PERTH AND KINROSS COUNCIL

Housing and Health Committee – 29 January 2014
Scrutiny Committee - 12 February 2014

First Joint Inspection of Older Peoples Services

Report by Executive Director (Housing and Community Care)

PURPOSE OF REPORT

This report describes the key findings of an inspection of the quality of Health and Social Care services for Older People in Perth and Kinross, carried out by the Care Inspectorate supported by Health Improvement Scotland – in to the quality of Health and Social Care.

1. BACKGROUND / MAIN ISSUES

In late 2012, the Care Inspectorate determined to conduct a series of Joint Health and Social Care Inspections in relation to Older Peoples Services – in order to test the quality of integrated working between Councils' Community Care Services and Older People Services provided by their local Community Health Partnerships. In the knowledge that this would produce learning for both the relevant agencies and for the Care Inspectorate, this Council offered itself as a test site for the proposed inspection methodology. This offer was duly accepted.

The inspection was conducted by a team of four Inspectors drawn from the Care Inspectorate and Health Improvement Scotland by the Senior Inspector, Richard Fowles, of the Inspectorate. The inspection itself comprised various elements, as follows:

- An inspection of the files of some 30 people in receipt of services from both Health and Social Care agencies. (This part of the inspection was conducted as a partnership exercise with readers drawn from both the Inspectorate and from local Health and Social Care teams)
- Feedback from Service Users/Carers
- Consideration of local performance against selected national performance indicators
- Consideration of a substantial body of evidence submitted by both Perth and Kinross Council and the Community Health Partnership in relation to strategy, policies and the development of new practice
- Meetings with a range of staff in the statutory and independent sectors

The Inspectorate were aware that a shadow Health and Social Care Partnership was already in place. A key function of the Inspection was to establish the extent to which this body and the Change Fund Board to support the Reshaping of Care for Older People were making a positive impact. The inspection process took place between late January and early March 2013 and the final report has been received by both the Council and Community Health Partnership – the findings of which are already being acted upon.

Key findings from the inspection

The Inspection team found that, overall the shadow Health and Social Care Partnership's capacity for improvement was good. The key factors which led the Inspectorate to this conclusion were:

- The Partnership's clear vision and sense of direction
- The work that had been undertaken in preparation for Health and Social Care Integration, including the development of an Integrated Resource Framework
- Recent evidence of service development and a strong focus on Community Engagement and Capacity Building
- The strong commitment of the workforce and the positive approach to partnership working between key stakeholders.

The Inspectorate also noted however, that the partnership should take account of:

- The importance of identifying a mechanism which supports the joining up of existing IT Systems
- The need to give further consideration to develop strategic solutions to the particular challenges posed through providing services and supports in rural areas
- The need to determine whether existing performance measurement arrangements are sufficiently robust and systematic to provide accurate feedback on the' lived experiences' of older people and their carers

The Inspectorate's report was wide ranging and covered both existing traditional services and endeavours to develop new services, particularly in rural highland Perthshire. Positive comment was made regarding the emphasis placed upon locality working and the importance of developing real choice for service users. Beyond the specific recommendations noted above, the report raised a number of areas for improvement which we propose to take forward within a comprehensive action plan, including actions to:

1.1 Develop a wider range of accommodation options for older people, in partnership with colleagues from the Council's Housing Service.

1.2 Develop Anticipatory Care Planning across the primary care sector and improve staff access to information held centrally within NHS Tayside to ensure identification of patients most at risk and/or readmission to hospital. In parallel, we will support the Council's Outcome Focussed Planning approach to ensure that assessed needs and personal ambitions continue to inform the shape of services provided.

1.3 Improve the level of engagement and joint working with GPs, using Integrated Resource Framework data and information generated by GPs as part of the Quality Outcomes Framework.

1.4 Review and refresh the provision and sharing of information between agencies to ensure a more systematic, joined up approach to partnership working.

1.5 Review the Carers Strategy to strengthen the voice of carers within the feedback process.

1.6 Extend communications across partnership staff and GPs with regard to the function and availability of new Change Fund Services such as the Rapid Response, Step-up and Immediate Discharge Services and Marie Curie Palliative Care.

1.7 Extend current good practice in relation to protection-risk to include non-protection risks associated with the individual's mental and physical health.

1.8 Focus on the quality of chronologies contained within files to ensure that these provide a relevant list of key events with a direct bearing upon the safety and wellbeing of the individual.

1.9 Enhance the extent of joint communication activity between Health and Social Care Services.

1.10 Extend the use of the Outcome Focussed Approach to include health professionals to ensure that health monitoring relates to the individual's overall health and not simply the interventions of individual disciplines.

