

## Services for older people in Moray

August 2014

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

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## Background

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

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

Most older people want to live independently in their own homes for as long as possible. Reshaping Care for Older People<sup>1</sup> aims to make sure that services are focussed on the impact they have on older peoples' quality of life. Reshaping Care for Older People aims to shift the balance of care towards anticipatory care and prevention and away from delivering care in a hospital setting to providing the necessary support and treatment in their own home or in a homely setting. This means that instead of reacting when problems arise, the focus is on prevention and helping people, with the right support to manage their own health conditions. It also recognises the role of unpaid carers and communities in delivering that support.

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

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

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

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The Public Bodies (Joint Working) (Scotland) Act 2014 provides the framework which will support improvement of the quality and consistency of health and social care services through the integration of health and social care in Scotland. The Act aims to

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

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

Areas to prioritise will include making sure:

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

NHS Health boards and local authorities will be required to put in place their local integrated arrangement by April 2015. Local partnerships are currently establishing shadow arrangements.

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The Care Inspectorate and Healthcare Improvement Scotland agreed to develop and carry out joint inspections of health and social care services provided for older people living in Scotland.

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

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

## **Methodology**

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

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

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

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

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

We inspect against the 10 quality indicators which focus on outcomes for older people, how partnerships are developing teams to deliver services, and the leadership within the partnership.

There are three key phases to the inspections:

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

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

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

The inspection team looks at a random sample of social work and health records for approximately 100 individuals to review practice. The team is assisted by file readers from the local area. This evaluation of practice includes case tracking (following up with individuals and the teams involved in their care). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. An anonymous staff survey is also carried out.

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

The inspection team publishes a local inspection report. This includes evaluation gradings against the quality indicators, any examples of good practice and any recommendations for improvement. Implementation of any necessary actions by the partnership arising from the inspection will be monitored through the link arrangements of the inspectorates.

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## Purpose of this report

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

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



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## Summary of inspection

Moray is a predominantly rural area situated in the north-east of Scotland. Moray sits between Inverness and the Highlands to the west and Aberdeen and Aberdeenshire to the east. Moray is one of the smallest regions in Scotland. Moray has a single council administrative area – The Moray Council.

NHS Grampian is the local NHS board, one of 14 NHS boards across NHSScotland. NHS Grampian includes six main acute or long-stay hospitals, 17 community hospitals and 80 GP practices<sup>2</sup>. NHS Grampian has three community health partnerships (CHPs) - Aberdeen City, Aberdeenshire and Moray. Moray Community Health and Social Care Partnership is aligned to the Moray local authority. This means they work together where both health and local authority contributes to services, for example in services for older people.

The Moray Community Health and Social Care Partnership is the organisation which brings together Dr Gray's Hospital, Elgin, community care services at The Moray Council, public health services, primary care, mental health, learning disability, health improvement and community health services. NHS Grampian and The Moray Council are the 'parent' organisations for the Community Health and Social Care Partnership. It can operate across the borders of Moray into a Grampian and North of Scotland context. Within The Moray Council, service delivery is organised through four departments. Social work services for older people are planned and delivered by the Education and Social Care Department.

The current population for the Moray area is 92,910. Just over half of the population live in the five main towns of Elgin, Forres, Buckie, Lossiemouth and Keith (GROS 2012 mid-year estimates).

The pilot joint inspection of services for older people in the Moray area took place between 4 November 2013 – 16 January 2014. It covered the health and social care services in the area that had a role in providing services to benefit older people and their carers.

The inspection team was made up of ten inspectors, two NHS clinical advisors and one carer inspector. We read social work services and health records for one hundred Moray older people, as well as other policy, strategic and operational documents. We spoke with health and social care staff with leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We reviewed practice through reading a sample of records held by services who work with older people. We then spoke with some of these older people and their carers. We are very grateful to all of the people who talked with us as part of this inspection.

<sup>1</sup> Information and Statistics Division (ISD) Hospital Profile (published Nov 12), Hospital Classification (published Nov 12) and NHS Community Hospital proforma (Oct 12); GP workforce and practice population statistics to 2013

We assessed the services against the 10 quality indicators. Based on the findings of this inspection, these services have been awarded the following grades (more information on grading can be found in Appendix 3):

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

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

- We generally found that very good outcomes for older people and their carers were being delivered in Moray.
- There were constructive plans to develop more integrated health and social services so that older people and their carers would have a more positive experience of these services.
- Health and social work staff in Moray were generally well motivated and we found that support from line managers made a good contribution to morale.
- We found a strong commitment in Moray to realise the capacity within the community to help older people and their carers.
- Most of the procedures to assist staff in delivering services were fit for purpose.

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- The Community Health and Social Care Partnership had made a good start on its plans to integrate their respective services more closely and it was beginning to monitor how well it was progressing.
  - Managers had generally put satisfactory recruitment processes and training opportunities in place for staff.
  - There has been a history of solid performance in the financial management of health and social work services in Moray.
  - Leaders in Moray clearly understood the future challenges in delivering joined-up services for older people in Moray.
  - The building blocks to achieve better integration of health and social work services were in place and the capacity for future improvement in Moray was good.

**We noted the following areas for improvement:**

- The number of bed days lost where there are delays in discharging older people from hospital.
- The capacity of the home care services to deal with the needs of older people and their carers.
- The effectiveness of the arrangements for older people and their carers to obtain access to social work services.
- The effectiveness of the joint arrangements between health and social work services to commission services for the benefit of older people and their carers.
- The procedures for ensuring that older people and their carers are protected from harm.
- The content of local plans to support the integration of health and social care services.

## Recommendations

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

### The Moray Partnership should:

- 1** take further steps to reduce the number of bed days lost in respect of older people whose discharge from hospital is delayed including those for reasons related to the application of the Adults with Incapacity (Scotland) Act 2000. It should ensure that Section 13 ZA<sup>3</sup> of the Social Work (Scotland) Act 1968 continues to be used when appropriate, streamline (where possible) the process of appointment of an adults with incapacity proxy and make sure all the required processes are carried out within appropriate timescales (Quality indicator 1- see Appendix 2).
- 2** further explore and implement any appropriate options to increase the capacity of the home care provision, particularly in respect of recruitment and retention in the area across all providers (Quality indicator 2).
- 3** carry out a review of the home from hospital and access teams, including their structures, staff roles, procedures and the effectiveness of their communications. The Partnership should continue with initiatives to ensure that hospital discharge arrangements and other referrals intended to support the wellbeing of older people in Moray are dealt with timeously and appropriately (Quality indicator 5).
- 4** ensure that future policy development of the joint commissioning strategy for older people, 'Living Longer Living Better', gives more detail on:
  - how priorities are to be taken forward and resourced
  - how joint organisational development planning is to be taken forward
  - how consultation and engagement are to be maintained
  - the use of advocacy in services for older people, and
  - action plans which are SMART (specific, measurable, achievable, realistic, time-bound) (see Quality indicator 6).

<sup>3</sup> This provision, in certain circumstances, enables the local authority to move a person who lacks capacity from an acute hospital bed to a care home.

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<b>5</b>	consult relevant partners and agree a proposal to review the reasons for the low level of adult protection meetings and case conferences in response to adult support and protection referrals. The Partnership should satisfy itself about the most appropriate use of these stages in the process, including maximising the involvement of service users and carers as appropriate (see Quality indicator 8).
<b>6</b>	provide more information on the integration pathway for its stakeholders. This should include the vision, objectives, implementation milestones, progress monitoring arrangements, sustainability and any key strategic elements such as the Three Tier Model, prevention, early intervention, reablement, self-directed support and joint information systems. This will also support its communication plan for the joint commissioning strategy for older people (see Quality indicator 9).

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## Quality indicator 1 – Key performance outcomes

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

### Summary

#### Evaluation – Very good

Social care services staff we met understood the principles of outcome-focussed practice and they carried this out with older people and their carers to their benefit. Health staff we met were justifiably confident that the health services they provided delivered good clinical outcomes for older people. A reablement approach was deployed across Moray's home care service users and this made sure that they had the optimum level of home care, with maximisation of their independence and capacity for self-care.

We found that, in general, the Moray Partnership delivered very good outcomes for older people and their carers. The provision of direct payments and other self-directed support options delivered good outcomes for older people, by giving them choice and control over the services they received. We had some concerns about the numbers of older people, particularly those with incapacity, in hospital waiting for arrangements for their discharge. However, where targets applied, the Moray Partnership was generally meeting the Scottish Government's targets on the number of people whose discharge from hospital was delayed.

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

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

We looked at the following key areas:

- emergency admission to hospital
- delayed discharge from hospital
- provision of home care services
- care homes
- self-directed support - direct payments
- respite care
- telehealthcare and telecare
- reablement
- regulated services

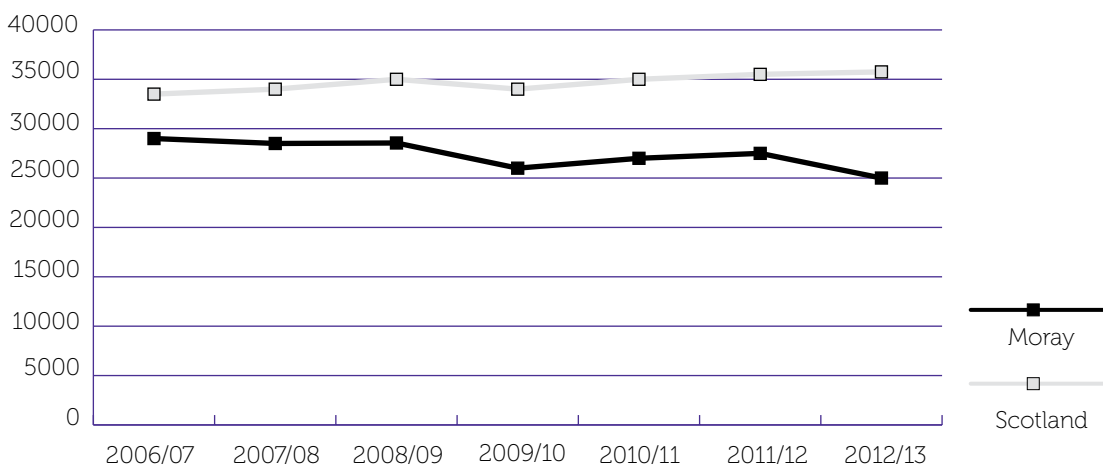
### Emergency admission to hospital

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

In general terms, we noted that the Moray Partnership was managing its emergency admissions well. The Partnership had comparatively low rates of emergency admissions of older people to hospital (see Charts 1 and 2).

#### Chart 1 (HEAT target)

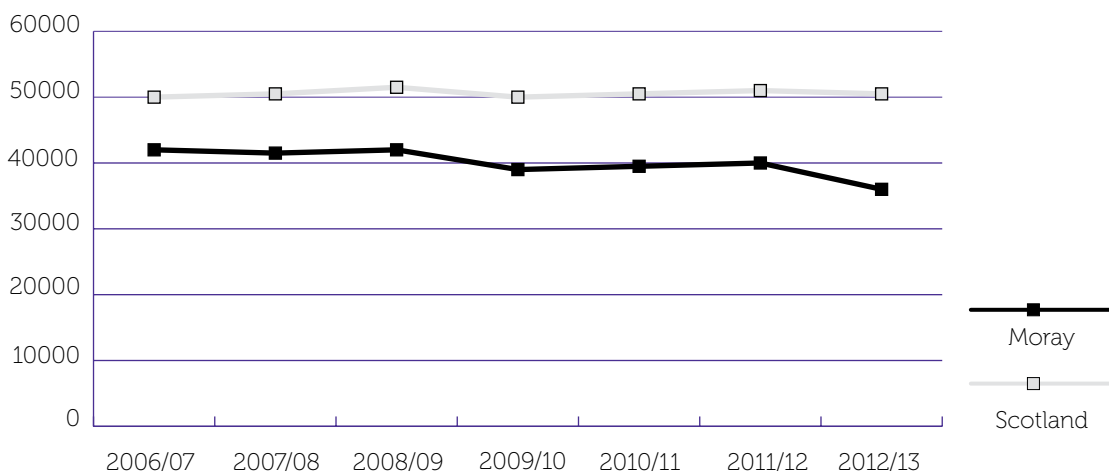
Emergency admissions 75+ per 100K population (source SG)



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## Chart 2

Emergency admissions of older people (65+) per 100K population (source SG)



### Delayed discharge from hospital

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

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

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

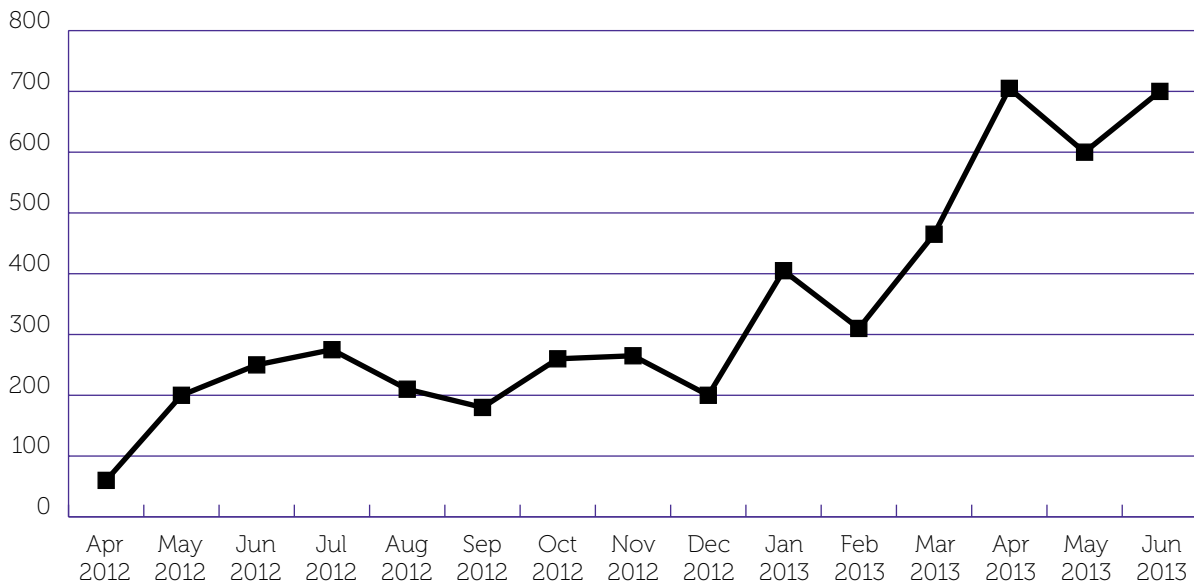
In April 2013, the Scottish Government set a target that there should be no delayed discharges of over 4 weeks' duration. This is a 2-week reduction on the previous target of 6 weeks. In 2015, the target will be reduced further to delayed discharges not exceeding 2 weeks.

The position of the Moray Partnership was complex in respect of older people whose discharge from hospital was delayed. Chart 3 below shows a rising trend (from a low base) for bed days lost to all delayed discharges over a 14-month period.



### Chart 3

Moray bed days occupied by delayed discharge patients all ages (source ISD)



We were advised by the hospital discharge team at Dr Gray's Hospital, Elgin that they were now reporting delayed discharges more accurately and this may influence the figures. When we met with the transitional leadership group, they reported no delayed discharges over 4 weeks in the most recent 2 months, with three people waiting 2 or 3 weeks.

The Moray Partnership had more bed days lost for delayed discharges of over 75s than the Scotland average (see Chart 4). The Moray Partnership was in the second highest quartile of the 32 partnerships for this indicator and ranked 9 out of 32 partnerships (1 is the worst).

