



Services for older people in the Shetland Islands

November 2015

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

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The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

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.

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Summary of our joint inspection findings

Background

Between January and March 2015, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services in the Shetland Islands. The purpose of the joint inspection was to find out how well the services of NHS Shetland and Shetland Islands Council (referred to in this report as the Shetland Partnership or the Partnership) delivered good personal outcomes for older people and their carers. In doing so, we recognised the stage of development the partner agencies shared at the time of the inspection. We wanted to find out if health and social work services worked together effectively to deliver high quality services to older people which enabled them to be independent, safe and as healthy as possible. We also wanted to find out if health and social care services were well prepared for legislative changes requiring them to integrate¹.

As part of our joint inspection, we met with older people, unpaid carers and with a range of staff. We read the health and social work records of some older people. We also read and analysed policy, strategic and operational information provided by the Partnership.

Summary

Outcomes for older people and their carers

The Shetland Partnership's performance in respect of its services for older people was strong. Most of the relevant data indicated its performance was better than the national average. Examples of this included:

- emergency hospital admissions
- the provision of care at home services
- telehealthcare and telecare
- respite provision.

The reablement service was achieving positive outcomes for the older people it supported, but the service was relatively new and needed to expand.

The Partnership faced challenges due to its geography across the islands in ensuring consistent service provision and outcomes for older people, but it had taken some actions to address this, including the deployment of advanced nurse practitioners. It needed to do more in some areas to improve how it measured the outcomes being achieved for older people. It also needs to increase the extent to which it collected benchmarking data to

¹ The Public Bodies (Joint Working) (Scotland) Act 2014 requires health board and local authority partners to enter into arrangements (the integration scheme) to delegate functions and appropriate resources to ensure the effective delivery of those functions.

help it measure its performance against other partnerships in Scotland and as a means to improve outcomes for older people in Shetland.

The Partnership was meeting the national target for delayed discharges from hospital, but faced challenges in discharging some older people from hospital who needed care home placements. However, the Partnership was doing well in its balance of care performance with older people being supported to remain at home.

From our review of health and social work services records, we saw positive personal outcomes were being achieved for nearly all the older people whose records we read. It was clear that staff were in the habit of talking to older people about their wishes and choices as well as their needs. Older people resident in King Eric House, an extra-care housing facility in Lerwick, received a very personalised service from a staff team who recognised the importance of promoting the independence of the older people they cared for.

What did older people and their unpaid carers think?

The Shetland Partnership was committed to ensuring that older people received the right support at the right time, delivered by the right people. There was a strong focus on encouraging older people to be involved in all aspects of their support. This ranged from assessment to planning and delivery of their own care, according to their own wishes and personal preferences.

Older people and their carers were generally happy with the services provided to them and told us that these contributed to better health and wellbeing. The care centres and voluntary sector made an important contribution to supporting older people.

Good outcomes for older people were evident from our review of health and social work services records. We were able to see positive changes for older people after interventions by health and social work services staff. This was helping older people to maintain their independence and in some instances to self-manage their conditions where appropriate. It was also helping the Partnership to move away from a culture of service-led provision to developing a more personalised approach to delivering services tailored to the individual.

The Partnership had made good progress in implementing the national dementia strategy and multiple medication reviews by the pharmacy service was leading to improvements in health for the older people involved.

The Partnership acknowledged the need to develop a more robust approach to service planning for carers. This should help to further improve the support initiatives and services already in place for them.

We saw evidence that self-directed support was being discussed with older people, although the limited availability of third sector providers meant the Council continued to be the main provider of social care and support.

Impact on staff

Staff were generally very well motivated and committed to their work. In community settings, there was good evidence of multi-agency team working, communication and a commitment to providing the highest possible standards of care to older people and their carers.

Recruitment difficulties for health and social work services, the impact of a Shetland Islands Council restructuring exercise and efficiency savings programmes had impacted on the morale of some staff groups. As one means of trying to address this, senior managers had sought to improve their communication with staff and to increase their level of contact with various staff groups.

There were pressures on the staff resourcing of some out-of-hours services, including the social work out-of-hours service. The Partnership needed to address these as a matter of priority.

Staff were generally positive about the support they received from their line managers, including the level of clinical and professional supervision they received and about their opportunities for learning and development. Dementia training and adult support and protection training were examples of this. There was evidence of staff consultation activities, although some staff groups felt that communication, engagement and involvement about proposed changes could be improved.

Involving the local community

The Shetland Partnership was committed to building community capacity using a co-production approach. This meant working together with older people and other stakeholders in co-producing services, solutions and developments in local communities.

We found that a strong sense of community spirit already existed within the localities of Shetland. A good range of support services were in place to promote independence and to help reduce reliance on health and social work services where appropriate.

There was less evidence of engagement and community capacity building from a more strategic perspective. The Partnership acknowledged this had not been given a great deal of priority in the past. It also recognised the need to strengthen relationships between third sector organisations as equal partners.

The Partnership had taken steps to engage with the public and communities. There were

some good examples of engagement with older people and their carers in rural and remote areas of Shetland. These include consultation around budget setting in 2014 and an online network for carers.

The Partnership needed to do more to try and increase community capacity. It also needed to build on the work it had done as part of its two pilot approaches to locality working by formalising the arrangements and structures for its localities.

Getting a service and keeping safe

Most of the public information available about how to access services and support was of a good standard. Apart from access to care home placements and, in some instances, care at home packages, access to services was provided quickly and without significant delays. Some services such as respite care could be accessed by a number of different routes and this needed to be rationalised.

Most of the findings from our review of health and social work services records on assessing need, involving older people and providing support were very positive. The needs of older people were subject to regular review.

The Partnership needed to strengthen its approach to offering, completing and taking action on carer assessments.

There were some significant tensions surrounding the discharge planning for some older people from Gilbert Bain hospital. A stronger multi-disciplinary and team approach was required in order to address this in the interests of patients.

In contrast to other findings from our file reading exercise, findings in relation to adult protection showed a need for improvement in ensuring that risk assessments and risk management plans were always completed when required. The Partnership needed to streamline risk assessment frameworks and to act on the findings from audits and enquiries.

Self-directed support was well embedded with enthusiastic staff now driving this forward. In contrast, better use needed to be made of advocacy services

Plans and policies

The draft community health and social care directorate plan for 2015–2016 was the Shetland Partnership's joint commissioning strategy for older people. This plan recognised national and local targets and strategies, and reflected planned changes in health and social care integration. It also linked with the portfolio of service plans.

The Partnership needed to ensure that it invested sufficient resources, including staff

resources, in strategic planning activity. This had been a challenge historically.

The Partnership had taken a joint approach to the deployment of resources to support improved personal outcomes for older people. By using Change Fund monies, the future shape of health and social care services was beginning to emerge, although some of these changes could usefully have taken place sooner.

A comprehensive range of performance indicators linked to national targets was in operation. Strategic groups in the Partnership were regularly using this information in developing service strategies. However, although progress had been made on self-evaluation, more needed to be done to ensure this drove an improvement agenda.

We saw evidence of a strengthening approach and culture around how complaints could and should be used to lead to service improvements.

The Partnership had a history of providing many key services within its own resources. However, developing the third and independent sectors was important to support the development of personalisation through self-directed support. The Partnership needed to improve contractual relations with the third and independent sectors by providing a clear contractual framework and strategy with dedicated contractual compliance officers. This would help ensure the effective development of contracted services in the future

Management and support of staff

The Shetland Partnership faced a number of recruitment and retention challenges. These included competing with the oil and gas industry for key posts, such as care at home staff and social care workers. There were also challenges in recruiting to a number of specialist consultant posts and for GPs. The Partnership had taken a number of initiatives to address these challenges. These included a successful trainee social work scheme and the imaginative development of a health and social care academy as part of the Shetland Training Partnership.

Joint health and social care workforce planning was still at an early stage, particularly to consolidate a locality-based joint service provision model. However, the principles and protocols surrounding the future staffing requirements had been agreed and work was underway on a workforce delivery plan.

An integrated management team was in place for the community health and social care directorate which was working well. Below this level, most services continued to be mainly structured on a single-agency basis. A limited number of joint posts and initiatives were in place. The multi-agency intermediate care team and the dementia service were good examples of joint teams.

Across health and social work services, training opportunities were of a good quality.

Both health and social work staff spoke favourably about the opportunities for training. The Partnership had a joint training plan, and health and social work staff made each other aware of relevant training opportunities. Most training was still provided on a single agency basis. Training on adult support and protection and on self-directed support were areas where training was provided jointly.

The Partnership provided good levels of clinical and professional supervision which most staff recognised in our staff survey and at our focus groups.

Working together

The Shetland Partnership had taken action to align community health and social care budgets. A financial governance framework had been agreed in advance of integration.

As elsewhere in Scotland, the Partnership faced significant financial challenges. It also needed to take account of funding made available from the Shetland Charitable Trust.

The Partnership faced many of the same challenges as other partnerships in sharing information and, in particular, personal data about individual older people, across separate IT systems. It had found some small-scale local solutions and was looking at developing EMIS Web as a web-based system for nursing services and potentially within social work services.

The Partnership's draft integration scheme was approved by the Scottish Government soon after the inspection. While more needed to be done to embed the third and independent sector, health and social work services were well placed to move forward into a new and operational health and social care partnership.

Leadership

The Shetland Partnership and, in particular, the Council's community care service, was emerging from a difficult period following an organisation and management restructuring exercise in 2011. This had been reflected by a number of changes in leadership personnel, a reduction in the number of senior managers and following financial efficiency savings. These had also impacted adversely on a number of key leadership activities, including strategic planning, the leadership of people, and the leadership of change and improvement.

The quality of leadership had improved in the 12 months before the inspection. This was reflected in the attention and priority given to service planning and development, the use of performance management information and self-evaluation activity. While improvement was needed in how the Partnership made best use of these activities, dementia and mental health services were two examples of where service reviews had

been carried out. Significant reviews of the social work function and of its assessment and care management arrangements were nearing completion.

The community health and social care directorate's senior management team was functioning well as an integrated team. This was important as the Partnership had a number of outstanding challenges that needed to be addressed. These included dealing with some outstanding difficulties and tensions with hospital discharge planning for older people and also the need to review the effectiveness of its broader partnership working arrangements.

Capacity for improvement

The Partnership was delivering positive outcomes for many older people and it had been helped in this by historically high levels of council expenditure. There was a positive approach to the development of self-directed support. Performance in planning and the discharge of older people from hospital was better than the national average, although there were some specific issues with older people requiring care home placements and some tensions between acute and community services in these areas.

Staff were well motivated and supported by line managers. They worked well and flexibly together at the front line, but the development of integrated teams and a structure to support locality working were still at relatively early stages.

Both service planning and senior leadership had suffered during a two-year period between 2011 and 2013, during which there had been significant restructuring activity, budget saving requirements and turnover of senior managers. The Partnership had been emerging from these difficulties over the previous 12 to 18 months and this was reflected in the greater level of service improvement and development activity and staff confidence in the visibility and leadership shown by senior managers. We saw evidence of both of these.

At the strategic level there were long-standing partnership arrangements between health and social work services and preparation for integration was proceeding relatively smoothly.

The Partnership still faced a number of important challenges, including the development of more integrated ways of working and joined up services to meet the needs of older people and carers. Having the necessary capacity to take forward important service development activity had been a long standing challenge in Shetland. The Partnership needed to look for opportunities arising from integration to address this.

Evaluations and recommendations

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

Quality indicators		
1	Key performance outcomes	Good
2	Getting help at the right time	Good
3	Impact on staff	Good
4	Impact on the community	Adequate
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	Adequate
9	Leadership and direction	Adequate

Evaluation criteria

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

Recommendations for improvement

1	The Shetland Partnership should take action to reduce the number of Code 9 delayed discharges from hospital. In doing so, it should ensure that it is adopting an approach which is consistent with the Scottish Government guidance on choice.
2	The Shetland Partnership should develop its strategic approach to community capacity building and co-production and should ensure that a partnership structure is in place which effectively supports locality planning and service delivery.
3	The Shetland Partnership should ensure that pathways for accessing services are clear and that eligibility criteria are confirmed and applied consistently across services. The pathways should be based on a whole systems approach and be built around multi-agency working.
4	The Chief Officer's Group for public protection and the adult protection committee should review the adult protection committee's business plan to ensure that it includes a focus on reviewing the key processes and procedures covering adult support and protection findings from internal and external reports. The Chief Officer's Group and the adult protection committee should take action to ensure that risk assessments and risk management plans are completed where required.
5	The Shetland Partnership should review its arrangements for strategic planning to ensure that this activity is adequately resourced.
6	The Shetland Partnership should ensure that improvement action plans are developed to implement recommendations when self-evaluation activity is completed in order to ensure learning is translated into improved practice and performance.
7	The Shetland Partnership should complete its strategy for older people so that it can provide a strong basis and a shared vision for the strategic plan for health and social care integration.
8	The Shetland Partnership should take decisive action to address the problems which are adversely impacting on effective multi-agency discharge planning for older people in hospital.
9	The Shetland Partnership should take action to review and improve its partnership working arrangements. This should include both external and internal partners and in particular the third sector partners.
10	The Shetland Partnership should develop an overarching plan which identifies its priorities for self-evaluation and improvement activity for the next three years. This should include a specific plan for how it can improve whole-systems approaches and working for older people.

Background

Scottish Ministers have requested the Care Inspectorate and Healthcare Improvement Scotland carry out joint inspections of health and social work services for older people.

The Scottish Government expects NHS boards and local authorities to integrate health and social work services from April 2015. This policy aims to ensure the provision of seamless, consistent, efficient and high-quality services, which deliver very good outcomes² for individuals and unpaid carers. Local partnerships have to produce a joint commissioning strategy. They are currently establishing shadow arrangements, and each partnership is producing a joint integration plan, including arrangements for older people's services. We will scrutinise partnerships' preparedness for health and social care integration.

It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

How we inspected

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against Appendix 1. Our findings on the Shetland Partnership's performance against the quality indicators are contained in separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector to deliver positive outcomes for service users and their carers. The inspection teams were made up of inspectors and associate inspectors from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors who were carers on each of our inspections. To find out more go to: www.careinspectorate.com or www.healthcareimprovementscotland.org

² The Scottish Government's overarching outcomes framework for health and care integration is centred on: improving health and wellbeing; independent living; positive experiences; improved quality of life and outcomes for individuals; unpaid carers are supported; people are safe; health inequalities are reduced; the health and care workforce is motivated and engaged; and resources are used effectively.

Our inspection process

Phase 1 - Planning and information gathering

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.

Phase 2 - Scoping and scrutiny

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

Phase 3 - Reporting

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

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

Shetland Islands context

Shetland is situated 338km from Aberdeen, covers 1468km² in area and has over 2700km of coastline. Shetland is an archipelago of islands which form part of the division between the Atlantic Ocean to the west and the North Sea to the east.

The largest island, known simply as Mainland, has an area of 899 km² making it the third-largest Scottish island and the fifth-largest of the British Isles. There are an additional 15 inhabited islands.

The 2011 census figures gave the total population of Shetland as 23,200; an increase of 5.5% from 2001 (21,988). Lerwick is the main centre of population with 7,500 inhabitants. The population's age profile is 18% under 15, 64% 15-64 and 18% aged over 64. The number of people aged over 64 has increased by over 20% since 2003. The population aged under 16 in Shetland Islands is projected to decline by 18.5 per cent over the 25-year period following the 2011 census.

Over the 25-year period, the age group that is projected to increase the most in size in Shetland Islands is the 75+ age group. This is the same as for Scotland as a whole. By 2035 the population of Shetland Islands is projected to be 22,534, an increase of 0.6 per cent compared to the population in 2010.

Life expectancy in Shetland, as in Scotland as a whole, has increased over time. People in Scotland currently aged 65 might expect to live, on average, another 15-20 years, and those currently aged 75, another 10-12 years.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Good

The Shetland Partnership's performance in respect of its services for older people was strong. Most of the relevant data indicated its performance was better than the national average. Examples of this included:

- emergency hospital admissions
- the provision of care at home services
- telehealthcare and telecare
- respite provision.

The reablement service was achieving positive outcomes for the older people it supported, but the service was relatively new and needed to expand.

The Partnership faced challenges due to its geography across the islands in ensuring consistent service provision and outcomes for older people, but it had taken some actions to address this, including the deployment of advanced nurse practitioners. It needed to do more in some areas to improve how it measured the outcomes being achieved for older people. It also needed to increase the extent to which it collected benchmarking data to help it measure its performance against other partnerships in Scotland and as a means to improve outcomes for older people in Shetland.

The Partnership was meeting the national target for delayed discharges from hospital, but faced challenges in discharging some older people from hospital who needed care home placements. However, the Partnership was doing well in its balance of care performance with older people being supported to remain at home.

From our review of health and social work services records, we saw positive personal outcomes were being achieved for nearly all the older people whose records we read. It was clear that staff were in the habit of talking to older people about their wishes and choices as well as their needs. Older people resident in King Eric House, an extra-care housing facility in Lerwick received a very personalised service from a staff team who recognised the importance of promoting the independence of the older people they cared for.

1.1 Improvements in partnership performance in both healthcare and social care

In the main the Shetland Partnership’s performance in respect of its services for older people was positive. Most of the relevant data indicated performance above the national average.

Emergency admission to hospital

An emergency admission is ‘when admission is unpredictable and at short notice because of clinical need’. The emergency admission data for the Shetland Partnership was an example of where its performance was and had been consistently better than the national average going back a number of years. This was the case for people in both the aged 65 or over and 75 or over populations. Charts 1 and 2 show information on the rates of emergency admissions and on multiple emergency admissions.

Chart 1

Rate per 100,000 population of patients aged 65 or over of bed days for emergency admissions to hospital. All s, 2013–2014.

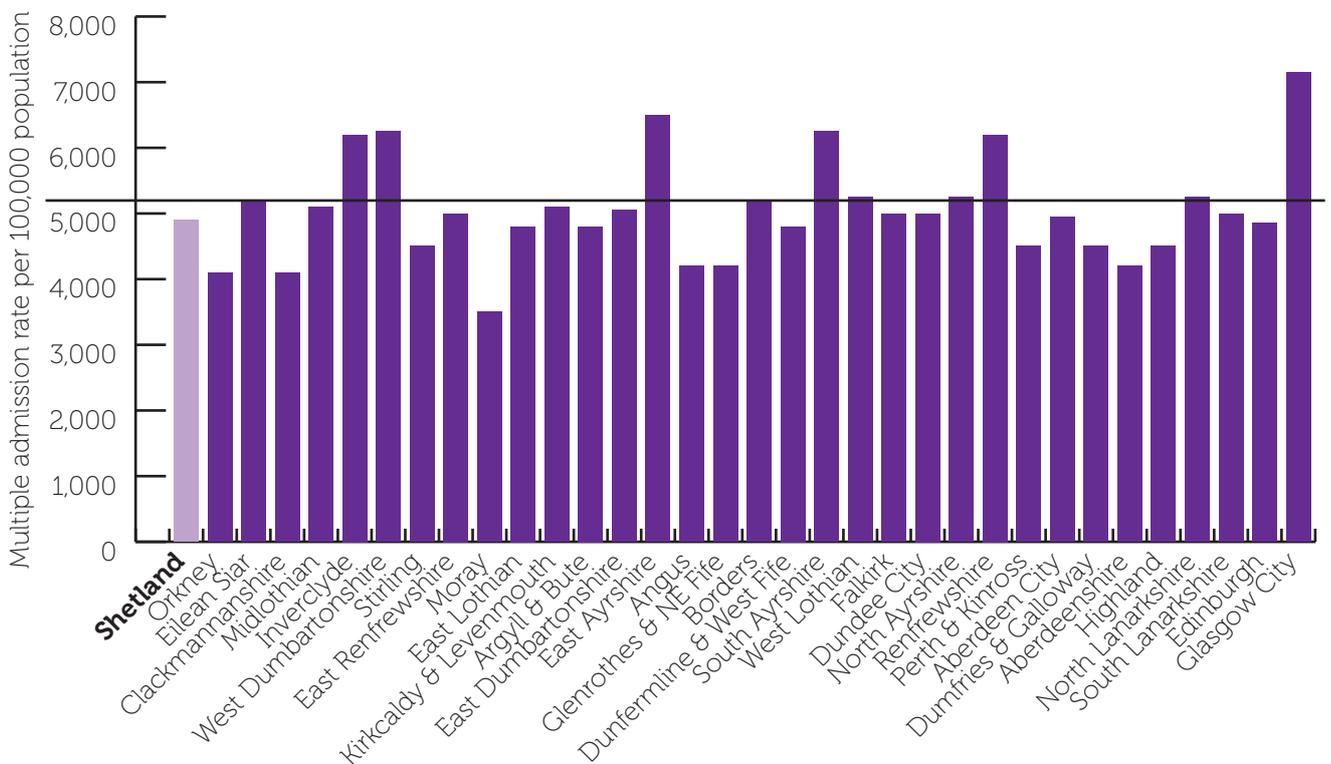
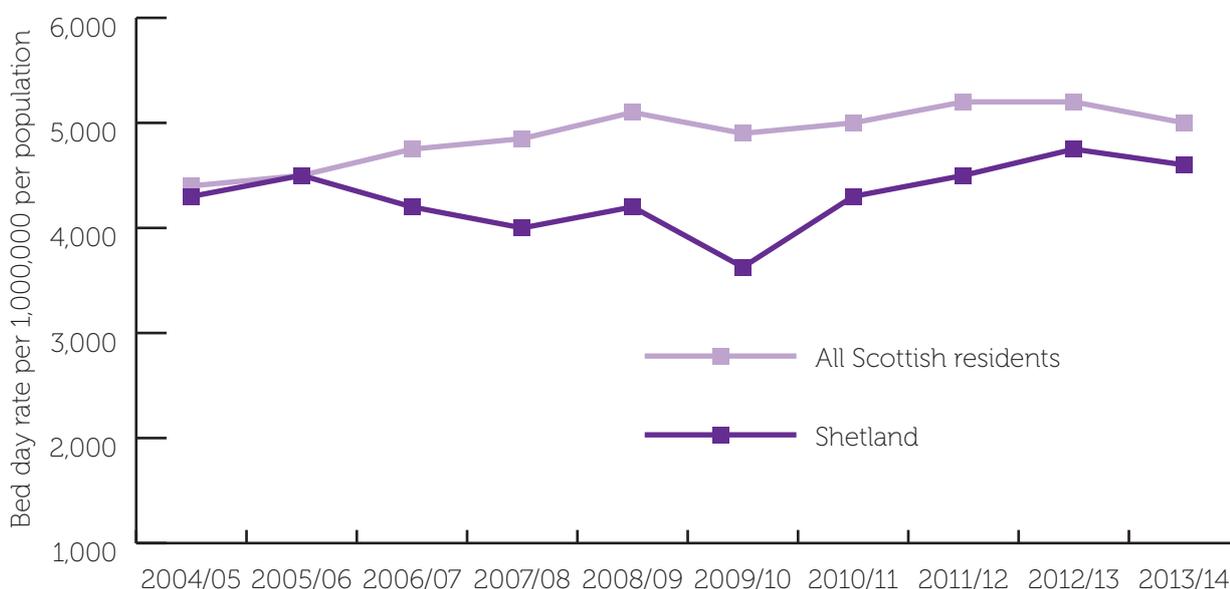


Chart 2

Rate per 100,000 population of two or more emergency admissions to hospital for patients aged 65 or over. Shetland, 2004–2005 to 2013–2014.

