

Services for older people in Angus

March 2015

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-centered care. It also inspects services to provide public assurance about the quality and safety of that care.

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Summary of our joint inspection findings

Between April and June 2014, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services¹ for older people in Angus. In Angus, social work services and most community health services were delivered by Angus Council and NHS Tayside. The purpose of the joint inspection was to find out how well the health and social work services partnership between Angus Council and NHS Tayside (referred to in this report as the Angus Partnership or, the Partnership) delivered good personal outcomes for people who use services and their carers. We wanted to find out if health and social work services worked together effectively to deliver high quality services to service users, which enabled them to be independent, safe, as healthy as possible and have a good sense of wellbeing. We also wanted to find out if health and social work services were well prepared for the legislative changes designed to get health and social work services to work closer together.

Our joint inspection involved meeting over 70 people service users and their carers, and over 180 staff from health and social work services. We read some services users' health records and social work services records. We studied written information provided by the Partnership about the health and social work services for service users and their carers in Angus too.

Outcomes for people who use services and their carers

The Angus Partnership performed well compared to other partnership areas on preventing avoidable admissions of older people to hospital. Its performance on ensuring the timely discharge from hospital of older people who used services who were medically fit for discharge varied in the previous months. Overall, there was a sound approach to providing care and support to service users at an early stage.

¹ S48 of the Public Services Reform (S) Act 2010 defines social work services as - (a) services which are provided by a local authority in the exercise of any of its social work services functions, or (b) services which are provided by another person pursuant to arrangements made by a local authority in the exercise of its social work services functions; "social work services functions" means functions under the enactments specified in schedule 13.

This helped to reduce the need for admission to hospital, supported discharge from hospital as well as supporting service users to remain at home.

The enablement service was delivering good outcomes for service users, helping to maintain their independence and ability to manage without the need for continued home care support. While home care services delivered good outcomes for service users, we found there were issues with home care capacity. This had an adverse impact on some service users and their carers.

The Partnership needed to address the balance of care to increase the number of people supported at home rather than in a care home through:

- reducing the time that some service users spent in hospital when they were ready to go home
- providing increased access to home care so that people can manage on their own
- providing increased access to self-directed support so that people have more of a say, choice and control, and
- responding to carers' needs so that they are better able to support people who use services.

What did people and their carers think?

The Partnership was supporting the involvement of service users in the assessment for, and delivery of, their own care as well as how they contributed to shaping future services. There was a focus on making sure that people were able to maintain their own independence, manage their own conditions, where appropriate, and have the care that they needed to do this provided at the right time by the right people.

A wide range of services was available to provide support to carers and those receiving support. Service users of health and social work services and their carers were, on the whole, satisfied both with the services that they received and the positive outcomes for them that resulted. They highlighted some areas, such as home care, where better communication would improve services.

Impact on staff

Overall, staff motivation across the Partnership was good. Staff had a positive attitude to their roles despite their concerns about the ability of services to cope with increasing demands.

There was good multidisciplinary and multi-agency team communication and a commitment to providing good standards of care to service users. Although there were some staff consultation activities, staff felt that communication about proposed changes could be improved.

Senior managers were able to recognise the changes needed to improve staff readiness and skills further. However, staff told us that communication about the progress of the Partnership and integration was not always good and they were not always fully engaged. Senior managers recognised that there was more work in these areas needed.

Involving the local community

We found that the Partnership was committed to developing the contribution that the wider community could make to improving services. It engaged with, and involved, local communities to meet the health and social care needs of service users.

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

However, the Partnership needed to do more to measure the impacts and outcomes of these community supports and establish how its own services were viewed by the wider public so that local people can have an increasing say in what happens in the future.

Getting a service and keeping safe

There was integrated working between health, social work and third and independent sectors in some adult services. The Partnership was seeking to build on this. It had reviewed and refined many of its ways of working. Partnership working was good in the community. Assessments of care and support needs were carried out efficiently, and care and support plans were regularly reviewed.

Self-directed support was being taken forward and enablement was generally having a positive impact in helping service users maximise their quality of life.

While staff felt confident and supported in managing risk, we identified areas for improvement in preparing and recording written risk assessments and risk management plans.

Plans and policies

We found that plans for developing services and performance measurement needed to improve. This reflected, in part, the stage of development of some of the work that was being taken forward by the relevant partners. Operational and strategic planning had been held up during recent management changes but was now being reinvigorated. There were areas for significant improvement including the need for more clarity in the plans on how priorities would be supported.

Stakeholder engagement had been uneven but was beginning to improve through better representation from the third and independent sectors in planning groups.

Management and support of staff

Workforce planning for joined up services was at a very early stage. Historically, vacancy and absence rates in Angus Council and NHS Tayside had, in general, not given cause for concern.

Work was under way to reconfigure local services in Angus. Funding was available to support workforce development. There was no joint workforce plan at this stage but there was evidence of good frontline team working and joint working between health and social work services staff.

A joint approach to support recruitment opportunities had been carried out involving a local college and apprentice schemes with local schools. Training and development opportunities were available and focused on improving outcomes.

Working together

There was progress towards the implementation of joint financial planning and monitoring arrangements for 2014-2015 and beyond.

NHS Tayside and Angus Council were committed to partnership working and were developing the necessary structures to make sure that arrangements were complete within the allocated timescales. However, there had been limited partnership working regarding financial planning and budget monitoring.

Although the structure within the health and social work services remained largely separate below the interim joint chief officer, we did not find that this created barriers to joint working at a managerial level.

The Partnership had a strong tradition of working well together at locality level, and between individual members of staff. Formal partnership arrangements were being put in place.

Leadership

The Partnership was at the early stages of developing its own approach to integrating health and social care in line with legislation. It had a shared vision and an agreed model for integration and was building working relationships. This needed to be developed further to ensure a positive transition to new integration arrangements.

Leaders of services had identified many of the future challenges in delivering joined-up services for service users. Service delivery plans needed to improve by fully showing clear links between an understanding of the current situation and the actions required to address the changing needs of service users and their carers.

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

Strengths and areas for improvement

The Angus Partnership had areas of strength. For example we noted that staff from different agencies were jointly working together to deliver good outcomes for service users and their carers at a local level. Staff from both health and social work services were generally well motivated. In addition, we found a commitment to realise the potential contribution from within the community to help service users and their carers.

Leaders had identified the future challenges in delivering joined-up services for service users and most of the procedures to assist staff in delivering services were fit for purpose.

However we also noted areas for improvement. The Partnership needed to improve services for service users and their carers by reducing the delays in discharging people from hospital. It needed to improve the carers' assessment process so that carers had better access to services for themselves and those that they cared for.

A more formal approach to help realise the potential of the community and third sectors to help service users and their carers should be put in place. Improvement was needed in the procedures for making sure that service users and their carers are protected from harm.

The content and monitoring of local plans to support the integration of health and social care services needed to be better. Strategic thinking needed to be translated into evidenced planning for future service delivery. Improvements in the joint arrangements between health and social work services to commission services for the benefit of service users and their carers were needed. Major financial risks needed to be better identified and managed. In addition, consultation, engagement and involvement arrangements with stakeholders needed to improve.

Evaluations and recommendations

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

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

Evaluation criteria

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

Recommendations for improvement

Angus Partnership should

- | | |
|----------|---|
| 1 | meet the Scottish Government target of no delayed discharges over four weeks' duration so that people can return to their own home or a homely setting in which their needs are better met. |
| 2 | improve the carers' assessment process so that carers have better access to services for themselves and those that they care for. |
| 3 | ensure that all relevant case records contain accurate chronologies and, where appropriate, have written risk assessment and risk management plans in place so that service users care needs are better assessed and planned for. |
| 4 | show clearly how it plans for, and commissions, services, across all sectors that improve the balance of care and deliver an increased range of support to help individuals to remain at home successfully. |
| 5 | assess and gauge in detail the strategic financial risks to the future development of the Partnership and the delivery of health and social work services and ensure that these risks are managed effectively. |
| 6 | develop its strategic planning processes setting out clear consultation and involvement measures so that all relevant stakeholders are consistently engaged. This should be part of its further development of its integration project planning in areas such as strategic needs assessments, service review and development, joint commissioning, monitoring arrangements and joint performance management. These developments should help to evidence how services are improving for the benefit of service users and their carers. |

Background

Scottish Ministers have requested that the Care Inspectorate and Healthcare Improvement Scotland carry out joint inspections of health and social work services for older people. The Scottish Government expects NHS boards and local authorities to integrate health and social care services from April 2016. This policy aims to ensure the provision of seamless, consistent, efficient and high quality services, which deliver very good outcomes² for individuals and carers. Local partnerships had to produce a joint commissioning strategy for older people in 2013. A joint Strategic Plan, covering all adult services, was expected by March 2016. At the time of inspection partnerships were establishing shadow arrangements, and each one was producing a joint integration scheme, including arrangements for older people's services. We scrutinised the existing planning, commissioning and delivery of services as well as partnerships' preparedness for health and social care integration. The scope of these joint inspections was to be expanded to include health and social work services for other adults.

The purpose of this report is to evaluate the progress the Angus Partnership is making towards joint working, and how that progress is impacting on outcomes for older people who used services. The Angus Partnership includes principally Angus Council and NHS Tayside (Angus community health partnership). However, it will be of interest to other partnerships and communities who are at different stages of progressing with this work.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (see **Appendix 1**). Our findings on the Angus Partnership's performance against the quality indicators are contained in separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector³ to deliver positive outcomes for service users and their carers.

The inspection teams were made up of inspectors and associate inspectors⁴ from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors who were carers on each of our inspections. To find out more go to: www.careinspectorate.com/ or www.healthcareimprovementscotland.org/

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

³The Third Sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers (Scottish Government definition).

⁴Experienced professionals seconded to joint inspection teams.

Joint inspection of health and social work services for older people in Angus

During our inspection between April and June 2014 we scrutinised social work services and health records for 112 people using services in Angus. We analysed nationally published and local statistical data about the Angus Partnership's provision of health and social work services for older people. We reviewed the Partnership's policy, strategic and operational documents. We spoke with people who received health and social work services and their carers. We spoke with health and social work services staff with leadership and management responsibilities. We talked to staff that work directly with service users and their families and observed some meetings. We are very grateful to all of the people who talked with us as part of this inspection.

Angus context

Angus is situated in the north east of Scotland. The council area borders onto Aberdeenshire, Perth and Kinross, and Dundee City. Angus covers an area of 2,182 square kilometres. The 2013 population for Angus was 116,240 and accounted for 2.2% of the total population of Scotland. Arbroath is the largest town. Other main settlements include Brechin, Carnoustie, Forfar (the main administrative centre), Kirriemuir, Monifieth and Montrose.

People aged 60 years and over made up 28.4% of the Angus population which was a higher proportion than Scotland. The age group that was projected to increase the most in size, in Angus by 2037, was people aged 75 years and over. This was the same as for Scotland as a whole. Angus' population of people of pensionable age was due to increase by 6% by 2020, and increase by 21% by 2030 respectively. The equivalent Scotland figures were 3% and 20%. More specifically, Angus' 75+ years population was due to increase by 29% by 2020 and increase by 72% by 2030 respectively. The equivalent Scotland figures were 23% and 62%.

People from a minority ethnic background made up a smaller proportion of Angus' population than Scotland as a whole. According to the Scottish Index of Multiple Deprivation, 4,530 (4.1%) of the population of Angus were living in one of the 15% most deprived areas in Scotland.

The ageing population profile in Angus brings with it significant opportunities, with health and social care a growing employment sector throughout the area. With nearly a third of total workforce working in public administration, education, health and social care, the care sector offers growth potential for both independent and third sector business. There are challenges too with the traditional working age population reducing.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

The Angus Partnership performed relatively well, compared to Scottish national trends, on preventing avoidable admissions to hospital. Performance on ensuring the timely discharge from hospital of service users who were clinically fit for discharge varied. The Partnership needed to consistently meet the Scottish Government's national set target of no delayed discharges over four weeks' duration.

While home care services in Angus delivered good outcomes for people, we found issues with home care capacity. This had an adverse impact on some service users and their carers. The Partnership's enablement service was delivering good outcomes for people, and maintaining their independence and ability to manage without the need for continued home care support.

1.1 Improvements in partnership performance in both health and social care

Emergency admissions to hospital

An emergency admission is when admission is unpredictable and at short notice because of clinical need. The Angus Partnership was consistently performing better than the Scotland average in the numbers of emergency admissions, multiple emergency admissions and bed days occupied by for older people subject to an emergency admission.

The Partnership had carried out initiatives to prevent emergency hospital admissions. The early supported discharge and prevention of admission scheme had been operating in Angus since 2001. This was developed in partnership between Angus Council's social work and health services and Angus community health partnership. The scheme provided augmented home care and rehabilitation services for up to 28 days to support timeous discharge from hospital or to prevent avoidable admission. The Partnership submitted data which showed that the following numbers of hospital admissions were prevented.

- 160 prevented admissions in 2011–2012
- 109 prevented admissions in 2012–2013, and
- 81 prevented admissions in 2013–2014.

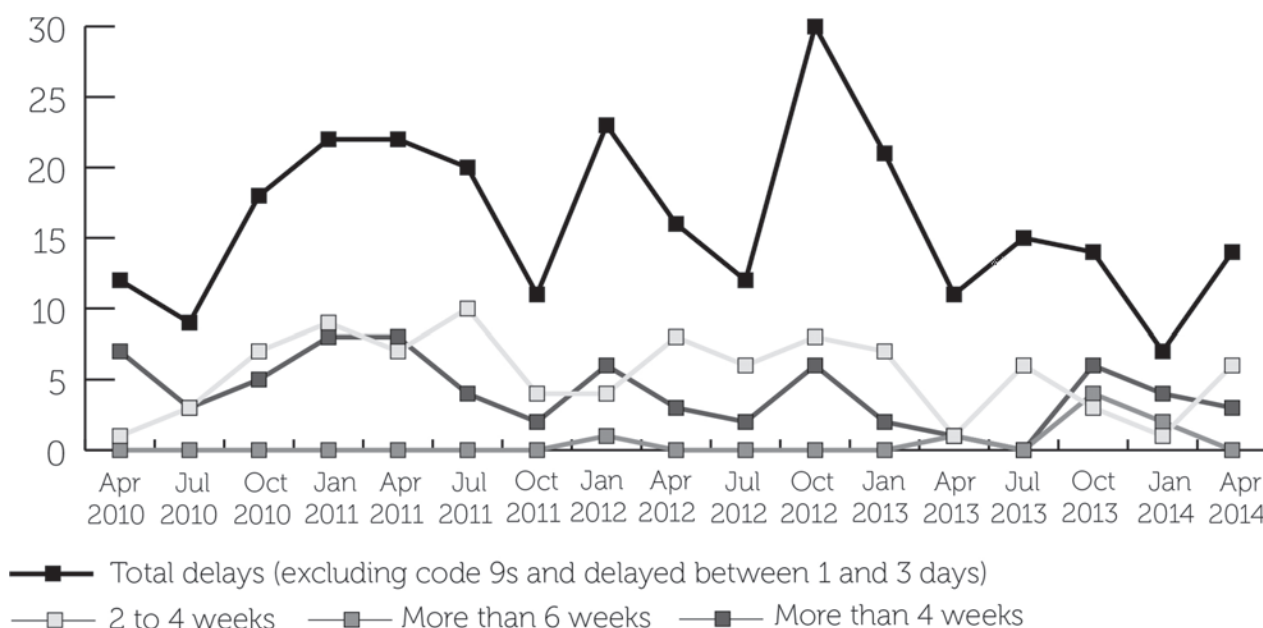
The Partnership had a successful falls prevention initiative (falls are a major cause of emergency hospital admissions for older people). This provided for around 700 people a year. This was a factor in reducing the number of emergency admissions of service users to hospital.

Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. The Scottish Government’s target is that there should be no individuals whose discharge was delayed for over 4 weeks’ duration.

Figure 1 shows that the Angus Partnership’s performance on preventing delayed discharge against the current four-week target and the previous six-week target, which existed before April 2013. The graph shows that the Partnership had failed to meet the four-week target in all but one of the quarters (July 2013).