### Chart 4

Annual 75+ years Delayed Discharge bed day rate per 1,000 population aged 75+, October 2012-September 2013 (source ISD)

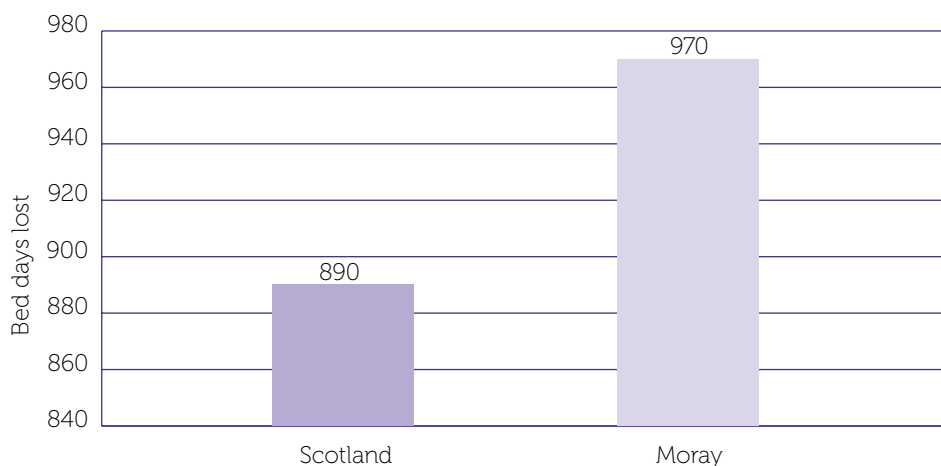
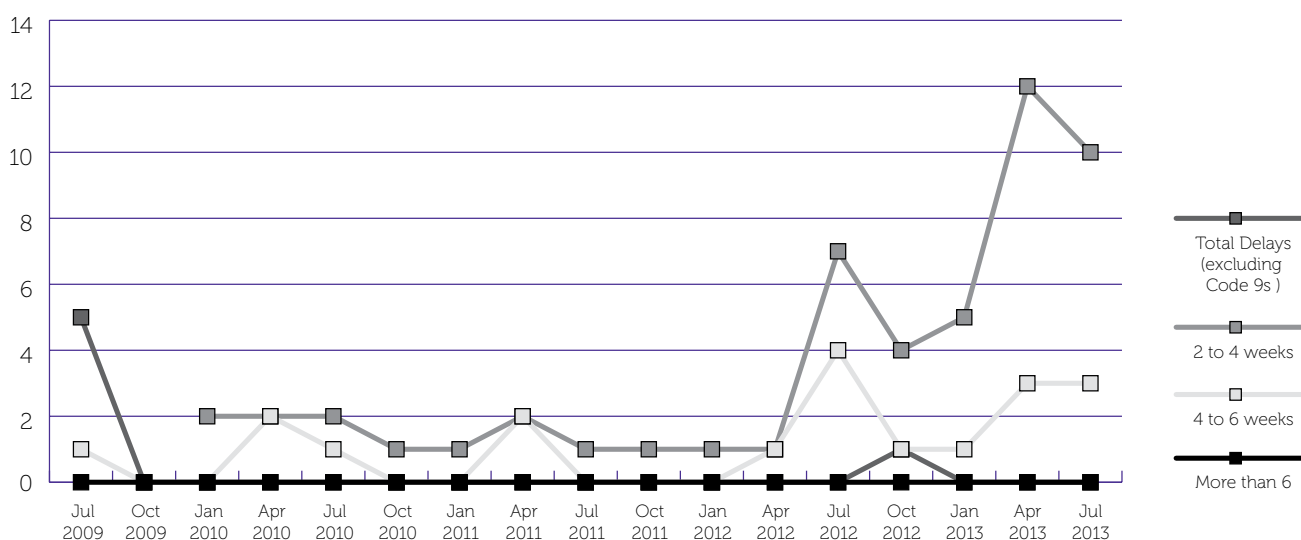


Chart 5 below shows the performance of the Moray Partnership on the current Scottish Government target of no delayed discharges over 4 weeks' duration, and on the previous Scottish Government target of no delayed discharges over 6 weeks' duration. The key points from this chart are:

- since April 2012, the Moray Partnership has had a recent upward trend in the total number of delayed discharges
- apart from October 2012, the Moray Partnership met its no delayed discharges over 6 weeks target
- in April and July 2013, the Moray Partnership met the current Scottish Government target of no delayed discharges over 4 weeks.

### Chart 5 (source ISD)

Moray delayed discharge trend & performance on targets



General reasons for delayed discharges in a partnership can include:

- healthcare arrangements
- availability of care homes
- awaiting funding for care home
- patients waiting to go home, and
- community care assessments.

The two most common reasons for delayed discharges in Moray were delays in the assignment and completion of community care assessments, and patients who were ready for discharge, but could not go home largely due to the unavailability of home carers.

## Delayed discharges due to reasons in line with the Adults with Incapacity (Scotland) Act 2000 and other reasons deemed beyond the control of the local authority (code nine delays)

It is recognised that there are some patients whose discharge will take longer to arrange and therefore the target is not applicable. These would include patients delayed due to waiting for a place in a specialist facility, patients for whom an interim move is unreasonable, or where an adult may lack capacity under adults with incapacity legislation. These are referred to as 'code nine' delays<sup>4</sup>. Details of all delayed discharges across Scotland can be found through the NHSScotland Information and Statistics Division<sup>5</sup>.

**Chart 6** (source NHS ISD)

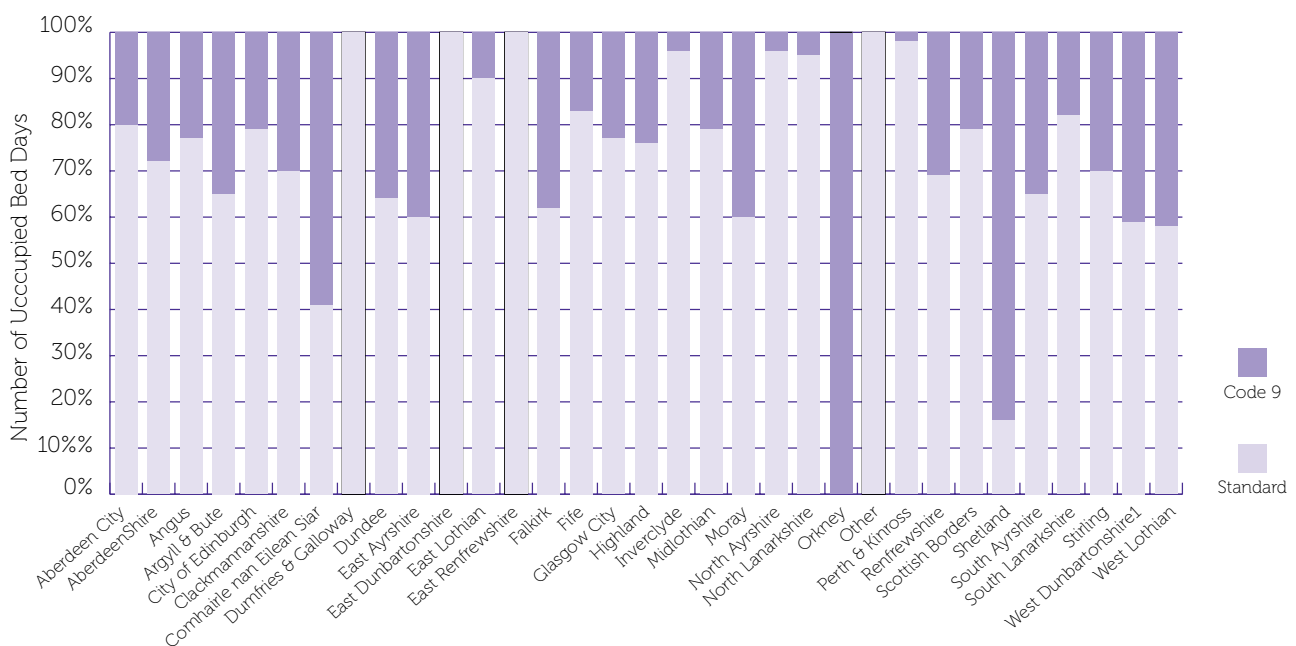


Chart 6 above shows the per centage of bed days lost to code nine<sup>5</sup> delays, and the per centage of bed days lost to standard delays for all Scottish local authorities (June 2013). Thirty nine per cent of all of the Moray bed days lost to delayed discharges in June 2013 were code nine delays.

A range of health staff told us that, as they perceived it, part of the reason for delays (which would include those in relation to the Adults with Incapacity (Scotland) Act 2000) was due to a lack of multidisciplinary team working of social care staff and community psychiatric nurses as well as a deterioration in the links between the acute psychiatric wards for older people and social care services. They also spoke about delays caused by time-consuming processes for dealing with older people who lacked capacity.

<sup>4</sup> Code nine delays are discharge delays that are related to patients who lack capacity and who require the appointment of a proxy under the terms of the Adults with Incapacity (S) Act 2000, as well as other delays that are deemed outwith the control of the local authority.

<sup>5</sup> Delayed Discharges in NHSScotland, Information and Statistics Division (ISD)

This included assessment, financial assessment, multidisciplinary meeting, possible further assessment and legal advice, preparation of welfare guardianship application to court, court proceedings and the making of an order.

**Recommendation 1:**

The Moray Partnership should take further steps to reduce the number of bed days lost in respect of older people whose discharge from hospital is delayed including those for reasons related to the application of the Adults with Incapacity (Scotland) Act 2000. It should ensure that Section 13 ZA<sup>6</sup> of the Social Work (Scotland) Act 1968 continues to be used when appropriate, streamline (where possible) the process of appointment of an adults with incapacity proxy and make sure all the required processes are carried out within appropriate timescales.

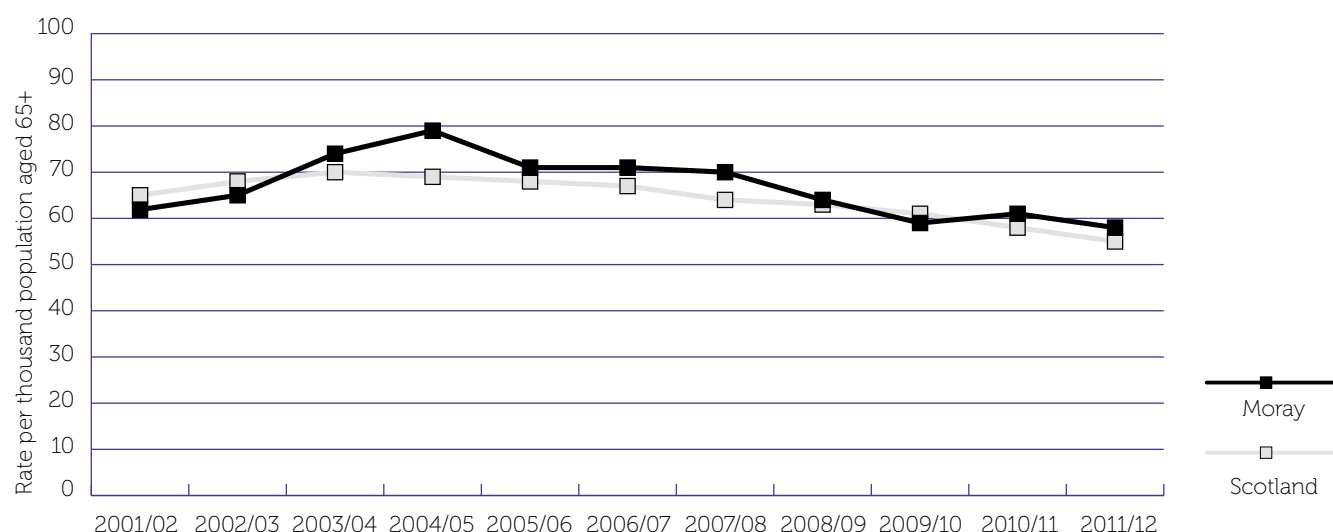
**Provision of home care services**

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

Overall home care and intensive home care levels in Moray were slightly above the Scottish average (see Charts 7 and 8).

**Chart 7** (source Scottish Government)

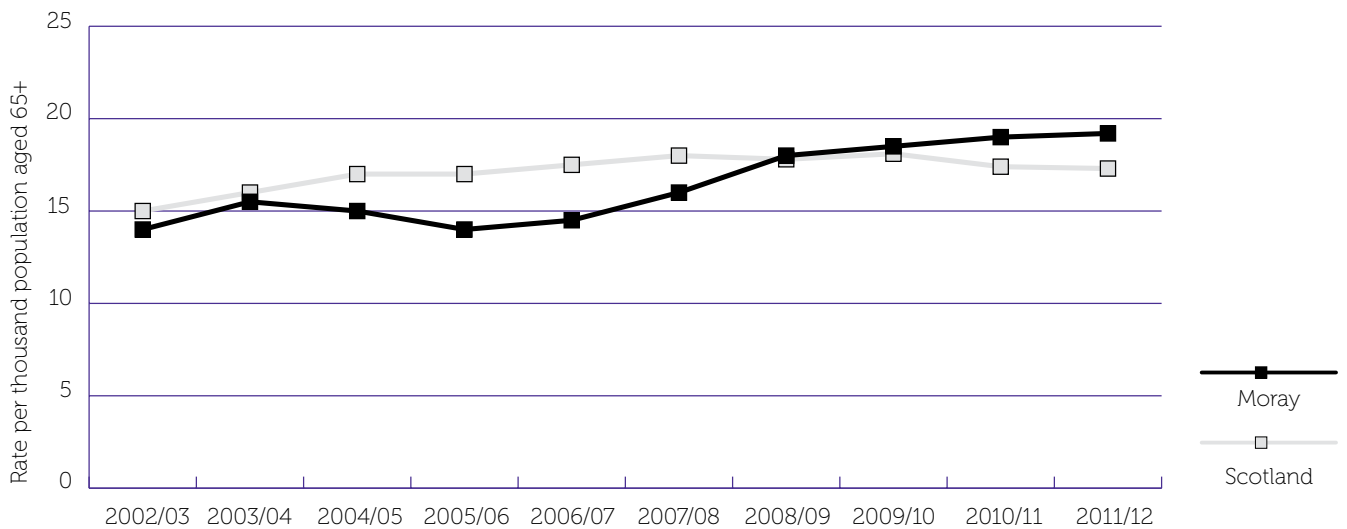
Number of people aged 65+ supported by local authority in home care, 2001/02 - 2011/12 (rate per 1,000 population)



<sup>6</sup>This provision, in certain circumstances, enables the local authority to move a person who lacks capacity from an acute hospital bed to a care home.

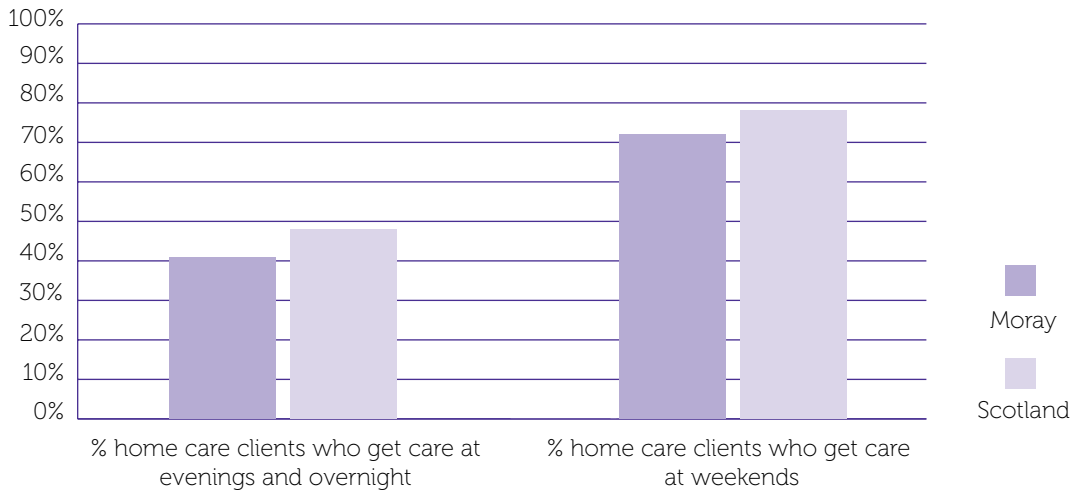
**Chart 8** (source Scottish Government)

Number of people receiving intensive home care, 2002/03 - 2011/12 (rate per 1,000 population aged 65+)



Moray delivered out-of-hours home care to older people at a level marginally below the Scotland average (see Chart 9). We look at home care provision further under Quality Indicator 2 in this report.

**Chart 9**



### Care homes - older people supported by the Council in care homes

Shifting the balance of care from institutional settings like hospitals to care at home presents a significant challenge for partnerships against a backdrop of an increasingly elderly population.

Chart 10 below shows that the Moray Partnership placed proportionally less older people permanently in care homes than the Scottish average.