We read NHS Shetland's local unscheduled care action plan 2014–2015. This contained 18



main action areas, most of which were designed to address unscheduled care, including emergency hospital admission. Some of these actions, such as the use of emergency and anticipatory care plans and a review of out-of-hours services, needed to be progressed. We talk more about this later in the report.

Accident and emergency services were provided at the Gilbert Bain Hospital, Lerwick, the only hospital in the Shetland Islands. This could be challenging given the geography of the Shetland mainland and its surrounding islands. We noted that the Partnership had taken some specific actions to try and address this. For example:

- GPs on the most northern islands (Yell and Unst) were able to call out ferries in an emergency
- the provision of community nurses on non-doctor islands to respond to appropriate medical issues and to provide some additional confidence to the local communities on emergency responses
- on two non-doctor islands, a First Responder scheme had been implemented with the Scottish Ambulance Service so there was a level of additional healthcare support in the absence of the registered nurse. There were plans in place to roll out this approach to the other non-doctor islands.

We were provided with information describing two ways in which falls management was provided to prevent hospital admissions, including emergency admissions. Firstly, the Scottish Ambulance Service would inform community nursing and the duty occupational therapist if they had been called to an older person who had fallen at home. Following

assessment by the ambulance service, a home visit would be undertaken by community nursing and/or occupational therapy to look at putting preventative supports in place.

Secondly, all patients who attended accident and emergency and who were assessed as being at high risk of falls would be referred to the occupational therapy service for follow-up and falls prevention intervention.

These were positive responses and preventative approaches. However, we did not see that the Partnership had data on the number of falls which would have shown how successful these initiatives had been in falls prevention and management.

The information provided by the Partnership showed that it took some account of nationally published outcomes and performance data and it was doing some more specific benchmarking with services in Orkney and the Western Isles. However, it was not yet at a stage where it was using benchmarking and benchmarking data in a comprehensive manner or as a key driver for service improvement.

Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. The Scottish Government's target is that there should be no delayed discharges over four weeks' duration. From April 2015, this target reduced to two weeks.

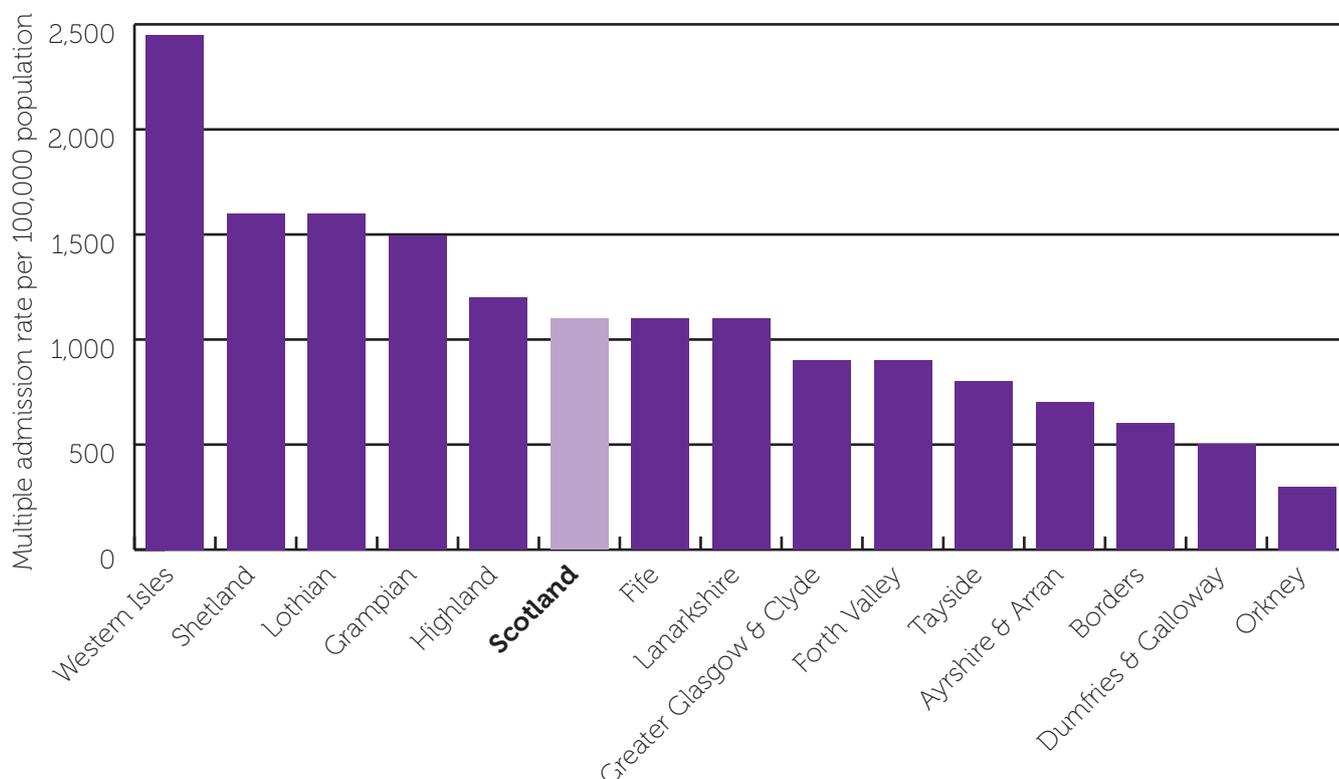
There is evidence that the longer an older person spends in hospital when they do not need to be there, the harder it becomes to discharge them home or to an appropriate care setting.

Historically, there had not been a problem with delayed discharges in Shetland, with only one older person not meeting the six week target for 'standard delays' in the period from 2009 until April 2013, when the target changed to four weeks. Since April 2013, the number of older people who had been categorised as standard delays had remained very small. For example, there were only two delayed discharges for Shetland in the two most recent census reports carried out in October 2014 and January 2015. Given this, the Partnership expected to be able to meet the revised two-week target.

Although the number of standard delays was very small, performance on the number of bed days lost by delayed discharge per 1,000 population aged 75 or over was less positive. Chart 3 shows the figure for Shetland for the period January–December 2014 was 1,614 per 1,000 compared with the Scotland figure of 1,062 per 1,000 population.

Chart 3

75+ delayed discharge bed-day rate per 1,000 population aged 75+ by health board



As elsewhere in Scotland, the number of bed days occupied by delayed discharge patients in Shetland had been increasing. This rose from 819 days in the quarter from April–June 2014, to 898 days in October–December 2014.

By the far the biggest reason for this increase was the rise in Code 9 delays. These had risen steadily from two in January 2014 to 10 in January 2015, the latest census point at the time of our inspection. Code 9 patients are older people whose discharge will take longer to arrange either because:

- they are waiting a place in a high-level special needs facility
- an interim placement is not an option or is unreasonable (Code sub-section 71X), or
- they lack capacity under the Adult with Incapacity (Scotland) Act 2000.

In Shetland, most of the Code 9 delayed discharges were older people assessed as requiring a care home place whose choice of care home was not available and the older person and their families were unwilling to consider an interim placement in another care home. An illustration of this was an older person from Lerwick whose choice of care home was not available and the interim placement offered was on Unst. For family members to visit would have entailed a considerable journey and two ferry crossings each way. In these circumstances, the Partnership had taken the view that it would be unreasonable to insist on the interim placement option. The Partnership said there had

also been instances where older people were fit for discharge, but who still had medical needs which required them to be placed in Lerwick and near the hospital. This meant care homes out with Lerwick could not be considered if a care home bed in Lerwick was not available.

In December 2013, the Scottish Government published with immediate effect Guidance on Choosing a Care Home on Discharge from Hospital³. This provided updated guidance for local authorities and NHS boards on the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993. It provided detailed advice on managing choice of care homes for people assessed as requiring ongoing long-term care in a care home, following a hospital stay. A key element of the guidance was that “where the preferred choice of care home is not immediately available, the person will be required to make a temporary move to another home to wait. The decision to discharge an individual will be based on clinical need and must not be influenced by a person’s choice of care home”.

We read an October 2014 report on delayed discharges which was presented to Shetland Islands Council’s social services committee and the committee. At that time, there were eight Code 9 delayed discharges of this nature. The report stated that a policy on choice would be completed by the end of the year. Senior managers told us that it had proved difficult to move some older people to interim care home placements as there was a public expectation that older people should be able to move direct to their care home of choice, normally their ‘local’ care home. They told us they were actively trying to tighten up their practice in line with the national guidance. Whilst we understood that there were some circumstances, such as that described in the earlier illustration, where it would not be appropriate to insist on an interim placement, we concluded that the Partnership needed to tighten up its compliance with the national guidance.

In 2006, the Scottish Government introduced national reporting to the Information Services Division (ISD) Scotland on Code 9 delayed discharges. During our inspection, senior managers expressed a degree of frustration about having to report on this aspect. While they recognised its importance, they also felt the heavy focus on Code 9 delays acted as a distraction from their focus and good performance with standard delays.

Recommendation for improvement 1

The Shetland Partnership should take action to reduce the number of Code 9 delayed discharges from hospital. In doing so, it should ensure that it is adopting an approach which is consistent with the Scottish Government guidance on choice.

³ Scottish Government Guidance on Choosing a Care Home on Discharge from Hospital, December 2013, mels/CEL 2013.

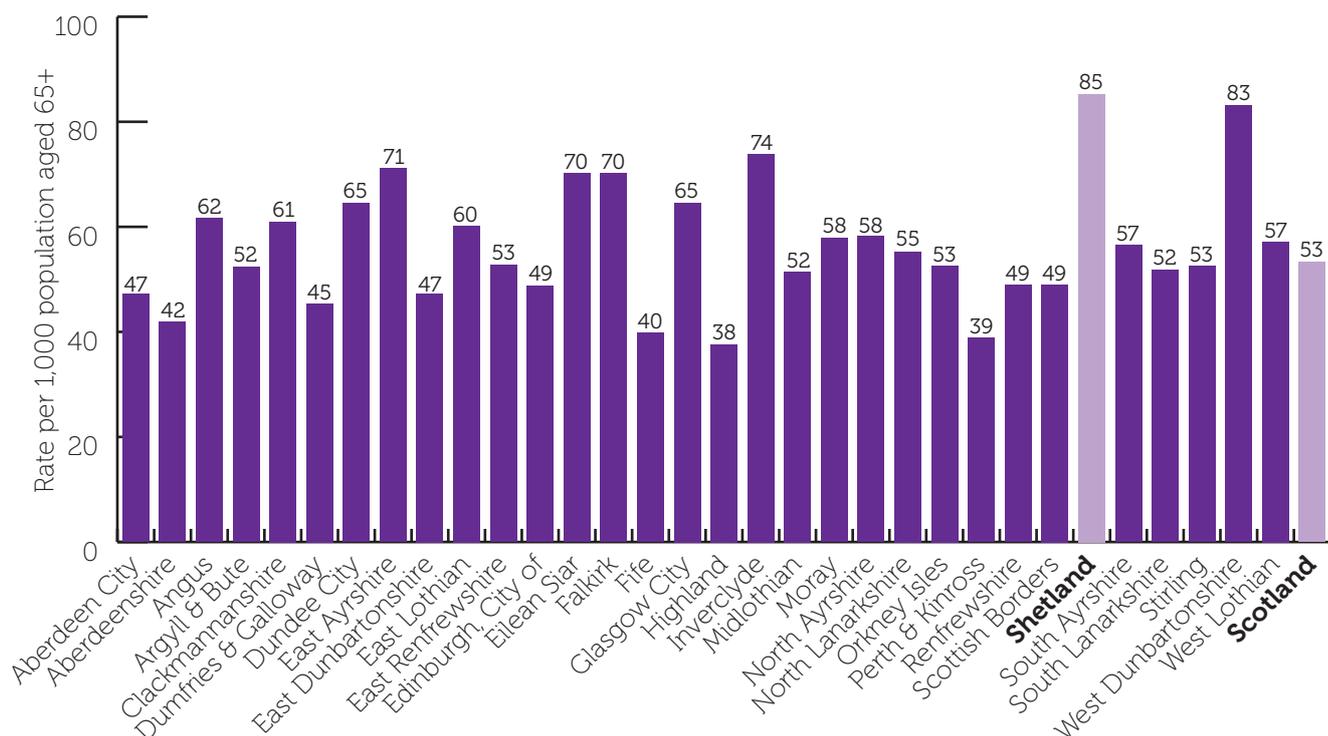
Provision of care at home services

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

In Shetland, all the care at home provision was supplied by Shetland Islands Council. In Scotland, the level of care at home provided to older people had declined by a few percentage points each year since 2005–2006. The level of care at home provision had also declined in Shetland during this period. However, it had always remained significantly above the national average. Chart 4 shows that in 2013–2014 the rate of care at home per 1,000 of the population aged 65 or over in Shetland was the highest in Scotland. The rate in Shetland was 85 per 1,000 population and in Scotland was 53 per 1,000 population.

Chart 4

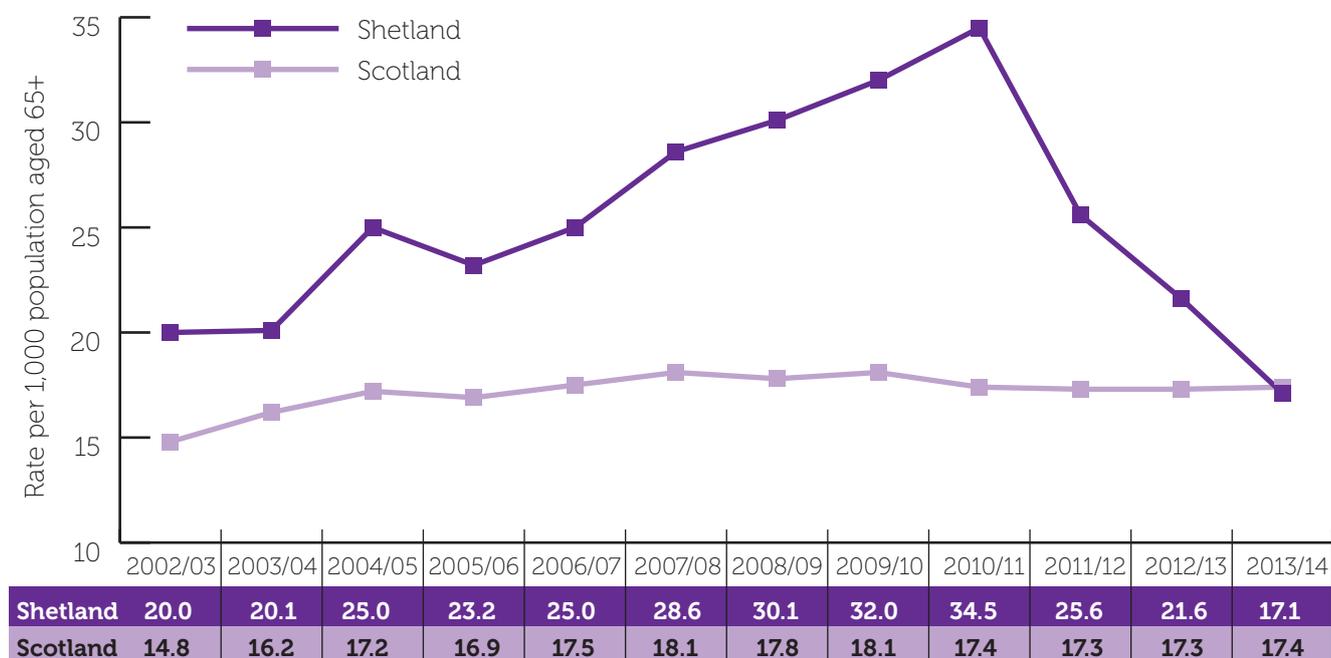
Number of people receiving intensive home care in 2013/2014 (rate per 1,000 population aged 65 or over)



Intensive home care (10 hours or more of care at home each week) had also been consistently and significantly well above the national average. However, Chart 5 shows that the gap between Shetland and the national average had narrowed and in 2013–2014 the gap was marginal. The reduction in intensive home care provision started to decline by 2011–2012. We noted that this coincided with significant financial restraints being faced by the Council, including the social work service.

Chart 5

Number of people receiving intensive home care, 2003–2004 to 2013–2014 (rate per 1,000 population aged 65 or over)



While the proportion of older people in Shetland receiving care at home was very high, the proportion of older people receiving this in the evening/overnight and/or at weekends was and had been below the national average since 2005–2006. In 2012–2013, Shetland was ranked in the bottom quartile for both evening/overnight and weekend care at home services of the 32 local authorities in Scotland. This performance was reflective of a more traditional model of care at home provision, rather than a service which was responsive to people’s needs and choices at any time of day.

In common with other parts of Scotland, the Partnership faced some challenges in recruiting to its care at home workforce. Levels of unemployment in Shetland were very low and the Partnership had to compete with the thriving oil and gas sector. Despite this, it was still delivering high levels of care at home. While we heard some comments from families and staff groups about difficulties and delays in setting up care at home packages or in providing cover for staff sickness, we heard less comments of this nature than during some other inspections. We looked at the grades awarded by the Care Inspectorate as part of the inspections of the regulated care at home services. These were nearly all graded as good or better.

Reablement

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

In Shetland, a reablement service was being provided by the multi-agency intermediate care service. This had only relatively recently been set up in September 2014 using monies from the Change Fund. Other partnerships in Scotland had operated similar services for a number of years.

It had been hoped to provide a service seven days a week. However, limitations on the size of the multidisciplinary team meant that it was only operating five days a week. It also had to concentrate its provision on older people living in and around Lerwick. We met the intermediate care team who were based in the Independent Living Centre in Lerwick along with the local care at home team and the joint equipment store. The intermediate care team impressed us as an energetic team who worked well together as a multidisciplinary and multi-agency team. They acknowledged the team was relatively new, but told us that work had been ongoing over the previous four to five years to adopt a reablement approach for older people.

While the numbers of older people the team had supported were still quite small, given their recent commencement, they were confident that they were having a real and positive impact on the lives and the outcomes for older people. Some examples they gave us included:

- an older person who had needed help and support with dressing and other daily living tasks in hospital was now getting themselves out of bed, dressed and organised to go out and attend a lunch club five days a week where they had met and made new friends
- intensive rehabilitation input had helped an older person who had been in hospital for a considerable time following a stroke to return home and no longer need help and support from the team.

The Partnership carried out an evaluation of the intermediate care service in January 2015. This showed that, of the 17 people admitted to the service, 11 had been able to be successfully discharged, two were still in receipt of the service and four were still at the stage of having their needs assessed and goals set. For the 11 who had been successfully discharged, the involvement of the service had:

- helped avoid hospital admission for three people
- allowed early supported discharge from hospital for five people

-
- enabled early discharge from a care centre for the remaining three people.

Of these 11 people, only one had needed to be re-admitted to a care setting or to hospital.

The team told us that, wherever possible, they tried to involve themselves in the actual transfer to home of an older person from hospital or a care home. They also tried to spend some time with the older person and their families. They added that families are understandably protective of their loved ones and that having staff members involved in the older person's transfer home was important as it could help ensure a focus from the very start on maintaining independence and reablement rather than doing everything for the older person. This positive and supportive approach was an example of a reablement approach being successfully adopted and applied.

One factor which had contributed to the difficulty in developing the service was that some team members were recruited on a temporary basis only. This was partly due to uncertainty about continuation of funding from the original Change Fund monies. This included the rehabilitation support assistant posts, a number of which the Partnership had been unable to fill. During the inspection, we were told that longer-term funding was secured in February 2015. This would allow for posts to be filled on a permanent basis.

The evaluation of the intermediate care service showed the significant positive impact that a reablement approach can achieve. The team said that they had had to work hard to persuade some families and some hospital-based staff of its merits. Evidence indicates that reablement approaches and services can significantly help alleviate pressures around admission to and discharge from hospitals and care homes. We concluded that the Partnership should look for every opportunity to expand its provision of reablement.

Palliative care

The proportion of people who spend their last six months of life at home or in a community setting rather than hospital had dropped from slightly above to slightly below the national average. In 2012–2013, this proportion of people was 89.1% for Shetland, compared with 91.2% for Scotland. At the time of our inspection, the Partnership was introducing a managed clinical network approach to meeting palliative care needs in support of its Palliative and End of Life Care Strategy 2013–2016.