1.11 Implement the findings of an 'Administration of Medication pilot' currently underway in the Blairgowrie area.

1.12 Develop a range of training initiatives to support:

- The articulation of SMART outcome focussed plans
- The introduction of Anticipatory Care Plans and improved use of an outcome focussed approach by health staff to support whole heath planning for patients
- The development of a wider training framework across health and social care to support skills development within the statutory, voluntary and private sectors in furtherance of the aims of the Commissioning Strategy

2. PROPOSALS

In response to the above findings, the following actions are now proposed:

2.1 Individual agencies will take appropriate action in relation to recommendations within this report, where action is not already underway to effect improvements.

2.2 The joint Action Plan attached to this paper will be taken forward by relevant Council and Health managers to action areas for improvement noted within the Inspection report.

2.3 The shadow Health and Social Care Board is invited to respond to the specific recommendations of the report in relation to the development of joint training and communication initiatives.

3. CONCLUSION AND RECOMMENDATIONS

This inspection was helpful to both Health and Social Care Management teams and to the Inspectorate in identifying areas for improvement in practice and in inspection techniques. In relation to certain findings concerning Chronologies, the communication of Change Fund activity information to GPs and the development of Anticipatory Care Plans, the relevant agencies had already identified these as areas for improvement. Other recommendations, such as those in relation to the development of joint communication arrangements and the articulation of a wider joint training strategy, are helpful to the emerging Health and Social Care Shadow Board at this stage in its development.

In light of the range of observations within the report, the Housing and Health Committee is asked to approve the following actions:

3.1 A Joint Improvement plan is taken forward by both agencies in conjunction with relevant partners (see Appendix 1).

3.2 The Executive Director for Housing and Community Care is instructed to bring forward a further report on progress towards the Joint Improvement Plan in 12 months time.

3.3 It is recommended that the Scrutiny Committee Scrutinises and comments as appropriate on this report.

Author

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Approved

Name	Designation	Date
John Walker	Executive Director (Housing and Community Care)	6 January 2014

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ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

The undernoted table should be completed for all reports. Where the answer is 'yes', the relevant section(s) should also be completed. Where the answer is 'no', the relevant section(s) should be marked 'not available (n/a)'.

Strategic Implications	**Yes / None**
Community Plan / Single Outcome Agreement	**Yes**
Corporate Plan	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Asset Management (land, property, IST)	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Strategic Environmental Assessment	**No**
Sustainability (community, economic, environmental)	**None**
Legal and Governance	**None**
Risk	**Yes**
Consultation	
Internal	**Yes**
External	**Yes**
Communication	
Communications Plan	**None**

1. Strategic Implications

Community Plan / Single Outcome Agreement

1.1 This paper contributes to the delivery of Perth and Kinross Community Plan / Single Outcome Agreement in terms of the following priorities:

(iv) Supporting people to lead independent, healthy and active lives
(v) Creating a safe and sustainable place for future generations

Corporate Plan

1.2 This paper contributes to the achievement of the Council's Corporate Plan Priorities:

(iv) Supporting people to lead independent, healthy and active lives
(v) Creating a safe and sustainable place for future generations

2. Resource Implications

Financial

2.1 The only aspect of the Action Plan attached to this report with a clear resource implication concerns the improvement in communication systems between Health and Social Care Services. The extent of these implications will be determined as part of the Action Plan. All other actions within the Action Plan will be contained within existing resources.

Workforce

2.2 The key workforce implications arising from this report relate to joint training initiatives around Outcome Focussed Planning, Anticipatory Care Planning and the development of a wider training framework across Health and Social Care staff. The detail of staff training and development required will be explored as representatives from relevant training and development sections in Health and Social Care and with respective Human Resource sections.

Asset Management (land, property, IT)

2.3 There are no immediate land implications arising from this report. As noted earlier, however, there are implications for the capacity of existing IT systems to support the exchange of necessary information between the relevant agencies.

3. Assessments

Equality Impact Assessment

3.1 The proposals contained within this report have been considered under the Equalities Impact Assessment process (EqIA) with the following outcome:

(i) Assessed as **relevant** and the following positive outcomes expected following implementation:

- Older people will enjoy access to a wider range of supports/services
- Agencies delivering such supports will plan their delivery in a co-ordinated manner
- Older people at risk of admission to hospital will be identified and, where possible, have their needs met in a manner which enables them to remain within the community

Strategic Environmental Assessment

3.3 The Environmental Assessment (Scotland) Act 2005 places a duty on the Council to identify and assess the environmental consequences of its proposals.

This section should reflect that the proposals have been considered under the Act and no further action is required as it does not qualify as a PPS as defined by the Act and is therefore exempt.

