



## Services for older people in Aberdeenshire

August 2014

Report of a pilot joint inspection of  
adult health and social care services

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## Background

People in Scotland, as with elsewhere in Europe, are living longer. While many of those people will live independent healthy lives, older people are more likely to have complex health problems which require hospital admission. Many will also require support to enable them to live in the community, either at home or in care homes. The ageing population presents a significant challenge to health and social care in delivering services which meet both the demand and individual's needs.

In 2010, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) launched Reshaping Care for Older People<sup>1</sup> to help meet those challenges. This aims to deliver a new way of providing care. Historically, health services have focussed on acute conditions and treating people in hospital. Patients have had things done **to** them rather than **with** them.

Most older people want to live independently in their own homes for as long as possible. Reshaping Care for Older People aims to make sure that services are focussed on the impact they have on older people's quality of life. Reshaping Care for Older People aims to shift the balance of care towards anticipatory care and prevention and away from delivering care in a hospital setting to providing the necessary support and treatment in their own home or in a homely setting. This means that instead of reacting when problems arise, the focus is on prevention and helping people, with the right support to manage their own health conditions. It also recognises the role of unpaid carers and communities in delivering that support.

In 2010, the Scottish Government introduced a Change Fund for 2011-12 to support the implementation of reshaping care for older people. The principal policy goal was to optimise independence and wellbeing for older people at home or in a homely setting. The fund acted as bridging finance to facilitate shifts in the balance of care from institutional to primary care and the community as well as enabling partnerships to make better use of their combined resources. This fund would be available over a four-year period.

In the second year of the Change Fund, partnerships were supported to complete Joint Commissioning Strategies for older people. Joint commissioning plans were to be submitted to the Scottish Government by February 2013.

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<sup>1</sup> Reshaping Care For Older People A Programme For Change 2011–2021

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The Public Bodies (Joint Working) (Scotland) Act 2014 provides the framework and principles for local authorities to join up the delivery of health and social care. This Act aims to:

- improve the quality and consistency of services for patients, carers, service users and their families
- provide seamless, joined-up quality health and social care services to care for people in their homes or a homely setting where it is safe to do so, and
- ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older people.
- improve the quality and consistency of services for patients, carers, service users and their families
- provide seamless, joined-up quality health and social care services to care for people in their homes or a homely setting where it is safe to do so, and
- ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older people.

The scrutiny and inspection of health and social care services supports organisations to improve and gives the public assurance that services are of a high standard. However, the shift in the balance of care from hospital and residential care to community services, and the integration of health and social care means that a different approach to scrutiny and inspection is needed. The new approach will have to consider how well partnerships are working together. In the future, we will consider how health and social care partnerships are commissioning services and delivering the national agreed health and social care outcomes for people. These national outcomes will help partnership discussions about local and national priority areas for action. Areas to prioritise will include making sure:

- everyone gets the best start in life, and is able to live a longer, healthier life
- people are able to live well at home or in the community
- healthcare is safe for every person, every time
- everyone has a positive experience of healthcare
- staff feel supported and engaged, and
- the best use is made of available resources.

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NHS boards and local authorities are expected to integrate health and social care services from April 2015. Local partnerships are currently establishing shadow arrangements, and each partnership is producing a joint strategic commissioning plan for older people's services.

The Care Inspectorate and Healthcare Improvement Scotland agreed to develop and carry out joint inspections of health and social care services provided for older people living in the 32 local authority (council) areas.

**The Care Inspectorate** is the independent regulator of social care and social work services across Scotland. It regulates, inspects and supports improvement of social care, social work and child protection services. Various kinds of organisations provide the services the Care Inspectorate regulates: local authorities, individuals, businesses, charities and voluntary organisations.

**Healthcare Improvement Scotland** works with healthcare providers across Scotland to drive improvement and help them deliver high quality, evidence-based, safe, effective and person-centred care. It also inspects services to provide public assurance about the quality and safety of that care.

## Methodology

Our two organisations worked together to develop an inspection methodology and a set of quality indicators to inspect against (see Appendix 2). We will be inspecting all 32 local authorities (councils) across Scotland to see how well they work in partnership with services provided through local NHS boards and hospitals and how this impacts on the lives of older people. The inspections will also look at the role of independent (private) and voluntary organisations in the community. The inspections will aim to provide assurance that the care of older people living in their own homes in the community is of a high standard. We also want assurance that people are getting the right kind of care at the right time and in the right place resulting in good health and quality of life outcomes for older people.

The inspection teams are made up of inspectors from both the Care Inspectorate and Healthcare Improvement Scotland. We will also have inspection volunteers on each of our inspections. These are people who use care services themselves or are carers of people who use care services, who bring a valuable user perspective to the inspection team. This means that there is a wide skill mix within the team that includes NHS and non-NHS, and people with inspection and regulation backgrounds.

The inspections are extensive and each one takes 24 weeks to complete. We will inspect six areas each year.

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The focus of the inspections is to look at the ways in which better outcomes for older people are being jointly achieved. Examples of this could include:

- early intervention and preventative support
- speedier assessments when needs are identified
- more effective setting up of care packages to support people at home
- promoting self-care, and
- reducing delays in discharge from hospital.

We have developed a framework to support partnerships in self-evaluation of their work (see Appendix 2). This framework invites partnerships to consider six high level questions relating to the quality of their work and the outcomes achieved. A suite of quality indicators lie below this which help partners examine their work more closely. Inspection teams use this same framework to reach judgements about the effectiveness of partnerships' activity and to reach evaluations focusing on outcomes for older people, how partnerships are developing teams to deliver services and the leadership within the partnership.

There are three key phases to the inspections:

### **First phase – preparation and analysis of information**

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

### **Second phase – file reading, scrutiny sessions and staff survey**

The inspection team looks at a random sample of approximately health and social work case files of approximately 100 individuals to review practice. 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. An anonymous staff survey is also carried out.

### **Third phase – reporting and follow up**

The inspection team publishes a local inspection report. This includes evaluation gradings against the quality indicators, any examples of good practice and any recommendations for improvement.

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## Purpose of this report

Following three test inspections to different local authorities in 2013, two pilot inspections were then carried out. Aberdeenshire was one of those pilots.

The purpose of this report is to describe the progress Aberdeenshire Partnership is making towards joint working, and how that progress is impacting on outcomes for older people. The Aberdeenshire Partnership includes Aberdeenshire Council and NHS Grampian (Aberdeenshire Community Health Partnership). Where we use the term “Partnership” in this report we mean the Aberdeenshire Community Health Partnership. The report is written primarily for Aberdeenshire Community Health Partnership and people living in Aberdeenshire. However, it will be of interest to other partnerships and communities who are at different stages of progressing with this work.

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## Summary of inspection

Aberdeenshire is a predominantly rural area situated in the north-east of Scotland. Aberdeenshire borders Angus and Perth and Kinross to the south, and Highland and Moray to the west. Aberdeenshire has six council administrative areas: Banff and Buchan, Buchan, Formartine, Garioch, Kincardine and Mearns, and Marr. The City of Aberdeen is a separate council area.

NHS Grampian is the local NHS board, one of 14 NHS boards across NHSScotland. NHS Grampian includes five main acute or long-stay hospitals, 18 community hospital, 11 of which are managed by Aberdeenshire CHP, and 80 GP practices<sup>2</sup>. NHS Grampian has three community health partnerships (CHPs) - Aberdeen City, Aberdeenshire and Moray. Aberdeenshire CHP is aligned to the Aberdeenshire local authority. This means they work together where both health and local authority contribute to services, for example in services for older people.

Social work services in Aberdeenshire are provided through a Housing and Social Work directorate. Services such as care management, care at home, residential care, day services and housing with support are provided based on the six council administrative areas identified above. The council works with third sector providers to provide some of these services.

The current population for the Aberdeenshire area from the Census 2011 was 253,000, approximately 4.8% of Scotland's total population. Major towns in Aberdeenshire are Peterhead, Fraserburgh, Inverurie, Westhill, Stonehaven and Ellon.

The pilot joint inspection of services for older people in the Aberdeenshire area took place between 26 August and 7 October 2013. It covered the health and social care services in the area that had a role in providing services to benefit older people and their carers.

The inspection team was made up of nine inspectors, two NHS clinical advisors and one carer inspector. Inspectors had their own area of responsibility to inspect, based on their expertise.

We read social work services and health records for 100 Aberdeenshire older people, as well as other policy, strategic and operational documents. We spoke to health and social care staff with leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We reviewed practice through reading a sample of records held by services who work with older people. We then spoke with some of these older people and their carers. We are very grateful to all of the people who talked with us as part of this inspection.

<sup>2</sup>Information and Statistics Division (ISD) Hospital Profile (published Nov 12), Hospital Classification (published Nov 12) and NHS Community Hospital proforma (Oct 12); GP workforce and practice population statistics to 2013

We assessed the service against 10 quality indicators. Based on the findings of this inspection, this service has been awarded the following grades (more information on grading can be found on page 84):

Quality indicator	Heading	Evaluation
1	Key performance outcomes	Good
2	Getting help at the right time	Good
3	Impact on staff	Good
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	Good
8	Partnership working	Good
9	Leadership and direction	Good
10	Capacity for improvement	Good

**We noted the following areas of strength:**

- Good outcomes for many people receiving health and social care services.
- Good progress on implementing early intervention and preventative approaches
- Positive staff morale.
- Demonstrable progress in implementing community development approaches.
- Beneficial joint working at local level.
- Good leadership and management in health and social care.
- Valuable preparation for the integration of health and social care.
- Good capacity for improvement.

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## We noted the following areas for improvement:

- Outcomes for some service users, particularly those receiving home care.
- Recruitment of home care staff.
- Support for carers.
- Risk assessments.
- Information technology and the sharing of information.
- Setting out clear steps and identifying individuals responsible to improve services.
- Developing option appraisals for the sustainability of projects funded with Change Fund monies from the Scottish Government.

## Recommendations

The actions that the Care Inspectorate and Healthcare Improvement Scotland expect Aberdeenshire Partnership to take as a result of this joint inspection of services for older people follow from recommendations. This inspection resulted in five recommendations. Aberdeenshire Partnership will be expected to produce an action plan detailing how they will implement each of the recommendations made. .

### Aberdeenshire Partnership should:

- |          |  |
|----------|--|
| <b>1</b> | continue to improve the uptake of carers' assessments and support to carers (see Quality indicator 2).   |
| <b>2</b> | take immediate action to ensure that risk assessments and risk management plans are completed and available within the case records of adults at risk of harm. (see Quality indicator 5).  |
| <b>3</b> | establish a clear programme of work and develop a strategy for rolling out implementation of new initiatives for reshaping of services. They should set out the steps which need to be completed to achieve proposals set out and identify who is responsible for delivering the actions on behalf of the Partnership (see Quality indicator 6). |
| <b>4</b> | ensure that the continued development of early intervention support makes the best use of limited staff resources in the care at home sector (see Quality indicator 6).  |
| <b>5</b> | have option appraisals in place for the use of resources for reshaping of services. This should include engagement with key service providers as well as other signatories to the joint commissioning strategy for older people, Ageing Well in Aberdeenshire (see Quality indicator 6).   |

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## Quality indicator 1 – Key performance outcomes

One measure of how successful partnerships are at meeting the aims of Reshaping Care for Older People is how many older people are able to stay independent and well at home and remain out of the formal care setting. In this quality indicator, we look at some of the measures which help to show the extent to which the Aberdeenshire Partnership is shifting the balance of care from hospital to care at home or a homely setting.

### Summary

#### Evaluation – Good

We found that, in general, the Aberdeenshire Partnership delivered good outcomes for many older people and their carers. They reported improvements in their circumstances as a result of health and social work intervention.

Good progress was also being made in the delivery of self-directed support, giving older people more choice and control over the support they received and the outcomes they wanted. However, we also found that there were some constraints to the delivery of good outcomes to older people and their carer, such as the availability of home care staff.

### 1.1 Improvements in Partnership performance in both health and social care

Here we look at some of the data which shows us how well the Partnership is performing in supporting people to be looked after at home or in a homely setting rather than in hospital.

We looked at the following key areas:

- emergency admission to hospital
- delayed discharge from hospital
- provision of home care services
- care home places
- self-directed support - direct payments, and
- respite care.

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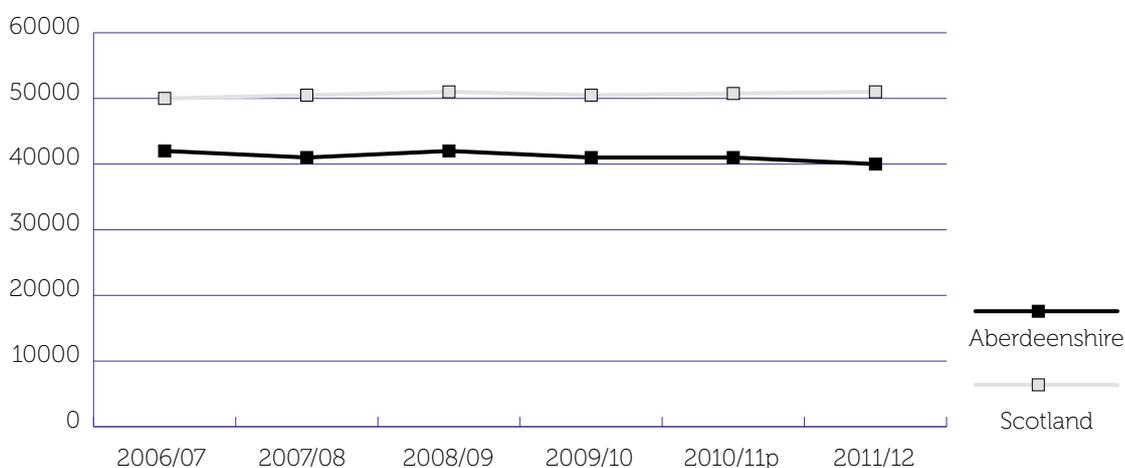
## Emergency admission to hospital

Many admissions to hospital are necessary. However, for a proportion of older people, hospital admission could have been avoided. One of the key areas of improvement in shifting the balance of care is preventing hospital attendance and admission for older people when their needs could be better met at home or in the community.

Compared with the rest of Scotland, we found that the rates of emergency admissions of older people to hospital in Aberdeenshire were lower than the Scottish average (see Chart 1).

### Chart 1

Emergency admissions of older people, rates per 100K pop 65+ and 75+ (source SG)



## Delayed discharge from hospital

For most patients, when they are clinically ready to go home from hospital, the necessary care, support and accommodation arrangements are put in place in the community and they can be discharged from hospital.

However, there are times when people no longer require hospital inpatient treatment, but they are unable to return home or be transferred to a more homely setting. For example, if home care services are not available to support the person at home or funding is not available to provide the person with a place in a care home.

This means that people are not being supported in the place that is most suitable for them. For some, remaining in hospital may even be putting them at increased risk of getting an infection or falling. It also means that the hospital bed the older person is occupying is not available for patients who do need to be in hospital.

Overall, in Aberdeenshire we found that the amount of available hospital bed days lost because of delayed discharges for people over the age of 75 was lower than the Scottish average in 2012-2013.

In April 2013, the Scottish Government set a target that there should be no delayed discharges of over 4 weeks' duration. This is a 2-week reduction on the previous target of 6 weeks. In 2015, the target will be reduced further to delayed discharges not exceeding 2 weeks.

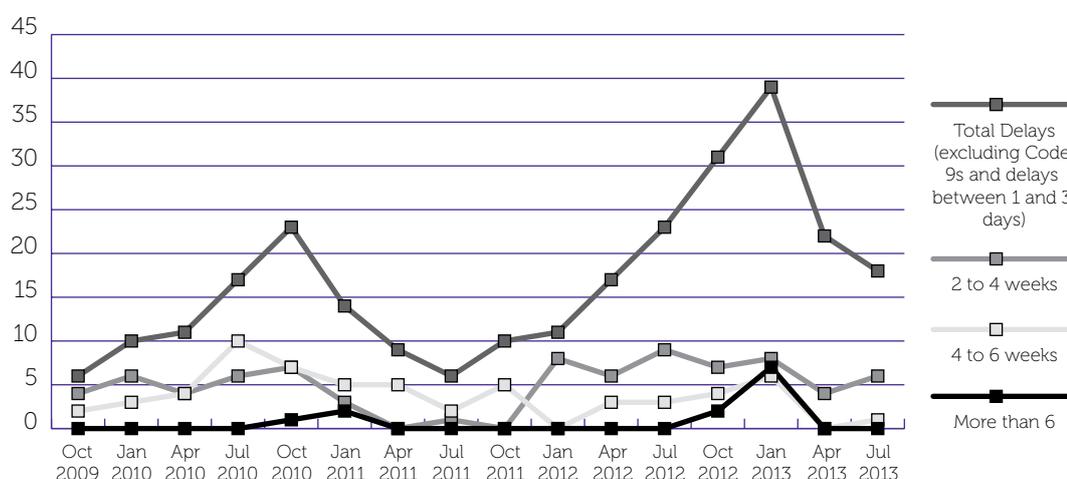
However, it is recognised that there are some patients whose discharge will take longer to arrange and therefore the target is not applicable. These would include patients delayed due to waiting for a place in a specialist facility, patients for whom an interim move is unreasonable, or where an adult may lack capacity under adults with incapacity legislation. These are referred to as 'code nine' delays. Details of all delayed discharges across Scotland can be found through the NHSScotland Information and Statistics Division<sup>3</sup>.

