

Members of the shadow Integration Joint Board acknowledged that they needed to further develop their skills and understanding of integration. Existing council elected members' training included personal development plans, seminars and 360^0 reviews.

Development sessions had supported council elected members and NHS board members. They saw their role as providing oversight of governance and financial accountability, ensuring equitable services and developing a structure that supported good quality services that delivered good personal outcomes for individuals.

A bespoke training programme for shadow Integration Joint Board members was in preparation. Gaining a detailed understanding of health and social work service delivery as well as financial, performance, clinical and care governance were identified as training priorities by the shadow board and senior officers. Leadership development was another area where the shadow Integration Joint Board required detailed understanding also. The training needs for the shadow Integration Joint Board were being developed in cooperation with the Scottish Government.

We learned of previous varying levels of productive interaction between senior managers and council elected members. Board members told us that they felt confident on their ability to balance their roles as representing local community interests and their wider strategic role on the Integration Joint Board. Collective accountability and responsibility for leading integrated services was central to their delivery. It was important that Integration Joint Board members were fully capable to discharge their responsibilities and therefore addressing their learning and development needs was essential.

From the interviews we carried out with elected members it was clear that they felt that members and officers were working effectively together. They also felt that members were acting together in an increasingly constructive manner and as a result, the council was managing its business more effectively.

9.3 Leadership of people across the Partnership

Positive efforts had been made to develop and implement leadership development programmes across sectors. However, feedback from our staff survey showed that more work was needed to make sure there were clearer joint strategies to communicate change to staff. We asked staff whether their views were fully taken into account when services were being strategically planned. A third of respondents agreed with the statement.

Most staff we met with told us they had been involved in a number of consultation exercises for a variety of initiatives including integration. However, many of them told us they had not had the opportunity to ask detailed questions. Therefore, they did not feel their views were always taken into consideration or that their queries had been fully clarified. Senior managers told us they were already aware of some of these issues and action plans were under way or in preparation. Council elected members and NHS board members were aware of the need to concentrate efforts on engaging and involving staff. The Partnership needed to refresh and further develop its health and social care integration communication and engagement plan.

The profile and visibility to staff of leaders could be improved. Strategic leadership and the role of senior managers and Integration Joint Board members in supporting employees to deliver effective outcomes could be improved. In our staff survey, of those who responded:

- 47% agreed their views were fully taken into account when services were planned or provided (38% disagreed)
- 45% agreed there was a clear vision for older people's services with a shared understanding of priorities (29% disagreed), and
- 37% agreed that senior managers communicated well with frontline staff (52% disagreed).

From our staff survey and the staff we met with during our inspection, it was clear that the majority of staff in both health and social work services had good professional relationships with each other. In our staff survey, three-quarters of staff said that joint working was supported and encouraged by managers. In addition 52% of staff reported that there were positive working relationships between practitioners at all levels.

Recommendation for improvement 11

The Partnership should update its consultation, engagement and involvement policies and procedures with stakeholders and ensure that these are fully implemented. This should include better engagement on:

- its vision and objectives
- integration pathways
- service redesign
- supporting improvement and change management
- realising the full potential of the third and independent sectors, and
- providing feedback on how the results of consultations have been considered, and the subsequent actions resulting from the views of stakeholders.

9.4 Leadership of change and improvement

Arrangements for self-evaluation (for example the Highland Quality Approach and thematic reviews) were in place. There was a history of joint working between health and social work services. The integration agenda was a challenging one. We had some concerns about the effectiveness of change management. From our staff survey, under half agreed that the quality of services offered to older people jointly by partner's staff had improved in the previous year. Only 30% of staff agreed that changes which affected services were managed well (53% disagreed). However, 58% of respondents agreed that high standards of professionalism were promoted and supported by all professional leaders, council elected members and NHS board members. This would provide a good basis for taking developments forward.

As is the case nationally, securing resources to meet all the requirements to deliver services was challenging. One challenge that the leadership faced was the ability to deliver services across a wide range of communities. In the light of this they were developing local partnerships to deliver localised approaches to health and social care.

Senior managers were engaging with other partners such as the third and independent sectors, local communities, users of services and carers. They were identifying resources to develop locality commissioning. However, progress was at an early stage.

Staff reported difficulties in ensuring consistency of joint working and standards throughout the partner organisations. The consistency and equity of service access and quality within each of the localities was also a major priority. Clear and consistent senior leadership would be needed to forge stronger links between outcomes, activity, disinvestment and investment decisions.

Quality indicator 10 – Capacity for improvement

We do not award an evaluation grade for this quality indicator. From our evaluations against each quality indicator 1–9 we look at how confident we are that the Partnership had the capacity for improvement.