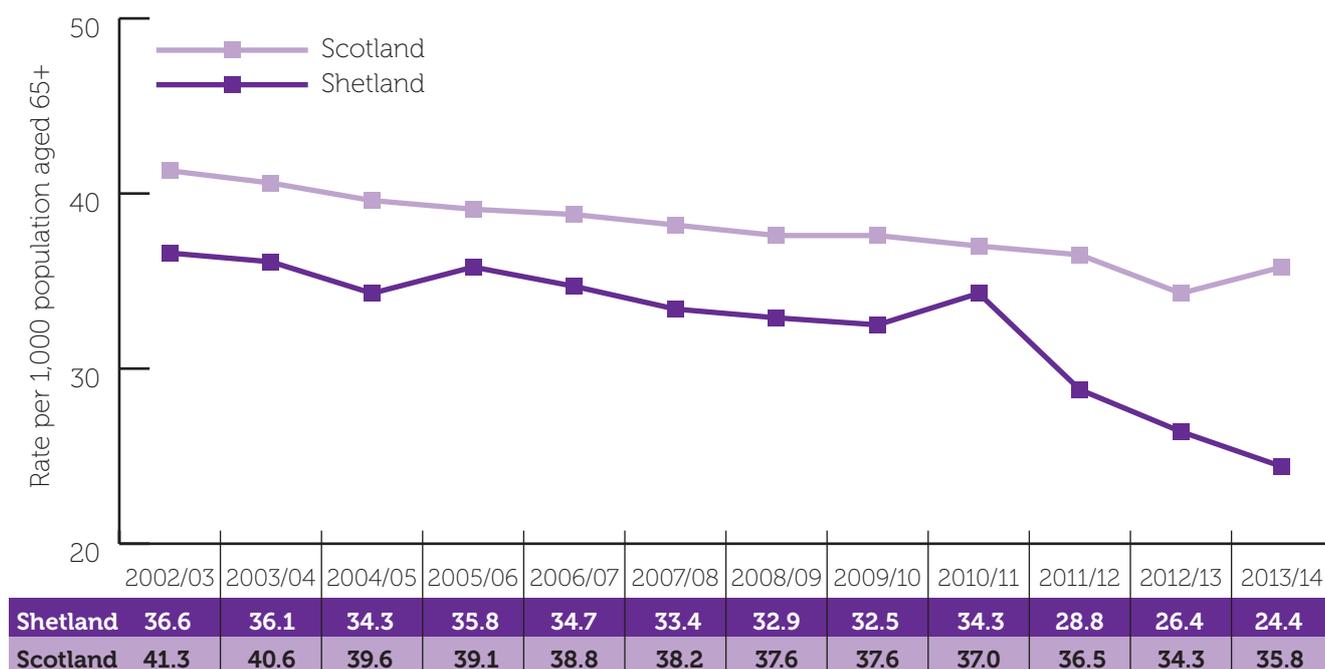
Care homes

Chart 6 shows that the number of older people in care homes in Shetland was below the national average. This figure had been declining over the last 10 years both in Shetland and across Scotland as a whole. The decline in Shetland had been more marked since

2010–2011 than nationally. This meant that by 2013–2014 the rate per 1,000 of older people aged 65 or over supported in care homes in Shetland was 24.4 per 1,000, and was significantly below the national figure of 35.8 per 1,000 population.

Chart 6

Long-term stay care home residents aged 65+ supported, 2002/03 - 2012/14 (rate per 1,000 population)



With one exception, Shetland Islands Council owned and operated all care homes for older people in Shetland. The Partnership told us this was because the market was not seen as a viable or attractive one for private or voluntary sector providers. The care homes were registered as residential care homes, rather than nursing homes. Shetland has never had nursing homes and this had been another source of pressure on the Council's care home resources.

Care homes in Shetland were known as care centres rather care homes. This reflected the way in which the centres had been developed and their key hub role in their local communities, including island communities. Data from the most recent Care Inspectorate inspections of the care centres showed that they had all been graded as good or very good for the quality of care and support they provided.

Respite care for older people and their carers

The Partnership provided the highest level of both overnight and daytime respite weeks to older people of any partnership in Scotland. Chart 7 shows that respite provision had expanded greatly between 2008–2009 and 2011–2012 before levelling off. In 2013–2014, the level of provision in Shetland was more than four times the national average.

We met a number of carers and families who had benefited from the respite provision. They told us how it had played an important part in allowing their loved ones to remain at home.

We also noted that there were a number of ways in which respite beds could be accessed. In some instances, respite beds were being used to provide what was effectively step-up care (to avoid unnecessary hospital admissions), step-down care (to support early supported discharge) or where respite had become permanent care. This raised a question as to whether the use of respite in these ways may have inflated, at least to a degree, the Partnership's respite figures.

Chart 7

Total respite weeks provided for older people 2006/07 - 2013/14



Self-directed support

Self-directed support means the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. Since April 2014, Councils have

had a statutory duty to offer the four self-directed options to older people and other adults who need support.

The self-directed support legislation was enacted in April 2014, so most of the available national data relates to one element of self-directed support, namely direct payments and is not specifically in relation to older people. The Partnership's performance for direct payments had been above the national average since 2008. In 2013, direct payments were received by 12.5 per 10,000 population in Shetland compared to 10.2 per 10,000 population for Scotland.

We talk more in the section on Quality Indicator 5 about the Partnership's approach to the implementation of self-directed support. We also report on our findings from our review of health and social work services records and from the older people we met who were either receiving or giving consideration to self-directed support.

Telehealthcare and telecare

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

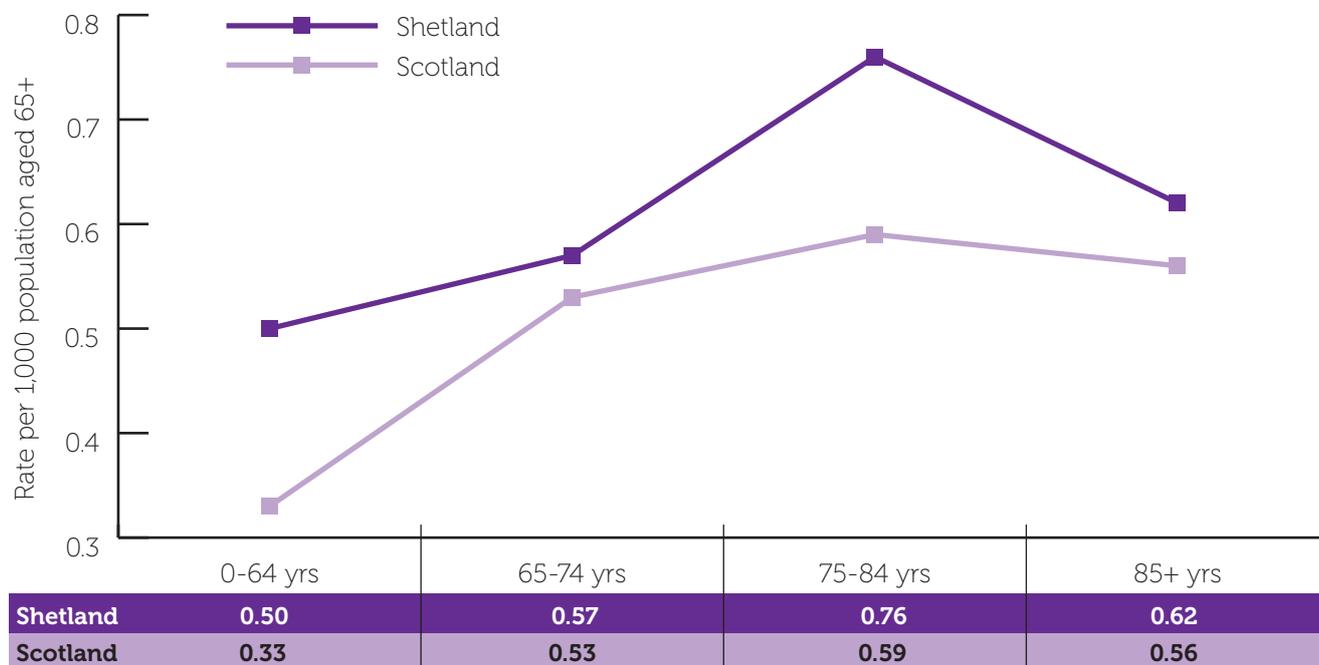
Chart 8 shows the use of telecare in Shetland and in Scotland, including by older people. In 2012–2013, the Partnership ranked in the top quartile of the 32 local authorities in Scotland for its telecare usage by care at home clients.

Information provided by the Partnership showed that there were 670 community alarms in use as well as some 800 pieces of sensory equipment.

The Partnership recognised the importance of using, and developing its use of, telecare and telehealthcare, especially given its dispersed geography and population. This included piloting its use with older people with dementia. We talk later in the report about this and about the Partnership's positive approach to exploring possible new developments in this area.

Chart 8

Number of care at home clients in receipt of a community alarm/other telecare service, 2012/13 (rate per home care client)

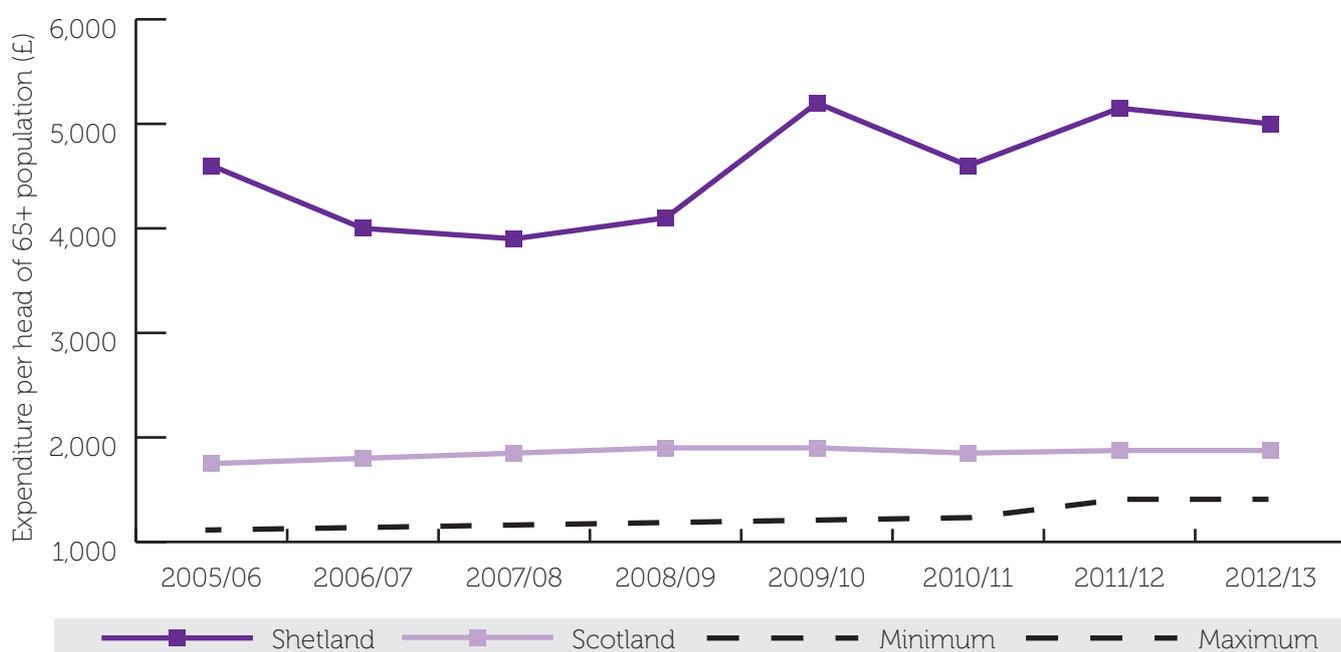


A combination of the provision of high levels of care at home, including intensive home care services, supported by good respite and assisted technology provision and the relatively low levels of care home usage are indicative of a Partnership achieving a good balance of care. The key performance outcomes evident in the Partnership met many of these requirements.

The unique economic position of Shetland as a key contributor to the oil and gas industry had enabled the Partnership and, in particular the Council, to invest significantly in a range of services. This included some services for older people. Chart 9 shows that Shetland Islands Council's expenditure on social work services for older people was more than twice the national average up to 2012–2013. This had helped contribute to the Partnership's positive service performance data. However, the need to balance the delivery of services with constrained budgets meant that the Partnership needed to address a number of significant strategic challenges to maintain its positive service performance outcomes in the future.

Chart 9

Social work expenditure: older people's services (per head of 65+ population)



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

Outcomes are the changes in individuals' lives that are a result of the services they receive. Outcome-focused assessments and care plans emphasise the desired positive changes the individual wants and the provision of services that are designed to achieve this.

During our review of health and social work services records, we looked at the personal outcomes being achieved for older people. We considered a broad range of personal outcomes and, as such, it was quite common for the files to contain a mixture of positive and poor personal outcomes. However, what was noticeable was the significantly greater preponderance of positive personal outcomes. We found positive personal outcomes were being achieved in 98% of the files (53 files). This contrasted with evidence of poor outcomes in 28% of files (15 files). Whilst 15 files contained some evidence of poor outcomes, 38 files contained no evidence of these. Chart 10 shows the individual personal outcomes we looked for and the extent to which we found evidence of them.

Chart 10

Positive outcomes	Frequency	Percentage
Dealing with stigma/discrimination	4	8%
Feeling safe	43	83%
Having things to do	17	33%
Living as you want	37	71%
Living where you want	32	62%
Seeing people	30	58%
Staying as well as you can	47	90%
Other	6	12%
Total	52	100%

We found evidence in the records of staff discussions with older people about their wishes and aspirations. Seventy nine per cent (79%) of care plans set out the individual's desired outcomes.

We also saw this positive personalised approach when we visited the community support team based at King Eric House in Lerwick.

Example of good practice: King Eric House

The community support team based at King Eric House, Lerwick, took a very individual and personalised approach to how they supported older people with dementia to remain actively involved and engaged with their families and in the local community. The team was supporting five older people with dementia living in extra-care tenancies in a former care home property. Staff members were able to agree with each older person on a daily basis what they wanted to do that day and then support them to achieve this. The team saw themselves as willing to take risks and described supporting two residents on a Sunday lunch trip to a local hotel one particular weekend, in spite of the poor weather conditions. The team had also been able to support some of the older people to die at home in their own tenancies.

In our staff survey, we asked staff for their views on how well services were working together to achieve positive outcomes for older people.

- 75% of staff agreed or strongly agreed that their service did everything possible to keep older people at home and in their local communities. 18% disagreed or strongly disagreed.
- 61% of staff agreed or strongly agreed that services worked well together to successfully prevent avoidable hospital admissions. 21% disagreed or strongly disagreed.

-
- 66% of staff agreed or strongly agreed that the service worked well together to support people's capacity for self-care/self-management. 16% disagreed or strongly disagreed.
 - 59% of staff agreed or strongly agreed that the service worked well together to enable people with long-term conditions and those with dementia to remain active. 23% disagreed or strongly disagreed.
 - 39% of staff agreed or strongly agreed that older people were able to access a range of preventative and enabling services to suit their needs when they needed them. 37% disagreed or strongly disagreed.

The joint inspection programme of adult services is still in its fairly early stages. However, the file reading results for the Shetland Partnership compared favourably with inspections to date. The staff survey findings were broadly comparable with other inspections.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Good

The Shetland Partnership was committed to ensuring that older people received the right support at the right time, delivered by the right people. There was a strong focus on encouraging older people to be involved in all aspects of their support. This ranged from assessment to planning and delivery of their own care, according to their own wishes and personal preferences.

Older people and their carers were generally happy with the services provided to them and told us that these contributed to better health and wellbeing. The care centres and voluntary sector made an important contribution to supporting older people.

Good outcomes for older people were evident from our review of health and social work services records. We were able to see positive changes for older people after interventions by health and social work services staff. This was helping older people to maintain their independence and in some instances to self-manage their conditions where appropriate. It was also helping the Partnership to move away from a culture of service-led provision to developing a more personalised approach to delivering services tailored to the individual.

The Partnership had made good progress in implementing the national dementia strategy and multiple medication reviews by the pharmacy service was leading to improvements in health for the older people involved.

The Partnership acknowledged the need to develop a more robust approach to service planning for carers. This should help to further improve the support initiatives and services already in place for them.

We saw evidence that self-directed support was being discussed with older people, although the limited availability of third sector providers meant that the Council continued to be the main provider of social care and support.

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

An outcome-focused approach

Some key strategies, such as the joint commissioning strategy for older people and the dementia strategy were still under development. They included a commitment from the Shetland Partnership to improve outcomes for older people and their carers by:

- moving away from a reliance on institutional settings
- avoiding unnecessary hospital admission
- reducing delayed discharges.

The strategies emphasised the importance of promoting a person-centred approach to service planning and design and to care delivery.

The Partnership was the main employer of staff and the sole provider of residential and care at home services. There was no independent nursing home provision. Recruitment challenges in health and social work services had increased pressures on the development of health and social work resources. Despite this, we found positive outcomes were being delivered for many older people and their carers in Shetland.

From our review of health and social work services records, we saw that almost all assessments identified older people's care and support needs, prioritised what was important to them and tailored services around this.

Voluntary organisations and volunteer groups provided good support to older people and their carers. This included befriending and respite at home. Older people who used support groups and advocacy services supported this view.

Shetland's care centres provided a central resource to support older people to remain at home, or in a homely setting in their local community. They were located close to the health centres. Both health and social work staff told us this contributed to their good joint working in supporting older people.

It was clear to us that many staff had good personal knowledge of the older people they supported. This helped them to deliver a more person-centred approach. Older people valued the close personal contact they had with staff in their communities. They told us this made it easier for them to talk to staff directly and to raise concerns or issues about gaps or changes in service.

Discharge planning is a continual process to make sure patients do not have to stay in hospital longer than required. Effective discharge planning should begin on, or shortly after, admission to hospital. We found this was working well in the hospital's rehabilitation ward. However, we were told this practice was not consistent in other wards of the

hospital. When we raised this with the Partnership, it recognised it needed to do more to develop a whole systems approach to improve the experience and outcomes for older people following hospital admission.

We saw some good approaches to personalising services for older people to achieve their personal goals and preferences. For example:

- We were told that it was routine practice for social care staff to carry out a broad range of support tasks and services for older people in their own home. We saw this as a good way to ensure continuity and consistency in meeting older people's care and support needs.
- Brucehall extra care housing project in Unst had a strong focus on person-centred planning to help older people achieve personal goals and to remain connected with their family and friends in their own communities.

Improving care and support for frail patients

The older people we spoke with had high praise for the support they received to help them manage at home following a hospital admission or a period of respite in the care centres. They attributed their successful recovery to the intensive support and specialist input they had from health and social work staff. It was clear this input had supported older people to regain confidence, skills and independence to enable them to remain at home for as long as possible. As reported in Quality Indicator 1, we received some very positive feedback from older people and their carers about the intermediate care service.

Montfield support services are based in a former hospital. Services had been re-designed to provide step-up and step-down care services, and also respite care beds. Services used the facilities to provide older people with a period of rehabilitation after hospital treatment for a fall or to provide some intensive support following ill health. However, we noted that increased dependency levels and pressure from the hospital to discharge patients had caused beds to become blocked. The Partnership was aware of the impact this could have on delayed discharges and on avoiding unnecessary hospital admission. The Partnership needed to take action to address this.

The pharmacy service was proactively monitoring and reviewing older people's medication at home, in hospital and in the care centres. GPs were using an electronic recording tool to trigger a polypharmacy⁴ review for patients over 75 years on seven or more medicines. Most staff spoke positively about the support, advice and training they received from the pharmacy service. A single standardised medication administration record was developed and introduced in all health and social work services. Social work

⁴ Polypharmacy – the use of multiple medications

staff had received medication training. We found some examples of older people being supported to self-manage their own medicines independently or by using a compliance aid.

We read that services operated differently in each geographical area of Shetland. This meant that older people's experience of support could vary according to where they lived, especially in the more remote areas of Shetland. For example, community nurses delivered scheduled healthcare services on islands with no resident doctor and NHS 24 responded to clinical emergencies out of hours. In contrast, some islands had GP-led health centres that delivered their own scheduled healthcare and out-of-hours service. These variations were understandable given the context of Shetland's geography and some of its recruitment challenges.

Generally, older people told us they had good support and services from their GP and other healthcare professionals. They were less positive about the out-of-hours service from NHS 24. Some told us they had experienced difficulties and unreasonable delays in accessing care and treatment when using NHS 24. Some staff we spoke with recognised these concerns and told us that these had been escalated to senior managers to make sure they were also aware of them.

In Shetland, there were no community or hospital-based consultants in old age psychiatry. Consultants from Aberdeen Royal Infirmary provided sessions in person or by video-conferencing. The Partnership had been successful in securing an additional session to help improve early diagnosis and prompt treatment for older people with mental health problems.

NHS staff had developed some positive initiatives to share information about health issues with local communities and to promote health improvement. These included:

- producing a comprehensive self-help guide to help people to self-manage a range of conditions and minor illnesses
- broadcasting a monthly programme on local radio to raise public awareness of health issues
- developing video-conferencing in the remote areas of Shetland to maintain links with care centres, health centres, pharmacies and GPs.

Supporting carers

Carers we spoke with were mainly positive about the support networks available from health and social work services to help them to continue in their caring role. A multi-agency carers' link group met every two weeks with representation from carers, voluntary groups, advocacy services and health and social work partners. Information from the meetings was circulated to other carers' groups in newsletters and through the virtual carer's forum.

Voluntary Action Shetland (VAS) led on the development of a carers' network across Shetland. It also managed the Lerwick carers' centre. This provided an information and advice service, offered support to carers at an emotional, practical and social level, and supported carer involvement in wider consultation about service planning. VAS had established links with local health centres to support carers registered in their practice. Health centres had started to produce a carers' register to signpost individuals to third sector partners to help them complete a carer's assessment. The Citizens Advice Bureau had a contract with the Partnership to develop a carers' telephone helpline.

The Partnership was piloting an outreach service from Change Fund monies to improve and develop support for carers living in the remote areas of Shetland.

A virtual carers' forum had been set up to enable carers to participate in meetings and access information about training and carers' assessments. The Partnership planned to extend this service across the whole of Shetland.

Carers were complimentary about the day and respite services available in the care centres. They appreciated the support from staff and management, and their quick response when they needed help and support in their caring role.

The Partnership had previously identified discrepancies in the number of completed carer assessments. This was due to information recording systems not being up to date. This had been rectified and early indications suggested an increase in the uptake of carer assessments.

The Partnership had yet to develop emergency plans to support carers in the event of an unexpected crisis. The Partnership needed to prioritise this to make sure the person being cared for was looked after in a safe and appropriate environment.

The Crossroads Service was the only provider of carer support to receive core funding. However, the service said it was experiencing some uncertainty in terms of its longer term planning. This was due to the need for decisions to be made on additional funding it had received as part of the Change Fund. The Partnership acknowledged this, but said this did not impact on the core funding which it had continued to provide as previously. Overall, carers and voluntary groups told us they had some concerns about the sustainability of supports for carers and plans for future funding. The Partnership was in the process of identifying priorities for carer support and then needed to develop an action plan to support these.

2.2 Prevention, early identification and intervention at the right time

Supporting people with long-term conditions

The increasing number of people living with long-term conditions such as diabetes, asthma and chronic obstructive pulmonary disease presents a major challenge for health and social work partnerships, and for private and voluntary sector partners. Better understanding of their long-term conditions helps people understand their symptoms and experiences, and improve their long-term health and wellbeing. One of the key roles of health and social work professionals is to build older peoples' self-confidence and their capacity for self-management, and to support them to have an improved quality of life and be as independent as possible.

