



## Services for older people in Orkney

March 2017

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

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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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## About this inspection

Between June and August 2016, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services for older people in the Orkney Islands.

The inspection took place at a time of considerable reform of health and social care services and the establishment of the Orkney Islands Health and Social Care Partnership (hereafter referred to as the partnership or Orkney Health and Care - OHAC). At the time of our inspection, NHS Orkney and Orkney Islands Council were working hard to embed and further develop the operational and governance arrangements needed to support the Integration Joint Board (IJB)<sup>1</sup> which had become operational on 1 April 2016. For 2016/17, the IJB had a budget of £33.7million (Orkney Islands Council - £17.1m and NHS Orkney - £16.6M) for the services within its delegated responsibilities.

As with partnerships across Scotland, many of the changes introduced as part of the integration agenda were at too early a stage to show impact, although they will provide the building blocks to help address the areas for improvement set out in this report. We hope that this report is a useful contribution to the IJB, NHS board and council as they continue to improve health and social work support available for older people living in the Orkney Islands.

The purpose of the joint inspection was to assess whether the health and social work services improved outcomes for older people and their carers<sup>2</sup>. We wanted to find out if health and social work services worked together effectively to:

- make sure people receive the right care at the right time in the right setting
- deliver high quality services to older people
- support older people to be as independent, safe and healthy as possible and have a good sense of wellbeing.

Our joint inspection involved meeting some 40 older people and their carers, and more than 100 staff from health and social work services and the third sector<sup>3</sup>. We read a sample of older people's health and social work services records. We also studied a number of documents provided by the partnership about the health and social work services for older people and their carers. We are thankful for the time and effort provided by the older people, their carers and staff who met with us during the inspection.

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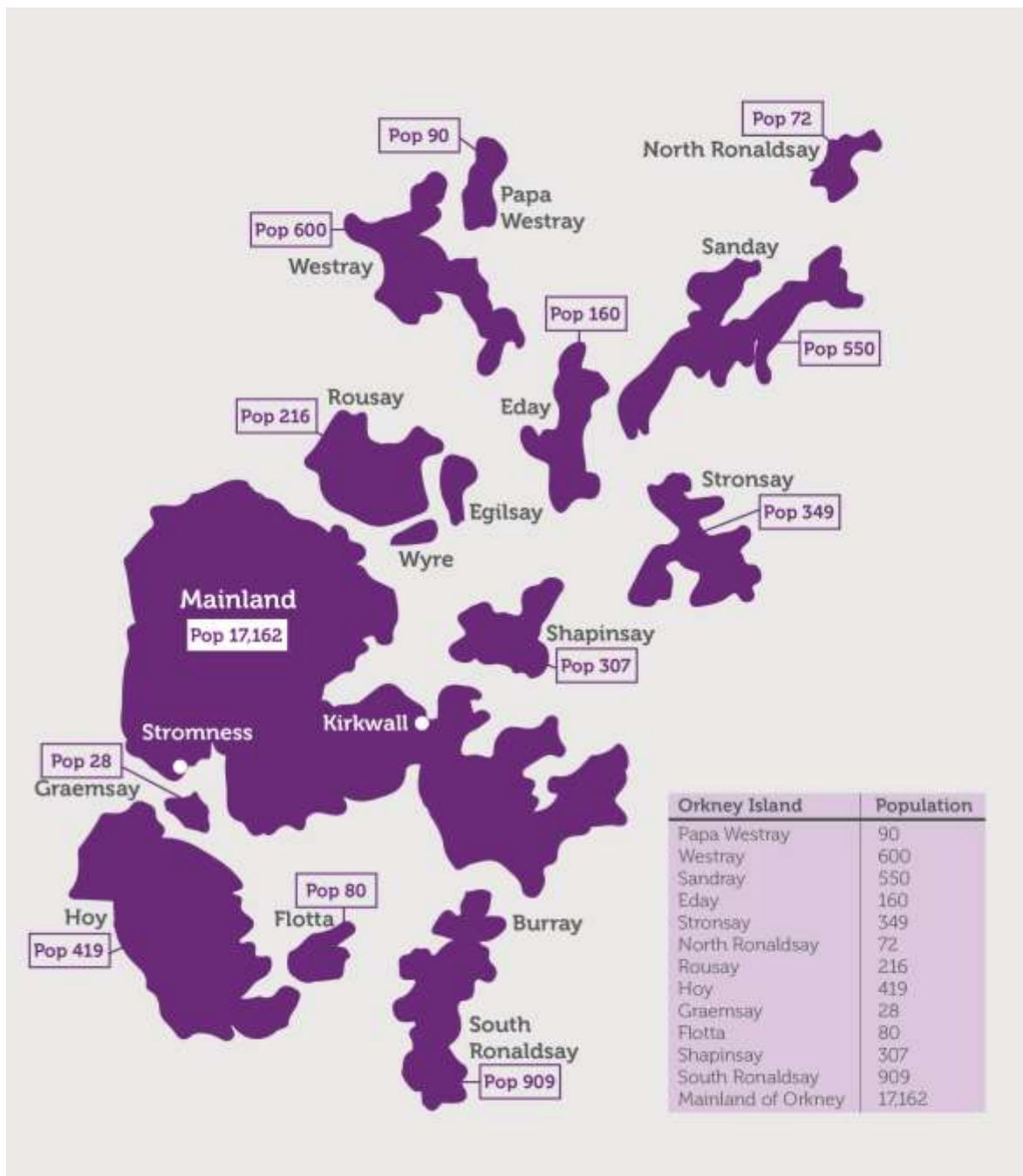
<sup>1</sup> The Integration Joint Board is responsible for the planning of integrated arrangements and service delivery of functions delegated to the IJB from NHS Orkney and Orkney Islands Council included in the Orkney Health and Social Care Partnership

<sup>2</sup> In this report when we refer to carers this means unpaid carers.

<sup>3</sup> The third sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

## 1. The Orkney Islands context

The Orkney Islands are a group of islands in the Northern Isles of Scotland. Orkney is 16 kilometres north of the coast of Caithness and comprises approximately 70 islands, of which 20 are inhabited. The largest island, referred to as the Mainland, has an area of 523 square kilometres, making it the sixth-largest Scottish island and the tenth-largest island in the British Isles. The largest settlement and administrative centre is Kirkwall.



The Orkney economy has had a traditional reliance on agriculture and fishing. However, over the last 20 years, there has been a growth in employment in a

number of economic sectors, including manufacturing, tourism, food processing and, more recently, renewable energy.

In 2011, the population of Orkney was 21,349. This represents an increase of 10.9% since 2001 and compares to a 7.5% increase overall in the Highlands and Islands and 4.6% increase in Scotland. The population of Orkney has a proportion of older people that is higher than the national average. Between the 2001 and 2011 censuses, the number of people aged 65 and over grew by 32.5% (the highest of all NHS boards). Orkney's overall population is projected to increase by 5.5% in 2037 and the largest increase will be seen in the older population aged 75 and over.

## 2. How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (Appendix 1). Our findings on the partnership's performance against the nine quality indicators are detailed on page 10. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for older people and their carers. The inspections also look at the role of the independent sector and the third sector to deliver positive outcomes for older people and their carers.

The inspection teams are made up of inspectors and associate inspectors<sup>4</sup> from both the Care Inspectorate and Healthcare Improvement Scotland and clinical partners seconded from NHS boards. We have inspection volunteers who are carers and also Healthcare Improvement Scotland's public partners<sup>5</sup> on most of our inspections.

### Our inspection process

#### Phase 1 – Planning and information gathering

The inspection team collates and analyses information requested from the partnership and any other information 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 consists of focus groups and interviews with individuals, managers and staff to talk about partnership working. A staff survey is also carried out. **In Orkney, our survey received a response rate of 17% of staff. This was less than the average response rate (26%) in other inspections to date. Given this, the survey findings need to be treated with a degree of caution.**

#### Phase 3 - Reporting

The Care Inspectorate and Healthcare Improvement Scotland jointly publish an inspection report. This includes evaluations against the quality indicators, any examples of good practice and any recommendations for improvement. We have reviewed the report format and have made some changes to the format from the previous inspections for this, and subsequent reports. The main changes are to ensure that the key messages from the inspection are clearly highlighted at the start of the report and to reduce the number of sections contained within the report.

To find out more go to [www.careinspectorate.com/](http://www.careinspectorate.com/) or [www.healthcareimprovementscotland.org/](http://www.healthcareimprovementscotland.org/)

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<sup>4</sup> Experienced professionals from local authorities seconded to joint inspection teams.

<sup>5</sup> Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to ensure that it engages with patients, carers and members of the public.

### 3. Evaluations and recommendations

Evaluations are awarded on the basis of a balance of strengths and areas for improvement identified under each quality indicator. The evaluation is not a simple count of strengths and areas for improvement. While each theme within an indicator is important, some may be of more importance to achieving good outcomes for older people and their carers that they are given more weight than others. Similarly weaknesses may be found which impact only on a small number of individuals but be so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

We assessed the partnership against the nine quality indicators. Based on the findings of this joint inspection, we assigned the partnership the following grades.

Quality indicator		Evaluation	Evaluation criteria
1	Key outcomes for older people and key performance outcomes	<b>Good</b>	<b>Excellent</b> – outstanding, sector leading <b>Very good</b> – major strengths <b>Good</b> – important strengths with some areas for improvement <b>Adequate</b> – strengths just outweigh weaknesses <b>Weak</b> – important Weaknesses <b>Unsatisfactory</b> – major weaknesses
2	Getting the right help at the right time	<b>Adequate</b>	
3	Impact on staff	<b>Good</b>	
4	Impact on the community	<b>Adequate</b>	
5	Delivery of key processes	<b>Adequate</b>	
6	Strategic planning and plans to improve services	<b>Adequate</b>	
7	Management and support of staff	<b>Good</b>	
8	Partnership working	<b>Adequate</b>	
9	Leadership and direction	<b>Good</b>	

<b>Recommendations for improvement</b>	
<b>1</b>	The partnership, in conjunction with its parent bodies, should review and rationalise all plans relating to services for older people to ensure that these are consistent with the strategic commissioning plan.
<b>2</b>	The partnership should develop a dementia pathway which provides a clear and efficient process to allow older people to receive a timely diagnosis of dementia. Where post-diagnostic support is provided by a range of professionals, they should be provided with adequate guidance, training and support.
<b>3</b>	The partnership should ensure that all care at home and care home staff are trained in its medication procedures and that staff have the opportunity to discuss this as part of supervision arrangements. The partnership should also ensure that information and support on medication issues are provided to unpaid carers.
<b>4</b>	The partnership should put a clear plan in place, with timescales, to increase the care at home capacity available to older people across the Orkney Islands.
<b>5</b>	The partnership should take urgent action to implement the IJB's financial recovery plan to ensure that a sustainable financial position is achieved. In the event that the recovery plan is unable to achieve a break-even position by the year end, the partnership should work with parent bodies to implement an alternative course of action in line with the provisions contained within the Orkney Integration Scheme.
<b>6</b>	Given the increasing demand for its services, the partnership should review its eligibility criteria and resource allocation processes to ensure the most effective arrangements are in place to manage and prioritise its services and resources.
<b>7</b>	The partnership should take action to increase awareness for both carers and staff of the right of carers to be offered and have an assessment of their own needs. Staff should be given training that highlights the potential benefits for carers of having an assessment of their own needs as a carer.
<b>8</b>	<p>The partnership should work with the chief officers' group and the adult support and protection committee to ensure that risk assessments and risk management plans are completed where required. They should provide oversight and quality assurance of these processes.</p> <p>The partnership should also work with the chief officers' group and the adult support and protection committee to develop their governance and quality assurance roles. The partnership should produce an improved quality and range of management information to support them in these roles.</p>
<b>9</b>	The partnership should ensure that it has effective processes in place to analyse and make best use of consultation feedback from the community, including both internal and external reporting arrangements.
<b>10</b>	The partnership should ensure that it works closely with public health colleagues and make best use of epidemiological data to identify local health needs and to contribute to a reduction in health inequalities.

## 5. Summary

### Key messages

The Orkney Islands are projected to experience one of the biggest increases in Scotland in its elderly population (and especially in the population that is aged 75 and over). It is essential that the partnership plans effectively to meet the future needs of the local population. As well as future service provision, the partnership needs to focus on developing preventative approaches, the management of long-term conditions and the contribution that local communities can make to supporting older people.

The partnership was achieving good outcomes for many older people. Few experienced a delayed discharge from hospital and the partnership had reduced the length of hospital stays associated with delayed discharges. However, the partnership faced considerable pressure on some of its services, including its care at home service. The lack of availability of care at home was a factor for the small number of older people whose discharge from hospital was delayed.

Integration Joint Board members, senior managers and staff showed a good awareness of current and future challenges. They were embracing health and social care integration as an opportunity to make best use of the available resources. The completion of the joint strategic needs analysis and strategic commissioning plan provided a useful baseline and direction of travel. However, both required further work in order for a more detailed longer term strategic plan to be developed. The partnership was still in the early stages of its work to develop approaches to planning on a locality basis.

We found that older people and carers were positive about the support and services they received. Older people identified GPs as playing a pivotal role in helping them access appropriate treatment, care and support. A good number of older people had a positive experience of accessing and using self-directed support<sup>6</sup>. However, the partnership needed to improve the speed with which older people could receive a dementia diagnosis and then post-diagnostic support. It also needed to improve its response and approach to falls prevention and management.

Staff clearly focused on involving older people in discussions and decisions about what support and services they wanted to help them to achieve their personal identified outcomes. Our review of older people's health and social work records evidenced that positive outcomes were being achieved for older people. However, the partnership needed to do more to promote the value of carer assessments.

A relatively small number of older people in Orkney were subject to formal adult support and protection procedures. We found improvement was needed in how the partnership ensured high standards of practice were followed for older people at risk of abuse and in need of protection.

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<sup>6</sup> Self-directed support. The Social Care (Self-directed Support) (Scotland) Act 2013 places a duty on local authority social work departments to offer people who are entitled for social care a range of choices over how they receive their support.

There was a well-motivated workforce, and health and social work services staff worked well together. Delivering services across the Orkney Islands' dispersed landscape was a challenge, as was recruiting and retaining staff. The partnership had taken a number of proactive initiatives to address these challenges. It was piloting a new generic support worker role to explore more integrated ways of supporting older people. Almost all social care services were provided by Orkney Islands Council. The partnership needed to act to meet the growing demand on and by its own services, for example care at home, and needed to consider attracting independent and third sector service providers.

The partnership demonstrated positive commitment to engaging with and involving local communities. However, it needed to improve how it made use of the feedback it received from such activity. It also needed to improve the range and quality of its data collection so it could use this to make confident decisions about future service development.

### **Key outcome measures and performance data**

A review of the partnership's performance against national outcome or proxy outcome performance indicators showed that, for the majority of indicators, the partnership's performance was above or in line with the Scotland average. However, this data needs to be interpreted with caution, especially for a partnership like Orkney with a relative small population. For some indicators where the performance was either above or below the Scotland average, the level of difference was not necessarily statistically significant. We describe the partnership's key performance outcomes in detail (including the sources of the nationally reported data we analysed) and their context in section 7 of the report. Chart 1 below provides a snapshot view of this.