**Chart 10**

Long-term stay care home residents, aged 65+ supported, 2002/03 - 2012/13 (rate per 1,000 population)

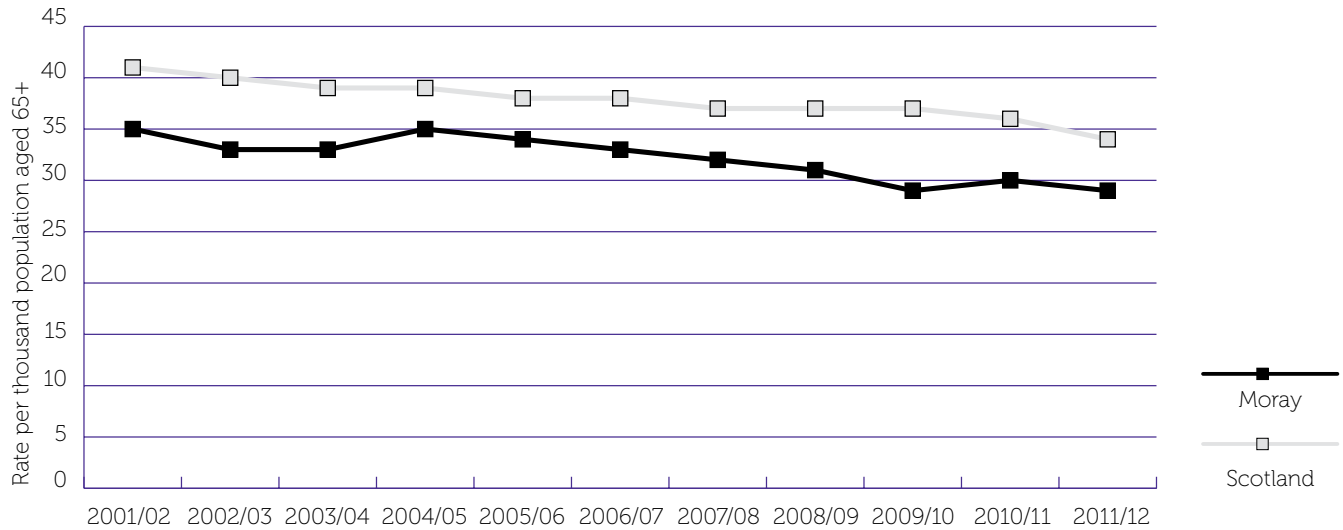
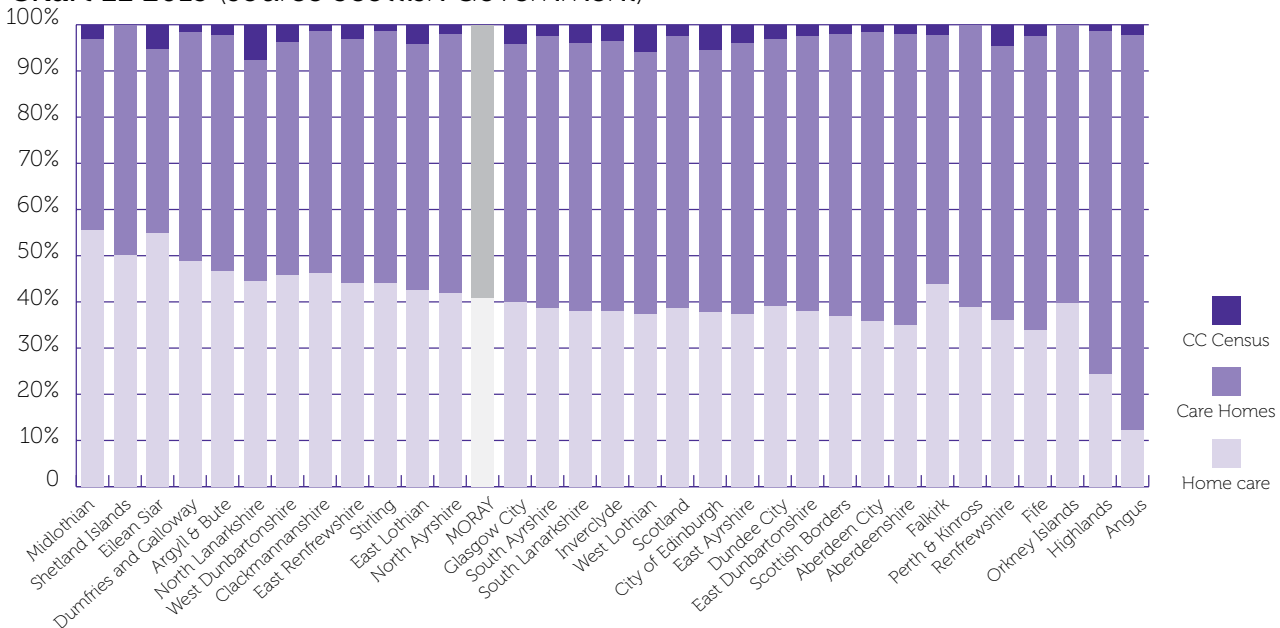


Chart 11 below shows one of the Scottish Government balance of care indicators. This indicator is the per centage of older people receiving intensive home care, the per centage of older people placed permanently in care homes, and the small per centage of older people occupying continuing care beds. The Moray Partnership's performance was 13 out of 32 (1 is the best). The Moray Partnership's balance of care ratio had slipped from 9 out of 32 in 2012 to 13 out of 32 in 2013; however, this is still better than the Scottish average.

**Chart 11 2013 (source Scottish Government)**



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## Self-directed support – direct payments

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

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

- a direct payment (a cash payment)
- the service and the service provider they want, and the council then pays the service provider
- the council to arrange and pay for the service
- a mixture of all three for different types of support.

We found that the Moray Partnership was making good progress on providing direct payments to older people. Overall, Moray was providing direct payments at a level significantly above the Scotland average, including a reasonable level of direct payment provision to older people. We also found that the Moray Partnership had made good progress with implementation of the Scottish Government's legislation on self-directed support. The Moray Partnership had produced new assessment templates that reflected the options that the new legislation requires to be put to service users.

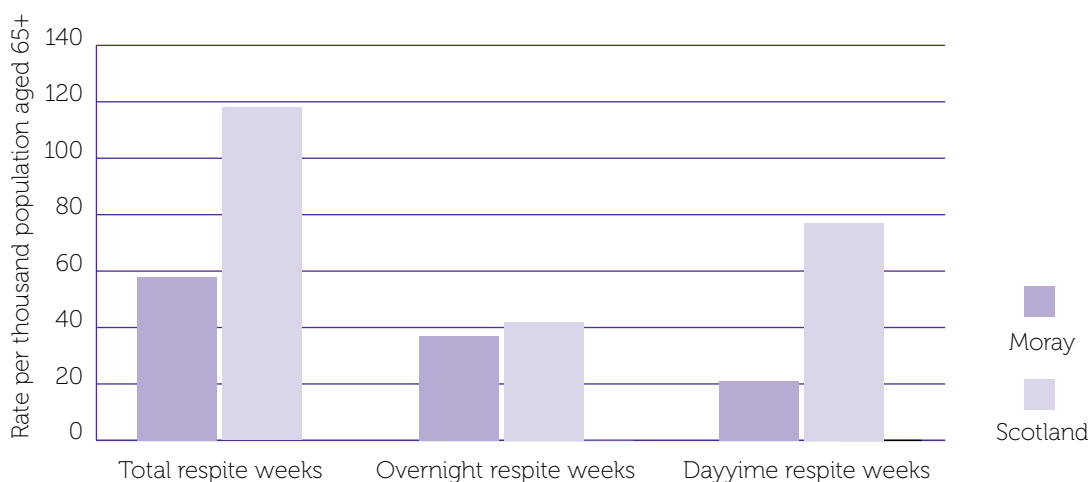
We met service users who were receiving direct payments. They stated that they valued the choice and control this gave them.

## Respite care for older people and their carers

Moray Partnership provided about 50% less respite to older people and their carers than the Scotland average, based on the rate of respite provision per 1,000 population (see Chart 12). It had used a portion of its Change Fund allocation from the Scottish Government to develop a short breaks bureau. Twenty per cent of the change fund allocation (as directed by Scottish Government) was invested in a range of improvements for carers. It is possible that some or all of this enhanced respite provision is not yet reflected in the nationally published figures. Carers we met said it was important that respite was tailored to their needs and the needs of the cared for older person.

## Chart 12

2011-12 Moray - respite for older people (source SG)



## Telehealthcare and telecare

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

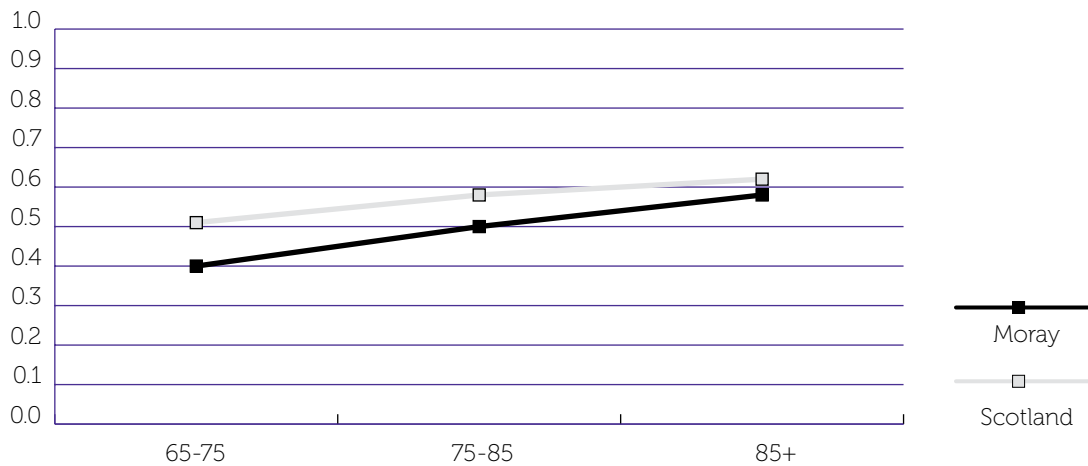
- a remote videoconference discussion between professionals
- a remote interaction between nurses and patients, for example a patient seeks advice from NHS 24
- a remote environmental monitoring device, for example a falls sensor in a patient's home triggers an alert in a control centre.

The Moray Partnership had a rate of telecare and community alarm provision around the Scottish average (see Chart 13). Increasing the provision of telecare to older people is a potential response to supporting a proportion of the Moray population of older people who live in isolated rural communities. However, increased telecare is not a solution to the capacity (of the Council's home care service and independent sector home care providers) to deliver home care to older people.



### Chart 13

2012 Older people who are home care clients with community alarm or other telecare service (rate per home care client) source SG



### Reablement

Providing personal care, help with daily living activities and other practical tasks, usually for a time-limited period, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home. The development of reablement services to support people to remain at home is an important element in the changing shape of services for older people.

In 2012, the Moray Partnership had applied reablement to all 1,928 of its home care clients (1,379 of them were older people). Essentially, the Moray Partnership had adopted a universal model of reablement rather than a targeted model of reablement. Chart 14 below shows the key results<sup>7</sup> of the application of reablement from the Moray Partnership's report on its pilot reablement service.

The main points are:

For the group of all older people, over one fifth experienced a reduction in their care package as a result of the application of Moray's reablement model. However, one fifth of this group of older people experienced an increase in their care package. Eleven per cent of this group (around 150 people) were able to manage without any ongoing care package, following their reablement episode. Over a third of this group experienced no change to their care package.

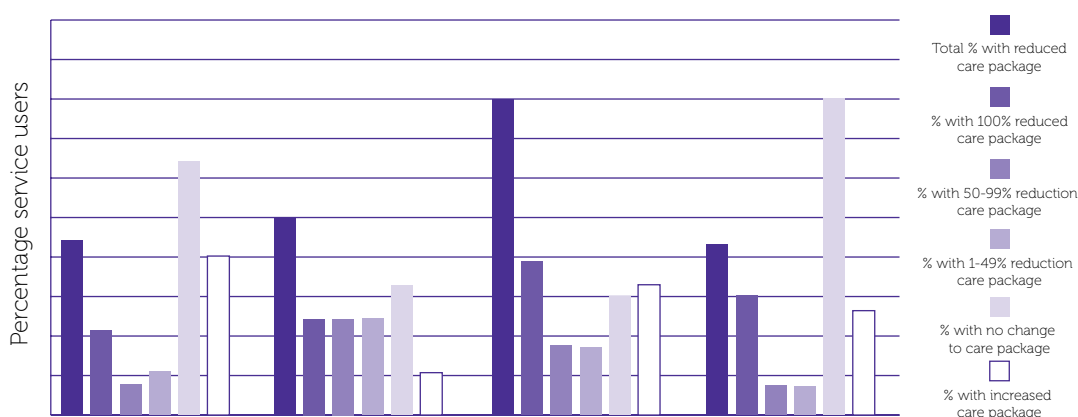
The home from hospital group (mainly older people) experienced the highest levels of reduction of their home care packages or termination of their care packages (40% and 18% respectively).

The group that experienced the highest level of no change to their care package were people with dementia.

<sup>7</sup>The data shown in chart 14 contains some service users who are included in more than one category. Some categories have a portion of service users who are not older people.

## Chart 14

2012 Moray reablement pilot (source internal report submitted)



### Performance of regulated services for older people

The Care Inspectorate inspects regulated services for older people that are operated by the local authority and the independent sector. The table below shows the inspection grades that the Care Inspectorate assigned to services in Moray. Overall, regulated services for older people delivered good outcomes for older people and their carers.

Summary of inspection grades for regulated services for older people in Moray at 30 September 2013 (28 services in total)			
	All quality themes graded unsatisfactory and weak (1 and 2)	All quality themes graded excellent and very good (6 and 5)	Mix of grades (3 and 4)
Independent sector care homes	0%	42%	58%
Local authority housing support service	0%	50%	50%
Independent sector housing support	0%	17%	83%
Independent sector care at home	0%	0%	100%

The local authority did not operate any care homes for older people itself. Its home care service received relatively poor inspection grades from the Care Inspectorate in July 2013. Despite this, most of the service users, carers and staff that we spoke with were very complimentary about the quality of the care delivered by the council's home carers. The reasons for the relatively poor inspection grades included management of the service and care planning for the service users. The Care Inspectorate was working with the local authority to implement a plan to improve the quality of its home care service. This was due to be inspected again within 12 months of the previous inspection.

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

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

### Outcomes for service users, evidence from our file reading and our survey of the Moray Partnership staff

From our survey of staff (172 responded, with 133 completing the entire template), 67% of respondents agreed or strongly agreed, for example, that their service did everything possible to make sure that older people received the healthcare they needed when they needed it most.

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

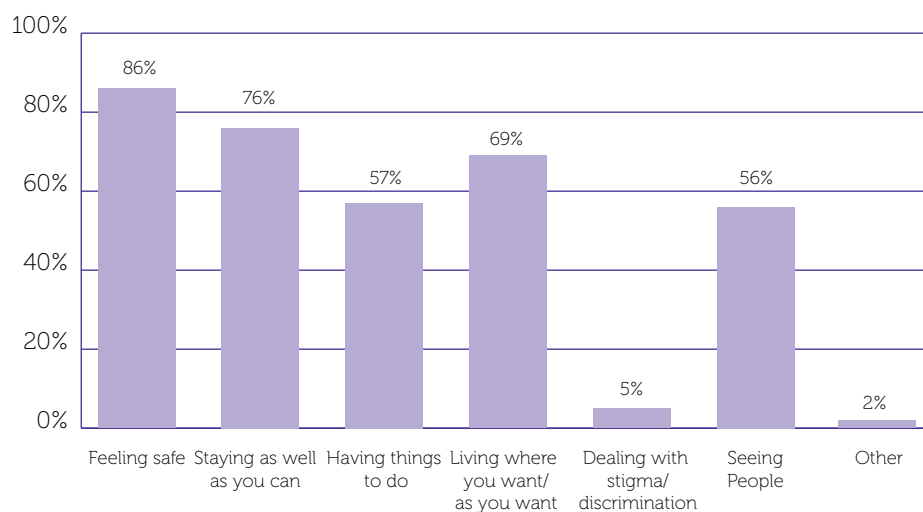
During the scrutiny phase of our inspection, we met a number of older people who said that, due to the delivery of health and social work services, they were:

- safe
- confident that they would receive timely life-saving treatment from NHS health services if they became acutely unwell
- living independently in their own home
- possessed of a good sense of wellbeing and keeping as well as they could
- able to get out and about, and
- generally included in their communities.

Chart 15 below shows the results from our review of 100 social work services and health records on the positive personal outcomes for the older people. This confirmed much of what we heard when we met people.

## Chart 15

Joint inspection file reading results, positive personal outcomes delivered by the Moray Partnership



## Outcome-focused care plans

Positively, we considered that 82% of the care plans we read were outcome focussed. It was very clear to us from our discussions with a wide range of frontline social care services staff that they understood the principles of focussing on achieving the outcomes that the older person wanted. Staff were also carrying out outcome-focussed practice. Health staff we met were very clear that all health services to older people should deliver good health and social outcomes for older people.

Eighty per cent of the older people whose health and social work services records we reviewed had had an improvement in their circumstances, completely or mostly commensurate with what you would expect to see (see Chart 16).