Twenty-nine per cent of bed days lost to delayed discharges in Aberdeenshire in June 2013 were code nine delays. We attended one of the regularly convened joint health and social care services meetings about delayed discharge. Managers told us that there could be particular problems when private welfare guardianship applications were made for delayed discharge patients who did not have capacity. Sometimes there were considerable delays lodging the guardianship application with the court, and this had caused the most prolonged delayed discharges, with the greatest number of bed days lost. Managers told us that due to the excessive delays with some private welfare guardianship applications, the local authority had had to petition the court to appoint a welfare guardian.

Chart 2 below shows trends in delayed discharges in Aberdeenshire for delayed discharges that are not code nine delays.

### Chart 2

Aberdeen delayed discharge trends against targets (source ISD)



<sup>3</sup>Delayed Discharges in NHSScotland, Information and Statistics Division (ISD)

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The number of delayed discharges in Aberdeenshire rose between July 2012 and January 2013. While we can see that the Partnership was performing well against the previous 6 week target it had been having more difficulty meeting the new 4 week target, but latest figures showed that the target was being met..

When we spoke to managers from the Partnership, we were informed that the increase between July 2012 and January 2013 and the challenges in meeting the 4-week target were mainly due to the unavailability of home care services and a lack of available care home places. The following two sections in our report look at home care and care home services.

### **Provision of home care services**

The provision of home care services is essential to making sure that people can be supported within their own home when they do not need to be in hospital.

The unavailability of home care staff in Aberdeenshire was a theme throughout our inspection. The number of people receiving home care, intensive home care, and out-of-hours home care in Aberdeenshire sits below the Scottish average. However, it is difficult to put this into context when there is no national data identifying the need for care at home.

Managers and frontline staff told us that there were difficulties in recruiting and retaining home care staff. The main reasons for this were:

- the high cost of living in Aberdeen due to the oil industry
- competition from other local industries such as supermarkets
- challenges in providing home carers in a rural area.

Although Aberdeenshire was performing well against the rest of Scotland for delayed discharges, frontline health and social care staff told us there were times when the lack of available home care services was impacting on getting people home at the right time. It also led to delays in people receiving care at home, even when their needs were assessed as being critical.

### **Care homes**

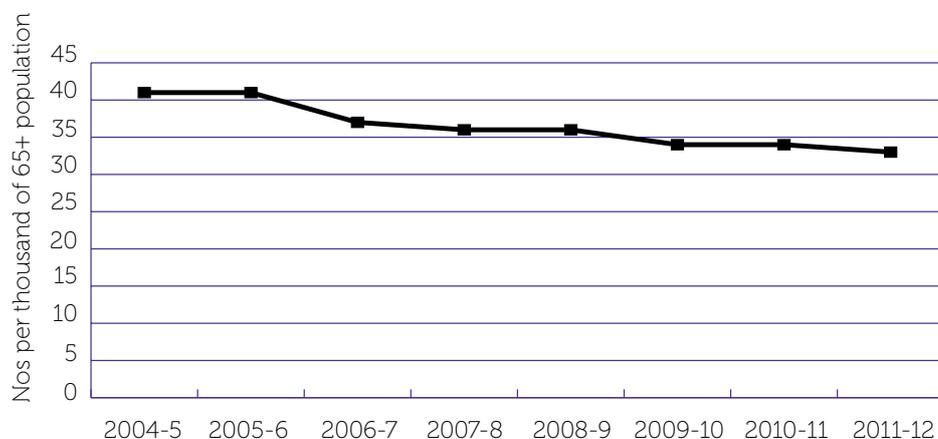
Shifting the balance of care from institutional settings like hospitals to care at home presents a significant challenge for partnerships against a backdrop of an increasingly elderly population. In line with its joint commissioning strategy for older people, Ageing Well in Aberdeenshire<sup>4</sup>, the Partnership is gradually reducing the number of people living in care homes (see Chart 3).

<sup>4</sup> Ageing Well in Aberdeenshire. Joint Commissioning Strategy for Older People 2013-2023. Aberdeenshire Council. February 2013

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### Chart 3

Aberdeenshire trend for nos of older people in care homes (source Aberdeen joint commissioning strategy)



The Care Inspectorate inspects regulated services for older people that are run by the local authority. In general, the Care Inspectorate assigned grades of very good and good to these services. The Care Inspectorate also inspects regulated services for older people that are commissioned and purchased by the local authority. The Care Inspectorate assigned poor grades to a small number of care homes and this led to the restriction of admissions to these care homes. However, the Partnership had developed a project to improve the quality and mentoring in care homes.

This had an impact on the numbers of older people whose discharge from hospital was delayed and the number of acute bed days lost to delayed discharges of older people.

We were concerned that, at the time of our inspection, there were more people waiting for a place in a care home than places available. This suggested it could be a challenge for the Partnership to further reduce the number of care home places.

The Care Inspectorate, the local authority and the care home providers were working together to improve the quality of care and support delivered by the care homes which received the relatively poor inspection grades.

### Respite care for older people and their carers

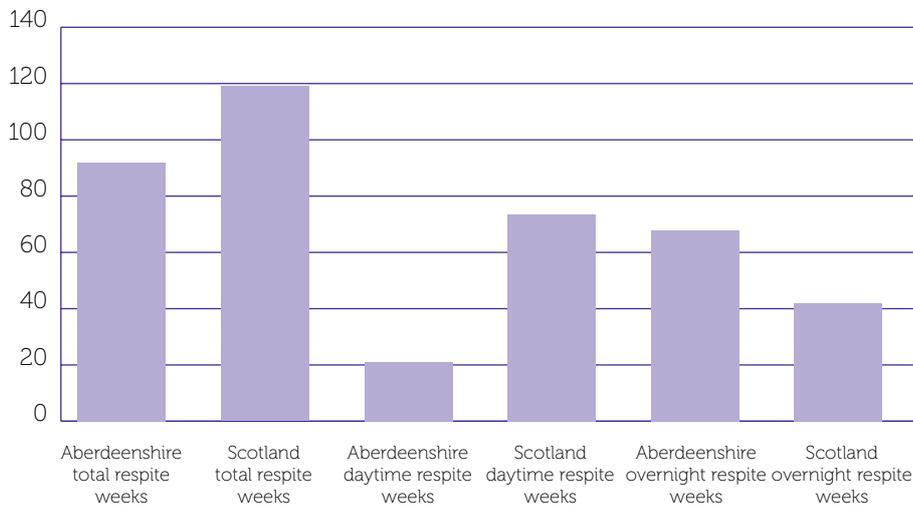
We looked at the provision of respite care within Aberdeenshire and found that Aberdeenshire provided less total respite to older people and their carers than the average for Scotland (see Chart 4). However, it did provide more overnight respite than the Scottish average.

We asked carers we met about availability of respite and the impact that this had on them. Carers told us that they were often not looking for a full week's respite, and they welcomed the development of more flexible respite options. The Aberdeenshire Partnership was working with Voluntary Service Aberdeen to develop flexible respite options for carers and those they cared for.

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## Chart 4

2011 -12 Aberdeenshire respite weeks for older people rate per thousand 65+ pop (source SG)



### Self-directed support

Another of the key areas in shifting the balance of care away from hospitals and care homes is giving people the ability to choose how their care is provided. In 2013, the Social Care (Self-Directed Support) (Scotland) Act was passed by the Scottish Parliament. Although councils are not expected to implement the Act until April 2014, it is expected that they will be starting to prepare for implementation now.

Self-directed support allows people to choose how their support is provided, and gives them as much control as they want of their individual budget. Self-directed support is the support a person purchases or arranges to meet agreed health and social care outcomes. It offers a number of options for getting support. The person's individual (or personal) budget can be:

- taken as a direct payment (a cash payment)
- allocated to a provider the individual chooses (sometimes called an individual service fund, where the council or funder, holds the budget, but the person is in charge of how it is spent), or
- the council can arrange a service.

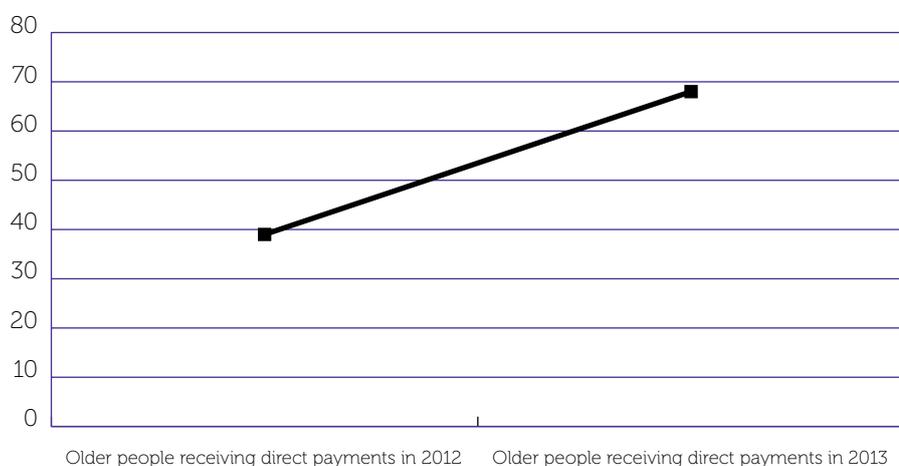
Individuals can choose a mixture of all three for different types of support.

We found that the Aberdeenshire Partnership was making good progress on providing direct payments to older people (see also Quality indicator 5). Chart 5 below shows the significant increase between 2012 and 2013. Managers told us that the local authority had streamlined its direct payments procedure, and this had made it easier for service users to access direct payments.

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## Chart 5

Aberdeenshire: 79% rise in number of older people receiving direct payments  
(source council's figures)



During the interviews with staff, we heard about an older person who had benefited specifically from a direct payment. The person required ongoing support to reduce their tendency to fall. Staff reported that the provision of a direct payment had given the older person choice and control over the support that they received. Staff reported that direct payment arrangements had been relatively easy to set up.

## Telehealthcare

The use of technology has been recognised as having an important role in reshaping the care of older people in Scotland. Telehealthcare is a technology-enabled and integrated approach to the delivery of health and care services. It can be used to describe a range of care options available remotely by telephone, mobile, broadband and videoconferencing. For example, telehealthcare may be:

- a remote videoconference discussion between professionals
- a remote interaction between nurses and patients, for example a patient seeks advice from NHS 24, or
- a remote environmental monitoring device, for example a falls sensor in a patient's home triggers an alert in a control centre.

The Aberdeenshire Partnership had a significantly lower rate of telehealthcare provision than the Scottish average. Increasing the provision of telehealthcare to older people has the potential to support a proportion of Aberdeenshire's population of older people who live in isolated rural communities. The Partnership has committed to further developing telehealthcare across Aberdeenshire.

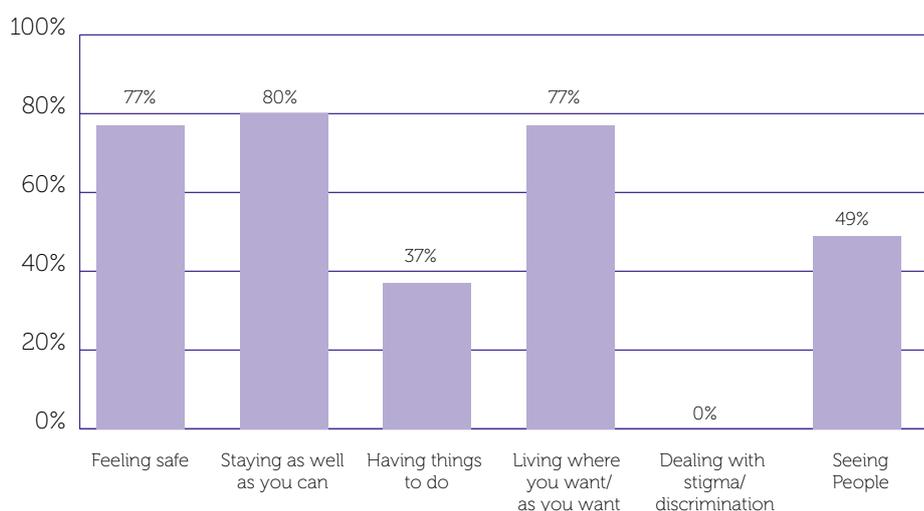
## 1.2 Improvements in the health and well being and outcomes for older people, their carers and families

In recent years, there has been a significant move towards outcome-focused approaches to delivering services. This means that the focus is on the results services have on the person's life. The focus is on the priorities, aspirations and goals identified by the person rather than those determined by those who deliver the service.

Chart 6 shows the results from our review of social care services and health records for 100 Aberdeenshire older people. We looked at the positive personal outcomes for the older people in our sample. The results for having things to do and seeing people are significantly lower than the other outcomes.

### Chart 6

Joint inspection file reading results, positive personal outcomes delivered by the Aberdeenshire Community Health Partnership



During the scrutiny phase of our inspection, we met a number of older people who said that due to the delivery of health and social care services, they were:

- safe
- living independently in their own home
- had a good sense of wellbeing and kept as well as they could
- were able to get out and about
- were generally included in their communities.

Overall, the service users we met were very complimentary about the health, social work and social care services that they received. Service users said that these services enabled them to continue living safely at home, which was very much what they wanted and valued.

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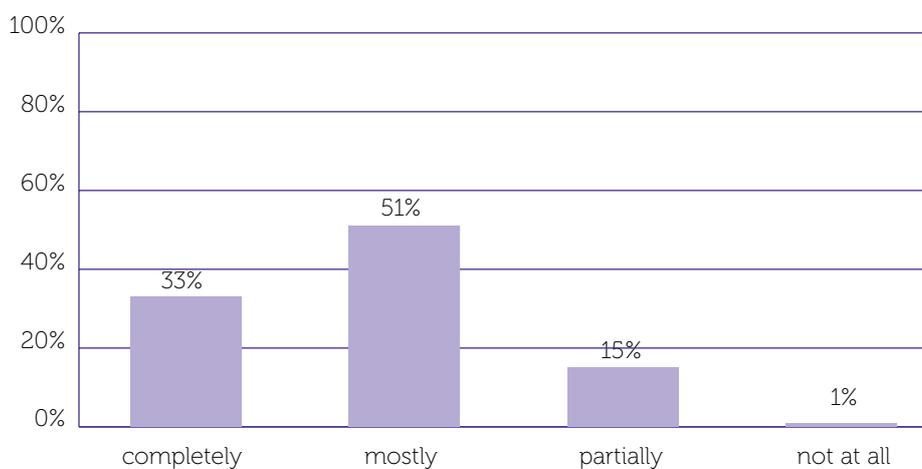
## Outcome-focussed care plans

We found that 82% of the care plans that we read were outcome focussed.

From our file reading, we saw that there were positive improvements in the service users' circumstances against reasonable expectations. Eighty-four per cent of the older people, whose social care services and health records we read, had mostly or completely had an improvement in their circumstances (see Chart 7).

### Chart 7

Aberdeenshire Community Health Partnership: Improvement in service users' circumstances (source joint inspection file - reading results)



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## Quality indicator 2 – Getting help at the right time

In this quality indicator, partnerships are assessed as to how well they are working to make sure that people get the help that they need at the right time. We look at three key areas.

- The experience of individuals and carers of improved health, wellbeing and support.
- Prevention, early identification and intervention at the right time.
- Access to information about support options including self-directed support.

### Summary

#### Evaluation – Good

There was a focus on ensuring the involvement of older people in defining outcomes for themselves and also in terms of shaping future services to best meet their needs. There was also a strong focus on the importance of older people being given the right services and support to be able to maximise their own independence, manage their own conditions where appropriate and have the care that they needed to do this provided at the right time by the right people.

It was clear that the Partnership had a robust suite of services that could inform, signpost, enable and support both older people and their carers as well as allowing people choice and control over the services they received.

The needs of carers could be met more effectively by more robust and systematic assessment of their needs.

### 2.1 Experience of individuals and carers of improved health, wellbeing, care and support

In assessing Aberdeenshire's progress against this part of Quality indicator 2, we focussed on three areas.

- How teams were working to a more outcomes-focused approach for individuals.
- Improving care and support for frail patients on admission to hospital.
- How the Partnership was supporting carers.

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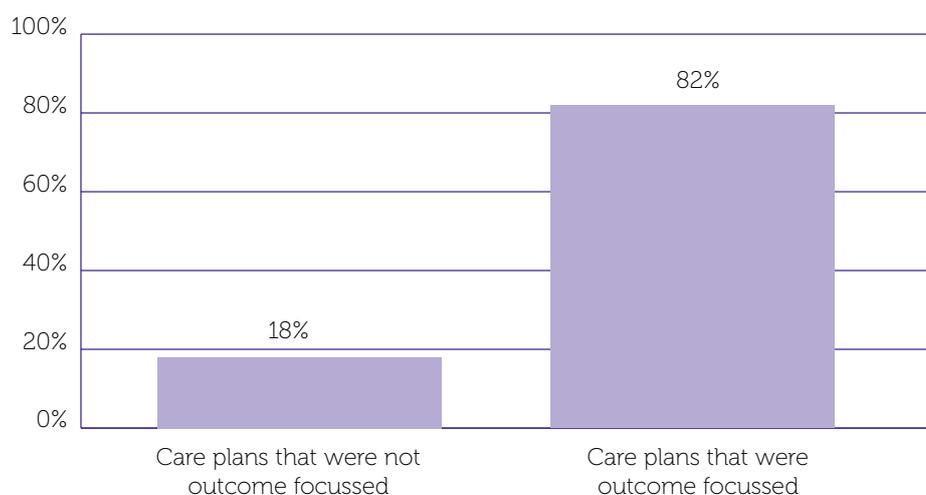
## An outcome-focussed approach

In Aberdeenshire, we found that health and social care staff were beginning to work effectively with older people and their carers by moving to a more outcomes-focussed approach to their work. Social care staff described how they worked with individuals to define their outcomes. However, they acknowledged that further work was needed to make sure that assessments were more outcomes-focussed.