Figure 1: Numbers of Angus delayed discharges by length of delay/performance against Scottish Government targets

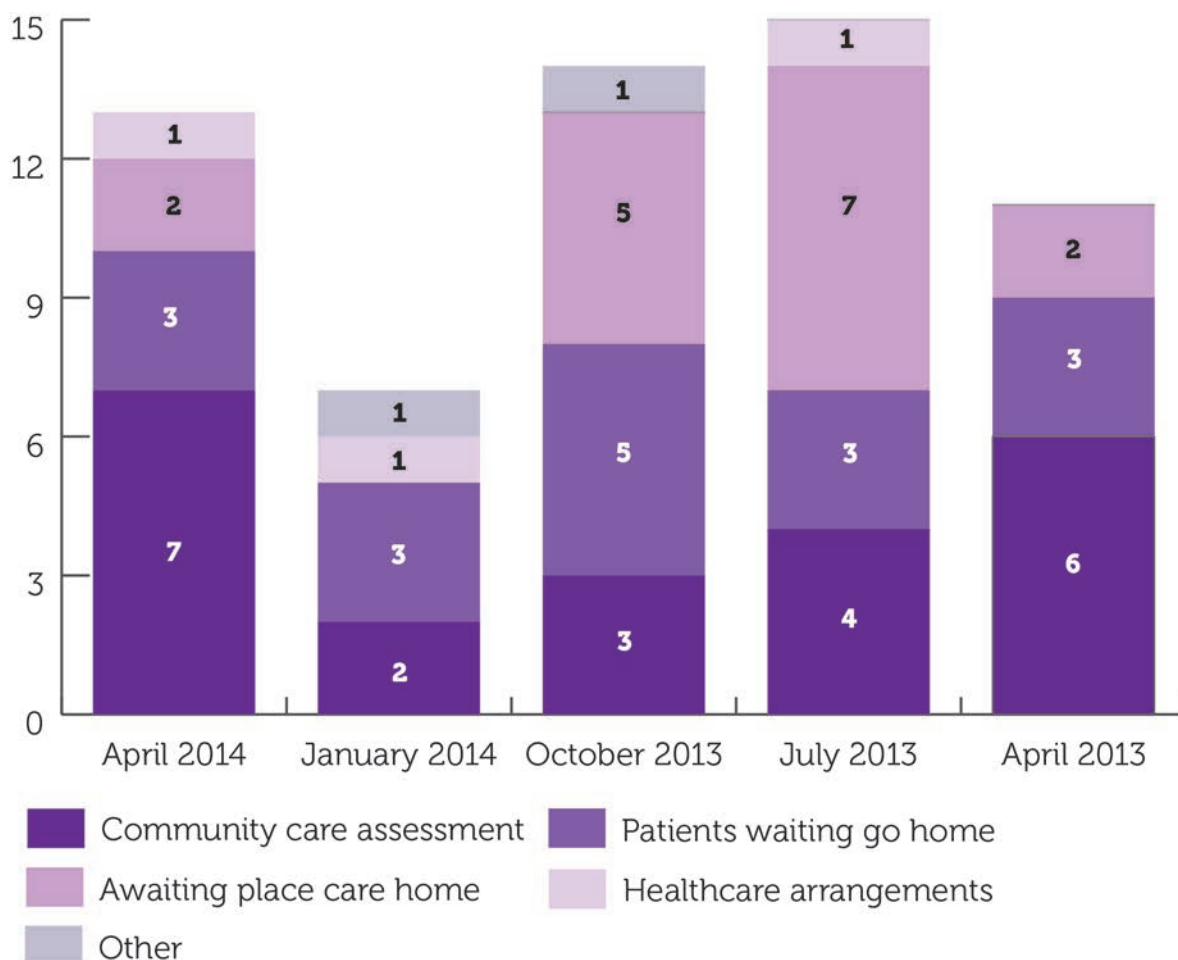


Source: Information Services Division

Between April 2013 and April 2014, the most common reason for patients having to wait in an acute bed when they were medically fit for discharge and whose discharge was delayed, was with the allocation and completion of community care assessments (22 cases). The next most common reason for delayed discharge was patients who were waiting to go home but they were unable to do so.

This was because, in the main, there were no home carers immediately available to look after them at home (17 cases). Frontline health and social work services staff we spoke with mentioned the unavailability of home carers as a significant causal factor of delayed discharge. Figure 2 also shows that another significant reason for delayed discharge in Angus was patients who were waiting on a care home place becoming available (16 cases).

Figure 2: Angus reasons for delayed discharge, (excludes code 9s and delays of 1-3 days), April 2013 – April 2014



Source: Information Services Division

The Angus Partnership performed better than the Scotland average for hospital bed days lost to delayed discharges of patients who were aged over 75 years, helping to reduce the time that some service users spent in hospital when they were ready to go home. The Partnership ranked 16 out of 32 local authorities for this indicator (the first ranked had the least bed days lost).

This relatively good performance was in contrast to the fact that the Angus Partnership had consistently failed to meet the Scottish Government’s target of no delayed discharges over four weeks. This led to avoidable periods of care in hospital settings for some people. However, a positive factor on delayed discharges was that the Partnership had relatively low numbers of code nine⁵ delayed discharges.

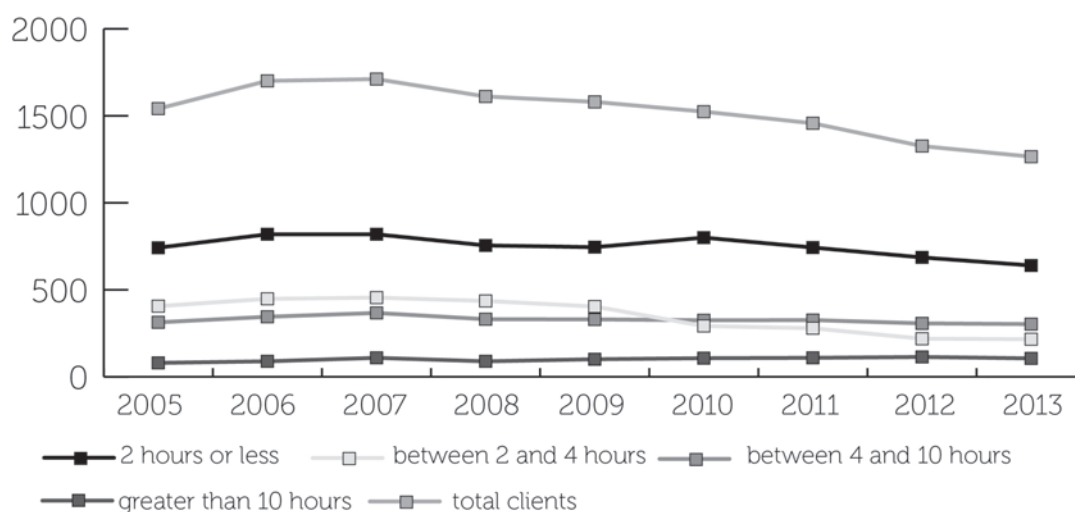
Recommendation for improvement 1

The Angus Partnership should meet the Scottish Government target of no delayed discharges over four weeks’ duration so that people can return to their own home or a homely setting in which their needs are better met.

Access to home care services

Home care is care and support for people in their own home to help them with personal and other essential tasks. Figure 3 shows the overall trend of the Angus Partnership providing home care to fewer service users in recent years. It also shows the flat trend of the number of service users receiving over 10 hours of home care each week.

Figure 3: Angus distribution of numbers of client home care hours per client per week and total, 2005–2013



Source: Scottish Government

⁵ Patients whose discharge is delayed for reasons linked to the Adults with Incapacity (Scotland) Act 2000 and for reasons related to the availability of specialist healthcare facilities

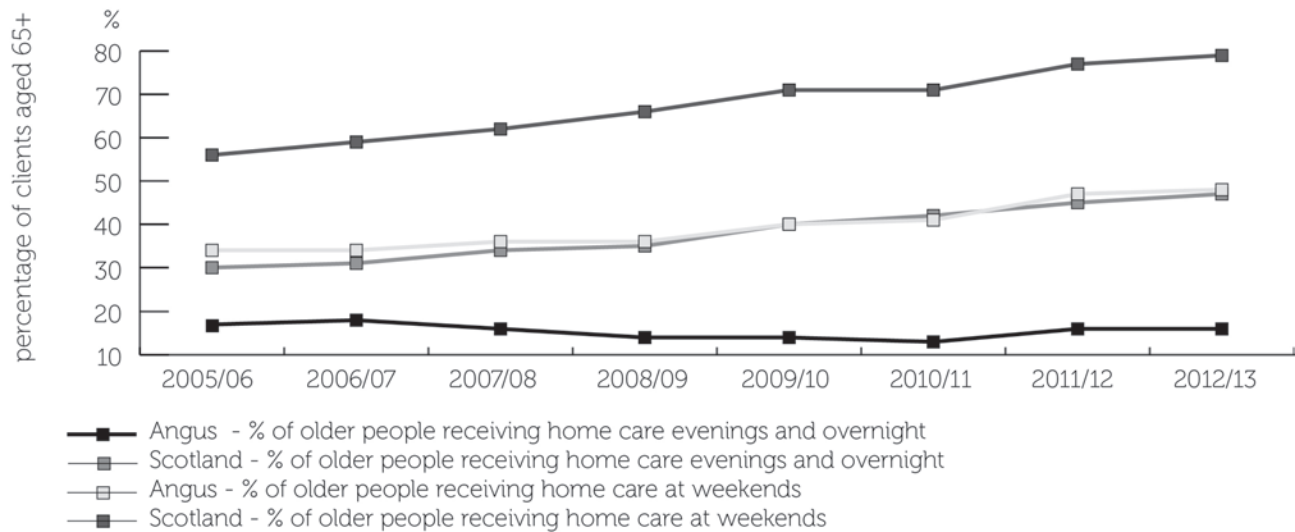
The Partnership provided intensive home care to service users at a level which was well below the Scotland average. The Angus Partnership ranked lowest out of all 32 local authorities in Scotland for the provision of intensive home care to people. There was a similar trend for the Partnership's low level of provision of home care to service users in the evenings, overnight and at weekends, compared to the Scotland average.

We found that the home care service sometimes had difficulties in providing the level of support that was needed when an older person moved on from a period of enablement. Enablement was about giving people the opportunity and the confidence to relearn or regain some of the skills they may have lost as a result of poor health, disability or impairment, or following their admission to hospital or residential care. Sometimes the service had difficulties in providing care for people at times when they needed it as they did not have staff to help, particularly when the person needed two staff for personal care. Managers planned to review the communications and support that was provided when people moved from enablement to home care to make sure that progress was sustained.

We had mixed findings on the impact of the Partnership's low level of home care provision. We met with a number of people who were very satisfied with the home care they received. They told us that their needs were met. We also met carers who were generally satisfied with the amount of home care that the person they cared for received, even when the home care support provided was relatively low. Most of the health and social work services staff we met with said that there was an adequate level of home care provision for people.

However, some other health and social work services staff and families of service users we met with said that there was sometimes insufficient home care provision to meet the needs of people in good time. Staff told us the impact of this was that some people had to wait for the home care support they needed, patients' discharge from hospital was delayed, and some people were admitted to hospital in an emergency which could have been avoided.

Figure 4: Angus care clients aged 65+ years receiving evenings/overnight and at weekends home care as percentage of total 65+ years home care clients



Source: Scottish Government

There were a number of instances when the enablement service was unable to transfer people to the mainstream home care service. Staff told us of some lengthy delays. Senior managers acknowledged that the current levels of home care would be unable to meet the anticipated levels of future demand. They were reviewing services to address this forthcoming issue.

Reablement

The Angus Partnership had adopted an enablement approach to support people. As well as regaining skills, enablement supports individuals to gain new skills to help them maintain their independence. This included the delivery of intensive and specialist home care support, often combined with services such as physiotherapy, occupational therapy and rehabilitation. This was usually delivered for a period of up to six weeks or more if particular needs were identified and focused on skills for daily living to help service users regain confidence. It could enable people to live more independently and reduce their need for ongoing services and supports.

From information they provided, the Angus Partnership had shown a good performance on enablement. Key messages from the data were that:

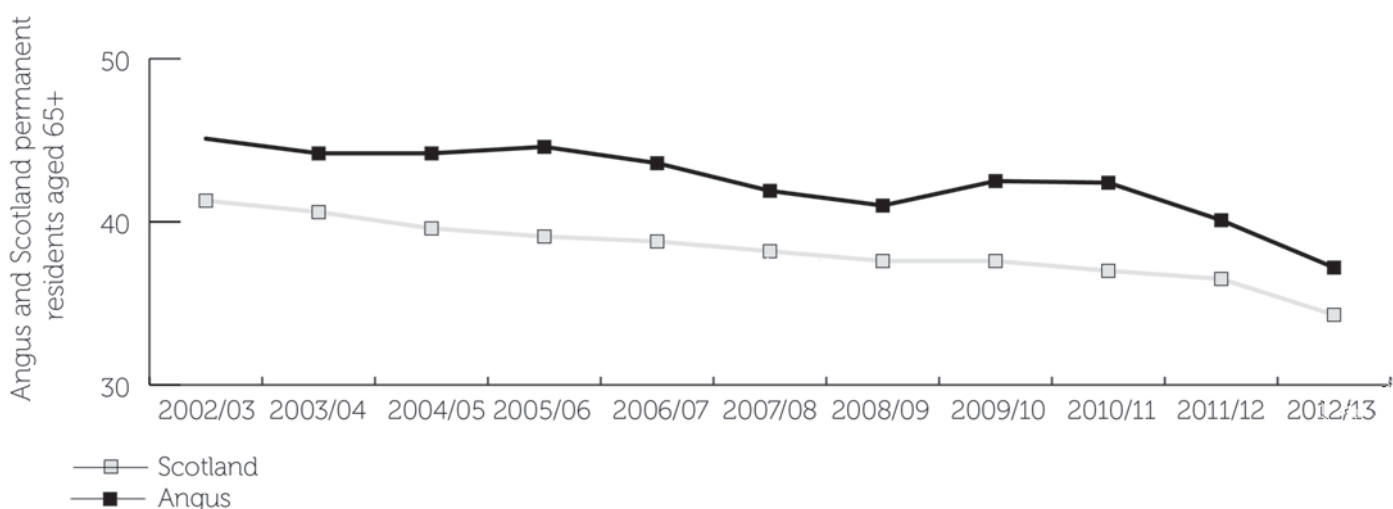
- high percentages of service users, (typically over 50% and over 80% in one quarter in 2013–2014), who had an enablement episode were returned to full independence with no requirement for on-going home care support
- for service users who did require ongoing home care support, a very high percentage, (usually over 70%), of them needed less home care support than they did before they received their enablement episode.

We met with some service users who had benefitted from enablement. This service had helped them to attain a high level of independence and capacity for self-care. Health and social work services staff we met with commented on the ability of the enablement service to deliver positive outcomes for service users. This included maximising their capacity for self-care, enhancing their wellbeing, ensuring their safety and ability to live independently in their own homes.

Care homes

Figure 5 shows that, over a period of years, the Partnership had proportionately placed more people permanently in care homes than the Scotland average. We noted that statistical evidence showed that that the Angus Partnership had the poorest balance of care ratio of any partnership area in Scotland. This means the proportion of overall care that is delivered in a range of settings from institutional to community and homely settings. One of the Partnership's strategic objectives was to reduce the numbers of people that it placed permanently in care homes. Figure 5 shows that the Partnership had made some progress with this objective, particularly between 2011 and 2013. The Partnership faced significant challenges to shift the balance of care. As shifting the balance of care is a major element of Scottish Government policy, the Partnership needed to address this as a priority.

Figure 5: Angus and Scotland permanent residents, (aged 65+ years), of care homes supported by councils, (rate per 1,000 popn. 65+ years), 2002–2003 to 2012–2013

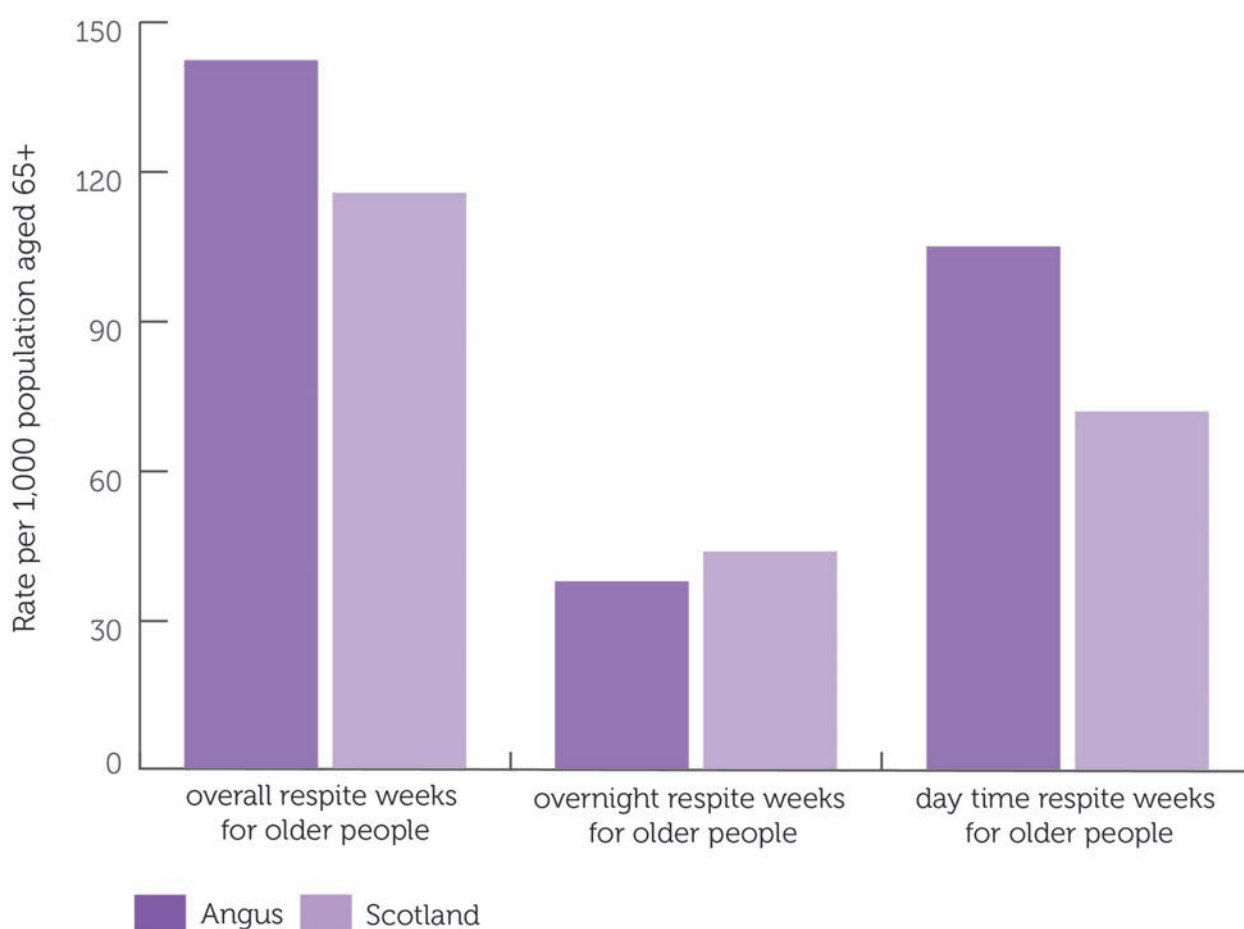


Source: Scottish Government

Respite care for service users and their carers

Figure 6 shows that, overall, the Angus Partnership delivered more respite to service users and their carers than the Scotland average. We met with a number of service users and their carers who said they had benefitted from respite provision and that they were content with the quality of this service. However, health and social work services staff expressed concern about the closure of Angus Council's 'short breaks' respite scheme and, at the time of the inspection, an absence of alternative provision.