## Chart 16

Moray Partnership: improvement in service users' circumstances: what you would expect to see (source joint inspection file reading results)

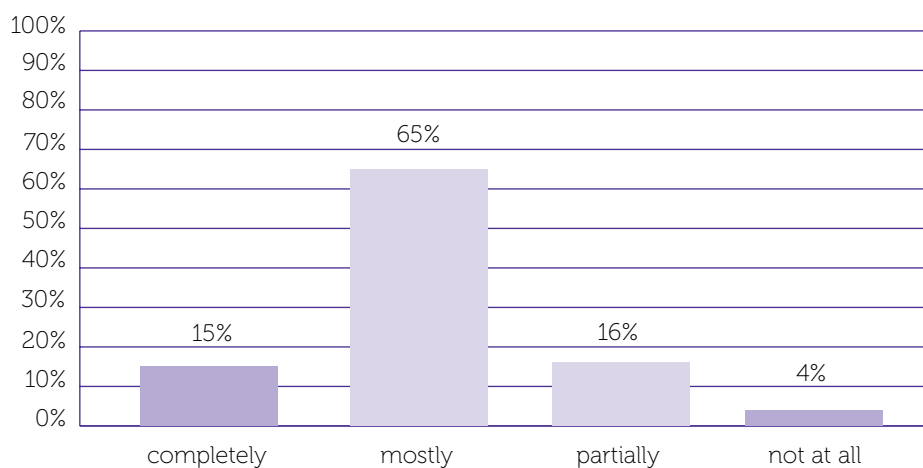
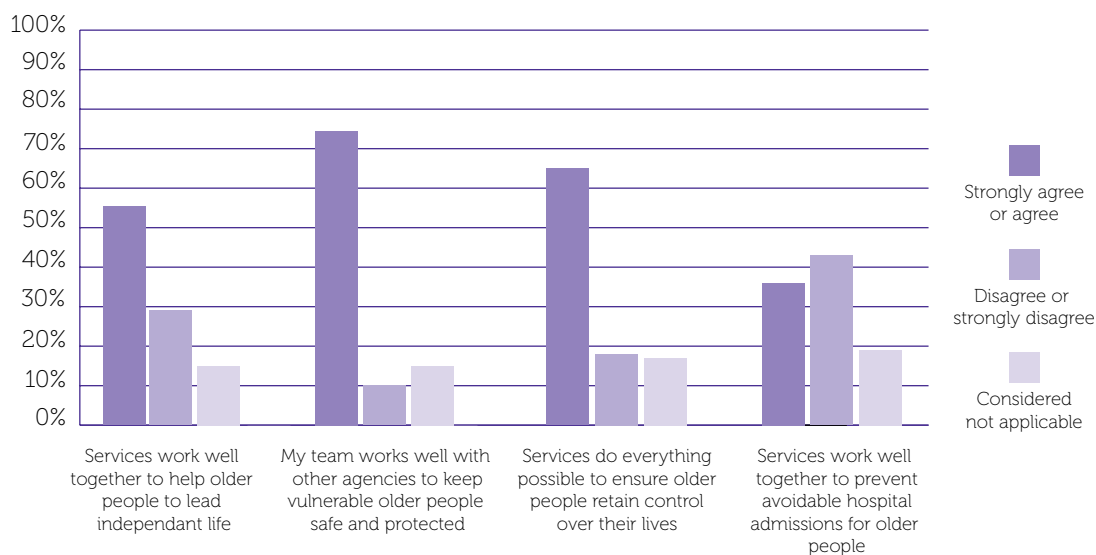


Chart 17 below shows the results of our survey of the Moray Partnership staff about their perceptions of the outcomes that services delivered for older people. Some of the survey results on outcomes were somewhat inconsistent with other findings, namely:

- A relatively high number of staff (nearly half) did not consider that services worked well together to prevent avoidable hospital admissions for older people. This is despite the fact that the Moray Partnership has some of the lowest rates of emergency admissions of older people in Scotland.
- Nearly a third of the staff who responded to our survey considered that services did not work well together to help older people to live an an independent life. This result is inconsistent with the results from our review of social work services and health records on delivery of outcomes to older people.

### Chart 17

Results of Moray joint inspection staff survey on outcomes for older people



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

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

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

### Summary

#### Evaluation – Good

We found that older people and their carers we met in Moray were generally happy with the services provided to them and felt that they contributed to better health and wellbeing. Good outcomes for individuals were evident from our case file reading and we were able to see positive changes for individuals after interventions by health and social work staff.

The Partnership was clear that it needed to provide the right services at the right time to older people. It was working hard to prevent avoidable admissions to hospital. It was also trying to make sure that the whole care system was providing better, more timely care for people within their own homes and the local community. We considered that more effort needed to go into the recruitment of home care staff to support this. We saw good evidence of an anticipatory care approach and more options being given to people to allow them to choose how they wished their care to be provided.

There was an impressive range of information available to people about support services in their communities.

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

In assessing the Moray Partnership's progress against this part of Quality Indicator 2, we focussed on three areas:

- how teams were working to a more outcomes-focussed approach for individuals
- how the partnership was supporting carers.
- supporting those with long-term conditions.

### An outcomes-focussed approach

The partners in the Moray Partnership had worked together to develop a joint commissioning strategy for older people, 'Living Longer Living Better', for developing and reshaping services for older people in the area.

The joint commissioning strategy for older people set out the shared vision and strategic outcomes for older people. It was informed by national policy and research guidance; comprehensive service mapping across health and social care; a health needs assessment of older people in Moray; and extensive consultation with older people themselves. The joint commissioning strategy aimed to address local and national challenges such as:

- demographic change
- the increase in the incidence of dementia
- supporting unpaid carers
- supporting frail older people and those with long-term conditions
- tackling housing needs
- reducing avoidable admissions to hospital as well as the number of people whose discharge from hospital was delayed.

The joint commissioning strategy for older people links with other local strategies such as the joint dementia strategy, carers' strategy and local housing strategy. As with the joint commissioning strategy for older people, the direction of the carers' strategy and joint dementia strategy were clearly articulated.

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## Supporting carers

On speaking with individuals and their carers, it was clear that they were generally happy with the services provided to them and felt that they contributed to better health and wellbeing. Good outcomes for individuals were evident from our case file reading and we were able to see positive changes for individuals after interventions by health and social work services.

The Partnership had commissioned Quarriers, a Scottish charity providing practical support and care for children, adults and families, to provide carers' support and also to carry out carers' assessments. They used the carers' money allocated through the Change Fund to test short-term projects. This would add value such as training on issues around capacity and dementia care. When reading service user's care files, the majority had been offered a carer's assessment, but take up was low. Where an assessment had been completed, the support provided had led to improved outcomes for carers in almost all instances. On meeting with carers, they told us that it was important to have only one person dealing with both the carer's needs and the needs of the person being cared for.

The Partnership felt that its current support to carers was good. It also felt it had a positive network of carers group. Under Quality Indicator 5, we discuss issues reported by carers about communication between health and social work services.

The Moray Council had recently begun redesigning respite services, developing an approach to respite that gave greater control to individuals and provided more personalised respite. They had maximised their respite resources with services commissioned using the entire budget across all service user groups. This has allowed the provision of alternatives to traditional respite and more options to carers for respite. We felt that this was a positive step forward.

Funding from NHS Grampian had also supported some unpaid carers to complete training courses as part of the Partnership's approach to changing their relationship with unpaid carers and supporting them in their role.

## Supporting those with long-term conditions

The increasing number of people living with long-term conditions, such as diabetes, heart conditions, chronic obstructive pulmonary disease and older people with functional psychiatric illness presents a major challenge for health, social care, community and voluntary sector partners. Better awareness of their long-term conditions helps people understand their symptoms and experiences and improves their long-term health and wellbeing. The role of the care professional is to encourage self-confidence and the capacity for self-management and to support people to have more control of their conditions and their lives.<sup>8</sup> The Long-term Conditions Alliance Scotland defines self-management as 'the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long-term condition'.

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



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We looked specifically at this group of people and were pleased to see that there were a number of initiatives in place to help people self-manage their long-term conditions. There were also a number of community services which support people and potentially stop avoidable hospital admissions. There were a number of good examples of work carried out within primary care services, in particular with community pharmacy support. This showed that the Partnership was working well in this particular aspect.

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

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

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

- supporting self-management for those with long-term conditions
- implementing Scotland's National Dementia Strategy 2013-2016<sup>9</sup> and Living and Dying Well<sup>10</sup>, and
- developing the use of anticipatory care plans.

The Moray Council's adult community care service had developed a model of care (Partners in Care, also known as the Three Tier Model). This promotes independence and gives better access to information about resources that can support individuals and their carers in their communities. The model supported greater choice and control and improved outcomes. The Partnership acknowledged that the implementation of this model can only work if it is delivered by the Council, its partners and the wider community. While this model was still in the consultation stage, it formed a robust platform on which the Partnership could focus on help at the right time. We saw this as a very positive move forward. The model is based on three offers, or tiers, to the community:

- Tier One - Help to help yourself: information and advice on services to the whole community with the emphasis on prevention and self-support
- Tier Two - Help when you need it: continuing to focus on early intervention, prevention and reablement so that people are supported early on and in a way that is right for them, and
- Tier Three - Ongoing support for those who need continuing support, and those who care for them, to plan for a better life.

<sup>9</sup>Scotland's National Dementia Strategy 2013-2016, Scottish Government. May 2013

<sup>10</sup>Living and Dying Well: a national action plan for palliative and end of life care in Scotland, Scottish Government. October 2008

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GPs we met had received a presentation on this model of care. They were receptive to this new model and could see how Tier One could reduce the less efficient take-up of GP time.

Staff we spoke with agreed that, while the introduction of the model of care was still work in progress, there was already quicker access to services. This meant that they were able to support people with complex needs at home more effectively. There were some issues raised by staff about trigger points for referring on between Tiers Two and Three. This was particularly problematic with people who were going through a period of reablement and needed ongoing service input. However, we accepted that this may be due to the model being in the early stages of implementation. We would expect to see this resolved in good time. We also found that not all health staff were familiar with the premise or the implementation of the model. This would need to be addressed by the Partnership to meet one of the main principles of the model: all partners working together.

Overall, we felt that this model, once fully implemented, would create a solid framework to provide support to service users and their carers at the right time.

Home care staff provided a high percentage of support to older people within the community. This contributed to keeping people out of hospital and long-term care.

The two most common reasons for delayed discharges were delays in the assignment and completion of community care assessments, and patients who were ready for discharge, but could not go home largely due to the unavailability of home carers.

In relation to home care services, frontline social work staff told us there were real limitations in finding personal assistants and meeting service user expectations for self-directed support in more remote and rural areas. Unpaid carers also confirmed that there was sometimes difficulty in getting home care staff when they were needed. Some staff stated that rurality and staff shift patterns were the main reasons for these difficulties. Due to very high demand at critical times, staff rotas appeared difficult to manage. This resulted in services being delivered when the service allowed and not when needed. This had an impact upon hospital discharge. At the time of our fieldwork in December 2013, there were 13 patients in total whose discharge from hospital was being delayed. Eight out of the thirteen were waiting on home care packages.

Commissioning officers and staff from the discharge team we met reported that limited home care sector capacity, primarily due to recruitment and retention problems (especially in the independent sector), had a negative impact on the accessing of services. In some cases, this led to the accessing of poor quality services.

Senior managers also acknowledged that there was a problem with employing sufficient home care staff. External providers had a restricted capacity within a context of high staff turnover. This meant that the overall available capacity of home care staffing in Moray was limited. The Partnership had started to look at increasing capacity and exploring more options to improve the availability of home care when it was needed.

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**Recommendation 2:**

The Moray Partnership should further explore and implement any appropriate options to increase the capacity of the home care provision, particularly in respect of recruitment and retention in the area across all providers.

Intermediate care was reported by both health and social work staff to be a valuable resource which could help prevent avoidable hospital admission. An intermediate care service had been commissioned with Crossroads (Crossroads Caring Scotland is a voluntary sector provider of support for carers and their families). This service could be accessed quickly to support service users in their homes for up to 4 days. We considered that there was capacity for the service to be used to an even greater extent.

We noted a very positive use of Change Fund monies received from the Scottish Government. Some funds had been used to re-design district nursing services. This additional funding had provided different skill mixes and skill bases to provide support to a higher number of people in the community. Other examples included step up/down beds (short-term beds) which were jointly commissioned in care homes as an alternative to hospital admission, led by community nurses.

**Example of good practice...**

The DALLAS (Delivering Assisted Living Lifestyle At Scale) project supported health improvement and the reduction in unscheduled care by using technology. It could provide people with better access to their personal health information and general information on health, community and innovative solutions. Working with NHS 24 project leads, this initiative had shown very positive beginnings and had attracted European funding. We felt that there was good potential and opportunities through the continued implementation of the project for it to have a beneficial impact on avoidable hospital admissions.

**Improving care and support for frail patients**

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

While there was an emphasis on trying to care for people in their homes in Moray, there will always be the need for hospital admission for some older people. In order to provide

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the best outcomes for vulnerable older people whilst in hospital and on discharge, it is important that they receive a comprehensive geriatric assessment. On speaking to hospital staff, there seemed to be very little access to a comprehensive geriatric assessment in the hospitals. Comprehensive geriatric assessment is a process that aims to identify problems and personalised goals. The identified problems are assessed, quantified and managed in a co-ordinated way by a specialist-led multidisciplinary team.

We also identified that, due to vacancies, there was a reduced consultant geriatric resource. We felt that this could impact on assessments and interventions to older people whilst in hospital. The Moray Partnership was aware of this and had identified a number of options to improve this situation and provide a sustainable way forward. An advanced nurse practitioner had been appointed to support the consultant resource and this had been received positively by hospitals and GPs. The Partnership was also looking at other ways to deal with this such as the potential to use a GP with a special interest to provide additional support.

We looked at the interaction between primary healthcare (GP services), secondary healthcare (hospitals) and social work (care homes and care provided in people's own homes). We know that a lack of communication and joint working can sometimes lead to avoidable hospital admissions. We were impressed with the networks in place to facilitate better joint working between health and social care to make sure that services worked together to provide early intervention and preventative services. Moray had dedicated GP leadership supported by community health partnership management and functional areas such as pharmacy, social work, nursing and allied health professionals. We saw good examples of GPs managing their beds within the community hospitals and minimising admissions where avoidable by having full knowledge of who needed support within the community. We also saw support plans for people within the community. These included visiting allied health professional support, therapy input and orthopaedic rehabilitation. These were good initiatives for keeping people within the community and reducing unscheduled hospital care.

Unscheduled care is a term used to describe any unplanned health or social care. The range of unscheduled care provision includes support to patients at their home, booking of urgent or emergency GP appointments, 999 ambulance services and emergency department/hospital treatment. There was also a Marie Curie out-of-hours contract working alongside the Grampian Medical Emergency Department in the community.

We were also very impressed with the increased use of the pharmacist within hospitals in providing medicine reviews at the right time and carrying out medicine reconciliation. There was a comment that there could be even more increased pharmacist support in some wards as this would help avoid potential adverse events.

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

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

The Moray Partnership's joint commissioning strategy for older people highlighted dementia as a key issue. It aimed to increase dementia diagnosis rates as they were slightly behind comparable areas.

The Partnership had produced a comprehensive joint strategy for dementia. We saw the draft action plan for the strategy. We were impressed with the range of actions identified. This included:

- raising public awareness about dementia
- working with housing to explore a range of housing options to meet people's needs
- a training programme for all staff within the Partnership which would also be accessible to the voluntary sector and primary care, and
- an integrated care pathway for dementia for primary care that would help to create a better journey through the health system for people with dementia.

NHS Grampian had appointed a nurse consultant for dementia. A subgroup in Moray had been set up to assess against the dementia standards. Health services were working closely with The Moray Council on this matter.

Following completion of the dementia strategy, Moray had been selected as a pilot site to test Alzheimer Scotland's Eight Pillar Model of Community Support. Funding would be received to support the testing of the dementia practice co-ordinator role across seven of the pillars. One of the objectives was to examine the sustainability of the model. The Scottish Government would be providing resources through a key co-ordinator to support the project. This model explores an integrated community model of care. This should improve the quality and capacity of interventions to people with dementia and care in the community.

There was a post-dementia diagnosis pathway in place. This detailed a 12-month post-diagnostic support timeline from point of GP or psychiatrist diagnosis through to support from a link worker provided by Alzheimer Scotland (which was jointly commissioned using the Change Fund). This was a good streamlined process which should provide a range of support to help service users and their family and carers to understand and manage their condition; stay connected in the community; plan for their future care and develop a patient support plan. Good post-diagnostic support continued to be given by GPs and old age psychiatry. The Partnership was considering how it could make sure that this was recognised and reflected as well as the support given through the pathway and the Alzheimer Scotland link worker.

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The Partnership intended to increase numbers of dementia cafes in Moray as well as improve the uptake of assistive technology and devices.

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

Palliative and end-of-life care was being developed in line with the Living and Dying Well National Action Plan (2008).

We found that good progress had been made in delivering palliative care for older people in Moray. Services we read about were flexible and responsive.

We read about the use of the Change Fund to support specialist clinical support to enable care homes to have a greater role in intermediate care and to support staff to care for older people with dementia and palliative care needs. This was stated to prevent admission to an acute hospital. Patient satisfaction was stated to be high. Other support was provided by Macmillan Nurses and the Marie Curie out-of-hours contract.

Health staff we met acknowledged that services such as end-of-life care were able to respond quickly.

'Collegiate meetings' were discussed by the GPs we met. These themed multi-agency development meetings, attended by GPs and consultants, were seen as very successful. Topics discussed included end-of-life care.

### **Anticipatory care planning**

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

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

We found that good progress had been made in delivering anticipatory care for older people in Moray. Services we read about were flexible and responsive.