Within health services, managers considered that there had been a significant shift in how staff worked with older people and carers. There had been an investment in leadership training to senior nurses and senior allied health professionals<sup>5</sup> over the past year to support staff in becoming more outcomes-focussed. It was acknowledged that the journey to establish this would be significant but they could see improvements. Interim outcomes paperwork was being developed to support health staff in the outcomes approach. Chart 8 from our review of social work services and health records shows that good progress is being made.

### Chart 8

Aberdeenshire outcome-focussed care plans (source joint inspection file reading results)



We met with older people using a range of different health and social care services. Most of the people we met spoke highly of the services they used. We met a number of older people who received home care. They spoke very highly of the home care service they received, the outcomes for them and, in particular, the caring and dedicated home care staff on whom they depended. A small number spoke of delayed discharge from hospital and the choice and timing of services.

We were particularly impressed with the staff at a number of these services who delivered care against a backdrop of staff recruitment difficulties and geographical challenges.

<sup>5</sup> In Scotland, the AHP group includes arts therapists, dieticians, occupational therapists (OTs), orthoptists, podiatrists, prosthetists and orthotists, physiotherapists, radiographers (diagnostic and therapeutic) and speech and language therapists.

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## **Improving care and support for frail patients**

Increasing numbers of frail older people are admitted to hospital, often as an emergency, where they are particularly susceptible to healthcare associated infection, episodes of delirium and compromised nutrition and skincare. They have longer length of stays, higher mortality, higher rates of readmission and are at increased risk of needing long-term institutional care. Appropriate and timely specialist multidisciplinary assessment for frail older people has been shown to improve functional outcomes, reduce dependency and length of stay in hospital and improve patient and carer experience.

Healthcare teams from acute hospitals across Scotland have been testing methods to improve the experience, co-ordination and outcomes of care for older patients in hospital who are identified as frail. The aim of these interventions is to improve the early identification of frailty and ensure that older people who are identified as frail can access timely comprehensive geriatric assessment delivered by a specialist multidisciplinary team.

Comprehensive geriatric assessment is a process that aims to identify problems and personalised goals. The identified problems are assessed, quantified and managed in a co-ordinated way by a specialist-led multidisciplinary team.

## **Supporting carers**

In Aberdeenshire, there was a carers' charter which detailed how the Partnership would like to work with carers. A carers' strategic outcomes group had created an action plan to help focus the direction for the development and delivery of services to carers.

A number of courses and training opportunities were available to carers to help them continue in their caring role. These provided information about certain health conditions and benefits information.

However, we found that there were few formal assessments specifically for carers being carried out. There was also a varied knowledge among staff, particularly health staff, as to the services that were available for carers. Many health and social care staff felt that the needs of carers were being met by providing support to the individual being cared for and, therefore, believed the requirement for a carer's assessment was not always necessary. However, the focus should be on the support the carer needs to continue to provide support to the person they are caring for.

Aberdeenshire Council had tried to address the issue of carers' assessments by appointing two dedicated staff members who carried out these assessments to make sure that the particular needs of carers were met. At the time of the inspection, these staff were no longer in post. However, the Carers Centre which provides information, advice and support to carers within the Aberdeenshire area had taken on a lead role in completing these assessments.

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All GPs hold a carers' register and this was managed differently across GP practices with nurses often taking the lead. However, support to carers was reported as variable.

**Recommendation 1: Aberdeenshire Partnership should continue to improve the uptake of carers' assessments and support to carers.**

## 2.2 Prevention, early identification and intervention at the right time

This section relates to how the Partnership is developing and implementing strategies to support the prevention and early identification of health and social care problems. These strategies detail how it will provide appropriate interventions to support people at that time when they need it.

In assessing the Partnership's progress, we looked at how the Partnership was:

- supporting self-management for those with long-term conditions
- implementing Scotland's National Dementia Strategy 2013-2016<sup>6</sup> and Living and Dying Well<sup>7</sup>, and
- developing the use of anticipatory care plans.

### Supporting those with long-term conditions

The increasing number of people living with long-term conditions, such as diabetes and asthma, presents a major challenge for health, social care, community, private and voluntary sector partners. Better awareness of their long-term conditions helps people understand their symptoms and experiences and improves their long-term health and wellbeing. The role of the care professional is to encourage self-confidence and the capacity for self-management and to support people to have more control of their conditions and their lives<sup>8</sup>.

The Long Term Conditions Alliance Scotland defines self-management as 'the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long-term condition'.

In Aberdeenshire, we found that the Aberdeenshire Community Health Partnership had carried out work to increase the focus on the management of long-term conditions. In particular, we found there had been some well-established work about patient self-management, especially with long-term conditions such as diabetes and asthma. GP practices were also starting to develop chronic obstructive pulmonary disease and heart failure condition patient self-management.

<sup>6</sup> Scotland's National Dementia Strategy 2013-2016, Scottish Government. May 2013

<sup>7</sup> Living and Dying Well: a national action plan for palliative and end of life care in Scotland, Scottish Government. October 2008

<sup>8</sup> The Long Term Conditions Collaborative: Improving Self Management Support. Scottish Government. May 2009

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Aberdeenshire Community Health Partnership was keen to extend self-management within hospital settings and was in the early stages of looking at more patient self-care. Patient self-administration of medication was to be piloted soon. There was an acknowledgement that this posed some challenges due to the need for additional resources to support this approach. However, the Community Health Partnership saw this move as a positive, worthwhile step which may support a reduction in people whose discharge from hospital was delayed.

There was strong evidence that GPs were becoming more involved in patient education and non-medical interventions (sometimes known as social prescribing). Social prescribing aims to strengthen the provision of, and access to, social and economic solutions to mental health problems, linking people (usually, but not exclusively, through primary care) with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as support with for example, benefits, housing, debt, employment, legal advice or parenting.<sup>9</sup>

There was a growing use of a 'non-prescription pad' by GPs. This is a sheet which is given to patients who, for example, do not need a prescription for antibiotics. The sheet provides an explanation as to why a prescription for medication is not appropriate and gives patients advice on how to self-manage their condition. In Aberdeenshire, this had been proven to work well, particularly in the reduction of antibiotic prescribing.

The extended role of the community pharmacist appeared to be well established, both within the community and within hospitals, and was seen to be working well. We were very encouraged by the work of the lead pharmacists in supporting an improved experience for individuals. The lead pharmacists were regularly involved in the review of patient medication, as well as providing increased support to clinicians both in the community and within hospitals.

A minor ailment scheme had recently been set up. People were encouraged to go to the pharmacist instead of to their GP or the accident and emergency (A&E) department. Some GP practices were actively directing people to the community pharmacists, which appropriately released clinician time and used the skills and knowledge of the pharmacists.

A chronic medication service for people with long-term conditions had been set up. This service again supported the release of clinician time and, although fairly newly established, it was building on the close links between the GP practices and the pharmacists. This should provide more manageable monitoring and review of people with long-term conditions as well as promoting better self-management by the patient.

Pharmacists were also providing guidelines and training for medicine management to

<sup>9</sup>Developing social prescribing and community referrals for mental health in Scotland. Scottish Government. November 2007

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home care staff. This was seen as a very positive initiative which would support better practice by staff in the community.

### **Implementing Scotland's National Dementia Strategy 2013-2016**

We found that the Aberdeenshire Partnership was making progress implementing Scotland's National Dementia Strategy 2013-2016.

We looked at how the Partnership was implementing the Standards of Care for Dementia in Scotland.<sup>10</sup> It should assess all the services it manages or commissions against these standards. We also looked at how the national dementia strategy impacted on the care of individuals and the Partnership's work with carers. The Partnership was considering what the strategy would mean in practice. They had developed a dementia website, invested in dementia cafes and will produce a joint, fully costed dementia strategy by March 2014. It will explore how it will fund meeting the eight pillars of community support identified in the national dementia strategy. This was to be the subject of a staff workshop in November 2013.

Work had also started within GP practices to address the national dementia strategy. GPs did not have an enhanced contract for dementia, but Aberdeenshire Community Health Partnership was building a dementia scholarship for GPs. Nine GPs were to carry this out. An enhanced contract will then be developed. We considered this to be a very positive move.

An agreed NHSG care pathway for the diagnosis of dementia was in place in the Grampian Health Board area. Post diagnostic support is being provided by post-diagnostic outreach teams and Alzheimer Scotland link workers.

Training, using Stirling University's "Best Practice in Dementia Care" materials had been carried out with social care staff. This had also been offered to health staff, but take up had been low. It had also been offered to third sector staff (such as staff from voluntary and community organisations). Local authority project officers had provided additional support and training to staff in supporting people with dementia and other long-term conditions. These posts had had their contracts extended to enable training to continue. In our staff survey, 90% of staff agreed that they had appropriate training to do their job. Multi-agency training based on the eight pillars of community support was prioritised by the joint strategic planning group and was under way at the time of the inspection. The multidisciplinary team working with people with dementia was engaged in supporting learning and development for staff in care homes working with people with dementia.

### **Palliative and end-of-life care**

Palliative and end-of-life care was being developed in line with the Living and Dying Well

<sup>10</sup> Standards of Care for Dementia in Scotland. Scottish Government. June 2011

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National Action Plan (2008). An electronic palliative patient care summary was available to the GP, district nurse and out-of-hours services. Plans were put in place to support palliative and end-of-life care, and these were available to as many professional staff as possible. Unfortunately at the time of the inspection, this care summary could not be shared with pharmacists and other agencies such as social care (see recommendation in Quality indicator 8).

Surveys carried out locally showed that patient satisfaction was high. A high proportion of palliative care patients had been able to die peacefully at home, in line with their choice and the choice of their families. We read about an extensive study to determine the palliative care needs of care home residents in Aberdeenshire. The study used a palliative care needs assessment-scoring tool. The study revealed that a relatively high proportion of care home residents had palliative care needs.

### **Anticipatory care planning**

The Scottish Government describes anticipatory care planning as adopting a ‘thinking ahead’ philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done, at the right time, by the right person(s), with the right outcome.<sup>11</sup>

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.

Anticipatory care planning for older people was well established in Aberdeenshire and was carried out within the community and hospitals. This anticipates significant changes in a patient’s care needs and, through discussion with the individual, their carers, and health and social care professionals, describes the action that should be taken to manage the anticipated problem.

During our scrutiny phase, we found that the Partnership was making progress in delivering palliative and anticipatory care for older people. We found that, on the whole, a significant proportion of appropriate older patients had an anticipatory care plan in place. At the time of our inspection, some 2,000 anticipatory care plans had been completed for older people in Aberdeenshire.

Multidisciplinary teams across the Partnership completed an anticipatory care plan for those individuals who were considered at risk of emergency admission to hospital using specific patient data. In some areas, pharmacists would undertake a polypharmacy review (where patients are prescribed a number of different medications, often for more than one condition) that sat alongside the patient’s anticipatory care plan, creating a robust future plan of care.

<sup>11</sup> Anticipatory Care Planning Frequently Asked Questions. Scottish Government. March 2010

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We met with frontline staff who had responsibility for preparing anticipatory care plans for older patients. They said that, although the plans were time consuming to prepare, they considered this to be well worth the effort in terms of the benefits to older patients and their families and carers.

We also heard a few more critical comments about patchy progress across Aberdeenshire in completion of anticipatory care plans. There was also an inability for these to be accessed by out-of-hours services in both health and social care or shared with social care colleagues. However, hard copies of the plans were sent to GMED (the health out-of-hours service) and entered on their electronic patient management system. Progress was being made to make sure that the anticipatory care plans were available to all staff who would need to access them (see recommendation in Quality indicator 8).

### **Intervention at the right time**

A range of initiatives were being implemented by the Partnership to make sure individuals received the right interventions at the right time. The following are some examples of what we found.

Change Fund monies had been used to pilot five-day access to allied health professionals in acute wards and community hospitals. This made sure that patients were seen more quickly, had a shorter length of stay in hospitals and had a better patient journey. The Change Fund is money provided by the Scottish Government in 2011-2012 to help organisations improve care and support for older people. This fund is available to organisations for four years. Staff were keen to see this pilot extended as it was felt that this could reduce the patient journey by missing out steps within acute care and providing additional care within the community hospitals.

NHS Grampian had improved the range of diagnostic and treatment services within Aberdeenshire. A development programme made sure that diagnostic services such as X-ray, endoscopy and ultrasound services would be provided closer to home for individuals with the intention of improving outcomes for patients.

A number of falls prevention and management groups had been set up. These were also funded by the Change Fund. These were very good initiatives with high patient satisfaction. However, they had been hampered by difficulties recruiting and retaining staff, particularly physiotherapists.

Unscheduled care is a term used to describe any unplanned health or social care. The range of unscheduled care provision includes support to patients at their home, booking of urgent or emergency GP appointments, 999 ambulance services and emergency department/hospital treatment.

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Within Aberdeenshire, a new approach to unscheduled care was in the early stages of being developed to include people in care homes. This aims to deliver 'high quality, safe and sustainable unscheduled care at the point of contact which was person-centred and organised to bring expertise to the patient/client'. The approach seemed a very positive one which would deliver a reduction in unscheduled care activity, improved patient/carer experience, improved staff/user satisfaction and a reduction in waiting times. It also had the potential to increase the telehealthcare approach and reduce hospital admissions.

Aberdeenshire Council appointed extra carer support and development workers in 2013. They identify, support and provide training to older carers as well as enabling carers to share common experiences and concerns. The workers linked with the rehabilitation and enablement in Aberdeenshire for care at home (REACH) teams, and would also raise awareness of the support service with health staff.

### **2.3 Access to information about support options including self-directed support**

This section refers to how well the Partnership was working to provide information to individuals and their carers about support options including self-directed support.

NHS Grampian had a 'Know Who to Turn To'<sup>12</sup> initiative, which provided people with online information, leaflets and booklets about what health services were available and how to access these services locally. The Know Who to Turn To booklet was a very good, easily understood document which directed individuals who to 'turn to' when they were ill, injured or had a long-term condition. It emphasised that going directly to the person with the most appropriate skills could help with a speedier recovery.

A useful, well laid out leaflet had been produced for carers about how or whether to get a carers' supported self-assessment. The Respite Bureau, which arranged short breaks for carers, had been re-launched and should now provide more flexibility for carers with bespoke breaks available. Funding was to be given to the Voluntary Services Agency to see if they could engage carers more. The Partnership was confident that the voluntary sector will be able to reach more carers.

In 2013, the Social Care (Self-Directed Support) (Scotland) Act was passed by the Scottish Parliament. Although councils are not expected to implement the Act until April 2014, it is expected that they will be starting to prepare for implementation now (see Quality indicator 1).

We looked at how well the Partnership was prepared for the implementation of the Act (see Quality indicator 5). Considerable awareness raising had been provided to staff and other stakeholders. For example, training on self-directed support was available for carers, and public roadshows had started aimed at increasing public awareness. A survey conducted in May 2013 about the joint commissioning strategy for older people, Ageing Well in Aberdeenshire, had shown that in advance of the legislation coming into force in April 2014 there was already a reasonable level (22%) of awareness of self-directed

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support among the general public. Aberdeenshire Council was continuing to provide information about self-directed support and its benefits to individuals using not only the roadshows, but also advertising, leaflets, events, news articles, websites and social media as appropriate.

<sup>12</sup> <http://www.know-who-to-turn-to.com/>

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## Quality indicator 3 - Impact on staff

This quality indicator looks at the impact joint working is having on staff and teams within the Partnership. For example, it considers how motivated staff are and how supported they feel by senior managers.

### Summary

#### Evaluation – Good

Staff motivation across health and social care was high. Management support and recognition of good practice had contributed to improving staff motivation and a range of initiatives were proving to make a difference.

However, morale for a few staff groups was noted to be less positive. Senior managers could identify changes being made that were expected to improve this.

While the review of home care services had taken longer than expected to be implemented, the majority of staff felt involved and listened to. There were a number of human resource (HR) and workforce initiatives. Health and social care services needed to continue to address home care issues and ensure the improvements in morale.

### 3.1 Staff motivation and support

In assessing how the Partnership was progressing against this quality indicator, we looked at how motivated staff felt, teamwork within the Partnership, and learning and development.

We considered a range of evidence, including employee surveys carried out by housing and social care services and a range of training plans. We also looked at the action plans that had been drawn up as a result of these surveys and the targets and timescales.

We met with approximately 150 health and social care staff over the duration of the joint inspection. We also issued an online staff survey to Aberdeenshire housing and social care and NHS Grampian health staff. Four hundred and eighty-one (481) staff responded to our survey - 52% from local authority, 43% from NHS Grampian with a further 5% employed in 'other' sectors (all of the 5% were employed in GP practices). This represents approximately 21% of the total workforce in the NHS and local authority services for older people. The total workforce is approximately 2,286 (526 Whole Time Equivalent in the Partnership and 1,760 in the local authority). (Source: "Ageing Well").

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## Motivation

Staff in housing, social care and health who responded to our staff survey were highly motivated. Results from the survey showed that:

- 88% of staff said that they enjoyed their work
- 98% agreed that they understood their role and responsibilities in the work they did
- 88% said there were positive working relationships between practitioners at all levels
- 80% felt valued by other practitioners and partners, and
- 69% of staff agreed that they felt valued by their managers (26% disagreeing).