Figure 6: Angus and Scotland respite for service users, (rate per 1,000 popn. 65+ years), 2012–2013)



Source: Scottish Government

Self-directed support

Self-directed support means the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. There had been until 2013 a declining trend in the overall provision of direct payments in Angus, in sharp contrast to

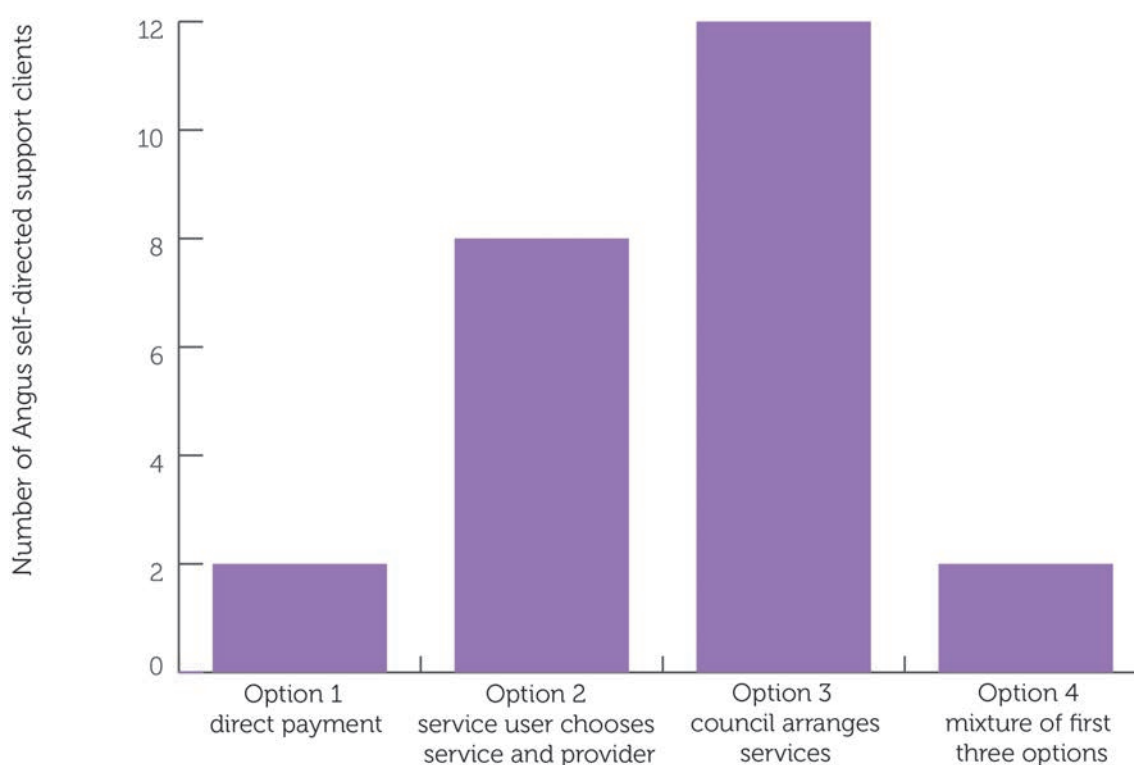
the rising Scotland trend. Angus was in the lowest ranked quarter of all 32 local authorities with regard to the level of all direct payment recipients in Scotland. Less than 10 service users in Angus were receiving direct payments in 2013. Since April 2014, Angus Council had a statutory duty to offer the four self-directed support options to service users and other adults who require social work services.

Angus Partnership had made progress, from April 2014, in implementing self-directed support legislation and had completed a number of self-directed support assessments. Approximately 60 self-directed support assessments, for all adults, (mostly older people), took place between 1 April 2014 and 30 June 2014 with 24 clients confirming their options. Two had chosen direct payments.

The Scottish Government expected that all relevant self-directed options should be made available to service users. The Partnership needed to maintain its recent progress and in particular explore ways of encouraging service users to access all the options so that they had more of a say, choice and control.

In addition, the Partnership needed to upgrade its electronic systems to make sure that the self-directed support options chosen by service users are properly recorded and monitored. This would allow the required aggregate data to be prepared.

Figure 7: Numbers of Angus self-directed support clients - options chosen by all adults, where recorded, June 2014



Source: Angus Council

Telehealthcare and telecare

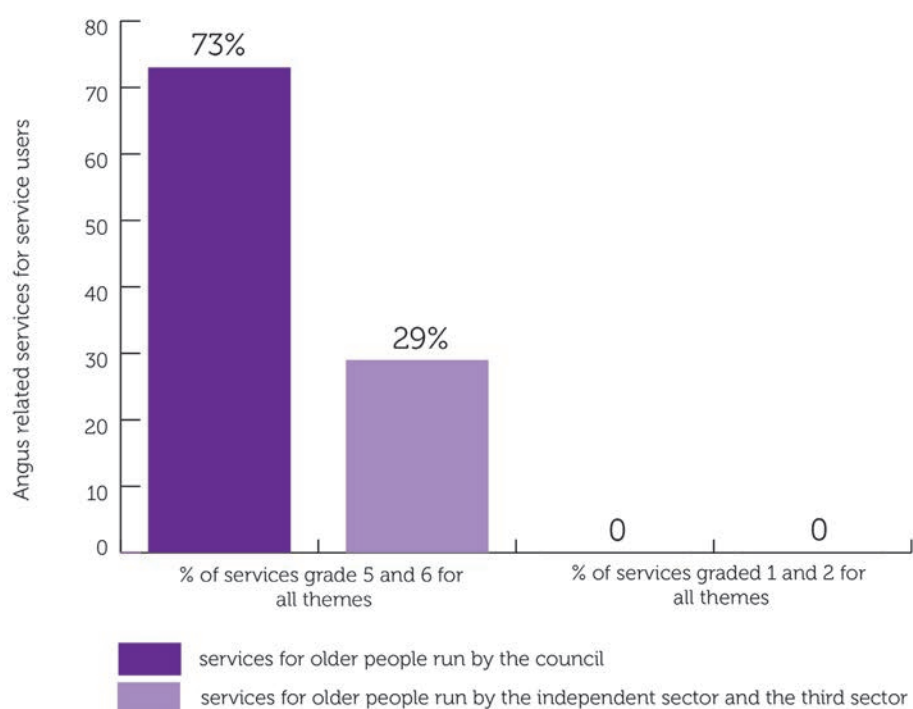
Telehealthcare assists the self-management of patients' conditions and may include video-conferencing, patients' remote consultations with health professionals or environmental monitoring devices installed in patients' homes. Telecare is equipment and services that support people's safety and independence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

According to the latest statistics published by the Scottish Government, the level of community alarms provision was higher than the average Scottish level. In addition around 650 items of telecare equipment were provided to service users. It is likely most of them were older people who used services, and many service users had more than one item of equipment. This type of service can help people to remain independent at home.

Performance of regulated care services for service users

The Care Inspectorate inspects regulated services delivered by local authorities, the voluntary and independent sectors. Figure 8 shows the aggregate performance of regulated care services for people in Angus. In the main, in Angus, regulated care services delivered good outcomes for service users and their carers. For regulated care services that were not performing well, the Care Inspectorate was working with these services to drive the required improvements.

Figure 8: Angus regulated services for service users (grades 5 and 6 - very good and excellent, 1 and 2 is weak and unsatisfactory), June 2014



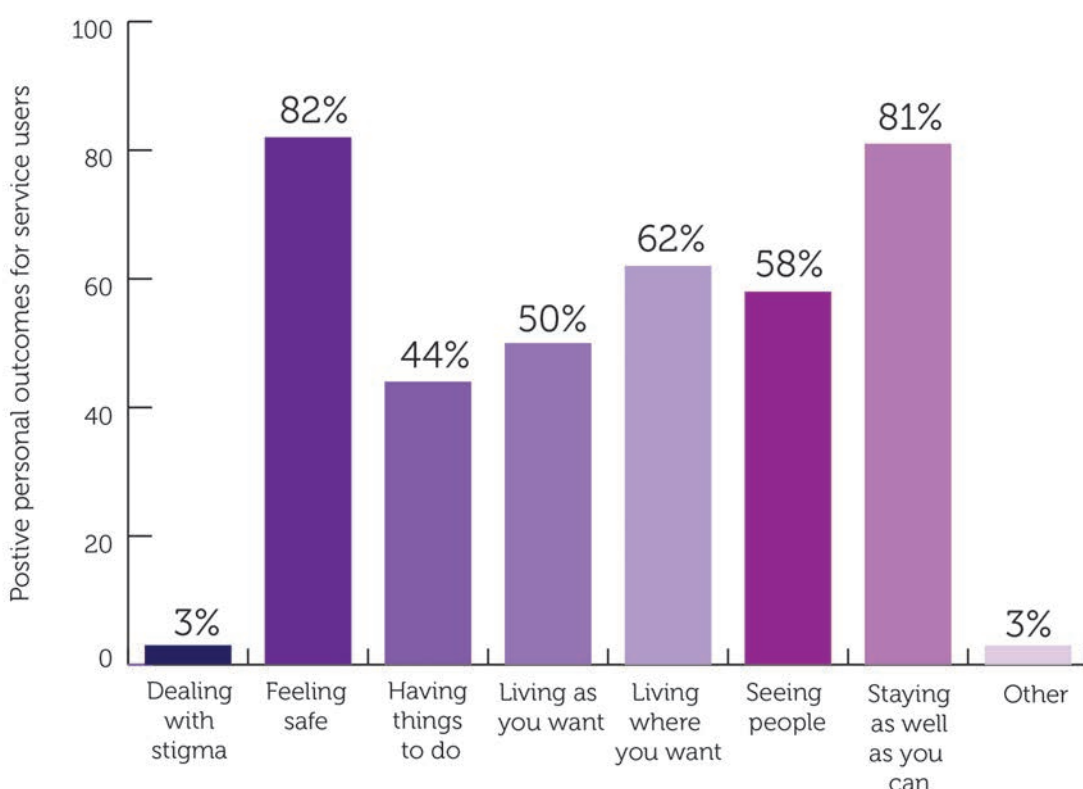
Source: Care Inspectorate

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

Outcome-focused care and support plans

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

Figure 9: Positive personal outcomes for service users delivered by the Angus Partnership, May 2014



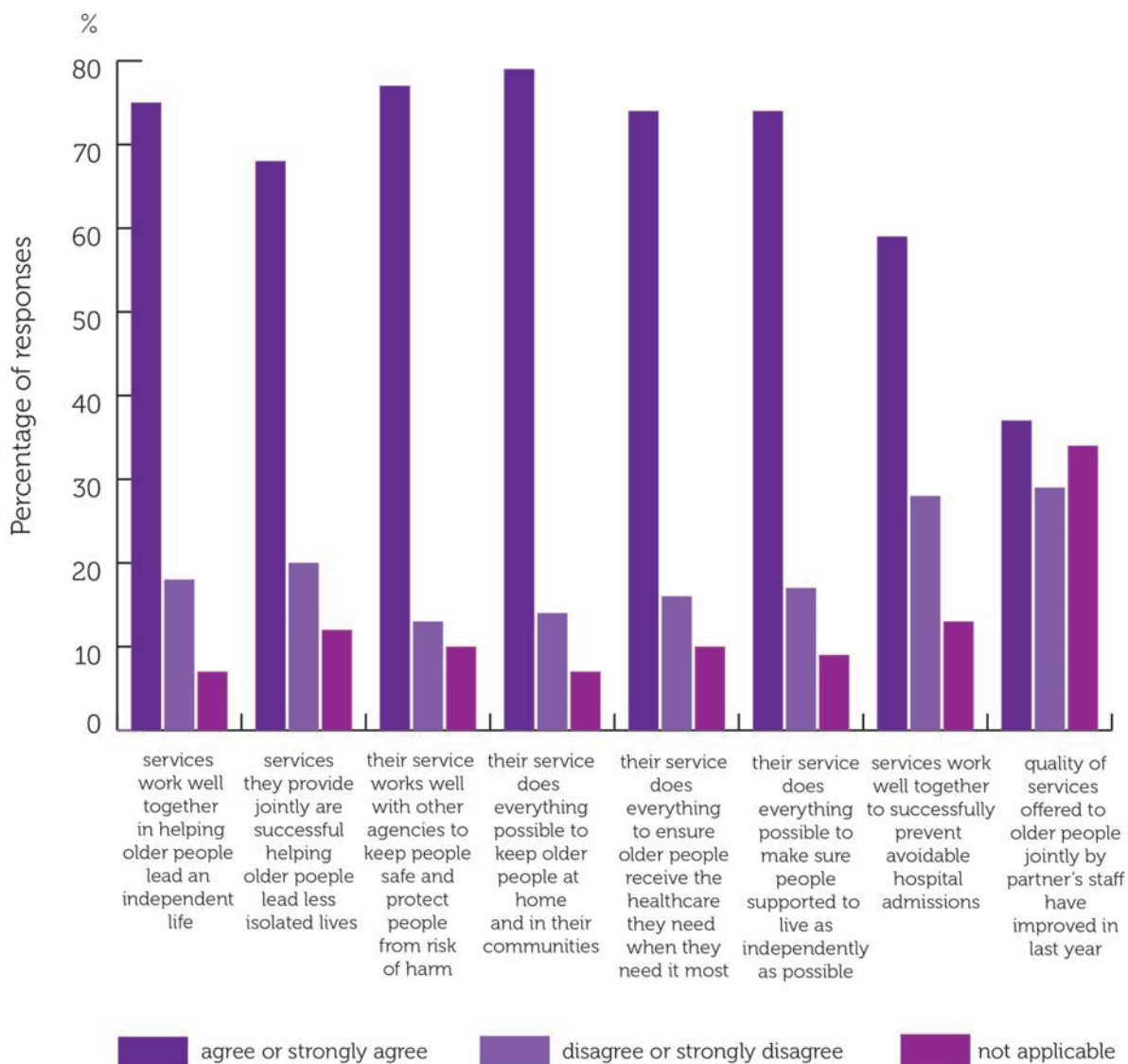
Source: Care Inspectorate /Healthcare Improvement Scotland based on 'Talking Points'.

Figure 9 shows the range of good outcomes delivered for service users by the Angus Partnership. We concluded from our analysis of service users' social work services and health records that 97% of individuals attained one or more positive outcomes. However it should be noted that 20% had also experienced one or more poor outcomes.

We were encouraged to find that 67% of care plans we read were outcome focused. During our inspection, we met with a number of service users and their carers. They told us that, as a result of the health and social work services they received, that they were safer, were living as well as they could be, had good wellbeing and things to do, as well as having friends and relationships. Figure 10 shows the results of our survey of health and social work services staff about the delivery of positive outcomes for service users and

their carers. Overall, the staff survey results on outcomes were positive. However there were less positive staff responses to the questions on services working well together to prevent avoidable hospital admissions (59% of staff agreed with this proposal). 37% of staff agreed that the quality of services offered to service users had improved over the last year.

Figure 10: Positive personal outcomes for service users delivered by Angus Partnership, May 2014: results of Angus joint inspection staff survey on outcomes for service users delivered by Angus Partnership, May 2014



Source: Care Inspectorate/Healthcare Improvement Scotland.

Health and social work services managers suggested that the climate of service and managerial changes might be a reason for some of the less positive responses from staff.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Good

The Angus Partnership was supporting the involvement of service users in the assessment for, and delivery of, their own care as well as shaping future services. There was also a strong focus on the importance of service users being given access to the right services and support. This helped to make sure that service users were able to maintain their own independence, manage their own conditions where appropriate and have the care that they needed provided at the right time by the right people.

While there was a wide range of services that provided support to carers and those receiving support, there were some examples where services were not working together as well as they might. These included prompting for medications and making sure relevant staff attended joint multidisciplinary meetings.

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

An outcome-focused approach

Key strategies in Angus, such as the carers' strategy and dementia strategy, included a commitment to improving outcomes for service users and their carers. These strategies put individuals and communities at the centre of service planning and delivery.

We found good outcomes were delivered for people where staff worked together as part of multidisciplinary teams and as multi-agency partners. Centred on GP practices, staff from social work, pharmacy, physiotherapy and occupational therapy alongside community nursing and carers' services considered how to provide the most appropriate support to individuals and their carers. The use of rehabilitation, enablement and supporting self-management was a core element of staff discussions with service users and their carers to inform care and support.