We noted that all the GP practices in Moray had anticipatory care plans for approximately 75% of their patients. Patients who had these plans had been identified using a tool which showed people most at risk of hospital readmission. Anticipatory care plans look at potential future care needs and were completed by health staff.

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

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Staff stated that anticipatory care plans seemed to be working well and GPs appeared more engaged in the process. It was acknowledged that nursing staff were not linking directly with carers in all cases. This would help with updating and recording any changes to the care plan.

There was little evidence that social care services used the anticipatory care plans. It was not clear how widely these plans were shared. However, there were examples of social care staff being involved in the completion of the plans.

We saw a draft anticipatory care planning policy. This was a very good, comprehensive document that will support health and social care services and external agencies in understanding the approach and where this sits within the Three Tier Model approach.

Positively, we noted that the Scottish Ambulance Service was keen to get involved in anticipatory care in order to reduce hospital admissions. All partners worked together, and with the Scottish Ambulance Service, to optimise the use of the estimated date of discharge, improve discharge planning and eradicate delayed discharges, including delays in short-stay specialty beds and for adults with incapacity.

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

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

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

As stated earlier, we found that the Moray Partnership was making good progress on providing direct payments to older people. It was reported that the appointment of two self-directed support development officers had greatly helped to increase the number of people accessing self-directed support. It had also helped some people access more flexible services which better suited their individual needs. Carers we spoke with who were receiving direct payments were positive about the flexibility that this offered to them.

The Partnership had also been active in helping external providers prepare for self-directed support.

We saw evidence of good information about self-directed support available to people in the community. This explained what self-directed support was, who was eligible and how it worked.

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The other main areas of self-directed support activity included:

- an external consultant who conducted an evaluation of the scheme and produced an action plan
- work with the Institute for Research and Innovation in Social Services to develop pilot projects with mental health and learning disabilities services
- a number of training events for staff as well as internal and external providers
- a reference group, involving service users, potential service users and practitioners established, and
- a press release in a local newspaper reporting good news stories from self-directed support.

We spoke with the self-directed support development officers. They were very positive about the progress being made to date. However, they acknowledged that there were some issues to work on, including:

- Scottish Government guidance to support the Council's policies and processes, and
- further work was needed to engage NHS staff more in the process.

### **Example of good practice...**

The Moray Partnership impressed with the amount of literature available to the community. This signposted and gave information about support services in the form of local community services, helplines, websites and health and social work services. A good number of prevention and early intervention leaflets were available. A very good community information source, MORINFO (an online resource), gave details about a wide range of clubs, groups and activities across Moray.



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## Quality indicator 3 - Impact on staff

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

### Summary

#### Evaluation – Good

Staff motivation across health and social care services was generally good. Senior managers could identify changes being made that were expected to improve morale further. Management support and the training opportunities available were helping to maintain staff motivation.

Staff views on joint working were mixed. In general, they were looking forward to more opportunities to strengthen the links with colleagues across the services. Despite some doubts about resources, staff were delivering good outcomes. Although there was evidence of staff communication in relevant consultation activities, staff felt that communication about proposed changes could be improved.

### 3.1 Staff motivation and support

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

We considered a range of documentary evidence, including information on service re-design and joint commissioning. It was clear, for example, that there had been consultation with staff on the redesign of adult community care services, including older people's services. Action had been taken to communicate with staff about the production of the joint commissioning strategy for older people, 'Living Longer Living Better'. Examples included stakeholder workshops (which included staff), a newsletter and team briefings at key stages during the development of the joint commissioning strategy. Staff were also involved in subgroups around the key priority areas for the strategy.

Two-thirds of those consulted, which included staff, were in favour of the proposed Three Tier Model for community care services.

We read about the efforts made to work towards more joint workforce development and reducing barriers to joint working. However, staff views were not always distinguished from other stakeholders. As a result, it was less clear exactly how community care staff had been involved.

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We met with approximately 150 health and social care staff over the duration of the joint inspection. We issued a staff survey to Moray education and social care services and NHS Grampian health staff. Of the staff who responded to our survey (172), 35% were from local authority, 63% from NHS Grampian, with a further 2% employed in “other” sectors.

## Motivation

Staff in education and social care and health who responded to our staff survey were generally well motivated. Results from the survey showed that:

- most staff (79%) enjoyed their work, and
- the majority (59%) felt valued by their managers.

Adult community care services and NHS Grampian reported that their own staff surveys revealed that staff were motivated and committed to providing a high quality service.

This was generally confirmed in the focus groups of health and social care staff we met during fieldwork.

However, some health staff we met described morale as being low. Reasons for low morale included a lack of understanding and an uncertainty around the restructuring, particularly in community psychiatric nursing and old age psychiatry.

## Teamwork

Staff were committed to providing services which helped older people lead as independent a life as possible. For example:

- 58% of those who responded to our survey agreed that they worked well together to enable people with long-term conditions and those with dementia to remain active
- 65% agreed that they did everything possible to make sure older people retained control over their lives, and
- 74% agreed that their team worked well with other agencies to keep people safe and to protect vulnerable older people.

Frontline social care staff said they received supervision from more senior staff and, while not always as regular as stated in the policy, they felt it was flexible enough to meet their needs. The advanced practitioner role (social work) was there to assist the teams. Frontline health staff said that there was effective clinical leadership in place providing good support for them.

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In our survey, staff in Moray confirmed that they had a wide range of training opportunities, with 82% saying they received appropriate training. The majority agreed that they had annual appraisal performance reviews with their line managers (54%). Staff we spoke with and training plans we saw confirmed that a wide range of training opportunities were provided for health, education and social care staff. A number of training and development plans were in place. However, there was less evidence of any of these being jointly prepared with partners.

Generally, staff felt there was effective joint working, with 79% in the staff survey agreeing that there were excellent working relationships with other professionals.

There was evidence from the case files we read that the role and responsibility of the social care professional was clearly stated in most instances.

Frontline social care staff were looking forward to working more closely again with colleagues in the wider range of services and hoped the integration agenda would facilitate this. They hoped communication would improve as they did not always know why decisions had been made and what was happening at a strategic level. Frontline health staff thought communication was poor across agencies and services. We consider communication further under Quality indicator 9 in this report.

Lack of access by health professionals to the Council's CareFirst electronic information management system meant that sometimes staff had to wait to be able to share information. Also, as they were not working in the same offices as colleagues, they felt there was a lack of direct contact that sometimes supported a flexible approach. We consider access to services further under Quality indicator 5 in this report.

Staff had reservations about whether there was enough capacity within teams. In common with other areas, only 26% of staff agreed that there was sufficient capacity within their team to carry out preventative work. While less than half agreed that their workload was managed to enable them to deliver effective outcomes to meet individual needs, our review of social work services and health records showed that almost all staff were delivering good outcomes for individuals (91% of cases).

## Learning and development

We considered the profile and visibility to staff of senior managers could be improved. The role of senior managers in supporting employees to deliver effective services could also be improved on. In our staff survey:

- only 32% agreed that changes which affected services were managed well
- only 36% agreed that senior managers communicated well with frontline staff
- only 42% agreed that there was a clear vision for older people's services.

We consider leadership again under Quality indicator 9 in this report.

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In relation to future integration of services, we learned that some of the frontline social care staff had been used to joint working arrangements in the past. They felt the actual integration process was moving slowly and were not really sure what was happening. Staff thought that working in the same offices as each other would mainly be a positive development and were looking forward to that aspect as it would help them do their job. Some individuals said they were “fed up with all the changes” and were struggling to keep up with the paperwork but nevertheless enjoyed coming to work. Frontline health staff also said putting workers and teams in the same offices more would help integration.

Senior managers were trying to ensure that communication with staff was efficient and effective. They said there had been a lot of investment in this activity through, for example, the use of the Public Service Improvement Framework,<sup>12</sup> Releasing Time to Care<sup>13</sup> and structured questionnaires as well as seeing teams regularly and being visible to staff.

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. A joint commissioning group (formerly the Change Fund group) had overall responsibility for the preparation and delivery of the joint commissioning strategy for older people. The joint commissioning group had multi-agency representation from a range of professionals who were committed to updating and informing the services they represented.

We heard about the ‘Sliding Doors’ initiative which was a series of discussion and consultation sessions involving staff from the NHS and the Council in the challenge of reshaping care for older people. A wide range of staff attended a series of joint events which featured actors playing care recipients. While there were mixed views about the success of these events, staff welcomed the opportunity to meet and discuss together.

Some thought that they were already operating an outcomes-focussed approach. The evaluation, as well as rating these events, looked at staff’s knowledge of reshaping care for older people and what actions they identified as needing to be taken in their area of practice. There were many positive results in achieving clarity about the situation and what future actions were needed. A consistent theme identified across all responses was a need to know more about what services were available in order to pass information on to people or to engage them directly on behalf of service users. A multidisciplinary training programme on identified topic areas had been developed.

<sup>12</sup> A self-assessment tool which encourages organisations to conduct a systematic and comprehensive review of their own activities and results.

<sup>13</sup> A national programme to help NHS staff review and streamline their work processes to focus on priority areas of care.

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## Quality indicator 4 – Impact on the community

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

### Summary

#### Evaluation – Good

We found a strong commitment to developing community capacity. The joint commissioning strategy for older people, 'Living Longer Living Better', represented sound potential for increasing community capacity.

A good range of community supports for older people was already in place with further proposals under development. The Partnership was seeking to work productively with older people and the third sector about this.

The Partnership was intending to do more to measure the outcomes of these community supports and to find out how well regarded its own services were by the wider public.

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

### 4.1 Public confidence in community services and community engagement

We saw that community capacity building was one of the seven themes within the Moray Partnership's joint commissioning strategy for older people, 'Living Longer Living Better' 2013–2023. The objective was "to build community capacity in order to facilitate earlier intervention and a preventative approach and to achieve a real shift in the balance of care. Building community resilience is key to working in partnership with older people in their communities. We aim to have supportive communities which have the capacity to provide care and support for older people".

It was clear from the joint commissioning strategy for older people, and from our meeting with senior elected members and senior managers, that they clearly recognised the need to develop community capacity. They placed significant importance on the role that local communities and community organisations could play in providing support to older people. The introduction of the joint commissioning strategy for older people acknowledged that current service configurations for the care of older people "are simply

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not sustainable". Having community capacity building as the first theme of the joint commissioning strategy for older people showed that the Moray Partnership recognised that it had an important role to play in developing and increasing community capacity.

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 older people. This was explained as being a reflection of Moray's rurality and its relative geographic isolation. 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 on an ad hoc basis, rather than as part of a clear, overarching strategy for co-production and capacity building.

BALL groups (described on page 48) work justifiably on an ad hoc basis and are identified as a good practice example later in this report. The BALL management group identifies any gaps in specific areas. And there were some individual strategies: for example, a very good volunteering policy and a number of separate initiatives such as 'community connectors'.

However, it was not clear how these were knitted together. The joint commissioning strategy for older people had the potential for doing so, depicting the reshaping care pathway for older people as part of whole system working for health and social care. It included a number of development areas for the next 3 years:

- progressing the development of social enterprise
- supporting the development of low level interventions as informed by older people, such as time-banking and befriending
- developing a sustaining network of community supports, and
- increasing the capacity of the third sector interface.

In our staff survey, less than half of staff who responded agreed that there were clear joint strategies to promote and expand community involvement. We also asked about consultation with local communities on the range, quality and effectiveness of existing services. For both questions, there was a relatively high number of staff (especially among NHS staff) who replied 'Not applicable'. This suggested, and as we found at our focus groups with frontline staff, that there was still limited awareness that the formal health and social care services had an important role to play in developing community capacity.

When we met with 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 voluntary sector was a key partner in this. However, they advised that there had been previous difficulties in their 'interface' with the third sector. To address this, three previous organisations had been merged in 2012 to form tsiMoray (Third Sector Interface Moray) with a remit to facilitate third sector

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capacity building. Change Fund monies had been provided as part of Reshaping Care for Older People to recruit a temporary jointly-funded post to provide training in support of reshaping care for older people.

Community development staff told us of the action being taken to map and create a database of existing organisations. At the time of our inspection, there were approximately 70 organisations on the database. A specific forum had been established to bring together those community groups currently involved with older people.

Both the joint commissioning strategy for older people and the position statement provided by the Moray Partnership ahead of our inspection highlighted the important role of public libraries in promoting community groups and as a source of information about healthy ageing. At the time of our inspection, the Council was proceeding with plans to close a number of its public libraries. This was being done as part of its required financial savings. This had generated considerable public opposition.

As part of the consideration of the library closures, an equalities impact assessment had been completed. However, staff, managers and elected members we met were not certain what impact the closures would have on older people. Senior elected members said that, while the library closures were regrettable, libraries had not been identified as a key priority in the extensive public consultation on the Council budget. In contrast, care of older people was identified as a key priority. Some of the savings from the library closures were going to be re-directed into reshaping care for older people.

### **Community initiatives - the development of community supports**

Notwithstanding the need for the Moray Partnership to firm up on how it delivered on 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 older people and the solid basis of existing community groups. Our joint inspection found similar positive results. We held a focus group with representatives of community groups that deliver services to older people. They said that older people were generally well supported by a range of services provided by the statutory and independent sector. In their view "Moray was a good place to be an older person". In support of this they referred to:

- the handyperson service - as well as carrying out minor repairs and odd jobs, they also provided a decluttering service. Some 900 older people in Moray had received support from this service.
- nail-clipping service - developed in partnership with the NHS podiatry service, and
- Be Active Life Long (BALL) groups.

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### **Example of good practice...**

Be Active Life Long (BALL) groups provided social stimulation, practical advice and physical activity for older people in Moray. This aimed to help people to remain fit, active and involved in their communities. There were now fourteen of these groups (with a further three planned) compared to seven in 2008. Most of the groups were now largely self-supporting.

Older people, their carers and staff we met were also generally positive about the community support services available for older people. As well as the services described above, these included shopping buddies, men's sheds and the community pharmacies. These had played a key role in a successful smoking cessation campaign.

Opportunities also included volunteering where there was a volunteer development co-ordinator with a specific remit for community care-related volunteering activity. Documentation we read showed that there were approximately 70 volunteers providing a diverse range of support from befriending, gardening and information technology (IT) assistance. In 2012, there had been 188 requests for volunteers of which 150 had been able to be met. Staff we met confirmed that most requests for volunteer input were able to be met.

The only critical comments we heard were in relation to some reductions in community transport provision and the difficulty faced by some older people in accessing services from the more distant communities. Managers said that in recognition of this, there had been a particular focus on supporting the development of self-directed support in the most remote areas, such as Tomintoul. Due to its isolated nature, a concentration of individuals were receiving support from personal assistants through self-directed support and as part of a micro-business.

### **Engaging with the community - community involvement and impact**

We saw from the documentation provided by the Moray Partnership that it had invested effort in seeking to engage with and seek the views of older people both on its Three Tier Model for community care and as part of the joint commissioning strategy for older people. This included using existing forums, such as the older people's reference group and invitations to public consultation events. A small number of people were at one of our focus groups who were members of the older people's reference group. They spoke positively about how the Partnership had involved them in the development of the joint commissioning strategy for older people.

We saw good informative newsletters on what was happening with services, what was planned and why. There was information on how to get involved in the joint



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commissioning strategy and a report on the subsequent launch of the strategy following the consultation.

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, such as the Citizen's Panel, to provide a picture of how well the public regarded its range of local health and social work services. However, managers told us that they were about to start working with the Institute for Research and Innovation in Social Services on a research project to measure the outcomes of preventative and community support services.

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## Quality indicator 5 – Delivery of key processes

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

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

### Summary

#### Evaluation – Adequate

The newly implemented access arrangements had made access to services easier and work on self-directed support was progressing. However, there were some difficulties in communication and joined-up working between health and social care services.

Generally, the needs of individuals were satisfactorily assessed and they were cared for in the community wherever possible. This was illustrated by low numbers of emergency admissions of older people to hospital. We found effective procedures were in place to plan and review the care for service users. Good use was being made of reablement.

Risk management arrangements for protecting service users had continued to improve.

We were impressed by the extent that the views of individuals and their carers were taken into account in directing their own support.

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

The Council was introducing a new model of support proposing a Three Tier Model. We discussed this model earlier under Quality indicator 2 in this report. We also discussed access to information about services.

In April 2012, the Council introduced an access team. This provided a single point of contact to adult social care services. This Council team included social workers, occupational therapists and care at home staff and was based in the Council's headquarters in Elgin. This meant there was excellent access to other Council departments and services that were co-located, such as housing and finance. There were

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no health service employees in the team. Frontline staff told us that the team provided a much quicker and easier referral route for service users, carers and professionals. This reduced the number of phone numbers needed by the public from almost 30 to one.

A range of staff told us that, in the early stages, the access team was struggling to meet demand due to staff absences and workers still working with caseloads from previous areas of work. While this situation appeared to have stabilised and some of the internal systems were bedding in, there was still some confusion and inconsistency about the timing for referring on.