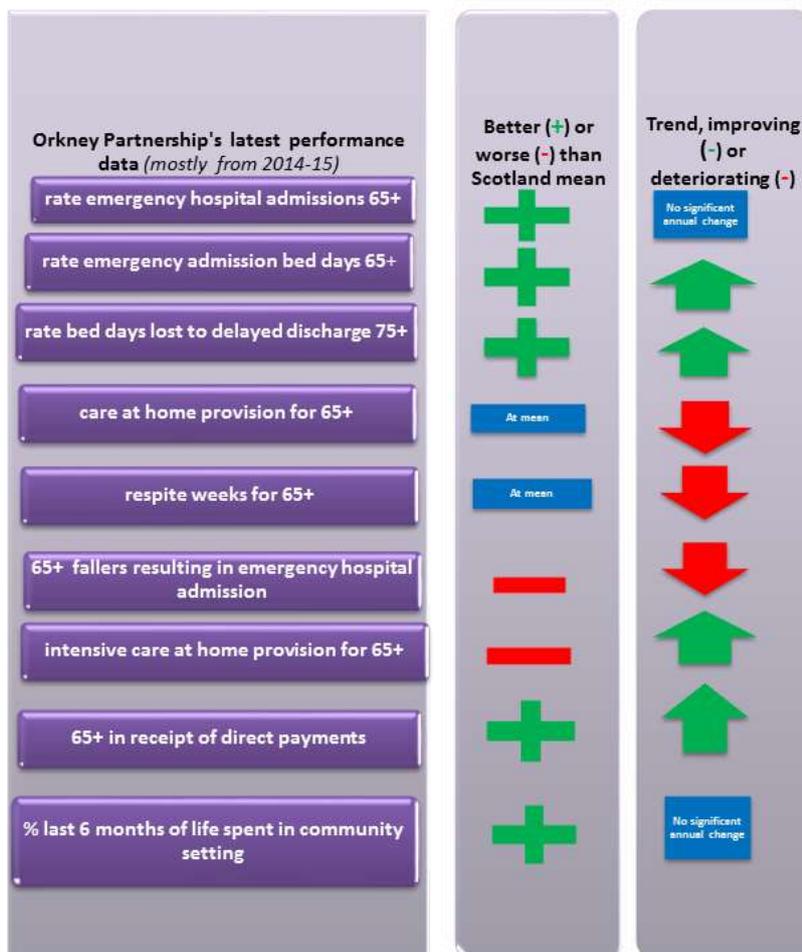


Chart 1 Orkney performance comparison summary

The findings from previous inspections of health and of social work services in Orkney have been mixed and have including comments about services struggling to manage necessary changes in a timely fashion. The limited size of the partnership’s workforce, especially the small number of staff who had a dedicated service planning role, had been and remained a challenge for the partnership’s capacity to deliver on a significant change and development agenda. In terms of this inspection, we have evaluated three of the nine quality indicators as good and six as adequate. Overall, given the historical context of health and social care provision in Orkney, we consider that the inspection findings are reasonably positive, notwithstanding the significant challenges the partnership faces moving forward.

We were impressed by the level of support provided to older people by community groups and organisations. We encourage the partnership to foster and make best use of this as it develops its locality working.

## 6. Leadership

We evaluated the leadership provided by the partnership as good. We found a good commitment to using health and social integration as an opportunity for health and social care services to move forward in partnership. The previous partnership arrangements had provided a good basis for this. The partnership had given detailed attention to setting up and developing the governance arrangements and structures to support integration. This said, and in line with other areas in Scotland, the partnership was still in a period of transition and needed to ensure that all of its planning and delivery of services were further developed on an integrated basis. The partnership had a well-established and collaborative joint working relationship with the third sector. It was still in the early stages of developing its approach to locality planning. The relatively small size of the partnership's workforce meant that it faces capacity challenges in delivering change. It needed to improve the quality and range of data on population needs and service outcomes so that it could make confident decisions about future service development. We found that Integration Joint Board (IJB) members and senior managers saw integration as an important means of overcoming these challenges and had started to develop integrated approaches to address them.

### Vision, values and culture across the partnership

NHS Orkney and Orkney Islands Council started to work together on a formal partnership basis in delivering health and social care services in 2010. This partnership arrangement was entitled Orkney Health and Care (OHAC). Its vision at that time was to make a real difference to the lives of the people living in Orkney by improving their health and social wellbeing, delivering high quality services closer to home. The health board and the council decided to maintain this vision, taking it forward into the new health and social care partnership. They also decided to maintain OHAC as the name for the new partnership in order to provide continuity and to consolidate how the partnership's vision was expressed and perceived. The vision sat alongside that of the Orkney Community Planning Partnership; "working together for a better Orkney". NHS Orkney had recently refreshed its vision and was aware of the need for this to become embedded alongside the IJB vision.

The partnership had used the new arrangements to consult and develop its strategic commissioning plan (2016–2019) and to refresh the vision. This plan clearly reflected national priorities, the key drivers for change and the direction of travel required.

There was awareness by the partnership of the requirement to meet the needs of people living in the outer isles and the challenges involved in this. There were examples of how the partnership had and was taking action to address these challenges.

Our staff survey findings in respect of vision and culture were positive, with 75% of respondents feeling valued by managers and 88% by other practitioners and partners. These findings were above the average for inspections to date. The IJB members we met had a good understanding of the vision and demonstrated a good commitment to working together.

Despite its general commitment to the outer isles, the partnership faced significant challenges in its capacity to meet the expressed needs of older people in remote and rural areas. It said that it was not always possible to provide equality of service provision across its geography.

### **Promotion of partnership working**

The partnership was now at a stage where it was acting increasingly as an integrated body and was adopting a joint strategic approach to service planning and delivery. Its approach to the strategic commissioning plan and the joint strategic needs analysis were good examples of this. They both demonstrated a clear commitment to a joined up approach to the health and social care needs of older people.

Most staff said that OHAC had provided a good foundation for moving into health and social care integration. This said, the partnership was still in the process of addressing the necessary transition to meet the requirements of the new national health and social care partnership arrangements. It was still having to address and manage a situation where a number of its priorities, planning and delivery of services were still single agency (health or social care), rather than jointly based.

### **Recommendation for improvement 1**

The partnership, in conjunction with its parent bodies, should review and rationalise all plans relating to services for older people to ensure that these are consistent with the strategic commissioning plan.

In the position statement<sup>7</sup> submitted by the partnership, it identified its working relationship with the third sector as a strength. Our contact with the sector during this inspection confirmed this was largely the case. Previous inspections had highlighted some problems in the partnership working between NHS Orkney and Orkney Islands Council. However, during our inspection, we found a strong commitment to moving forward as a partnership and generally good joint working relationships at all levels. We met with the partnership's chief officer on a number of occasions. Based on comments from IJB members, managers, and staff and from our own observations, it was clear that the chief officer was very well regarded by both social work and healthcare staff. The chief officer had previously been the chief social work officer and impressed as a positive and unifying force within the partnership and in its relationship with partners.

The partnership was committed to and had actively been seeking to involve older people and carers in its service planning and development arrangements. Despite this commitment, its efforts had not always been successful, especially in involving

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<sup>7</sup> Position statement. The partnership provided a position statement as part of the documentation it provided as part of the inspection. In the position statement the partnership described how well it considered it was performing against the inspection quality indicators.

older people from harder to reach groups. It needed to continue looking at new and imaginative ways to maximise involvement.

The partnership had developed some joint outcome measures and shared reporting arrangements. Examples included the performance framework prepared in support of the strategic commissioning plan and the local improvement and co-production plan. These both included a suite of broad, jointly agreed outcome measures and reporting arrangements on areas such as person-centred care and unscheduled care. However, the partnership was still at the early stages of agreeing and reporting on detailed shared outcome measures with a specific focus on its services for older people.

We found commitment to and evidence of a joint and collaborative approach between health and social work services staff and managers in the partnership. Positively, this extended beyond the key statutory agencies.

A good example of this was how the strategic planning group was taking an inclusive approach to how it carried out its pivotal role. The strategic commissioning plan provided a good high-level basis for future service provision and how it would maximise integrated approaches. The plan also demonstrated a good understanding of the key drivers for change. The completion of a joint strategic needs analysis provided useful baseline data in support of Orkney's strategic context.

However, as with other partnerships in Scotland, further work was needed to build on the initial information provided by the joint strategic needs analysis. The partnership needed to improve the quality and range of its data so detailed action plans can be developed to support the high-level objectives contained in the strategic commissioning plan. We noted that the partnership had established a data and information sub group of the IJB to take forward work in this area.

## **Governance**

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) (Scotland) Act 2014<sup>8</sup> 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 health care service is complying with the integration delivery principles.

Both NHS Orkney and Orkney Islands Council had initially favoured and proposed a lead agency model. However, they were unable to reach agreement on which organisation would act as the lead agency. In the absence of such agreement, both parties then decided in February 2015 to go forward with the body corporate model. The Orkney Integration Scheme was then submitted for approval to the Scottish Government in March 2015 and was approved, which was agreed further to making some minor amendments shortly afterwards.

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<sup>8</sup> Section 31 of the Public Bodies (Joint Working) (Scotland) Act 2014 states in summary: high quality integrated, effective, efficient, and preventative services should improve service users' wellbeing, take account of their particular needs and characteristics, where they live (locality), their rights and dignity, keep them safe, involve them and engage with their communities.

All primary care and social work services were included in those delegated within the scheme of integration, as were all children's health and social work services, and criminal justice services. Acute health services were not included. The partnership provided a range of documentation which showed that it had given detailed attention to the structures and governance arrangements to support integration. It was assisted in this by its established history of joint working between statutory health and social work partners and with the third sector. It was aware of and committed to the need for further development including its relationship and decision making processes with its two parent bodies, NHS Orkney and Orkney Islands Council. The chief officer for the partnership was appointed in July 2015 and the shadow integration joint board had been meeting on a monthly basis since October 2015.

## 7. Outcomes and experiences

We evaluated the partnership's performance in the outcomes and experiences it achieved for older people as good. Its performance based on a review against national outcome or proxy outcome performance indicators was better or line with the Scotland average for the majority of indicators. Few older people experienced having their discharge from hospital delayed, but for some of those that did, the delays could be significant. The partnership had managed to reduce the amount of bed days lost to delayed discharge. It admitted fewer older people to hospital in an emergency than the Scotland average, but it performed less well for these admissions when older people had fallen. A high number of older people were benefitting from telecare support and the partnership was performing well in the number of older people in receipt of self-directed support, including direct payments. The partnership's balance of care in terms of social care provision was improving. However, it was struggling to meet the increasing demand for care at home provision. Our review of health and social work services records showed that the partnership delivered positive desired outcomes for almost all older people in the sample. We met a number of older people with very significant level of needs who were being supported to remain at home. The partnership needed to improve how it was able to collect and aggregate detail on outcomes for older people and carers and use this for service improvement purposes.

### Improvements in partnership performance in both healthcare and social care

There were relatively few instances when an older person, medically fit for discharge, had their discharge from hospital delayed. The partnership had relatively few older people in a month who required a package of social care to enable them to be discharged from hospital. In the period April 2015 to June 2016, the partnership's performance on meeting the Scottish Government target of no delays over two weeks duration, was an average of one delay each month that breached this target. However, low numbers of delayed discharges do not mean that the impact for the individual older people involved and for their families are not significant. We met a few older people and their families where there had been a significant delay. It was clear that this had been a negative experience for them. The partnership was aware that it needed to continue trying to minimise the number of older people whose discharge from hospital was delayed.

Positively, the partnership had achieved a reduction in the number of beds days lost to delays with the average loss dropping from nearly 60 days in April 2015 to nearer 40 days by March 2016. The partnership performed better than the Scotland average on bed days lost to delays.

The partnership admitted fewer older people to hospital on an emergency basis than the Scotland average. There were also related positive trends of less repeat admissions of older people to hospital and of rates of bed-day usage for emergency admissions and repeat emergency admissions that were lower than the Scotland average.

Orkney emergency admissions of older people (source Information Services Division)

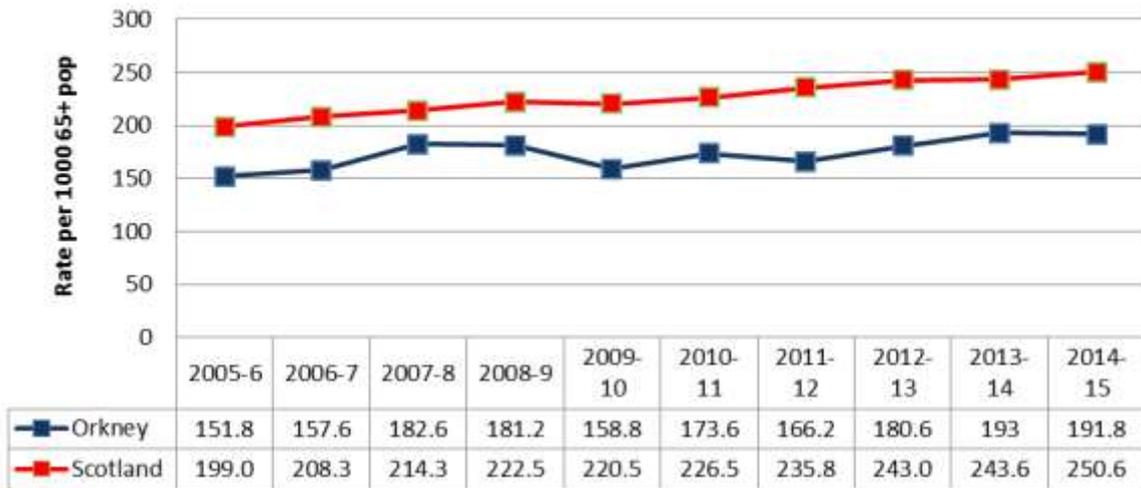


Chart 2

The partnership also performed relatively well on preventing older people experiencing an avoidable episode of unscheduled acute care. Some older people who were acutely unwell had to be transported to Aberdeen for emergency treatment. We met some older people who had experienced this. They praised the care and efficiency of the patient transfer service and the spoke positively of the quality of treatment and care they received in Aberdeen Royal Infirmary.

Care at home plays a key role as a service in supporting older people to remain at home and in facilitating their discharge from hospital. Orkney Islands Council was the sole provider of care at home support. The partnership delivered care at home and intensive care at home (10 hours plus) at the level around the Scotland average. However, the partnership was not able to provide enough care at home to meet the demand from older people. The partnership acknowledged this. Partnership staff and third sector staff told us about a number of instances where older people had to wait for the care at home service that they needed. The problem was particularly acute for individuals who required two care at home workers to support them, generally people who required two staff to help them to transfer move from one position to another. The partnership had had to purchase care at home services from an agency that did not normally operate in Orkney. This provided a few individuals with the care at home service they needed to facilitate their discharge from hospital, after a prolonged stay in an acute bed.

The intermediate care team successfully carried out reablement with older people after they were discharged from hospital. Older people who had had a reablement episode were supported to regain their confidence and ability to do as much as possible for themselves. This helped to remove or reduce their future dependency on care at home services. The intermediate care team also supported older people to prevent their admission to hospital. This meant their health and social care needs were appropriately met at home. The partnership's care at home staff had received reablement training and managers described the service as having a 'reablement ethos'. However, due to capacity issues, this service was not realistically able to carry out reablement with older people.

The partnership placed fewer older people permanently in care homes than the Scotland average. Over the last two years, the balance of care for older people was shifting in a positive direction (a higher percentage of older people were being supported to live at home).

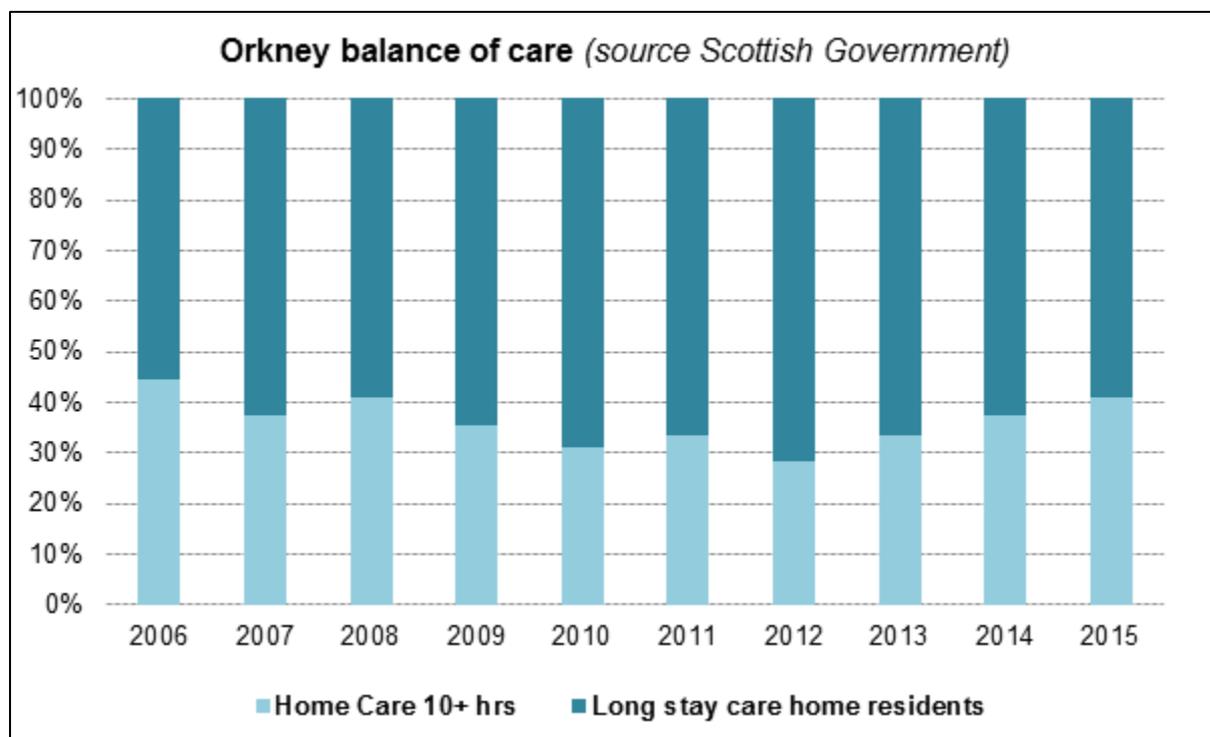


Chart 3

The partnership had established an intermediate care bed in Smiddybrae care home in Dounby. GPs provided the medical cover for this bed. Staff said that this facility enabled older people to be discharged from hospital and prevented admissions to hospital. One of the partnership's objectives was to expand its intermediate care capacity and this was linked to the building which would include some intermediate care beds.