The Partnership was developing its approach to clinical care and governance by using care pathways for specific long-term conditions. In Shetland, expectations were that primary care services staff would support people to manage their long-term conditions. Individuals with more complex health needs received support from locally based hospital consultants in their area of special interest such as cardiology, diabetes and rheumatology. The Partnership told us it had introduced a managed clinical network approach. However, we saw little evidence during the inspection to demonstrate how effective this approach was. We were told about a 'one-stop shop' approach for people with complex health conditions. This involved individuals attending an outpatient appointment to have a medical review with a consultant. They would also meet with the specialist nurse and other healthcare professionals such as a dietician, speech and language therapist or podiatrist.

Older people we spoke with had mixed views about the support they received to manage their long-term conditions. There were no specialist community-based teams in Shetland. This meant that primary care services staff relied on input from hospital-based consultants and specialist nurses. This could result in variable support for people with long-term conditions.

Peer support networks were being developed to provide educational sessions and create opportunities for people with long-term conditions to come together to share their experiences. The Partnership needed to improve access to information and improve support arrangements to enable older people to self-manage their long-term conditions.

Implementing Scotland's National Dementia Strategy 2013-2016

The Partnership had made some very good progress with implementing Scotland's National Standards of Care for Dementia. It had commissioned the Dementia Services Development Centre, University of Stirling, to review its dementia services. The review

had helped to inform and shape the Partnership's planning and development of its dementia services. An improvement action plan had been developed with a strong focus on early assessment, diagnosis and post diagnostic support, personalisation and carers' support. We were confident that older people with dementia and their carers were getting timely health and social care support from skilled and experienced health and social care practitioners.

The Partnership was achieving national targets on early diagnosis of dementia. Work to promote a better understanding of dementia had taken place in both health and social work services. This had included setting up a dementia liaison team, and identifying support workers and dementia champions.

Following a diagnosis of dementia, 60% of older people had accepted post diagnosis support. This was provided by link support workers. Alzheimer's Scotland was closely involved in developing community supports such as the dementia cafe, reminiscence groups and tea dances. In the hospital, dementia champions in the accident and emergency department had made good efforts to make the department more 'dementia friendly'. This included using clear signage to help with finding, appropriate equipment and reminiscence activities. We noted that older people over 65 years of age were routinely screened and assessed for problems with memory, pressure ulcer care, food, fluid and nutrition, and risk of falls.

Example of good practice: dementia services

The Shetland Partnership had made good progress with implementing Scotland's national dementia strategy and standards. An improvement action plan had been developed which focused on early assessment and diagnosis, post diagnostic support and person-centred planning.

We saw good investment in community support services. This included dementia cafes, reminiscence groups and supported housing models to help older people to remain in their local community.

The dementia services partnership brought together a range of professionals from health, social work and the third sector to ensure a collaborative approach for the treatment, care and support of individuals with a diagnosis of dementia and their carers.

We were told about some developments in technology within the remote areas of Shetland which were supporting older people with dementia to live at home in their own community. The Partnership was piloting some innovative monitoring equipment to keep older people safe from harm and improve their health and wellbeing. Video-conferencing was also working well to provide ongoing support for people with dementia.

We heard positive comments from older people and staff about access to equipment from the joint equipment store. We also heard about the fast response from Hjalmland Housing Association in completing small repairs and adaptations. Older people and carers told us that equipment was normally delivered to them very quickly. This included examples of stairlifts being ordered and installed within six weeks despite contractors from the Scottish mainland needing to be involved.

Anticipatory care planning

An anticipatory care plan anticipates significant changes in a patient (or their care needs) and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals.

Anticipatory care planning is more commonly applied to support those living with a long-term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well.

During our review of health and social work services records, we found limited evidence of anticipatory care plans. We also saw that there were variations in how this was developing across the Partnership. GPs had completed some anticipatory care plans which they recorded in electronic Key Information Summaries (KIS). These summaries were a way for healthcare professionals to record and share information about people with complex care needs. This information could be shared with other colleagues such as NHS 24 and the Scottish Ambulance Service. Social work staff could not access this system. However, we were told information could be shared with social work staff if requested.

We were told that anticipatory care plans were routinely completed for people diagnosed with a terminal illness. We read about how this work was progressing for some people with dementia. The Partnership said it had taken a number of different approaches to anticipatory care planning to date, including health plans for people with long-term conditions and wellness and recovery plans in mental health services. However, it acknowledged it needed to strengthen its approach to anticipatory care plans to make sure their use was firmly embedded in practice and as part of an overall framework.

Intervention at the right time

During our review of health and social work services records, we saw some good examples of joint preventative work. For example, a falls prevention pathway with standardised paperwork had been developed across health and social work services. There was a single point of contact for enquiries to manage referrals to the occupational

therapist to look at putting preventative measures in place. This included the use of telecare and sensory equipment to minimise risks and support older people to remain at home for as long as possible.

A falls prevention programme aimed at promoting physical exercise and reducing the risk of falls for older people was being piloted in one of the remote areas of Shetland. NHS Education for Scotland (NES) had provided funding for 12 staff to support the programme.

Palliative and end-of-life care

We read the Partnership's Palliative and End-of-Life Care Strategy 2013–2016. We noted this was being updated to incorporate a Shetland-specific approach. The hospital oncology unit had developed a day care facility to enable chemotherapy patients to return home after their treatment. A new chaplain was in post to offer spiritual comfort for people at the end of their life.

The palliative care team was based in Gilbert Bain Hospital. Some community outreach support was provided by the Macmillan nurses in response to referrals by GPs and community nurses. Specialist nurses had delivered training for community-based staff. We were told about some very positive engagement by the Partnership with GPs to improve communication and provide consistent treatment for patients' palliative care needs.

Staff told us that all GP practices across Shetland had a palliative care register. Summaries for palliative care patients were recorded electronically to enable this information to be shared with other healthcare professionals. We saw some evidence of this during our review of health and social work services records.

Community-based health and social work staff delivered the majority of palliative care for older people in Shetland. However, we found limited provision to support older people at the end of their life to remain at home. No dedicated overnight cover was available except an 'on call' community nurse and some input from the volunteer befriending services. Out of hours, staff relied on the support of families. However, for some people, their only alternative was admission to hospital or a care centre. The Partnership needed to address this so that older people and their families could make real choices about their preferred place of care at the end of their life in line with national palliative care guidance.

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

Members of the self-directed support team highlighted to us the significant progress made with embedding self-directed support into the initial assessment process, and with signposting older people and their carers on how to access support. The Council had a

service level agreement with the Citizens Advice Bureau to support individuals and their carers in managing their self-directed support arrangements and documentation.

Self-directed support options were discussed with the older person as part of the assessment process. From 1 April 2014, all new service users assessed were eligible for funded support. Existing service users were offered the four self-directed support options at review meetings.

Quality indicator 3 - Impact on staff

Summary

Evaluation – Good

Staff were generally very well motivated and committed to their work. In community settings, there was good evidence of multi-agency team working, communication and a commitment to providing the highest possible standards of care to older people and their carers.

Recruitment difficulties for health and social work services, the impact of a Shetland Islands Council restructuring exercise and efficiency savings programmes had impacted on the morale of some staff groups. As one means of trying to address this, senior managers had sought to improve their communication with staff and to increase their level of contact with various staff groups.

There were also some tensions about hospital discharge planning for some staff which needed to be resolved.

There were pressures on the staff resourcing of some out-of-hours services, including the community psychiatric nursing service and the social work out-of-hours service. The Partnership needed to address these as a matter of priority.

Staff were generally positive about the support they received from their line managers, including the level of clinical and professional supervision they received and about their opportunities for learning and development. Dementia training and adult support and protection training were examples of this. There was evidence of staff consultation activities, although some staff groups felt that communication, engagement and involvement about proposed changes could be improved upon.

3.1 Staff motivation and support

We issued a survey to health and social work staff in the Shetland Partnership. Twenty five per cent (25%) of the workforce responded, with 207 staff completing the survey. Of these, almost two-thirds (65%) were employed by the local authority with the remaining 35% employed by the NHS. Most staff responded positively to our survey. For example:

- 88% of staff agreed or strongly agreed that they enjoyed their work
- 64% of staff agreed or strongly agreed that they felt valued by their managers.

We met with some 70 health and social work staff over the course of the inspection. They were generally well motivated and enthusiastic about their role in delivering care, treatment and support to older people.

The Partnership acknowledged that staff in different areas of Shetland received varying levels of support and that, as a result, staff morale could vary.

Although staff we met were generally very positive about their work, they told us about some factors which had impacted negatively on morale. These were:

- recruitment difficulties for both health and social work services
- the impact of restructuring by the Council in 2011, including the lack of stable leadership for social work services
- the impact of significant efficiency savings .

Despite these pressures, staff told us they had continued to work hard to deliver a good service to the older people. This included working together at times of crisis for older people.

It was clear that the Partnership had been working to address some of these issues by improving general communication with staff. For example, senior managers and human resources staff had visited a number of care centres to speak to social care staff, as this was a staff group whose working arrangements had undergone significant change. The Council had also carried out a staff survey in 2014 of social care staff to assess the impact of these changes. Results showed that 69% of the staff who responded strongly believed that the reduction in staffing levels and changes to rotas had adversely affected the delivery of services. Fifty four per cent also said that the changes in service had impacted negatively on the time available for support and supervision.

Senior managers acknowledged that more robust structures of supervision and greater clarity of roles and responsibilities for social care workers and senior social care workers were needed.

The director of community health and social care had identified a gap in professional social work leadership within the community health and social care directorate. In order to address this, an executive manager's post for community care had been established on an interim basis. Staff we met told us that this had made a significant positive difference.

Information on key developments within the Partnership, and on the health and social care integration agenda, was cascaded to staff through websites, workshops, newsletters and team meetings. Most staff told us that they welcomed integration and saw this as a formalisation of already existing working relationships between health and social work services. However, some staff groups appeared uncertain of how integration would develop and how it would impact on both them and on service users. We found variation among staff groups in terms of their involvement in consultation and opportunities to contribute to the work to take forward the integration agenda.

Staff who worked in community settings told us there were very good informal working relationships between health and social work staff. They described a mutual

understanding of each other's roles and working together to deliver support and care for older people to remain at home. We saw that when staffing difficulties had been experienced, community nursing staff had worked flexibly along with social work staff. This ensured continuity of service provision to help maintain and support services for older people at home. Staff across the Partnership were committed to providing services which helped older people to lead an independent a life as possible.

Staff in the multi-agency intermediate care team were an example of this. Despite the staff recruitment issues which had hindered the development of the service, they were an enthusiastic team who were keen to make sure that as many older people as possible were able to benefit from their input. This was also reflected in our staff survey where we found that:

- 79% of staff agreed or strongly agreed that their service worked well with other agencies to keep people safe and to protect people from risk of harm
- 70% of staff agreed or strongly agreed that services worked well together to ensure that they were successful in helping older people lead as independent a life as possible
- 69% of staff agreed or strongly agreed that their service had excellent working relationships with other professionals.

Staff at various levels told us that, at times, there was a disconnection between community and acute healthcare services and staff. They said this could hinder the development of new initiatives and models of care in the Partnership. Some staff and managers told us that, within some areas of the acute sector, there was a reluctance to commit to multidisciplinary working and to move away from a medically-led and traditional model of care. Some staff said that tensions in these areas made them feel undervalued at times.

Pressures on resourcing the social work out-of-hours service provision and, in particular, the necessary staff cover was also a problematic area. Some staff and managers told us that this was a long-standing problem and one which had impacted on their ability to maintain a healthy work-life balance. Senior social work managers provided the management cover for the out-of-hours service. The pending retirement of the Chief Social Work Officer at the time of our inspection meant that the number of senior managers available to provide this cover was due to reduce (at least temporarily) to three. They told us this was not sustainable and the Partnership appeared to accept this.

An independent review of the social work function had recommended that the Council should consider entering into a service level agreement with a Scottish mainland local authority for the provision of an out-of-hours telephone service. However, a similar arrangement had been tried previously, but was discontinued as it failed to address what was and remained the main issue, namely the need for locally available support. As an alternative, the service, having consulted further with staff, decided to trial extending the

managers' rota to include team leaders and senior social workers. It reported that initial conclusions were positive and had not impacted negatively on the social workers' rota.

Mental health officers told us of some difficulties with out-of-hours mental health provision. No formal out-of-hours rota was in place and Community Psychiatric Nurses (CPNs) were not routinely available out of hours.

In more rural parts of Shetland where there were smaller staff groups, healthcare staff such as GPs and district nurses would regularly be on call. For older people and their carers, this had the advantage that there was a real sense that their needs were well known and understood by their care providers and that they had seamless access to care and services. However, this placed significant demands on the GPs and staff involved.

In common with findings from inspections to date, of the staff who responded to our survey, significantly more staff (53%) disagreed that there was sufficient capacity within their team to carry out preventative work; 28% agreed with this. Just over half (55%) agreed that their workload was manageable to enable them to deliver effective outcomes to meet individual's needs.

Learning and development

We saw that staff regularly received supervision both in a formal and informal way. From our staff survey, 71% of staff agreed or strongly agreed that they had access to effective line management (regular profession-specific clinical supervision within the Partnership). This compared favourably with the findings from other inspections to date.

NHS Shetland had a clinical supervision policy for nursing, midwifery, dental and allied health professional staff. An organisation-wide database of supervisors and supervisees was also available. This enabled supervisees to select an appropriate supervisor from those available. In the 2013 national NHS survey for Shetland, (38% workforce response), 70% agreed that their line managers encouraged them at work and that they understood how their work fitted into the overall aims of NHS Shetland. Eighty three per cent (83%) of staff agreed that they were clear what their duties and responsibilities were.

During our review of health and social work services records, it was encouraging to see that, in 85% of cases, there was evidence that the decisions about care and/or discussions from supervision were recorded.

Qualified social work staff we met were very positive about the frequency and quality of supervision they received. However, some social care workers told us that their supervision and support could have been better. They told us there was a lack of supervision due to staffing constraints. This could result in them feeling isolated. Senior social care workers also indicated that they lacked support at times in the completion of

the With You For You assessments. These assessments were the main means by which older people could access social care support and services. Senior managers for social care staff had recognised the need to ensure this group of staff was better supported in carrying out appropriate tasks. The Council had committed itself to ensuring that all social work staff received the right help and training to drive up the quality of the With You For You assessment process, supported through high quality supervision and support.

Generally, we found that staff were positive about their learning and development opportunities. In particular, they spoke positively about adult support and protection and dementia training were both identified. Both formal and informal dementia training and awareness sessions were readily available for health and social work staff and for the third sector. This was much valued by staff who saw it as enhancing their skills and supporting them to deliver good quality care to older people with dementia.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Adequate

The Shetland Partnership was committed to building community capacity using a co-production approach. This meant working together with older people and other stakeholders in co-producing services, solutions and developments in local communities.

We found that a strong sense of community spirit already existed within the localities of Shetland. A good range of support services was in place to promote independence and to help reduce reliance on health and social work services where appropriate.

There was less evidence of engagement and community capacity building from a more strategic perspective. The Partnership acknowledged this had not been given a great deal of priority in the past. It also recognised the need to strengthen relationships between third sector organisations as equal partners. The third sector organisations said their relationship with the Partnership tended to be episodic, rather than ongoing.

The Partnership had taken steps to engage with the public and communities. There were some good examples of engagement with older people and their carers in rural and remote areas of Shetland. These included consultation around budget setting in 2014 and an online network for carers.

The Partnership needed to consolidate its intentions to increase community capacity. It also needed to build on the work it had done around two locality model pilots by formalising arrangements for its localities structure and delivery model.

4.1 Public confidence in community services and community engagement

Engaging with the community

We saw that building community capacity was a theme in the Shetland Partnership's plans and agreements for developing community health and social work services. In moving ahead with integration plans, the Partnership's vision was to ensure that everyone in Shetland was able to live and participate in a safe, vibrant and healthy community.

Council elected members recognised the need for more joined up and structured working between the key partners in Shetland as this would help determine how locality working would be defined and develop. They acknowledged the role and valuable

contribution that local communities and voluntary organisations could provide in building community capacity to support older people in Shetland.

NHS Shetland had produced its latest patient focus public involvement (PFPI) strategy 'What Matters to You'. This covered a broad range of activity carried out to engage, inform and consult with the local population. The Partnership told us it had received positive comments about the level of engagement with local people from the Scottish Health Council. This is the independent scrutiny body that monitors this work.

The Partnership acknowledged it needed to prioritise the development of a community engagement strategy. It intended to review the patient-focused public involvement strategy, to encompass all engagement activity in one overarching strategy across health and social work services. Its vision was that the developing multidisciplinary teams in the localities would have a key role to play and that to do so they needed to strengthen their relationship with community development staff. This was a good foundation to build on for the development of community engagement across Shetland.

We saw some examples of where older people and carers used community resources and services, and also of where the wider community had participated in engagement activities and events.

- The public partnership forum supported local people to raise issues to help improve services from a community perspective. A recent feedback survey of registered patients in Lerwick Health Centre had resulted in a redesign of the appointments system.
- Shetland Islands Council organised a 'Building Budgets' event in 2014 to provide an opportunity for the public to participate. Although there was a relatively low attendance, the Partnership told us that those who did attend helped to inform the Council's budget priorities.
- Voluntary Action Shetland had developed an online network for carers in remote and rural areas. This was enabling carers on the islands to link up with the multi-agency carers link group through a virtual carers' centre. The network also helped to circulate information and encouraged collaboration of carers' support across Shetland.

Senior health and social work managers acknowledged that, as a Partnership, they still had some way to go in developing a joint approach and strategy for community capacity building and locality planning. A good range of community supports and services were in place. However, it was not clear to what extent their development involved working productively with older people and independent service providers in the third sector. We asked about community involvement in our staff survey. The findings were that:

- 37% of staff agreed their service recognised and consulted diverse local communities

about levels, range, quality and effectiveness of service; 15% disagreed or strongly disagreed

- 35% of staff agreed there were clear joint strategies to promote and expand community involvement and communicate change; 16% disagreed or strongly disagreed
- 41% of staff agreed there was strong positive engagement between the partners and local community and voluntary groups; 17% disagreed or strongly disagreed.

A subgroup of the Community Planning Partnership was responsible for supporting the third sector to develop community-based services to support older people to remain at home. We asked third sector providers about their involvement with the Partnership to meet the challenges of integration of health and social work services. We found there was a lack of positive engagement with the third sector. They told us they had been given no opportunity to input into the development of the joint commissioning strategy for older people. They also had limited opportunities to contribute to planning and development of services. They also described pressures on short-term funding. This had resulted in reduced staffing and increased waiting times for older people who needed support. They told us that much of their engagement with the Partnership was episodic and that they did not have clear contact and liaison arrangements in place. Overall, the third sector providers told us they were not satisfied with the existing arrangements.

In contrast, the Partnership said that it had taken a number of actions to engage with and support the third sector. For example, it said:

- the joint commissioning strategy was a rebranding of the old CHCP agreement; the third sector had been involved in this and they updated their contributions annually
- Voluntary Action Shetland had been specifically funded to support the third sector and their chief officer was a key member of all partnership forums; VAS had also been commissioned through the Change Fund to carry out a piece of research into community capacity to assist in enhancing planning
- for those services directly commissioned by the Partnership, there was a named contact and ongoing communications.

Given the very different manner in which the Partnership and the third sector described their relationship, we concluded that the Partnership needed to strengthen and develop its involvement with the third sector providers as equal partners to help build and increase community capacity and to enhance locality planning.

Recommendation for improvement 2

The Shetland Partnership should develop its strategic approach to community capacity building and co-production and should ensure that a partnership structure is in place which effectively supports locality planning and service delivery.

Community initiatives

We were encouraged by the strong sense of community spirit that already existed within the localities of Shetland. There was a long history of health and social work services working together. This had been easier to develop in some areas because of the close physical location of health and care centres.

Older people and their carers were very positive about the services and the support arrangements they had in place to allow them to remain connected with their local community. During our review of health and social work services records, we also found evidence of this. We also saw some good examples where staff had worked productively with older people to support them to have choice and control over their care and support needs.

In recent years, the de-centralisation of some decision-making to a more local level had enhanced the development of care centres as a central resource within local communities. They provided a range of services including residential care, planned and emergency respite, day care, community meals and a care at home service.

Culturally, older people in Shetland with a lower level of need had come to expect a service from the Council. We were told there was pressure on the care centres to maintain this, as well as using existing resources to support older people with more intensive support needs. With an increasing older population, recruitment challenges and a lack of independent providers, the Partnership had difficulties finding staff to provide care and support. Nevertheless, it was clear from speaking with older people and carers how much they valued the range of services and support from staff to help them to stay in their local communities.

The geography of Shetland posed a particular challenge for the Partnership to achieve effective consultation and engagement with older people and their carers. In recognition of this, video-conferencing was developing across Shetland to enable older people to gain better access to health and social work services.

For example, the pharmacy service was using video-conferencing to link with GPs on islands with no pharmacy provision. It was also linking with care centres to provide support, advice and monitoring of prescribed medicines. Older people were also attending virtual appointments with healthcare staff and specialist consultants as an alternative to spending lengthy periods travelling to hospital in Lerwick. This was a very positive development for older people living in rural and remote areas of Shetland.

As part of the integration agenda, work had begun to introduce locality-based services. The proposed localities model was still in draft form. However, senior managers indicated that a model of three or four localities was likely to be the preferred option.

During our inspection, we visited one of the two pilot projects initiated in a remote area of Shetland. The Brucehall extra care housing project in Unst provided a 'core and cluster' model of specially adapted flats (the cluster) with access to 24-hour care (the core). It was clear that a number of older people were benefiting from living in their own community close to family and friends where previously the only option would have been residential care. The Partnership hoped to replicate this model in other remote areas of Shetland.

The Lerwick pilot project had a focus on developing the interface between hospital and community settings. This involved reviewing pathways and processes to support avoidance of hospital admission and early, supported hospital discharge. A multi-agency intermediate care team was set up to support older people to return home from hospital. It provided intensive rehabilitation using a reablement approach or by using a step-up or step-down care facility in a supported environment.

The timescales for evaluating these pilot projects had slipped. It was expected that this would not take place until later in 2015.