There were particular challenges for some health staff in working with the access team. They thought there was a lack of clarity of roles and that communication could be improved. They stated that there were sometimes delays in services and support being allocated. This had had a negative impact on service user outcomes. It was acknowledged that some services were able to respond quickly, such as more practical services like the supply and installation of equipment such as community alarms and telecare.

Both frontline health and social care staff told us their workloads had significantly increased since the access team had been set up. This was affecting their ability to respond.

As part of the care and support pathway, we considered the issues around hospital admissions and discharges of patients. A detailed draft hospital discharge policy set out the roles and responsibilities for the Partnership, along with timescales for completion. This showed a timescale of 3–14 days between the decision to discharge from hospital and the actual discharge itself.

When we met with frontline health staff and social work officers, we were told that their main areas of concern were discharges from outlying hospitals, such as in Aberdeen when there was no pre-arranged community support in place. The Moray Partnership needs to continue monitoring and managing these issues closely to make sure best practice in discharging patients from hospitals both within and outside Moray.

Carers also reported some issues with ineffective communication between health and social care services. This was specifically around problems which had arisen on patient discharge from Aberdeen Royal Infirmary where no home care services had been put in place. From our review of health and social work case files, we saw that, despite good documentation that would support hospital staff to identify and put in place services on discharge, this was often not completed. We noted that the documentation was in the process of being reviewed.

In speaking with staff, we were aware that the home from hospital and access teams were both working hard to improve discharge arrangements from hospital and to make sure that care and support were in place when they were needed.

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### **Recommendation 3:**

The Moray Partnership should carry out a review of the home from hospital and access teams, including their structures, staff roles, procedures and the effectiveness of their communications. The Partnership should continue with initiatives to ensure that hospital discharge arrangements and other referrals intended to support the wellbeing of older people in Moray are dealt with timeously and appropriately.

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

From our review of health and social work case files, we found positive outputs on assessing need. However, there was room for further improvement in the quality of these assessments.

- In most cases (85%), there was an assessment of needs on file.
- File readers rated nearly half of the most recent assessments on file as very good or good (49%) with 41% rated as adequate.

In May 2013, the Council made changes to CareFirst, their electronic information management system for service user information. Staff were trained to use the system and those we spoke with said they were reasonably happy with the system despite some limitations, such as word count restrictions. In general, they felt equipped to use it effectively. The system was not available to NHS employees. Similarly, NHS electronic information systems were not available to social care services staff. Electronic communication was generally difficult between the organisations but managers had proposals to improve this which we discuss further under Quality indicator 8.

In almost half (45%) of the cases we read where the assessment indicated a range of services were required, the assessment did not indicate that other professionals, such as an allied health professional, had contributed. However, through the case notes, it was clear that joint working was occurring as other professionals were mentioned and had clearly contributed to the care package.

From our review of health and social work case files, we found more positive results on planning and delivering care and support.

- In 82% of cases, readers recorded there was a care and support plan.
- In 88% of cases, the current care and support plan mostly or completely addressed the individuals' needs.
- In 89% of cases, the services that the individual received had reduced the risks faced by the individual.

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Less positively, 35% of the care plans were not comprehensive and almost half were not SMART (specific, measurable, achievable, realistic, time-bound). The most common limitations were a lack of measurable outcomes and timescales.

In most cases (81%), the health and social care support of individuals was subject to regular review. A range of frontline staff told us they shared information on an individual, informal basis, usually by telephone and email. From these discussions and our review of health and social work case files, it was clear that health and social care staff were discussing cases on a joint basis. However, these seemed to be informal arrangements rather than more structured processes.

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

This linked into the tiered model of support rather than operating as a separate team to deliver reablement. We thought this was a positive approach as it promoted good practice across the Partnership. Social care staff we spoke with had a very good understanding of the principles of reablement and said they tried where possible to follow these principles in practice. When we spoke with a range of health staff, there was a mixed level of understanding of reablement. However, there was clearly a shared aim to deliver good services and promote independence through a variety of forms, including recovery, reablement and rehabilitation.

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

#### **Example of good practice...**

There was a positive approach to making sure service users and carers were included in the process of reducing risk. Speech and language services had developed guidance for use by the Police when supporting a person with communication difficulties. A guide, available in hard copy as a 'Z card', which provided information on recognising and reporting harm, has been developed into a web-accessible guide.

We saw a multi-agency strategy for adult protection which included high levels of training and initiatives. An information-sharing protocol for adults at risk of harm had been agreed by the Grampian adult support and protection partnership. However, the Moray Partnership acknowledged that a more robust risk management framework was needed.

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It was hopeful that this would be helped by the integration agenda. Staff we spoke with agreed with this, but were nevertheless very clear about protection risk categories (those concerned with adult support and protection) and non-protection risk categories (those which are not protection issues such as risk of falling for frail elderly people). At the time of our inspection, the risk documentation was being integrated into the Council's CareFirst electronic information management system.

Following previous inspections of social work services in 2011 and 2012, we noted improvements in risk assessment and risk management during this inspection.

Taking protection and non-protection risks together, the proportion of files in community care with a risk assessment was 45% in 2011.

The quality of risk assessments in community care needed to be improved with 'weak' cases featured in 19% of the total in 2011.

The proportion of files in community care with an up-to-date risk management plan was only 17% in 2011.

During our inspection, we saw improved practice, although we again found weak assessments. Overall, we found a range of results which pointed towards an improvement, although this needed to continue.

- Most (89%) files that required protection type risk assessments (for example protecting adults at risk of harm, protection of the public) had them in place. Similarly 81% for non-protection type risks (for example a frail older person who is at risk of falling or a person with dementia who is at risk from wandering).
- Almost half of the assessments were of adequate quality, with a third being good. However, 22% of protection type risk assessments were graded as weak.
- The majority (67%) of protection and non-protection assessments took into account multidisciplinary views.
- The majority (56%) of protection type cases had a risk management plan in place. The figure was 60% for non-protection type cases.
- The majority (67%) of protection type cases had dealt with adequately. The figure was 75% for non-protection cases.
- In most cases (89%) where there were issues of risk (both protection and non-protection type risk), the file reader concluded that the services which the older person received had helped to reduce the risk.

Staff we spoke with were clear that communication was generally good on the ground and risks were being managed well. It was acknowledged that formal risk assessments were mostly in the social work files. These were reviewed verbally or through email with colleagues from health.

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

From our review of health and social work case files, we concluded that staff were taking the views of individuals into consideration throughout the different stages of the assessment, care planning and review process.

- In 95% of cases, the individual's needs and choices were taken into account in the assessment.
- In 85% of cases, there was evidence at the care plan stage that the services actively sought and took account of the individual's views. This figure was 89% for the review stage.
- In 89% of cases, there was support for the individual to contribute to the care plan.

### Independent advocacy

Independent advocacy in Moray was provided by North East Advocacy to adults over 16 years and carers. They did not have a specific remit for older people. At one of our focus groups, we were told that uptake is patchy dependent on locality. The independent advocacy service supported 45 carers at the time of our inspection. This included carers of older people. We discuss advocacy further under Quality indicator 6 in this report.

#### Example of good practice...

The Council was committed to making sure carers were informed about the range of support and services available to them in Moray. They established a network of carers group, which had been running for 2 years. The group had representation from Alzheimer Scotland, Quarriers, Shared Lives, Short Breaks Bureau, NHS Grampian and The Moray Council. This group provided information about, and signposting to, services in the area. This came in the form of a booklet, which was available through various Council and NHS outlets.

The Council also commissioned a voluntary organisation (Quarriers) to carry out carer assessments on its behalf. They were set a target of 250 assessments each year. The completed assessments were passed on to the relevant social worker within 28 days.

It was encouraging to read that in 90% of the cases where there was an assessment in place there were positive outcomes for the carer. In 70% of cases, this led to positive outcomes for service users.

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## **Self-directed support – direct payments**

We read the self-directed support policy. Before our inspection, the Council was performing well ahead of the Scottish average for overall direct payments. We spoke with a number of service users and most were happy with the service they received. We discuss the challenges for self-directed support in more remote areas under Quality indicators 2 and 4 in this report. There was further positive feedback from service users involved in the Institute for Research and Innovation in Social Services pilot project.



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

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

We look at:

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

### Summary

#### Evaluation – Adequate

The Partnership had made a good start on planning together through the production of a joint commissioning strategy for older people, 'Living Longer, Living Better'.

The Partnership continued to build on a well-established history of community involvement by making good use of Change Fund monies to support early intervention.

Joint self-evaluation was still at an early stage.

Joint performance reporting was beginning to be evidenced. However, this would benefit from further development.

The extent to which stakeholders felt involved in the Partnership's planning processes was mixed.

The joint commissioning strategy for older people gave a clear sense of direction, but more detail was required about how it was to be implemented.

### 6.1 Operational and strategic planning arrangements

The joint commissioning strategy for older people, 'Living Longer Living Better' contained good overviews of health, social work and housing needs analysis, a strategic direction summary (for example Reshaping Care for Older People pathways) and identified strategic

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priorities. We noted good examples of partnership approaches included early engagement with the Institute for Public Care commissioning training, stakeholder consultation (for example the older people's reference group), and engagement on the joint commissioning strategy for older people.

The strategy identified seven key commissioning themes:

- community capacity building
- supporting informal carers
- housing
- dementia
- frail elderly
- modernising community services, and
- embracing technology.

Commissioning officers and managers we met acknowledged that the joint commissioning strategy for older people and related policy documents did not have resource plans, detailed delivery timescales or delivery responsibilities identified. This made it difficult to use as a delivery management and accountability tool. The 'joint strategies' referred to above did not have pooled investment. While the direction of travel of the joint commissioning strategy for older people was clear, it was not costed, delivery timescales were not identified, and areas for growth or disinvestment were not clarified.

#### **Recommendation 4**

The Moray Partnership should ensure that future policy development of the joint commissioning strategy for older people, 'Living Longer Living Better', gives more detail on:

- how priorities are to be taken forward and resourced
- how joint organisational development planning is to be taken forward
- how consultation and engagement are to be maintained
- the use of advocacy in services for older people, and
- action plans which are SMART (specific, measurable, achievable, realistic, time-bound).

The Partnership's senior management team had responsibility for the overall delivery of services for older people. Individual service managers were responsible for particular service areas. A joint commissioning group (formerly the Change Fund Group) had overall responsibility for the preparation and delivery of the joint commissioning strategy for older people. This group had multi-agency representation.

The Council's strategic housing investment plan programme had set aside a significant

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proportion of available capital investment for extra-care housing and amenity housing. However, the future sustainability of revenue funding to support such developments was uncertain.

We were told that housing staff were represented at the strategic workshops for the joint commissioning strategy and were kept informed at all stages of the development of the strategy. However, housing staff reported that, while housing services were represented at joint commissioning group meetings, they would have preferred to have had closer involvement with the setting of priorities within the joint commissioning strategy.

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

There was a good history of community involvement in Moray. The Partnership was using resources from the Change Fund to test and develop some elements of its early intervention and support services. This included:

- enhanced respite
- re-designed district nursing services
- specialist clinical support
- a handy person service
- a temporary training officer for reshaping care for older people.

The Three Tier Model formed the basis of a comprehensive approach to early intervention and prevention aiming to provide an incremental approach to support.

Multidisciplinary meetings at GP practices were a good example of staff working together to identify changing needs for older people and their carers. Allied health professional staff were increasingly engaged at an early stage to support individuals to recover maximum functioning. This included early referrals from GPs to avoid admission to hospital. Working closely with individuals on the outcomes they wished to achieve, the home from hospital team reported that they had helped to reduce the level of support needed by people discharged from hospital for 45% of those referred to them.

## 6.3 Self-evaluation and improvement

The partners were working together to develop more joined up self-evaluation and improvement. The Council used the 'Public Sector Improvement Framework' and NHS Grampian used 'Releasing Time to Care' as part of their self-assessment and efficiency approaches. The Partnership had also used the Joint Improvement Team's<sup>14</sup> option appraisal tool to evaluate potential Change Fund projects. Self-assessment against the

<sup>14</sup>The Joint Improvement Team (JIT) is a strategic improvement partnership between the Scottish Government, NHSScotland, Convention of Scottish Local Authorities (COSLA), and the third, independent and housing sectors. The team provides direct practical support to local health, housing and social care partnerships across Scotland.

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reshaping care pathway was used to assess the spread of initiatives across the pathway bundles and informed further Change Fund investments.

Learning from these had led to service redesign such as:

- the development of the access team
- the reablement service, and
- the acute health services portfolio including Dr Gray's Hospital.

A suite of performance information based on the information collated by the Joint Improvement Team, local service plans, national and local indicators as well as NHS Grampian performance dashboards formed the basis of the joint approach. This helped partners to identify areas where performance was improving or required improvement. The Partnership had also carried out a specific self-evaluation exercise based on the joint draft quality indicators before this inspection. Senior managers had advised that they would prepare an action plan to progress the findings of their evaluation.

Commissioning officers advised that externally commissioned services needed to have quality assurance measures in place and report on these as part of contractual and contract compliance procedures. The commissioning team did not have a quality assurance relationship with directly provided services. Officers were keen to stress that they had clear processes in place when assessing need for new services or reviewing existing services. The Change Fund group had evolved into the joint commissioning group. It was envisaged that this group would inform future commissioning decisions. However, as the integration process was at an early stage, officers reported that the role of the joint commissioning group was unclear.

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

A wide range of performance information was produced, reported and made available for consideration by the Partnership's senior management team and elected members. This included information on progress in delivering local service plans, national and local indicator 'score cards'. A draft joint performance framework was being prepared. The draft contained a 'score card' of national and local indicators. It was intended that the framework would focus on outcomes as well as indicators. The completed version should include outcomes and indicators for:

- the contribution of the third sector
- co-production
- information on individual service user outcomes based on Talking Points, and
- equalities and 'hard to reach' groups.

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The Partnership needed to be sure that the framework contained challenging, but achievable targets.

Officers within social care services reported that the introduction of the latest version of the Council's CareFirst electronic information management information system in May 2013 had brought about challenges for performance monitoring. A joint performance management group met monthly to review the 'score card' and looked at trends. The group had representation from health and social care. The group reported to the Partnership and joint commissioning group to help inform strategic decision-making.

Through the Change Fund, the partners were taking a joint approach to the deployment of resources to support improved outcomes for older people. These were evaluated and reviewed. Moray reported performance against a set of service performance targets for housing and social work. A jointly commissioned performance officer had developed a basket of measures for reshaping care for older people. These measures give an indication of the whole system working to shift the balance of care to the community.

Social care managers carried out periodic file reviews to assure the quality of practice. Examples of direct service user feedback included an annual carer survey and a five per cent sample survey of occupational therapy clients. People referred to the access team were also sampled to find out their views on their experience of the service. However, this was in the early stages of development and sample sizes were small. For sheltered housing tenants, there was a local authority tenant's survey once every 3 years.

The Partnership had done extensive service mapping and needs analysis to inform the joint commissioning strategy's priorities for improvement. However, we did not find a comprehensive approach to how information from feedback mechanisms was used to improve and assure practice generally.

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

Partners had formal policies for engaging with people who were using their services as well as with other stakeholders, including staff and external providers.

Overall, independent sector providers were positive about the level of support they were given by the Council to improve their performance. We found that engagement with providers of services could be improved. This would make sure they were better engaged in reshaping how they provided services to meet future challenges.

The communication plan for the promotion of the joint commissioning strategy for older people aimed to engage with a wide range of stakeholders across Moray. The consultation group of the older people's reference group explored ways of engaging with older people to shape and reshape support and service options. This group was engaged in consultation on the joint commissioning strategy for older people.

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We found that team managers felt involved in development and improvement activity and this was clearly led. However, frontline staff were less positive and not as clear. Senior managers needed to better engage and communicate with staff on future direction and implementing change. We give further consideration to leadership and communication under Quality indicator 9 in this report.

Managers acknowledged that there was unrealised potential in the third sector and that the Partnership needed to improve its joint working with voluntary sector agencies. The third sector interface group had a lead role in identifying different volunteering and support opportunities. The third sector was beginning to improve capacity, capability and co-ordination between its own organisations.

Some voluntary sector initiatives were funded, at least in part, by the Change Fund, such as the handy person service. Over 600 older people were involved in a range of support groups. However, there was no formal co-production strategy. It is unclear how activities are targeted and progress or impacts measured, for example there did not seem to be formal links to individual client assessment and service plans. The current measure was stated as 'real people's stories'. Groups perceived themselves as autonomous and self-reliant and not part of 'health and social care services'. There was limited direct and routine feedback from the groups to those who were commissioning services.

## 6.6 Commissioning arrangements

Although discussion had taken place with partners about how to build and implement a personal outcomes approach to commissioning, it was not clear when this would be translated into how services were procured. The implementation of the joint commissioning strategy for older people included developing the care at home and care markets. However, providers of these services were not always fully engaged in how their services might be reshaped or enhanced to support this element of the plan. The joint commissioning strategy for older people sets out the Partnership's approach to developing services into the future. We found that the strategy gave a clear view of the direction of travel. However, it lacked much of the detail on how it would be achieved. We made a recommendation about the strategy earlier in this chapter.