Sustainability

Legal and Governance

Risk

The key risks noted within this paper relate to the effective sharing of information between Council and Health Services and the systems and protocols to support information sharing. Work is being taken forward locally and within the Tayside Data Sharing Partnership to mitigate these risks.

4. Consultation

Internal

4.1 The following parties have been consulted prior to submission of this report:

- The General Manager of Perth and Kinross Community Health Partnership
- Head of Legal Services
- Head of Human Resources
- Head of Finance

5. Communication

5.1 The existing communication arrangements within the Change Fund for Older People's management structure, together with feedback proposals to relevant groups of staff will be employed to support the improvement plan attached to this paper.

2. BACKGROUND PAPERS

The report from the Pilot Inspection of Older Peoples Services in Perth and Kinross was relied upon in preparing this report.

APPENDIX 1

JOINT IMPROVEMENT PLAN – FOLLOWING INSPECTION OF OLDER PEOPLES SERVICES (JAN-FEB 2013)

1. OUTCOME FOCUSSED APPROACH / ANTICIPATORY CARE PLANNING

ITEM	KEY FINDING	HIGH LEVEL ACTION	RESPONSIBLE OFFICER (S)	TIMELINE
1.1	Develop a common understanding of an Outcome Focussed Approach (OFA)	Develop an integrated education and training and Organisational Development programme for outcome focussed approaches. Ensure that OFA are SMART.	Diane Fraser Jane Dernie Sandra Gourlay Susan Nevill Lesley Sinclair	April 2014
1.2	Promote Anticipatory Care Planning across agencies	Develop and promote the roll out and understanding of Anticipatory Care Planning (ACP)	Ruth Buchan	October 2013 onwards
1.3	Focus on the quality of chronologies contained within files to ensure that these provide a list of key events	Ensure that chronologies are embedded across all community care and health teams with training provided to all staff.	Learning and Development Team / Clinical Improvement Team	April 2014

2. PERFORMANCE / IT SYSTEMS

ITEM	KEY FINDING	HIGH LEVEL ACTION	RESPONSIBLE OFFICER (S)	TIMELINE
2.1	Co-ordinate work to reduce the number of days lost to delayed discharges	Review the whole systems data work	Sandy Strathearn / David McLaren	January 2014
2.2	Improve access to information held within IT systems	Agree to introduce one IT system which is accessible and holds both key health and social care information (including Anticipatory Care Plan)	Bill Nicoll / John Walker	April – May 2014
2.3	Develop a more systematic approach towards the provision of public information	Develop a joint approach to information provision for the general public on access to services.	Lisa Potter / Debbie Kerr	April 2014
2.4	Improve feedback to GPs who make referrals for community Support Services as an alternative to hospital or care home admissions (step up)	Develop information sharing process with GPs on patients who have received services eg • Change in provision • Admission • Discharge	Audrey Ryman / Sandy Strathearn	April 2014
2.5	Develop a more forensic approach towards gathering information from service users/carers	Establish systematic surveys of service users and carers who use Health and Social Care services within localities.	Suzi Burt / Mark Dickson	2014

3. REABLEMENT / HOME CARE

ITEM	KEY FINDING	HIGH LEVEL ACTION	RESPONSIBLE OFFICER (S)	TIMELINE
3.1	Ensure appropriate, effective and speedy entry into and exit from reablement service to avoid bottlenecks	• Improve the quality of referrals to reablement • Ensure the appropriate balance between the level of home care, reablement and rapid response provision	Community Care Service Managers Community Care Service Managers / Sue Muir	October 2013 January 2014 onwards
3.2	Improve access to information held with IT systems	Agree to introduce one IT system which is accessible and holds both key health and social care information (including ACP)	Bill Nicoll / John Walker	April – May 2014
3.3	Develop a more systematic approach towards the provision of public information	Develop a joint approach to information provision for the general public on access to services.	Lisa Potter / Debbie Kerr	April 2014

4. CARERS

ITEM	KEY FINDING	HIGH LEVEL ACTION	RESPONSIBLE OFFICER (S)	TIMELINE
4.1	Ensure that all carers for older people are offered an assessment	• Develop a self evaluation process to ensure that carers for older people are offered an assessment • Build in feedback from key agencies on instances where carers are not offered an assessment • Increase the focus on carers health checks • Review the Carers Strategy	Paul Henderson / Evelyn Devine	June 2014