Our survey results were similar to those found by housing and social care in their own staff surveys. These results were also confirmed in the focus groups of health, housing and social care staff we met during our fieldwork.

Less positively, only 37% of staff agreed that there was sufficient capacity within their team to carry out preventative work (it was slightly lower for NHS staff). Only 59% of staff agreed that their workload was managed to enable them to deliver effective outcomes to meet individual needs.

Only 37% of staff agreed that changes which affected services were managed well. Evidence from Aberdeenshire's own surveys highlighted that the profile and visibility of senior managers could be improved and that the role of senior managers in supporting employees to deliver effective services could be improved on.

Senior managers had recognised the need for increased visibility and communication and these were identified within action plans drawn up as a result of their surveys. The housing and social care service had carried out a number of employee engagement events to involve staff in service planning. Both NHS Grampian and the local authority circulated staff newsletters which effectively kept staff up to date with policy changes and practice initiatives.

Some health, housing and social care staff we met described morale as being low. They described themselves as working hard to do a good job, and working well together in difficult circumstances. Reasons for low morale included:

- recruitment difficulties (particularly within physiotherapy, occupational therapy and home care)
- the recent impact of the home care review which changed the way home care was organised and delivered, and
- a reduction in administration support.

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There had been changes in older people services which included changes of role for some staff. For example, some responsibilities for the assessment of need had been transferred to local area co-ordinators and care managers from home care supervisors. For this reason, we looked at the responses of home care staff, and housing with care/extra care staff results to allow us to see whether this group's views were different to their colleagues and partners. For most results, their responses were similar to the larger survey results. Only 31% of home care respondents agreed that changes which affect services were managed well (in comparison to 37% of other staff groups) and 65% felt valued by their managers (in comparison to 69% of other staff groups). Given the importance of preventative approaches in caring for older people, low morale is an issue which the Partnership needs to continue to address.

### **Teamwork**

Staff we met told us there was good day-to-day communication and working relationships between health and social care staff. Much of this was informal and staff stressed that they saw these links becoming stronger.

During our fieldwork, staff said that where health and social care teams had been located in the same offices as each other, this had helped improve joint working. Some staff were uncertain about what the future integration of health and social care might mean for their work.

However, generally staff felt there was effective joint working, with 70% of survey respondents saying that services worked well together and were successful in helping older people develop or maintain their skills and abilities. Staff were committed to providing services which helped older people lead as independent a life as possible. For example:

- 68% of those who responded to our survey agreed that the support they provided jointly was successful in helping older people lead less isolated lives
- 89% agreed that their team worked well with other agencies to keep older people safe and to protect vulnerable older people
- 73% of staff who responded agreed that they worked well together to enable people with long-term conditions and those with dementia to remain active.

### **Learning and development**

Staff in Aberdeenshire confirmed that they had a wide range of training opportunities, including joint training on adult support and protection, with 90% saying they received appropriate training. Staff we spoke to and training plans we saw confirmed that a wide range of training opportunities were provided for health, housing and social care staff. A number of development and training plans were in place, with evidence of these being

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jointly prepared with partners for training in adult support and protection, dementia, Self Directed Support (SDS) and Adults with Incapacity. From our survey, 77% of staff agreed that they had annual appraisal performance reviews with their line managers.

Generally, we found that staff were encouraged and supported at most levels to agree outcomes with older people and were empowered to try to improve performance.

Kaizen for Daily Improvement was one of the improvement approaches used by housing and social care services to engage staff in improving processes for service users with the aim of involving staff in improvement activity across all services. This approach introduced staff to improvement techniques and used a self-assessment model to identify improvement actions. Feedback from the teams was that the Kaizen process had improved team members' interpersonal skills, improved team working, improved communication within teams and reinforced the focus on caring. Five locality home care teams had gained a bronze award which looks at culture change and staff empowerment. The Kaizen approach was to be used with staff from the joint equipment store.

NHS Grampian used the 'Releasing Time to Care' national programme to help staff review and streamline their work processes to focus on priority areas of care. The programme aims to free up staff time to help them spend more time on direct patient care in an improved environment.

There was evidence of a few joint human resource and workforce initiatives. There had been two integration workshops to identify human resource, workforce and organisational development issues from the integration agenda that were likely to affect public sector staff in Grampian. The latest workshop was held in June 2013 and resulted in agreed actions to take forward. We would encourage managers to continue to measure the impact of these actions.

Senior managers were committed to getting the workforce more actively involved through action learning sets. This involved a wide range of professionals and was a good example of providing staff across health and local authority with opportunities to contribute to change and to improve the quality of practice. We saw a positive evaluation of the action learning sets and met staff during our fieldwork who spoke positively of the experience.

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### **Example of good practice**

The action learning sets had been particularly successful in developing positive working relationships, empowering problem resolution and redesigning local systems to improved outcomes.

The concept of using the action learning sets was identified in the Aberdeenshire Partnership Change Plan 2011-12. During August 2011, action learning sets were created and were planned in 11 areas in Aberdeenshire, with meetings scheduled on a six-weekly cycle until March 2012. During this time, 172 people regularly attended the meetings, with a wide range of participants involved including NHS area managers, care management team managers and local authority occupational therapists. There had been particularly good involvement from GPs. Participation was reinforced and encouraged by the head of older people's services, the community health partnership general manager and the clinical lead. Funding was provided for locums to enable GP participation.

These sessions were facilitated by the senior improvement officer. Topics explored included:

- better understanding of factors contributing to multiple admissions and length of stay
- identifying blocks in patient flow from community to hospital and back to community, and
- identifying behaviours required to support integration.

The action learning set intervention created opportunities for a range of professionals to come together to constructively challenge and improve practice. Staff who participated in the evaluation believed that, as a result of the action learning sets, relationships across multidisciplinary teams had greatly improved and had resulted in better patient care and better communication and sharing of information. As a result of data analysis, they had a better understanding of their locality.

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## Quality indicator 4 – Impact on the community

In considering this quality indicator, we looked at the impact the Partnership was having on the community in Aberdeenshire. In particular, we looked at the way the Partnership was consulting and engaging with local communities in the development and delivery of services. We also looked at some local community initiatives which were supporting people in Aberdeenshire.

### Summary

#### Evaluation – Good

The Aberdeenshire Partnership was taking the co-production agenda seriously. It had a useful range of consultation processes and events and was using them to help improve community capacity. These identified challenges for the Partnership as well as strengths.

There was a variety of local community projects to encourage independence and reduce health and social care involvement where appropriate. The Partnership supported these through strategies, policies and funding, including Change Fund monies. This raises questions about their sustainability.

We saw clear evidence that the Partnership had a strong commitment to engaging and involving local communities to meet health and social care needs of older people in Aberdeenshire.

### Engaging with the community

Ageing Well in Aberdeenshire is Aberdeenshire's joint commissioning strategy for older people for 2013–2023. This strategy proposes how local care and health services will develop over the next 10 years. The strategy states that it is 'always aiming to provide the best possible outcomes, as defined by older people themselves, collectively and individually'.

The strategy has three key themes:

- prevention and early intervention
- rehabilitation and enablement, and
- improving quality, choice and control in long-term care.

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In 2012, the Partnership carried out a public consultation on the Ageing Well in Aberdeenshire strategy. Of the 211 written responses, there was general agreement with the aims of the strategy. The strategy also had a communications plan being delivered using a range of media to encourage debate and promote key messages.

Aberdeenshire Council has a Citizen's Panel. They conducted a Viewpoint Survey in May 2013 which reported on:

- the joint commissioning strategy for older people, and
- self-directed support.

Seventy-two per cent of the 1,034 panel members responded.

In relation to the joint commissioning strategy for older people, the great majority agreed:

- on the importance of active lifestyles for older people
- that treatment and diagnosis should be received locally, and
- that the quality of care should be improved.

Thirty per cent agreed that the standards of care for older people were good (15% disagreed, 37% gave a neutral response and 18% gave a 'don't know' response).

Forty-eight per cent agreed that local health and social care services supported people to eat healthily, stay active and remain connected in the community as they get older (11% disagreed, the remainder giving a neutral or 'don't know' response)

Twenty-six per cent agreed that there was an appropriate range of accommodation choices for those who need long-term treatment and support (32% disagreed, the remainder giving a neutral or 'don't know' response).

These results pose a significant challenge to health and social care services in Aberdeenshire, in making sure that people in Aberdeenshire are aware of the changes taking place, and in improving services and the public perception of services. Senior managers were using these results to inform their strategies for improvement of services for older people.

We asked about community involvement in our staff survey. The majority of those who replied from both NHS and local authority staff thought that they recognised and consulted diverse local communities about levels, range, quality and effectiveness of service. They also thought there were clear joint strategies to promote and expand community involvement and communicate change. They agreed that there was strong positive engagement between the partners and local community and voluntary groups.

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Aberdeenshire Council had a clear policy on accommodation for older people, set out in their Accommodation with Care Strategy (Older People) 2013–2018. This plan recognised the importance of health support. The council had plans to develop care villages, with a mix of care home and supported accommodation, and to increase sheltered and very sheltered housing. One care village, Edenholme, in Stonehaven, was already partially open at the time of our joint inspection. We saw an inclusion project document showing consultation with the residents with dementia about aspects of the accommodation in advance of them moving in, and to help residents with the transition to a new home.

A transitional leadership group was established to lead and provide strategic direction in relation to the implementation of the integration of health and social care in line with emerging national policy and legislation. This group formed an engagement and involvement short life working group to give citizens, users of social care services and patients of health services a voice in shaping the way integrated health and social care is delivered.

The older people's strategic outcome group had co-production issues high on its agenda. This group reviewed co-production projects funded through the Change Fund, and identified the importance Aberdeenshire placed on co-production, sustainability and the use of community assets. Co-production means that public services are delivered in a way in which people have an equal relationship with professionals - where they are in control rather than dependent on what services are delivered. Co-production recognises that people have 'assets' such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be used to support people's health and wellbeing.

Partnership arrangements with the third and independent sector were largely positive. For example, a co-production steering group makes decisions about allocating small amounts of funding to the third sector as 'seed monies'. However, it was recognised this had not been easy due to the wide variation in what people thought was co-production, and concerns about sustainability. This group's presence showed that Aberdeenshire was taking the issue of co-production, sustainability and using community assets seriously.

The co-chair of the co-production steering group spoke of good partnership working and support from health and social care, but expressed concerns about sustainability and consistency in community projects. In May 2013, the co-production steering group had carried out a review which identified that the Partnership needed to be clearer about the sustainability of projects funded.

Public awareness campaigns had been run on adult support and protection, and future campaigns were planned.

Both Aberdeenshire Council and NHS Grampian had clear volunteering policies. Community capacity building included a plan to increase the number of volunteers and to support voluntary groups to develop and grow. Targets were set to assess whether

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local people were able to identify and meet their own needs, either on their own or with other bodies.

The 'signposting project' had been successful in linking many older people in rural communities with individuals, groups or activities which suited their needs. The project reported working with 122 individuals in 2013. In case studies they reported success in improving mental wellbeing, self-confidence, physical activity, and in reducing isolation.

## Community initiatives

We visited some community initiatives:

- the Men's Shed in Westhill
- the Meams Healthy Living Coastal Network in Laurencekirk, and
- the Neuk in Fraserburgh, a day centre for people with dementia, which offered community support.

The Men's Shed project supported men with feelings of isolation, anxiety and other health and social issues. NHS public health staff were working with primary care staff to signpost service users to the shed. There were good community links with the Westhill Wellbeing Forum. A development worker had recently been appointed for a 2-year period to develop Men's Sheds in other parts of Aberdeenshire. These were now already being considered in one or two other towns.

The Healthy Living Coastal Network started in Laurencekirk 11 years ago. They provided assistance with shopping and transport, and ran lunch clubs, walking groups and exercise classes. They also signposted people to befriending services.

In 2010, they were commissioned to develop a network of older people's forums across Aberdeenshire. This has now expanded to include Inverbervie, Portlethen, Peterhead, Cuminestown, Ellon, Inch, Stonehaven, Banff and Fraserburgh, as well as the small villages surrounding these towns. These forums explore and capture the concerns of older people, and support them to devise their own solutions to issues raised and engage with policy makers.

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### **Example of good practice**

During our scrutiny phase, we visited the Neuk Day Centre in Fraserburgh. This day centre is run by the local authority for people with dementia. We were highly impressed with the quality of this service and the care given to the older people with dementia who used this service. We considered this service delivered good outcomes for those who attended.

The centre provided outreach into the community. It had a small and positive staff group with good working relationships with community health staff such as community psychiatric nurses. There were very good examples of how the centre was helping the community to understand dementia and bringing the community into the centre to meet people with dementia.

The centre staff were in the process of developing a small Men's Shed for up to eight service users in their garden. The centre's co-ordinator would be running short courses at the local Tesco store, to help Tesco staff understand dementia, and the Tesco staff had offered to run food 'taster' sessions for service users of the Neuk Centre. Local primary school children also came into the centre on a regular basis for 8-week programmes to learn about issues of importance to those who used the centre

We also read a helpful report from the Ellon Health and Wellbeing Forum outlining activities such as community allotment, a Men's Group and physical activity initiatives.

We heard from public health staff about initiatives such a 'tobacco buddies' where local people who had stopped smoking helped others in scattered communities to cut down or stop. This had proved very successful, as had support from community pharmacies.

Community pharmacies in Aberdeenshire supported people to remain in the community as long as possible, for example, by giving information about services (the Know Who To Turn To initiative). They held stocks of palliative care medication and were available at weekends. They also offered medication management support to care homes and were involved in the development of anticipatory care plans.

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## Quality indicator 5 – Delivery of key processes

In this quality indicator, we look at how partnerships are performing against four key areas:

- access to support – getting help at the right time
- assessing need, planning for individuals and delivering care and support
- shared approach to protecting individuals who are at risk of harm, and
- involvement of individuals and carers in directing their own support.

### Summary

#### Evaluation – Adequate

In Aberdeenshire, some good public information was available to people seeking information on services and how to access them.

Older people were being involved in decisions about their care and support. Work had been done to support an outcomes approach and a positive start had been made on self-directed support.

However, greater recognition and attention needed to be given to the needs of carers.

Consideration needed to be given to how information could be shared electronically between health and social care.

There was also a need for prompt action to improve important aspects of risk assessment and risk management practice.

### 5.1 Access to support - getting the right help at the right time

The Partnership had a range of public information designed to help people know who to contact about health and social care services. Good examples of this included:

- Know Who To Turn To'- an easy to follow leaflet which provided advice on who to contact during periods of illness (see Quality indicator 2)
- Aberdeenshire's Carer's Charter which had useful information for carers, and
- the Neuk Day Centre in Fraserburgh which had a good package of leaflets for older people with dementia and their families (see Quality indicator 4).

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We looked at the websites of Aberdeenshire Council and of the Aberdeenshire Community Health Partnership. The council website had a designated social care and health section. This had a good range of information about supports and services, in particular social care services. The community health partnership website contained little or no equivalent information about health services within the area. The community health partnership should address this omission.

The social care service was involved in broader council initiatives, including 'Tell Us Once' and 'Improving the Customer Experience'. More specifically, the service told us that as well as free access to the internet in public libraries, equipment such as large keyboards and magnifying software was available. This encouraged more use by older people, including those with a sensory impairment.

While most of the public information we saw was single agency, we did see some which had been prepared jointly, for example the March 2013 telehealthcare brochure.

Most older people and their families we met during the inspection were reasonably clear about who they would contact if they needed information and/or support. In most instances, they said this would be their local health centre or social care office. Some staff referred to the range of service developments and pilot projects which had taken place. They said this could be challenging for them in providing good signposting information to the public.

Some of the questions we considered as part of our review of social care services and health records were about getting help at the right time. Positively, we found that:

- in 99% of files, there was evidence of the person having an assessment timeously, and
- in 85% of files, there was evidence of key services being provided timeously after the assessment had been completed.

This was not to say that the Partnership did not face a number of service pressures. As we comment elsewhere in the report, a number of these related to staff recruitment challenges. Occupational therapy services and, in particular, the provision of equipment and adaptations was an area where the level of demand was a key pressure. We noted from service user records that where there was a significant delay in service provision, occupational therapy featured most frequently. Within health services, we heard from staff and managers that older people could have to wait to receive a physiotherapy service and that, at times, there could be a waiting list for admission to a community hospital.

We read the social care service's eligibility criteria (dated October 2012) which had been revised to take account of national guidance. They contained the normal eligibility criteria of critical, substantial, moderate and low risk. Generally, the staff we met seemed clear about the eligibility criteria and its operation.

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In the small number of the service user files we read where there was a delay in providing a service, most of the people had been given an explanation for the delay.

The Partnership was putting considerable effort into the development of a number of care pathways in order to achieve better joint working approaches. Some of this work had been taken forward initially on a Grampian-wide basis, followed by more recent activity to consider their operation on a local level. We reviewed a number of these pathways, including those for older people, for dementia, for falls prevention and for palliative care. They all provided a good basis for effective joint working.

The Partnership was taking action to review the effectiveness of its pathway approaches. For example, a delayed discharge management group brought together local social care and health managers and practitioners to review delayed discharge performance and joint working arrangements. The Partnership considered that this group and approach had been influential in helping achieve Aberdeenshire's improving performance in reducing delayed discharges.