The Institute for Public Care framework<sup>15</sup> had been adopted for all local government commissioning. A market position statement had been produced setting out forthcoming tender opportunities for prospective providers with regard to self-directed support.

Staff advised that Change Fund plans and resource investment were jointly agreed and pooled. The joint commissioning group managed the Change Fund resources. It did not review the mainstream budgets. Integration of financial management was limited to the Change Fund.

<sup>15</sup> In order to help those responsible for improving joint commissioning skills and capacity across the partnership, the Joint Improvement Team and the Scottish Government commissioned the Institute of Public Care to produce a learning development framework focusing on joint commissioning. This explores the skills needed to deliver effective joint strategic commissioning of older people's services.

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Integrated Resource Framework information<sup>16</sup> was reported to be unavailable. Therefore, this had, as yet, not been used extensively to inform financial planning and budgeting.

Hanover Housing Association had been commissioned, through a pilot project, to deliver additional care at home capacity and its own extra care housing development. This 'housing with care' pilot project is one of the few of its kind in Scotland.

<sup>16</sup> The Integrated Resource Framework (IRF) is being developed jointly by the Scottish Government, NHSScotland and COSLA to enable partners in NHSScotland and local authorities to be clearer about the cost and quality implications of local decision-making about health and social care. This will help partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups.

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## Quality indicator 7 - Management and support of staff

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

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

### Summary

#### Evaluation – Good

The Partnership's recruitment policies and procedures were clear, relevant and fit for purpose. We saw a multi-agency adult protection strategy, detailing good joint training opportunities. However, most staffing processes were not joint. Historically, vacancy and absence rates in the Council and NHS Grampian had, in general, not given cause for concern. The Partnership needed to continue driving forward its recruitment initiatives.

Joint working on workforce planning was limited. However, there was good evidence of joint working in the direct work with service users.

Training and development opportunities were of a good quality and focussed on improving outcomes. Some were delivered on a multi-agency basis. The Partnership was planning to further develop the workforce on a joint basis through its leadership subgroups.

### 7.1 Recruitment and retention

We read a range of relevant and clear documentation including recruitment and retention strategies and human resource policies given to us by the Council and NHS Grampian. These documents were fit for purpose, but were separate documents rather than jointly compiled. In relation to workforce planning, no formal joint planning was taking place. NHS Grampian had a 2012–2015 workforce plan and the Council had a 2010–2013 social Work workforce strategy. However, we did see a multi-agency strategy for adult protection. This included high levels of training and initiatives. There had been other workforce initiatives such as carer recruitment and specialist nursing development. While there was a recognised need to reshape the skills profile of the workforce, it remained unclear how future joint working would look. We consider partnership arrangements under Quality indicator 8 in this report.



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In the interviews and focus groups we carried out, we were told by staff and managers that recruitment could be an issue impacting on the delivery of services. For example, recruitment to community health posts had been a problem. There was no shortage of trained nursing staff. In fact, there was a surplus of applicants. However, there was only a 0.5 whole time equivalent consultant geriatrician. The service had adapted by using highly qualified advanced nurses to complement the consultant geriatrician's time. Some GPs were providing a safety net with the use of emergency care practitioners and virtual wards in the community to enable inter-disciplinary discussion of patients.

In recent years, the overall vacancy and absence figures we read for the Council and NHS Grampian had generally not been problematic. There had been a recent recruitment drive to attract more staff. Elected members we met were very supportive on this issue. There was no lack of financial resources made available for this purpose.

In relation to social care services, development officers we met told us that staff turnover in home care could be an issue. However, there was no real sense that this was worse than elsewhere. Health staff recruitment was reported to be less challenging in Moray than in other parts of Grampian.

## 7.2 Deployment and joint working

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 to provide care at times of crisis (76%). There was evidence that multi-agency partners' views informed risk assessments in most instances (67%). Information was shared on the whole between professionals and recorded in their files (71%). Positive comments were recorded during the file reading on staff deployment.

- "Overall, partly due to the deployment of health, social work and social care services, the service user has achieved a good set of positive outcomes."
- "As stated the deployment of health, social work and social care services has sustained this very infirm lady in her own home for a very considerable time."

From our staff survey, we found that 56% of respondents agreed or strongly agreed that there were positive working relationships between practitioners at all levels.

Internal deployment of staffing resources was not a prominent issue during our fieldwork. We did note one example where there had been attempts to free up district nursing time by delegating elsewhere, for example to the Crossroads crisis support service.

Frontline staff as well as NHS and social care managers we met during fieldwork reported good working relationships with colleagues across the services. They said that an increased focus on outcomes was evolving as a result.

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### **Example of good practice...**

There were sound joint working arrangements between the pharmacy team and the care homes. Members of the pharmacy team had been involved in training care home staff. Care home managers were reported to be initially cautious about joint working with the pharmacy team. However, this was now well established, with considerable benefits for the residents of the care homes. Pharmacy staff reported a history of good relationships and effective joint working in Moray. Joint working issues tended to be resolved informally and joint working was effective because of the quality of the local relationships

## **7.3 Training development and support**

The local authority had a staff supervision policy which was fit for purpose. All health staff had formal personal development plans linked to a national knowledge and skills framework (KSF). Action learning sets was an approach being used to be clear about each other's roles across health and social care services as well as to be clear on the approaches to goal setting and reablement.

We read about a wide range of training and development opportunities and initiatives in the Partnership. The local authority had a training plan and workforce development planning. NHS staff followed the training and development outlined in the KSF. There were particular joint initiatives in personal outcome planning for health and social care staff.

From our staff survey, we noted positively that 74% of respondents agreed or strongly agreed that joint working was supported and encouraged by managers. A majority (53%) agreed or strongly agreed that they had good opportunities for professional development.

Frontline health staff we met during fieldwork were positive about training opportunities. We heard that there was a useful new training directory. In relation to adult support and protection, staff appreciated that there was an online resource available. Initial joint training had been held and a public event.

Also in relation to adult protection, we heard from senior health managers that more funding was needed for legal advice and training. Some wider training had been done together with offers to join programmes being extended across the Partnership.

Frontline health staff indicated their experience of dual trained staff (nursing and social work) was very positive. These individuals were aware of wider aspects of clinical and social care and were able to provide wider perspectives and opinion in complex cases. They indicated there was now a good opportunity to develop a joint working role through dual training.

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Health staff acknowledged that more joint training would be welcome. In particular, they thought that it would be helpful to have problem-solving sessions between health and social care.

Following the recent pilot of the joint Sliding Doors initiative to engage community staff across health and social work, a multidisciplinary training programme of identified topic areas had been developed. Following the setting up of the transitional leadership group and its subgroups to take forward the integration agenda, the need for a dedicated training resource had already been identified. An options appraisal will be developed and brought to the transitional leadership group for consideration.

Frontline staff considered that the Council's home care staff were well trained and equipped to do their job. They told us about a 3-week induction programme for new home care workers with the Council. Allied health professional training staff had developed and delivered training to care at home staff to support them in their reablement role. This training was also available to unpaid carers and carers in the independent sector. The recent allocation of an allied health professionals' training budget was welcomed. They planned to invest in training that would be of benefit across the professions. Work in training all care at home staff was shifting the attitude of staff to a more outcome focussed approach to delivering care and support as well as consideration of where support could be reduced for positive benefit.

In November 2013, the Partnership produced a project initiation document which set out the pathway towards integration. Five subgroups had been put in place to take this forward: "Joint Outcomes", "Developing Joint Systems", "Joint Resources & Financial Planning", "Governance & Accountability" as well as one for developing the workforce. Features of the "Workforce" subgroup's activity would include organisational design and key workforce integration principles.

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## Quality indicator 8 – Partnership working

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

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

### Summary

#### Evaluation – Adequate

Both NHS Grampian and the Council had a history of solid performance in the financial management of health and social work services. However, they faced a number of challenges in developing a more joint and integrated approach.

As elsewhere, the Partnership needed to make sure that its information systems supported the effective sharing of information in a way which promoted good outcomes for older people.

The Partnership had produced a plan for how it would take forward its approach for preparing for health and social care integration. This provided a useful way forward, but the Partnership needed to address the detail of how integration would be delivered. Partners needed to examine whether their joint processes for adult support and protection needed to be improved.

### 8.1 Management of resources

To support the planned integration of health and social care, the Partnership had produced a formal project initiation document. To inform the plan, a joint resources and financial planning group had been set up. The group was to identify an indicative budget and a rationale for its calculation. At the time of the inspection, the group had not yet met and, as such, there was no indication of the composition of the integrated budget.

Despite this, the group appeared to have sufficient profile to meet its scope. Proposed membership included the director of finance of NHS Grampian, the head of financial services of The Moray Council and other relevant officers from both parties. An integration management group was expected to submit all workstream reports to the transitional leadership group by September 2014 so that a single integration plan could be generated.

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The joint resources and financial planning group faced a number of challenges. For example, some budgets were being treated corporately by NHS Grampian, rather than on a locality basis. NHS Grampian might seek to have consistent practice in place across the three relevant local authority areas. The Partnership expected that integration might reduce their individual financial flexibility.

### **Financial performance of The Moray Council**

The Council had a high-level, 10-year strategic financial plan. This was reported in draft to the Council on 20 November 2013. There had been an intention to produce a detailed 4-year financial plan, a draft of which was due to be reported by February 2014. In the interim, the Council's budgeting had been carried out on a one-year basis. The financial management of the Council had been considered as part of the Audit Scotland-led, shared risk assessment exercise on an annual basis since 2010–2011. This had identified no significant concerns in relation to the Council's financial management and planning.

The health and social care budget within The Moray Council was £38.464million for 2013–2014. As at September 2013, the Council had spent £19.259million against a budget of £19.100million. This was an overspend of £0.159million (0.8%). Particular pressures included overspends against the staffing budget in the care at home team (£0.113million) and the purchasing of domiciliary, day and respite care (£0.231million). However, these overspends had been somewhat offset by higher than expected income, particularly due to client contributions. The forecast outcome for the Council's health and social care budget at the year-end was an overspend of £0.558million (1.5%).

The Council faced significant challenges in relation to care at home budgets, although some savings were expected following the implementation of a new home care scheduling system. The Council had also recognised the move towards self-directed support as a budget pressure, but specific costs had yet to be identified.

### **Financial performance of NHS Grampian**

NHS Grampian reported that the Moray Community Health and Social Care Partnership (the Partnership) has an authorised budget of £20.502million. The summary financial report for the Partnership advised an overspend of £0.270million for the year to October 2013. The variance was reported as mainly due to an overspend of £0.186million in pay expenditure. The largest contributor had been an overspend in nursing pay of £0.202million, of which £0.188million was attributable to nursing teams within the community hospitals. The nursing pay overspend had only been partially offset by small underspends elsewhere.

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## Joint financial reporting

The health and local authority spending streams were reported together through a provisional joint finance report to the Partnership. The joint report attempted to align the expenditure of both parties, but was produced solely for information. This was because the health and the local authority budgets for the Partnership were managed separately.

The provisional joint finance report, which included Dr Gray's Hospital, covered an annual net budget of £103.848million (including prescribing). The spend against the year to October 2013 was £1.261million higher than budget with a forecast outturn overspend of £2.153million. The overspend was principally attributable to NHS Grampian budgets, as previously noted.

## Change Fund

The joint commissioning group managed the allocation of Change Fund monies. It was supported by finance officers from both partners. The group was the only clear example of integrated financial planning that was identified during the inspection. Change Fund resources were £1.456million in 2013–2014, made up of an annual allocation of £1.353million and a carry forward from 2012–2013 of £0.103million. The projects funded by the Change Fund had focussed on community-based initiatives to support a change in the balance of care towards prevention. Through the mid-year review of the Change Fund, the Partnership had reported that it expected £0.205million of funds to be carried forward into 2014–2015.

The Partnership reported that all Change Fund projects had been subject to an options appraisal process and that each investment had a clear exit strategy. However, reports to the Joint Improvement Team had highlighted the Partnership had been unable to quantify any change in spend profiles of the total resource envelope as they did not have robust reporting mechanisms in place. This was at least partially due to the inherent difficulty in assessing savings achieved through preventative care and lack of access to Integrated Resource Framework data.

## 8.2 Joint IT systems

We saw that the partners did not have a joint IT strategy that supported the sharing of information at both the individual and strategic levels.

Before our inspection, the Partnership told us in its position statement that the health and social work systems “do not talk to each other and are not necessarily compatible”. In this regard, we found that the position in Moray was similar to that in many areas in Scotland.

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This position was also reflected in our inspection. During our review of social work services and health records, we found that records were largely single agency or, in some instances, single discipline in nature. From our discussions with local file readers and from the staff we met as part of the file reading follow-up, it was clear that the records did not fully reflect the extent of information sharing between health and social care staff.

As part of our staff survey, we asked whether information systems support frontline staff to communicate effectively with partners. In response:

- while 20% of NHS staff agreed with this statement, 49% either disagreed or disagreed strongly, and
- while 18% of local authority staff agreed with this statement, 27% either disagreed or disagreed strongly.

At focus groups, staff and managers said that the small size of Moray and the fact that most staff knew each other helped them to get round some of the problems of disjointed systems. They said that multidisciplinary team meetings helped and were an important forum for sharing information. They also used email as a means of day-to-day communication and information sharing.

The GREAS electronic system for ordering items from the joint equipment store<sup>17</sup> was one system used jointly by health and social care staff. This was commented on positively. They said the system worked well, especially for staff who used it regularly. They said that it also provided much more accurate information on the extent of the use of telecare than was generated by the Council's CareFirst electronic information management system.

We saw that the Partnership had made good use of its existing IT systems to generate information to help inform the joint commissioning strategy for older people, 'Living Longer Living Better'. We read the detailed service mapping exercise which the Partnership had carried out. It contained data, including information on demand and costs of all health and social care services within the Partnership. This had also been useful in providing a baseline for costs. However, the Partnership acknowledged that it was still at an early stage in terms of proactively being able to use the data for service planning purposes.

With the termination of the national eCare programme in June 2013 (a partnership between the Scottish Government, NHS boards, local authorities and other agencies throughout Scotland to streamline information sharing activity between agencies to better improve the lives of those for whom they care), we saw that the Grampian Data Sharing Board was being re-launched. This had been awarded funding of £118,000 from

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<sup>17</sup>The equipment store is jointly funded by The Moray Council and NHS Grampian. This is where community occupational therapy equipment for Moray residents is bought, stored, repaired and decontaminated.

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the Scottish Government for 2014–2015. The new Board had agreed a number of key objectives. These included:

- developing support for improved collaborative working in support of better outcomes for people who use services
- supporting the overall direction of health and social care integration
- an approach based on IT systems making information available rather than passing data through IT systems, and
- a project manager was to be recruited by the Board who would have a leading role in the production of a joint strategy.
- We also noted that the project initiation document for health and social care integration highlighted the importance of developing effective joint information systems as part of the workstream for developing joint systems

### 8.3 Partnership arrangements

Health and social work services in Moray had a longstanding history of partnership working. The Partnership was originally established in 2004 as one organisational structure with aligned budgets. Unusually for a community health partnership, it had included the local acute sector provision at Dr Gray’s Hospital in Elgin. The Partnership described its partnership as a “mature” one which had allowed a whole systems approach to planning. The most recent inspection of the Council’s social work service<sup>18</sup> in 2011 found strong evidence of partnership working across community health and social care. The Partnership had worked closely together in producing a comprehensive report on Shifting the Balance of Care 2010–2011.

Most staff and managers we met said that health and social work services worked well together. Partnership staff were, for example, working together to improve their use of Edison (Electronic Discharge Information System Online Nationally - a system used by both health and local councils across Scotland for the management of delayed discharge patients). In our staff survey, the majority of staff who responded agreed that the priorities set at Partnership, team and unit levels reflected joint agreed plans.

Some health managers we met during the inspection expressed some frustration about their ability to impact on approaches taken or decisions made by the local authority. Changes made by the local authority to the procedures for dealing with the handling of adults with incapacity and guardianship for older people in hospital were cited as an example of this. We made a recommendation about this under Quality indicator 1 in this report.

In relation to adult support and protection, only five case conferences (which consider

<sup>18</sup>Moray Council scrutiny report, Social Care and Social Work Improvement Scotland. July 2011



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protection measures) had been held and reported on in 2010–2012. We considered this to be a relatively low number compared to the number of enquiries and investigations (294), representing only 2% of the total. In addition, only 47 adult protection meetings (multi-agency initial referral discussions) were held, representing 16% of the total. We were not given clear reasons for such a low level of use of these important meetings.

Each of the case conferences was attended by service users and carers and was supported by advocacy services commissioned specially for this purpose. The Council was looking to improve its approach to gathering the views of service users and carers involved in this process.

**Recommendation 5:**

The Moray Partnership should consult relevant partners and agree a proposal to review the reasons for the low level of adult protection meetings and case conferences in response to adult support and protection referrals. The Partnership should satisfy itself about the most appropriate use of these stages in the process, including maximising the involvement of service users and carers as appropriate.