5. INTEGRATION

ITEM	KEY FINDING	HIGH LEVEL ACTION	RESPONSIBLE OFFICER (S)	TIMELINE
5.1	Improve outcomes for older people and their carers by developing a clear vision and commitment to health and social integration	Develop integration at locality level through strong middle management leadership in both agencies	Bill Nicoll / John Walker	April 2014
5.2	Improve the standard and level of joint communication with health and social care staff	Identify and develop appropriate communication tools and media	Heads of Community Care and Older Peoples Service CHP	March 2014
5.3	Develop the Joint Commissioning Strategy to provide longer term direction and workforce planning	Provide further detail within draft strategy to ensure clear direction and develop long term workforce plan in urban and rural areas	Evelyn Devine / John Gilruth	January 2014
5.4	Ensure the establishment of appropriate, effective and efficient arrangements for the administration of medication to older people requiring assistance	Evaluate the Blairgowrie pilot and identify key issues to improve practice. Develop an action plan for roll out across the area.	Andrew Radley / Kenny Ogilvy	June 2014

Services for older people in Perth and Kinross

Report of a pilot joint inspection

1. Introduction

The Care Inspectorate and Healthcare Improvement Scotland are undertaking pilot joint inspections of health and care services for adults. The initial focus of these pilot inspections is on services for older people, and in particular how health and care services are working together to enable older people to remain living at home. This is what the vast majority of older people consistently say they want to do.

The inspection teams are made up of inspectors from the Care Inspectorate and from Healthcare Improvement Scotland.

This report contains the findings of the inspection in Perth and Kinross which took place in February 2013. As this was a pilot inspection, this means that future inspections may be carried out differently and that the reports of future inspections may be published in a different format.

2. Methodology

A draft framework of performance indicators was developed and provided the basis for the inspection. The framework is designed both to assist health and social care Partnerships in evaluating their own performance and to provide an inspection model. The framework is attached at Appendix 1. It includes six key questions and ten areas for evaluation. The six questions are:

- What key outcomes have we achieved?
- What impact have we had on people who use our services and other stakeholders?
- How good is our delivery of key processes?
- How good is our management?
- How good is our leadership?
- What is our capacity for improvement?

In undertaking the inspection, we undertook the following scrutiny activity:

- Analysis of key nationally reported performance data.
- Analysis of some 200 documents provided by Perth and Kinross Council and Perth and Kinross Community Health Partnership (CHP).
- Analysis of the findings from the Care Inspectorate's inspections of care at home services during the previous twelve months.
- Scrutiny of the case records of thirty older people who were in receipt of both health and social care services. The files were read by a small group of inspectors from the Care Inspectorate and Healthcare Improvement Scotland and local staff from Perth and Kinross CHP
- Follow-up meetings with the older people, their families and the staff involved from six of the thirty case records we had read.
- Twenty three scrutiny sessions with a range of stakeholders.

In this pilot inspection we concentrated on some of the areas of evaluation more than others (which are the focus of other pilot inspections) and this is reflected in this report. Of the ten areas of evaluation, we focused on:

1. key performance outcomes
2. getting help at the right time
3. impact on staff
4. impact on the community
5. management and support of staff
6. capacity for improvement.

Although this report covers the Perth and Kinross area, much of the scrutiny we undertook was focused on the Highland Perthshire and Strathmore areas. These are two very rural areas where the NHS and the Council had taken a number of initiatives to take forward and test out their approach to health and social care integration.

3. Local context

Demography

Perth and Kinross has a population of some 146,000 people of whom almost a third live in the city of Perth. It is a predominantly rural area and covers 5286 square kilometres.

In Perth and Kinross, 59.7% of the population are of working age. This compares with a Scotland figure of 62.4%. Of the population of Perth and Kinross, 23.6% are over 65 which compares to 20.2% for Scotland as a whole.

Perth and Kinross' population of those of pensionable age is due to increase by 7% by 2020 and by 24% by 2030. More specifically, its 75+ population is due to increase by 29% by 2020 and by 72% by 2030. These are greater increases than the equivalent Scotland figures which are 23% and 62.0% respectively.

Heath and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Bill has been introduced to Parliament and provides the framework for the integration of health and social care in Scotland. In Perth and Kinross. The key providers of community health and social care services for older people are Perth and Kinross Community Health Partnership (CHP)[1] and Perth and Kinross Council's Housing and Community Care Service. They work together to provide and commission community-based support, residential and hospital care for older people. In this report, when we are talking about their joint approach, we refer to them as the Partnership.

[1] Perth and Kinross CHP is part of NHS Tayside.

The Partnership has been working in conjunction with Scottish Care and Perth and Kinross Association of Voluntary Services (PKAVS) in order to reshape care for older people. They have an agreed shared vision “to promote the independence and wellbeing of older people at home or in a homely setting”. The work being undertaken by the Partnership and described in this report was in line with this vision. It was also consistent with and reflected key national policy initiatives relating to older people and the broader national social and financial context. For example:

- Reshaping Care For Older People
- The Christie Commission and the Scottish Government’s Community Engagement Strategy
- The proposals for health and social care integration which include an emphasis on making the most of staff’s knowledge, skills and experience in local service development.
- The challenging financial position faced by public sector organisations and best value requirements.