Overall, care services for older people regulated by the Care Inspectorate delivered good outcomes for the individuals who used and depended upon them. Most of these services had been graded as good or very good for the quality of support they provided in their most recent inspections by the Care Inspectorate. We met with older people who strongly praised the caring and competent care at home staff who looked after them.

The partnership delivered compassionate and effective support to older people at the end of their lives or who had palliative care needs. Health and social care staff worked alongside Macmillan nurses to provide support to individuals and their carers. Families and other staff told us about how palliative care staff gave sensitive, considerate and compassionate care to older people who had reached the final stage of their lives. In 2014–2015, the partnership was in the top quarter (rank 4 out of 32) for the percentage of time (89.4%) individuals spent at home or in a community setting in the last six months of their lives.

The Orkney Heart Support Group delivered very good support to older people who had chronic cardiovascular disease. It provided an impressive range of community support to help individuals manage their condition and enjoy as full and active a life as possible. We met with representatives from this group and they all praised the excellent support that the partnership's cardiac nurse gave to individuals. The group has been campaigning actively for the creation of an additional cardiac nurse post.

The partnership also had specialist nurses for diabetes, neurology and a newly appointed dementia specialist nurse. These staff members worked coherently across primary, secondary and tertiary care. They linked to multi-agency teams to support people to manage their long-term conditions and deliver good outcomes for individuals with these long-term health conditions.

The partnership admitted a greater proportion older people who had fallen to hospital as an emergency than the Scotland average. Falls risk assessments were not always carried out on older people at risk of falling. When falls risk assessments were carried out, they were not always shared amongst all relevant staff.

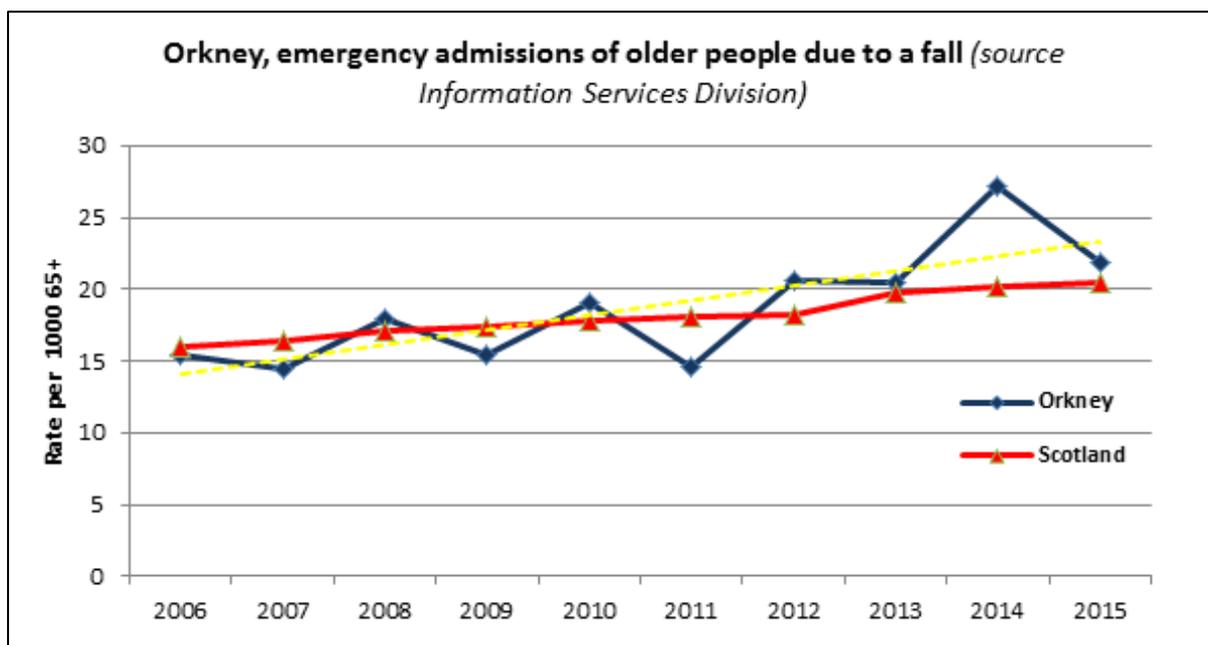


Chart 4

The partnership delivered respite for older people at a level close to the Scotland average. In 2014/15, the partnership delivered 510 respite weeks for older people. This was equivalent to 108 weeks per 1,000 population aged 65 and over compared to the Scotland figure of 109 weeks.

The partnership delivered telecare at a level above the Scotland average. There had been a significant investment to increase the use of telecare. As of March 2015, 730 people were receiving a community alarm or another telecare service supported by Orkney council. This was equal to 154.8 per 1,000 population. The Scotland figure was 126.7 per 1,000 population. Of the 730 people who were receiving a community alarm or another telecare service, 86% (630) were aged over 65 years

old. Information provided by the partnership showed that the number of people using these services had continued to increase to 770 by 2016. Our review of health and social work services records showed 43% had some form of telecare such as community alarms, falls sensors, bed and door alarms, and electronic medication dispensers. Older people we met who used telecare said it gave them increased confidence within their own homes and about receiving prompt help if they needed it.

There were more older people in Orkney than the Scotland average in receipt of direct payments. Individuals we met said direct payments gave them choice and control over the services they had arranged. They said that direct payments were relatively easy to secure and to administer. At the time of our inspection, 63 individuals received direct payments with 134 individuals in total in receipt of self-directed support.

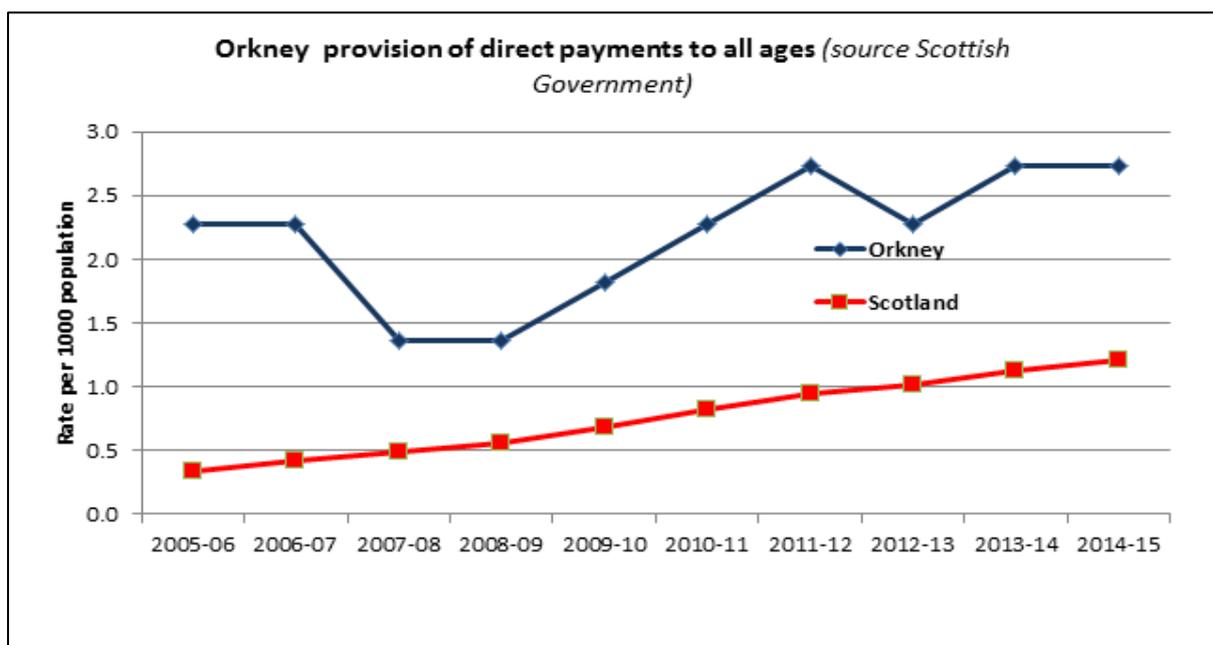


Chart 5

### Improvements in outcomes for individuals and carers in health, wellbeing, and quality of life

Our review of health and social work services records revealed that the partnership delivered positive desired outcomes for almost all individuals in the sample (98%). As a result of the partnership's support, older people were safer, healthier, able to live independently at home and had enhanced wellbeing. The partnership supported a number of older people with multiple long-term medical conditions and extensive social care needs.

Many older people, carers and staff alluded to the resilience of Orcadians and the supportive character of local communities. We met some older people with complex medical conditions and high support needs who were able to remain living independently at home. This was in line with their choice and that of their families. The majority of older people and their carers we met described having positive outcomes as a result of the care, treatment and support provided by the partnership.

They reported such outcomes in respect of keeping as well as possible, living independently at home, and enhancing their wellbeing.

The partnership generated some aggregate data to measure outcomes that it delivered for older people and their carers. However, the quality of the data we saw was variable, as was the extent to which it actually focused on personal outcomes, rather than proxy indicators. A proportion of the statistical data submitted was out of date. We saw some evidence of activity to measure achievement of the national health and wellbeing outcomes, but this was limited. In its position statement, the partnership acknowledged the need to further develop the ability of its IT systems to extract performance and outcome data. This was a challenge for the partnership given evolving national expectations around data suites and data collection and its limited resources to develop systems to keep up with changing demands.

## **8. Providing the right help at the right time**

We evaluated how the partnership provided the right help at the right time to older people as good. Older people and carers knew how to access services when they needed them and who to contact if their needs changed. Most were positive about the support they had received, including those who had accessed self-directed support. They spoke positively about their experience of a number of services, including the mobile community responder service, the Selbro equipment store, palliative care services and the Red Cross House which provided a form of intermediate care. Travelling to community and statutory services could be a problem for older people. Older people who fell did not always get a co-ordinated response. Older people also had to wait for some time before being provided with a dementia diagnosis and post-diagnostic support. The partnership had made some good progress in the completion of anticipatory care plans, but needed to develop how these were made best use of. Older people who received care at home, reablement and intermediate care support received good quality services, but it was not uncommon for older people to have to wait to receive these services when they needed them. Community groups and third sector organisations provided a range of supports which were well regarded by older people and carers. The partnership needed to improve the consistency with which it collated and made productive use of feedback from older people and carers about their experiences of its services.

### **Access to information**

A range of information was available to older people to help them access services and support. The IJB's website met accessibility standards and recent initiatives taken by the partnership had included a blog and Facebook page.

The Orkney third sector services directory provided information on support organisations and activities across the Orkney Islands. Examples of these were:

- the Orkney Heart Support Group distributed leaflets in supermarkets to raise awareness of its profile
- The Blide Trust provided support to people facing mental health difficulties and produced a regular newsletter.

The partnership had a single point of referral arrangement in place. This was supplemented by the OHAC helpdesk which provided information to the public on how to access services.

There was a relatively high uptake of self-directed support in Orkney. Those older people and their families we met who were in receipt of self-directed support options said that they had been provided with good information about what these entailed and how to access them. They said their discussions with staff had been informative.

### **Experience of individuals and carers**

We met with approximately 40 older people and carers during the inspection. We did not meet with as many older people as we would have wished to. This was partly because some older peoples' groups we would have attended did not meet during the time of our on-site scrutiny activity.

Overall, older people were appreciative of the supports and services they received. This was reflected in the older people's records we read, where we found that a high proportion of the assessments had taken account of the older person's choices. The majority of older people we met said the services they received provided them with good outcomes.

Positively, we found that older people and carers knew how to access services and who to contact if their circumstances changed significantly. Most older people had their needs assessed and services provided in a timely fashion. Exceptions to this were dementia diagnosis and the provision of a care at home service in some instances for older people. The partnership had demonstrated a commitment to using video conferencing to allow older people to have medical consultations rather than having to travel from the outer isles to Kirkwall, or from Orkney to mainland Scotland.

We met a number of older people and their carers who were in receipt of self-directed support. This was normally in the form of a direct payment. They described how this had enabled them to employ a small and consistent group of carers who were able to provide support in flexible ways and at times which best suited their needs and wishes. They described examples of how the support provided had allowed them to maintain important social interests. For example:

- one older person had been able to be present and play an active part in their son's wedding
- another older person and their spouse had been able to enjoy occasional rides in a horse and carriage on a nearby beach which had been a favourite pastime when they were younger
- one carer had been able to have some time on their own to go swimming.

We received information and met with staff from a number of services regarded by staff, older people and carers as good and valued services. These included the Selbro joint equipment store. This was located in Kirkwall and provided a similar range of services to other joint equipment stores. However, in addition it acted as the base for the care and repair service one day per each week. Most older people and their families we met had involvement with the store. They all described in extremely positive terms the efficient and speedy manner in which items were provided, and the flexible and responsive nature of staff. One significantly disabled older person described how there was no ramp at their son's house. The store loaned them a ramp so that they could visit their son's house and then told them "just to keep it". They said the store provided "a super service where they felt known and welcome." We carried out our review of health and social work services records exercise in a room attached to the store and observed the welcoming manner in which members of the public were greeted by staff.

A number of older people and carers we met raised problems associated with having to travel to access supports and services. The partnership's investment and development in video-conferencing for consultations was designed to address this. Although not suitable for all instances, feedback we heard from older people indicated that this arrangement was working to their benefit. The Island Network of Care also provided a mechanism and forum where staff were able to share

knowledge and expertise to minimise travel where this was a cause of anxiety for an older person. For some older people, the Dial-a-Bus service provided a useful source of transport to enable them to attend community activities and events. However, they said that a cut in local authority funding for Dial-a-Bus had resulted in a reduced service. The partnership advised that Dial-a-Bus had been providing a service beyond its contract. For example, it had provided some hospital transport in circumstances where this should have been done by the Scottish Ambulance Service. Orkney Islands Council and OHAC were carrying out a review of community transport. We considered it important that the review included a focus on the importance of transport in maintaining older people's health and wellbeing.

### **Example of good practice – The Orkney Community Mobile Responder Service**

This provided 24 hours a day, seven days a week community mobile responder service on the Orkney mainland. In addition to providing the standard initial response to community alarm call outs, the team also provided extended support in response to emergencies. This enabled older people to remain safely at home until an enhanced and planned package of care was put in place. Examples included working alongside the intermediate care team, acting as double up with the care at home service when a service user was less well, or providing further check visits to allay the anxiety of a service user or family member. One older person we met described how this extended input from the responder service had helped avoid a hospital admission. They described the responder staff concerned as “magnificent”.

### **Carers**

A number of carers we met received ongoing support from Crossroads, including attending a carer support group. A number also received support from Crossroads in carrying out their role as employers, for example in managing the payroll of the carers they employed. They all said the organisation carried out this role in a very efficient and helpful manner. Asked about the support they received they said we should “raise a flag for Crossroads”.