We were impressed with the use of multidisciplinary teams to make sure that services worked together to provide early intervention and preventative services. In almost all case records we read, positive personal outcomes were achieved for the individual. However, we heard from frontline health services staff that there were occasions when key staff from social work did not attend multi-agency meetings. Social work services staff told us that attendance was often not necessary as the individuals whose needs were discussed

did not require care support at that time. However, health services staff told us that more social work staff attending these meetings would help in identifying any non-clinical support needs earlier.

Example of good practice – Multidisciplinary working

The Enhanced Support in the Community Winter Project in Angus was developed and tested as a model to provide a multi-agency and multidisciplinary working model. The primary aim and outcome of the project was to reduce unscheduled bed days in hospital.

The project generated better team working through multidisciplinary team meetings held at GP practices co-ordinated by a primary care team co-ordinator. Those involved in the project reported that they worked well together to provide better co-ordinated care so that service users did not need to be admitted to hospital.

The multidisciplinary teams brought together GPs, consultants for medicine of the elderly, district nurses, physiotherapists, occupational therapists, pharmacists and social work staff. Most were regular attendees although some staff felt that social work engagement could be improved.

Key outcomes included a 13% reduction in emergency admissions, a 23% reduction in occupied bed days and a reduction in average length of stay in hospital by 1.5 days.

Voluntary organisations and volunteer groups provided good support to people, including befriending. This helped to achieve good outcomes for service users and carers.

Individuals using support groups and advocacy services supported this view.

Service users reported that home care and enablement staff provided good support to them in their own home. Council surveys of service users showed that in the majority of cases good outcomes were being achieved.

We met with a range of individuals living in supported housing. They told us they were happy with the outcomes they experienced, and they felt supported and looked after by staff. Some service users were able to access support from community groups organised to support self-management of long term conditions. They told us about the personal benefits they gained from these group activities.

Improving care and support for frail patients

The Angus Partnership had well-established prevention of admission to hospital and early discharge support for service users as a means to improve outcomes for people before, and following, hospital admission. We found that these supports worked well. This was confirmed by service users. They had high praise for the support they received to manage at home following hospital admission. Several people who received support told us that they had good support from health and social work services before being admitted to hospital, and that they were encouraged to remain at home for as long as possible.

The Angus Partnership had taken steps to increase the number of consultants in old age psychiatry and medicine for the elderly to improve early diagnosis and prompt treatment of service users. Recent recruitment for a further consultant post was unsuccessful. We felt that this could adversely impact upon assessments and interventions to service users whilst in hospital. The support from community-based consultants working with service users whilst in hospital was having a positive impact in reducing delays in diagnosis and access to services.

We looked at the interaction between primary health care, (for example GP services), secondary health care, (for example hospitals), and social work, (for example care homes and care provided in people's own homes). Health services staff used beds within the community hospitals as step down facilities to enable people to regain confidence, for example after receiving treatment for a fall. This was supported by the use of the Angus discharge facilitators who provided a hospital-based care assessment to speed up early discharge. In the community, members of the multidisciplinary team effectively and easily shared information on the progress of the person and used different therapies to support recovery.

Polypharmacy reviews⁶ for people aged over 75 years who were on 12 or more repeat medications had been carried out. Service users we spoke with said that they felt that the changes, after review, had helped them to gain a better quality of life. This was due to the number of medications they were taking being reduced, and they were less confused about the medication that they were prescribed. Carers also confirmed that medication reviews had helped individuals to stay independent. In some cases, individuals had been helped to self-manage their medication.

⁶Polypharmacy refers to the concurrent use of multiple medications by a single patient.

Example of good practice – Polypharmacy review

Angus residents aged over 75 years were offered a multidisciplinary polypharmacy review aimed at decreasing the number of repeat medications they took. Nearly 1,000 people took part in the review across all GP practices in Angus. Carers were actively encouraged to participate in the review to make sure they felt considered and supported.

Volunteer drivers helped attendance at the clinics for these reviews. Repeat medications were reduced on average from 12 to 11.2. A high proportion of service users and their carers had reported feeling better and having a better understanding of their medication. These reviews also had a positive impact by reducing emergency admissions of service users to hospital.

Both health and social care frontline staff we spoke with raised an issue with the prompting of medication that was being carried out by community nurses and healthcare assistants. This was at a considerable cost to the service.

One local community nursing team reported that they carried out around 20 medication prompt visits a day, (not including patients where medication was administered by injection).

This was a contributory factor on placing additional demands on the community nursing service. This meant that, on some occasions, service gaps were being met by resources from outside Angus. The Partnership should examine existing practice and the feasibility of developing and implementing a plan which would provide assurance that the current model for providing medication prompts to service users is robust in terms of skills mix being used to carry out this task. The Partnership should also consider the cost effectiveness of this model.

Supporting carers

Carers and staff we spoke with found that co-locating carer support workers within local GP practices had helped to increase the support and information to carers and helped partnership working. Carers' health checks were carried out by a community nurse.

Co-locating carer support workers was making a difference in increasing the number of people being offered a carers' assessment. However, we found that carers' assessments were offered in just over half of the case files we read where there was a carer who provided a substantial level of care. Where the offer of an assessment had been accepted, a completed assessment was evident in two-thirds of cases. Where an assessment had been completed, we found that service users and carers were mostly involved or consulted and informed in the assessment and care planning process. The completed assessments had also led to improved outcomes for the carer and the person they cared for.

Angus Carers Centre was an independent organisation managed by Angus Carers Association. It provided an information and advice service, offered support to carers at an emotional, practical and social level and enabled carers to become involved in service consultation and planning. In some instances, we found confusion among staff and carers about the carers' assessment. There were difficulties regarding sharing of assessments between social work services and Angus Carers Centre as there were different types of assessment. This led to a twin assessment process. Efforts were being made, by the Partnership and Angus Carers Centre, to streamline the carers' assessment process to ensure a timely response to carers needs and to support access to self-directed support options. Almost all carers we met with told us they felt supported by the Angus Carers Centre to continue in their caring role.

A small number of carers we met felt that the services that they had been offered had been inadequate or had been offered at the wrong time. For example, they told us that home care services were less likely to be available during evenings and weekends. They said that one of the reasons this had happened was due to difficulties with the recruitment of care workers. Independent advocacy services were available to carers. Carers told us that advocacy had helped to improve outcomes for themselves and the people they cared for. Carers were engaged in a range of activities within the community. Activities such as Zumba, massage, stress management and social support were offered across a number of community groups. Other activities included the Angus 'Care Free' project for befriending support to carers and training on dementia. Events were held regularly to attract carers and introduce them to support groups and local activities.

The carers' strategy had a draft performance framework that identified actions to support carers. This was linked to local and national outcomes. The action plan identified key lead agencies responsible for delivering various supports to carers. However, the strategy lacked detail on resources and, as a result, it was difficult to be clear about investment priorities. The NHS Tayside Carers Information Strategy also needed to be refreshed to make sure that priorities for carers' service development were being jointly articulated by all relevant partners.

Recommendation for improvement 2

The Angus Partnership should improve the carers' assessment process so that carers have better access to services for themselves and those that they care for.

2.2 Prevention, early identification and intervention at the right time

Supporting people with long-term conditions

The Partnership was developing its approach to clinical and care governance. Using care pathways for specific conditions, (such as chronic obstructive pulmonary disease), was beginning to impact on improving outcomes for individuals.

The increasing number of people living with long-term conditions presented a major challenge for health, social work services, community, independent and third sector partners. Better understanding of their long-term conditions helped people understand their symptoms and experiences, and improved their long-term health and wellbeing. The role of health and social work professionals was to build peoples' self-confidence and their capacity for self-management, and to support them to have more control of their conditions and their lives.

We found that the community health partnership had developed a long-term conditions programme. This included professional and patient-led support groups and initiatives along with groups which provided support to people with specific conditions.

An annual long-term conditions event engaged individuals and groups about self-management activities. Voluntary organisations and patient support groups told us this was a helpful event which helped them to identify support for managing their conditions which they might otherwise not have found. Specific initiatives to support and inform people with illnesses such as diabetes, chronic lung conditions, asthma, cardiac disease, arthritis, dementia and Parkinson's disease were evident. Advice and support were available to help people with pain management, smoking cessation, weight management, emotional wellbeing and good mental health.

Service users who attended support groups told us that they found the self-management groups very helpful in supporting them to remain well at home. They thought more should be done to support self-management groups. Groups were not always accessible to people living in more rural areas and travel was challenging for people with long-term conditions.

Many of the service users we spoke with in self-management groups were positive about how they had been signposted to a helpful activity by staff at the time of diagnosis or during their enablement service.

We were impressed with the enthusiasm of the third sector to engage in joint working in support of areas such as long-term conditions. The redesign of community pharmacy supported better experiences for individuals by placing pharmacists alongside GP practices. This helped more individuals to have a polypharmacy review. GPs access to pharmacy advice helped prescribing practice which also benefitted the individual.

Some services such as speech and language therapy, podiatry and dietetics were provided from health services hosted by NHS Tayside. Both staff and members of the self-management groups expressed concern that those services could impact on the level of service available locally. There was a perception that this led to a reduction in service. However, we found that planned redesign in certain types of service such as podiatry were complemented by specialist input. Both staff and patients perceived that this was delivered on a less frequent basis. These types of changes were not always fully communicated to service users by the Partnership. The Partnership had recently developed communication activities in response.

Audits carried out in local GP practices suggested no indications from service users that there were significant areas of unmet healthcare need with the management of their long-term condition.

Implementing Scotland's National Dementia Strategy 2013-2016

Angus had made progress implementing Scotland's national dementia strategy 2013–2016. The Partnership's dementia improvement plan focused on themes such as treatment and managing behaviour, assessment and diagnosis, improving service response, rights, dignity and personalisation as well as developing health improvement, improving public attitudes and tackling stigma.

The Partnership had invested both significant capital and revenue with the recently completed Kinloch Care Centre development in Carnoustie. This 'dementia friendly' designed unit provided both high dependency residential care and day care alongside supported housing. This development was complemented by the expansion of additional dementia day care and housing support in two supported housing schemes. However, there had been lower than anticipated supported housing demand and social work managers advised that extending these services further was under reconsideration.

The Partnership was developing more dementia focused care planning. We found that staff used the 'This is me' tool to help people with dementia to better express their needs, preferences, likes, dislikes and interests to better identify their care needs and desired outcomes within a range of services including home care and day care. Another positive initiative that supported the sharing of important information included the 'butterfly scheme'. This aimed to improve the safety and wellbeing of people with dementia during their time in hospital.

We noted from statistical evidence that the Partnership performed above the Scottish average in diagnosis of dementia. Work to promote a better understanding of dementia had also been carried out both within health and adult social work services. This had included dementia liaison team and early dementia support workers support for

dementia champions and ambassadors. There had been an increased referral rate for post-diagnostic services and the Partnership was working to respond to this. Training on dementia had been well received by health and social work services staff. Within the community, supports such as the 'dementia café' and tea dances took place. These local groups were supported by Alzheimers Scotland.

People with dementia and their carers told us these groups were a very positive and supportive experience for them. They were a worthwhile link into community services and to other families in similar situations. Improved support had also been offered to people who had been recently diagnosed with dementia in response to Scottish Government targets. We were told of development work to target support for men both as carers and people with dementia.

Support to community groups was often provided by volunteers. The Partnership was keen to support this development. This was evident not only in the provision of services such as the dementia cafe, but also in training and support for volunteers such as in advocacy services.

Palliative and end-of-life care

We noted from statistical evidence that the Partnership performed better than the Scotland average in the proportion of people, most of whom would have been older people, living their last six months at home or in a community setting.

There was improved access to palliative care in the community and increased support from volunteer befriending. The Partnership had increased access to day treatment for palliative care patients.

We found a good use of volunteers by Macmillan nurses. They were able to refer patients on to a palliative care befrienders scheme. Befriending visits were available in both hospital wards and the community. This was a good example of health care agencies working with the third sector to deliver integrated services.

We learned that staff in multidisciplinary teams were aware of the particular needs of patients who required palliative or end-of-life care. They were keen to do as much as possible for this group of patients and, as far as possible, comply with the wishes of the patients and their carers and families.

Anticipatory care planning

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

During our inspection, we found that the Angus Partnership had been making progress in anticipatory care. The use of anticipatory care plans was well established in community health centres and hospitals. An interagency group of health and social work services staff was also working to further develop the key information summary and anticipatory care plan.

Key information summaries were a way for health professionals to record and share important information about people with complex care needs or long-term conditions. This information could be shared with others such as NHS 24, the Scottish Ambulance Service and the out-of-hours service. These were being developed in partnership with patients and their families and would help to support good outcomes for service users. Staff felt these would be very helpful to both staff and families in managing crisis and end-of-life care in a positive and considered way.

The out-of-hours service, 'See and Treat', had access to anticipatory care plans to support their response. This service responded to 999 calls and some carers support calls. We heard from frontline home care staff that this service was effective in reducing admissions to hospital.

Intervention at the right time

A falls prevention programme, aimed at older people at risk of falls, was in place. This included a clear pathway of care. Training was targeted staff and carers. A falls prevention co-ordinator and administrative support had been appointed to promote a single point of contact. From the health and social work services records we read, we found that a number of individuals had falls recorded, but there had been no onward referral to the falls service for assessment. Services such as occupational therapy and podiatry were working to increase referrals to the falls service with falls specific questions and routine referral from small injury clinics. Further development of the falls service was anticipated by staff.

Angus Council had recently moved to its 'First Contact' service. This meant there was a single point of contact for enquiries and to manage referrals for service more effectively. Capacity had increased within the occupational therapy service to reduce waiting times for assessment. This had allowed a release of occupational therapy staff time in locality teams to carry out assessments of service users and arrange relevant provision of services and equipment.

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

Angus Council had made progress in preparing for self-directed support implementation. In March 2012, an initial conference was held with stakeholders about self-directed support and the implications for current and future service users. This conference was modelled on the principle of co-production. Feedback from the conference was widely regarded as successful. The report from this conference was widely circulated to staff. Communication and engagement activity events, newsletters and formal and informal inputs into community groups and meetings were carried out across Angus.

The Partnership had developed and circulated leaflets on self-directed support, developed a web page and produced a booklet for those considering this approach. This booklet was designed to be sent out to enable the individual to make their own application for self-directed support. Some carers told us they had limited information on self-directed support. The Partnership had commissioned Voluntary Action Angus to improve carers' information on self-directed support. A staff member had recently been recruited to lead on this communication. Voluntary Action Angus was an independent organisation which supported the development of the third sector in areas such as recruiting and training volunteers and liaising with the Partnership on the planning of future services.

The service user self-management network had led on developing information and engagement with individuals and the local resources available to support the self-management model in Angus. The network held an annual long-term conditions information day for service users, as well as individual groups holding promotional events throughout the year. Almost all of the attendees said they were going to do something different as a result of going to one of these events. The groups engaged local shops and businesses to support these events.

The network was developing its use of the 'A Local Information System for Scotland' (ALISS)⁷ system for people with long-term conditions. This system was intended to share information from local resources about self-management support. The Partnership was in discussion with Voluntary Action Angus to develop a co-ordinated third sector services directory to take the system forward in local communities. Discussions were ongoing with partner organisations to gain agreement that ALISS could be used as a community information sharing resource within localities, owned and managed by community members. The projected full implementation date for ALISS was 2017.

⁷ ALISS (A Local Information System for Scotland) is a search and collaboration tool for health and wellbeing resources in Scotland developed and delivered by the Health and Social Care Alliance Scotland

Quality indicator 3 - Impact on staff

Summary

Evaluation – Adequate

Staff had a positive attitude to their roles despite their concerns about the ability of the services to cope with increasing demands. There was evidence of good multidisciplinary and multi-agency teamworking, communication and a commitment to providing good standards of care to service users.

Although there was evidence of some staff consultation activities, staff felt that communication about proposed changes could be improved.

Senior managers recognised the changes needed to improve dialogue with staff. However, staff told us that communication about the progress of partnership and integration was not always good and, as a result, they were not always fully engaged.

3.1 Staff motivation and support

Motivation

In assessing how the Partnership was progressing against this quality indicator we looked at how motivated staff felt, how supported they felt, teamwork within the Partnership, and learning and development opportunities. We used a range of evidence, including an online staff survey, documentation submitted by the Angus Partnership and face-to-face meetings with a range of managers and staff groups from health and social work services and also those working in other care settings.

We met with approximately 180 health and social work services staff over the duration of the inspection. We issued a staff survey to the Angus Partnership staff. Of the 439 staff who responded to our survey:

- 25% were from local authority
- 73% were from NHS Tayside, and
- a further 2% were employed in 'other' sectors.

Overall, there was a response rate of 25% to the staff survey. Staff we met with during the inspection were generally well motivated and enthusiastic about their role in the delivery of care to service users and their carers. Responses to our staff survey showed that most staff were positive in that they:

- enjoyed their work (91%), and
- felt valued by their managers (79%).

This was generally confirmed in our focus groups with health and social work services staff we met with during our inspection. However, a few home care staff we met with described morale as being low. The reasons for low morale included an uncertainty around integration and temporary contract work.

Despite the introduction of dedicated websites, presentations and newsletters reporting the progress of partnership and integration, staff groups told us they did not feel engaged or have enough information about integration and what it might mean for them or service users. Senior managers told us they recognised the need for increased visibility and communication and were developing plans to progress this. A series of events were under way to better inform a wide range of staff groups.