In January 2015, the Institute for Research and Innovation in Social Sciences (IRISS) hosted a two-day workshop called 'Imagining Your Future' to support the Partnership to look at its progress with integration. Their role was to facilitate conversations with senior managers and leaders to help them consider ways to work more collaboratively and provide processes to support action moving forward.

In its report, IRISS described a genuine enthusiasm from partners and staff to work together and a shared sense of purpose. It also said that staff had not known if they had permissions or the trust of leaders to effect change within their own sphere of influence. Further to the report, the Partnership worked in conjunction with staff to develop a seven-page action plan covering issues such as structure and communication and, staff training and development.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

Most of the public information available about how to access services and support was of a good standard, although most of this was generic in nature, rather than specifically designed for older people and their carers. Apart for access to care home placements and in some instances care at home packages, access to services was provided quickly and without significant delays. Some services such as respite care could be accessed by a number of different routes and this needed to be rationalised. The high level of services provided to older people meant that there was a lack of clarity about the eligibility criteria and this needed to be clarified.

Most of the findings from our review of health and social work services records on assessing need, involving older people and providing support were very positive. The needs of older people were subject to regular review.

The Partnership needed to strengthen its approach to offering, completing and taking action on carer assessments. It had taken some action to address this.

There were some significant tensions surrounding the discharge planning for some older people from Gilbert Bain hospital. A stronger multi-disciplinary and team approach was required in order to address this in the interests of patients.

The Shetland Partnership worked well together in supporting older people in their communities. It was reviewing and improving some of its processes to provide more seamless services.

In contrast to other findings from our file reading exercise, findings in relation to adult protection showed a need for improvement in ensuring that risk assessments and risk management plans were always completed when required. The Partnership needed to streamline risk assessment frameworks and to act on the findings from audits and enquiries.

Self-directed support was well embedded with enthusiastic staff now driving this forward. In contrast, better use needed to be made of advocacy services.

5.1 Access to support

We saw that some good public information was available and in a range of formats. The Council's website was user friendly, easy to navigate and contained a wide range of information on relevant topics including self-directed support. NHS Shetland's website

had basic details of services, for example dentists, opticians and community nursing. Before peak holiday periods, information was placed in the local Shetland newspaper. This was a good way to communicate and disseminate information as this newspaper was read by most households in Shetland. We saw less information specifically designed for carers or older people, or on actual service provision such as respite care or care centres.

The Council used the national eligibility criteria for social care provision. These set out the different priorities used to inform assessments. Priority was given to people who had critical and substantial need. However, people assessed as needing a lower level of service were also often given support. The Council explained this was to support earlier intervention. Some of the public information on the Council's website about the eligibility criteria could have been clearer. This reflected a continuing debate within the Council about the extent to which it should continue providing services to people with lower level of needs or whether it should only focus its engagement with people with critical or substantial needs.

The Shetland Partnership was committed to providing a seamless method of service delivery not restricted by organisational or professional boundaries. This commitment included having single and shared eligibility criteria so that older people's needs would only be assessed once for eligibility.

The With You For You process was the main means by which older people could access social care support and services. A recent review of With You For You by the Partnership had recognised that professionals had varying skill sets which had affected the quality of the assessments completed. This had also resulted in different interpretations and understanding by professionals when applying the eligibility criteria for social care provision. Managers in social work services were concerned this had resulted in situations where high levels of service were provided to people with lower levels of need. Some staff we met were less aware than others of the need to use the eligibility criteria during the assessment process. The Partnership was developing an improvement action plan as a result of the With You For You review. This aimed to ensure that staff were aware of and applied the eligibility criteria consistently.

Local care centres acted as a first point of call for many people. Direct referrals were accepted from a range of professionals including GPs. This included access to simple assessments including care at home, day care and respite. These centres provided professionals, service users and carers with a very good way of providing and receiving local support near to home. Some GPs were able to admit older people directly into care centres' beds. Whilst this enabled good local access for GPs, it also posed some challenges in allowing a centralised overview of care centre bed usage.

GP services also varied across Shetland with seven independent practices as well as three salaried practices where all the staff, including the GPs were employed by NHS Shetland.

Health centres across Shetland provided scheduled appointments. The five islands without on-site GP practices were staffed by community nurses. NHS 24 was generally the first point of contact out of hours. Where there was a GP on island, they provided 24-hour cover. Some allied health professionals had a duty system in place to provide an immediate response and to support the accident and emergency department within the hospital. It had been recognised that the referral system to allied health professionals was not as robust as it should have been and work was underway to improve this process.

Access to a range of aids and equipment was available through the occupational therapy service and the joint equipment store located at the Independent Living Centre. This was a purpose-built facility to provide an environment for people to try a wide range of equipment. However, we heard from staff, older people and carers that the location of the centre in an industrial estate on the outskirts of Lerwick was not easy to access.

Apart from small waiting lists for permanent residential care, and the issues with providing timely packages of care at home for those being discharged from hospital, services were generally provided in good time and without the need for waiting lists. However, the GPs we spoke with were concerned that care packages were not always actioned in a timely manner.

Social work services managers and staff acknowledged that the challenges of recruiting care at home staff put a constant pressure on services.

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

We saw assessments of needs had been completed in both the health and social work services records we read. The assessments in the health records mainly related to people's individual health conditions. Our findings on assessments were very positive in that:

- 100% of records contained an assessment of needs on file and most were up to date
- 100% of the assessments took account of the individual's needs
- 9% of the assessments we evaluated as excellent and 87% we evaluated as very good or good with none evaluated as weak or unsatisfactory
- in the majority (84%) of all records, the purpose of assessments and reports were clearly stated and 98% of assessments took account of the individual's choices.

A range of staff we spoke with told us about the difficulties they had experienced with using the With You For You process to assess need. Reablement leads described the With You For You process as being a "step too far". On reflection, they felt this had allowed decisions to be made on a person's future without a full detailed assessment and without consideration being given of all the options available. Housing representatives told us they were not using the With You For You assessment and review forms because they did not include relevant information necessary for housing officers. Frontline social work staff

explained there were problems in identifying who would take a lead on the assessment work. This had resulted in further assessments being completed at a later stage. Managers told us that not all agencies had signed up to using the assessment in the same way, which meant that differing levels of detail were being recorded.

This had prompted the Partnership to review the quality of the With You For You assessment and the supporting process. A report and action plan were presented to the Council in March 2015. The review findings confirmed that the principles that underpinned the With You For You process remained appropriate and fitted well with personalisation and self-directed support. However, the review identified a number of difficulties in using the process. These included the inconsistent quality of assessments and information about older people's needs not being shared. The review recommendations included the need to ensure that all assessors were appropriately skilled and qualified to deal with the level of assessment required. A complementary assessment tool also needed to be introduced to capture more complex assessments. We read the improvement action plan which provided a useful list of the key improvement actions required and a supporting timeline. However, it needed to be supported with more specific detail of how these actions were going to be achieved.

In most areas, we found that systems were in place to support communication and joint working between staff. The majority of older people's health and social work services records we read showed evidence that health, social work and other services shared information to help inform the care and support needs of individuals. This contrasted somewhat to how staff responded to our staff survey where less than half (47%) agreed or strongly agreed that key professionals worked together to inform a single, user friendly assessment whilst 34% disagreed or strongly disagreed.

Some frontline staff we spoke with were more critical of working relationships between colleagues, particularly when supporting older people to leave hospital. We found systems and joint working were less effective in supporting discharge and delayed discharge planning. Discharge planning was described as being medically determined rather than based on multi-agency working and shared staff contributions. Some staff expressed concerns that decisions about discharge plans for older people were not always consistent with the needs of older people. This led to inappropriate levels of support provided. One explanation we heard for this was that some areas within the acute sector did not understand how services had changed within the community to meet more complex needs of older people.

Best practice is that estimated discharge dates should be identified as soon as possible after an older person is admitted to a hospital ward. This was not always the case in Shetland. Discharges appeared sometimes not to be planned until people were deemed medically fit for discharge by consultants. Older people were then recorded as delayed discharges before there had been any real opportunity for discharge planning to be

carried out. Social work staff told us they were often given limited warning of a person being discharged from hospital. Occasionally, they were not given any information until the person was about to reach the delayed discharge deadline. All health and social work professionals we met acknowledged the pressures to put supports in place to enable discharge from hospital. More positively, we heard of some examples where senior staff from health and social work services within the community had worked constructively together to improve outcomes for older people ready to leave hospital.

A few GPs we met expressed concern at the discharge planning processes from both the Gilbert Bain Hospital in Lerwick and from Aberdeen Royal Infirmary on the Scottish mainland. This was a particular concern when older people were discharged towards the end of the week when services had not been put in place or were not available. In trying to improve the discharge process from hospital to home, a discharge co-ordinator had been appointed to work alongside the liaison social worker. This was to improve cover in the discharge and medical wards within the main hospital. They were due to start in April 2015.

Intermediate care supports timely discharge from hospital, promotes recovery and return to independence for older people. Multiple referral pathways to access intermediate care and places in care centres were in place. This made the system complex to manage. Staff from the multi-agency intermediate care team told us that they provided the service whilst a person was still in hospital and they worked to a clear remit and specification. This flexible resource provided short-term intervention only to older people based in the Lerwick area.

Six step-down beds were also available at Montfield Support Services that could be used for intermediate care. Respite beds within a care centre were used for step-down care. GPs also used respite resources to prevent admission to hospital. People being discharged from the medical ward could also be referred directly to a care centre for reablement if it was felt they were not able to return home. There were consequently multiple routes into intermediate care services and into care centres. Health and social work staff told us that, as a result, respite beds were often unavailable for respite use. These multiple routes could cause confusion for both older people and staff about how these services should be accessed. It also presented challenges for social work managers in maintaining an overview of resources.

Recommendation for improvement 3

The Shetland Partnership should ensure that pathways for accessing services are clear and that eligibility criteria are confirmed and applied consistently across services. The pathways should be based on a whole systems approach and be built around multi-agency working.

Clinical lead personnel told us that anticipatory care plans were in place, particularly for those older people with long-term conditions. However, they acknowledged that anticipatory care plans were being used differently with different levels of recording within different sectors. The plans were also starting to be used as part of polypharmacy reviews. In contrast, frontline allied health professionals told us there were few anticipatory care plans in use or that they were aware of. No overarching plan was in place for the implementation of anticipatory care planning. However, we were told that anticipatory care plans were routinely completed for people diagnosed with a terminal illness. We also saw there had been a proactive approach to their introduction within dementia services. Some GPs were using electronic key information summaries. However, this information was not always comprehensive or available to all staff groups across the Partnership. Senior managers realised they needed to ensure that completed anticipatory care plans were shared among staff and knew this was not yet happening.

From our review of health and social work services records, we found that:

- 81% had a comprehensive care and support plan
- 19% did not have a comprehensive care and support plan.

These results compared favourably with the findings of other inspections to date.

We also looked at carer assessments as part of our review of health and social work services records. Carers have a legal right to have their own needs assessed if they so wish. In 47% per cent of the files we read (25 files) there was a carer who provided a substantial amount of support. Of these 25 carers:

- 11 had been offered and had accepted a carer assessment and for 10 of these an assessment had been completed
- seven had been offered, but declined, a carer assessment
- seven had not been offered a carer assessment where they should have been
- for 8 of the 10 carers who had had a carer assessment there was evidence that the support provided had allowed them to continue in their caring role.

The multi-agency carers' link group told us about a number of planned initiatives and projects such as the introduction of emergency carer cards. A carers' group on Unst told us about some of the challenges in supporting carers living on the islands. They spoke positively of the support they received from social work services, and particularly from the carer support worker.

Example of good practice: Memory Lane Café

Alzheimer's Scotland Memory Lane Café was held in various venues around Shetland and was attended by older people with dementia and their carers. One such event was held in the Shetland Museum. This was jointly co-ordinated by the community activity co-ordinator from dementia services and Shetland Museum's activities education co-ordinator and archivist. The session took place to coincide with Valentine's Day and the focus was on weddings and where older people had been encouraged to bring along their wedding dresses and other mementos. Older people and their carers were observed reminiscing, engaging and enjoying the session.

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

The adult protection committee was revising its procedures to fit with the Adult Support and Protection code of practice (2014). Guidance was available for service providers on adult support and protection, and adults with incapacity. Providers received a good level of training. Staff from advocacy services told us they felt confident in their role in relation to vulnerable adults and with incapacity legislation. However, they were less confident that professionals were clear about the potential role of advocacy services in adult support and protection matters.

The Chief Officer's Group had recently consolidated its remit to cover the broader public protection agenda, namely adult and child protection, offender management and domestic abuse. Senior managers told us that adult support and protection was now a standing agenda item at the community health and social care directorate's management team meetings.

We attended the adult support and protection screening group. This group provided a forum for a structured multi-agency sharing of information in response to adult support and protection situations. They made considered decisions as to whether people referred met the three-point adult protection test. However, we saw that staff absences, such as annual leave or sickness absence could cause some delays in the speed with which some information reached, and could be considered by, the group.

The Partnership was developing its approach to quality assurance through multi-agency case file reviews. The first of these reviews had been completed in 2014. It found evidence of good inter-agency communication. However, it also found that risk assessment and risk management, other than in adult protection cases, was not always comprehensive. A number of risk assessment templates were also being used. It identified the need for the approach to risk assessment and risk management planning to be streamlined. However, the findings from this review were not supported by a SMART (Specific, Measurable, Achievable, Realistic and Time bound) action plan to take forward learning from this exercise.

We also noted in the adult support and protection committee's biennial report 2014 raised concerns about the capacity of managers to carry out quality assurance work given the reduction in numbers of managerial posts. The Partnership had completed an initial case review of an elderly man who had died and who had been subject to two adult protection referrals. This internal review was later criticised by the Mental Welfare Commission, as part of its review report, as having not being sufficiently robust. It highlighted the lack of a clear action plan and timescales. We found a similar issue during our file reading exercise in the records of one of the older people's files we read. We noted that the Partnership was in contact with the Mental Welfare Commission about this individual.

During our review of health and social work services records, we had mixed findings in relation to risk assessment and risk management. Given the importance of adult protection, some of these results were disappointing. For the 11 files where adult protection type risks were identified (current or potential issues regarding adult protection or protection of the public), we found that:

- seven of the records contained a risk assessment where this was needed; four of the records did not
- six of the records contained a risk management plan where this was needed, one did not
- we evaluated some 50% of risk assessments and risk management plans as good or very good and none as weak or unsatisfactory. This was a positive finding. However, some 50% were also evaluated as adequate suggesting room for improvement
- whilst all concerns about adult protection risk had been dealt with adequately in nine of the records, they had not been in two
- where there were risk assessments and risk management plans, these were almost all up to date and informed by the views of multi-agency partners.

We also looked at files where non-protection types of risks had been identified, such as a frail older person at risk of falling and sustaining an injury, or the risk to an adult with dementia of experiencing harm. In the 41 relevant files we found that:

- 28 of the 41 records contained a risk assessment where this was needed; 13 of the records did not
- of the records requiring a risk management plan, 18 records contained one, but 11 records did not
- overall, the quality of risk assessments and risk management plans was better for non-protection type risks than for protection type risks; we evaluated more as being good and very good and fewer as adequate
- all concerns about adult protection risk had been dealt with adequately in 37 of the 41 files; they had not been in four files
- where there were risk assessments and risk management plans, these were almost all up to date and informed by the views of multi-agency partners.

Chronologies can give an early indication of emerging patterns of concern and risk. From our review of health and social work services records, we found that 79% contained a chronology of key events where we considered a chronology was needed. Only 2% of cases did not have a chronology where there should have been one. Of those cases that had a chronology, most were of an acceptable standard (83%).

Health and social work staff told us of some of the challenges in providing adequate support to more vulnerable older people. This included difficulties in getting flexible out-of-hours services. The only place of safety for those at major risk in Shetland was Gilbert Bain Hospital, with emergency resources also available at the Royal Cornhill Hospital in Aberdeen. No dedicated facilities for those with dementia and challenging behaviour were available anywhere in Shetland. Managers were aware of the lack of resources and told us they were looking for a place-of-safety resource which would be close to the hospital near Lerwick.

Clinical leads believed all professionals made efforts to attend case conferences. In recognition of the pressure on professionals' time, particularly for GPs, they had been looking to do this through video-conferencing or by telephone conference call. They told us this was proving to be a good way of working for some professionals.

We saw a range of risk assessments and specific risk assessment frameworks being used for vulnerable older people. During our review of health and social work services records, we found that, most commonly, the assessment of risk was contained within the overall assessment of the older person's needs. While this allowed lower level risks to be identified, higher level risks could be better and more comprehensively captured and shared through a specific risk assessment template. We found that staff were not routinely using the appropriate adult protection referral form (AP1) to record initial adult protection concerns.

In our staff survey, whilst 62% of staff agreed or strongly agreed that there were a range of risk assessment tools which they could use, some 15% disagreed or strongly disagreed and a further 23% said that they didn't know. Our findings for risk assessment and risk management showed that the Partnership needed to ensure a clear risk assessment framework was in place which was used consistently. The Partnership had already recognised this and had started to develop a new risk assessment tool. The Partnership needed to take this forward as a matter of priority.

Recommendation for improvement 4

The Chief Officer's Group for public protection and the Adult Protection Committee should review the adult protection committee's business plan to ensure that it includes a focus on reviewing the key processes and procedures covering adult support and protection findings from internal and external reports.

The Chief Officer's Group and the Adult Protection Committee should take action to ensure that risk assessments and risk management plans are completed where required.

5.4 Involving individuals and carers in directing their own support

Independent advocacy

During our review of health and social work services records, we looked at the provision of independent advocacy services. We found that:

- independent support or advocacy should have been offered in 17 cases; while we saw evidence that this had been offered in 10 of the records, there was no such evidence in seven of the records
- in the small number of records (four) where there was evidence that the older person had received advocacy support, this had helped the older person to articulate their views in all of these cases.

Staff from independent advocacy services we spoke with believed there was a lack of understanding of the role of advocacy among health and social work professionals. In the previous year, there had been no referrals from NHS staff for advocacy. The staff we met said the service did not have a good relationship with the Council at a strategic level. They said this had impacted on their ability to plan future service provision and to maintain the existing service. The Partnership said that most of its communication with the service was through its board, rather than with its staff. It said this arrangement had been put in place at the board's request.

Self-directed support

Self-directed support is about offering individuals and their carers choice, control and flexibility over how their support is planned and provided. Practitioners must have regard to the set principles when engaging with individuals who are assessed and who then require support. To do this, local authorities must promote a variety of providers of support and a variety of support options.

Individual budgets were calculated using the equivalency model. This meant that budgets were set at the same level as Council-provided services. The self-directed support lead told us that uptake of self-directed support was mainly by older people.

Members of the self-directed support team highlighted the significant progress made with embedding self-directed support into the initial assessment process as self-directed support options were always discussed with the older person as part of the assessment. Good progress had also been made with signposting older people and their carers on how to access support. The Council had a service level agreement with the Citizens Advice Bureau to support individuals and their carers in managing their support. Documentation had been revised to improve the assessment process. Staff told us that this had enabled more robust auditing and performance measurement.

From 1 April 2014, all new service users assessed were eligible for funded support. Existing service users were offered the four self-directed support options at review meetings. During our review of health and social work services records, we found that, where applicable, 51% of older people had taken up one of the four options for self-directed support, but that 48% of older people had not been offered self-directed support options where they should have been. While take up of self-directed support in Shetland was reasonable, results from our review of health and social work services records showed that the Partnership still had more to do in ensuring that self-directed support options were discussed and offered to older people as a matter of routine.

During our review of health and social work services records, we found good levels of engagement with older people and their families. For example:

- in 91% of files, there was evidence that the time when support was to be provided had been discussed with the older people
- in all of the files where self-directed support was in place, there was evidence that the older person had control over the kind of support they received.

Carers

Support to carers varied across Shetland. During our review of health and social work services records, we found that where support had been provided, there was strong evidence to show that this had improved outcomes for the carers. Carers who accessed respite services following a carers assessment were provided with this service free of charge.

The few staff we met who were employed to support carers were highly motivated and committed to improve and develop services for carers. We were told about positive initiatives in place to try to use community venues to advertise services and to hold events, particularly in more remote areas. We attended a carers' group in Yell which was supported by sessional staff. The multi-agency carers' link group met on a regular basis. Its

membership consisted of a carer, advocacy worker, carer project manager and staff from Voluntary Action Shetland, an educational psychologist and representatives from Shetland Islands Council and NHS Shetland. The remit of the group was to begin to plan more strategically for the development of services.

Voluntary Action Shetland organised carer cruises. These were well attended with invited speakers covering areas such as long-term conditions and telehealthcare. Staff we spoke with described early beginnings in the development of some carer support services rather than these being embedded.

Carer support staff and carers we met told us there were issues about sharing of important information, particularly when the Council implemented change. Carers told us that it had been challenging to get information about what support was available and found that, at times, accessing services was confusing. A few carers described the Council's website as "a nightmare" in trying to find out information specifically about carers.

The Partnership needed to embed support to carers across Shetland and to make sure they had good access to information and more effective pathways of communication.

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

Summary

Evaluation – Adequate

The draft community health and social care directorate plan for 2015–2016 was the Shetland Partnership’s joint commissioning strategy for older people. This plan recognised national and local targets and strategies, and reflected planned changes in health and social care integration. It also linked with the portfolio of service plans. These service plans were being developed and contained some good initial detail on how services would be developed. The service plans needed costed action plans and strategic priorities in the context of health and social care integration. The Partnership needed to ensure that it invested sufficient resources, including staff resources, in strategic planning activity. This had been a challenge historically.

The Partnership had taken a joint approach to the deployment of resources to support improved personal outcomes for older people. By using Change Fund monies, the future shape of health and social work services was beginning to emerge, although some of these changes could usefully have taken place sooner.

A comprehensive range of performance indicators linked to national targets was in operation. Strategic groups in the Partnership were regularly using this information in developing service strategies. However, although progress had been made on self-evaluation, more could be done to ensure this drove an improvement agenda.

We saw evidence of a strengthening approach and culture around how complaints could and should be used to lead to service improvements.

The Partnership had a history of providing many key services within its own resources. However, developing the third and independent sectors was important to support the development of personalisation through self-directed support. The Partnership needed to improve contractual relations with the third and independent sectors by providing a clear contractual framework and strategy with dedicated contractual compliance officers. This would help ensure the effective development of contracted services in the future.