In order to take forward health and social care integration, NHS Tayside and Perth and Kinross Council established a Transitions Board comprising senior elected members and officers from both organisations. From 1 April 2013 this developed into a Shadow Heath and Social Care Transition Board to allow the development of effective governance arrangements for adult health and social care integration.

4. Inspection findings

Particular strengths that are making a difference for older people and their carers

- A growing focus on achieving positive individual outcomes for older people
- The high motivation and strong commitment of staff to improving the lives of older people
- The development of a strategic approach to community involvement and community capacity building
- A clear and shared vision and positive leadership from senior managers at all levels.

Examples of good practice

- The Integrated Resource Framework, as part of which the Partnership had produced and was analysing valuable data to help plan and shape service provision.
- The Strathmore Dementia Project which was a national dementia strategy demonstrator site and which was providing a range of community based supports to people with dementia and their carers.
- The Healthy Communities Collaborative which had provided a wide range of community based initiatives which had helped improve older peoples' sense of their health and well-being.
- Action Learning Sets which had allowed front line health and social work staff to come together to understand each other's roles and responsibilities and to jointly identify service improvements.

4.1 Key performance outcomes.

The findings on the outcomes achieved for the older people in our file reading exercise were very positive and an outcomes approach was being embedded, especially amongst social work staff. The Reablement service was making an important contribution to this. The Partnership was performing well in managing delayed discharges from hospital, although it faced some challenges in trying to maintain reduced levels of emergency admissions. The Partnership had invested considerable effort into the Integrated Resource Framework (IRF)[2] . This was providing a range of information which should constructively help shape future service provision.

As part of the inspection we read the case files of 30 older people. Given the sample size, the findings should be regarded as indicative, rather than as a "statistically significant" representation of practice to be found across Perth and Kinross. However this said, many of the findings about outcomes for the older people whose files we read were positive in that:

- In 93% of files there was evidence that positive outcomes were being delivered and in 74% of files the improvements in the individual's circumstances was completely or mostly attributable to effective Partnership working.
- Only a small proportion of files (20%) contained evidence of poor personal outcomes. Of these twenty percent of files, the lack of improvement in the individual's circumstances was partially attributable to ineffective Partnership working in only 19% of the files and completely or mostly attributable to this in none of them.

[2] IRF - by mapping cost and activity data, IRF aimed to inform partners of the current distribution of their resources to enable them to make better informed and equitable resource investment decisions.

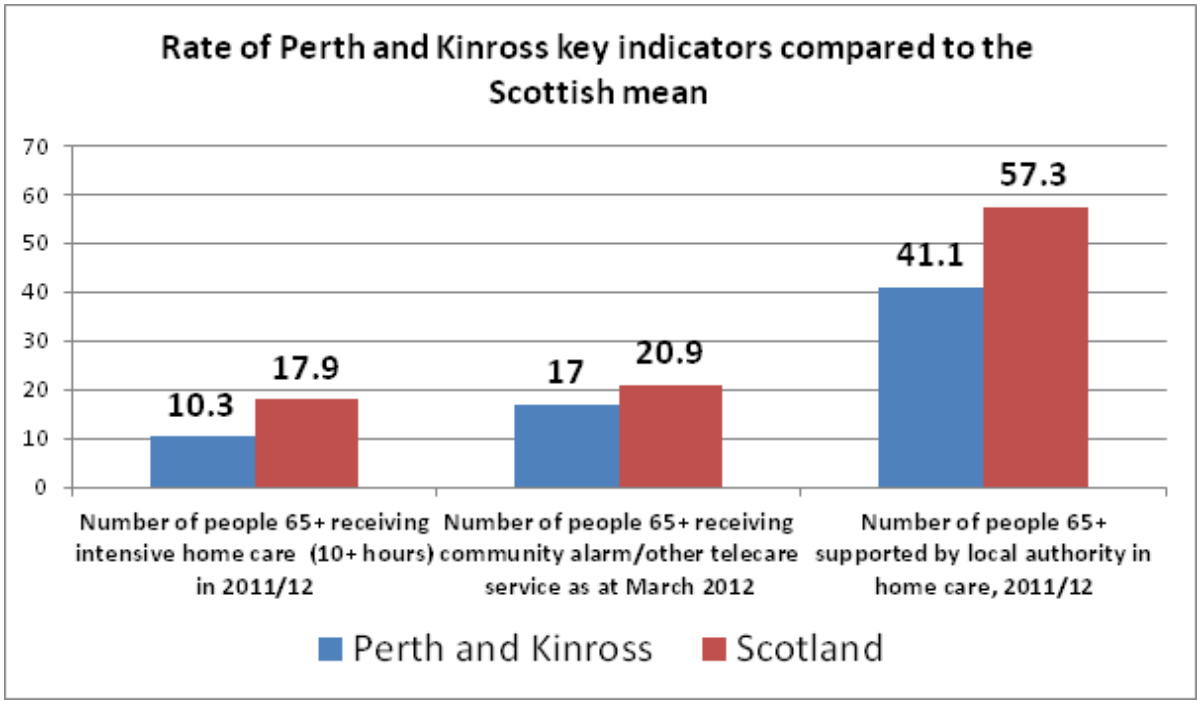
Evidence of positive outcomes was most evident around “feeling safe” and “staying as well as you can”. It was less evident for “living where you want/ as you want”. Staff and senior managers said that more needed to be done to develop a range of accommodation options for older people, for example extra care housing.