The Partnership was also keen to develop clear arrangements for how older people could access services and supports. They were considering a number of models which would enable individuals to access appropriate locally-based resources, including building on the current links which exist between GP practices, community hospitals and community-based health and social care teams.

Aberdeenshire Council's contact centre had been developed to take an increasing role in access to adult care services. Starting with home care in October 2009, this had extended to include hospital discharge, occupational therapy and telecare/community alarms by December 2012. We heard mixed views from staff about how well they thought the contact centre was working. Some staff, including health staff, were not confident that referrals they made would be passed in sufficient detail to social care colleagues. Where possible, they 'backed up' their referral to the contact centre by contacting their local social care colleagues directly.

We visited the contact centre and reviewed some of the customer feedback information. This showed good levels of customer satisfaction. For example, the data showed that some 75- 80% of the calls and enquiries relating to social care were resolved at the first point of contact. The biggest proportion of such calls related to the occupational therapy service.

Staff at the contact centre said that taking on these enquiries had been quite challenging. As well as taking the call details, they had also then been asked to provisionally apply a prioritisation to the enquiry and enter information onto Aberdeenshire Council's Carefirst electronic record system. They said that considerable scoping and planning work (including a KAIZEN improvement activity) took place before the contact centre took on new service areas. They then had regular liaison meetings with the managers of the service. They suggested that it would be helpful if a detailed review then took place six

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months after a new service area became operational. An occupational therapy review, which began in the summer of 2013, is under way.

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

The Partnership was aware that older people in need of care and support could still be subject to various assessment processes. However, it had been taking action to develop a more integrated approach to assessment as part of its care pathways activity. It was also trying to make sure that this was built on a personalised outcomes approach. To support this:

- a new outcome focussed and care planning toolkit was being developed. This included a revised assessment format. We saw this in some of the service user and patient files we read. We considered this provided a good basis for assessing personal outcomes.
- social care practitioners had participated in a 5-day care management training programme, and
- in 2012, following a review of home care services, all assessment and care planning activity for older people had been brought together into a single care management process.

All of these actions were designed to strengthen assessing for individual outcomes, rather than against available resources. Most of this activity was social care related. Health staff we met had an understanding of older people's wider needs and aspirations, and saw their primary focus as being concentrated on positive health outcomes.

This was reflected in the files we read. All of the assessments we evaluated were located in the social work records. Although, in nearly 60% of these, we saw that information from other professionals (for example allied health professionals) had contributed to the assessment. Our main findings from our file reading on assessment practice were that:

- 100% of files contained an assessment
- two thirds of these had been completed within the last six months, and
- the quality of 61% of the assessments was evaluated as good or very good.

These findings were largely positive, although the fact that 35% of the assessments were evaluated as adequate suggested some room for improvement.

Our findings on carers' assessments indicated the need for improvement. This was reflected throughout the inspection (see Quality indicator 2). Staff demonstrated a general awareness of the important role of carers. However, they seemed less aware of the

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statutory requirement that carers should be offered an assessment of their needs and of the potential benefits arising from this. Senior managers acknowledged that increasing the number of carers' assessments was a challenge. They planned to provide funding to Voluntary Service Aberdeen for this purpose as they considered the voluntary sector was perhaps better placed to engage with carers. Carers also had the option of completing an online carers' self-assessment.

Similarly to other partnerships, the Aberdeenshire Partnership faced major difficulties in being able to share information electronically between health and social care staff. The health service, has national arrangements for IT systems and practice around information sharing that cannot generally be varied locally. The Aberdeenshire Partnership had made considerable efforts over several years to find local solutions.

With the termination of the national Ecare project (a partnership between the Scottish Government, NHS boards, local authorities and other agencies throughout Scotland to streamline information-sharing activity between agencies to better improve the lives of those for whom they care), the decision had been taken to re-invigorate the Grampian Data Sharing Board to look at the sharing of information.

Staff said that the inability to share information electronically was a significant frustration. However, they did their best to work round this and used it as an encouragement to try and talk directly to their colleagues. Indeed, throughout the inspection we saw or heard about many instances where staff worked well together in sharing information. One good example of this was the local multidisciplinary team meetings where health and social care staff met regularly (sometimes in the community hospitals) to share information and to jointly plan for frail and vulnerable older people.

All staff said the different recording systems and incompatibility of NHS and council IT systems, which made it impossible to share records, were both time consuming and very frustrating. This is a situation replicated throughout many partnerships in Scotland.

Staff told us they would like to be able to share core information. However, they thought this was unachievable and quoted the time and expense of the attempts to implement single shared assessments as an example of why it could not be achieved. Staff said they had to communicate on a person-to-person basis, for example at case management meetings. Hospital staff did not know which community staff were working with individuals when the individuals were admitted to hospital. Hospital staff were starting to use shared emails to all local area co-ordinators and care managers when patients were discharged. Staff thought this was helpful, but were waiting to see how effective it would be.

There were limitations to the joint IT systems that did exist - for example, at the time of our inspection, the IT ordering system in the joint equipment store was not working properly. As a result, NHS staff were using paper forms. This equipment store is jointly funded by Aberdeenshire Council and NHS Grampian. This is where community

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occupational therapy equipment for Aberdeenshire residents is bought, stored, repaired and decontaminated. The Partnership will need to address how information sharing will be managed in the future (see recommendation in Quality indicator 8).

The findings from our file reading about care planning were generally positive. For example:

- virtually all of the files contained a care plan and in 61% of the files the care plan was comprehensive
- the majority of the care plans had been completed relatively recently, and
- 79% of the care plans addressed the individual's assessed needs either completely or mostly.

However, many of the care plans we read had standard text on outcomes embedded in the care plan template. Although the care plans did contain information about outcomes, and 82% of the care plans we read were outcome focussed, these outcomes were not personalised to the individual service user. The Partnership should continue to develop its outcome-focussed assessments and care plans.

Less positively, 37% of the care plans were not comprehensive and almost half were not SMART (specific, measurable, achievable, realistic, time-bound). The most common limitations were a lack of detailed actions and timescales.

The Partnership told us that there were difficulties in ensuring that care plans of older people receiving a care at home service were reviewed. However, this aside, there did not appear to be widespread problems in making sure that the needs and care plans of older people were kept subject to some ongoing monitoring and review. For example:

- in 69% of the files we read, there was evidence that the health and social care support of the individual was kept subject to regular review
- the regular multidisciplinary ward meetings at the community hospitals were seen as an effective review mechanism. Although patchy, we heard examples of GPs being involved in the reviews of very frail older people, and
- care home providers we met were positive about the quality and robustness of reviews carried out by staff in the designated review team.

As part of our file reading, we considered the extent to which the delivery of care and support met the needs of the older people concerned. Positively, we evaluated that this was completely the case in 39% of the files and partly the case in a further 53% of files. We met with a number of the older people (and their families) whose files we had read. Not unusually, we heard some mixed views, but in the main these were more positive than negative. We also contacted a few people who had home care and they generally expressed satisfaction with the service they received.

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### 5.3 Shared approach to protecting individuals who are at risk of harm

Much of the Partnership's work in respect of adult support and protection took place under the auspices of the Grampian Adult Support and Protection Partnership. It carried out a co-ordinating role on behalf of the three adult protection committees within the Grampian area, especially in relation to policy development and training.

The Aberdeenshire adult protection committee provided the strategic direction for the partner agencies. Regular attendance and joint progress reporting by partners at this committee showed their commitment to the strategy development. High levels of attendance at joint training events supported the linkages between training and staff confidence.

We read the Aberdeenshire adult protection committee's two-year report for 2010-2012. We could see from the report, some of the public information we received and by looking at the council and NHS websites that good efforts had been made to raise public awareness of adult protection issues.

The adult protection committee had used a questionnaire to review its own partnership working and its findings were largely positive. The 2010-12 report had identified that, for some time, there had been a relatively low number of adult protection referrals from health professionals (as was the case nationally). It also identified a significant drop in the number of referrals made by the police. As part of the inspection, we attended a meeting of the adult protection committee and noted that it was monitoring progress on a number of issues covered in the 2010-12 report, including the drop in the number of police referrals. The committee considered that this was due to a change in the police's referral process. They were also aware that referrals from health were low, as in other parts of Scotland.

Senior managers acknowledged the need to analyse the available management information on a regular basis. They were also committed to the continued shared understanding and approach towards adult support and protection.

One means of doing this would be through training, including joint training. Again, we saw from material provided that there was a good range and amount of adult support and protection training (see Quality indicator 7). This had been evaluated by the adult protection committee and, while this identified some room for improvement, the findings were largely positive.

We read the Grampian interagency adult support and protection procedures which had been reviewed in September 2011. We also studied the Grampian information-sharing protocol which was included as an appendix to the procedures. Both were clearly written, were comprehensive and laid out the responsibilities of individual staff and agencies.

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The Partnership told us that its intention was to have a clear and accessible shared risk management framework in place. It acknowledged that further work was required before this would be in place. The results of our file reading in relation to protection issues reflected this. The findings were mixed, with some clearly indicating the need for improvement. In particular, we found that:

- 61% of the files with protection type risk (those concerned with adult support and protection) which should have had a risk assessment did not have one. The equivalent figure for the non-protection type risk (those which are not protection issues such as risks of falling) files was 40%
- while we saw a number of good and very good risk assessments, a significant proportion were only of adequate quality
- 76% of the files with protection type risk which should have had a risk management plan did not have one. The equivalent figure for the non-protection type risk files was 29%, and
- in 47% of the protection risk type files, not all of the concerns about risk had been dealt with adequately. The equivalent figure for the non-protection type risk files was 27%.

We heard from a range of social care staff and managers that staff were completing risk assessments where these were needed, but these were not always formally recorded in the service user's case record. Health staff said that their risk assessments were placed in their nursing documentation. This was not the case in the health records we looked at.

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.

**Recommendation 2: Aberdeenshire Partnership should take action to ensure that risk assessments and risk management plans are completed and available within the case records of adults at risk of harm.**

Some of the findings from the file reading were more positive. For instance:

- in nearly all of the files where there were issues of risk (both protection and non-protection type risk), the file reader concluded that the services which the older person received had helped to reduce the risk, and
- in 71% of the files with protection type risk, there was evidence that the views of partner agencies had informed the risk assessment. The equivalent figure for the non-protection type risk files was 84%.

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This suggests some good joint working and information sharing around adult support and protection. Staff and managers we met considered that this was generally the case in their experience.

During our fieldwork, we heard positive comments about training in risk assessment, but also a few more critical ones. Some of these related to some uncertainty around the introduction of new risk assessment forms. This, and some of the file reading findings around risk assessments and risk management plans, suggests that the Partnership needs to give careful consideration to the training provided to support the implementation of its revised risk management framework. It also needs to quality assure this process.

#### **5.4 Involvement of individuals and carers in directing their own support**

We saw from the documentation provided by the Partnership that its proformas and supporting guidance for assessment and care planning included references to the need to actively involve and seek the views of older people and their carers. Specific policies and procedures had been and were under development to support the introduction of self-directed support. A number of exemplar proformas had been developed to assist good practice in encouraging staff to work with older people (and their families) on the personal outcomes they wanted to achieve and how they could have some control over this.

Findings from our file reading showed that staff were involving older people in considering their care and support. The findings here were encouraging:

- in 94% of files, the individual's needs and choices were taken into account in the assessment
- in 89% of files, there was evidence at the care plan stage that the services actively sought and took account of the individual's views. This figure was 92% for the review stage
- in 94% of cases there was support for the individual to contribute to the care plan.

#### **Independent advocacy**

One way in which older people can be supported in having their views and wishes taken account of is through independent advocacy. We saw very little information about advocacy services for older people in Aberdeenshire. In our file reading, the vast majority of older people were not in need of advocacy services. However, for the small number of older people (eight) where this may have been appropriate, there was no evidence that this had been offered. At a focus group with carers, we were told that there was only one carer advocate in the north east of Aberdeenshire and that there was a very big waiting list for their services.

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## Self-directed support and direct payments

### Self-directed support

We considered that the Partnership was well prepared for the implementation of the Scottish Government's self-directed support legislation. The Partnership had created the following:

- a pilot self-directed support project, with a dedicated self-directed support team to design and develop resources, policy and practice, which was being evaluated
- a suite of templates, forms and documents for practitioners
- an extensive programme of self-directed support training, in the run up to the commencement of the relevant sections of the Self-Directed Support Act in April 2014, and
- a self-directed support roadshow, which was well attended.

We met the self-directed support team and were impressed with their enthusiasm in being able to play a role in the development of self-directed support. After a slow start with 20 people in receipt of self-directed support in 2011, this number had grown to 100 by the time of our inspection, of which about 20 were older people. In 14 of the files we read, self-directed support had been considered.

The Partnership was actively trying to encourage smaller local providers to develop opportunities for self-directed support. The re-launched Respite Bureau had been changed in order to be responsive to self-directed support.

Work was also being developed to make sure that all staff knew the key messages and the importance of individual budgets as a means of allowing individuals to choose the care most appropriate to meeting their needs. Health staff felt they could benefit from more information about self-directed support, and thought that joint training with social care would be beneficial. The Partnership should look how it can increase the knowledge of health staff in relation to self-directed support to develop all staff's knowledge.

### Direct payments

The provision of direct payments was already working well for most of the service users who had chosen it, as it gave them more flexibility in how they received their care. The local authority had streamlined its direct payments procedure, and this had made it easier for service users to access direct payments.

As we commented earlier in the report, there had also been an encouraging increase in the number of older people in Aberdeenshire in receipt of direct payments. This gave them greater control over the care and support they received.

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We were told by staff, service users and carers that in small communities the word got round that direct payments could be a very effective solution for individuals who needed home support. Individuals were told that they could have a direct payment immediately, and then they could arrange their own home support. Alternatively, they could have their home care provided by the local authority, but they would have to wait for this. Individuals arranged their own home support with Cornerstone who recruited and trained carers to provide home care. Managers told us that increasingly older people were taking up the option of direct payments, and this worked well for them.

Another benefit of the increased use of direct payments was that Aberdeenshire Council's home care staff time was freed up allowing support to be focussed on other service users.

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

In this quality indicator, we look at how partnerships are developing and implementing their plans for the joint strategic commissioning and delivery of services for older people in their area.

We look at:

- operational and strategic planning arrangements
- partnership development of a range of early intervention and support services
- self-evaluation and improvement
- performance management and quality assurance, and
- involving older people who use services, carers and other stakeholders.

### Summary

#### Evaluation – Adequate

The Partnership's strategic approach to improving the health and wellbeing of older people and their carers was documented well in its joint commissioning strategy for older people, *Ageing Well in Aberdeenshire*. This strategy documents sets out how health and social care services would develop over the next 10 years and work jointly to provide the best possible outcomes for older people and their carers.

Comprehensive plans for reshaping services for older people were in place, with a strong emphasis on supporting people to remain at home. However, the Partnership should continue to develop strategies for implementing initiatives in reablement and rehabilitation to improve long-term care to enable people to look after themselves with support for as long as possible.

The Partnership also needed to take account of benchmarking with other partnerships or against national averages. It also needed to set out which steps needed to be taken to achieve targets and who was responsible for delivering actions on behalf of the Partnership.

We found that a number of initiatives had been taken forward both on an individual agency basis and in partnership. Many of these were at an early stage and therefore it was difficult to fully assess their impact.

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## 6.1 Operational and strategic planning arrangements

Aberdeenshire Council and Aberdeenshire Community Health Partnership had worked together to progress a comprehensive plan for developing and reshaping services for older people in the area. Informed by the community planning partnership's single outcome agreement, the plans for services for older people were set out in their joint strategic commissioning strategy, Ageing Well in Aberdeenshire. These jointly agreed plans clearly showed a shared vision which aimed to reduce the number of people whose discharge from hospital was delayed.

The shared vision was underpinned by the community health partnership and social care service plans. The Aberdeenshire older people's strategic outcome group oversaw the financial framework and implementation. An action plan set out strategic objectives. However, the targets and timescales were medium to long term with no clarity on how these would be measured. The transitional leadership group should have a clear role in reporting on progress.

Priorities set at partnership, team and unit levels reflected jointly agreed plans. Included as key priorities were:

- support to older people to live independent, healthier lives for longer in a homely environment
- support to carers, and
- joint working across partners to prevent problems arising among older people.

Strategic plans acknowledged that some services would be changed to improve long-term care and enable people to care for themselves. A number of initiatives were testing out different ways of working, some of which were being evaluated. However, there was not a strategy for rolling out implementation and further improvement and reshaping of services. The timescales set out in the Partnership's self-evaluation should have been showing results at the time of the inspection, but some developments such as reablement and the redesign of day support were not yet at the full implementation stage.

**Recommendation 3: Aberdeenshire Partnership should establish a clear programme of work and develop a strategy for rolling out implementation of new initiatives for reshaping of services. It should set out the steps which need to be completed to achieve proposals set out and identify who is responsible for delivering the actions on behalf of the Partnership.**

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Aberdeenshire compared to or was above the national average in relation to life expectancy. Twelve per cent of Aberdeenshire pensioners live alone. This proportion was likely to increase in line with the estimated increase in the numbers of those aged 65 years and over. This may have significant resource implications particularly around home care.

Aberdeenshire's joint plans for older people's services included plans to build new care homes as well as set up care villages in a number of communities. The development of sheltered housing and extra care housing would be staffed by staff experienced in working with older people. The implementation of this work was at too early a stage to evaluate its impact.