10. 1 Improvements to outcomes and the positive impact services have on the lives of individuals and carers

From evidence gathered in our inspection, we concluded that the Partnership delivered, in the main, good outcomes for service users and their carers. This evidence included our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership and results from our review of social work and health service case records. This was complemented by the views expressed by service users, carers, council elected and NHS board members as well as the Partnership staff we met with. We saw a range of services that helped deliver good personal outcomes in areas such as:

- prevention of admission to hospital
- joint multidisciplinary and multi-agency working
- telecare
- care at home
- assessment and care planning, and
- community infrastructure.

However, to additionally help deliver good personal outcomes there was room for improvement in areas such as:

- delayed discharges
- reablement
- respite
- out of area care home placements
- risk assessment, planning and recording
- independent advocacy
- geographical equity of service delivery
- joint strategic commissioning
- workforce planning (including staff recruitment and retention), and
- information technology systems.

10. 2 Effective approaches to quality improvement and a track record of delivering improvement

The Partnership was progressing well with its plans on integration and monitoring how well they were delivering. The Partnership had well-established performance frameworks. A wide range of performance information was produced, reported and made available to senior and local management, as well as council elected members and NHS board members.

A draft joint performance framework linked to national outcomes was being produced. The Partnership needed to ensure that the joint performance framework contained challenging but achievable targets. Commissioning was still largely separate. An outline joint strategic commissioning plan was in place with a strong commitment to realise the capacity within the community to help service users and their carers. The council and NHS Highland were identifying joint financial resources with a joint financial framework under development. There was broad agreement on what resources were included in the Partnership.

10. 3 Effective leadership and management

With regard to integration, in the main, there was positive leadership and positive working relationships at senior levels between officials following a period of significant change. Leaders, including council elected members and NHS board members, needed to better share and communicate with staff the merits of the integration agenda in detail.

Senior managers told us that council elected members and NHS board members engaged with health and social work officers and were involved in addressing the issues of health and social care integration. This had been fostered in the Reshaping Care for Older People work. Council elected members, NHS board members and senior officials acknowledged the need to concentrate their efforts developing the capacity and capability of the shadow Integration Joint Board further. This would help deliver the sustained and focused effort that would be needed if a shared vision was to be implemented to meet future challenges. Good frontline working needed to be built upon by senior managers.

10. 4 Preparedness for health and social care integration

NHS Highland and Argyll and Bute Council had a good history of joint working with each other, the third sector and the independent sector. The Partnership had fostered a positive culture of working together. Leaders understood the future challenges in delivering joined-up services for older people. Constructive plans were in preparation to develop more integrated health and social work services. This would mean that older people and their carers would have more positive experiences and better personal outcomes. Our conclusion was that the building blocks to achieve better integration were being put in place and progressing well but needed further development.

What happens next?

We will ask Argyll and Bute Partnership to produce a joint action plan detailing how it will implement each of our recommendations. The Care Inspectorate link inspector, in partnership with Healthcare Improvement Scotland colleagues, will monitor progress. The action plan will be published on www.careinspectorate.com and www.healthcareimprovementscotland.org

February 2016

What key outcomes have we achieved?	How well do we jointly meet the needs of our stakeholders through person centred approaches?	How good is our joint delivery of services?	How good is our management of whole systems in partnership?	How good is our leadership?
1. Key performance outcomes	**2. Getting help at the right time**	**5. Delivery of key processes**	**6. Policy development and plans to support improvement in service**	**9. Leadership and direction that promotes partnership**
1.1 Improvements in partnership performance in both healthcare and social care **1.2** Improvements in the health, wellbeing and outcomes for people and carers	**2.1** Experience of individuals and carers of improved health, wellbeing, care and support **2.2** Prevention, early identification and intervention at the right time **2.3** Access to information about support options including self-directed support	**5.1** Access to support **5.2** Assessing need, planning for individuals and delivering care and support **5.3** Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks **5.4** Involvement of individuals and carers in directing their own support	**6.1** Operational and strategic planning arrangements **6.2** Partnership development of a range of early intervention and support services **6.3** Quality assurance, self-evaluation and improvement **6.4** Involving individuals who use services, carers and other stakeholders **6.5** Commissioning arrangements	**9.1** Vision ,values and culture across the partnership **9.2** Leadership of strategy and direction **9.3** Leadership of people across the partnership **9.4** Leadership of change and improvement
	3. Impact on staff **3.1** Staff motivation and support		**7. Management and support of staff** **7.1** Recruitment and retention **7.2** Deployment, joint working and team work **7.3** Training, development and support	**10. Capacity for improvement**
	4. Impact on the community **4.1** Public confidence in community services and community engagement		**8. Partnership working** **8.1** Management of resources **8.2** Information systems **8.3** Partnership arrangements	**10.1** Judgement based on an evaluation of performance against the quality indicators
← What is our capacity for improvement? →				

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