We met with the head of community care (The Moray Council) and the community health partnership general manager. They had important leadership roles to perform. The latter was relatively new in post. As such, they were still developing their working relationship. However, we were impressed at how motivated they were to working constructively in partnership.

At a strategic level, it was clear that the development of the joint commissioning strategy for older people had provided a strong impetus to partnership working. Senior managers in the Partnership had worked hard to take this forward. A joint commissioning group had been established involving personnel from the local authority, NHS, third sector and independent care. The group had a dual role of leading the development of the joint commissioning strategy for older people and providing governance for Change Fund (including fund allocation and monitoring that Change Fund objectives were being met).

The Partnership recognised the need to include a wider group of stakeholders and GPs, housing officers and older people themselves joined the joint commissioning group. An early decision was also made to commission the involvement of the Institute of Public Care, Oxford Brookes University, in a facilitating role. The Partnership told us that the Institute's input had been very positive in supporting the further development of a positive culture of partnership working. Older people we met who had been involved in the development of the strategy spoke positively about how they had been included in the process and the level of communication which took place. There had been difficulties in the Partnership's previous relationship with the third sector. However, there were indications that the action taken to establish tsiMoray in 2012 had helped resolve these.

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To support partnership working, a joint performance management group had been established. We met with some of the staff involved with the group. They informed us that joint performance measures for 2013–2014 were in draft form and were subject to an extensive staff and public consultation. They said the Partnership was keen to secure widespread agreement for the most important and appropriate measures. They acknowledged that there was a considerable way to go in the development of effective joint performance management and reporting. While performance data was provided to commissioning staff, there was some uncertainty about how this was being used to inform gap analysis and service planning.

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

At the time of the inspection, the Council and the NHS in Moray had made a number of decisions to help prepare for health and social care integration.

- In line with most areas, they had decided on a 'body corporate' model.
- They had carried out a scoping exercise to help inform what services would be included in the Partnership. Their intention was that, initially at least, the Partnership would include adult services only.
- A job description for the chief officer post had been agreed. This was due to be advertised internally and externally in early 2014.

While mindful of the challenges, including the financial challenges associated with integration, senior managers, elected members and NHS board members were generally positive about the requirement and need for further integration. They said there had been good buy-in from corporate finance, legal and human resources staff from both organisations.

A transitional leadership group had been formally established in August 2013 and had met twice by the time of our inspection. As with all local authorities, the Partnership was required to submit an integration plan to the Scottish Government for approval in March

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2015. We read the project initiation document which had been prepared to support the development of the plan which was to be taken forward under five workstreams. While this provided a useful outline of the main stages and timescales involved, it was clear that considerably more work was needed to detail how the workstreams would deliver on their remits. For example:

- while the scope for the joint resources subgroup identified the need for a pooled budget, the emphasis was on matters such as aligning budget setting processes, rather than on the actual process for identifying and agreeing the pooled budget.
- at operational level, there was little evidence of joint or integrated teams in Moray at the time of our inspection. The workforce subgroup was developing an outline of the future organisational design of the integrated service. However, this was in the absence of any apparent steer on whether or not this would be built around integrated teams at frontline level.

An integration management group had a key role in overseeing the work of the five workstreams. We concluded that it was important that this group made sure that the workstreams produced reports with detailed conclusions on how their proposals for integration would be achieved. We consider action on integration again under Quality indicator 9 in this report.

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## Quality indicator 9 – Leadership and direction

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

### Summary

#### Evaluation – Adequate

Leaders of services in Moray clearly understood the future challenges in delivering joined-up services for older people in Moray. Through their plans, they were able to demonstrate clear links between the analysis of the situation and the actions required to address the changing needs of service users and carers.

The leaders' priorities were aligned with community planning priorities. They were promoting collaboration between social care services, health teams and external partners. It was early days and difficult to find evidence of positive impact on the progress towards more integrated working.

Some staff and other stakeholders remained to be convinced about the merits of integration. Leaders had plans in place to communicate better. This needed to be supplemented by more detail on the proposals for integration.

While we saw evidence of good joint working across the Partnership, the management of change needed to become more robust.

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

There was evidence that the Partnership had a clear appreciation of the need for change in the delivery of older peoples' services, with a shared understanding of priorities. This could be evidenced by the production of the joint commission strategy for older people, 'Living Longer Living Better'. The strategy spanned from 2013 through to 2023. It had been clearly developed in accordance to the national Joint Improvement Team guidance. The Partnership committed to facilitate a shared understanding of the commissioning cycle and the processes involved, through seven learning workshop sessions

The joint commissioning strategy for older people was a well written and developed document. In reading the strategy, there was good evidence of the commitment to shifting the balance of care and joint working. There were some good examples of reducing bed days in hospital, reducing the need for hospital-based care and generally supporting people with long-term conditions.

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In our staff survey, we asked whether there was sufficient capacity to carry out preventative work. Of the 148 respondents, 59% disagreed or strongly disagreed with this statement. This was surprising given that, through Partners in Care, the Council was proposing a new model of support based on a three tier system. Tier one focussed on prevention. Nevertheless, rates of satisfaction among staff to having the skills to carry out their role were fairly high.

In order to achieve the aspirations within the joint commission strategy for older people, there were some clearer future needs in terms of staffing resources and skill mix/levels. A workforce development officer had developed an integrated workforce plan and further work was to be taken forward in the workforce development subgroup of the arrangements for developing an integration plan.

In our staff survey, we asked whether there was a clear vision for older people's services with a shared understanding of the priorities. Of the 133 respondents, 42% agreed with the statement, 38% disagreed or strongly disagreed and 20% indicated the statement was not applicable to them. A comment in relation to this statement was submitted:

"The will for integrated working is there but in reality we have a long way to go before we can claim to be working effectively together. This is due in part to different views on priorities, risk management and lack of communication between the agencies involved."

The transitional leadership group was recently set up and comprised three elected members and three NHS board members, and a small number of officers from both the NHS and local authority. It also had membership from wider stakeholders. The key aim of the group was to provide direction and recommendations to both parent organisations. It was envisaged that from this transitional leadership group there would be a number of working groups established to look at issues such as finance and governance.

At the time of inspection, the transitional leadership group was in its infancy. As a result, it was not possible to gather evidence on the impact it was having in progressing the integration of services. Subgroups had been set up under this main group and were beginning to meet. There was a SMART action plan to enable progress to be tracked.

The vision of future services in Moray meant that delivering services in different ways needed to be developed if Moray was to embrace appropriately the challenges of the demographics.

In the staff survey, we asked for feedback on where there were changes to services, whether these were managed well. Of 133 responses, 60% of staff disagreed or strongly disagreed that this was the case. Only 32% of respondents agreed that such changes were managed well.

Of the 133 respondents from the staff survey, only 48% agreed that high standards of professionalism were promoted and supported by all professional leaders, elected

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members and board members. 30% of respondents disagreed or strongly disagreed, with 22% indicating that the statement was not applicable to them.

## **9.2 Leadership of strategy and direction**

We noted that the strategic commissioning work linked with the community planning priorities outlined in the single outcome agreement.

The Institute of Public Care had been commissioned to support the development of the joint commissioning strategy for older people, 'Living Longer Living Better'. The strategy has been fully endorsed by both elected and board members. We considered this to be a positive step forward.

A report presented to both the Council and the NHS board in July 2013 was co-written by health and council senior managers. This paper clearly advocated the development of a joint board model (body corporate) to support integration. The authors of the report advised that, at all levels, people found the idea of creating a new entity both energising and attractive, fostering a spirit of respect and partnership, which could be carried through the organisations. Options on models were considered during the workshops facilitated by the Institute of Public Care. The transitional leadership group agreed that the 'body corporate' would be the model going forward in Moray.

The transitional leadership group and its five subgroups had only been recently established. As a result, the impact on local progress towards integrated working was difficult to evidence at the time of the inspection. There were no fully documented workstreams for this group with attached timescales. However, the transitional leadership group is a role model of joint working at all levels and represents a positive way forward.

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

Feedback from our staff survey provided evidence that more work needed to be carried out to make sure there were clearer joint strategies to communicate change to staff.

Staff were asked in our survey whether their views were fully taken into account when services were being planned and provided. Only 46% of respondents agreed or strongly agreed with the statement. However, from the same number of responses, a majority (59%) of respondents agreed or strongly agreed that they felt valued by their managers.

Staff we met told us they had been involved in a number of planning groups and had contributed to consultation exercises for a variety of initiatives and projects. However, they did not feel their views were always taken into consideration.

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Senior managers told us they were already aware of these issues and explicit action plans were under way. The transitional leadership group was aware of the need to concentrate efforts on engaging and involving staff.

Like some other partnership areas, the formal integration of health and social care services was at a very early stage. The project initiation document produced in November 2013 set out the integration progress timescales.

In relation to the integration agenda, GPs told us that they did not have a great sense of the agenda moving forward. However, there was now a weekly joint managerial meeting. GPs thought that there needed to be more engagement with the primary sector on the integration agenda. They indicated that there were no extra resources for keeping patients in the community. While GPs agreed that integration was generally a good idea in principle, there was a need to see the practicalities.

The Partnership had developed a communication plan for the promotion of the joint commissioning strategy for older people. This should begin to address these shortcomings. It contained a mix of approaches for communicating with staff including workshops, team meetings and newsletters. It covered the period November 2013 to November 2014.

#### **Recommendation 6:**

The Moray Partnership should provide more information on the integration pathway for its stakeholders. This should include the vision, objectives, implementation milestones, progress monitoring arrangements, sustainability and any key strategic elements such as the Three Tier Model, prevention, early intervention, reablement, self-directed support and joint information systems. This will also support its communication plan for the joint commissioning strategy for older people.

## **9.4 Leadership of change and improvement**

The Moray Partnership was at an early stage of identifying and implementing changes to achieve full integration.

We had some concerns in relation to effective change management.

- Only 36% of respondents agreed or strongly agreed that senior managers communicated well with frontline staff.
- Only 32% of respondents agreed or strongly agreed that changes which affected services were managed well.

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However, 74% of respondents agreed that senior managers supported and encouraged joint working.

The Partnership's investment in engaging the Institute of Public Care had proved very valuable in supporting the development of future older peoples' services. In particular, this facilitated wider stakeholder engagement and involvement. It also led to lead officers in the Partnership having a shared understanding of commissioning and the principles that underpinned it.



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## Quality indicator 10 – Capacity for improvement

To determine the Partnership's capacity for improvement, we considered the following areas:

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

### Summary

#### Evaluation – Good

We saw evidence of some very good outcomes for older people and their carers in Moray. A positive start had been made towards integrating health and social care services more closely. The Partnership was beginning to monitor how well this was progressing. We witnessed constructive working relationships among the leaders we met. The preparations for integration were well under way, but evidence that the changes were impacting positively on outcomes was awaited.

### 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 Moray Partnership delivered very good outcomes to older people who used services and their carers. This evidence included our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership, results from our review of social work services and health records, and views expressed by older people who used services, carers and Partnership staff we met

We heard about the good development of anticipatory care and examples of reablement.

Room for improvement was needed in relation to delayed discharge, providing appropriate care at home, geriatric assessment and responding to carers. We recognised that recruitment problems were in part responsible for this.

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

The Moray Partnership had made a good start on its plans to integrate its health and social care services more closely. It was beginning to monitor how well this was progressing.

The Council and NHS Grampian have had a history of solid performance in the financial management of health and social work services in Moray.

We found a strong commitment in Moray to realise the capacity within the community to help older people and their carers.

We heard about a recent self-evaluation exercise carried out with a number of staff focus groups in Moray's rural communities. This will help the transitional leadership team to use staff's experiences to improve the work of the Partnership.

Overall, there was a clear view of the direction of travel, but plans were sometimes lacking in detail, for example in major decisions about investment and disinvestment. However, the Partnership joint commissioning group had agreed decisions on change fund investment throughout the relevant period.

## **Effective leadership and management**

There was stable leadership, good planning and positive working relationships at top level from officials. Leaders, including elected members, needed to work harder at convincing staff about the merits of the integration agenda. This was evident from papers we read, decisions taken about integration, from those we spoke with and the development of groups such as the transitional leadership group to take integration forward together.

The transitional leadership group acknowledged the need to concentrate its efforts on engaging and involving staff further. The partners recognised that sustained and focussed effort would be needed if a shared vision was to be developed and implemented to meet future challenges and the necessary resources found to realise their intentions.

We saw some results from the efforts to date. Partnership staff were, for example, working together to improve their use of Edison (Electronic Discharge Information System Online Nationally - a system used by both health and local councils across Scotland for the management of delayed discharge patients). Staff at Dr Gray's Hospital had been involved from 2013 as part of their approach to improve discharge planning pathways. The access staff felt the systems generally worked well and access to equipment had also worked very well.

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

Leaders in Moray clearly understood the future challenges in delivering joined-up services for older people in Moray. There were constructive plans to develop more integrated health and social services so that older people and their carers would have a more positive experience of these services. However, access to systems and information about service users were restricted for both social care and health staff. There had been a shared approach to the development of a joint commissioning strategy for older people, 'Living Longer Living Better'. This had helped to foster a joint understanding of commissioning and the needs and expectations of the older population in Moray.

Our conclusion was that the building blocks to achieve better integration were in place, but that the pace of change needed to be accelerated. The partners needed to be clearer about the sustainability of some of the processes in place, particularly those funded through the Change Fund. The transitional leadership group and its subgroups were positive developments, but were very recent. Leadership and preparation of integration were good, but evidence that the changes were impacting positively on outcomes was awaited.

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## What happens next?

The Care Inspectorate and Healthcare Improvement Scotland will ask the Moray Partnership to submit a joint action plan detailing how it intends to make any necessary improvements identified as a result of the inspection.

The inspectorates will monitor the implementation of any relevant actions for improvement by the Partnership arising from the inspection and continue to offer support for improvement through their link arrangements.

**David Rowbotham**  
**Inspection Lead**  
**May 2014**

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## Appendix 1 - Recommendations

The actions that the Care Inspectorate and Healthcare Improvement Scotland expect the Partnership to take as a result of this joint inspection of services for older people follow from recommendations.

The Partnership will be expected to produce an action plan detailing how they will address each of the recommendations made.

### Indicator 1 – Key performance outcomes

#### The Moray Partnership should

- 1 take further steps to reduce the number of bed days lost in respect of older people whose discharge from hospital is delayed including those for reasons related to the application of the Adults with Incapacity (Scotland) Act 2000. It should ensure that Section 13 ZA<sup>19</sup> of the Social Work (Scotland) Act 1968 continues to be used when appropriate, streamline (where possible) the process of appointment of an adults with incapacity proxy and make sure all the required processes are carried out within appropriate timescales.

### Indicator 2 – Getting help at the right time

#### The Moray Partnership should

- 2 further explore and implement any appropriate options to increase the capacity of the home care provision, particularly in respect of recruitment and retention in the area across all providers.

### Indicator 5 – Delivery of key processes

#### The Moray Partnership should

- 3 carry out a review of the home from hospital and access teams, including their structures, staff roles, procedures and the effectiveness of their communications. The Partnership should continue with initiatives to ensure that hospital discharge arrangements and other referrals intended to support the wellbeing of older people in Moray are dealt with timeously and appropriately.

<sup>19</sup>This provision, in certain circumstances, enables the local authority to move a person who lacks capacity from an acute hospital bed to a care home.

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## Indicator 6 – Policy development and plans to support improvement in service

### The Moray Partnership should

- |          |  |
|----------|--|
| <b>4</b> | ensure that future policy development of the joint commissioning strategy for older people, 'Living Longer Living Better', gives more detail on: <ul style="list-style-type: none"><li>- how priorities are to be taken forward and resourced</li><li>- how joint organisational development planning is to be taken forward</li><li>- how consultation and engagement are to be maintained</li><li>- the use of advocacy in services for older people, and</li><li>- action plans which are SMART (specific, measurable, achievable, realistic, time-bound)</li></ul> |
|----------|--|

## Indicator 8 – Partnership working

### The Moray Partnership should

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|----------|---|
| <b>5</b> | consult relevant partners and agree a proposal to review the reasons for the low level of adult protection meetings and case conferences in response to adult support and protection referrals. The Partnership should satisfy itself about the most appropriate use of these stages in the process, including maximising the involvement of service users and carers as appropriate. |
|----------|---|

## Indicator 9 – Leadership and direction

### The Moray Partnership should

- |          |  |
|----------|--|
| <b>6</b> | provide more information on the integration pathway for its stakeholders. This should include the vision, objectives, implementation milestones, progress monitoring arrangements, sustainability and any key strategic elements such as the Three Tier Model, prevention, early intervention, reablement, self-directed support and joint information systems. This will also support its communication plan for the joint commissioning strategy for older people. |
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## Appendix 2 – Quality indicators

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

What is our capacity for improvement?

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## Appendix 3 – Grading scale

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

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



## Appendix 4 – Inspection process flowchart

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



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