A clear approach to improve the use of premises and, where possible and practicable, to share resources, including community hospitals was set out in the joint infrastructure plan. Plans were in place to develop co-location of staff to help support joined-up working. We saw evidence of an approach to develop joint teams. Health plans were being developed across the six localities of Aberdeenshire. However, more work was needed to bring these together with the overarching strategic plan and the plans for developing social care services. This would make sure that locality planning was a partnership activity.

Reporting to the performance committee did not include benchmarking with other areas across Scotland or against the Scottish average.

Short life working groups and action learning sets supported the development of the plans and associated strategies. These included:

- care of older people with dementia
- how to improve communication, and
- staff learning and development.

We have already highlighted some of the challenges associated with discharge planning from the acute sector and actions taken for improvement. There was evidence that partners were seeking to identify some of the underlying causes of service pressures. GP practices in Kincardine were working with the local authority care management team to establish how partners might change how they worked together to meet both short and longer term needs through better joined-up working. This reflects practice across all of Aberdeenshire.

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

The development of services to support older people had a strong emphasis on supporting people to remain at home. Across Scotland, partners were developing reablement and rehabilitation services alongside strengthening care at home to help manage the number of people supported by such services. Reablement is about giving people the opportunity and the confidence to relearn or regain some of the skills they may have lost as a result of poor health, disability or impairment, or entry into hospital or residential care. As well as regaining skills, reablement supports service users to gain new skills to help them maintain their independence.

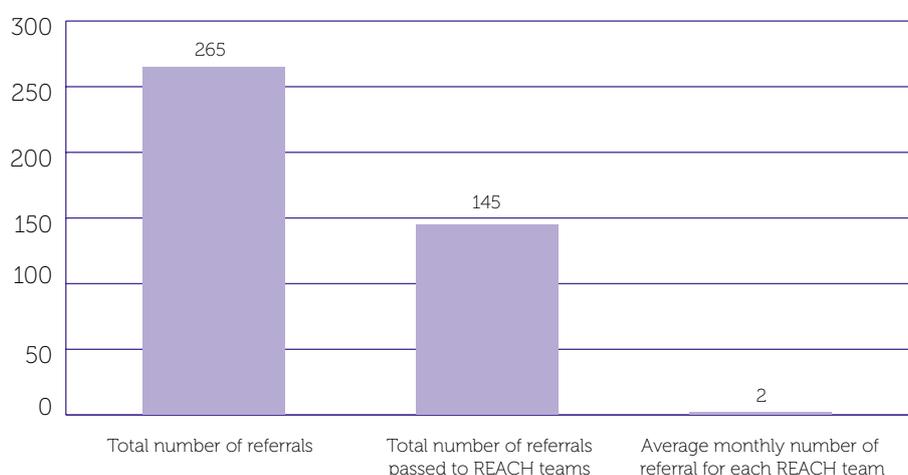
Rehabilitation and reablement formed one of the key strategies for early intervention and prevention in Aberdeenshire, and they aimed to reduce the level of support needed by individuals in the longer term.

The rehabilitation and enablement in Aberdeenshire for care at home (REACH) teams were set up as pilots in 2011. They had been operating under slightly different models as well as with differences between health and social care team membership. Home care was a dedicated team and the occupational therapy posts were not.

An evaluation of REACH by Robert Gordon University, Aberdeen, was almost complete. The Partnership will then look at how they will mainstream the service. A detailed in-house evaluation was under way and due to report by June 2014. Most people were happy with the brief and transitional support which helped them to regain independence. Most participants in the study said it was easy to gain access to the service, usually through health and social care staff in hospital, as well as through some GPs. They were positive about the outcomes, for example in being able to carry out domestic and personal care tasks themselves, and regaining confidence.

### Chart 9

2011-13, Aberdeenshire reablement on 3 pilot sites  
(source REACH progress report June 13)



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As Chart 9 shows, the numbers of individuals going through the service had been surprisingly low and staff were looking at the reasons for this. Although there had been a point where they could not take referrals due to staffing issues, there would appear to be reasons over and above this for low referral rates. Health staff said that the very strict eligibility criteria meant that only a very narrow band of people would be eligible. They were disappointed that the service had not developed in the way they had anticipated and had not been accessible by the group of people they felt would benefit more from this type of service.

However, senior managers were quite clear that the service was a multidisciplinary wraparound service which did support early discharge, but was only ever intended for certain individuals. The criteria for the service had been revised, but they had tried to retain the initial principles. These were to:

- provide focussed, intensive interventions and self-management to prevent avoidable admission to hospital
- to facilitate early supported discharge, and
- that individuals should have the potential to achieve identified goals within a 6–8 week period to maximise their independence and reduce reliance on traditional home care.

Geography had also posed a challenge in delivering the service. The Partnership felt strongly that when providing services they had to be careful that there was equity across all areas. Managers stated that REACH was an expensive service and they could not afford to replicate this service across all localities. It was not the intention to rollout REACH beyond the three pilot sites. The intention was to design a mainstream model based on the learning from the pilot sites.

A number of other rehabilitation and enablement options had been suggested, particularly by medical staff, with home from hospital services and rapid response services used to enhance the REACH approach. Some work had been carried out at the Inverurie GP practice to test a rapid intervention joint team to help support an individual at home and avoid the need for hospital admission. The Partnership will consider all these options following the evaluation.

Therefore, the development of reablement services was at an early stage when compared to many other areas across Scotland. Other areas had developed this as an effective approach to managing staff capacity as well as improved outcomes. The pilots were due to be completed in March 2014. We did not see an action plan or proposals for the future. The Partnership will need to move quickly to implement any recommendations and findings of the evaluation to make sure that it does not lose momentum.

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**Recommendation 4: Aberdeenshire Partnership should ensure that the continued development of early intervention support makes the best use of limited staff resources in the care at home sector.**

In the meantime, training was being delivered to staff to support developments in rehabilitation and reablement. This made sure that staff were familiar with an approach that supported individuals' capacity for self-care and self-management, particularly for long-term conditions.

In community-based health services, increased access to allied health professionals' support had led to improved outcomes for people through providing support in the community rather than in an acute hospital setting. The proposals for the future of this pilot still had to be finalised. The same was true of the Men's Shed project which had been supporting men who were isolated in the community and helping them to engage in social activity. Recognising that older people can be isolated and depressed, the PILLAR project in Stonehaven supported people with mental health issues including older people and their carers.

A number of services had been developed as part of the Change Fund to promote early intervention and support transport services, including access to physiotherapy at Aboyne Hospital.

Partners, including public health, were working together to promote and maintain individuals' health and independence. Some plans were at an early stage of development. It was not yet clear how the approach to community capacity building would impact on community-based supports.

We comment further on the development of early diagnosis and support for people with dementia in Quality indicator 2.

The commissioning team had been working with providers to develop a system to speed up allocation of care packages. However, some challenges remain to making this work efficiently to make sure that individual service users were allocated quickly to providers to put support in place.

### **6.3 Self-evaluation and improvement**

The partners were working together to develop self-evaluation and improvement. Aberdeenshire Council used 'Kaizen for Daily improvement' and NHS Grampian used 'Releasing Time to Care' as their self-assessment approaches. This had led to changes, including how occupational therapy services had been delivered across the area.

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A suite of performance information based on the information collated by the Joint Improvement Team<sup>13</sup> as well as NHS Grampian performance dashboards formed the basis of the joint approach. This helped partners to identify what local people wanted from services.

There was some joint performance information as well as quality assurance exercises that informed continuous improvement of services. Some developments looked at the quality of services and identified those that the Partnership wanted to invest in. This included reshaping the council run care at home service to support reablement through the development of the REACH team.

Managers had reviewed the role of the sheltered housing warden service and introduced changes that supported the development of other housing models. These offered greater individualised support to people living in sheltered housing through the provision of care at home services. The review of sheltered housing services had engaged with current and future potential users of housing to inform their development of other resources.

The Partnership had used action learning sets effectively and brought together a range of staff from across health and social care (see Quality indicator 7). This was used alongside Kaizen events and provided a positive approach to engaging staff in the improvement agenda.

An audit of people whose discharge from hospital was delayed had been carried out to assess the impact of delays on individuals.

Managers across health and social care were working together to review the findings of the Francis Report<sup>14</sup> and to identify and reduce the risks identified within the report occurring in Aberdeenshire.

## **6.4 Performance management and quality assurance**

Aberdeenshire Partnership was taking a joint approach to the deployment of some resources, such as the Change Fund, to support improved outcomes for older people. The Partnership was regularly evaluating and reviewing these joint approaches. Some joint organisational targets and priorities for the use of resources were being agreed and were set out in the Aberdeenshire joint performance framework (April 2012–March 2013). This framework gave data such as the improvement on outcomes. The revised performance framework had been developed as a single agency tool based on the Aberdeenshire community health partnership quality strategy. This set out four areas for evaluation: two for quality: people and safety, and two for efficiency: staffing and resources.

The joint performance framework included targets for the Partnership to show how it was shifting the balance of care year on year. The Partnership had reporting arrangements or performance against strategic outcomes based on single-agency reporting. ‘Talking Points’

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<sup>13</sup>The Joint Improvement Team (JIT) is a strategic improvement partnership between the Scottish Government, NHSScotland, Convention of Scottish Local Authorities (COSLA), and the third, independent and housing sectors. The team provides direct practical support to local health, housing and social care partnerships across Scotland.

<sup>14</sup>The Francis Inquiry report. The report of a public inquiry into the failings at the Mid Staffordshire Foundation Trust February 2013

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had been used within the Partnership. This programme provides a clear focus on activity around outcomes. This puts the individual at the centre of their services and makes sure that organisations are focussed on the difference they make to people's lives as well as the activities carried out. Plans to introduce new recording arrangements to capture personal outcomes could further the development of this aspect of work.

There was limited evidence that priorities set at partnership, team and unit levels reflected these jointly agreed targets and priorities. However, we saw some clear guidance on how to use resources to achieve some priorities, such as the guidance for multidisciplinary teams on how to carry out anticipatory care planning.

Aberdeenshire Council reported performance in housing and social work against the Housing and Social Work Service Plan and reports performance against priorities in the SOA using Covalent.<sup>15</sup> Most were on target. Support to carers was highlighted as an area for improvement.

Audit information was used at joint meetings of health and social care staff to review the experiences of people admitted to and discharged from hospital to help inform improvements. We observed a joint meeting between GPs practices, community nursing staff and social care managers. This forum was set up to look at how partners might work together to improve outcomes for people.

Managers in social care carried out periodic file reviews to assure the quality of practice. The adult protection unit monitored the quality of referrals and assessment decisions. However, continued gaps in the number and quality of risk assessment and risk management plans still needed to be addressed (see Quality indicator 5). Grampian Police division was leading a national scoping exercise on referral practices and adult protection policy across Police Scotland's 14 national divisional areas. This showed a positive approach to quality improvement across the sector. The future adult protection committee strategy would be based upon available management information. Some data gathering had only been started recently. Further work was needed to make sure the effective strategic deployment of resources.

The care needs system was an online application process for providers to tender for individual packages of care and support. This was developed to help both Aberdeenshire Council and care at home providers to advertise and allocate hours of care quickly. Providers were not always clear whether they were the successful applicant and, as a result, carer hours were held unallocated while waiting confirmation. The commissioning team needed to review how they could improve communication with providers.

The performance management system should provide the Partnership with information and evidence on the range and level of care needs in terms of type of service required, length of waiting time and geographic challenges. This would inform future developments and service improvement. We did not find a well-co-ordinated approach to how information was used to improve and assure practice.

<sup>15</sup> Covalent is a bespoke performance management system used to electronic record and report on performance information across a range of defined indicators

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## 6.5 Involving individuals who use services, carers and other stakeholders

Both partners had clear policies for engagement with people who were using their services as well as with other stakeholders, including staff and external providers. Information for carers was very clear, well illustrated and well laid out with a format consistent with other Aberdeenshire Council information.

One of the actions as part of the local implementation of the national 2020 Workforce Vision<sup>16</sup> was to replace the facilities at Inverurie Hospital with the proposed introduction of a new model of health and social care for the local community. This aimed to deliver services as close to home as possible, placing less reliance on acute inpatient beds and with a clear focus on responding to individuals' needs. This would be developed further to become the Inverurie integrated health and social care hub, replacing existing inpatient accommodation, expanding outpatient facilities and co-locating health and social care services.

Care home providers were positive about the level of support they were given by Aberdeenshire Council to manage difficulties and improve their performance. We found that providers of services were less aware of the joint strategy and its possible impact on the future shape of services. They could be better engaged in reshaping how they provided services to meet future challenges.

The communication strategy and communications plan for the promotion of the joint commissioning strategy for older people aimed to engage with a wide range of stakeholders across Aberdeenshire. One example was the 'Your Voice' project supporting user-led forums which provided one avenue for engaging with older people about plans to reshape support and service options. These groups, made up of older people, were consulted on the joint commissioning strategy for older people. Consultation on the strategy also included gathering views from community groups, those living at home, those attending day care and in care homes about transport, information and advice, and how they wanted to be supported in the future.

We found that team managers felt involved in development and improvement activity and thought that this was clearly led. However, frontline staff were less positive and not as clear.

## 6.6 Commissioning arrangements

The joint commissioning strategy for older people set out the Partnership's approach to developing services into the future. Central to this was to provide more community-based preventative support services. The strategy identified the range and type of services they would aim to develop and provide, and the IRF in the strategy set a 10-year overview. However, it needed to be further developed to show the relative spend available for the

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<sup>16</sup> The 2020 Workforce Vision, published in June 2013, sets out the core values of NHSScotlan and captures the things that staff said need to change and be done better, including a commitment to valuing the workforce and treating people well. NHS boards are to ensure that their local values align with these overall NHSScotland values.

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different types of resource and how the resource shift would be achieved (see Quality indicator 8). We found that the strategy gave a clear view of the direction of travel, but lacked some of the detail on how it would be achieved.

Performance indicators were mainly those from the single outcome agreement rather than more detailed actions. We did not find a clear indication of what needed to be done to support putting planned changes in place. A number of planned initiatives were not due for completion until next year.

A major priority for the Partnership would be investment and disinvestment decisions to allow implementation of the plan. One of the challenges would be telling the public what would change and what might no longer be available. A strong option appraisal process with clear criteria and a robust decision-making process based on the application of relevant and focussed information needed to be put in place.

**Recommendation 5: Aberdeenshire Partnership should have option appraisal processes in place for the use of resources for reshaping of services. This should include engagement with key service providers as well as other signatories to the joint commissioning strategy for older people, Ageing Well in Aberdeenshire.**

Engagement with communities and identification of local assets in Aberdeenshire had the potential to form a strong basis to develop improved outcomes for local residents into the future and needed to be built on (see Quality indicator 4).

Although discussion had taken place with partners about how to build and implement a personal outcomes approach to commissioning, it was not clear when this would be translated into how services were procured.

Implementation of the joint commissioning strategy for older people included developing the care at home market. However, providers of these services were not engaged in how their services might be reshaped or enhanced to support this element of the plan. Providers' forums are designed to support strategic commissioning. These could be further improved to share information on service direction as part of the joint strategic commission plan and encourage providers to shape the market to be ready to deliver on the key strands of the plan.

Procurement of services had been developed to try to encourage smaller local providers to offer support that could be purchased as part of a self-directed support package. Positive developments included flexible support to carers, for example a local voluntary organisation had been commissioned to deliver 'creative breaks' which supported their caring role.

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## Quality indicator 7 - Management and support of staff

In this quality indicator, we looked at how the Partnership is managing staff across health and social care services. For example, we looked at how the Partnership was addressing:

- recruitment and retention of staff
- deployment of staff and joint working
- staff training, development and support.

### Summary

#### Evaluation – Good

Health and social care were making attempts to engage with staff at different levels to develop a workforce prepared for taking the integration agenda forward. There was good support from both human resources departments on a strategic and operational basis with initiatives being developed to address recruitment problems. Steps had also been taken to manage transition to an integrated partnership and to develop and consult on a joint workforce plan. Absence was being carefully monitored.

Training and development opportunities were of a good quality and focussed on improving outcomes. The Partnership was beginning to look at more opportunities to deliver training and workforce issues on a joint basis. The Partnership needed to drive forward its plans to pool resources in joint recruitment of frontline staff to support older people at home.

### 7.1 Recruitment and retention

We read a range of relevant and clear documentation including recruitment and retention strategies and policies for safer recruitment given to us by Aberdeenshire Council and NHS Grampian. These documents were fit for purpose. However, these were separate documents rather than jointly compiled.

In almost all interviews and focus groups we carried out, frontline and senior staff told us that recruitment was a major issue impacting on the delivery of services, including new projects introduced as a result of the Change Fund. Senior managers told us that recruiting appropriate staff was not just an Aberdeenshire health and social care problem, but a North East of Scotland problem. They said that public sector jobs were adversely affected by the oil and gas industry. There appeared to be a high number of vacancies particularly within physiotherapy and home care services. A senior health manager told us

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that the major difficulty was in relation to recruiting Band 2 nursing staff (clinical support worker) and filling unqualified posts.

We found a range of evidence of very positive and proactive approaches to try to recruit residential care and home care staff. A high profile recruitment campaign for home carers was launched in October 2012 when acute staff shortages were delaying access to care and preventing timely hospital discharge. With a backdrop of lower than average unemployment rates, the housing and social care service had accessed additional funding and recruited 35 additional home carers (target was for 50) and had appointed a dedicated recruitment officer. A home care recruitment group was chaired by the head of service in social work.

Other approaches had also been tried, for example advertising in local papers, production and distribution of leaflets and posters, use of school drops, community websites, radio and recruitment events. Successful mini recruitment drives had been held within the care homes. A recruitment team was created for difficult or hard to fill posts, senior management recruitment and key social care posts.