Carers described mixed views about respite provision and their experience, (and the experience of the older person they cared for) of this. Some described some problems in trying to arrange respite on a rolling, planned basis. A small number described a very poor experience with the supports needs of the older person not being adequately planned for or met. However, most were positive about the respite provided. We visited the respite service on Westray and were impressed by the quality of its respite provision. The older people and carers we met who used the service spoke very positively about it.

We found a variable picture in terms of the extent to which the partnership had systems in place to gather feedback from older people and carers of their experiences of using health and social care services. The partnership had a well-established history of using the Talking Points framework to engage with people who used social work services to discuss their needs and to obtain feedback on the services they received. However, as the partnership acknowledged, there were

limitations to the levels and quality of information that could be extracted from this and other systems in use. This included their ability to generate aggregated data on personal outcomes and unmet needs.

Respite provision was an example of where we saw evidence of services obtaining feedback from older people. Survey returns we saw showed a service which was valued by older people. However, not all the survey forms we saw were dated, so it was not clear how recent this feedback was. Other services which had feedback mechanisms were telecare, community nursing and the hospital's inpatient experience survey. However, we did not see information confirming the levels of response to these surveys or of how feedback was used to inform practice or service development.

### **Prevention, early intervention and the intervention at the right time**

The partnership worked jointly with the public health department to deliver a range of preventative and early intervention services, for example smoking cessation and physical activity programmes. NHS Orkney's public health annual report contained information on a number of these activities, most which related to adults in general, rather than older people specifically. An exception was *Campylobacter* where eating improperly prepared and cooked food can have particularly severe effects for older people. There had been an increase in cases in Orkney in the preceding years and the public health department was working closely with colleagues in environmental health to increase public awareness on how to avoid food associated disease.

Some older people we met who lived in care homes or attended a day care service participated in group physical exercise activities. They told us they enjoyed them and found them beneficial. However, we saw less evidence of older people being involved in more community-based preventative services of this nature. Staff told us that funding had been available a few years previously to enable people to be transferred from the falls service into exercise classes and use of the sports centre in Kirkwall, but this had not been continued.

More positively, there had been a drive in recent years to promote home exercise. Volunteers had been trained to deliver programmes, including on the outer isles, with three visits taking place on each island over the 8–10 week period of the programme. Identifying suitable community premises for this activity could be problematic, although on some islands they were able to use funding from the local development trust to meet the costs of hiring a hall. The falls team told us they thought a greater availability of more exercise-based programmes in the community would benefit older people's health and wellbeing as well as preventing the need of referrals to services such as their own.

From our discussions with older people, it was clear that a broad range of local community groups provided a considerable source of support to them and their families. They said this support played an important role in maintaining their independence. We met some older people with very significant levels of needs, but who were determined to carry on living at home with minimal reliance on health and social care services.

The partnership was one of the areas working with the national development team to pilot a national anticipatory care planning model that linked electronically to Ekis (Electronic Key Information Summaries). Its initial focus on anticipatory care planning had been on supporting end-of-life care.

Anticipatory care plans support prevention, early identification and intervention at the right time. The partnership had made some good progress with the development of anticipatory care plans for older people. During our review of older people's records, we saw some comprehensive anticipatory care plans completed by community nurses. These were highly useful documents which enabled older people and their carers to set out their wishes and preferences if their health deteriorated or their circumstances changed in other significant ways.

We also saw a few anticipatory care plans completed by GP. These tended to be lists of people's health conditions and medication. Further development of anticipatory care plans was required. However, some GPs and community nurses told us they were now feeling more confident about "having difficult conversations" with older people and their families to help identify and record their future wishes and care preferences.

We found a mixed picture in terms of how well information contained in anticipatory care plans was shared. A number of staff we met at various levels were unclear about what arrangements were, or should be, in place for sharing information contained in these plans. However, for older people in care homes, staff described how anticipatory care plans were used to good effect to prevent unnecessary transfers to hospital.

The number of older people with an anticipatory care plan was increasing and the circumstances in which one was being completed was extending. However, we did not have an opportunity to get direct feedback from older people themselves and their carers about the benefits of having an anticipatory care plan. This was mainly due to the initial focus of anticipatory care plan for people at the end of their life, and given the relatively small number of older people we met for an individual discussion as part of the inspection.

Older people and their carers were able to benefit from good quality palliative care services. The Macmillan nursing service was based in Kirkwall and, from comments we heard from families and from OHAC staff, it was evidently highly regarded. The Macmillan nurses worked closely with staff in other services, such as community nurses and occupational therapists. This meant that, unlike some other service areas, the partnership was able to provide end-of-life care and support across the islands. This allowed older people to have a choice in where they received their care. The Macmillan service and community nurses also worked closely with staff in care homes, visiting on a regular basis to support staff in their care for older people approaching the end of life.

They provided similar support to care at home staff where the older person was in their own home and made sure the appropriate medication, advice and equipment was available. Medicines and equipment were supplied by the Macmillan unit and then distributed from there in a timely and efficient manner.

## **Example of good practice – Palliative and end-of-life care provision**

The Macmillan nursing service worked very closely with other professionals and with families to make sure that high-quality end-of-life care was provided across the Orkney Islands in a way which respected the wishes and choices of older people. The service was widely regarded by families and staff.

## **Self-management and the management of long-term conditions**

One of the key actions contained in the strategic commissioning plan was for the partnership to provide technology-led care to improve self-management, especially for patients with long-term conditions and to support the repatriation of services from the Scottish mainland. The partnership was also mindful of the need to consider the provision of 'realistic medicine' as outlined by the Scottish Government's Chief Medical Officer's annual report for 2015 and the need to avoid over-treatment.<sup>9</sup>

Older people with cardiac problems, including having had a heart attack, described the positive treatment and support they received. A 12-week rehabilitation programme following a coronary event was delivered by the cardiac nurse with support from occupational therapy and physiotherapy services. Consultant cardiologists in Aberdeen ran video-conferencing consultations. We met with members of the Orkney Heart Support Group who said this was a helpful way of receiving follow-up monitoring. The group had 75 members aged from 40–93 years. They said that "the cardiac nurse does a magnificent job" and that "The support from the third sector for cardiac patients is absolutely brilliant". The partnership had plans in place to have a lead GP for cardiac conditions to strengthen local cardiac support and co-ordination.

## **Dementia**

Older people faced difficulties in obtaining a timely diagnosis of dementia and the partnership performed below the Scottish average on dementia diagnosis. Both carers and staff indicated that obtaining a diagnosis, where the involvement of a consultant psychiatrist was required, was often a lengthy process. The average timescale was about 10 months. Some older people and carers described this as being distressing and had caused some to disengage from the process. This could result in a lost opportunity to receive support.

We found there was no clear referral pathway in place for dementia diagnosis. Where diagnosis was thought straightforward, some GPs, but only a few, were making a diagnosis. The partnership had purchased a computerised tomography (CT) scanner for Balfour Hospital. This could be used where imaging was required for diagnostic purposes and removed the need for patients travelling to Aberdeen. However, some staff and families we met questioned whether the best use was being made of this resource. GPs were unable to access the scanner without going through a consultant psychiatrist, but this line of communication could be

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<sup>9</sup> The Chief Medical Officer's Annual Report 2014-15 – Realistic Medicine. Dr Catherine Calderwood

complicated by the lack of a consultant geriatric psychiatrist on the island. Often, the partnership needed to rely on the use of locum consultant psychiatrists instead. We were told that this could impact on the timescales for CT scans being completed and in results being fed back to families.

The partnership's ability to provide post-diagnostic support was impacted upon by the capacity of the community mental health team. There was only one dedicated social work support worker for post-diagnostic support, a support worker for carers and community psychiatric nurses working within the older people's team. We heard some positive feedback from older people and families about this staff group, but this was coupled by frustration and concern about the team's capacity to respond to the level of demand. This position was replicated for older people with other mental health needs. An important exception was where the involvement of a mental health officer was required to fulfil statutory obligations. This work was prioritised and the partnership was generally able to fulfil its responsibilities in a timely manner.

The partnership acknowledged that the number of people diagnosed with dementia fell short of its projected target based on national expectation. To address this, a working group has been set up to establish a clear pathway for people with dementia. It has also recently recruited a clinical nurse specialist for dementia. Part of their role would be to more clearly define the role of the post-diagnostic support worker and extend delivery of this support to older people in care homes and across the community. The clinical nurse specialist was also to be heavily involved in developing the local pathway for delivery of post-diagnostic support, and in providing training in the Promoting Excellence Framework<sup>10</sup> to all staff delivering this support.

The partnership was also well aware of the pressure on the community mental health team. However, it highlighted the expansion of the team, which had almost doubled in size, in recent years. Further to recent review, additional posts were also being advertised. The team was also now providing psychological therapies.

## **Recommendation for improvement 2**

The partnership should develop a dementia pathway which provides a clear and efficient process to allow older people to receive a timely diagnosis of dementia. Where post-diagnostic support is provided by a range of professionals, they should be provided with adequate guidance, training and support.

## **Falls prevention and management**

We found a varied picture on the partnership's approach to falls prevention and management and how this impacted on older people and their carers. In its position statement, the partnership recognised the need for further work in this area.

In our review of health and social work services records, 11% of older people were receiving support for falls. Most of the relevant records included falls risk assessments and plans to manage the risk of falls. The majority were of a good or

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<sup>10</sup> Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers - The Scottish Government 2011

adequate standard, but some needed to be updated. Not all were clear about how the risk of falls was to be managed or mitigated.

The partnership had carried out work to ensure an appropriate response to falls. This placed the response to falls primarily through the community responder service, rather than by an immediate request for community nursing attendance. A falls pathway was in place designed to make sure a fall automatically triggered a referral to the multidisciplinary falls prevention service.

We found that how older people would access falls support and the quality of this was variable. Where an older person was a hospital inpatient or day patient, the route to access falls prevention and management services was well defined. However, it was less clear for older people in the community, as was how the falls team could support other staff working with older people in the community. Our meetings with older people, carers and staff confirmed the findings from our review of health and social work services records that the sharing of information on falls risk assessments and how to manage this risk was not taking place as consistently and as often as it should have been.

Older people who had accessed the falls service described it as having been beneficial. There was evidence of older people using falls monitoring and having support on the outer isles from community nursing staff. However, this was not consistently the case. Similarly, access to a falls prevention programme was patchy. No overarching plan to underpin falls prevention and to make best use of community services across Orkney was in place.

To address the relatively high instances of older people being routinely taken to hospital by the Scottish Ambulance Service, the partnership had developed an approach, 'Right Call for a Fall'. This was designed to ensure the most appropriate and proportionate response to falls. At the time of our inspection, the partnership was in the process of securing the agreement of partners to this approach, including the Scottish Ambulance Service.

The falls strategy was dated 2010 and needed to be updated. We met with the falls strategy group who were carrying out this work. They were enthusiastic about their desire to revise the strategy as it would support more consistent and improved outcomes for older people who had fallen.

The partnership had been taking action to improve pharmacy provision and medication management for older people. We met with pharmacists who described how services for older people had developed over the previous two years. This now included medicine reconciliation with the care homes and the provision of policies and procedures for care homes, supported living and care at home services.

Some other changes were still being implemented or were in the process of transition. It was clear from some older people, carers and staff groups we met that this was causing them some anxiety. Historically, there had been considerable use of medication compliance devices (dosette boxes), particularly on the islands. Pharmacists told us this could result in unnecessary dependency by older people as

medication could be provided on an ongoing basis without adequate assessment or review.

To address this, medication administration record sheets (MARs) had been introduced to accompany medicines which required to be checked and the medication dispensed to be recorded. Some carers and care at home staff we met expressed some concern about the new arrangements. Some care at home staff said they were not confident about their responsibilities for using the medication administration sheets, particularly when they were providing care to older people whose medication regime they were not familiar with. Some carers were also concerned about the amount of medication that was stored in an older person's home as a result. Care at home managers had addressed this and medication safes were being used when required.

The partnership had provided a range of training to support the introduction of the medication administration sheets. This included holding training sessions that unpaid carers could attend. Pharmacy staff advised that these carers had been informed about the training by letter and by a leaflet. However, unpaid carers we met seemed unaware of the training, and pharmacy staff were unaware of the extent to which carers had taken up the training. This suggested the partnership should continue to be mindful of the need to provide information and support to unpaid carers on medication issues.

### **Recommendation for improvement 3**

The partnership should ensure that all care at home and care home staff are trained in its medication procedures and that staff have the opportunity to discuss this as part of supervision arrangements. The partnership should also ensure that information and support on medication issues are provided to unpaid carers.

The medication administration sheets could be used as a trigger for polypharmacy<sup>11</sup> reviews for older people. However, this was dependent on individual cases being highlighted by a pharmacist. Despite the improved provision over recent years, the availability of pharmacy input was still limited. For example, when we visited Westray, frontline staff told us that only one scheduled visit by a pharmacist took place each year.

### **Reablement and intermediate care**

The partnership had a well-established intermediate care team providing reablement. We read a robust audit and review of the team's activity during the period from December 2014 to February 2015. This focused on 36 older people discharged from hospital to the intermediate care team. This found that 33 older people were successfully rehabilitated to normal levels of independence in their own homes. The remaining three older people had to be re-admitted to hospital during this period. Although this audit was now over a year old, comments from older people who had

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<sup>11</sup> Polypharmacy – the use of multiple medications

been involved with the service and from other staff groups indicated that the intermediate care team was still providing an effective and well-regarded service.

However, there were some limitations to the service. It was not available to people on the outer isles, and pressure on the mainstream care at home service could mean the team had to continue their input beyond the time when the person's rehabilitation goals had been achieved. This in turn could impact on the team's capacity to pick up new referrals. The partnership told us the team was able to work with other staff to support a reablement approach in other situations and team members described a few examples where this had happened. However, this seemed sporadic and, again, was limited by capacity issues. Care at home managers said that this was partly because their previously close, joint working relationship with the intermediate care team had weakened due to the workload pressure on the care at home service.

The care at home workforce had been trained in the 'reablement ethos'. However, care at home staff and managers said opportunities to provide this were minimal given the level of demand on the service. Older people who received care at home were generally very positive about the care and support they received. "I don't know what I would do without my care at home workers" was an example of the comments we received. However, older people (and their families) who had to wait to receive a service or an increase in service, for example when there was a need for two staff to be present, could experience significant frustration. Care at home is a key service in supporting older people to remain at home and we made a recommendation about this in section 9 of this report.

In that section, we also referred to the pilot intermediate bed (step-up/step-down<sup>12</sup> bed) in the care home at Dounby. GPs were able to refer patients to this as an alternative to hospital admission. Initially, this was only available to older people who were patients of the Dounby GP practice. The close relationship between these GPs, their patients and with the care home staff was seen as a positive feature. We did not meet any older people who had been involved in the pilot. However, GPs and staff we met were able to describe how it had prevented a number of hospital admissions or facilitated discharge from hospital. Access to the bed was being opened up to other GP practices.

Intermediate care was also provided at the Red Cross House in Kirkwall. This was used when older people were discharged from hospital, but they could benefit from a short period of rehabilitation. Additionally, where there were issues around transportation, this accommodation was able to be used. As well as the older people themselves, it could also accommodate their relatives. The house was provided by Orkney Housing Association using a six-week residency agreement. Support to the older people was provided by the intermediate care team and associated healthcare professionals. The local GP practice provided temporary primary care support. Staff who worked with older people who had stayed at the house said it was a very useful resource, including for people from the outer isles where it facilitated a smooth discharge and transition from hospital back home. We visited the house and met older people staying there at the time. They spoke very positively about the

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<sup>12</sup> Step-up care aims to avoid unnecessary hospital admissions and step-down care aims to support early supported discharge.

experience. One said “This place has been fantastic; I can’t tell you how grateful we are”.

### **Example of good practice – The Red Cross House**

In partnership with Orkney Health and Care and with Orkney Housing Association Limited, the Red Cross provided an extra care supported living resource in Kirkwall offering additional support to older people and their families when further reablement was required and to facilitate hospital discharge. This service was highly regarded by staff and older people.