Health and social work staff showed a positive attitude to teamwork and their job. However, in our focus groups they told us about a perceived lack of support from management in some areas, especially as the capacity of the service was at times stretched. We were told this was due to the increasing complexity of the care required by individuals. At a meeting with frontline health and social work staff, they expressed concern about their ability to meet future demand.

In relation to the future integration of health and social care services, we learned that some of the frontline social work services staff felt that they were not well informed about the progress of this, or otherwise, and were not clear what was happening. Senior managers were committed to getting the workforce more actively involved. They acknowledged that staff engagement at all levels was key to successfully implementing change and new approaches.

Teamwork

Staff were committed to providing services which helped service users lead as independent a life as possible. For example, from those who responded to our survey were positive in that:

- 85% agreed that their service works well with other agencies to keep people safe and protect them from harm
- 75% agreed that they had access to effective line management
- 74% agreed that they worked well together to enable people with long-term conditions and those with dementia to remain active, and
- 69% agreed that their workload is managed to enable them to deliver outcomes to meet individual needs.

Frontline home care staff said they received supervision from more senior staff and, while not always as regular as they would wish, they felt it was flexible enough to meet their needs. From the health and social work services records we read, we saw that needs assessments carried out for individuals reflected the range of professionals contributing to their care.

At times of crisis, services worked well together to provide the necessary care and support required. Generally, staff felt there was effective joint working, with 72% of respondents to the staff survey agreeing that there were excellent working relationships with other professionals. Most staff felt that joint working was encouraged by managers.

Staff had reservations about whether there was enough capacity within teams. In common with other partnership areas, staff disagreed that there was sufficient capacity within their team to carry out preventative work (33% agreed). Our review of social work services and health records showed that almost all staff were delivering good outcomes for individuals (97% of cases).

Staff we met with told us there was good day-to-day communication and working relationships between health and social work services staff. The Partnership had good multidisciplinary and multi-agency working for a number of years. Community learning disability and community mental health services were well established in localities. Links were in place with medicine for the elderly and old age psychiatry.

We saw good evidence of team working. In some GP surgeries, multidisciplinary meetings discussed the needs of a number of service users whose condition was causing some concern. The meetings provided an opportunity to share information and expertise which was used to improve the care for the individual patient. From our survey, 79% of staff told us they felt valued by other practitioners and partners when working as part of a multidisciplinary team.

We saw evidence of good team working between nursing homes, healthcare staff and social work services staff for residents who had complex needs and required specialist interventions.

Learning and development

We considered that the profile and visibility to staff of senior managers could be improved. Strategic leadership and the role of senior managers in supporting employees to deliver effective services could also be improved. In our staff survey, of those who responded:

- 52% agreed that senior managers communicated well with frontline staff
- 52% agreed that there was a clear vision for older people's services
- 50% agreed that their views are fully taken into account when services are planned or provided, and
- 43% agreed that changes which affected services were managed well.

Frontline social work services staff were looking forward to working more closely with colleagues in the wider range of services. They thought communication needed to be improved across agencies and services. They did not always know why decisions had been made and what was happening at a strategic level. We discuss communication further under quality indicator nine in this report.

In our survey, staff confirmed that they had a wide range of training opportunities, with nearly three quarters saying they received good opportunities for training. For example, training to support those caring for people with dementia had been widely available across Angus. This had also included those working in the care home sector. Close links had been formed with the University of Stirling's dementia services development centre to support and advise on this training. Allied health professionals told us they had good access to training opportunities including dementia training.

The Angus Partnership had set up a planning group to explore opportunities for joint training across health and social work services. This group was at an early stage, but it aimed to standardise training and build the capacity for trainers. This approach would support the development of future joint posts and provide shared opportunities for team learning.

We met with a group of volunteers who were strongly motivated to support individuals in their community. Voluntary organisations had access to training provided by health and social work services. However, they expressed concerns that this was not always consistent, planned or resourced. For example, some volunteers were given the opportunity to access a training module to improve their understanding of falls in older people. They told us that the learning and development services had not identified a budget to cover the licencing cost to enable them to access this module.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

We found that the Angus Partnership was committed to developing community capacity. We saw evidence that the partnership engaged and involved local communities to meet the health and social care needs of older people in Angus.

A good range of community supports for older people was already in place. The partnership was seeking to work productively with older people and the third sector about this. The partnership was working with the third sector to improve engagement and increase awareness of the local community responses to delivering support.

The partnership needed to do more to measure the outcomes of these community supports and establish how its own services were viewed by the wider public.

4.1 Public confidence in community services and community engagement

Engaging with the community

We saw that community capacity building was a theme within the Partnership's joint commissioning strategy for older people. The Partnership was committed to engaging and involving local communities to meet health and social care needs of older people in Angus.

The Partnership had taken steps to support staff to engage with the public and communities by producing a health and social care communication and engagement plan. This advised staff on engaging with staff, the public and communities. This was to help support the formation of improvement plans. The Partnership had chosen north west Angus to be the first area to roll out locality-based working. A workshop was held in June 2014 with stakeholders from agencies in the third sector alongside service users and carers with a view to developing a locality plan.

We read about the engagement activities that the Partnership was carrying out, covering patient and public engagement, in areas such as:

- service user and patient engagement
- public and community engagement
- health and social care integration, and
- volunteering.

It was clear from our meetings with senior elected members and senior health and social work managers that they recognised the need to develop community capacity. They placed importance on the role that local communities and community organisations could play in providing support to service users.

A significant number of community supports and services were in place. However, it was not clear to what extent the development of these had been part of a clear, overarching strategy for co-production and capacity building.

From our meetings with staff and managers, we were made aware of the important role that those living in local communities could and needed to play in looking after service users. This was explained as being a reflection that a large proportion of Angus' population lived in rural areas or relatively deprived urban areas.

We asked about community involvement in our staff survey. The majority of those who responded from both health and social work services thought that they recognised and consulted diverse local communities about levels, range, quality and effectiveness of service. They also thought there were clear joint strategies to promote and expand community involvement and communicate change. In addition, they agreed that there was strong positive engagement between the partners and local community and third sector groups. However, there were still some staff who disagreed with these statements. From our focus groups with health and social work services frontline staff, we also found that there was a limited awareness that health and social care services had an important role to play in developing community capacity.

When we met with health and social work services senior managers, they acknowledged that, as a partnership, they still had some way to go in developing a joint approach and strategy for community capacity building. They recognised that the third sector was a key partner in this.

Community development staff told us there were in total over 900 different third sector organisations across Angus. These ranged from local self-funded reading groups to grant-funded organisations delivering specific support services. Not all the groups catered for older people. A third sector collaborative agreement had recently developed. This had enabled improved communication and representation from the third sector on local planning groups as well as identifying the breadth of delivery by the sector. A primary

focus of the agreement was how third sector and other groups worked together to meet the challenges associated with the integration of health and social work services. Both the third sector and the Partnership stressed the importance of the third sector interface to making sure that future locality services engaged with the third sector effectively. This arrangement was a recent development and the Partnership should monitor its progress.

The community planning partnership board told us that the community plan needed to fit around people and not people fitting around the community plan. However, we heard of gaps in how the Partnership was engaging with the community.

Voluntary Action Angus had been involved in some community consultation activity and had strong links with the community planning partnership and was represented on the board. However, Voluntary Action Angus reported that the council's approach to community learning and development was fragmented. There were different approaches from within different directorates of the council. The Angus Carers Centre told us that it was well supported by the Partnership, and it had the resources to deliver a wide range of services to carers in Angus.

Community initiatives - the development of community supports

Although the Partnership needed to clarify its intentions to increase community capacity, we saw that it had good foundations to build on. This included a history of supporting the provision of community-based supports for service users, and the solid basis of existing community groups. Our inspection found similar positive results. We held a focus group with representatives of community groups. They said that service users were generally well supported by a range of services provided by the statutory and independent sector.

Opportunities also included volunteering. The Angus Carers Centre had a volunteer co-ordinator to assist in recruiting, training and placing volunteers. We heard some good examples of volunteers supporting people with long-term conditions, and service users of befriending services through the community mental health teams through befriending. Voluntary Action Angus had also become involved in offering befriending to people who were being supported by multidisciplinary teams.

Example of good practice – Long-term conditions self-management network

In Angus a proactive approach to long-term condition identification and management had existed for over 10 years. The Angus Partnership had developed a long-term conditions network to support:

- early identification of long-term conditions
- consistent and early access to condition-specific and generic education and self-management support for all adults living with long-term conditions
- maximising the capacity and skills available within the long-term condition populations themselves and the wider community, and
- identification and proactive management of those with complex healthcare needs.

The long-term conditions self-management network encouraged sharing and collaboration between a range of peer support groups in Angus and service providers such as health, council, leisure services and Voluntary Action Angus. Promotion and support included:

- a long-term conditions information event held every year
- a self-management week
- a self-management toolkit for professionals, and
- an expert patient programme online support hub offered in Angus, which was the only such programme in Scotland.

Service users, their carers and staff we met with were also generally positive about the community support services available for older people. However, in common with other rural areas, we heard critical comments about some issues with community transport provision and the difficulty faced by some people in accessing services from the more rural communities.

Engaging with the community - community involvement and impact

At the time of the inspection, the Partnership was at the early stages of developing a joined-up approach to increasing community investment in its services. The Partnership had recently redesigned community planning to reflect the development of communities in four localities by bringing together community learning and development, strategic and local community planning. The redesign was to support 'planning for place'. The goal was to lead and support planning for place activity within localities as well as providing leadership in thematic areas. This work was at an early stage and a newly formed group talked of the cultural shift that was required by all sectors to find future community-based solutions. This approach would aim to develop the localities to link directly to the community planning partnership's action plan.

We saw from plans provided by the Partnership that it had invested effort in seeking to engage with and seek the views of service users. This included using existing forums and public consultation exercises. However, carers told us about a recent closure of a day care centre for people with dementia in Arbroath. Carers who had used the service told us that there was no consultation before this closure and that engagement needed to be more transparent.

We saw less evidence of how the Partnership currently sought to measure the impact of, and the outcomes achieved, by the various community support services. It was also not clear how the Partnership used existing feedback mechanisms to provide a picture of how well the public regarded its range of local health and social work services.

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

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Good

The Angus Partnership had integrated working in some adult services for many years and was seeking to build on this. It had reviewed and refined many of its processes, and was reviewing others in the light of new legislation and ways of working. Partnership working was good between staff working in the community. Assessments were carried out efficiently, and care and support plans were regularly reviewed. Self-directed support was being taken forward and enablement was generally having a positive impact in helping older people maximise their quality of life.

While staff felt confident and supported in managing risk, we identified areas for improvement in preparing and recording written risk assessments and risk management plans.

People who used health and social work services and their carers were, on the whole, satisfied both with the services they received and the positive outcomes for them that resulted. They highlighted some areas where improved communication would improve services.

5.1 Access to support

Initial contact with health and social work services was seen positively by people seeking support. The public made initial contact with Angus Council through a call centre 'Access Line'. Managers within the council told us there was good communication between the call centre and social work services. We were told that staff in the call centre had regular contact with the First Contact team. Any concerns that the call centre staff had would be discussed and action agreed with social work services staff in the First Contact team. The call centre passed on any referrals about social care and would signpost callers to appropriate resources within the community who may also offer support.

The First Contact team dealt with referrals for adult social work and health services. All referrals to the service were screened through this team. Access to services would be made by referral to them by the First Contact staff. Likewise, the First Contact team would refer into health services should that be needed. Managers and staff spoke of the effort they made to speed up early access to support either from social care and health resources or by supports available in the community. Referrals were also made as normal through community health services and GP practices. Work was ongoing to further

develop pathways for referrals to make sure that all people got the right support at the right time.

It was clear that some development work had been carried out to make sure that these pathways were congruent with integrated practice. This ensured that people using services from NHS Tayside and Angus social work services received a seamless service. Some services had clear delivery timescale targets. However, not all services had these in place yet.

There were some good examples of the Partnership supporting people to manage long-term conditions with the appropriate amount of support from services. Work had been carried out to support such conditions as chronic obstructive pulmonary disease by nursing staff within the community. Three groups for this condition were already established within Angus, and a fourth group was beginning in the near future. The focus of these groups was to support people within the community. This was a useful model for other long-term conditions. Members of these groups told us they needed fewer services as a result of their participation and they felt in control of their situation.

The Partnership had a clear set of criteria for accessing services. There were a clear set of priorities to allow for the appropriate targeting of services across both health and social work services. In our discussions with service users, they were generally clear about how long services would be offered before review, which services would be charged and where this was not the case. Service users and their carers were generally complimentary about the clear information they were given on services by health and social work services staff. However, we met with some carers who felt that communication was not always clear. They felt they were not as informed as they might have been about the care of their family member or about wider supports and options available to them.

Example of good practice – See and Treat Service

This mobile service was staffed by nurses and paramedics working alongside the ambulance and out of hours medical services operated from 9pm and 8am. It responded to all minor injuries, minor illness and supported planned care which could support the prevention of admission to hospital. They did this by offering flexible support to carers, supporting other care staff if needed and offering specialist support such as palliative care. It provided clinical assessment, care and treatment to meet the patient's needs.

In offering this support, it meant that there might be no need to call out the ambulance service or, if admission to hospital was required, they could help by supporting direct admissions, saving patients from going through accident and emergency departments. They liaised with GPs, district nurses and social work services staff to ensure continuity of care for individuals within the community.

The project's work had led to a significant reduction in overnight and weekend admissions to hospital with high satisfaction levels of people who used the service.

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

The Partnership was currently carrying out work to refine and improve the assessment and care management processes. It had recently carried out work to improve their assessments and support plans to focus on individual outcomes for people, as well as giving staff tools to include self-directed support options in all of their assessments. Managers and staff were also developing an ability/dependency tool to further refine these assessments.

Social work services managers told us they had provided clear guidance to staff as well as some initial training on self-directed support. Although all this was a new policy, the Partnership had, at the time of the inspection, completed approximately 60 self-directed support assessments. While not all of these had led to people choosing to direct their own support rather than the council arranging the service on their behalf, it did show the Partnership's positive commitment and development of this area. Managers recognised that there was still some work to be done in this. Further training was set for the autumn of 2014. This would support staff who still felt lacking in confidence and clarity about applying this assessment tool.

Staff in both NHS Tayside and Angus social work services generally worked well together. All health care and social work services staff groups that we spoke with, from basic grade staff to senior managers, said that they were committed to integrated ways of working. Some managers pointed out that this practice was well embedded within Angus and that many of the integrated teams had been operating for some years. The Partnership

had continued to base much of its ongoing work on these integrated multidisciplinary teams, which were often co-located. Managers saw this as a positive way of working with benefits which impacted positively on service delivery. This integrated approach was being further developed to create team structures around the four localities.

Overall, we saw evidence of staff from each agency attending each other's meetings to facilitate good outcomes for people using services. This promoted positive working relationships and a flexible response to make sure that service users were well supported and there was reduced duplication. Developments such as clear pathways and response times following the admission of patients to hospital supported appropriate assessment and discharge planning.

We saw examples of multidisciplinary meetings which identified issues for patients and ensured that service users experienced a smooth discharge from hospital along with the allocation of resources which were required to meet their needs. However, staff told us that in a few cases, discharge from Ninewells Hospital in Dundee, could be problematic. They had received little notice of discharge and packages of support could not be planned in advance. Some home care staff were concerned that service users discharged from Ninewells Hospital had not had their needs, including their cognitive capacity, considered appropriately by staff before discharge. This lack of co-ordinated planning and support for discharge should be addressed by health and social work managers.

Example of good practice – The orthopaedic pathway for Angus patients

The orthopaedic pathway developed for Angus patients, (over 65 years), delivered very positive outcomes for them. Angus patients spent less time in hospital (following an orthopaedic admission), and were less likely to be readmitted to hospital than patients from other areas. The average length of stay in hospital (September–November 2012) for Angus patients, admitted with fractured neck or femur, was 7.8 days. This compared to 16.5 days for non-Angus patients who were not on the orthopaedic pathway. The key elements of the orthopaedic pathway were:

- timely assessment by medicine for the elderly doctors
- osteoporosis assessment
- polypharmacy review, and
- effective multidisciplinary and multi-agency working.

NHS Tayside was rolling out the orthopaedic pathway to other medical and surgical specialties and to patients from other council areas.

Evidence from individuals' case records supported a generally positive picture of assessment and care management. From the health and social work services records we read, 96% of people had a needs assessment completed. In 71% of those assessments, it was clear that a range of professionals had contributed to the assessment and that early intervention and prevention options had been considered. We evaluated 59% of the assessments we read as good or better. In 6% of the assessments, we evaluated them as weak and needing improvement. The remainder were evaluated as adequate.

Chronologies set out key life events that can influence the care and support offered to individuals. They are a useful tool in assessment and practice which promote engagement with service users. An accurate chronology has sufficient detail but is not a substitute for file recording. They should be reviewed and relevant to the individual's circumstances. The majority of records we read (62%) contained a chronology. However, about half of those chronologies were of an acceptable or better standard. This was an area of work that the Partnership needed to improve its performance.

The Angus Partnership needed to ensure that all relevant case records contain accurate chronologies so that people's care needs are better assessed and that the services they receive are better planned and delivered to meet individual need.