Housing and Community Care had introduced outcome focused assessments based on the Talking Point[3] personal outcomes framework, such as feeling safe, having things to do and seeing people. We saw these assessments in most of the social work files we read. Although we concluded that some of the assessments could have been more detailed, it was positive that staff were trying to consider the needs and aspirations of older people in terms of individual personal outcomes. We say more about this in section 4.5 (delivery of key processes). There was less outcome information in the health files which we read and this tended not to relate to overall health outcomes, but to the intended outcomes of the intervention by individual health disciplines, such as District Nursing and Physiotherapy. Health staff in the CHP had introduced the concept of “health passports” which stayed with patients at all times.

Social work staff and managers we met said they had made progress in developing an outcomes approach in the previous two years, and in general they demonstrated a good understanding of an outcomes approach. They said the training they had received on outcome focused assessment had been influential in this. Heath staff seemed less familiar with a focus on broader personal outcomes, rather than narrower health inputs and outcomes. Some health staff had undertaken the outcomes focused assessment training and said this had been helpful in informing their practice.

We reviewed nationally published outcomes and proxy outcomes data. Some work is currently underway nationally to develop new performance indicators. For example, the NHS Information Services Division (ISD) is currently developing new indicators to better capture the impact of preventative care and reablement. In the interim, the Care Inspectorate has agreed a core data set with ADSW (Association of Directors of Social Work) which includes services for older people and which will be used consistently as part of joint adult services inspections. Examination of the relevant data for Perth and Kinross suggested a predominantly positive picture in terms of performance. Historically, performance in some areas (for example, shifting the balance of care indicators) had been below the national average, although importantly the gap had been narrowing. The most recent data showed:

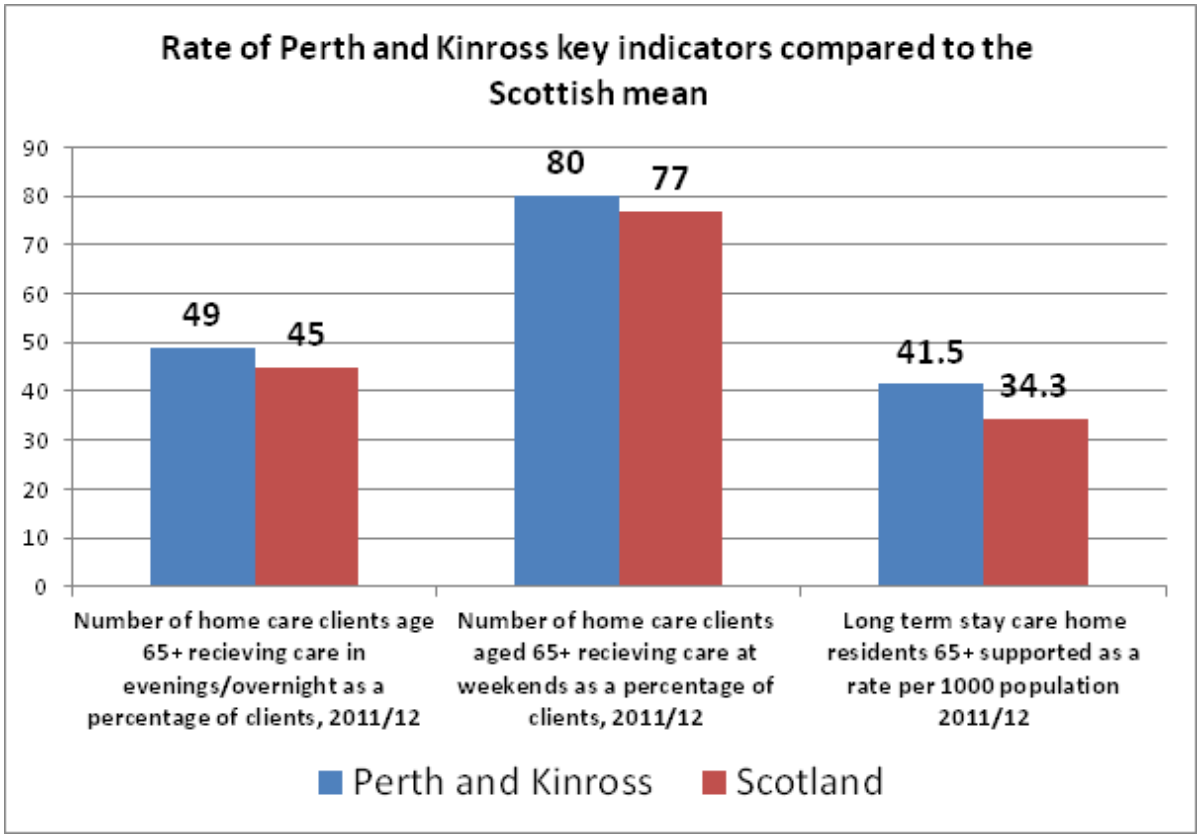
[3] Talking Points: An outcomes approach to assessment, planning & review which aims to shift engagement with people who use services away from service-led approaches.