Within Aberdeenshire Council, there was a recruitment freeze in 2011. Since this had been lifted, social care had recruited 850 additional hours since June 2012 and filled 57 mainstream vacancies. However, the net effect of these steps was proving difficult to measure as staff continued to leave. Housing and social care services had made a major financial commitment to maintain the workforce with £1.5million being set aside to recruit home care staff. As a result, senior managers believed that the home care workforce was becoming more settled.

One of the transitional leadership group workstreams, which had recently been established, was the involvement and engaging of people. The remit of this short life working group was to manage transition to an integrated partnership and to develop and consult on a joint workforce plan.

Heads of human resource were working with other partners to look at a joint and more strategic approach to recruitment. Senior managers were considering the possibility of sharing care staff across different care sectors, including health. Consideration was also being given to developing career pathways providing opportunity to complete Scottish Vocational Qualifications above the required level for the post. We were also told that NHS Grampian was looking at the potential for an Aberdeen weighting to attract more staff. Through Agenda for Change (the NHS pay and grading system), NHS Grampian had been able to offer a retention premium which had helped to retain staff.

Changes to home care contracts meant that home care staff had been removed from zero hours contracts and were now on permanent employment contracts. Home care staff were recruited on 18-hour contracts, giving the managers more flexibility.

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<sup>17</sup> A 'zero hours contract' is an employment contract between an employer and a worker, which means the employer is not obliged to provide the worker with any minimum working hours, and the worker is not obliged to accept any of the hours offered.

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However, there remained issues about how the home care service hours were being managed. The hours allocated to an individual could not be re-allocated in the short term if, for example, that individual went into hospital. There was no consistent system to use bank hours across all home care services.

Sickness and unplanned absence can have an impact particularly when recruitment is an issue. Aberdeenshire's own analysis of its workforce highlighted a number of issues such as an ageing workforce and sickness absence levels. A number of initiatives were being put in place to improve attendance. For example, an attendance management policy was being revised and an early intervention attendance management pilot carried out. A wellbeing support service ran for six months in early 2013, with findings from the pilot currently being assessed.

## **7.2 Deployment and joint working**

We found that resource allocation and deployment of staff was still at an individual agency level. There was also variability across localities in terms of their ability to retain and deploy staff.

Many members of teams, which included primary care and social care practitioners aligned to GP practices, were co-located. Most of the staff we spoke to in these teams were clear that they had positive working relationships, but they did not always see themselves as joint or integrated teams. They were, in effect, aligned teams.

The partners were beginning to develop joint services such as the rehabilitation and enablement in Aberdeenshire for care at home (REACH) teams. The aligned teams and REACH remained accountable to their respective NHS and council employers for management, budget allocation and professional practice. This meant that no governance issues, for example in relation to changes in line management, had arisen.

When asked about the future of integration, the majority of staff said they did not know what was happening. They thought that it was not really necessary in Aberdeenshire as joint working was so well-embedded in practice. Staff were largely uncertain about the future of their posts in relation to future developments around integration.

From our staff survey, we found that 68% of respondents agreed or strongly agreed that there were positive working relationships between practitioners at all levels and 84% agreed or strongly agreed that there were positive examples of joint working and shared approaches to service delivery.

Most job descriptions and profiles were still specific to each of the partners. Almost all staff were clear about their roles and responsibilities. However, there had been recent joint appointments. We met the recently appointed joint integration manager whose remit was to lead and develop a model of integration in joint strategic planning and to provide

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leadership to staff on matters of integration. There was also a joint equipment service manager in post.

Staff we met and who responded to our staff survey from both health and the local authority were generally positive about the support they received from their line managers, believing good supervision arrangements were in place.

### **7.3 Training development and support**

The NHS and local authority operated separate arrangements for individual supervision, team meetings and annual appraisal systems.

A wide range of training opportunities were available to staff including some examples of more established joint initiatives such as adult support and protection training. An established Grampian adult support and protection multi-agency learning and development strategy provided evidence of joint training and working in partnership to deliver this.

A North East public sector development group had been established to facilitate the sharing of training courses among Aberdeen City Council, Aberdeenshire Council and NHS Grampian as well as other partners such as the Robert Gordon University. This group produced a number of joint initiatives, including a joint mentor scheme for managers, and facilitation of critical skills for critical time events which focussed on change management.

There were generally well-established opportunities for staff from both partners to attend other training sessions together, for example falls and manual handling training. It was less clear what joint training approaches might be introduced to deliver on common themes between partners such as rehabilitation and enablement training.

We found evidence of the use of training needs analyses being carried out and informing the training needs of teams.

There was a detailed workforce plan for Aberdeenshire Community Health Partnership. This identified future priorities and use of the Change Fund. This plan referred to 'working with partners' rather than developing a more integrated approach.

A dedicated project officer for older people led on the publication of a housing and social care newsletter. NHS Grampian published a similar newsletter for their staff. A joint newsletter was also recently published.

We attended a 'good practice' event which involved presentations from 12 projects. These described how partners improved services and worked more effectively with colleagues to do so. Some of the projects provided examples of effective partnership working with colleagues from health, the police and voluntary and private sectors. Two specific projects were joint initiatives: the joint equipment store and the action learning set projects.

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Feedback from staff who attended was very positive.

From our staff survey:

- 85% of respondents agreed or strongly agreed that joint working was supported and encouraged by managers
- 66% agreed or strongly agreed that they had good opportunities for professional development
- 90% agreed that they had received appropriate training to do their job
- 62% agreed or strongly agreed that their views were fully taken into account when services are being planned and provided.

GPs had participated in the one-year leadership programme with a yearly GP event which looked specifically at multidisciplinary working with older people. These events contributed positively to a changing culture.

Generally, we found that senior managers were purposefully trying to engage with staff to begin to take forward the integration agenda with some very positive initiatives.

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## Quality indicator 8 – Partnership working

This quality indicator looks at partnership working. We looked at how the Partnership was developing its budget-setting process. We also looked at how the Partnership was using the Change Fund to support shifting the balance of care from hospital to community-based services.

In this indicator, we considered the extent to which IT systems in Aberdeenshire were 'joined up' across the Partnership. We then looked at the arrangements the Partnership is putting in place in preparation for the integration of health and social care.

### Summary

#### Evaluation – Good

The Aberdeenshire partners had a strong tradition of working well together at strategic and locality level, and between individual members of staff. Formal partnership arrangements were in place and good progress in joint working arrangements had been achieved. However, the requirement to develop a joint commissioning strategy for older people's services and the need to prepare for the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 had given additional impetus to partnership arrangements.

Significant steps had been taken such as the establishment of the transitional leadership group. The partners had a detailed joint strategy on the rationalisation of their premises. At the time of the inspection, finances were not jointly managed and there was no joint IT strategy. Work on these issues was to be developed by the resources group set up by the transitional leadership group.

### 8.1 Management of resources

The partners were in the process of agreeing and implementing a strategic planning framework for the provision and allocation of resources through the joint commissioning strategy for older people. Ageing Well in Aberdeenshire. This was supported by a three-year rolling budget comprising all social care and primary healthcare funding for the care of older people.

NHS Grampian and Aberdeenshire Council had recently agreed in principle that, although budgets and allocations would still be managed separately, for the time being any changes in the budget allocation pattern for savings, investing or disinvesting should be planned and approved jointly through the Aberdeenshire older people's strategic outcome group and the joint community care partnership group. They intended to develop ways

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to jointly review and appraise options to maximise opportunities to reduce costs and minimise duplication. This would be developed through the work of the resources group (recently set up by the transitional leadership group) and through the joint commissioning strategy for older people.

Within the Aberdeenshire joint financial framework, the total aligned gross budget for services for older people in Aberdeenshire was £122.365million in 2012–2013 and is £120.540million for 2013–2014.

Aberdeenshire Council's gross budget for services for older people in 2012–2013 was £67.918million. The gross budget for 2013–2014 is £66.077million. Key factors included the net spending on care at home decreasing from £10.429million in 2012–2013 to £9.352million in 2013–2014. There was a planned capital expenditure of £10.87million to be spent on building a second care home by Aberdeenshire Council by April 2016. There was a history of underspends within social care services due to problems in recruiting staff.

The NHS gross budget for primary and community services in Aberdeenshire in 2012–2013 was £30.374million. In 2013–2014, the gross budget is £30.390million. Key factors included the fact that in 2010–2011 £87million was spent on acute hospital care of older people, with an estimated £11.547million spent on community hospitals. There were options appraisals taking place for the redevelopment of primary and community services in Inverurie.

The Change Fund from Scottish Government amounted to £3.83million in 2012–2013. This resource was being used across both health and social care services for early intervention, rehabilitation and enablement and improving long-term care.

As in other areas in Scotland, the existing total health and social care funding for older people's services in Aberdeenshire was still very much seen as two distinctive funds with different management, governance and approval processes. The Partnership acknowledged that, despite long and formally established joint planning arrangements, it was only now that work was being carried out to make sure that Aberdeenshire Council and the NHS carried out medium-term financial management, planning and monitoring activities together.

In common with other areas in Scotland, budget-setting processes and timescales were not aligned and plans, governance arrangements and efficiency targets were not yet joined up. Responsibility for financial management had also not been devolved by NHS Grampian to the community health partnership for all primary and community health services such as general medical services and community mental health services. The Partnership explained that, for these reasons, it had been difficult to develop short, medium and long-term planning for health and social care services. There are few examples of pooled budgets in Scotland and there had been no drive in Aberdeenshire towards pooled budget arrangements.

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More could be done to redirect funding to interventions which maximised achievement of key priority outcomes regardless of funding source. The partners were not yet proactive in reshaping services by identifying spend to save opportunities. While the joint commissioning strategy for older people set out the key intentions in shifting the balance of care and redesign, and the description of how services were to be changed in terms of mix and type of activity was given, there was less clarity in the related redistribution of resources that would need to happen. This is in line with the situation in many partnerships in Scotland.

The joint commissioning strategy for older people stated the Partnership's intention to 'invest in new ways of working by integrating budgets and reshaping care to meet the needs of a growing older population.' There was little information in the strategy on how greater financial integration would work in practice. The use of joint or integrated budgets was not yet clearly articulated within an integrated services plan for older people, with clear sets of priorities and targets for all services. Information and analysis from the Integrated Resource Framework<sup>18</sup> did not appear to be used when considering the development of services, although the partners had stated their intention to develop and use it in future planning, using new data that will be available in 2013.

There was joint forward planning for assets such as sharing buildings and offices as well as capital and staff assets. The joint infrastructure plan 2013-2020, draft dated June 2013, was an excellent example of this. It brought together the properties owned by NHS Grampian and Aberdeenshire Council, including community hospitals, health and GP centres, and social care buildings. It contained proposals for their shared use and co-location, upgrading and getting rid of surpluses.

Managers in the Partnership worked collaboratively to make effective decisions about the allocation of resources towards mainstream services and more innovative services such as anticipatory care planning, early intervention, prevention and supported discharge. The work of the older people's strategic outcome group demonstrated the effective collaboration of health and social care managers and professionals in using joint resources across the whole of Aberdeenshire. However, this activity was mainly focussed, at the time of the inspection, on the use of Change Fund resources.

There were a number of single-agency risk management plans, such as risk management plans and procedures for social care cases and health cases. However, the partners did not appear to have either a systematic approach to the joint management of organisational risk or organisational risk management plans, for example at a service level. This was probably a reflection of the limited number of joint initiatives and services to date.

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<sup>18</sup>The Integrated Resource Framework (IRF) is being developed jointly by the Scottish Government, NHSScotland and COSLA to enable partners in NHSScotland and local authorities to be clearer about the cost and quality implications of local decision-making about health and social care. This will help partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups.

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Scottish Government expects the Change Fund to be used as 'bridging finance' to enable the redesign of services and facilitate achievement of national policy. It also expects that the use of the fund should also influence decisions on the totality of partnership spend on older people's services. In the joint commissioning strategy for older people, the Partnership stated that it had used the funding to make faster progress to move away from reactive, institutional care and towards more preventative and anticipatory care that enabled older people to remain safe and well in their own homes. In 2011–2012, the first year of the Change Fund, the partners thought that slow, but positive progress was evidenced in reshaping care towards a greater emphasis on self-care, care at home and in local communities for those with complex care needs.

There had been a large underspend on the Change Fund. The budget allocation in 2012–2013 was £3.830million, and the amount committed/spent was £2.278million. This significant underspend on Change Fund budgets was due to a lack of capacity and difficulty in filling posts, primarily as a result of the local employment market and health staff being unwilling to apply for short-term posts. Some steps had been taken to address this. However, the Change Fund for 2013–2014 was almost completely committed.

Nevertheless, the Change Fund was still seen by the Aberdeenshire Partnership as a 'separate box of funding' for short-term projects rather than as an enabler to change practices within the £120.540million joint financial framework for long-term services, improvement and sustainability.

There had not been a robust and formal business case procedure that would prioritise Change Fund projects based on respective contribution to key priority outcomes. Equally, there had been no formal evaluation of the contribution to outcomes which the approved Change Fund projects had delivered on the ground, with one or two exceptions such as the rehabilitation and enablement in Aberdeenshire for care at home (REACH) project. We noted that a procedure had been established by the older people's strategic outcome group to prioritise the projects that would receive Change Fund resources.

Managers expressed concern about the sustainability of all projects funded by the Change Fund. They did not appear to have developed a process for considering or managing this issue.

Joint reviews of budgets were carried out in a variety of ways, mainly at a high level such as through Aberdeenshire's joint performance framework. This tracked the Partnership's progress in achieving the aims of the Change Fund. Using more detailed reviews would assist the partners to demonstrate how collective management and deployment of resources and expenditure has driven better outcomes for older people. The partners reported effectively to their own agencies and to their partners on their single agency budgets and they had therefore achieved financial transparency across the Partnership.

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Partners were kept well informed about collective financial resources, for example the single outcome agreement which reported on outcomes identified through the aligned resources for 2012–2013.

In conclusion, we recognised that there were a number of significant challenges and pressures that may arise in the implementation of more joint and integrated resources, particularly in relation to financial governance arrangements such as the questions of handling underspends or overspends and accounting timeframes. Locality focussed budgeting based on a geographic approach to commissioning and service provision will also prove challenging. Guidance from the Scottish Government on these issues will assist the implementation of future work by partnerships.

## **8.2 Joint IT systems**

Data sharing between health and social work services is a problem throughout Scotland.

As is the case in many other partnership areas, the Aberdeenshire Partnership did not have a coherent joint IT strategy that supported the sharing of information at both individual and strategic levels in the joint delivery, management and planning of services. There was little information on how greater information sharing would work in practice. The resources group of the recently established transitional leadership group had been asked to look at this issue and make recommendations.

The partners' computer systems were not able to communicate and share information. As a result, there were no clear security protocols and permissions between agencies that protected sensitive data captured in IT systems. Staff were supported by clear protocols to create joint assessments and care plans, but the IT systems did not enable this to take place. Information systems provided practitioners with tools to monitor their own work and performance. Recording and measurement of outcomes for individuals were supported by Aberdeenshire Council's IT Carefirst system, but these could not be shared with NHS staff. All staff said the different recording systems and incompatibility of NHS and council IT systems, which made it impossible to share records, were both time consuming and very frustrating.

Information generated by the IT systems was beginning to be used to provide profiles of need and to provide accurate information on the range of care, treatment and support services that were required now and into the future. Staff in health and social care provided regular reports to their own managers that helped with monitoring results and identifying good performance. For example, the Change Fund palliative care in care homes final project report in July 2012 showed how data generated by NHS Grampian had been used to help professionals understand the nature of the palliative population in the care home sector and to provide appropriate care. However, the use of management information as a basis for key decisions and improvements in services was not well evidenced.

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The joint commissioning strategy for older people set out the Partnership's approach to developing services in the future to provide a more community-based preventative support base and showed information use and analysis was in place. The Aberdeenshire joint strategic needs assessment and summary from June 2012 had a comprehensive analysis of key information and statistics to inform the future shape of services. However, datasets could be further developed to support redesign proposals and options more directly with relevant information.

The Partnership had been working to improve IT communication and had invested considerable resources to this end, and should continue to improve the situation.

### **8.3 Partnership arrangements**

The Public Bodies (Joint Working) (Scotland) Act 2014 requires NHS board 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. The Act provides two options for integrating budgets and functions. First, delegation to an integration joint board established as a 'body corporate'. In this case, the NHS board and local authority agree the amount of resources to be committed by each partner for the delivery of services to support the functions delegated. In the second option, there is delegation of functions and resources between partners. In this case, the NHS board and/or local authority delegates functions and the corresponding amount of resource to the other partner which then hosts the services and the integrated budget.

The Aberdeenshire partners had a strong history of joint working between statutory partners, the third sector and the independent sector. The Partnership ethos had developed a positive culture of involvement and working together. Relationships were equitable, mutually respectful and characterised by positive engagement. Partners were working to reach a consensus on targets, priorities and how to effectively deliver the best outcomes. There was an agreed approach to evaluating partnership working that was regularly reported. The development of partnership arrangements was being driven forward through the production of the joint commissioning strategy for older people and the need to move forward on the changes which will be required by the integration legislation.