## 9. Strategic planning

We evaluated the partnership's approach and delivery of strategic planning as adequate. The partnership had completed a joint strategic needs analysis, which supported the development of its strategic commissioning plan. The strategic commissioning plan is vital to ensure a robust approach is taken in medium and longer term planning. The partnership needed to ensure that all of its current approaches to service delivery and development were consistent with the strategic commissioning plan objectives. Some positive actions had been taken to develop a range of preventative services. However, some of these services, such as care at home, were not always available to older people when they needed them. Given the projected significant increase in Orkney's elderly population, the partnership needed to take effective strategic action to develop its service capacity and range. The building of a new hospital and healthcare facility in Kirkwall and two new replacement care homes represented significant investment by the partnership in new provision. Funding had been identified for the additional staffing required for the new care homes. The chosen model of care, small group living, needed to be further defined and developed. It demonstrated an inclusive approach to involving people who used services, carers and partner agencies in its service planning activity, but did not always achieve the level of involvement it had hoped to.

### Strategic plan

The partnership had consulted upon and published a strategic commissioning plan for 2016–2019. This set out the drivers for change and the key service developments, commissioning priorities and objectives. The plan was relatively high level. It included a functional high-level action plan for each area. This linked local actions to national priorities and included a method for measuring progress. The plans for care and support to older people were contained within the 23 identified strategic developments for adults as part of primary and community care services. These were linked to the national health and wellbeing outcomes. A local performance framework was included and was set alongside the strategic financial plan. The framework included a housing contribution statement. This clearly laid out the contribution that housing could make to meet the future housing needs of older people in Orkney, how this contribution should be monitored and some detail of the available resources. The statement was due for review in 2017 and in preparation for this, the housing needs and demand assessment and the local housing strategy were being reviewed and updated.

The partnership had started work on developing the strategic commissioning plan into a longer term (10 year) and more detailed document. As part of this, it was considering the findings of the joint strategic needs analysis. Information to inform planning was also gathered from the director of public health's annual report and the chief social work officer's annual report.

The plan was used to inform how the partnership would use its resources, including finances and specifically the integration care fund<sup>13</sup>. An example of this was the development of two new replacement care homes for older people with increased bed capacity. This aimed to address demographic increases in the number of older people anticipated in the next 10 years. Care home bed capacity in Orkney was currently below the national average.

Producing operational and strategic plans was a challenge for the partnership, given its limited staffing capacity. This presented issues for the partnership in terms of aligning its broader operational and strategic priorities and activities. The strategic commissioning plan sat alongside some other plans. We found that it was more aligned with some of these plans and supporting activities than others. An example of good alignment was NHS Orkney's local improvement and co-production plan 2016–2017. This addressed the national priorities, including safe and person-centred care, primary care, integration, and scheduled and unscheduled care. The IJB's commissioning intentions for health and social care were evident and referenced in this plan. The approach to falls management and prevention, and intermediate care were just two examples of this. Work was also included to align the standards, targets and indicators between the strategic commissioning plan and NHS Orkney's local improvement and co-production plan.

However, there were a number of areas where activity was taking place which did not reflect the strategic priorities of the strategic commissioning plan, including the following examples.

- The provision of some services remained more driven by service demand and/or was financial based rather than strategically led. For example, care at home and respite services struggled to meet service demands. This hindered more preventative approaches being taken. The use of respite care home beds as emergency or permanent care home beds could make access to planned respite difficult and lead to increased pressure on frail older people and their carers.
- A number of single-service and single-agency plans pre-dated the strategic commissioning plan and did not always reflect the same priorities of the strategic commissioning plan.
- Papers being discussed at meetings that we observed indicated that decisions taken in respect of developments were not always being made by the planning partners with clear and obvious reference to the strategic commissioning plan. This included discussions about resources still to be committed for the 2016–2017 integration care fund.
- The existing performance data was not always linked or relevant to the key strategic activities and priorities.

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<sup>13</sup> Integration care fund: The fund is provided by the Scottish Government and is accessible to local partnerships to support investment in integrated services for all adults. Funding is designed to support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions.

The partnership's strategic planning group was a key group in driving forward strategic planning and delivery. We had a number of opportunities to attend the strategic planning group and some of its sub-groups. We observed a strong commitment to joint working. There was also a shared determination from the group to be as inclusive as possible by involving local people, carers, community representatives and the third sector. The group was still developing its role, including how it related to the IJB and to the two parent bodies. Exception reporting was used for monitoring the range of strategic development activities. This carried a degree of risk in that it might not subject all its activity areas to sufficient review.

## Needs analysis

The partnership had commissioned a joint strategic needs analysis (JSNA), produced by OHAC in collaboration with NHS National Services Scotland's local intelligence support team. We found the JSNA to be a detailed document containing a large amount of information, including population, health and socio-economic data. It also covered acute service provision, social care provision, and details of health and social care expenditure. It included a summary of key points which should help focus the partnership's thinking when making service development and commissioning decisions. We considered that it provided a reasonable starting point from which more detailed strategic planning could be built upon.

The JSNA was presented at a strategic planning group meeting we attended. From the discussion which followed we noted the following.

- There was a variable level of understanding among strategic planning group members about the role of data and an evolving shared understanding of this.
- The data contained in the JSNA was based on existing service provision. It did not cover service gaps and older people's broader needs and unmet needs.
- The work to revise the housing needs and demand assessment was already showing that the population (including the working-age population) on some of the outer isles was declining. This was making the future of some of the islands potentially "unsustainable".

To further develop the work identified in the JSNA, an external public health expert would be based in Orkney for a three-month period along with the continued input of an NHS Education for Scotland staff member until March 2017. This work would feed into a small group involving the partnership's chief officer and the locality leads. This would inform the further development and refreshing of the strategic commissioning plan.

We met with a group of managers and support staff who had been involved in completing the joint strategic needs analysis. They said that the need to complete this and the integration outcome indicators had led to an increased and improved focus on outcomes and outcome indicators over the last 6-12 months. Service managers and data management colleagues had continued to meet on a monthly basis. They said this had resulted in a better shared understanding and analysis of key performance and needs data.

## Strategic commissioning

The strategic planning group had a key role in taking forward strategic commissioning. We attended meetings of the group and saw evidence of senior and middle managers jointly considering the service development agenda.

Two key areas of activity involved the building of the new hospital and healthcare facility in Kirkwall and two new care homes, one in Kirkwall and the other in Stromness. These would replace existing care homes which would not be fit for purpose in the medium or longer term. The new care homes would increase bed capacity from 110 beds to 134 beds by 2018–20219 and would include some intermediate care beds. A best value commissioning approach to these developments was evident in strategic planning group minutes and as part of consultation documents we read. The new care home in Stromness was scheduled to open in the second half of 2018 and the care home in Kirkwall in the first half of 2019. In total, these new care homes would provide 24 additional beds.

Annual funding of some £1.1 million had been identified and approved to meet the additional staffing costs for the model of care for the two homes which was to be based on a small-group-living model. For example, the new care home in Stromness was going to be based around four wings. In advance of the formal registration application process, the partnership had shared the architect plans for the new home with the Care Inspectorate. The new homes were to include some non-chargeable beds, allowing intermediate care capacity to be increased. The partnership now needed to press ahead to further define the proposed model of care and in particular how this would offer greater personalisation and support to increasingly frail older people.

The NHS's National Information Services Division was providing support with bed models for the new hospital and healthcare facility. The existing hospital had 48 beds and the approved business case for the new hospital and healthcare facility was for 49 beds. The planned model was consultant-led to deliver improved clinical care outcomes for people in Orkney. Primary care and dental services were to move to the new hospital and healthcare facility

The partnership was constrained by a lack of alternative providers on the islands, especially for services for older people. The council was the sole provider for a key number of regulated social care services such as care at home, day care, respite and residential care. This was a major challenge for the partnership given the projected significant rise in the number of older people and the demands on existing services, most notably care at home services. We concluded that the partnership was likely to struggle to be able to offer personalised support unless new models of care were identified.

Some families and staff told us about instances where the partnership had needed to commission staff from a Grampian-based agency to provide care at home input which it was unable to provide itself. This was not an ideal solution and was an expensive one. However, it was well received by the families concerned. We talk later in this section about public opposition to outsourcing services as evidenced by the response to a care at home review completed in 2012. However, the experience

from other partnerships is that positive real-life examples of new and alternative forms of how services are provided can be effective in addressing concerns about change. The partnership was aware of this and was involved in discussions with some of the existing third sector organisations in Orkney to see if they were interested in expanding their remit to take on care at home type of provision.

#### **Recommendation for improvement 4**

The partnership should put a clear plan in place, with timescales, to increase the care at home capacity available to older people across the Orkney Islands.

Early discussions were taking place to explore the setting up of social enterprises on the islands to develop and deliver self-directed support options. This would expand the amount of choice for older people about care and support options. This approach would be important for meeting the needs of older people, especially those with complex needs, on the outer isles. We saw evidence of the partnership and local communities working hard and imaginatively to support older people on the outer isles. However, realistically, the same range and level of services could not be provided equitably across all the islands. This led to some older people with high-level needs having little choice but to move to the Orkney mainland.

NHS Orkney was one of six NHS boards participating in a national initiative to lead complex change, led and facilitated by AQuA alliance<sup>14</sup>. The focus of NHS Orkney's AQuA project was on preventative approaches to avoid unnecessary hospital admission and on patient flow to improve hospital discharge planning. The project had started in January 2016 and there had been a significant investment in staff training. Staff involved said it was still too early to evaluate its impact. However, they expressed confidence that a change in ethos and culture as a result of the training would lead to improvements in the experience of older people and in the partnership's performance. We considered that the project was showing some promising potential, for example, in using data analysis to identify areas of improvements in patient pathways.

We found a varied picture in terms of how successful the partnership had been in developing an effective range of early intervention and support services. Positive examples of supports and services developed by the partnership included the following.

- The **intermediate care team** was effective in providing reablement.
- The **Selbro joint equipment store**: a number of families praised the staff's responsiveness and ability to find imaginative solutions to mobility and daily living issues.

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<sup>14</sup> The Advancing Quality Alliance (AQuA): The Advancing Quality Alliance (AQuA) was established in 2010 to improve health and care quality. It undertakes consultancy work across the UK. It works with partnerships in Scotland to help them build improvement capability at all levels of their workforce, to develop and implement quality strategies and to address their quality priorities.

- The **mobile community responder service** where team members were able to provide some short-term care at home support in response to an emergency, as well as dealing with the immediate emergency. This allowed time for more planned supports to be introduced.
- The **Red Cross House** provided an extra care supported living resource in Kirkwall offering additional support to older people and their families when further reablement was required. This service was highly regarded by staff and older people.

We described the positive experiences older people had of the above services in the previous section of the report. More recently, the partnership had identified funding to pilot a rural generic support worker on Hoy. This would be a combination of the social care assistant and health care assistant roles and we say more about this later in this section in respect of the workforce.

However, there were limitations to the availability and extent of some of these services. For example, reablement was restricted to the intermediate care team; the mobile community responder service did not operate on the outer isles and the Dounby intermediate care bed pilot had been hampered by staffing difficulties. The extension of intermediate care provision would not happen until the new care homes became operational.

Preventative and early intervention services were not well developed in some areas. For example, some staff were unaware of the benefit of pursuing early diagnosis of dementia and dementia support for older people. Mental health services were struggling to provide mental health support beyond statutory mental health officer activity. Care at home services were not always available in a timely fashion and this risked an escalation in an older person's needs.

Staff received support with procurement activity by specialist staff based in Orkney Islands Council and NHS Orkney. However, health and social care staff with commissioning and contracting responsibilities carried these out in addition to their operational requirements. The partnership recognised the need to develop the confidence, experience and skills of staff in dealing with commissioning and contracting activity.

Operational managers had an established relationship with the Care Inspectorate and worked with inspectors to address improvement issues in care homes and care at home services identified through regulatory inspections. We saw evidence of the needs of older people being reviewed by care services and some examples of changes being made to how services were provided in response to feedback from older people and their families. The partnership had arrangements in place to monitor procurement practice through its procurement strategies. Operational managers were responsible for reporting on this.

## Consultation and involvement

In March 2016, the partnership had published a communication and engagement strategy for 2016–2017. This aimed to “make sure that our stakeholders have

positive opportunities to get involved and truly influence the way services are designed and delivered". The strategy was a comprehensive document reviewing the legislative and national drivers behind community engagement. It identified the local engagement groups and approaches that staff in Orkney should employ. It contained an action plan detailing nine key actions to be achieved by April 2017. These included mapping all engagement and communication groups, and ensuring partnership representation and the continued development of the use of social media. The relatively recent completion of the strategy meant the partnership now had to concentrate on its implementation and on achieving more consistent and comprehensive levels of public engagement than it had sometimes been able to previously.

We found positive commitment among staff at all levels to engaging and consulting with the local community about change. We saw this reflected when we attended the strategic planning group and the Alcohol and Drug Partnership. Both of these showed good evidence of seeking broad stakeholder involvement. IJB members were involved in consultation activity on the new hospital and health care facility and the care homes.

We saw a number of good and diverse examples of how the partnership had sought to engage with local people and communities. These included:

- consultation on the strategic commissioning plan
- the Orkney Peer Network
- consultation exercises for the intermediate care bed pilot at Dounby and for the Hoy day care service.

We say more about these in the section on the impact on communities in the final section of the report.

However, the partnership faced challenges in its engagement approach. Not all of its efforts to involve local people and community representatives had achieved the desired results or level of engagement. For example, it had sought to have a carer representative on the IJB and on the strategic planning group, but had been unable to secure one. The small population of Orkney and its dispersed nature means that attracting and maintaining community representation could be difficult. Staff said that acting as community representatives often fell to the same small group of people who themselves could then suffer from 'consultation fatigue'.

There was no history or precedent of alternative providers of social care services for older people in Orkney. We heard from both staff and community representatives about the strong attachment of Orcadians to services being directly provided by the council. In 2012, an extensive review of the care at home service had been carried out. This had included a recommendation to outsource some of this provision. However, this ran into considerable public opposition and did not proceed as a result. Managers and council elected members told us this was in part a reflection of the public reaction to difficulties with the delivery of the ferry services when this had been outsourced to a private company. They said this had reinforced public opposition to outsourcing, especially to service providers who had no local connection to Orkney.

More recently, the decision to move the community mental health team from Stromness to Skerryvore Health Centre in Kirkwall had been criticised and was reported in the local media for being taken without proper consultation, including with the Orkney Community Planning Partnership. The partnership told us that as the move involved staff only, from a building which did not provide public access, there was no requirement for broader consultation.

Senior managers were aware of the specific challenges they faced in engaging with the public and with the diverse local communities in Orkney. They recognised that their previous efforts had not always achieved the desired results. They were keen to learn from the lessons of these. For example, a further review of the care at home service was under way. As the council was struggling to meet both current and projected demand in some areas, it was keen to explore commissioning alternative providers. However, it planned to do this in an incremental way and using service providers who already had an established connection and positive reputation in Orkney. We considered that this was a positive and sensible approach.

In our survey of staff, the response on whether their views were taken into account in service planning was broadly in line with other inspections to date. However, 34% of respondents still either disagreed or strongly disagreed that their views were taken into account. We discussed this with senior managers who were surprised and disappointed with this result. Some who had worked in a number of other partnership areas said that, in their experience, staff had more opportunities in Orkney to be directly involved in policy and service development than in other places. They cited the work on establishing the single point of referral, the islands network of care and the design of the new care homes as examples of where staff had played a leading role.

We considered the partnership's approach to strategic commissioning taking account of the characteristics of good strategic commissioning contained in Audit Scotland's 2012 audit of commissioning social care.<sup>15</sup> We concluded that the partnership's approach had reflected the positive characteristics in most areas. Where it had not, it was aware of the further action it needed to take, for example by the development of a more detailed analysis of local needs.

### **Management of resources**

There was evidence of well-established joint working between the health and council finance teams. This was a positive development given that the chief finance officer had not been appointed until March 2016. Both NHS Orkney and Orkney Islands Council had a good understanding of the financial pressures affecting their organisations and had comprehensive budget monitoring arrangements in place. An initial combined budget monitoring report was submitted to the IJB in September 2016. The partnership was facing a projected overspend for 2016/17 for the services delegated to the IJB. A detailed recovery plan still needed to be developed at the time of our inspection, but we noted that a draft recovery plan was submitted to the IJB in September 2016. The partnership intended to utilise non-recurring funding set aside to support budget overspends and the under achievement of savings plans and ensure that a year end break even position was achieved. We

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<sup>15</sup> Audit Scotland: Audit of the commissioning of social care. March 2012.

concluded that the partnership needed to further develop the plan as a matter of priority in order to achieve a longer term sustainable financial position that did not rely on the use of non-recurring revenue.