Senior Managers acknowledged that historically the level of home care provided to older people in Perth and Kinross had been below the national average. However, this was not a cause of concern to them given their emphasis on promoting independence and self care via reablement. Their data showed that 35-40 percent of older people receiving a reablement service did not require a home care service on an ongoing basis after the reablement period. We noted that there had been a reduction in the number of older people receiving a home care service since 2009/10 and that this coincided with the establishment of the reablement service.

Perth and Kinross' performance in terms of the provision of home care at evenings/overnights and also at weekends for older people was above the national average and had been for a number of years.

There has been a steady reduction over previous years in the number of long term care home residents aged 65 + supported by Perth and Kinross. This had gone from well above the national average in 2002/03 to 27.5 per 1,000 population in 2011/12 compared to the Scotland figure of 36.4 per 1,000 population.



Ensuring that older people are not delayed in hospital once they are medically fit for discharge is an important outcome objective for older people. It is also a key target of the Scottish Government and at the time of our inspection this target was set at six weeks.[4] The most recent quarterly census in January 2013 showed that no older people had been waiting for more than four weeks to be discharged from hospital to an appropriate setting. ISD[5] data showed that during 2012 no older people had fallen into this category and that historically the numbers of delayed discharges in Perth and Kinross had been relatively low, reflecting good performance by the Partnership in this area. This data also showed that the rate per 1,000 of beds days associated to emergency hospital admissions had been consistently below the Scotland figure. In 2011/12, this rate for older people aged over 75 years had dropped significantly.

Improving discharge from hospital planning and reducing the numbers of bed days lost through delayed discharges are key elements of the Perth and Kinross Partnership's approach to reshaping care for older people. Discharge planning is one of the five Change Fund workstreams. Information provided by the Partnership showed a fluctuating picture in terms of the number of bed days lost due to delayed

[4] The delayed discharge target was reduced from six to four weeks with effect from April 2013. The April 2013 census showed that no older people in Perth and Kinross had remained in hospital for more than four weeks after they were clinically ready for discharge.

[5] ISD – The Information Services Division of NHS Scotland

discharge. The Partnership told us that initially as part of the Change Fund they had been able to achieve a significant reduction and that the number of lost bed days in the first quarter of 2012/13 was 64% less than the first quarter of 2011/12. The Partnership had developed a number of pathways to supports its approach. These included a prevention of unplanned admission pathway and a discharge pathway.

Despite these potentially positive developments, the Partnership had then struggled to maintain this progress in the period from the summer of 2012 until the time of our inspection. The number of lost bed days had increased as local authority resources were under pressure in coping with the demand to provide support for older people in the community and returning to the community. The January 2013 census showed that that number of bed days lost in the last quarter of 2012 had remained fairly static with 1017 days lost in October 2012, 1144 lost in November and 1030 lost in December.

During the fieldwork phase of the inspection, we saw that there was considerable pressure in terms of the availability of beds at Perth Royal Infirmary. Staff and managers we met said that the causes of this were more complex than the normal "winter pressures" and they identified the following possible reasons:

- An increase in the complexity of the needs of the older people admitted to hospital, some of who already had intensive support packages in the community
- A consequential increase in the length of stay in hospital from an average of 6 days to 8 days
- Some difficulties in the availability of care at home support to allow hospital discharge to take place without any delay. This service was having to respond to the increased flow of older people through the general hospital at this time.