Almost all assessments we read had taken account of the individual's needs (97%) and the individual's choices (99%). Two thirds of all the assessments read were outcome-focused. Staff generally got agreement to share information across agencies. Most files (77%) included clear evidence that health, social work and other services had shared relevant information.

We noted from statistical evidence that the Partnership performed better than the Scotland average for the time from referral to completion of assessment, and from assessment to the delivery of services.

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

There was a mixed picture regarding care and support plans. We considered that less than half were comprehensive. Reviews of care and support plans took place regularly in almost all of the cases.

The Partnership had put enablement at the heart of its practice for people when they were first referred to services. Staff within the enablement team spoke very positively about their practice. They felt they were making a positive contribution to better outcomes for people who had been referred to them. Enablement was offered as part of the initial assessment package to any one referred by health and social work services staff for services in the community. Managers noted that people needed less continuing support as the result of work by the enablement teams.

However, some staff told us that some people had to wait for home care. Staff told us that, on occasion, people received home care services from whichever team had resources to address it at that time. While this approach supported people getting services as soon as possible, it did not allow resources to be properly targeted. Staff illustrated this by saying that people sometimes received mainstream care services rather than enablement services and, as a result, their opportunity for enablement was missed or delayed. Other issues such as the area in which people lived could also impact on the speed at which they received services.

We heard about the community meals service which helped enable people to live independently in their own home. The Partnership performed above the Scotland average level in the delivery of this service. Some service users said that they had not been always consulted on changes to the service.

Social work service managers told us about their quality assurance system. Council managers regularly read service users' case records to make sure that service users had their needs met. They did this to an agreed quality assurance template. The template was being further developed to make sure that they maintained a degree of objectivity. Managers tended to read cases which came from neighbouring teams rather than their own. The Partnership was developing a range of performance information to closely monitor how efficient services were, and to give senior managers and the public assurance about the quality of services.

Generally, information systems had information which related to one agency only. However, within particular areas such as occupational therapy and physiotherapy, work had been carried out to streamline pathways and to set delivery timescale targets to try to achieve a consistent approach across Angus. This had been to the benefit of people using these services. We noted there was currently no waiting list for community allied health professional services. There were still some small waiting lists for home care services. However, the issue already noted on the flexible use of home care teams may disguise a resourcing shortfall at times.

At the time of the inspection, the Partnership was carrying out a tender exercise for personal care and housing support services. This aimed to address some of the gaps in providing home care. Reshaping home care services had been subject to considerable local political scrutiny. The process of widening the market to meet future self-directed

support demands was not due to be completed until the end of 2014 at the earliest. While this was a positive step, it made the issue of communication between health, social work staff and social care providers all the more crucial to make sure that services are developed in partnership.

The Partnership was looking at the further development of information technology systems to support sharing information for assessment and care management. However, it recognised that finding an electronic solution was partly a national issue.

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

The Partnership had clear guidance for adult support and protection. The guidance we read was undated and required some updating, but was comprehensive and had a clear multi-agency approach.

Staff said that they felt generally confident in dealing with adult support and protection and they were well supported. Social work managers felt that this area was tightly managed with clarity for staff when dealing with protection issues. They said that dealing with this as a multi-agency team was a support to staff and helped people to manage risk.

We had mixed findings from the health and social work services records we read. In those cases where a protection risk had been identified, 40% did not have a risk assessment. There was no risk management plan in 67% of cases where a protection risk was identified.

Where there was a non-protection type risk identified, 48% did not have a risk assessment. There was no risk management plan in 46% of files where a non-protection risk was identified. The quality of assessment, care planning and review where there was protection and non-protection risk needed to be addressed.

Training on adult support and protection was offered on a multi-agency basis. All staff we spoke with said that they had received training. However, some staff expressed the need for more training for adult protection awareness, so that reporting and sharing of information could be carried out appropriately.

We were told that the Partnership continued to deliver a range of training opportunities for adult protection, from basic half-day sessions on awareness, to three-day courses for staff carrying out investigations. Voluntary sector partners had access to awareness training in adult support and protection. Staff we spoke with in the third sector felt able to access this type of training with ease. An assessment of the impact of this training was under way.

In its most recent draft adult support and protection committee annual report, the committee had gathered a comprehensive set of performance data. Of referrals that the Partnership received within the last year, almost half of these concerned older people. Referrals were screened by a multi-agency screening group. Managers thought this allowed the integrated teams to focus more on the adult protection inquiries. Locally, staff had been proactive in seeking adult protection banning orders to support vulnerable adults. During 2012–2013, nine such orders were granted by the local sheriff court.

Most of the people supported by adult protection services indicated that they felt safer as a result of the actions taken to protect them. The draft annual report noted that, in 42% of instances, the adult at risk of harm attended the adult protection case conference.

As well as the annual report's comprehensive range of data and analysis, the adult protection committee had a draft action plan with clear areas for improvement identified and timescales for action clearly noted. However, this draft action plan needed to be updated to record the impact of work completed to date.

The adult protection committee carried out work across a wide range of partners to address the issue of financial harm to individuals. Angus adult support and protection committee had successfully engaged partners within trading standards and within the wider community to support individuals who had been financially harmed. The committee had produced a good range of public information, and staff were aware of the issue. Within the adult support and protection referrals in Angus, 62% were noted as having financial harm as one of the risks involved.

Recommendation for improvement 3

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

Staff within the community teams and in the community hospitals said that the support they got from mental health officers was very good when considering the capacity of older people, to make decisions, within their care. Social work managers told us that staff were confident in this area of work and considered less formal orders where these were felt to be more appropriate than a statutory route. A planned review of self-directed support, in which risks to vulnerable adults would be considered, would be carried out by the Partnership later in the year.

5.4 Involvement of individuals and carers in directing their own support

Service users of both health and social work services and their carers said they had good outcomes from their support. They felt included in the development of their care package. Support was available to them should it be required from organisations such as Angus Advocacy. Some additional funding had recently been provided to the organisation to support this ongoing work.

The health and social work services records we read showed that almost all people were involved in their assessment (99%), care and support plan (88%) and review (97%). This was a very positive result. Most service users we spoke with felt clear about their care package and the kind of support that they received. Managers told us that the tools to support this work were user friendly and supported carers and service users in expressing their views and the outcomes that they wished to pursue. They felt included in the development of their care package.

People who received home care had personal records for each service they received held in their own home and some found the multiple records to be confusing. Staff from each agency found person-held records to be effective. However, it was not clear that they regularly consulted each other's records.

Carers said that different agencies did not read each other's records, leading to issues being missed or duplicated. Carers clearly felt that this was an area for improvement. The Partnership and all providers should consider how to make sure that there was no duplication or areas not covered by staff. We also found that there were times during the day when there was more limited provision, making it more likely that service users experienced a lack of continuity of carers. Likewise, some carers reported a waiting list for specialised staff such as a Marie Curie nurses.

From our review of health and social work services records, we noted that 43% of carers had not been offered a carer's assessment. This was an area where some improvement was required. Senior Partnership managers agreed that not all staff were as involved with carers as they should be. This was an area that the Partnership needed to consider how best to support and develop staff.

In 23% of the files we read, carers had been offered an assessment but had not accepted it. In the 34% of assessments that were completed, positive outcomes were noted for carers and the person that they were caring for. This helped show the value of completing a carers' assessment. In 43% of files a carer's assessment was not offered.

We spoke with carers who felt they were supported and that there were good outcomes for the service users that they cared for. We attended the Angus Carers' Centre annual conference. This was well attended by carers. The conference provided an opportunity for carers to learn about the wider carers' agenda, as well as meeting with one another to

share experiences. Partnership managers told us that carers had access to education and training to support the use of telecare in people's homes. There were two demonstration flats to support this initiative. The Angus Carers Centre was seen by carers as a useful and helpful organisation that would offer support and advice when needed.

We were told that NHS Tayside had set up a working group to improve the workplace support for members of staff who have a significant caring role at home. This group had produced a carers' information pack for staff and a helpful document for managers outlining 'top tips' to support staff in the workplace.

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

Summary

Evaluation – Weak

Overall, we found that policy development and planning in Angus Partnership was weak. Operational and strategic planning had been held up during recent management changes but was being reinvigorated. There were areas for significant improvement. There needed to be more clarity in plans on how priorities would be supported.

Stakeholder engagement had been uneven. This was beginning to improve through better representation from the third and independent sectors in planning groups.

6.1 Operational and strategic planning arrangements

The Angus Partnership was working towards developing a locality-based approach for the planning and delivery of services. This would support communities in line with its vision to place individuals and communities at the centre of planning and delivery. The key elements of planning focused on care pathways covering:

- preventative and anticipatory care
- proactive care and support at home
- effective care at times of transition
- hospital and care homes, and
- services to support carers.

The Partnership had agreed where the four integrated delivery localities would be. Planning and reshaping services for older people was based on a range of plans including the best value review of older people's services, community medicine and rehabilitation redesign, Angus Council's people's directorate adult services plan and the draft joint strategic commissioning strategy. The Angus Council Best Value review, completed in 2009, had set out the direction of travel for older people's services in Angus. Although many strands from this had been taken forward, some had not. As a result, it was not clear how services would be shaped in the future. Some actions from the various plans remained outstanding or would not be progressed. Plans needed to be updated to include these changes.

We found that strategic planning in Angus was being reinvigorated. Delays in progress had been due, in part, to changes to key staffing and organisational structures. The Partnership had set up a joint planning group to take its development planning forward. They had a range of data available to inform the planning and were working with public health analysts to gain a greater understanding of need on a locality basis and drive change.

Like many partnerships across Scotland, work on developing the joint strategic plan and integration scheme was at an early stage. It was unclear to us how the various workstreams would be jointly articulated. Detailed resources were not identified as part of the plans and, as a result, it was difficult to be clear about investment and disinvestment decisions.

The Angus Partnership had used the Change Fund to effectively test different working models. Some had a clear health promotion and prevention approach. To date, these had been relatively small scale. More work was needed to set out plans that would implement change using approaches that had been tested. Partners had used the Change Fund and other tests of change to inform some of their investment and disinvestment decisions, and this had created an environment to make step changes to services in the future. These provided a basis to set the future direction and needed to be incorporated into a comprehensive plan that was shared with all key stakeholders.

The interim joint chief officer had a view of the direction of travel that still had to be shared with all staff groups.

Health and social work services managers needed to be clearer about which elements of the various service plans were continuing, those which were completed and those which were no longer being taken forward. We found that this lack of clarity about planning had created uncertainty for staff and how they delivered their services which, if continued, could have an impact on outcomes for service users and their carers.

Some staff groups already operated within locality groups so the shift to locality planning, commissioning and delivery would fit with their current work practices. Community planning had a clear focus on developing locality models with engagement from the third sector to facilitate locality engagement. However, they had not yet set out the process for agreeing and implementing locality and wider Partnership priorities. The Partnership had not yet progressed its commitment to locality commissioning highlighted in their draft joint commissioning strategy produced in 2013.

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

The development of services to support older people had a strong emphasis on supporting people to remain at home. This included developments in both health and social work services, including enablement and rehabilitation services alongside strengthening home care, to help manage the number of people supported by such services.

A Partnership project set up in 2012 aimed to build on work already established through the early supported discharge and prevention of admission teams. The aim was that services would be delivered in the community wherever possible, and any admission to hospital that was required would aim to support the individual to return to their home or local community as soon as possible. Staff and managers had worked well together to deliver early support to service users.

Community hospitals provided a resource for some short-term care and treatment. Our observation of joint multidisciplinary meetings found that partners worked well together to deliver the vision of supporting people in the community using community hospitals and care home placements to improve service users' functioning. These facilities were used to provide step-up and step-down options. Work was at a very early stage with care home providers to carry out a small scale test of different ways of working.

The Partnership was promoting a shift in the balance of care that aimed to support more service users to remain in their own homes. To help do this, it had invested in supported housing. However, housing staff said that supported housing had been under used and the future provision was under review.

6.3 Quality assurance, self-evaluation and improvement

The community planning partnership had set out the joint vision for Angus in the single outcome agreement. Angus Council's performance against the single outcome agreement was reported to the community planning partnership every three months, with performance reporting to the council's people's directorate management team from the different service sections.

The single outcome agreement for 2013-2016 identified challenges in obtaining and agreeing data across the different agencies. Delays in the Partnership receiving integrated resources framework data had further delayed opportunities for it to consider the range of information that would inform developments and areas for change and improvement. The Partnership had engaged with a public health specialist to help identify and predict future need that would support locality planning.

Although the ultimate aim was to bring together improvement planning across Angus into one plan, this was not yet in place. Separate plans, like the single outcome agreement, community medicine and rehabilitation redesign and Angus Council's

people's directorate adult services plans had some clear links. The deadline for producing reports to the community planning partnership had been extended to December 2014. The partners remained on target for producing plans for place, (locality plans), by March 2015.

We saw evidence that managers in social work services audited the work of staff to assure the quality of what was delivered, and that some action plans for improvement were produced as a result. Quality assurance in health services included 'walk rounds' by senior management in hospital wards to monitor practice.

File audit and review in social work services was already in place. However, from the health and social work services records we read, we saw limited evidence of first line management scrutiny of files with 26% of records scrutinised by line managers.

This particular approach was not so well developed in health services. In home care and enablement services, team managers routinely visited individuals receiving these services as part of their quality assurance. Future development of this approach would include peer review by managers.

Staff in social work services were beginning to take a more improvement focused approach and use available data to understand what was working well and what needed to change. NHS staff were very positive about the changes and improvement to services, but were concerned that improvements may not be sustainable, due to increasing demands across localities.

Initiatives developed as part of the community medicine and rehabilitation redesign had been measured and evaluated. These were starting to be used to begin to inform the future shape of how health and social work services would be delivered. The direct impact of some developments was not always used to inform the future shape of services.

The Partnership was considering strategic risk management. The development of a joint performance framework was at a very early stage. Outcome focused and qualitative measures were still to be agreed and rolled out across all commissioned services.

Health and social work services managers and staff recognised that they needed to do more to evidence the outcome and impact of some of the supports delivered to service users and their carers. Work was being taken forward by senior managers to produce better qualitative and quantitative measures that were service specific and outcome focused. Links between learning from self-management and self-directed support initiatives could be used better to inform this work.

The council's people's directorate adult services plan identified a number of services that would be subject to review in the current year. The Partnership needed to make sure that the reviews involved all sectors in shaping how support would be delivered to service users and their carers in the future. As locality plans developed, the Partnership

also needed to set out a quality assurance framework for localities and how they would measure local performance.

NHS Tayside had a performance dashboard with a range of indicators that were reported monthly to managers. NHS performance data was relatively well developed and provided good information on which services were working well and where demand for services was changing.

The Partnership had recently received the integrated resource framework data. It was concerned that the data was already out of date and did not reflect current practice. Staff were starting to link key data across health and social work services, but this was at an early stage. The use of management information as a basis for key decisions and improvements for the Partnership was not well evidenced.

6.4 Involving individuals who use services, carers and other stakeholders

The focus on localities was starting to increase involvement from key stakeholders, although this was better developed in some localities than others. The planned development of the new community hub in Brechin aimed to bring together key services in the area including all community health and social work services along with the police and ambulance services.

Planning for the new community hub in Brechin had included engagement with the local community and included representatives from stakeholders. However, the community representatives were keen for a wider consultation on the hub itself. This was to be undertaken with NHS Tayside.

Overall consultation and engagement with staff across all sectors was incorporated into an engagement plan, but this still had to be actioned fully. Less than half of the staff who responded to our survey agreed that the views of staff, service users and their carers were taken into account when planning services at a strategic level.

Senior managers acknowledged that the draft joint commissioning strategy had been developed without detailed involvement from some stakeholders. They were now trying to redress this. Stakeholders who participated in groups and activity to self-manage their conditions told us that they had been fully engaged in workshops about developing services in their locality.

Angus Council did not always engage with providers when proposing changes to services. Providers considered that the council was slow to respond to initiatives for change put forward by them. The gaps in strategic planning and lack of detail in the draft joint commissioning strategy, for example around co-production, had added to providers feeling disengaged from the processes.

Involving the third and independent sectors in shaping the plans was improving. Both sectors could identify some activity where they were well engaged, but a more open and shared approach was needed. Staff and managers within health and social work services recognised that they could engage better with the third sector to commission innovative services and support.

6.5 Commissioning arrangements

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

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

The Partnership produced the draft joint commissioning strategy for services for older people in June 2013. It was circulated to communities for consultation. The structure of the strategy contained some of the work to date and the impact on how service users were supported as well as future intentions. However, a finalised plan was not produced.

The development of its joint strategic needs assessment and resource plan to support the joint strategic plan was at an early stage. High level information was still to be shared locally to help communities and providers of services understand how to shape their services for the future. The proposed joint strategic plan was in development with a consultation draft expected in the autumn of 2014.

Joint strategic commissioning activity to date had primarily focussed on older people's services, testing new ways of working and using the Change Fund. Otherwise there had been limited progress in joint strategic commissioning in Angus. We saw evidence of cross-sector engagement and consultation between health and social work partners, but we saw less in terms of how developments would be progressed and how these would be led. A new compact with the third sector had helped to consolidate their engagement, but work was still at an early stage with independent sector providers.

A relatively higher proportion of individuals in Angus were placed permanently in care homes compared to the Scotland average. A proposal to increase capacity in the independent care at home sector was being developed. It was intended that this tendering exercise would enable greater choice of provider. However, much of this development aimed to replace existing services provided by the council rather than new service capacity. Managers needed to make sure that further quality assurance processes were in place. These processes showed that the proposed increased choice in the home care market would deliver a level of care at home that met people's assessed needs.