The partnership had some major capital developments planned, including the new hospital and healthcare facility and two new, replacement care homes. Some actions had been taken to support a shared use of partnership properties, but it did not yet have an overarching co-ordinated approach and strategy in place for its estate. The partnership did not have an integrated IT strategy. However, it demonstrated a good commitment to making the best use of technology for the benefit of people using its services. We saw a number of examples of this, many of which aimed to alleviate the challenges and costs of delivering services across its island's geography.

## Finance

A chief finance officer was not in place during the establishment of the initial IJB joint budget. As a result, due diligence was not able to be fully completed before the IJB went live. The chief finance officer was appointed in March 2016. A subsequent internal audit report found a number of areas where action was required to strengthen governance and financial arrangements. The IJB developed an action plan to implement these recommendations by March 2017. We were assured that the partnership had the necessary financial systems in place to mitigate any financial governance risks in the intervening period.

Joint working between both partners' finance teams was evident as this was embedded with the establishment of the IJB working group, and the service managers' and lead professionals' finance and performance group.

Individual budget monitoring reports from both NHS Orkney and Orkney Islands Council were comprehensive and gave a clear picture of the financial performance of health and social care services against each budget heading. Work was under way to amalgamate this budget information into a single budget monitoring report to provide the IJB with a complete understanding of its current financial information and future financial challenges. The first combined report was due to be submitted to the IJB meeting in September 2016 and we subsequently noted that it had been.

The council recorded an overspend of £0.492 million in those social care services delegated to the IJB for the year ending 2015/16. The largest areas of overspend were with the elderly care budget, with a 9.5% overspend of £0.457 million, and the care at home budget, with a 7.1% overspend of £0.209 million. Lower than anticipated fee income and the high costs of direct payments were given as the main causes for the budget pressures.

As at July 2016, social care services delegated to the IJB had an anticipated year end overspend of 4.1% (£0.712 million). The elderly care and care at home budgets were anticipated to overspend by 7.3%, £0.412 million and £0.214 million respectively.

The council had an overall savings target of £0.540 million for 2015/16 which was achieved in full. The council projected a total savings requirement of £9.5m over the

four-year period from 2016/17 to 2019/20 to maintain a balanced budget. This presented a significant challenge to the council.

A savings target of £1.360 million had been set for 2016/17, £0.319 million of which was to be delivered from the council services delegated to the IJB. The largest savings were to be achieved from the commissioned services and supported accommodation budgets. Delivery of these savings was required to achieve the outcomes in line with the IJB's finance plan. The council expected the financial position to become more challenging with reduced levels of funding going forward.

For 2015/16, the NHS board met its financial targets, including achieving an overall underspend of £0.107 million. During this period, there was an overspend of £0.183 million for the health services delegated to the IJB. The largest area of overspend was within primary care with a 5.1% overspend of £0.289 million. This had arisen from the use of locums and additional staff for long-term sickness absence cover.

As at June 2016, there was a year-to-date overspend of £0.600 million across the NHS board services. Healthcare services delegated to the IJB were anticipated to underspend by £0.278 million by the year end. However, the NHS board-wide savings requirement of £2.066 million for 2015/16 had not been apportioned to individual services at the time of the inspection. Officers indicated that the year-end budget position for services delegated to the IJB would be an overspend once the savings requirements were taken into consideration.

We noted that both the council and NHS Orkney had experienced overspends which had been cross-subsidised from other services not delegated to the IJB. The partnership intended to utilise non-recurring funding set aside to support budget overspends and the under achievement of savings plans and ensure that a year-end break-even position was achieved. We concluded it was essential, and as required as part of the Orkney Integration Scheme, that the partnership develop a comprehensive recovery plan to address the projected overspends. At the time of the inspection a recovery plan had still to be developed. We subsequently noted that a completed recovery plan was submitted to the IJB for approval in September 2016. The action plan addressed the main areas of overspend across the IJB budget to date, assigned a responsible officer and a timetable for completion. However, the plan did not include actions to promptly identify the NHS savings and attribute these to budget areas. The partnership needed to further develop the plan in order to achieve a sustainable financial position that did not rely on the use of non-recurring funds.

The NHS board had a track record of achieving efficiency savings and financial targets. The 2015/16 savings target of £1.229m was achieved with 81.2% coming from recurring sources. This was an improvement from the 2014/15 position where only 42.6% of the savings achieved were recurring. For 2016/17, the savings target was £2.187 million representing a 77.9% increase compared to 2015/16. The NHS board planned for 72.6% of this target to be achieved on a recurring basis. The large increase in savings requirement represented a significant challenge to the NHS board. In line with the pressures faced by NHS boards across Scotland, the identification and achievement of recurring savings was essential to ensure long-term sustainability of services.

## Recommendation for improvement 5

The partnership should take urgent action to implement the IJB's financial recovery plan to ensure that a sustainable financial position is achieved. In the event that the recovery plan is unable to achieve a break-even position by the year end, the partnership should work with parent bodies to implement an alternative course of action in line with the provisions contained within the Orkney Integration Scheme.

The partnership was allocated £1.073 million from the Social Care Fund. This funding would be split equally between supporting existing and additional financial pressures. The partnership was also allocated £0.410 million of funding from the Integrated Care Fund (ICF). The awarding and monitoring of the use of ICF funding was carried out by the Integrated Care Fund group which had participation from senior finance staff. We were informed by officers that all 2016/17 ICF funding had been allocated. The largest projects related to home care modern apprentices, GP direct-referral beds, a community worker role to support the patientflow co-ordinator and a health intelligence team post.

### Buildings

In its position statement, the partnership said it had aspirations towards more co-location and more flexible use of the buildings across the health, social care and the wider estate but did not currently have an overarching joint approach. There was no requirement for this although it had been recommended by the Scottish Government's Integrated Resource Advisory Group that chief officers consulted with partners to identify capital investments opportunities and submitted business cases. The partnership expressed the intention to move towards co-location where appropriate and to use buildings flexibly across the health, social care and wider estate. Examples of this included Selbro, the One Stop Shop, the Balfour Hospital, Garden House, and Smiddybrae Care Home.

Individually, the council has a property asset management plan in place, approved in May 2016, covering the period between 2016 and 2018. The health board's Property and Asset Management Strategy 2015 – 2020 was approved by the board in December 2015. Both these plans were individually subject to ongoing scrutiny through relevant committees as part of each partner's governance arrangements.

For 2015/16, the social work capital programme budget was £0.767 million of which £0.454 million (59.2%) was utilised. The majority of capital expenditure related to the new children's home and design work for the replacement of St Peter's House. In accordance with the council's Property Asset Management Plan 2016 - 2018, agreed in May 2016, a total of £9.990 million has been allocated to the St Peter's House replacement. It was anticipated that no external funding would be used for this project.

The health board capital budget for 2015/16 was £2.688 million, of which £2.541 million (94.5%) was used within the year. NHS Orkney was in the process of undertaking a major project to develop a new general hospital and associated

healthcare facilities in Kirkwall. The estimated capital value of the project was £67.5 million with completion expected in early 2019.

### Information systems and technology

Sharing data across health and social care systems is a challenge nationally. We found this to be the case in the Orkney Isles. There were issues with access to information technology (IT) in some of the more remote and rural areas. IT services were looking at ways of improving connectivity, including access to some emergency services' airwaves which was being piloted on Stronsay.

Many staff spoke of the difficulties they faced resulting from the incompatibility of electronic systems. These included information having to be entered numerous times and the danger of important information not being shared. In our staff survey, only 40% of respondents agreed that information systems supported frontline staff to communicate effectively with partners, with 37% disagreeing.

There was no joint IT strategy and integrated working around this was still in the early stages of development. However, we found that the partnership demonstrated a good commitment to making best use of technology for the benefit of people who used its services and to support staff in their role. This included a partnership approach with Scottish mainland authorities, for example the use of the Trakcare healthcare patient information system with NHS Grampian. This allowed clinical staff in Orkney to see patient records while the patient was in hospital in Aberdeen. Similarly, video-conferencing was being used effectively to support telemedicine, including consultation with Scottish mainland hospitals such as the Golden Jubilee National Hospital in Clydebank for orthopaedic purposes. It cost the partnership some £2.5 million annually to meet the costs of people from Orkney being transported for treatment on the Scottish mainland. The partnership was confident that its plans to further develop suitable technological solutions would help secure a reduction in these costs.

The social work service had its own established IT system (PARIS) for recording 'client-based' information. This had been useful in its implementation of the Talking Points<sup>16</sup> approach. We found it a relatively easy system to navigate during our review of social work services records. Staff also spoke in generally positive terms about the system. Some teething problems were described further to a recent upgrade of PARIS, but staff and managers said these were now largely resolved.

Social work services staff carrying out assessments had started to use tablet devices or mini computers, which they could remove from their desk to operate remotely. New information could then be synchronised back to the system once the device was connected back at their desk. This had increased efficiency for frontline staff especially when out working in the outer isles. Community nurses had piloted the use of tablet devices for similar purposes and to access clinic appointments for their patients. Out-of-hours IT support had recently been introduced to support clinical staff working at these times. The use of an IT system called Florence was being

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<sup>16</sup> Talking Points: The Talking Points framework classifies the outcomes important to individuals into three broad categories: quality of life, process and change. A total of 15 outcomes are apparent across the categories.

considered to provide home monitoring for some conditions such as diabetes where the patient could text their readings to a nurse.

Care at home rostering was carried out using the StaffPlan software system. This monitored staff arrival and departure times in service users' homes and then generated invoices and payroll returns. The system also allowed staff to record and report significant changes in the service user's circumstances and wellbeing. Work was under way to integrate StaffPlan into the short-breaks accommodation service.

NHS Orkney was undertaking a programme of work to upgrade desktops and servers which it hoped would result in wider use of the PARIS system by health staff. In addition the council and NHS Orkney were working together to adopt Microsoft Office 365, and the creation of datacentre facilities at the new hospital and healthcare facility designed to allow more joint access to each other's systems.

Not all IT initiatives had been successful. For example, some telemedicine equipment had been purchased and not used effectively. The equipment had become outdated and needed to be replaced. Healthcare staff said this was partly due to a lack of their involvement in the planning process. However, overall, we were impressed with the steps the partnership had taken to develop its use of technology, especially given the limited resources at its disposal.

## **Workforce**

We evaluated the partnership's management and support of its staff as good. The partnership was still in the early stages of developing an integrated approach to workforce planning, but we saw some examples of where it had started to address this. Recruitment and retention and providing services to the outer isles were an ongoing challenge. However, we saw that the partnership had taken a number of positive and imaginative initiatives to address this, including the development of some new staff roles. Most staff were still deployed on a single agency basis, but good joint working was evident and the partnership was looking at new opportunities for staff to share the use of premises. Staff were largely positive about how they were supported and the training they received, but further development was needed for the provision of joint training opportunities.

### **Recruitment and retention**

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

The partnership had made some early progress with the development of a strategic approach to workforce planning. Although this had largely developed on a single-agency basis, we saw evidence that the partnership had begun to develop workforce profiles to identify the future staffing needs, skills mix and resources needed to address an ageing workforce in health and social work services. For example, NHS Orkney reported an increase in the recruitment of nursing staff within the 25–30 years age band. This was a promising development to help shift the balance of a projected ageing workforce in health.

The partnership acknowledged it needed to develop a joint workforce plan. However, discussions about this were at a very early stage. The partnership's intentions were to reshape staffing models to increase efficiency, and to provide greater capacity to meet the future needs and demands on services for older people. To achieve its strategic aspirations, the partnership recognised it needed to adopt a more joined-up approach to workforce planning to respond to demographic changes of an increasing older population and a diminishing workforce age population.

Frontline staff and managers told us about the ongoing challenges of recruitment and retention in key service areas, including care homes, care at home services and the community mental health team. Orkney Islands Council was the sole provider of care homes and care at home provision for older people in Orkney.

Each care home had its own 'bank staff' system. Despite this, recruitment and staffing challenges could lead to existing staff providing cover over and above their contracted hours. The council's human resource managers reported an increase in overtime and excess hours accrued by social care staff in both the care home and care at home services.

The partnership had recruited to 29 nursing posts since 2015 and a workforce report in 2016 highlighted that 'bank' hour usage was at its lowest level since July 2015. However, there was an over-reliance on locums to cover vacant consultant posts in medical specialties, psychiatry and public health. The partnership had recently appointed a clinical nurse specialist for dementia.

At focus groups involving healthcare staff and managers, we were told that specialist consultants from NHS Grampian provided good support for Orkney GPs and other healthcare staff. However, staff reported that the quality of locum support was variable, and depended on the skills, knowledge and experience of the individuals concerned. The partnership had advertised a vacant consultant psychiatrist post five times without success. Staff we met considered this a significant deficit in the management of care and treatment of older people with dementia. Senior managers told us some early progress had recently been made in obtaining some dedicated locum provision to provide greater continuity and consistency for older people accessing mental health services.

Human resources managers told us about initiatives they had taken in response to the recruitment and retention challenges the partnership faced. These included the use of recruitment campaigns, local advertising and media broadcasts. The partnership had offered incentives such as generous relocation packages and affordable housing options to try to attract people to work in the area. Other positive developments under way to make health and social work jobs a more attractive career option were various 'grow your own' initiatives. These included:

- modern apprenticeships
- enhanced use of distance learning materials and Open University courses to support career progression for staff
- links with schools and the local college to develop career pathways for young people.

An Open University nursing course had attracted an encouraging number of applicants, exceeding the amount of places available on the course.

We looked at staff absence data for the partnership. Adult social work services had almost reached their absence target in 2015/16, but a rise in long-term sickness absence resulted in an increased percentage absence of 6.27%. This had improved but remained the highest in the council. NHS Orkney had experienced a similar rise in long-term sickness absence. This had also resulted in an increased percentage absence of 5.20%. However, since March 2016, NHS Orkney had achieved the national NHS absence target of 4%. Both partner agencies had comprehensive strategies in place to reduce absence levels and deliver on absence targets. Managers regularly monitored and reported on performance.

### **Deployment, joint working and teamwork**

The partnership had a well-established integrated management structure. Service managers and the senior management team held joint posts underpinned by jointly agreed job descriptions. Honorary contracts were in place with the non-employer organisation to support cross-organisational management arrangements, and access to health and social work information systems. This was a positive step towards developing further joint posts to enhance the flexibility of the workforce to deliver new models of integrated care services for older people in Orkney.

Historically, most staff deployment had been on a single-agency basis. Exceptions were the community mental health team, which was an integrated team, the intermediate care team, the Selbro joint equipment store and the council's housing service, which positively included a social worker as a liaison point between housing and social care services.

We saw a few examples where staff members shared offices or were co-located in the same building. Staff we spoke with said this had helped to improve information sharing and enhanced multi-professional working. Social workers operated a rota system to provide on-site cover in the hospital to carry out multidisciplinary assessments of older people in preparation for their discharge from hospital. We observed several multidisciplinary meetings attended by a range of health and social work professionals.

Frontline staff said that managers actively supported and encouraged joint working. Our staff survey results supported these findings with 84% of respondents agreeing that joint working was supported and encouraged by managers, and 80% agreeing they had excellent working relationships with other professionals. From our review of older peoples' health and social work records, we also found similar positive aspects of joint working. In 91% of the records, there was evidence that services had worked together to provide care at times of crisis, and 86% of records contained evidence of multi-agency working having informed care and support plans.

We visited some of the outer isles where deployment of staff was a constant challenge. GPs and advanced nurse practitioners often worked as lone practitioners providing 24-hour cover seven days a week. A robust emergency support network from local community responders and air ambulance crew was in place. However,

dedicated relief cover for resident practitioners' annual leave, training or unplanned absence had only recently been put in place. The partnership was testing a two-weeks-on and two-weeks-off rota to free up staff from work commitments while on holiday and provide protected time for individual professional learning and development. Comments we received from staff involved were positive with the pilot being well received. We considered this a promising development to enhance working conditions for staff working on the outer isles.