6.1 Operational and strategic planning arrangements

The Shetland Islands Community Planning Partnership (CPP) had set out the joint vision for Shetland in its Single Outcome Agreement (SOA). This contained 14 local outcomes in

support of five strategic objectives within the community. A number of these outcomes helped shaped services for older people. Shetland's Community Health and Care Partnership Agreement 2014-2017 set out the future direction of the Partnership within the wider national context. Planning for the future delivery of services was carried out by the Community Health and Care Partnership strategic group on behalf of the committee. This higher level group met regularly and included key senior managers from both the community health and social care directorate, and from nursing and acute services. This arrangement was described as supporting active partnership working within the islands and also to further plan for joint service delivery with mainland-based health services in NHS Grampian. It was also supported by a number of thematic planning groups, including the:

- Shetland mental health partnership
- housing strategy group
- Community Health and Care Partnership strategic group
- Scottish Ambulance Service liaison group
- Adult protection committee.

The Community health and social care directorate Plan 2014–2015 detailed the vision, aims and objectives for community health and social care services. The plan gave a clear direction to the priorities which linked directly back to the objectives in the single outcome agreement. However, it was not always clear about how actions would be carried forward within the timescales identified. Also, the target outcomes did not always have measures which would demonstrate progress in meeting those targets. From reviewing the performance information within the directorate plan, it was difficult to see co-ordination between the areas where progress was being made and the actions that needed to be taken to address underperforming areas.

The Partnership had also developed a more comprehensive draft directorate plan for 2015–2016. This took account of national and local targets and strategies, and reflected planned changes in health and social care integration. It linked with the portfolio of service plans. This plan covered high-level strategic objectives, joint finance and costs, and workforce resources. It included an action plan, and proposed performance measures across health and social care.

The draft plan was scheduled for completion by December 2014. Before this, the plan was to be circulated for comment to a number of key stakeholder groups including the patient-focused, public involvement steering group, the area partnership forum and the joint staff forum. The plan incorporated a significant number of service plans. These reflected the activities of health and social work services initiatives. The plan committed the Partnership to follow the PRINCE project management principles for service development across health and social work services.

Key strategic partners led the various planning groups. Membership of these groups included voluntary and private sector partners, carers and users' groups who were involved in monitoring the quality of services.

The planned Integration Joint Board (IJB) was to be fully operational in August 2015. Its membership included co-opted members. It would include the Joint Accountable Officer (chief officer), three senior clinicians, Chief Social Work Officer, a patient/service user representative, a carers' representative and a third sector representative. The development of the draft integration strategic plan was being driven forward with the involvement of a project officer. Consultation on the draft plan was underway at the time of our inspection.

Operational managers in health and social work met regularly to review progress in meeting action plan targets and to share information on the development of services. Senior managers told us that health and social care integration might allow greater resource to be given to planning activity. They also told us that historically, NHS Shetland had been better resourced in this area than the Council. The joint work carried out to develop a medication management protocol was an example of the potential benefits of an integrated approach to service planning.

However, some managers also expressed concerns that they would not be able to develop service and strategic plans as they needed to. This was as a result of management staffing capacity social care reducing by 40% in the previous two years. They told us this was having an impact on the delivery of the strategic plan and that the situation was made more problematic as key vacancies were difficult to fill.

In our staff survey, 37% of staff agreed or strongly agreed that priorities set at partnership, team and unit levels reflected jointly agreed plans. 13% disagreed or strongly disagreed with this statement and 50% said that they didn't know.

It was clear to us that the development and continued maintenance of the range of the Partnership's plans would stretch the capacity of managers and staff unless this was properly resourced. For example, managers had highlighted the need for analytical and statistical support to help them in their planning work.

Recommendation for improvement 5

The Shetland Partnership should review its arrangements for strategic planning to ensure that this activity is adequately resourced.

The Partnership said that planning was made more difficult as the funding for care services in the past had been "generous". The Partnership was now working within specific financial constraints and the challenges of investment and dis-investment were often referred to in our discussions with staff.

As part of the integration agenda, the Partnership was working to introduce locality based services. Locality development and planning had been included in the Community Health and Care Partnership agreement 2014–2017 and in the Health and Social Care Directorate Plan 2015–2016 Initial work was concentrated on the development of integrated locality-based service plans and focused on the management of long-term conditions. This work was at an early stage. However, the recently commissioned Assessment of the Health of a Population - Northmavine Report had provided recommendations for improvement to the Partnership. The report recommended that the approach taken to profiling the local health needs in Northmavine should be used more widely across Shetland as a model for recording the incidence and distribution of long term conditions for older people and for developing options to address them.

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

The development of services across the Partnership included a significant emphasis on reablement, the early diagnosis of dementia and support to long-term conditions. Care at home and telecare were used to support people in their own homes to retain independence.

The Partnership had used the Change Fund to jointly support initiatives that addressed early intervention and support to older people. The Change Fund had been used for a number of initiatives to identify new ways of supporting improved outcomes for older people. These initiatives were planned and implemented with identified exit strategies in recognition of the time limitations on funding. There were seven key workstreams which included:

- hospital discharge
- localities working
- preventive and anticipatory care
- housing and mental health in old age
- development and support of carers' groups.

A recent Change Fund project, the multi-agency intermediate care team, had shown some very good performance in helping people home from hospital and care settings. This had now been moved to mainstream funding following successful implementation. However, as stated previously the availability of the service provided by the team had been restricted by challenges in recruitment.

Health improvement staff had been recruited to develop locality liaison and service development. Locality development was assigned a strategic lead from within the operational management team. Work was being carried out to pilot more integrated working to facilitate faster discharge from hospital to home in Lerwick and North Isles.

Recruitment of healthcare support workers to the rapid response team had proven to be a challenge.

The dementia service was a key joint development by the Partnership, designed to provide the most appropriate response to people with dementia. The service included health, social work and independent sector support through Alzheimer's Scotland. The service was working well and provided tailored support to people with dementia and a speedy response following a diagnosis of dementia. The service was supported by input from the consultant for old age psychiatry whose input and advice was accessed consistently, and on occasions, by using video conferencing.

Dementia was a strategic priority for NHS Shetland and the 10 care actions for hospitals, detailed in the national dementia strategy, were being rolled out across Shetland to the care centres. Youth volunteers were working through inter-generational work with older people in the care centres. This was a good example of using the strengths of the strong community identity in Shetland to benefit older people.

Extra-care housing was particularly important in Shetland given the absence of nursing care homes in the islands. A pilot of extra-care housing in both Lerwick and Unst had provided positive outcomes for a significant number of older people who might otherwise have been placed in residential care. Many staff told us they thought the extra-care housing model was a good one. This view was confirmed by the older people we met who were living in this type of supported accommodation and by their families.

Frontline staff told us they thought the extra-care housing model could be best used in promoting further development of new build housing. Other staff suggested that the adaptation of existing housing stock in local communities would be most effective in supporting long-term plans for housing development. An evaluation of the extra-care housing pilot project to determine the preferred model was needed. The Partnership needed to ensure that housing services and housing considerations were fully integrated into its service development activity.

We saw examples where the PRINCE project management system was being used to structure developments, such as the befriending scheme for older people and the development of the dementia assessment service. The use of this approach clearly identified funding arrangements and joint responsibilities for the delivery of service change.

Long-term care planning was hampered by difficulties in developing a joint approach locally to long-term care services. Some GPs had difficulty in attending multidisciplinary joint planning meetings for both long-term conditions management and hospital discharge due to geographic and workload constraints. Social work managers acknowledged that more needed to be done to include GPs in developing long-term

care services in localities. Encouragingly, partnership working around palliative care was identified by staff and GPs we met as being of a good standard.

6.3 Quality assurance, self-evaluation and improvement

While there were a number of quality assurance measures across the Partnership, no systematic and comprehensive approach was yet in place.

A range of performance information was produced, reported and made available to the Partnership. Joint performance targets had been set to support service redesigns. The performance of services was jointly monitored through the business structure across the community health and social care directorate and the acute and specialist service directorate.

Performance reports were provided to the Committee⁵ every three months. These joint reports summarised the activity and performance of the community health and social care directorate in managing service plans. The reports were linked to Council-wide and local government benchmarking performance indicators and to the directorate's performance indicators.

In the performance reports we read, the majority of areas were recorded as green (progressing as planned or completed) with some graded either amber or red indicating slow progress or as not yet started. However, the measurement and criteria used to determine performance in each area were not always clear.

Service plans were not yet linked to the nine national health and wellbeing outcomes. However, the Partnership was in the process of addressing this. The Partnership had completed a review of the With You For You process and the business report would include feedback from an evaluation exercise. Best practice quality audits of assessments were under way and monitoring of six-monthly reviews was evident. The Partnership intended to move to annual monitoring of assessment and care management documentation for less complex cases.

The adult protection committee had carried out work to develop strategic planning arrangements for adult protection. This came from its self-evaluation activity the previous year and in response to comments within the Care Inspectorate's public protection report of 2014. The opportunity to follow up the review activity with contact with service users had not been taken up due to re-prioritisation. An improvement action plan had also not yet been developed to take forward the recommendations from the self-evaluation exercise. We concluded from this, and from our inspection as a whole, that the Partnership needed to concentrate not just on self-evaluation activities, but also on ensuring that these activities led to real improvements.

⁵ Reports were previously submitted to both the Social Services Committee and CHP committee. In 2014, these two committees started to meet jointly as the Community Health and Social Care Partnership Committee.

Recommendation for improvement 6

The Shetland Partnership should ensure that improvement action plans are developed to implement recommendations when self-evaluation activity is completed in order to ensure learning is translated into improved practice and performance.

The Chief Social Work Officer provided an annual report to the health and social work committee on performance aspects of the Council's social work services. The annual report included information on the investigation of complaints and summary information on performance and scrutiny. The report for 2014–2015 was comprehensive and provided a good level of information to Council-elected members on the performance of the social work services. The Chief Social Work Officer had recently been invited to attend the Chief Officer's Group for public protection. Although overdue, this was a positive development.

Complaints can be useful in identifying the need for service improvements and developments. However, some staff told us that complaints were sometimes not made as the Shetland communities were close and complainants might be easily identified.

The Patient Opinion website provided a forum where the public could post feedback on their experiences of health care. These were then reported back to senior managers who would identify any themes for consideration in developing future service. We were told that the way services were managed in admissions to mainland hospitals had been subject to complaints by families and patients. This had been one of the reasons the dementia services team had been developed. We read the NHS Shetland Feedback and Complaints 2013-14 report, which had been submitted to Scottish Ministers. This provided detailed information about both the number and nature of both formal and informal complaints received. Positively, it included examples of where specific improvement actions had been taken in response to complaints and indicated that senior managers from the Partnership met on a regular basis to consider complaints received and any whole system implications arising from them.

6.4 Involving individuals who use services, carers and other stakeholders

In our staff survey, we asked about the involvement of a range of stakeholders in policy and service development. The results were mixed and we also found that staff were more positive about the involvement of older people, carers and other stakeholders than were these groups themselves. In our staff survey:

- 44% of staff agreed or strongly agreed that the views of older people and their carers who use services were taken into account fully when planning services at a strategic level; 23% disagreed or strongly disagreed

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- 39% of staff agreed or strongly agreed that there were effective partnerships which focused on delivering key policies and plans for older people and included relevant stakeholders; 13% disagreed or strongly disagreed with this statement
 - 32% of staff agreed or strongly agreed that the views of staff were taken into account fully when planning services at a strategic level; 43% disagreed or strongly disagreed.

Senior managers we spoke with felt involved in development and improvement activity. This was also the case for some frontline staff associated with particular initiatives such as the dementia services partnership, extra-care housing provision and the implementation of policies such as self-directed support.

However, independent service providers in the third sector were not content about the level of support they were given by the Partnership to deliver and develop their services. Partnership staff told us that attendance rates at service planning events were often low, and it was difficult to get a wider representation of opinion into strategic planning. An event planned to discuss future changes in service with carers and service users was cancelled due to poor take up. As an alternative, the Partnership had sought advice from user and carer representatives and was planning to address consultation differently as a result.

Housing staff had been consulted on the draft joint commissioning strategy for older people. However, they indicated that they were not convinced how much their voice had been heard. They did however, have a place on the partnership group which looked at any implications for the local housing strategy when service planning discussions took place.

The Public Partnership Forum was seen by the Partnership as being integral in ensuring that the views of those people who were considered hard to reach were gathered and taken account of. The Partnership had organised a series of engagement events to consult on specific areas of interest. Events had taken place during 2014–15 on subjects including services for older people, primary care, dementia and self-directed support.

This engagement had been carried out using a variety of forums including:

- using the Association of Community Councils
- specific community Council meetings
- targeted meetings
- open, public meetings.

Existing scheduled meetings and professional groups were also used to gather ideas and comments. We were told that following the event on self-directed support Hjaltland Housing noted an increase in enquiries about this. As a result, it was reviewing its supported housing tenancy agreement to enable tenants to have greater choice and control over their support arrangements.

6.5 Commissioning arrangements

Joint strategic commissioning means all the activities involved in the Partnership jointly assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. The Scottish Government expected health and social care partnerships to produce joint commissioning strategies for older people's services by April 2014.

The Shetland Partnership had carried out some extensive consultation events in preparing its draft joint commissioning strategy for older people. The resource and performance monitoring arrangements shared between the NHS and the Council were listed within the draft strategy.

The actions of the directorate in supporting increased voluntary sector capacity and the development of localities were not addressed within the community health and social care directorate plan 2015–2016. Staff told us that, due to spending cuts, there had been a reduction in the amount of funding to some third sector groups and clubs and that these reductions would continue.

Voluntary Action Shetland represented third sector providers. However, it did not represent all organisations working in Shetland. There were some tensions in the relationship between the Council and Voluntary Action Shetland, in part as a consequence of changes in contractual arrangements. Third sector representatives told us that their previous service level agreements with the NHS and with the local authority were for four years' duration. This had allowed secure planning. These service level agreements dated back to 2009. However, the renewal negotiations in 2013 resulted in the withdrawal of the four-year contract. A one-year contract was put in place instead, with a six-month monitoring report requirement.

Partnership managers told us that there were very few third sector groups and organisations in Shetland who had sourced funding from outwith Shetland. They told us this would need to change as the level of grant funding available to third sector groups and organisations from the Partnership had reduced. Commissioned services such as befriending and the Citizens Advice Bureau were in a better position as they had not faced the same level of funding restrictions as other third sector services.

The Partnership's relationship with the third and independent sectors needed to improve, especially so it could effectively contribute to the integration agenda and help to build community capacity. The Partnership was aware of this, but this needed to be supported by the necessary time and effort to sustain good working relationships with the third and independent sectors.

Shetland had strong community links based around the traditional crofting townships. The development of local care centres alongside primary care services had provided a

strong base for delivering personalised services. However, with changing models of care, a key question for staff was how services could be further developed to meet the needs of the growing elderly population. Social work staff told us it was a major challenge to put the necessary services in place to enable and support some older people. They told us that by the time this had been done, the needs of the older people had often changed or increased. This made early intervention and prevention difficult to sustain. Staff also told us that the lack of private sector providers limited options for both staff and for older people when self-directed support was being considered.

The planning of services in support of long-term conditions was being developed at a local level jointly by the Partnership. However, this work was being piloted and not all aspects of early support for older people were fully resourced. For example, the use of telecare was recognised as an important aid to allowing older people to remain independent within their homes. However, there was no dedicated telehealthcare strategy and, as a result, the expectations for partnership working between telehealthcare and telecare were not well defined. Some staff expressed frustration about this and said that progress had been slow. More positively, a joint approach to telehealthcare was being developed across Shetland. Health and social work services were jointly piloting the effectiveness of advanced technology equipment in supporting older people with dementia who live in remote areas to remain at home.

The Partnership was seeking views from individuals and groups about future service provision. Work was carried out to support the Public Partnership Forum which was a stakeholder group made up of lay representatives and third sector organisations. It had an interest in the delivery of services which support health and wellbeing and provided input into a wide range of service review programmes. The forum had focused on patient appointments systems in the local GP practice in Lerwick. This had contributed to a number of changes already commented on in this report. The forum was also playing a role in raising awareness about the changes and to provide patient information about the different healthcare roles in the health centre.

Older people's views were also sought through the use of the With You For You quality assurance framework. This sought to identify older people's experiences and a pathway was developed to share this feedback up through the Partnership to influence service development. However, it was not clear how this feedback was being used by the Partnership in developing services. There was no indicator within the service plans which formally used feedback to develop and improve services. The Partnership had decided that service users feedback should be specifically considered as part of care plan reviews and that this should be used to inform service development.

We read the 2014 NHS Shetland Hospital Inpatient Experience Survey which included some positive findings in response to the questions about leaving hospital. It found that

72% who needed help were confident it had been arranged and that 94% were positive about the care/support they received after leaving hospital.

Care centres were based within communities and were well placed to gather local opinion on what services might work well. Staff within care at home and care centres did not think they had the opportunity to put their views into development discussions. They met once a year with managers for employee development reviews. However, they had no developmental input at this time either for forward planning or for being told of future plans. This was inconsistent with the use of the With You For You assessment which should have ensured feedback of this type was captured. Staff were concerned that the model for care centres was no longer working and a new model needed to be developed. They felt that the development of services was imbalanced and that recent changes were NHS led.

The recently developed draft older people's strategy recognised the importance of delivering services locally and in a timely manner within local communities. However, the strategy did not specifically identify early support and intervention for older people to prevent crisis as a key theme. The Partnership needed to address this. The strategy also needed to further support opportunities for older people and carers to influence service development.

Quality indicator 7 - Management and support of staff

Summary

Evaluation – Good

The Shetland Partnership faced a number of recruitment and retention challenges. These included competing with the oil and gas industry for key posts, such as care at home staff and social care workers. There were also challenges in recruiting to a number of specialist consultant posts and for GPs. The Partnership had taken a number of initiatives to address these challenges. These included a successful trainee social work scheme and the imaginative development of a health and social care academy as part of the Shetland Training Partnership

Joint health and social care workforce planning was still at an early stage, particularly to consolidate a locality-based joint service provision model. However, the principles and protocols surrounding the future staffing requirements had been agreed and work was underway on a workforce delivery plan.

An integrated management team was in place for the community health and social care directorate which was working well. Below this level, most services continued to be mainly structured on a single agency basis. A limited number of joint posts and initiatives were in place. The multi-agency intermediate care team and the dementia service were good examples of joint teams. We also saw numerous examples of good joint working, including joint working involving GPs, district nursing and social care staff in the more remote areas.

Across health and social work services, training opportunities were of a good quality. Both health and social work staff spoke favourably about the opportunities for training. The Partnership had a joint training plan, and health and social work staff made each other aware of relevant training opportunities. Most training was still provided on a single agency basis. Training on adult support and protection and on self-directed support were areas where training was provided jointly.

The Partnership provided good levels of clinical and professional supervision which most staff recognised in our staff survey and at our focus groups.

7.1 Recruitment and retention

We read a range of relevant and clear documentation on recruitment, retention, and the management and support of staff. The documents were predominantly single agency reflecting the separate histories of Shetland Islands Council and NHS Shetland. The Shetland Partnership acknowledged it needed a joint robust workforce plan to support

health and social care integration. Senior managers told us that a set of protocols and joint arrangements for workforce planning were under development as part of the integration preparation agenda. The development of a joint workforce strategy was being taken forward as part of the work to support health and social care integration.

In almost every focus group and interview we carried out, frontline and senior staff told us that recruitment was a major issue impacting on service delivery. The Partnership told us that it had struggled to recruit to a number of clinical and professional posts for some time, including psychiatry, GPs and social workers.

Some staff said there had been gaps in the availability of occupational therapists on the outer islands and also on some part of the mainland. Long-standing difficulties in recruiting GPs had resulted in changes to the way healthcare was delivered in Shetland's busiest health centre. Four advanced nurse practitioners had been recruited to help address this.

The multi-agency intermediate care team, funded through the Change Fund, had also faced recruitment difficulties. The Partnership acknowledged that offering temporary contracts was a disincentive to people in applying to join the team. As a result, the Partnership had approved a proposal to offer new staff permanent contracts, on the basis that if long-term funding failed to be secured, they would be redeployed into other substantive posts.

To address some of the difficulties with recruitment, the Partnership and, in particular the Council, had developed a 'grow your own' approach to nurture and develop the local workforce.

- The Shetland Training Partnership had been established which included a health and social care academy. Partners included human resources, the community health and social care directorate, Shetland College and high schools. Sixteen pupils had so far been offered a range of placements aimed at helping to prepare and make them ready for employment in health and/or social care services.
- A successful trainee social worker scheme had been established and maintained for a number of years.
- Due to difficulty in recruiting social workers who were mental health officer trained, social worker applicants were now employed and supported to undertake the MHO training.
- Previously, social care workers had also been able to access a trainee scheme. This ran for three years and was seen as being successful in providing them with a broad range of relevant work experience. However, it had been discontinued as part of budget savings.

Example of good practice

To address some of the difficulties with recruitment, the Shetland Partnership had developed a 'grow your own' approach to nurture and develop the local workforce. This included establishing the Shetland Training Partnership to create a health and social care academy. Partners included human resources, the health and social care directorate, Shetland College and high schools. Sixteen pupils had already been offered a range of placements aimed to help prepare them and make them ready for employment in health and/or social care services.

We were told that some service users who had successfully been supported with the self-directed support and reablement process, and who had secured funding to employ staff, then experienced problems in doing so. For example, they were unable or were delayed from returning home from hospital or a care centre due to difficulties in the recruitment of support workers or care at home staff. As well as for the individual and their families, this could be frustrating for staff who had supported service users through the self-directed support process.

Managers told us there was no longer a housing-incoming-workers policy in Shetland. However, housing points were available for incoming workers which allowed prioritisation against other groups. We saw that accommodation costs for rental and sale properties on the islands were high. Private company lets also impacted on the social rented housing market. Over a period of time, health, police and fire services had sold their tied housing stock to meet financial savings targets. Human resource managers acknowledged that the need for an incoming workers policy could usefully be reviewed given the existing recruitment pressures.

Staff sickness and turnover can impact on service delivery, particularly when combined with recruitment difficulties. The Council's analysis of its own workforce highlighted a turnover rate of 25% among social care worker staff in community care for 2013–2014. This was an increase from the previous year of 12.5%. The Council related the turnover of this staff group to the lure of better paid employment in the oil and gas industry, and the offer of full-time and permanent positions.