Our findings suggested that the Partnership already had insufficient capacity to deliver home care to older people. This resulted in some people not immediately receiving home care when it was needed. Any further reduction in home care capacity would be likely to have a significantly negative impact on service users and their carers. It would also make it very difficult for the Partnership to realise its objective of reducing the numbers of older people it placed permanently in care homes. The unavailability of home carers was one cause of discharges for service users from hospital being delayed. Senior managers acknowledged that the current levels of home care would be unable to meet the anticipated levels of future demand.

The Partnership needed to develop its commissioning approach to further shift the balance of care. A key driver in shaping the draft joint commissioning strategy included developing a market position of having a range of options available, in areas such as home care and housing support, to meet the changing landscape that self-directed support would require. This would help enable a greater degree of choice and control for service users and their carers.

The Angus Partnership should produce a SMART (specific, measurable, achievable, realistic, time-bound) joint strategic plan. This should make sure that future joint commissioning plans for older people give more detail on:

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

Recommendation for improvement 4

The Angus Partnership should show clearly how it plans for, and commissions, services, across all sectors that improve the balance of care and deliver an increased range of support to help individuals to remain at home successfully.

Partners needed to make sure that services commissioned across sectors had a clear locality link where this was a desired result. We saw some early work to help improve access for people needing support. For example the proposed 'My Life' portal would enable access to commissioned support. This was an online care and support planning tool that individuals could access to arrange their care. It aimed to give them increased control over their own services in line with a person-centred approach to commissioning.

Early intervention support, including self-management options, needed to be more prominent as part of the joint strategic plan than was evident in the joint commissioning strategy for older people. This should show how it contributed to the wider strategic plan, as well as considering the housing and transport strategies as part of locality planning. Annual contracts for funding third sector services did not promote good relations or stability in the sector or encourage innovation and development.

A number of senior managers we met with said that strategy had been driven by budget cuts rather than as part of a forward looking plan to change and improve services. A range of service reviews were underway and had identified project leads and timescales for completion. These reviews aimed to inform a more strategic approach into the future. Senior managers had identified that service reviews would help reshape services to be more responsive and deliver a preventative approach. However it was unclear which reviews were prioritised.

For example, the development of supported housing had not progressed as envisaged. This needed to be reviewed to explore its role within the different models of care.

It was unclear what the future role of traditional sheltered housing would be, taking into account the need in some areas for more, very sheltered housing. A recent review of the Kinloch Care Centre supported housing in Carnoustie by Angus Council housing services had found that it was not fully utilised and queried the demand for this kind of service. We saw limited evidence of positive ongoing strategic working relationship between housing providers and the Partnership. Housing providers needed to be more firmly involved in strategic and operational planning groups.

Management guidance to the service review project leads needed to include impact assessments to make sure that any decisions made did not adversely impact on other services and developments. The inclusion of health and other partners would also improve the process and help identify shared outcomes.

The Partnership's approach and model for working in localities had been agreed. This had set out a clear map and approach for taking forward partnership working and how commissioning would be informed. The Partnership needed to make sure that their approach included both third and independent sector initiatives and was informed by housing strategies and the outcome of any community hospital reviews. The Partnership should identify all relevant available resources and how these would be allocated to help inform the integration plan. The Partnership had not yet made decisions about investment and disinvestment. This should form part of the overall approach to budget planning.

Although a draft joint commissioning strategy for older people had been issued for wide consultation locally, managers acknowledged that some of the developments did not include the views of some stakeholders. The joint strategic plan should now be developed to include both health and social work developments as well as identifying key outcomes that other stakeholders could submit proposals to meet. Identifying available resources would be key to such activity. There was no overarching agreement yet on how locality commissioning for NHS services would work. Senior officers from health and social work services acknowledged that joint strategic commissioning was not well developed in Angus and was at a very early stage. A high level group was now developing the Partnership's joint commissioning intentions.

We were not assured that Angus Council's people directorate's adult care services plan had been fully costed, took account of other developments and included partners in its development. However, we recognised that the need to produce a plan and the relative recent change in management had meant that the process was not fully planned and forward looking.

Overall, we evaluated the Partnership as weak on this indicator. However we noted positive operational planning in areas such as supported discharge and self-management preventative initiatives.

Quality indicator 7 - Management and support of staff

Summary

Evaluation – Adequate

Joint health and social work services workforce planning was at a very early stage, particularly with moving to a locality commissioning and delivery approach. Staffing processes were, generally, not joint. Historically, vacancy and absence rates in Angus Council and NHS Tayside had, in general, not given cause for concern. Recruitment was a challenge for some services and, although there were few joint posts, at present, there was evidence of new approaches to service delivery.

Work was under way to reconfigure local services in Angus. Funding was available to support workforce development. There was evidence of good frontline team working and joint working between health and social work services staff.

A joint approach to support recruitment opportunities had been carried out involving a local college and apprentice schemes with local schools. Training and development opportunities were available and focused on improving outcomes for service users.

7.1 Recruitment and retention

We read a range of relevant documentation on recruitment and retention, and on human resources given to us by Angus Council and NHS Tayside. These documents were fit for purpose but were separate documents rather than jointly compiled. In relation to workforce planning, limited formal joint planning was taking place. While there was a recognised need to reshape the skills profile of the workforce, it remained unclear what future joint working would look like.

Joint health and social work services workforce planning was at a very early stage particularly with moving to a locality commissioning and delivery approach. Four geographical localities have been identified and work was under way to identify what staffing model and skills mix would be required for each area. We were told by senior managers that this work was based on the health and social care profiles of each locality supported by NHS Tayside public health department. Senior managers needed to set clear timescales for completing this work.

During our interviews and focus groups with a range of frontline staff and managers, the ongoing challenge of recruitment in some areas such as home care and community nursing services was identified. Allied health professionals stated that they had little

difficulty recruiting and retaining staff, with many having been in post for a number of years. However, in dietetics, new service developments and projects meant that some posts could only be filled on a temporary basis.

While the Change Fund offered opportunities to test innovative ways of service delivery, in some cases, recruitment difficulties prevented managers from doing so due to the temporary nature of the posts. We were told of the difficulties recruiting professionals such as GPs and consultant psychiatrists. This was causing some issues, particularly for out-of-hours and crisis services. A recent advert for a consultant post had received no applicants. This issue was being looked at locally, however we were told that it reflected the national picture. GPs told us that they appreciated the strong multidisciplinary and multi-agency model in Angus and felt this was a feature which could attract new recruits to the area.

In recent years, the overall vacancy and absence figures provided to us by Angus Council and NHS Tayside had generally not been problematic. For example, we were told that the staff absentee levels in Angus community health partnership at May 2014 were 4.16%. Of this, 1.7% was long-term absence and the remaining 2.46% was short-term. These figures were better than the absence rates for NHS Tayside (4.5%) and the rest of NHS Scotland (4.76%). Angus community health partnership was near the national target of 4% and demonstrated good management of absences. We were also told that staff had access to consultations with physiotherapists who provide advice and treatment to them, if needed. For Angus Council, statutory performance indicators for absence showed rates slightly below national averages for non-teaching staff. This information was regularly reported to the Council's scrutiny and audit committee and had recently shown improvement.

7.2 Deployment, joint working and team work

From our review of social work services and health records, we found positive aspects of joint working. In most cases, there was evidence of multi-agency working and that services worked together, for example, to provide care at times of crisis. There was evidence that multi-agency partners' views informed individuals' assessments in nearly three-quarters of files and two-thirds of risk assessments. There was evidence of multi-agency working in 91% of cases.

From our staff survey, we found that 72% of respondents agreed that there were positive working relationships between health and social work services practitioners at all levels. Internal deployment of staffing resources was not a prominent issue during our inspection. Frontline staff as well as NHS and social work services managers we met with reported good working relationships with colleagues across the services. They said that an increased focus on outcomes was evolving as a result.

GPs told us that they had good links and felt well supported by medicine for the elderly specialists. Joint working in mental health services had been in place in Angus for

some years. Staff reported this was working well. We saw evidence of good day-to-day operational work carried out in one locality to reduce the number of avoidable admissions of service users to hospital.

7.3 Training development and support

From our staff survey, we noted positively that 83% of respondents agreed that joint working was supported and encouraged by managers.

A clear majority (74%) agreed that they had good opportunities for professional development. Frontline health and social work services staff we met with were positive about training opportunities.

We heard about a wide range of training and development opportunities and initiatives in the Angus Partnership. We read the Partnership's transitional organisational development plan. This plan set out the priorities for organisational development to support health and social care integration and the resources required to do this. As a result of this, resources received from the Scottish Government's integration fund had been set aside to carry out this work.

We were told that Angus community health partnership and Angus Council had set up a workforce development group in 2012 to develop a joint response to the national dementia strategy. As a result, a range of training on dementia awareness was put in place for all health and social work services staff. The training included 'promoting excellence', (a learning framework for all health and social work services staff working with people with dementia), local training to support dementia care, and training to develop dementia ambassadors and dementia champions. Attendees evaluated all these events positively. We were told that a network to support dementia ambassadors and dementia champions had been set up to develop and share learning twice a year. These roles would strengthen support and leadership for staff providing care for individuals and the carers of those with dementia.

Example of good practice - Health and Social Care Academy

As a result of an ageing workforce and difficulties recruiting healthcare and social work services staff, innovative approaches had been considered. The Angus Partnership had worked with Angus College to support and encourage training for young people in caring careers. A 'Health and Social Care Academy' was developed along with the introduction of modern apprentice schemes in local schools. This gave opportunities to young people to work in social care as part of the school curriculum.

We heard that there had been an increased awareness of dementia standards among staff. This was achieved through training programmes and focus groups throughout the Partnership. Local care home staff we met with were well informed in dementia care, with input from the University of Stirling's 'Best Practice in Dementia Care' model of training. They received effective support from the dementia liaison team regularly. Sometimes, local social work staff considered that the dementia liaison team duplicated work they had already carried out, such as assessments. Managers needed to consider how they streamlined their approaches.

Other examples of available learning opportunities included training for self-directed support that had been carried out for social work services staff. The Angus Carers' Centre was reviewing the referral pathway they had in place to support and improve access for carers as a result. For several years, Angus Council took part in an effective graduate recruitment campaign for social work services staff. Around ten graduates each year were recruited. Most of them remained working with the Council.

Quality indicator 8 – Partnership working

Summary

Evaluation – Adequate

The Angus Partnership had made progress towards the implementation of joint financial planning and monitoring arrangements for 2014–2015 and going forward. NHS Tayside and Angus Council were also committed to partnership working and were developing the necessary structures to make sure that arrangements were complete within the allocated timescales. However, this was against a history of limited financial planning and budget monitoring partnership.

The Partnership had a strong tradition of working well together at locality level, and between individual members of staff. Formal partnership arrangements were being put in place.

8.1 Management of resources

As with many other areas in Scotland, the Partnership was not at a stage of pooling of budgets. Although health and social work services partners were working towards a shared approach to planning and budget management, many decisions continued to be made separately. We did not find impact assessments that took account of the wider implications of decisions, particularly when they led to a change or reduction in existing service provision. This included the council's decision to create a five-year budget plan without full engagement with health partners on the wider implications for the Partnership. A shadow joint board was in place and members were working towards agreeing the full scope of the health and care social partnership and the allocation of resources. Some of this work was being taken forward jointly with other local authorities in the Tayside area and NHS Tayside.

Angus Council and NHS Tayside had worked closely together on the delivery of some care services for a number of years. Before the 2014–2015 budget, local authority and health budgets had been managed separately, and the Partnership's focus had been on identifying gaps in funding. However, this had started to change and an outcome-based budget process had been adopted for 2014–2015, to begin to make sure that budgets were allocated and aligned to stated Partnership outcomes.

Finance officers from health and social work services met regularly during the 2014–2015 budget setting process to discuss budgets for the year and to begin to embed joint budgeting arrangements for the Partnership.

The community planning partnership resources group had not been as effective as it had hoped. For this reason, this group was being reinvigorated and its remit widened to consider workforce planning and other cross-cutting resource issues.

It had also been appointed to improve communication to the Angus community planning partnership. We found a reasonable level of trust between the partners in Angus. Progress was being made towards achieving increased integration of services.

To support the move towards integrating the appropriate care budgets between NHS Tayside and Angus Council, a joint work plan had been developed. This set out the tasks to be completed by the Partnership before integration. It was organised around six themes. These were:

- budgeting
- reporting
- financial governance
- technical accounting
- finance departments, and
- localities.

An integration plan would set out the financial resources which would be available for the delivery of agreed services. Senior managers needed to make sure that this work aligned with the strategic planning and commissioning groups to inform their plans.

The community planning partnership's community care and health partnership had identified that there would be no transfer of staff between Angus Council and NHS Tayside. However, NHS Tayside had identified a number of joint finance posts between the NHS board and its three partner councils. These posts were jointly funded by both NHS Tayside and the councils, although they were based within the NHS team. This was to facilitate joint reporting on areas such as district nursing, the joint commissioning strategy and Change Fund allocations. The joint posts would also develop and enhance joint financial planning arrangements.

No joint financial reporting was in place for NHS Tayside's and Angus Council's revenue spending on the community care and health partnership. As such, it was not clear what the Partnership's aggregated financial position was as a whole throughout the year. Additionally, there may be financial benefits created across the Partnership as a result of over/underspends in certain areas through streamlining of processes. Joint financial reporting as well as the use of sources such as the integrated resource framework could allow such combined effects to be identified and built into future budget analysis and budget setting processes.

Angus social work and health services' budget variances were reported on a six- to eight-weekly basis to the Angus Council's policy and resources committee. However, this was at a fairly high level and did not include a detailed review of budgets against actual spend.

Spending against NHS Tayside's overall community health partnership budget was reported every two months to the Angus community health partnership committee and every month to community health partnership management.

NHS Tayside had developed a joint reporting framework for all three of its health and social care partnership areas. This was as part of its wider work on integration of budget setting and reporting. The framework was due to be rolled out for the Partnership from 31 July 2014.

Through this joint reporting framework, NHS Tayside and its other Tayside partner councils had attempted to align budgets to report actual positions against budget for their partnership as a whole. The Partnership had anticipated that the addition of this framework and the appointment to joint positions would lead to better financial information and a more transparent approach across the Partnership.

There had been examples of joint capital investment in capital projects. As yet, integrated capital planning was not fully developed. The limited joint sharing of capital resources, and limited formal discussion on capital planning needed to be addressed. As such NHS Tayside had commissioned a working group to develop an approach to the integration of capital planning and budgeting. It planned to roll out this approach across all three NHS Tayside health and social care partnerships including Angus.

Financial Performance of Angus Council

Angus Council's budget was prepared on an annual basis with a high level five-year financial projection. The community care services budget within Angus Council was £44.105m for 2013–2014. Draft year-end figures indicated that as at 31 March 2014 the council had spent £45.105m. This was an overspend of £1.000m (2.27%). The £1.000m overspend included overspends against the provision of externally provided home care (circa £0.644m) and independent and third sector services (around £0.816m). However, these overspends were mitigated to some extent by underspends in other areas of community care services.

We noted that there was no regular reporting of financial information to Angus Council's social work and health committee. The committee received limited and high level financial information and did not receive an up-to-date position on spend against budget throughout the year. This hindered effective decision making and scrutiny by the committee. In addition, the Council did not report separately on budgets for older people's services. This means that decisions made regarding older people's services may not have been based on a complete understanding of the budget position or current

spending levels. As such, the council could not be held accountable by members, partners or stakeholders for the level of resource and investment it was making to the Angus community care and health partnership.

Angus Council had identified a number of cost pressures for 2014–2015, including the need to achieve £1.029m of efficiency savings for older people's services. The Council had also identified that it had to find an additional £18.728m of savings across all services over the next three years to have a balanced budget.

The Council faced significant challenges if it was to achieve the required level of efficiency savings. The 2013–2014 overspend of £1.000m was roughly equal to the £1.029m of efficiency savings required in 2014–2015.

Therefore, a gross saving of over £2.000m was needed from 2013–2014 performance in order to meet the 2014–2015 budget. However, the Council had provided £0.850m to mitigate the impact of demographic change.

This level of gross savings would be difficult to achieve. Some savings were expected following the re-organisation of home care working patterns to help sustain the service under self-directed support, but these may not be enough. For example, the council had identified a budget pressure from the growth in the number of older people creating additional demand. However, the number of older people requiring support was actually above expected levels. This had not been quantified. Therefore, the potential spending pressures were not included in budget projections. Angus Council was confident that it could meet its budget and deliver the required savings for 2014–2015. The council needed to refresh its charging policy to make sure that the resource envelope was maximised.

Financial Performance of NHS Tayside

NHS Tayside produced a high level five-year financial plan that was supported by a detailed one-year financial local delivery plan. NHS Tayside reported that the Angus community health partnership had an authorised budget of £99.422m. The summary financial report for the community health partnership stated an overspend of £0.858m (0.86%) for 2013–2014. This variance was reported as mainly being due to a net overspend of £0.395m in hospital and community health services and £0.472m for prescribing.

Prescribing was seen as a significant risk area by NHS Tayside and the community health partnership. NHS Tayside met none of its £0.390m savings targets in prescribing for 2013–2014 and was actually overspent by £0.080m. The largest contributor to the prescribing overspend for 2013–2014 had been an overspend in family health services prescribing of £0.472m. This was due largely to unit prices of medicines being in excess of planned levels. However overall NHS Tayside met all of its financial targets in 2013–14.