The Scottish Government was supporting the partnership with the development of a more flexible workforce model of integrated care. Plans were under way to pilot a rural generic worker to support the community nursing team on the island of Hoy. The job description was being finalised and one of the pilot's objectives was to look at new ways of providing care and support to older people especially given the challenges of doing so on the outer isles. NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC) were supporting the partnership with a training programme to address the educational needs for this new role. Although this was an innovative development, the partnership had not yet identified how it intended to support the sustainability of this model following the pilot. This was a source of frustration for healthcare professionals who told us they were concerned about raising expectations of the local community.

### **Training, development and support**

In our staff survey, just over three-quarters of respondents said they had good opportunities for training and professional development. This was broadly consistent with the partnership's own staff survey results. Frontline healthcare and social work services staff we met were generally positive about the training opportunities available to support their individual professional development.

We found there was a good but informal network of training from healthcare professionals who had supported social work services staff working in care homes and in the community. Themes included input on palliative and end-of-life care, anticipatory care planning and support with medication management.

Most partnership staff told us they felt they had good opportunities for training. However, staff who worked on the outer isles told us that, as most of the training was organised on the Orkney mainland, it was difficult for them to attend as there was limited capacity in their teams to provide cover. The partnership had recognised this and had begun to invest in more distance learning opportunities and online courses.

NHS Orkney and Orkney Islands Council had separate arrangements in place for individual supervision, appraisal and professional development. We read a range of documents and training plans for healthcare and social work services staff. This included statutory, mandatory and core training. It was evident that a good variety of training was available to ensure staff maintained their skills, knowledge and accountability in their respective professions.

The partnership's move towards a more strategic approach to joint training was at an early stage. Generally, health and social work training was delivered separately. However, there were some positive examples of joint training, including dementia

awareness, adult support and protection, adults with incapacity and releasing time to care.

Dementia training was rolled out to health and social care staff as part of their induction and on-going development. The clinical nurse specialist for dementia was progressing plans to develop a joint approach to dementia training to build on the success of a previous joint training pilot.

The majority of staff we met told us they felt supported by their managers and had access to formal opportunities for regular profession-specific supervision and appraisal. For some staff teams working in health and social care, this was less so due to workload demands and the dispersed staffing arrangements. As a result, less formal arrangements had evolved to compensate which were less robust. This was particularly so in the outer isles for staff working in care at home services and in community nursing. The partnership acknowledged difficulties meeting its targets for supervision and appraisal. It said this was largely due to staffing shortages and long-term sickness absence. Both partners had governance arrangements in place and were monitoring progress with this.

## 10. The provision of care, support, treatment and protection

We evaluated the partnership's performance in this area as good. Access to support and services for older people was generally good and was boosted by a good range of third sector supports. Some services such as care at home were struggling to meet demand. Given the increasing demand for its service, the partnership needed to review how some services were prioritised and to the consideration of alternative forms of support for older people. The approach to assessment, care planning and review activity all showed a good focus on outcomes. However, the value of carers' assessments was not well acknowledged by staff. There were relatively low numbers of adult support and protection referrals. The partnership needed to improve how staff recorded and shared their activity in this very important area and in how it fulfilled its quality assurance responsibilities. Staff demonstrated a clear commitment to involving older people and their families in decisions about how they were supported. There was a good uptake up of self-directed support by older people and also good access to independent advocacy when this was required.

### Access to support and services

Access to services was generally good with clear procedures and pathways in place. The development of the single point of referral, although a single-agency social work service, had improved the co-ordination and streamlining of referrals. It had also reduced the need for older people to make multiple separate requests for services. Third sector services offered a good range of effective supports that they had developed alongside the partnership to provide early and continuing support. Most older people we met were satisfied with the access they had to health and social care services, although a few wanted better access to specialist medical care, including neurological services.

Our review of older people's health and social work services records found only a few instances where there were delays in people being assessed or receiving services. Of the six where there were delays in assessment, three related to assessment of mental health or capacity. For those older people waiting for services to be provided, the care at home service was the most common. Separate data provided by the partnership showed between three and five people were waiting for services each month. About half of these were older people who had been placed in a respite care bed while waiting for a permanent care home bed to become available.

The setting up of the intermediate care team had helped to improve access to early support, enabling the prevention of admission to hospital as well as facilitating discharge. However, as we described in Section 8, pressure on the care at home service impacted on the capacity of the intermediate care team. At the time of our inspection, the team was covering around 250 hours care at home each month.

We noted that waiting lists for some services were beginning to grow. Waiting list management systems had recently been introduced for care at home services. We concluded that managers needed to review the level and type of need of older people waiting for services to better inform how the provision of services was best managed and prioritised.

## Recommendation for improvement 6

Given the increasing demand for its services, the partnership should review its eligibility criteria and resource allocation processes to ensure the most effective arrangements are in place to manage and prioritise its services and resources.

Multidisciplinary meetings involving health and social work services staff were held every week in the hospital. A weekly meeting of the allocation resources committee also took place. These both considered early intervention and responses at the right time. They provided a good basis for considering priority for access to services and the consideration of alternative supports. The involvement of a range of staff from with health, social work and housing services helped to identify and consider where and how an individual's needs could be met better. However, based on minutes from these meetings and our observations at them, we questioned whether sufficient consideration was always given to the broad range of available service and support options and to imaginative responses to meeting needs, rather than just to available mainstream services.

The development of the Orcades GP practice had supported a more consistent approach to delivering medical care in the outer islands. This had created a single health practice across several island locations.

### Assessment of needs and wishes

From our review of health and social work services records, we saw that clear assessment tools were available for staff to support them in completing outcome-focused assessments for older people. Most of the records we read set out the individual's desired outcomes in the care plan (84%) and addressed the individual's needs and risks. The majority of the assessments were of a good quality, and we assessed 63% as good, very good or excellent. We assessed 31% as adequate and only a small number (four) as weak.

The assessment tools linked into the person-centred requirements for offering self-directed support options to older people. However, although the paperwork included information about self-directed support, we found limited evidence of the four self-directed support options being discussed with older people and their families. The relevant section of the paperwork was mostly left blank meaning that any discussion of the four self-directed support options went unrecorded. More positively, the use of Talking Points as part of the engagement with older people was clearly reflected in many of the older people's records we read. We found that in 95% of the records we read, their wishes had been taken into account.

Clear protocols were in place to support information sharing between partners. Generally, these worked well and we found that services worked well together at times of crisis for older people. Information was often shared verbally and over the telephone. However, frontline staff did not often share their final assessments with relevant colleagues. For example, our review of health and social work services records highlighted that falls assessments were not consistently shared between staff. This could hinder effective planning for falls management and prevention. The

partnership was working hard to improve how it managed the flow of patients through the health and social care systems. A co-ordinator had been appointed using the integrated care fund to analyse patient pathways for discharge from hospital to better understand where the key pressure points were. This work needed to be linked to the recording and analysis of unmet needs, as it was not being used to support strategic planning. Managers acknowledged the social work PARIS system did not allow for the recording of unmet needs. The pathway to a dementia diagnosis was not clearly defined and could create delays in older people obtaining a clear diagnosis.

We found only a few completed carers' assessments in the older people's records we read. The majority of carers' assessments were completed by Crossroads<sup>17</sup>. We reviewed a sample of these and found them to be good quality and to have made some positive impact for the carers concerned. However, while Crossroads completed an assessment whenever a carer asked for one, they had completed only a limited number (14) in 2016 in the period up to July. There was no mechanism for Crossroads to share the assessments with health and social work staff. We did not see evidence of the value of carers' assessments being actively promoted by health and social work services staff. However, more positively, we met with carers who were supported by Crossroads to access respite, occupational therapy services and advice about using power of attorney as a result of their assessment.

### **Recommendation for improvement 7**

The partnership should take action to increase awareness for both carers and staff of the right of carers to be offered and have an assessment of their own needs. Staff should be given training that highlights the potential benefits for carers of having an assessment of their own needs as a carer.

### **Care planning**

The results from our review of health and social work services records on care planning were positive. For example, almost all (96%) of the records contained a care plan. We evaluated the majority (57%) of these as being comprehensive. Eighty four per cent (84%) of the care plans completely or mostly addressed the older person's identified needs. We found that for 90% of the older people these needs were being met. There was strong evidence of older people being supported to remain in their homes and engaged in their communities for as long as possible. Where older people were living in care homes, we saw clear evidence of care plans that engaged older people and were responsive to their changing needs.

Less positively, some of the information that helps to inform effective care planning and care management decisions was missing from the records we read. In a number of files where a power of attorney was in place, it was not recorded when or if the relevant powers had been activated. Healthcare Improvement Scotland carried out an inspection of the care of older people in acute hospitals at Balfour Hospital in May 2016. The inspection report published in July 2016 identified gaps in recording in

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<sup>17</sup> Crossroads Caring Scotland is a national third sector provider of support for carers and their families.

key information summaries and in anticipatory care plans. This included whether or not 'do not attempt cardiopulmonary resuscitation' (DNACPR)<sup>18</sup> was in place. The inspection report identified areas for improvement including the need for NHS Orkney to improve the completion of documentation and to ensure that clinical staff consistently complied with the national policy on DNACPR. Our joint inspection confirmed that recording the wishes of older people and their carers needed to improve for both health and social work services staff.

In 89% of the older people's records we read, we saw evidence that health and social care support for older people was subject to regular review. In 97% of the records, we found that the service actively sought and took account of the older person's views, either directly or through an appropriate, identified representative. The older people and their families we met confirmed that reviews of their needs took place on a regular basis and that they knew who to contact in between reviews if they needed to.

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

Good guidance and risk assessment tools were available to support staff in assessing and managing risk. However, some practices we saw did not reflect this guidance in the small number of records we read. This included any significant adult protection type activity (current or potential issues regarding adult support and protection or protection of the public). There had only been eight such cases in the previous two-year period. We read the records for all the older people concerned. It was a concern that only two of these contained a risk assessment and a risk management plan. We sought further information from the partnership on how risk had been assessed, managed and recorded for three older people whose records we read. It was disappointing that it took a repeated request for clarification on the questions which we raised for these to be addressed.

The partnership suggested that a relatively small amount of adult protection activity meant that risk assessment and risk management activity was able to be shared between the small number of professionals directly involved, rather than properly recorded. Senior managers acknowledged the need to ensure that this important area of work was properly carried out and recorded.

Frontline staff spoke positively about multi-agency working delivering a cohesive approach to adult support and protection. This included good engagement from healthcare and police services. They said that two or three people met the three-point test<sup>19</sup> every three months, and partners worked well together to minimise the impact of the adult support and protection process on the older person.

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<sup>18</sup> Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient's heart stops or they stop breathing.

<sup>19</sup> Adult at risk are defined as those who meet the following three criteria:

- are unable to safeguard their own wellbeing, property, rights or other interests
- are at risk of harm, and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.

Chronologies can give an early indication of emerging patterns of concern and risk. This means they can play an important role in helping staff to assess risk. As we have seen in other partnerships, we found room for improvement in staff understanding and completion of chronologies. Twenty of the older people's records that should have contained a chronology did not have one. Although a good number of other records did contain a chronology, most of these were not of an acceptable standard. This was because, in many cases, they were a list of meetings and staff activities rather than key life events that impacted on the individual.

We attended the adult support and protection committee. This committee provided a forum for structured multi-agency sharing of information in response to adult support and protection situations. It has a key oversight role of the quality of the adult support and protection activity. The chief officers' group and the chair of the adult support and protection committee acknowledged the need for improved performance information to support the quality assurance roles of the adult support and protection committee and the chief officers' group. They pointed to the information and approach already developed for child protection as a useful model to follow. As a start to this process, the chief officers' group and adult support and protection committee had agreed to develop an adult support and protection action plan to include outcome measures and resource requirements.

### **Recommendation for improvement 8**

The partnership should work with the chief officers' group and the adult support and protection committee to ensure that risk assessments and risk management plans are completed where required. They should provide oversight and quality assurance of these processes.

The partnership should also work with the chief officers' group and the adult support and protection committee to develop their governance and quality assurance roles. The partnership should produce a better quality and range of management information to support them in these roles.

We also looked at records 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. Our findings in this area were more positive in that:

- 66 out of the 76 records contained a risk assessment where this was needed and 51 of these contained a risk management plan
- 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 (66%) and fewer (28%) as adequate
- the risk assessments and risk management plans we saw were almost all up to date and the majority were informed by the views of multi-agency partners.

We found evidence of good partnership working with healthcare staff actively referring concerns for investigation. We saw and heard from staff about an approach that supported learning and reflective practice following incidents. We saw that the need for positive risk taking by older people was acknowledged and encouraged.

Within clinical settings, there was a strong approach to monitoring incidents to support improvement. The regular consideration of Datix<sup>20</sup> incident reporting had helped to identify areas of concerns and promote improvement in patient care, as well as the safety of older people and staff. The Datix incident reporting system had been introduced as a result of learning from a case where communication had not been as good as it should have been.

In line with some other assessments, risk assessments and risk management plans were not always shared appropriately to help inform and plan how non-protection type risks should be addressed. Some older people had had a number of risk assessments completed at a similar time that were not informed by each other. There was scope to look at earlier input from the falls team and the telecare service to help assess and mitigate risk, including the risk of falls.

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

We found positive evidence that older people and their carers were listened to and supported by staff to make choices about their care and support. Many older people told us they felt involved in discussions about their support needs. In the older people's records we read, 95% of assessments took account of individual's choices and, in 88% of records, the time when support was to be provided had been discussed with the individual. However, some older people we met said that some of their choices about support options were limited.

The social work service used Talking Points as the basis for many of its discussions with older people to help them and their carers identify what outcomes they wanted. However, not all staff were trained or confident in using Talking Points. This could limit the extent of opportunities for good engagement with older people. The number of people in receipt of self-directed support (direct payment) was 134, with 30% of the funding spent on support to older people who were the largest group in receipt of direct payments. We found that self-directed support primarily supported social activity that helped older people remain engaged in their communities.

We saw that a good level of advocacy support was available and provided when older people needed it to help them engage with service providers. From our review of health and social work services records, we found evidence of advocacy being offered and provided. There was only a small number of files (four) where evidence of access to independent advocacy had not been offered by staff where it should have been.

Two advocacy staff members had received self-directed support training in anticipation of the work that this would create. However, they told us this had not been used at the level they had anticipated. Although the majority of the service's work was about statutory activities (such as guardianship and mental health detentions), the service was able to provide more general advocacy support to older people.

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<sup>20</sup> Datix is a software system for the recording incidents and adverse events in a range of healthcare settings, including hospitals.

The advocacy service was independent of the partnership. This allowed it to help the service user to articulate their views to the partnership and other agencies. When we met with staff in focus groups, we found that staff (especially social work services staff) had a clear understanding and were supportive of the role of independent advocacy.

### **Example of good practice – The Orkney Advocacy Service**

The Orkney Advocacy Service provided good quality advocacy to older people who were involved with statutory proceedings, but who also wanted more general support in their engagement with service providers. It had taken action to increase awareness of its role among the public and staff working in health and social work services.

## 11. Impact on staff and on the community

### Experiences of staff

We evaluated the partnership's impact on its staff as good. The findings from our staff survey were mostly positive, although the response rate was comparatively low. Health and social care staff were well motivated and committed to providing older people with a good quality service. Staff morale was positive but, in some service areas, workload and capacity pressures had a negative impact on this. Generally, staff at the various levels spoke positively about the support they received from managers. The partnership expressed a commitment to communicating with and involving staff in service planning and development. A number of approaches and initiatives had been taken in support of this. There was a mixed view from staff on how successful some of these approaches had been. Staff were mainly positive about their access to training and opportunities for their personal development.

### Staff motivation and support

During the inspection, we had the opportunity to meet with over 100 staff. We also invited 962 staff to complete a staff survey with 156 responding. This was a 17% response rate, which was below the average response rate of 26% from inspections to date. The partnership said other survey activity which was carried out at around the same time may have been a factor for the comparatively low response rate to our staff survey. It also advised that there was a technical problem with the council's email system at the time of the survey, which may also have contributed to the response rate. As indicated previously, the low response rate means that the survey findings need to be treated with some caution. Of those who returned the survey, just over half were employed in the local authority (51%) and, the remaining 49%, were employed by NHS Orkney. The single largest group of respondents were social care assistants (29%) followed by community nurses (10%).