The sickness rates for community care staff in 2013–2014 was 9.2%. The Council had been making efforts to reduce sickness absence by supporting staff whilst on sick leave in returning to work. NHS Shetland's sickness absence rate for the year 2013–2014 was 4.79%. This was in line with the national NHS average of 4.76%. NHS Shetland had supports in place to help staff to return to work and to remain at work. This included a self-referral pathway to occupational health. Both NHS Shetland and Shetland Islands Council had their own attendance management policies. These were both due to be reviewed and updated.

When we met with the Partnership's human resources managers, we found that they attended meetings with the community health and social care directorate on an ad hoc basis when required. We saw some indications that the Council and NHS corporate human resources services lacked a detailed understanding of the human resources needs and challenges of operational health and social care services. Senior Partnership managers said that for health and social care integration to be successful, corporate services, such as human resources needed to change, evolve and integrate.

As a result of the recruitment and retention difficulties, we saw long-standing pressures on staff in both health and social work services around out-of-hours service provision. This particularly affected district nursing, mental health and social work services. The Partnership recognised that services were extremely stretched and, as well as the 'grow your own' approach to recruitment, some more innovative ways of attracting key workers to Shetland were required. Some frontline staff told us they believed that the Partnership should be more proactive in addressing this long-standing issue.

Shetland Islands Council and NHS Shetland had established a joint staff forum for staff consultation purposes and to support the integration agenda. This was a positive move to support partnership working.

7.2 Deployment, joint working and team work

Since June 2013, executive managers from the Council and senior managers from clinical services had met as an integrated and joint management team. This was as part of the community health and social care directorate led by a jointly funded director's post. A number of seminars and events about integration had been held for staff at various levels to keep them informed about integration.

We saw that resource allocation and deployment of staff was still predominantly at single agency level. However, we saw many examples of good joint working relationships between health and social work staff. One example of this was with the close working relationship between district nursing staff, GPs and community care social care workers in remote areas. We saw that where anticipatory care plans were being completed both health and social work staff were working co-operatively. An agreement was in place that the professional who knew the older person best and who was best placed to do so would take the lead role in completing the anticipatory care plan.

A key joint initiative was the development of the dementia service to provide the most appropriate response to people with dementia. The service included health, social work and independent sector support through Alzheimer's Scotland. It was working well and provided tailored support to people with dementia and their families as well as helping to speed up the diagnosis of dementia. This was a good example of using the strengths of the strong community identify in Shetland to benefit older people.

Further good team and inter-agency working was shown in the North Isles pilot project. This combined existing community care support staff with local allied health professionals and nursing staff to support older people. This pilot project had been developed to test out multi-disciplinary support to extra care housing. The Council's housing department had carried out a service redesign. This combined support staff from homeless and housing support services worked under the same terms and conditions. This allowed them to be deployed as required across the isles. The success of the project was built on the principle of not reducing service but widening the scope of the staff group's responsibilities and skills.

The Partnership was beginning to develop joint services such as the multi-agency intermediate care team and the Independent Living Centre in Lerwick. The intermediate care team told us that, even though they were an integrated joint team, they struggled with having to use two human resource teams and two information technology systems. As a joint team, there had also been some confusion about where ownership and leadership of the team rested. This had now been resolved, with the overall responsibility and management resting with the chief nurse.

7.3 Training development and support

In our staff survey, we found that 61% of staff agreed or strongly agreed that they had good opportunities for training and professional development. From our discussions with senior managers in health and social work services, it was clear that they recognised the importance of equipping and training their workforce. They acknowledged a more joined-up working approach was needed, and an expansion of learning and development between services to support the move into integration.

To support the integration agenda, the Partnership established an action-learning set for managers from across the community health and social care directorate. This was supported by an external facilitator through NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC). This was part of a national programme to support partnership development. Both health and social care managers told us that this had been extremely useful in enabling the Partnership to start to build a picture of how it saw itself progressing towards integration.

NHS Shetland and Shetland Islands Council operated their own arrangements for individual supervision, team meetings and annual appraisal. The Partnership had a joint training plan. However, adult support and protection training was almost the only training provided jointly on a regular basis. Health and social work staff told us that they regularly shared training by making each other aware of relevant training opportunities. Examples of this included dementia awareness and manual handling training.

In the hospital's accident and emergency department, two nurses were trained as dementia champions. All other accident and emergency nursing staff had completed an online dementia informed module. They were also able to access other training relevant to the care of older people, for example, falls prevention, pressure care and nutrition.

All staff in the community care social work team had received self-directed support training so that they understood their role in explaining the four options of self-directed support to older people and their families. Training for a wider group of staff, including colleagues in the NHS and third sector had also been rolled out across the Partnership.

Plans were under way to deliver Equal Partners in Care (EPiC) core principles for working with carers and young carers training to health and social work staff. This was being led by Voluntary Action Shetland.

Quality indicator 8 – Partnership working

Summary

Evaluation – Adequate

The Shetland Partnership had taken action to align community health and social care budgets. A financial governance framework had been agreed in advance of integration. A local Partnership finance team and the Council's Section 95 officer had been identified as the chief finance officer for the new integrated partnership.

As elsewhere in Scotland, the Partnership faced significant financial challenges. Its combined budget for 2015–2016 was 9% less than in the previous year. It also needed to take account of funding made available from the Shetland Charitable Trust which, whilst a unique contribution, could vary dependent on investment returns. The Council had taken determined action to move towards a sustainable budget. It had a five-year medium term finance plan in place to help achieve this. However, this would need to be reviewed to take account of funding levels from the Scottish Government. NHS Shetland was on track to deliver the required efficiency savings for 2014–2015.

The Council was still in the process of managing the transition from the Change Fund to the Integrated Care Fund. Some decisions about continued funding had been made on ad hoc basis, rather than as part of a clear transitional plan.

The Partnership faced many of the same challenges as other partnerships in sharing information and, in particular, personal data about individual older people, across separate IT systems. It had found some small-scale local solutions and was looking at developing EMIS Web as a web-based system for nursing services and potentially within social work services.

The Partnership's draft integration scheme was approved by the Scottish Government soon after the inspection. While more needed to be done to embed the third and independent sector, health and social work services were well placed to move forward into a new and operational health and social care partnership.

8.1 Management of resources

Community health and social care budgets had been aligned and jointly monitored in advance of integration. Funding for a number of services had been pooled. For 2014–2015, there was a combined budget of £42.4 million from the Council and NHS Shetland along with an additional £3.2 million from the Shetland Charitable Trust. This gave a total of £45.6 million. For 2015–2016, a combined budget of £38.6 million was approved by the Council and NHS Shetland in December 2014. This represented a 9% reduction from the

previous year, excluding the Shetland Charitable Trust contribution. Shetland Charitable Trust funds available to contribute to the Partnership and other projects were dependant on uncertain investment income. As a result, there was a risk that investment income fluctuations could require the Council and NHS Shetland to make increased contributions to cover for any shortfall. The Partnership needed to ensure that agreement between the Council and NHS Shetland was in place to address any potential shortfall in Shetland Charitable Trust funding resulting from lower than anticipated investment returns.

Financial performance of Shetland Islands Council

At 31 March 2014, the Council had total usable reserves of £240.9 million. The Council had reviewed its funding levels going forward and identified a growing budget gap. This was due to inflationary cost pressures not met by increases in Scottish Government funding. This gap was projected to be £20 million by 2016–2017, the first full year of operation for the Partnership. This represented 16.7% of expected expenditure. The Council had projected that total reserves would be depleted by 2029–2030 if the planned savings of £22.4 million were not achieved and revenue expenditure was increasingly subsidised by drawing on reserves.

The Council's five-year medium-term finance plan 2014–2019 highlighted that the Council was seeking to pursue a sustainable budget whereby reserves were either maintained at their current level or were increased. This was agreed by the Council in July 2014. This position will require significant savings to be achieved year on year across the Council's service directorates. Efficiency savings targets of 2% for each directorate had been set from 2016–2017. Although the Council had made positive steps in moving towards a sustainable budget, the effectiveness of the medium-term finance plan in closing the budget gap was currently uncertain. This would be adversely impacted by future reductions in Scottish Government funding.

The management accounts for the Council's social services directorate position at December 2014 was that there would be projected revenue underspend of some £1.5 million as at the year end. This related mainly to lower than anticipated expenditure arising from unfilled staff posts. As a result, there was a risk that increased cost pressures could arise if these posts remained unfilled and had to be filled by expensive agency staff. If these posts remained unfilled, this could also have an adverse impact on the level and quality of services provided.

Within the Council's social services budget for 2014–2015, community care services had identified a budget gap of 2% (around £0.4 million) which was to be managed through efficiency savings. Efficiency savings of 2% were then required each year up to 2019–2020 to maintain a sustainable budget. However, this budget approach assumed continued Scottish Government funding at 2014–2015 levels with an inflationary rise included each year.

Financial performance of NHS Shetland

In April 2014, NHS Shetland agreed a three-year local delivery plan 2014–2017. This set out how NHS Shetland would deliver transformational change. The plan aligned NHS Shetland's strategic priorities with financial, workforce and capital plans. NHS Shetland's five-year financial plan (2015–2020) identified a break-even position was planned for each of the five years. This position relied on the achievement of planned efficiency savings of 3% of funding each year. This ranged from £1.2 million to £1.3 million and totalled £6.1 million over the 5-year period. These savings were required to fund both immediate cost pressures and any planned investment in services.

NHS Shetland was required to meet various financial targets set by the Scottish Government. This included remaining within its revenue budget. Its 2013–2014 financial statements disclosed that all financial targets were met and a surplus of £0.088 million was achieved.

As at December 2014, there had been a net overspend against budget of £0.3 million (0.79%). An overspend of £0.5 million, relating to community health and social care, had contributed to this net overspend. This had arisen from increased use of locum staff and lower than anticipated savings.

Overall, NHS Shetland was on track to achieve its efficiency savings target of £1.6 million for 2014–2015, with £1.5 million (94%) achieved as at December 2014. Of these savings, £0.5 million (31%) were non-recurring savings. This meant this was not sustainable in the long-term. With the integration of services with Shetland Island's Council, NHS Shetland was also likely to have reduced flexibility to achieve these savings.

Due to the financial pressures of the existing economic environment for public sector bodies, most Councils and NHS boards had been experiencing challenges in delivering their services. As a result, the longer-term financial plans of both Shetland Islands Council and NHS Shetland remained at risk of not being affordable.

This presented a significant challenge to ensure that older people received the services they required in the future. It meant that it was important that budget overspends were resolved. Affordable financial plans were essential for ensuring that the Partnership was placed in a sustainable financial position going forward

Partnership financial arrangements

In preparation for integration, the Council's social services committee and NHS Shetland's committee had been meeting together regularly. This was expected to continue in an informal basis until the Partnership was fully established.

A local partnership finance team was in place. This consisted of the Council's Section 95 officer, NHS Shetland's director of finance and other representatives from both NHS Shetland and the Council. The team's remit was to lead on the development of the financial aspects of the legislative changes. This included the preparation of the integrated financial resource framework. This set out the protocols required for health and social care integration. The finance team would be responsible for submitting the Partnership's budget to the combined social services and committee for recommendation to NHS Shetland and the Council.

A chief finance officer for the Partnership has been agreed by both the Council and NHS Shetland. This officer would be responsible for presenting the accounts and monitoring reports to the Partnership. The postholder, who was employed by the NHS, would carry out this position as part of their existing role. They would be supported by staff across the two organisations. It was anticipated that this arrangement would not incur any additional costs. This was because it would replace work currently being carried out to support existing joint financial arrangements for health and social work services through the . The impact of this, along with all support arrangements for the Partnership, would be reviewed after six months of operation. It was important this role was given the appropriate status and resources to effectively fulfil the required responsibilities.

An integration scheme and health and social care partnership strategic (commissioning) plan (2015-2018) were agreed by the Council and NHS Shetland in February 2015. The integration scheme had since been submitted to and approved by the Scottish Government. A financial governance framework was also agreed. This sets out the procedures for budget setting, reporting and monitoring. The framework also covered areas such as administration cost liability, internal audit arrangements and the use and treatment of assets.

A health and social care integration transition programme action plan had been created. This set out the timescales for putting in place all the necessary arrangements needed to implement the Public Bodies (Joint Working) Scotland Act 2014, including financial arrangements. As at March 2015, further work was still needed for developing programme budgeting and marginal analysis to support the setting of the integrated budget. It was important that these areas were progressed to ensure that an integrated budget was set within the required timescales.

Change Fund

Since 2011–2012, the Scottish Government had provided funding to the Partnership to assist the move to more community-based care. The Change Fund was provided to support Reshaping Care for Older People. The funding was expected to be used as 'bridging finance' to enable the redesign of services and facilitate achievement of this

national policy. It was also expected that the fund should be used to influence decisions on the nature of partnership spending with a significant shift to anticipatory and preventative approaches. This would help to achieve and sustain better outcomes for adult care, including older people.

By 31 March 2015, the had received £1.4 million in funding. The work programme was being taken forward and monitored by the Community Health and Care Partnership's management team. The funding had contributed to a number of workstreams. These included:

- telecare
- hospital and care centres
- proactive care and support
- preventative and anticipatory care
- mental health in old age
- carers
- community capacity.

The Change Fund ended in April 2015. The majority of the associated projects were either non-recurrent (purposely time limited) or one-off spends. However, a number of projects did not yet have an exit plan in place when reported in October 2014. The Partnership needed to move quickly to determine the future of Change Fund initiatives.

The Scottish Government had provided additional resources to health and social care partnerships to support investment in integrated services through the Integrated Care Fund. However, this fund was not restricted to older people, but extended to include support for all adults with long-term conditions. For 2015–2016, £0.4 million would be available to the Partnership. The Scottish Government recommended that to begin fully implementing related spending plans from the start of April 2015, plans should be signed off by December 2014. At the time of our inspection, the Partnership did not have a coherent plan in place to manage the ending of the Change Fund. The availability of the Integrated Care Fund was allowing continued funding on an ad hoc basis to be provided to some projects, such as the carers' support service. A draft plan of how the Integrated Care Fund was to be allocated was only due to be presented and agreed at the joint social services and committee in March 2015.

8.2 Information systems

Data sharing between health and social work services is a challenge throughout Scotland. It was further complicated in Shetland because of structural issues which were difficult to resolve. This affected usage of systems, for example poor band width and poor reception, particularly in remote and rural areas.

The Partnership acknowledged that its information systems did not 'talk' to each other

and sharing of sensitive data was challenging. It confirmed data sharing arrangements were in place and these were monitored by the data sharing partnership. We were told that all information systems used across the Partnership had permissions and security in place to protect sensitive data. We read a good data sharing policy document dated 2012. The policy had been developed and adopted by the Shetland Islands Council, NHS Shetland, Northern Constabulary (now Police Scotland) and Voluntary Action Shetland.

The Council's social work service used SWIFT. Staff confirmed good internal IT systems were in place which linked with each other and helped to keep staff up to date and informed. The SWIFT system was challenging for their partners, including NHS staff, to access. However, a number of staff described local solutions that had been put in place to allow this. For example, the multi-agency intermediate care team's physiotherapists could access the SWIFT system when they went into social work offices. Staff also explained that when emailing confidential information, one-off passwords were set up to allow professionals to access the information.

Senior social care workers used the telephone, or sent sensitive minutes or emails using the protected gsx email address. They did this by sending reports to administrative staff who then forwarded information to the secure NHS site. Social work staff acknowledged this was a "clunky" process which could cause delays. However, they believed it to be more efficient than using internal mail. With the exception of the occupational therapists, allied health professionals used paper notes.

From our review of health and social work services records, we found evidence that that, in 94% of cases, consent to share information had been sought from individuals. In 94% of cases, health, social work and staff from other services were sharing and recording this in their files.

We read a draft project initiation document describing plans to carry out a programme of work to purchase and implement EMIS Web as a clinical system. This would initially be used for community and specialist nursing, with consideration being given to its use within social work services. Initial investigations began in 2013 with an eventual demonstration session held in late 2014. This gave a full overview of the functionality of the system. This document was waiting for final approval from the eHealth steering group to accept the re-scoping of the original EMIS Web project. Amongst a list of benefits included improved care pathway by sharing information between primary and secondary care services. This also included social work services and other Shetland-wide services. Senior managers hoped this system would be launched by 2017. Finance officers told us that a small amount of money was being invested in developing a shared system.

Data collection from SWIFT informed monthly quality assurance reports. Business reports were also collated for key activities. Senior managers told us that SWIFT was due to be updated in the summer of 2015. The aim was to reduce confusion and bureaucracy and

make the IT system easier to use. NHS Shetland's IT department gathered data which enabled managers to monitor information such as waiting times for clinics and treatment times. These information systems helped to record performance against a range of key outcomes. This provided practitioners and managers with tools to monitor their own work and performance.

The Partnership needed to put in place a coherent strategy to gather and use data to improve outcomes and to agree a shared model for monitoring performance.

8.3 Partnership arrangements

Compliance with integration delivery principles

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

In response to the Public Bodies (Joint Working) (Scotland) Act 2014, Shetland Islands Council and NHS Shetland had put in place interim arrangements combining the Council's social services committee and NHS Shetland's committee.

The health and social care integration project board, with equal representation between the Council and NHS Shetland, was set up in 2011. Its aim was to develop and implement a health and social care integration model. The project board's responsibilities were to:

- co-ordinate projects and workstreams to deliver the programme objectives on time
- ensure that the programme was completed on time
- develop the integrated governance arrangements.

In July 2014, the Council and NHS Shetland subsequently agreed to establish a Shetland health and social care partnership based on a 'body corporate' model. This was the delegation of functions and resources by NHS boards and local authorities to a body corporate. This would be managed by an Integration Joint Board with an appointed chief officer who would be jointly accountable to both chief executives.

An integration scheme and health and social care partnership strategic (commissioning) plan (2015-2018) had been agreed by both the Council and NHS Shetland in February 2015. This had been submitted to and approved by the Scottish Government.

At the time of our inspection, the Partnership was operating as a shadow partnership. The Community Health and Social Care Partnership was operating as a shadow Integration

Joint Board. This was a cohesive, well-functioning group with appropriate representation from stakeholders.

The director of the Community Health and Social Care Partnership had been in post since the end of 2013, initially on an interim basis, and on a permanent basis since early 2014. Before this, he was employed as the director of clinical services where he had responsibilities covering both acute and community health services. He appeared confident in the Community Health and Social Care Partnership's role in getting the shadow Integration Joint Board to the point of being functional as an Integration Joint Board. He believed the knitting together of integration was beginning to happen.

The Integration Joint Board was to become operational from August 2015. There would be three elected members from the Council and three NHS non-elected members. The Board was to be chaired by an elected member from the Council. Senior managers said they were pleased with this outcome and the decisions taken on the make-up and balance of the Board.

The joint financial arrangements for the Partnership were arranged so that the budget for the Community Health and Social care Partnership would be shown jointly, but also separately so that both the Council and the NHS could "follow its pound". The Council and NHS Shetland had previously vired monies between each other. This facility would continue to be available as part of the new partnership.

The workstreams of the Integration Joint Board were reflected in the reporting and governance structures. A strategic planning group reported to the shadow board with locality strategy groups and thematic strategy groups supporting this work. The existing Community Health and Partnership Committee monitored performance and advised on all aspects of partnership arrangements, service planning and delivery for the Community Health and Social Care Partnership. This function was expected to transfer across to the Integration Joint Board when it became operational.

Early work had been carried out in developing services within localities. The Partnership viewed localities and locality working as having a key part to play in taking the integration agenda forward. However, challenges remained for the Partnership as development work in this area was in early stages. Some senior managers and elected members said that more work was needed to develop a structure and shared vision. The Partnership recognised the advantages of having GP practices in the same areas as the care centres.

The Partnership had spent a significant amount of time and resources communicating with staff groups about partnership working and integration. The majority of staff we met during the inspection reflected this. In our staff survey, we found that 78% of staff agreed or strongly agreed that joint working was supported and encouraged by managers. Only 12% disagreed or strongly disagreed.

Elsewhere in this report, we have highlighted that the Partnership needed to improve how it engaged with some of its partners, including the third sector. However, we were satisfied that the basis upon which partnership working between health and social work services in Shetland was being built would meet the expectations contained within the integration principles as required by the Public Bodies (Joint Working) Scotland Act 2014.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Adequate

The Shetland Partnership and, in particular, the Council's community care service, was emerging from a difficult period following an organisation and management restructuring exercise in 2011. This had been reflected by a number of changes in leadership personnel, a reduction in the number of senior managers and following financial efficiency savings. These had also impacted adversely on a number of key leadership activities, including strategic planning, the leadership of people, and the leadership of change and improvement.

The quality of leadership had improved in the 12 months before the inspection. This was reflected in the attention and priority given to service planning and development, the use of performance management information and self-evaluation activity. While improvement was needed in how the Partnership made best use of these activities, dementia and mental health services were two examples of where service reviews had been carried out. Significant reviews of the social work function and of its assessment and care management arrangements were nearing completion.

The community health and social care directorate's senior management team was functioning well as an integrated team. This was important as the Partnership had a number of outstanding challenges that needed to be addressed. These included dealing with some outstanding difficulties and tensions with hospital discharge planning for older people and also the need to review the effectiveness of its broader partnership working arrangements.

9.1 Vision, values and culture across the partnership

The Shetland Partnership's vision was "to ensure that everyone in Shetland is able to live and participate in a safe, vibrant and health community". This vision had been in place for a number of years and was contained within the Shetland Islands Health and Social Care Partnership's integration scheme for 2015. The vision was supported by a number of key aims. These included:

- more flexible and better quality services
- a shift in the balance of provision towards community-based services
- actively engaging people and their carers in promoting self-care and self-managed care
- integrating services around the needs of our customers
- listening and responding to community needs and aspirations.

The Partnership told us that its vision was underpinned by a strong commitment to a personalisation agenda. This commitment was reflected in the health and social work services records we read, and at the various focus groups and meetings we held with health and social work staff. At these sessions, staff showed a clear commitment to trying to achieve the best possible outcomes for the older people they were supporting. However, staff were less clear about what constituted the Partnership's key strategic service development priorities and how these were to be taken forward. In general, frontline staff and staff working at a distance from Lerwick seemed less clear about this. Some of these staff questioned whether there was a leadership vision and commented on the limited opportunities to input their views into service development discussions.

In our staff survey, 48% of staff agreed or strongly agreed that there was a clear vision for older people's services with a shared understanding of the priorities. Twenty seven per cent (27%) of staff either disagreed or strongly disagreed with this statement. The level of agreement for this statement was broadly in line with other inspections to date.