It was noted by NHS Tayside that there was a relationship between the community hospitals overspend and other underspends in aligned services, such as medicine for the elderly. NHS Tayside's working assumption was that community hospital overspends would be offset by underspends in medicine for the elderly. It should be noted that the year-end position of the community care and health partnership had been assisted by non-recurring underspends of roughly £0.500m related to items such as vacancies throughout the year. A further £0.250m of saving relating to vacancies was included in the recurring savings for the year as they occurred year on year. As these savings were non-recurring and non-budgeted, there was no guarantee that the same level of savings could be achieved during 2014–2015.

Both partners recognised the significant ongoing challenges that will be faced due to continuing demographic changes and the pressure this will create on meeting future saving targets. For 2013–2014, NHS Tayside achieved 55% of in year savings targets and 46% of recurring savings targets.

The joint commissioning group managed the allocation of Change Fund monies and was supported by finance officers from both partners. Change Fund resources, (including carry forward), were £3.362m in 2013–2014. This was made up of an annual Scottish Government allocation of £1.691m and a carry forward from 2012–2013 of £1.671m. In its mid-year review of the Change Fund, the Partnership had reported that it expected £1.654m of funds to be carried forward into 2014–2015. However, this was the last time that the Partnership would be able to carry forward this funding stream. The Scottish Government had written to all partnerships stating that any unspent change fund monies, (at March 2015), would be returned to the Scottish Government.

Recommendation for improvement 5

Assess and gauge in detail the strategic financial risks to the future development of the Partnership and the delivery of health and social work services and ensure that these risks are managed effectively.

8.2 Information systems

Data sharing between health and social work services is a challenge throughout Scotland. A Tayside-wide group was set up to find a local solution to information management and sharing. This was complicated due to the different councils within Tayside working with differing social work information management systems.

As with many partnerships in Scotland, the Angus Partnership did not yet have a coherent joint information technology strategy that supported the sharing of information at both individual and strategic levels in the joint delivery, management and planning of services similar to other partnerships in Scotland. There was little information on how

greater information sharing would work in practice. Key existing gaps were identified that included referral, assessment, care and treatment plans, and risk assessment and risk management. The partners' computer systems were not able to communicate and share information. A project manager was to be employed, funded from the Change Fund, to identify business needs.

Information systems provided practitioners with tools to monitor their own work and performance. Recording and measurement of outcomes for individuals was supported by Angus Council's 'Carefirst' system. Although some NHS staff had access to 'Carefirst', this information could not be shared with all relevant NHS staff. Staff said the different recording systems and incompatibility of NHS and Angus Council information technology systems, made it impossible to share records, and made joint information sharing and working more time consuming and sometimes very frustrating.

Our review of social work and health records found that records were largely single-agency. Few showed multi-agency or multidisciplinary electronic information sharing.

However, in 71% of records that we read, information from partners informed the assessment. This showed that there was good communication between frontline staff. Staff told us about some developments that were beginning to make a difference to how staff accessed and shared information.

The integrated mental health team had agreed from the outset that the entire team would use 'Carefirst' as their integrated information technology system. This was a very positive approach to overcoming some of the difficulties that staff experienced if they had to work over two systems.

The evaluation of the winter pressures enhanced response project was published during our inspection. This project had set up multidisciplinary team meetings to improve information sharing across partners and to improve outcomes for individuals in the community. The project plan included the aim to develop and populate a measurement plan that clearly demonstrated the impact of improvements and system changes. Partners had made a number of recommendations to support continued improvement. This included the continued gathering of data to evaluate the impact of the project. The clinical portal for health formed the basis to access and share information. The Partnership should make sure that this approach to support sharing information was developed as proposed across all settings both in the community and in community hospitals.

Angus Council used 'COVALENT', a performance and governance software application, to manage and monitor performance. Managers recognised that, in the past, decisions about service development and delivery were not always based on sound performance data. NHS Tayside was testing 'STRATA', a web-based performance information platform, and intended to make this available to partners. Health services staff were testing mobile

working using 'MiDIS' (Multi Discipline Information System)' that aimed to improve access to their system and improve recording and sharing data. They had still to agree a shared model for monitoring performance.

8.3 Partnership arrangements

The Public Bodies (Joint Working) Scotland Act 2014 requires NHS boards and local authority partners to enter into arrangements (the 'integration scheme') to delegate functions and appropriate resources to ensure the effective delivery of those functions. This is a major national change programme with the Scottish Government setting timescales for the delivery of the Integration Scheme and Joint Strategic Commissioning Plan. At the time of inspection not all of the relevant integration guidance had been published.

Compliance with integration delivery principles⁸

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

Partnership working was established through the Angus community care and health partnership. The new arrangements for the health and social care partnership, (Angus Integration Authority), were to build on this to further develop an integrated partnership covering both health and social care.

Some of the groundwork was in place, including the formation and development of the shadow joint board and associated supporting work streams. The decision on delivering a body corporate model and the appointment of an interim joint chief officer had been agreed by Angus Council and NHS Tayside in April 2014. The final constituent parts of the Partnership had not yet been finalised. This would be set out in the draft integration scheme due to be published for consultation late 2014 or early 2015.

Membership of the shadow joint board included elected members of Angus Council, and non-executive NHS board members of NHS Tayside. At the time of our inspection, membership was under review to include further stakeholders. A clinical and care governance group had also been set up to take forward governance between healthcare and social work services. The interim joint chief officer had been appointed and was beginning to draw together the key priorities for the Partnership.

⁸ 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.

There would be significant challenges ahead for the Partnership. The precise services included in the integrated budget had yet to be identified. The impact of current and future savings and efficiencies targets for both partners also needed to be considered jointly. NHS Tayside was concerned that, in order to align with Angus Council, it needed to bring forward some aspects of its budget setting processes. To address these challenges, NHS Tayside and Angus Council had developed additional advisory groups. The groups included the shadow joint board and a project board for the Angus Partnership. The project board had a responsibility to plan and progress the Partnership agreement and the locality model for Angus. The project board, along with key officers from the partnership bodies, was beginning to pull together the key information to be able to shape the health and social care partnership.

Elected members and NHS board members, although concerned about the lack of national guidance on the roles and responsibilities of the integration authorities, were satisfied that, in the main, they received sufficient information from the interim joint chief officer to be able to make decisions. At the time of the inspection, recent guidance from the Scottish Government aimed to provide clearer information on the governance arrangements for carrying out integrated functions, by the constituent authorities in overseeing the delivery of these functions.

Development sessions had supported elected members and NHS board members. They saw their role as providing oversight of governance and financial accountability, ensuring equitable services across Angus and developing a structure that supported good outcomes for individuals. The guidance from the Scottish Government would help establish a firmer basis to determine the roles and responsibilities that the future joint board would be accountable for. Elected members and NHS board members acknowledged future challenges included:

- person-centred approaches and services linked to self-directed support
- workforce planning and development to meet the identified needs of service users
- public engagement that made sure views were heard and reflected in developments, and
- good performance information.

Senior managers in Angus Council told us that elected members and NHS board members engaged well with health and social work services officers and were fully involved in addressing the issues of health and social care partnership working. Elected and NHS board members took time to consider reports presented to them. The Partnership was in the process of further developing governance arrangements that made sure that the Council's committees were fully briefed and engaged in decision making.

Performance targets, improvement measures and reporting arrangements which related to integration functions still had to be developed. Elected members and NHS board members still had to agree the process to be used to prepare a list of all targets, measures and arrangements for integration functions and for which responsibilities transferred either in full or in part to the integration authority. This would include a statement of the extent to which responsibility for each target, measure or arrangement would transfer to the integration authority.

Health and social work services in Angus had a well-established history of partnership working. For example this included lead agency arrangements for community mental health services. Other examples of effective partnership working were adult protection services, occupational therapy and the joint equipment store. Managers gave examples of how the trust built at their level had helped to progress some better pathways for service users discharged from hospital.

The development of the multidisciplinary team meetings in GP practices had provided a good starting point for joined-up locality working. This was beginning to show benefits for both people using services and for staff. The Partnership had good engagement from GPs in the different strategic planning groups including the locality forums.

The Partnership had identified a number of areas where it would continue to improve partnership working. This included preparing and delivering a comprehensive clinical and care governance framework, joint performance plan, joint information technology plan and joint finance plan in partnership with NHS Tayside, Dundee, and Perth and Kinross partnerships.

Quality indicator 9 – Leadership and direction

Summary

Evaluation – Adequate

The health and social work services partners in Angus were at an early stage of developing their own approach to integrating health and social care in line with legislation. They had a shared vision and an agreed model for integration and were building working relationships throughout the partnership. This needed to be developed further to ensure a positive transition to new integration arrangements.

Leaders of services in Angus had identified many of the future challenges in delivering joined-up services for older people. However, weaknesses included the articulation of the partnership's vision. Service delivery plans needed to fully demonstrate clear links between an analysis of the current situation and the actions required to address the changing needs of service users and carers to help improve outcomes.

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

9.1 Vision, values and culture across the Partnership

The Angus Partnership appreciated the need for change in the delivery of older people's services, with a shared understanding of general priorities. The vision of future services in Angus meant that delivering services in different ways needed to be developed if the Partnership was to embrace appropriately the challenges of changing demographics such as shifting the balance of care from institutional care towards more homely settings.

In order to achieve the Partnership's strategic aspirations, it needed to fully identify the future needs in terms of staffing resources and skill mix/levels. Senior Partnership officers told us that future joint commissioning priorities and the development of an integrated workforce plan would be prepared as part of developing an 'integration scheme' by March 2015. The Partnership needed to focus its activity towards the preparation and delivery of this scheme.

The Partnership needed to take steps to promote ownership of its vision at all levels. From our staff survey, just over half of respondents agreed that there was a clear vision for older people's services with a shared understanding of the priorities. 20% disagreed with

this, and the remainder stated that it did not apply to them. We asked staff if the vision for older people's services was set out in comprehensive joint strategic plans, alongside strategic objectives with measurable targets and timescales. Under half (48%) agreed with the statement. Nevertheless, across the Partnership, staff were committed to delivering joint services.

9.2 Leadership of strategy and direction

Leaders of health and social work services in Angus had identified many of the future challenges in delivering joined-up services for older people. They had a shared vision and an agreed model for integration and were building working relationships throughout the Partnership. Collective accountability and responsibility for leading integrated services was developed in some areas including community mental health services. The Partnership did not have an overarching strategy in place for focusing further resources on prevention and early intervention. They did not always consider the success of their approaches and delivery of services and use this to measure the benefits for people and the future direction of services.

A shadow joint board was set up with a key aim to provide joint direction and recommendations to both parent organisations (Angus Council and NHS Tayside). A supporting project board had a wider membership from stakeholder groups. The shadow joint board was still in a development phase, and an "integration scheme" was still in an early draft. An integration scheme project plan had been prepared to enable progress to be tracked. The scheme was due for completion in March 2015 and would be developed in co-operation with other partnerships in Tayside.

We attended a meeting of the shadow joint board and saw evidence of a developing working relationship between NHS and Council members, with agreement about the way ahead in relation to integration. Shadow board members needed further support from senior officers to improve their capability to fulfill their roles. Senior officers had commented that financial briefings in particular had been insufficient to enable members to make fully informed decisions.

9.3 Leadership of people across the partnership

Feedback from our staff survey provided evidence that more work was needed to make sure there were clearer joint strategies to communicate change to staff. We asked staff whether their views were fully taken into account when services were being planned and provided. Half of respondents agreed with the statement. However, over three-quarters of respondents agreed that they felt valued by their managers.

Most staff we met with told us they had been involved in a number of consultation exercises for a variety of initiatives and projects. However, many of them told us they had not had the opportunity to ask questions. Therefore, they did not feel their views were always taken into consideration or that their queries had been clarified.

Senior managers told us they were already aware of some of these issues and action plans were under way or in preparation. Elected members and NHS board members were aware of the need to concentrate efforts on engaging and involving staff. The Partnership needed to refresh and further develop its health and social care integration communication and engagement plan.

From our staff survey and the staff we met with during our inspection, it was clear that the great majority of staff in both health and social work services had good professional relationships with each other.

In our staff survey, 83% of respondents agreed that joint working was supported and encouraged by managers and 7% disagreed. In addition 70% of staff reported that there were positive working relationships between practitioners at all levels.

Recommendation for improvement 6

The Angus Partnership develop its strategic planning processes, setting out clear consultation and involvement measures so that all relevant stakeholders are consistently engaged. This should be part of its further development of its integration project planning in areas such as strategic needs assessments, service review and development, joint commissioning, monitoring arrangements and joint performance management. These developments should help to evidence how services are improving for the benefit of service users and their carers.

The Angus Partnership strategic planning process should set out clear consultation, engagement and involvement policies and procedures with stakeholders. This should include better engagement on:

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

9.4 Leadership of change and improvement

As with many partnership areas the Angus Partnership was at the early stages of implementing changes necessary to deliver integration in line with the Scottish Government's integration agenda. There was a history of joint working in Angus, but the change agenda was a challenging one. We had some concerns about the effectiveness of change management. From our staff survey, 37% of respondents agreed that the quality of services offered to older people jointly by partner's staff had improved in the previous year. Less than half of respondents agreed that changes which affected services were managed well and just over half of respondents agreed that senior managers communicated well with frontline staff.

However, 74% of respondents agreed that senior managers supported and encouraged joint working, and 62% of respondents agreed that high standards of professionalism were promoted and supported by all professional leaders, elected members and NHS board members. This would provide a good basis for taking developments forward.

The partners were engaged in planning and delivering improvements in health and social care delivery and integration. Elected members, NHS board members and officials from health and the council were in general agreement about the way forward.

Senior managers were engaging with other partners such as the third sector, local communities, users of services and carers. They were identifying local assets to enhance locality working, but progress was at a very early stage.

A challenge for the Partnership would be to make sure consistency of joint working and standards across the partner organisations and within each of the localities. Clear and consistent senior leadership would be needed to forge stronger links between outcomes, activity and investment and disinvestment decisions as a priority.

The Angus Partnership should further develop its integration project planning. This should include a clear statement how it will address the following areas:

- strategic needs assessments
- prioritisation resulting from the assessments
- policy review and development
- service review and development
- pooled budgeting, joint commissioning (including locality commissioning), and
- monitoring arrangements and joint performance management.

It should also include key strategic elements such as prevention, early intervention, enablement, self-directed support and joint information systems.

Quality indicator 10 – Capacity for improvement

10.1 Judgement based on an evaluation of performance against the quality indicators.

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

From evidence gathered in our inspection, we concluded that the Angus Partnership delivered, in the main, good outcomes for service users and their carers. This evidence included our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership, results from our review of social work services and health records, and views expressed by service users, carers and the Partnership staff we met with.

Managers and staff were working well across agencies and with service users. The Partnership's development of multidisciplinary working, locality commissioning and delivery and enablement all contributed to building positive outcomes for service users and their carers.

There was room for improvement in areas such as shifting the balance of care to support more people to live independently in their own homes rather than in care homes and meeting Scottish Government delayed discharge targets. Providing increased access to home care should be a priority alongside enabling self-directed support (particularly enabling direct payments) and responding to carers' needs more consistently. The continued development of enablement and telecare could contribute to enabling better use of limited resources.

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

The Angus Partnership had made a start on its plans to integrate its health and social work services more closely. It was beginning to monitor how well this was progressing. Strategic planning was being reinvigorated. Delays in progress had been due, in part, to changes to key staffing and organisational structures as well as the political leadership.

The partners were beginning to develop a performance framework. However, there was not yet a co-ordinated approach to this, and commissioning was still largely separate. Angus Council and NHS Tayside were starting to jointly identify financial resources. However, significant challenges lay ahead. Financial and organisational development issues were of particular importance.

We found a strong commitment in Angus to realise the capacity within the community to help service users and their carers. However, this needed to be integrated and supported better. Overall, there needed to be a more shared view of future joint commissioning.

The Partnership's joint commissioning group had agreed decisions on Change Fund investment throughout the relevant period. However, some plans were lacking in detail, for example, in major decisions about investment and disinvestment.

Effective leadership and management

There was stable leadership and positive working relationships at senior levels between officials following a period of significant change. Leaders, including Council elected members and NHS board members, needed to better share and communicate with staff the merits of the integration agenda. This was evident from some of the staff we spoke with.

Elected members, NHS board members and senior officials acknowledged the need to concentrate their efforts on engaging and involving staff further. The Partnership recognised that sustained and focused effort would be needed if a shared vision was to be developed and implemented to meet future challenges. Good frontline working needed to be built upon by senior managers.

Preparedness for health and social care integration

The Angus partners had a good history of joint working between statutory partners, the third sector and the independent sector. The Partnership had developed a positive culture of working together. Leaders in Angus understood the future challenges in delivering joined-up services for older people in Angus. Constructive plans were in preparation to develop more integrated health and social services so that older people and their carers would have a more positive experience of these services. A shared approach was needed for the development of joint commissioning for older people's services. This would help to deliver a joint understanding of the needs and expectations of the older population in Angus.

Our conclusion was that the building blocks to achieve better integration were being put in place but this needed much further development. In particular, improvements in the way that future services are planned for were needed. The partners needed to be clearer about the sustainability of some of the processes in place, particularly those funded through the Change Fund. Delivery of the improvements required needed to be evidenced by the Partnership.

What happens next?

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

March 2015

Appendix 1 – Quality indicators

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



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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.