The partners were clearly engaged, and had made some progress towards implementing a strategic framework for partnership working and key joint strategies, plans, and initiatives. There was no agreed plan, detailing priorities and approaches for closer joint working or integration to maximise the potential of joint working to the benefit of adults and older people. Progress had been slow in achieving in-depth change, although many partnership arrangements had been put in place. This included the Aberdeenshire health and community care strategic partnership 2009–2014 (set up in 2008), the Aberdeenshire

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integration development group, and the older people's strategic outcome group which included clinical and professional staff.

Many of these arrangements had had limited reach and impact. The Aberdeenshire Community Health Partnership's strategic plan for 2013-20, containing the community health partnership's 2020 workforce vision, was a high-level aspirational document about developing 'an integrated approach' to the delivery of care both within and across health, social care, the independent and third sectors. This had been produced as a requirement for health services and did not detail the joint working in place, except for a short section on 'integration of health and social care' which set out the new legislation's requirements for joint working. Staff thought there was little impetus to develop joint or integrated services because the positive quality of informal multidisciplinary working made sure that good outcomes were achieved for individuals.

However, partners were developing a collaborative and strategic framework for services for adults, older people and carers that supported strong partnership working. At the time of the inspection, the Partnership had set up the transitional leadership group, agreed to appoint a chief accountable officer and to establish an integrated health and care partnership committee to shadow the NHS community health partnership committee in 2013-2014. The decision taken by the Partnership to adopt the 'body corporate' model as the way forward is evidence of this. The Joint commissioning plan for older people - short term action plan, 2013-2016, was a significant document. However, this was high level with limited details of what needed to be done, although timescales and responsible people were clearly identified.

There was a strong emphasis on partnership arrangements at the locality-based service delivery level. For example, the partners saw GP practices, health and community care teams and community hospitals remaining fundamental to the delivery of local integrated health and community care based around natural communities. They anticipated that local clinicians, care professionals and local communities themselves would have a clearly defined role and opportunity to be involved in the planning, decision-making and commissioning of services for their area through the area management structures and local community planning partnership groups.

The Partnership thought that the integration legislation set out a coherent framework within which integration could be progressed while leaving room for local partnerships to develop 'best fit' solutions which took account of different local contexts within statutory boundaries.

The partners had developed some effective multidisciplinary ways of working, such as the weekly hospital multidisciplinary discharge team meetings, the joint equipment service and the 24 locality-based multidisciplinary health and community care teams. The older people's strategic outcome group was well attended by health and council staff and demonstrated good partnership working. Projects agreed by the group using funding

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from the Change Fund covered a range of both single-agency and multidisciplinary approaches such as a transport service for older people provided by a third sector organisation, a physiotherapy service at Aboyne Hospital and identification of people likely to fall.

Since there were very few joint and integrated services, the issues of sound governance for financial and other resources, including employee deployment in these services, had not arisen. The resources group of the transitional leadership group had been tasked to develop clear governance arrangements that would apply to the financial arrangements for future developments envisaged as emerging from the health and social care integration agenda.

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## Quality indicator 9 – Leadership and direction

In this quality indicator, we look at leadership and direction. For example, we expect to see a shared vision for older people's services and a clear strategy which outlines the Partnership's priorities. As well as looking at the leadership of staff, we also considered how change and improvement is being led within the Aberdeenshire Partnership.

### Summary

#### Evaluation – Good

The partners in Aberdeenshire had a history of working well together. They were at the early stages of developing their own approach to integrating health and social care in line with policy initiatives. They had a shared vision, an agreed model for integration, and good working relationships throughout the Partnership, including at NHS board and elected member level. More work was needed to ensure all staff understood the vision and priorities. The links between the agreements and good working relationships at the top, and the many examples of good joint working to support service users and patients, now need to be developed further to ensure a positive transition to new integration arrangements.

### 9.1 Vision, values and culture across the Partnership

We found evidence of a clear vision for older people's services with a shared understanding of priorities. The joint commissioning strategy for older people, Ageing Well in Aberdeenshire, showed a shared vision and values for the development of services for older people. The Partnership was taking steps to promote ownership of these at all levels. The annual Change Fund plans gave evidence of a consensus between the partners about how the balance of care should be shifted towards helping people stay in the community. The single outcome agreement for 2013–2023, the older people's development template, and the subsequent action plan clearly set out the community planning partnership's vision and actions to develop a community-based approach to older people's services, with many of the actions jointly delegated to both health and social care staff.

Aberdeenshire held an integration event in May 2013 which was well attended by councillors, NHS Grampian board members, the NHS executive team, community health partnership officers and Aberdeenshire Council officials. The transitional leadership group was agreed to be set up at this meeting.

The transitional leadership group was co-chaired by a councillor and a member of NHS Grampian's Board. There were five councillors and five NHS board members on

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the group as well as a voluntary representative, a union representative, lead officers and advisors. We attended a meeting of the transitional leadership group and saw evidence of a good working relationship between health and local authority members, and strong agreement about the way ahead in relation to integration. At the time of the inspection, the transitional leadership group had met on only three occasions.

Fifty-three per cent of those who responded to our staff survey agreed that there was a clear vision for older people's services with a shared understanding of the priorities, while 30% disagreed and 17% said that this was not applicable to them. Sixty-three per cent of respondents agreed that high standards of professionalism were promoted and supported by all professional leaders, elected members and NHS board members. Only 9% disagreed and 27% indicated it was not applicable to them.

## 9.2 Leadership of strategy and direction

A report, Integration of health and social care services in Aberdeenshire - proposed model, scope and next steps, was submitted to Aberdeenshire Council and NHS Grampian's Board in September 2013. It recommended that an integration joint board (the body corporate) should be the model of integration for Aberdeenshire, outlined the scope of functions to be delegated to an integration joint board and the recruitment arrangements for a chief accountable officer. A job profile for this post had been drawn up.

The transitional leadership group had set up four short life working groups to take forward initiatives. These were:

- governance
- engagement and involvement
- integrated care pathways, and
- resources.

These groups had been recently formed at the time of the inspection and had met on only one or two occasions so it was difficult to assess their impact at this stage. The governance group was looking at what other areas of Scotland were doing in relation to the integration agenda, and pulling together a shadow agreement.

The Partnership also had a health and community care strategic partnership group, which took forward integration in general, and the older people's strategic outcome group. It decided how the Change Fund was used. Part of this group's remit was to operate a joint financial framework, in effect an aligned strategic budget that included all health and social care funding streams for older people at community health partnership and local authority level. In Quality indicator 8, we identify further steps which need to be taken to develop joint budgetary arrangements.

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The Partnership had an infrastructure plan which set out how health and the local authority might use property in localities they both own more effectively. One aim of this plan was to identify sites where health and social care staff could be co-located.

The clinical lead for the Partnership has an important part to play in the integration process. His role was leadership, across all health professions, on quality improvement, service development and strategic shaping. He was a member of several strategic groups such as the transitional leadership group, strategic partnership group and older people's strategic outcome group. He was particularly active in providing leadership to health professionals and in attendance at the strategic groups. He was very positive about the future, felt optimistic about joint working and thought that co-location where it existed had contributed to this.

An integration project manager had recently been appointed from within Aberdeenshire Council to co-ordinate and drive forward the various integration initiatives. We would expect this role to more firmly drive the changes needed to be ready for the implementation of health and social care integration legislation in 2015.

Attendance at adult protection committee meetings by partner's representatives showed the commitment of partners to the delivery of adult protection strategies.

Fifty-six per cent of the participants in our staff survey agreed that the vision for older people's services was set out in comprehensive joint strategic plans, strategic objectives with measurable targets and timescales, while 17% disagreed and 27% said it was not applicable to them. Sixty-two per cent of staff agreed that their views were fully taken into account when services were being planned or provided.

### **9.3 Leadership of people across the Partnership**

We saw evidence of a positive working relationship between the director of housing and social work and the director of the community health partnership within the strategic groups we attended and when we met them together during our scrutiny week.

The Partnership had also promoted workshops for staff to inform them about integration and encourage debate.

The first staff newsletter on integration was issued in September 2013. This set out what health and social care integration was, how the partners were preparing, and how it would work in practice. There was also a short section 'What does this mean for my job?' which stated that: 'The recommended joint integration board model does not involve the transfer of any staff from one organisation to the other and so there will be no change to anyone's employer or their terms and conditions.'

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From our staff survey and the staff we met during our inspection, it was clear that the great majority of staff in both health and social care had good professional relationships with each other. For example, staff at an annual GP forum meeting were clear that they saw a lot of genuine co-working. They stated that they felt integrated and had been for years. They said that joint working had led to more respect for each other's disciplines.

In our staff survey, 85% of respondents agreed that joint working was supported and encouraged by managers. Only 7% disagreed.

## 9.4 Leadership of change and improvement

Aberdeenshire Partnership was at the early stages of implementing changes necessary to improve integration in line with the Scottish Government's integration agenda. Much of the groundwork was in place including:

- the formation of the transitional leadership group
- the forming of the four short life working groups looking at governance, engagement and involvement, integrated care pathways and resources
- the appointment of a joint integration manager
- the decision on a body corporate model, and
- the process of appointing a chief accountable officer.

There was a history of good joint working in Aberdeenshire, but the change agenda is a challenging one. Only 37% of respondents in our staff survey agreed that changes which affected services were managed well, while 52% disagreed.

The partners were clearly engaged with each other in planning and delivering improvements in health and social care delivery and integration. Elected members, NHS board members and officials from health and the local authority were in agreement about the way forward, but there was potential for further development. They had also tried to engage other partners. The third sector, local communities, users of services, patients and carers were involved in the change process. They had engaged with local communities and identified local assets to enhance locality working, but there was the potential to develop this further.

The challenge for the partners will be to ensure consistency of joint working and standards throughout the partner organisations and within each of the localities that they were clear they wanted to promote. Clear and consistent senior leadership was in evidence, but forging stronger links between outcomes, activity and investment and disinvestment decisions and developing option appraisals for change is a priority.

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## Quality indicator 10 – Capacity for improvement

To reach a judgement on the Partnership's capacity for improvement we considered the following areas:

- outcomes for older people and their carers
- performance management and improvement activity
- leadership, and
- how prepared the Partnership is for health and social care integration.

Evaluation – Good

### 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, in general, the Aberdeenshire Partnership delivered good outcomes to older people who used services and their carers. This evidence included our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership, results of file reading and the views expressed by people who used services, carers and Partnership staff we met.

We saw good development of anticipatory and palliative care and care for older people with dementia. There were areas in relation to delayed discharge, providing appropriate care at home and supporting carers, where there was room for improvement. We recognised that recruitment problems were in part responsible for this. However, the development of reablement, telecare and telehealth could all contribute to allowing better use of limited staff resources.

### 10.2 Effective approaches to quality improvement and a track record of delivering improvement

The partners were beginning to develop a performance management approach on a joint basis through a joint performance framework and joint discharge meetings, but there was not yet a co-ordinated approach to improving practice, and commissioning was still separate despite the joint commissioning strategy for older people, Ageing Well in Aberdeenshire, outlining the way ahead.

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There was a clear view of the direction of travel. However, plans were often lacking some detail, for example in decisions about investment and disinvestment. The options appraisal process needed to be further developed.

### **10.3 Effective leadership and management**

There was stable leadership and a helpful shared vision, albeit this now needs to be disseminated across all staff. Positive working relationships at top level from officials and members was in evidence. This was clear from papers we read, decisions taken about integration, and the development of groups such as the transitional leadership group, the strategic partnership group, and the older people's strategic outcome group to take integration forward together. The partners had a detailed joint strategy on the rationalisation of premises, and they were beginning to communicate the process of integration with stakeholders.

The partners recognised that sustained and focussed effort would be required if a shared vision was to be developed and implemented to meet future challenges and the necessary resources found to realise their intentions.

### **10.4 Preparedness for health and social care integration**

The Partnership had a strong history of joint working between statutory partners, the third sector and the independent sector. The Partnership ethos had developed a positive culture of involvement and working together. Relationships were equitable, mutually respectful and characterised by positive engagement.

The timing of this inspection in relation to the legislative process for integration made it difficult to judge how well placed Aberdeenshire was. Our conclusion was that the building blocks to achieve better integration were in place. However, the pace of change needed to be accelerated as the integration agenda moved forward. The transitional leadership group and a joint integration post were positive developments, but were very recent. Leadership and preparation of integration were good, but evidence that the changes were impacting positively on outcomes was still to be gathered and used to influence further change.

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## **What happens next?**

The Care Inspectorate and Healthcare Improvement Scotland will ask the Aberdeenshire Community Health Partnership to publish a joint action plan detailing how it intends to make any improvements identified as a result of the inspection. We will consider with the Partnership what further support we can provide to assist them in continuously improving the quality and effectiveness of their work.

**Tom Leckie**  
**Inspection Lead**  
**June 2014**

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## Appendix 1 - Recommendations

### Quality indicator 2 – Getting help at the right time

#### Aberdeenshire Partnership should:

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|---|--|
| 1 | continue to improve the uptake of carers' assessments and support to carers. |
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### Quality indicator 5 – Delivery of key processes

#### Aberdeenshire Partnership should:

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|---|---|
| 2 | take immediate action to ensure that risk assessments and risk management plans are completed and available within the case records of vulnerable adults. |
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### Quality indicator 6 – Policy development and plans to support improvement in service

#### Aberdeenshire Partnership should:

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|---|--|
| 3 | establish a clear programme of work and develop a strategy for rolling out implementation of new initiatives for reshaping of services. They should set out the steps which need to be completed to achieve proposals set out and identify who is responsible for delivering the actions on behalf of the Partnership. |
| 4 | ensure that the continued development of early intervention support makes the best use of limited staff resources in the care at home sector.  |
| 5 | have option appraisal processes in place for the use of resources for reshaping of services. This should include engagement with key service providers as well as other signatories to the joint commissioning strategy for older people, Ageing Well in Aberdeenshire.  |

## Appendix 2 – Quality indicators

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?		
<b>1.</b> Key performance outcomes	<b>2.</b> Getting help at the right time	<b>5.</b> Delivery of key processes	<b>6.</b> Policy development and plans to support improvement in service	<b>9.</b> Leadership and direction that promotes partnership		
<b>1.1</b> Improvements in partnership performance in both healthcare and social care  <b>1.2</b> Improvements in the health and well-being and outcomes for people, carers and families	<b>2.1</b> Experience of individuals and carers of improved health, wellbeing, care and support  <b>2.2</b> Prevention, early identification and intervention at the right time  <b>2.3</b> Access to information about support options including self directed support	<b>5.1</b> Access to support  <b>5.2</b> Assessing need, planning for individuals and delivering care and support  <b>5.3</b> Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks  <b>5.4</b> Involvement of individuals and carers in directing their own support	<b>6.1</b> Operational and strategic planning arrangements  <b>6.2</b> Partnership development of a range of early intervention and support services  <b>6.3</b> Self-evaluation and improvement  <b>6.4</b> Performance management and quality assurance  <b>6.5</b> Involving individuals who use services, carers and other stakeholders  <b>6.6</b> Commissioning arrangements	<b>9.1</b> Vision ,values and culture across the Partnership  <b>9.2</b> Leadership of strategy and direction  <b>9.3</b> Leadership of people across the Partnership  <b>9.4</b> Leadership of change and improvement		
	<b>3.</b> Impact on staff				<b>7.</b> Management and support of staff	<b>10.</b> Capacity for improvement
	<b>3.1</b> Staff motivation and support				<b>7.1</b> Recruitment and retention  <b>7.2</b> Deployment, joint working and team work  <b>7.3</b> Training, development and support	<b>10.1</b> Judgement based on an evaluation of performance against the quality indicators
	<b>4.</b> Impact on the community				<b>8.</b> Partnership working	
	<b>4.1</b> Public confidence in community services and community engagement				<b>8.1</b> Management of resources  <b>8.2</b> Information systems  <b>8.3</b> Partnership arrangements	
<b>What is our capacity for improvement?</b>						

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## Appendix 3 – Gradings

The report uses the following word scale to make clear the judgements made by inspectors.

<b>Excellent</b>	outstanding, sector leading
<b>Very good</b>	major strengths
<b>Good</b>	important strengths with some areas for improvement
<b>Adequate</b>	strengths just outweigh weaknesses
<b>Weak</b>	important weaknesses
<b>Unsatisfactory</b>	major weaknesses

## Appendix 4 – Inspection process flowchart

1. Planning and Notification		2. Information gathering		3. Scoping Phase			4. Scrutiny		5. Reporting												
Week 1	<b>Notification</b> Notification letter sent Team Identified and informed Initial preparation Request core documents	Week 2-5	<b>Care Service Inspections</b>	Week 6-8	<b>Briefings</b> Gather internal information and intelligence Issue surveys Deadline for submission of core documents	Week 9-10	<b>Scoping phase 1</b> Analyse core evidence Deadline for submission of case file list	Week 12-13	<b>Scoping phase 2</b> Activity in relation to delivery of services File reading – identify initial sample for follow up (case tracking) Meet with service users and carers (support network focus groups)	Week 14-15	<b>Scoping phase 3</b> Analysis of file reading Complete analysis of scoping information Produce interim scoping report	Week 17-18	<b>Core</b> On site scrutiny activity Follow up case files Validation of good practice	Week 20-21	<b>Reporting</b> Complete draft scrutiny report Report findings to Local Authority Area	Week 22	<b>Moderation</b> Quality assure report Moderation meeting Sent to Local Authority area for comment	Week 24	<b>Publication</b> Complete final scrutiny report Send report for publication		
	Team Meeting 1- Initial briefing meeting		Team Meeting 2 - Assign tasks and documents	Team meeting 3 – Onsite preparation		Team meeting 4 – Pre scrutiny meeting															



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