Positive responses to our survey were that staff enjoyed their work (97%) and felt valued by other practitioners and partners (88%). Other findings confirmed positive views about how staff felt supported. For example, respondents agreed that:

- they felt valued by their managers (75%)
- their workloads were well managed to enable them to deliver effective outcomes (75%)
- they were well supported in situations where they might face personal risk (71%).

These findings were broadly consistent with the partnership's own results from recent health and social work services surveys. They were also reflected by our meetings with staff, including focus groups, at which they said they had a clear understanding of their roles and responsibilities within the partnership. We found staff to be very well motivated and committed to delivering and improving the care, support and treatment for older people and their carers.

Staff at all levels reflected a strong culture and commitment to continuous improvement to securing the best possible outcomes for older people. Across the

range of services, staff morale impressed us as being good. The only exceptions to this were in teams or service areas where staff told us they were “fire fighting” and unable to deliver the level of personalised care and support that they wanted to. This was particularly evident within the care at home service and the integrated community mental health team. The partnership was reviewing its care at home provision to address shortfalls in staff capacity, but this was still at an early stage. Senior managers also acknowledged the community mental health team was under significant pressure. They told us that in response to this they were taking action to cover sickness absence and that additional posts were being advertised to further enhance the size and capacity of the team. Despite the pressure on these two staff groups, we found that the staff involved remained positive and committed to their work.

The partnership had developed a range of communication methods and approaches to help inform and involve staff in developments on the integration of health and social care. These included newsletters, information bulletins, team meetings and stakeholder events.

A positive initiative had been the development of professional reference groups and partnership forums to help strengthen workforce involvement. We attended a number of these groups, most of which were organised to bring together professional staff groups, such as allied health professionals<sup>21</sup>, dentistry and qualified social workers. They provided a useful forum at which both operational and service development issues could be discussed. For example, we observed a detailed discussion about a recent increase in waiting times for older people to be seen at orthopaedic clinics. A number of options for addressing the issue were identified by staff at this meeting.

Staff acknowledged the potential value of these groups, but told us the groups tended to be most active for those service areas which were subject to the most change. They also stated that workload demands and staffing constraints could hinder their involvement in the groups and in other service planning activities. Our staff survey reflected this view with 40% of respondents agreeing that their views were taken account of when planning services, and 44% agreeing that senior managers communicated well with frontline staff. Senior managers were disappointed with these findings as they believed they had worked hard to develop a range of communication and staff involvement initiatives. However, they acknowledged the importance of strengthening communication and engagement with the workforce.

Staff described a long history of positive joint working between frontline health and social work staff to support older people to live independently at home. We saw some good examples of this when we met with the intermediate care team, care at home staff, the falls steering group and palliative care staff. Our review of older peoples’ records reflected this as did our staff survey, and as stated earlier in the report, with most respondents saying they had excellent working relationships with other professionals.

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<sup>21</sup> Allied health professionals include occupational therapy and physiotherapy staff.

Most staff told us they received effective support from their line manager and had good access to profession-specific supervision and professional development. This was consistent with our staff survey results and that of the partnership's own staff surveys. However, workload pressures and the dispersed geography of the islands could at times impact on the frequency and delivery of this support. Positively, we noted that the partnership had made some meaningful progress to improve support networks for staff working in the outer isles. For example, a positive development had been the establishment of the Isles Network of Care.

### **Example of good practice – The Isles Network of Care**

The Isles Network of Care provided peer support to doctors and advance nurse practitioners working in some of the most remote islands in Orkney. Acting as a virtual peer support network, this enabled healthcare professionals to discuss and share views about the most appropriate interventions and treatment for patients to help inform clinical decision-making using a multidisciplinary approach.

Almost all staff we met enjoyed their work and felt valued and supported by their managers and other professionals. Overall, our staff survey results were generally positive. Our staff focus groups identified a flexible, well motivated and committed workforce. Despite some of the challenges caused by staff shortages and demands on time, staff remained committed to delivering high standards of personal care and support for older people. Feedback from service users and carers was generally very positive about health and social care services. However, the partnership needed to make better use of this information to help inform service development and to achieve good outcomes for people who used its services.

The majority of staff had access to professional development and effective line management. However, supervision and support could at times be affected by workload pressures. This could then impact on their frequency and delivery. This was particularly difficult to maintain for health and social care staff based in the outer isles, and in dispersed workforce teams such as the care at home and community nursing services.

### **Impact on the community and community capacity**

We evaluated the partnership's impact on the community as adequate. We found that the partnership had a strong commitment to public engagement, and had a comprehensive communication and engagement strategy in place. It had adopted a number of imaginative initiatives to engage and consult with the public and sought to involve people living on the outer isles. A concerted consultation exercise took place on the strategic commissioning plan. However, the partnership needed to strengthen how it incorporated consultation feedback into its service planning and how it provided public feedback on this. Although not all of its engagement initiatives had been successful, the partnership was committed to learning from this and to developing new approaches. Securing and maintaining carer representation on formal Integration Joint Board (IJB) committees and groups had proved challenging. The partnership had supported the development of a range of community groups

and projects with the aim of these becoming largely self-sufficient. However, the partnership needed to do more to formally evaluate these projects. The partnership was still in the early stages of its development locality planning. The well-established community councils provided a solid basis for locality development to take place. The partnership needed to make better use of public health and the role it could play in providing data on the needs of the local population. Older people were able to benefit from the support provided by a wide range of community groups. Voluntary Action Orkney played an important and valued role in promoting and supporting these groups.

## Community impact

We found a good level of commitment by the partnership to community engagement. This was reflected in the Orkney Health and Care communication and engagement strategy 2016–2017 and the Orkney community plan. Involving the public in policy and service development, co-production and community resilience building were themes that ran throughout these plans.

The partnership had identified community councils as being key to its engagement with local communities. A reflection of its commitment to the role of the community councils was a decision by the Orkney Islands Council to increase the funding it provided to the community councils. The 20 community councils covering the Orkney Islands each received an annual grant of some £3,500 to meet running costs. The partnership wanted the councils to play a pivotal role in the development of its approach to locality planning.

Staff, managers and IJB members had a clear understanding of the important role that communities and community groups played in supporting the population as a whole and older people in particular. They said the dispersed nature of the population made this very real for them. In our staff survey, we asked three questions about the partnership's community engagement. The answers for all three were above the average in other inspections to date, although not significantly so. For example, 58% of respondents agreed there was strong positive engagement between the partners and local community and third sector groups.

The community and engagement strategy was a comprehensive document which, as well as confirming the national and legislative drivers behind communication engagement, also provided a local context. It identified and listed all the local engagement groups, none of which were specifically for older people. It also provided information on a range of engagement approaches that partnership staff could use. The strategy was supported by a nine-point action plan covering the period up to April 2017. However, this lacked detail about the supporting actions required.

The Orkney community plan included detailed demographic information and demonstrated a detailed understanding of the needs of the population as a whole. It incorporated a local outcomes improvement plan for 2015–2018 which had 'positive ageing' as one of its three strategic priority areas. This priority workstream was overseen by a delivery group with a broad range of stakeholders. It had identified 12 action areas to be taken forward. These included action to:

- pilot community gardening project(s) for people unable to maintain the external environment around their homes
- develop and deliver retirement packs and workshops for people nearing retirement, recognising their positive contribution whether paid or unpaid
- explore and establish two pilot projects to increase the number and type of activities and services within community halls
- develop and support older people's forums to enable effective consultation and engagement
- establish a 'know what your options are' campaign to ensure effective signposting to alternative community services to achieve early intervention.

The delivery group also aimed to support community groups to establish projects which could become self-sustaining. Two pilot projects were underway to increase older people's awareness of their own health needs, to be more active and more independent. Community development money was used and some 20 older people benefitted from the initiative which was now operating without requiring support from the partnership. The focus of the projects and their activities had varied to take account of local need and had included lunch clubs, gentle yoga and IT skills. The partnership recognised the need for more robust evaluation of the outcomes delivered by the projects it sponsored.

The partnership's commitment to effectively engaging with communities was underpinned by relevant forums. These sought feedback on strategy and policy development as well as providing relevant information about service changes. The partnership had an established public partnership forum, but wanted to build on this with a more innovative approach. In collaboration with Voluntary Action Orkney, it had recently set up the Orkney Peer Network. Its role was to provide a mechanism by which the IJB could engage with the public and the community, including people who used health and social care services. As well as being a vehicle for seeking formal user and carer representatives on IJB committees and groups, it also provided a virtual network whereby interested individuals could register and sign up as an Orkney Peer Network member. They were then able to receive and respond to a range of IJB communication and information as well as be invited to consultation events.

Yammer<sup>22</sup> was being piloted within the network to provide a closed members-only network to provide a safe discussion and peer support network for members. At the time of our inspection, 35 people had signed up as Orkney Peer Network members and a further promotional exercise was being carried out. The partnership was keen to develop Orkney Peer Network membership across its localities and to use this as a key part of its locality development and planning processes. The relatively recent formation of Orkney Peer Network meant that it was too early to measure its impact. However, we considered it showed some good potential for involving members of the public in engagement about the delivery and development of health and social care services.

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<sup>22</sup> Yammer is an enterprise social network used for private communication within organisations or social communities.

The partnership had a patient and public reference group for health services. We saw from documentation provided that this was positively supported by the partnership. The group had been provided with information and consulted on the plans for the new hospital and healthcare facility. The results of these consultations were supported by an action plan.

Orkney Voices was a group with a specific interest in older people and obtaining their views. It aimed to use other community groups as a means of getting in touch with older people. It saw itself as having a dual role: as a group which would participate and respond to consultation events, and also as one which would act as a lobbying group on issues affecting older people in Orkney. We discussed the role of Orkney Voices when we met with representatives from a range of third sector organisations. They told us that awareness amongst older people about Orkney Voices was limited and that it could usefully raise its profile and clarify its role.

We found the partnership had taken some innovative approaches to include older people in the consultation of the strategic commissioning plan. This included people for whom participating in sessions on the Orkney mainland was not feasible. A variety of engagement methods had been used including:

- drop-in sessions
- providing paper copies of the plan and consultation in GP practices
- email
- a short survey
- a successful session using social media by the chief officer.

Not all engagement approaches and initiatives were successful. For example, a dedicated phone-in opportunity for members of the public to use as part of the strategic commissioning plan attracted no response. The partnership also faced a challenge in attracting and maintaining service users and carers as representatives on formal groups and committees. It had been unable to attract a carer to join the IJB committee as a carers' representative. A Crossroads member of staff had taken on this role whilst attempts were made to recruit a carer. Managers told us the small population of Orkney meant there was a small pool of people to draw from. They said some people acted as community representatives on a number of groups and later stood down due to "consultation fatigue". Despite these challenges, partnership staff and their partners showed a determination to press on being as proactive and imaginative as possible in pursuit of their commitment to community engagement.

Less positively, we found that the partnership did not always make best use of some of its consultation responses. For example, there was limited evidence of the response from the consultation impacting on the final draft of the strategic commissioning plan. Of the five themes presented to the IJB, only one was evident in the strategic plan. We considered that the partnership needed to improve how it made use of consultation feedback and how it shared this with the wider public, for example by using a 'you said - we did' approach.

### **Recommendation for improvement 9**

The partnership should ensure that it has effective processes in place to analyse and make best use of consultation feedback from the community, including both internal and external reporting arrangements.

Given the well-established position of community councils in Orkney, the partnership has identified them as having a pivotal role in its engagement with communities. However, it had recognised that its original plan to have GP-led sessions with each of the community councils by 2016 had been overly ambitious. As an alternative, it had started a rolling programme of engagement with the community councils. The locality managers would play a leading role in the locality development and planning work. This made sense given the OHAC management structure and their integrated role. However, it was another example of where significant demands would be placed on staff members given the partnership's limited staffing capacity. The partnership needed to improve and make fuller use than it had in the past of the expertise of its public health colleagues. They had a key role to play in identifying the needs of the population and in the development of early intervention, preventative approaches and locality planning to reduce health inequalities. The partnership needed to take account of the Public Health Review.<sup>23</sup>

### **Recommendation for improvement 10**

The partnership should ensure that it works closely with public health colleagues and make best use of epidemiological data to identify local health needs and to contribute to a reduction in health inequalities.

A significant number of community groups and projects in Orkney provided a range of support to older people and their carers. This included support for older people managing their long-term conditions. Older people and carers often spoke positively about these sources of support. There was a well-established culture of volunteering and befriending and a reasonably good availability of volunteers to carry this out. Other examples included the following.

- Two knitting groups in extra-care housing facilities were being supported by staff on a voluntary basis. Older people in the group enjoyed the company they shared as part of the groups and, as well as the knitting, enjoyed other social activities. Some blankets they had made were being used on council transport services to keep older people warm as they travelled. Knitting group members were very pleased that their work was being appreciated by others.
- Walking football had been available for some six months. This new activity and group had been well received in the community with the oldest participant being 80 years old.

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<sup>23</sup> Scottish Government Review of Public Health February 2016 in Scotland: Strengthening the Function and Re-Focussing Action for a Healthier Scotland

- Older people were supported by the partnership and the Royal British Legion to participate in and enjoy the centenary 2016 Jutland celebrations which took place during our inspection.

Voluntary Action Orkney played a key co-ordinating role in promoting and supporting community activities. We found that it played a very visible and valued role in the community. We met with the organisation who told us that it enjoyed a well-established and positive relationship with the partnership. The success of Voluntary Action Orkney in supporting the local community was recognised with a Committed to Excellence Award at the Scottish Awards for Business Excellence in July 2016.

Staff in the partnership frequently undertook a range of roles within their employment with NHS Orkney or Orkney Islands Council. However, in addition we also met a number of staff who played important community roles, for example acting as volunteers in support of fire and rescue services and other key community services. We were impressed by their commitment to serving the local community in a variety of roles.

## **Conclusion: capacity to improve**

We concluded that the partnership has potential to develop further and to have a positive impact on the lives of older people and carers. A positive factor was that the partnership was already providing a number of effective services and achieving positive outcomes for many older people. It also had a good awareness of those areas where improvement was required. Another strength was the shared commitment among staff at all levels and amongst IJB members to move forward in a real spirit of partnership. The partnership had a well motivated and committed workforce and had invested significantly in its training and development.

The partnership was facing some major challenges, most notably how to meet the significantly increasing need and demand for services at a time of financial austerity. In some key areas, such as care at home provision, the partnership did not have an established history of having commissioned new providers to complement council directly provided services for older people. Findings of some previous external scrutiny had found that both the council and NHS Orkney have sometimes struggled to make changes in a timely fashion. This was partly because of the longstanding capacity issues they faced given their small size. However, the leaders we met viewed health and social care integration as an opportunity to combine resources and expertise to maximise the ability to achieve the best outcomes for older people in Orkney.

## **What happens next?**

We will ask the Orkney Islands Partnership to produce a joint action plan detailing how it will implement each of our recommendations. The Care Inspectorate with Healthcare Improvement Scotland will monitor progress.

**March 2017**

## 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?
<b>1. Key performance outcomes</b>	<b>2. Getting help at the right time</b>	<b>5. Delivery of key processes</b>	<b>6. Policy development and plans to support improvement in service</b>	<b>9. Leadership and direction that promotes partnership</b>
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  5.4 Involvement of individuals and carers in directing their own support	6.1 Operational and strategic planning arrangements  6.2 Partnership development of a range of early intervention and support services  6.3 Quality assurance, self-evaluation and improvement  6.4 Involving individuals who use services, carers and other stakeholders  6.5 Commissioning arrangements	9.1 Vision ,values and culture across the Partnership  9.2 Leadership of strategy and direction  9.3 Leadership of people across the Partnership  9.4 Leadership of change and improvement
	<b>3. Impact on staff</b>		<b>7. Management and support of staff</b>	<b>10. Capacity for improvement</b>
	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 Judgment based on an evaluation of performance against the quality indicators
	<b>4. Impact on the community</b>		<b>8. Partnership working</b>	
	4.1 Public confidence in community services and community engagement		8.1 Management of resources  8.2 Information systems  8.3 Partnership arrangements	
<b>What is our capacity for improvement?</b>				



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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.