We saw that there had been some gaps in the development and completion of some key strategies for older people. For example, at the time of our inspection, both the joint commissioning strategy for older people and the dementia strategy were still under development. This was reflected in our staff survey where less than half (41%) of staff either agreed or strongly agreed that the vision for older people's services is set out in comprehensive joint strategic plans, strategic objectives, measurable targets and timescales.

In January 2015, the Partnership produced a draft strategy for older people. This aimed to update and refresh previous strategies going back to 2003. The vision contained within the draft strategy was designed to take account of important social developments over the intervening period. In particular, it was built on the principle "that older people should be seen as a positive source of time and energy, life experience and sometimes forgotten talents and skills, accumulated wisdom and a unique perspective". The strategy and its revised vision were designed to cover the next 10 years and to coincide with the first 10 years of the new health and social care partnerships in Scotland. Whilst it was encouraging that the Partnership had reviewed and revised its vision, it needed to invest time and effort in ensuring the vision was widely shared and understood. It was clear from the draft strategy and its limited section on who had been involved in its development that there was more to be done in this regard.

Recommendation for improvement 7

The Shetland Partnership should complete its strategy for older people so that it can provide a strong basis and a shared vision for the strategic plan for health and social care integration.

Overall, we found that staff working across the Partnership had a shared sense of values and commitment to their work. This was reflected in the way in which they worked together. This was also reflected, to a limited degree, in the staff survey. We found that 56% of staff agreed or strongly agreed that there were positive working relationships between practitioners at all levels, although some 30% of staff either disagreed or strongly disagreed with this statement.

We found that the community health and social care directorate's management team had now come together well. From meeting with management team members both individually and collectively, we could see that they saw themselves as having a shared responsibility for delivering on the Partnership's agenda. This was irrespective of whether they had a health or social work background or whether they were employed by the NHS or the Council. This was reassuring, as some cultural challenges needed to be addressed. These included:

- all key stakeholder organisations being convinced of the Partnership's commitment to working with them in genuine partnership
- trust being established between some professionals on new models of providing care, treatment and support.

We met with some Council elected members and non-elected NHS board members. They acknowledged that the Council and NHS Shetland were and had been two culturally different organisations and that there would be challenges in achieving a consensus around the culture for the new health and social care partnership.

9.2 Leadership of strategy and direction

Shetland's Community Health and Care Partnership had been in existence since 2002, and had evolved over time. Its management model was essentially a joint NHS and Council management structure headed by the Director of Community Health and Social Care. He had been jointly appointed by NHS Shetland and Shetland Islands Council in 2013, initially on an interim basis. By the time of our inspection, the appointment had been confirmed on a substantive basis with the director also appointed as the joint accountable officer (chief officer) elect for the new Community Health and Social Care Partnership.

The longstanding nature of the Community Health and Social Care Partnership's arrangements in Shetland were reflected in the documents we read. These contained a strong emphasis and recognition of the benefits of developing services jointly and in partnership. In the main, this was acknowledged by the staff we met.

We found that there was a relatively clear set of arrangements in place for partnership working, and for developing and taking forward the Partnership's key priorities and its strategic direction. This was largely done through:

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- The Community Health and Social Care Partnership agreement 2014–2017. This brought together the work of the various strategic planning groups. These were a combination of thematic groups, for example the Shetland mental health partnership and the housing strategy group, and groups focusing on key operational issues, such as hospital admissions and discharges. These groups had also overseen the range of joint service plans, including long-term conditions and palliative care. The partnership agreement also included sections on governance and accountability, performance management and human resources. It served as the Partnership’s joint commissioning plan.

Whilst it was positive that the plan allowed the Partnership to pull together all its key strategic plans into one document, it was a rather long and unwieldy document. Some sections did not appear to have been reviewed since July 2013. We were unclear whether the Partnership was able to ensure it maintained a strategic overview of all its planning and service improvement activity, so that it could focus on agreed priorities. We were reassured to note that the plan included a manageable number (14) of key development priorities. In addition, for areas where the Partnership had identified “disappointing” progress in 2012–2013, we found much better progress had been made by the time of our inspection. This included a strategy for self-directed support and the building and opening of a new Independent living centre.

- The Community Health and Social Care Strategic Group. They had a key role to play in developing and implementing key strategies. The team comprised of senior community health and social managers. The medical director and director of nursing and acute care were also members of the team. It provided an important interface between primary and secondary care services. We saw a good shared commitment to the Partnership’s priorities by the management team, with individual team members having an individual lead responsibility for taking forward specific workstreams. Locality working and self-directed support were examples of this.

Previous inspection reports, in particular of Council services, had highlighted the challenges faced by Shetland in developing policies and plans due to its size. Unlike many larger Councils, it had few staff with a specific remit for policy development. This meant that managers had to try and carry out this work alongside their day-to-day operational responsibilities. This remained a challenge, but the management team was hopeful that the move into the new health and social care partnership would allow more staff capacity to be invested in policy planning and development activity.

The management team demonstrated a good understanding of the key national policy drivers for older people and what these meant within the local Shetland context. A risk register had been developed which identified key risks and challenges as well as the high-level actions which would be required to militate against these. Examples of this were:

- the need for improved management information to facilitate service planning

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- the need to develop more public information to explain service developments and limitations
 - the need to have better and consistent recording of unmet needs to improve service planning and development.

The longstanding basis of the existing Community Health and Social Care Partnership also appeared to have assisted the Partnership in its preparations for the new health and social care partnership. Well-established governance arrangements were already in place. These provided a good basis for moving forward to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. In July 2014, NHS Shetland and the Council had agreed the 'body corporate model'. Agreement had also been reached that, at commencement, the new Partnership would not include children's services as Shetland already had an established education and children's services directorate working in partnership with NHS Shetland and other key partners.

A health and social care integration transition programme had been established. This was led by the director of corporate services for Shetland Islands Council on behalf of and the Council and in order to support the director of the Community health and social care directorate. Arrangements for the Integration Joint Board had been agreed. The Board had already met on four occasions on a shadow basis since October 2014. A draft integration scheme had been submitted to the Scottish Government in early 2015. At the time of our inspection, the Partnership told us that it had received initial feedback from the Scottish Government and no significant amendments to the draft integration scheme had been requested. The scheme was approved by the Scottish Government shortly afterwards.

We met with a small group of Council Council elected members and NHS non-elected Board members. They acknowledged some of the challenges they faced in moving into the new Partnership. These included how best to reconcile the two different cultures of the NHS and the Council, firming up locality working arrangements and operating pooled budgets. However, they expressed some confidence in how the new Partnership would function. They described it as predominantly a greater formalisation of existing positive joint working. They also described the input they had received from the Scottish Government's Joint Improvement Team and from the Institute for Research and Innovation in Social Services in their preparatory work and told us these had been very helpful.

9.3 Leadership of people across the partnership

In its position statement submitted to us before the inspection, the Partnership acknowledged that there had been some considerable change and disruption following the Council's organisation and management restructure in 2011. Two separate directors had left the directorate in relatively quick succession. The management structure within

the community care service had also been reduced. This coincided with significant Council-wide efficiencies and a drive to reduce the levels of spending. This resulted in a reduction in the budget from £26 million to the current £19.5 million. The Partnership acknowledged that this had impacted negatively on the senior leadership it had been able to provide to staff and, in particular, to community care social work staff from 2011 and into 2013.

This view was echoed by staff at all levels. They spoke about this period as being a very difficult one. They told us this had been reflected in a number of ways and, in particular, from a staff perspective by:

- a lack of leadership, sense of direction and visibility from the top
- a range of efficiency savings which seemed very blunt and not linked to service priorities. One area where this had been evidenced was among social care workers, a staff group employed by the Council in both its care home and care at home services. This staff group had reduced in size and changes were made to work rotas. A subsequent survey carried out by the Partnership found that 69% of social care workers said the changes had been introduced in a manner which had a significantly adverse effect on the service.

Team leaders and service managers told us they had been particularly affected during this period. They described having to work excessive hours and feeling both exposed and often unsupported. They told us they had tried hard to support their staff groups during this period. This was acknowledged by most staff we met.

More positively, most staff told us that senior leadership had improved over the previous 12 months or so. The appointment of the director of the Community Health and Social Care Partnership and the action taken to create an executive manager post to act as professional lead for social work were identified as being important factors in this. We met with the health and social care managers who formed the health and social care directorate's senior management team. Both staff groups told us that they thought the team was now working well together as an integrated management team. Our own observations of the team reflected this. A number of staff and staff groups we met spoke positively about the visibility and leadership now being provided by senior managers.

For the majority of staff in the Partnership, leadership was provided through a predominantly professionally based line management route. For example, the chief nurse (community) was responsible for the direction of the community nursing teams and the professional lead for various nursing teams. Similar arrangements were in place for social work staff, allied health professionals, dentistry and pharmacy. Where this was not possible, specific arrangements had been put in place. For example, the mental health nursing service was managed as part of the responsibilities of the executive manager for mental health, with professional accountability provided by the chief nurse.

One consequence of the Council's restructuring exercise in 2011 was that the social work function was essentially divided between two separate Council directorates. This combined with some specific concerns which had arisen about aspects of the social work service (primarily within children and families services) led to a decision by the Council to have an independent review completed of the social work function. This included the role of the Chief Social Work Officer. The review was carried out by a former director of social work from a Scottish mainland local authority and was completed between May-August 2014. The review report contained 28 recommendations. Some of these recommendations were relevant to social work services for older people. These included:

- the role of the Chief Social Work Officer be strengthened, including their inclusion in the Chief Officer's Group for public protection and the Integration Joint Board
- the post of executive manager for adult social work (an interim post at the time of our inspection) be established as a permanent post
- consideration was given to entering into a service level agreement with a Scottish mainland local authority for the provision of an out-of-hours telephone social work service.

The report and its recommendations were considered by the Council in December 2014. It was agreed that the recommendations should be implemented by June 2015. These recommendations should help to support improvements in social work services for older people. However, while we saw that discussions had taken place with staff groups as part of the review, we found that staff and managers were less familiar with the review's findings, its recommendations and the reasons for them. The Partnership needed to make sure that implementation of the review recommendations was supported by clear communication with staff.

We heard mixed views on communication from the various staff groups we met. A number commented on an over-reliance of cascaded e-mails and the need for a more developed communications strategy. Senior managers had visited the outer islands to meet with groups of staff, but acknowledged they needed to invest more time in this on a more regular basis. While some information and newsletters had been distributed about health and social integration, awareness among staff we met was variable. However, in general, we found that staff seemed reasonably at ease about it. A small group of staff and managers had been involved in a two-day event in January 2015, *Imagining Your Future*, facilitated by the Institute for Research and Innovation in Social Sciences. Staff we met who had been involved spoke positively about the event.

The governance frameworks of the NHS and the Council were under review to take account of health and social care integration. The intention was to set up a joint governance group. This would oversee clinical governance activity across the NHS and the Council, including the new health and social care partnership.

Overall, we concluded that the leadership of staff in the Partnership had improved significantly since the end of 2013. This was based on comments from staff we spoke with and also from the results of our staff survey which were better, albeit only slightly than in other inspections to date. For example:

- 62% of staff agreed or strongly agreed that high standards of professionalism were promoted and supported by all professional leaders, elected members and board members; 11% disagreed or strongly disagreed; the figures in other inspections to date agreeing or disagreeing with this statement were 59% and 14% respectively
- 50% of staff agreed or strongly agreed that senior managers communicated well with frontline staff; 43% disagreed or strongly disagreed; the figures in other inspections to date agreeing or disagreeing with this statement were 46% and 46% respectively.

9.4 Leadership of change and improvement

The Partnership acknowledged that the period of change and disruption following the organisation and management restructure in 2011 had also had a negative impact on the attention given to self-evaluation and improvement activity during this period. They told us senior managers had to concentrate on delivering the required savings and the delivery of operational services. As a consequence, robust and joint quality assurance activity and a focus on self-evaluation had not developed as they would have liked. They also told us that they had experienced delayed or fragmented starts and progress in relation to some significant national change programmes including Reshaping Care for Older People and self-directed support. We saw some examples of this, such as the establishment of the multi-agency intermediate care (reablement) service not taking place until the end of 2014 and the lack of strategy to support community capacity building and co-production.

This was also reflected in the findings from our staff survey.

- 32% of staff agreed or strongly agreed that the quality of services offered to older people jointly by partner's staff had improved over the last year. 31% disagreed or strongly disagreed.
- 38% of staff agreed or strongly agreed that changes which affected services were managed well, whilst 50% either disagreed or strongly disagreed.

From our inspection, we found that, in the previous 12 to 18 months, there had been an increased focus on performance reporting, self-evaluation and service improvement activity.

- A range of performance information was produced, reported and made available to the Partnership. Joint performance targets had been set to support service redesigns.

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- A number of key service reviews had been carried out. These included dementia services where the external “deep dive” review by the Stirling Dementia Services Development Centre had contributed to some service improvements. Evidence was now available to demonstrate that this had helped lead to improved performance and outcomes such as in dementia diagnosis and post diagnosis support. The flexible deployment of pharmacy services and the action taken to redesign the operation of Lerwick Health Centre were other examples where a self-evaluation approach had been used in order to improve service delivery for older people.
 - There was evidence of some improvement activity being developed and taken forward within relatively short timescales and using elements of a project management approach. The development of self-directed support and the review of With You For You were both illustrations of this.
 - During our review of health and social work services records, we saw a positive commitment to, and evidence of, a quality assurance approach at the individual ‘case and patient’ level. However, there was a need to develop larger-scale audit or sampling activity beyond the area of adult support and protection.

Most of the above activities had been approached on a single issue basis. The Partnership was aware that it needed to develop a much more systematic approach to its self-evaluation and improvement agenda. While this was positive, the Partnership needed to have a plan in place to address this.

The areas for improvement identified by our inspection activity were mainly ones which the Partnership had itself recognised. However, there were a few, including some significant ones, which either the Partnership did not appear to have been aware of and where it was still to take effective action.

- Whilst it was clear that the Partnership was committed to partnership working, from our meetings with a range of its partners, it was evident that its relationship with them was not as positive and productive as the Partnership thought it was. This included both external and internal partners. A number of partners described their relationship with the Partnership as “episodic”, rather than ongoing. Some also told us they sometimes felt they were treated as junior partners when it came to service planning and development.
- A range of systems were in place for accessing care, treatment, services and support. These included hospital admission and discharge as well as access to care home beds, including respite provision. The Partnership had an awareness of this and the need to develop ‘pathways’ and service provision models which worked together in a more holistic way. It had taken some actions to address this. For example, the With You For You review was, in part, designed to look at dealing with initial public contact and

assessment. However, the Partnership still needed to develop a plan for how it would review and develop pathways on a whole systems basis.

During the inspection, we developed some concerns about aspects of planning, including discharge planning for older people in Gilbert Bain Hospital. These concerns included decisions about if and when older people were fit and ready for discharge.

Contributory factors included:

1. a lack of clarity about some key processes
2. a lack of trust between elements of the acute and community services about newer models of care
3. some difficulties with team working in discharge planning decision making, including some personality tensions.

Senior managers were aware of these challenges and told us that they were about to restart meetings between the acute sector and community-based strategic management groups in order to address them. While this was a positive development, we were aware that these difficulties had been in place for some time and noted that the Partnership had struggled to overcome them to date.

Overall, we concluded that the leadership and direction provided by the Partnership was showing positive signs of improvement and was strengthening. It was clear that it was committed to achieving further improvement. In order to do this, the Partnership had some key outstanding challenges which needed to be addressed.

Recommendation for improvement 8

The Shetland Partnership should take decisive action to address the problems which are adversely impacting on effective multi-agency discharge planning for older people in hospital.

Recommendation for improvement 9

The Shetland Partnership should take action to review and improve its partnership working arrangements. This should include both external and internal partners and in particular the third sector partners.

Quality indicator 10 – Capacity for improvement

Summary

The Partnership was delivering positive outcomes for many older people and it had been helped in this by historically high levels of council expenditure. There was a positive approach to the development of self-directed support. Performance in planning and the discharge of older people from hospital was better than the national average, although there were some specific issues with older people requiring care home placements and some tensions between acute and community services in these areas.

Staff were well motivated and supported by line managers. They worked well and flexibly together at the front line level, but the development of integrated teams and a structure to support locality working were still at relatively early stages.

Both service planning and senior leadership had suffered during a two-year period between 2011-13, during which there had been significant restructuring activity, budget saving requirements and turnover of senior managers. The Partnership had been emerging from these difficulties over the previous 12-18 months and this was reflected in the greater level of service improvement and development activity and staff confidence in the visibility and leadership shown by senior managers. We saw evidence of both of these.

At the strategic level there were longstanding partnership arrangements between health and social work services and preparation for integration was proceeding relatively smoothly.

The Partnership still faced a number of important challenges, including the development of more integrated ways of working and joined up services to meet the needs of older people and carers. Having the necessary capacity to take forward important service development activity had been a long standing challenge in Shetland. The Partnership needed to look for opportunities arising from integration to address this.

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

The Shetland Partnership was delivering positive outcomes for many older people. This was evidenced through our analysis of nationally and locally published performance data, documentation submitted by the Partnership, results from our review of health and social work records, and from views expressed by older people, carers and staff we met.

Most of the relevant data indicated the Partnership's performance was better than the national average. Examples of this included:

- emergency hospital admissions
- the provision of care at home services
- telehealthcare and telecare
- respite provision.

The reablement service was achieving positive outcomes for the older people it supported, but the service was relatively new and needed to expand.

The Partnership was meeting the national target for delayed discharges from hospital, but faced challenges in discharging some older people from hospital who needed care home placements. The Partnership was doing well in its balance of care performance with older people being supported to remain at home.

From our review of health and social work services records, we saw positive personal outcomes were being achieved for nearly all the older people whose records we read. We were able to see positive changes for older people after interventions by health and social work services staff. This was helping older people to maintain their independence and self-manage their conditions where appropriate. It was also helping the Partnership to move away from a culture of service-led provision to developing a more personalised approach to delivering services tailored to the individual. It was clear that staff were in the habit of talking to older people about their wishes and choices as well as their needs

The Partnership was committed to ensuring that older people received the right support at the right time, delivered by the right people. There was a strong focus on encouraging older people to be involved in all aspects of their support. This ranged from assessment to planning and delivery of their own care, according to their own wishes and personal preferences.

Older people and their carers were generally happy with the services provided to them and told us that these contributed to better health and wellbeing. The Partnership acknowledged the need to develop a more robust approach to service planning for carers. This would help to continue to improve the support initiatives and services already in place for them.

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

The Partnership acknowledged that the period of change and disruption following the Council's organisation and management restructure in 2011 had had a negative impact on the attention given to self-evaluation and improvement activity during this period. Joint quality assurance activity and a focus on self-evaluation had not developed as they

would have liked. They had experienced delayed or fragmented starts and progress in relation to some significant national change programmes.

More positively, we found that, in the previous 12 months to 18 months there had been an increased focus on performance reporting, self-evaluation and service improvement activity. Some examples of this were the review of dementia services, the flexible deployment of pharmacy services, and the work undertaken to review assessment and care management provision as part of the review of With You for You.

Most of the above activities had been approached on a single issue basis. The Partnership was aware that it needed to develop a much more systematic approach to its self-evaluation and improvement agenda.

Recommendation for improvement 10

The Shetland Partnership should develop an overarching plan which identifies its priorities for self-evaluation and improvement activity for the next three years. This should include a specific plan for how it can improve whole systems approaches and working for older people.

Effective leadership and management

It was very clear from the inspection that the Partnership, and in particular its community care service was emerging from a very difficult couple of years where it had struggled with a Council restructuring exercise, significant budget reductions at an unprecedented level for Shetland and rapid turnover and change in senior managers. The Partnership acknowledged that this had impacted negatively on the senior leadership it had been able to provide to staff during this period. This view was echoed and reflected by staff at all levels.

More positively, most staff told us that senior leadership had improved over the previous 12 to 18 months. The appointment of the director of community Hhealth and social care and the action taken to create an executive manager post for adult social work to act as professional lead for social work were identified as being important factors in this. We had several opportunities to meet with the directorate's senior management team and saw that this had come together well and was now able to concentrate on service performance and improvement in a way that had not been the case in the previous period. However, their view of the state of partnership working, and in particular with the third sector was more positive than was reflected by the third sector itself. However, with this exception, the Partnership demonstrated a good level of self-awareness of the key challenges it needed to address. These included developing more integrated "pathways" and service provision models and ones which took account of geographic needs and financial constraints.

Preparedness for health and social care integration

In response to the Public Bodies (Joint Working) (Scotland) Act 2014, Shetland Islands Council and NHS Shetland had put in place interim arrangements combining the Council's social services committee and NHS Shetland's committee.

In July 2014, the Council and NHS Shetland agreed to establish a health and social care partnership for Shetland based on a 'body corporate' model.

An integration scheme and health and social care partnership strategic (commissioning) plan (2015-2018) had been agreed by both the Council and NHS Shetland in February 2015. This had been submitted to and approved by the Scottish Government.

At the time of our inspection, the Partnership was operating as a shadow partnership. The Community Health and Social Care Partnership was operating as a shadow Integration Joint Board. This was a cohesive, well-functioning group with appropriate representation from stakeholders. However, independent sector representatives had only recently been identified.

The Integration Joint Board was to become operational from August 2015. There would be three elected members from the Council and three NHS non-elected members. The Board was to be chaired by an elected member from the Council. Senior managers said they were pleased with this outcome and the decisions taken on the make-up and balance of the Board.

The workstreams of the Integration Joint Board were reflected in the reporting and governance structures. A strategic planning group reported to the Board with locality strategy groups and thematic strategy groups supporting this work. The existing Community Health and Care Partnership committee monitored performance and advised on all aspects of partnership arrangements, service planning and delivery for the . This function was expected to transfer across to the Integration Joint Board when it became operational.

Early work had been carried out in developing services within localities. The Partnership viewed localities and locality working as having a key part to play in taking the integration agenda forward. However, challenges remained for the Partnership as development work in this area was in early stages. Some senior managers and elected members said that more work was needed to develop a structure and shared vision.

The Partnership had spent a good amount of time and resources communicating with staff groups around partnership working and integration. The majority of staff we met during the inspection reflected this.

Improvement was needed in how the Partnership engaged with some of its partners,

including the third sector. However, we were satisfied that the basis upon which partnership working between health and social work services in Shetland was being built would meet the expectations contained within the integration principles as required by the Public Bodies (Joint Working) Scotland Act 2014.

What happens next?

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

November 2015

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



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