One consequence of this was that a number of patients had to be "boarded" [6] within the hospital which meant being transferred to another ward pending discharge. We say more about this and the action being taken by the Partnership to further reduce unplanned admissions and delayed discharges in the next section.

We saw two examples of how the partners were working well together and were seeking to share information and knowledge to improve outcomes and services for older people. In Pitlochry, we attended the Integrated Care Meeting which brought together key health and social care professionals in the area. They had jointly identified and agreed a list of those older people living locally who were deemed most at risk of being admitted to hospital or to a care home. They reviewed the care plans of these older people to see if any additional action could be taken to support

[6] "Boarding" is when patients are moved from one ward to another to meet the needs of the service not because of the patient's clinical needs. For example, medical patients being boarded outwith the appropriate specialty to surgical wards – Healthcare Improvement Scotland

them to remain living at home. On the day we attended, there were a number of older people discussed where additional action and support was identified and agreed. This included:

- Taking action to ensure that a woman with dementia who had missed a number of medical clinic appointments was able to attend them in future.
- The decision to pursue SDS (self-directed support) to enable an isolated older person to employ a live-in carer.

The ambulance service was in attendance and they were able to provide useful intelligence about older people the service had been called out to attend on a repeated basis. Information was also being passed to the ambulance service of those older people with an agreed plan for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in order to ensure that ambulance paramedics would not attempt CPR if attending an older person with a DNACPR plan. The Integrated Care Meeting provided a useful joint locality forum for health and social care professionals where they could monitor and review the circumstances of some of the most vulnerable older people. The Partnership planned to extent this approach across Perth and Kinross. Staff did however identify the need for improvement in being able to access information held centrally in NHS Tayside on patients identified as being at risk of admission and of patients experiencing re-admission. Whilst acknowledging this, senior managers confirmed that staff had access to SPARRA data and that the Partnership had piloted the Peony II tool in Highland Perthshire as part of the virtual ward model.[7]

We saw that the Partnership had engaged actively with the Integrated Resource Framework (IRF)[8] and had been able to map the consumption of resources for all community care expenditure across the whole of Perth and Kinross. The information provided allowed the Partnership to explore practice and variability in practice. Interestingly it had demonstrated that there was not an increase in unplanned admissions to hospitals at weekends and out of hours. Prior to seeing the actual data, they had thought the opposite was the case.

General Practitioners (GPs) play a key role in the care and support of older people. The Partnership was keen to engage GPs in a constructive dialogue and was in the process of having discussions with individual GP practices around the IRF data. We met with GP representatives who said that the IRF data was “fascinating” and they welcomed the Partnership’s positive approach to their engagement with GPs on this.

[7] SPARRA – Scottish Patients at Risk of Re-Admission and Admission. A means of identifying those people at greatest risk of emergency admission to hospital over the next year.
Peony II. A tool using both individual patient and practice team data to identify those in risk of emergency admission to hospital

However, they cautioned that the Partnership needed to take account of the significant variances in the levels of funding available to GP practises. They also hoped that work could be done to bring together the IRF data and the information generated by GPs as part of the Quality Outcomes Framework (QOF)

4.2 Getting help at the right time.

The file reading results were positive about how older people were engaged in discussions and decisions about the supports they received. We saw some good examples of how the Partnership sought the views of older people, but the provision of public information would benefit from a more systematic approach. Self Directed Support and Anticipatory Care Planning were still in their initial stages, but the Partnership had plans for their development. The Community Hospitals were a well regarded resource and the Strathmore Dementia Project was enabling a community based approach to be developed for supporting people with dementia. The Partnership was reviewing how it could best ensure the provision of medication to older people who needed support with this. Carers we met expressed mixed views about services and the Partnership recognised it needed to review its carers' strategy.

In the file reading we looked at the extent to which the services took account of the views of the older people they were working with to deliver their care and support. The results were positive in that there was evidence of this in 100% of the files at the assessment stage and in 84% of the files at the care planning stage. In most instances where there were barriers to communication there was evidence of staff taking action to address these. However, in a few of the files we saw room for improvement in this regard.

We saw a number of surveys seeking the views of older people and reports of consultation events. These were primarily of individual services seeking feedback, for example, Blairgowrie Community Hospital or local community consultations (e.g. survey of local transport needs in Loch Tay and Glen Lyon). We saw less evidence of systematic surveys seeking feedback from older people who used health and social services. However, staff in the reablement service said they routinely sent out questionnaires to service users. Health Managers said that they focused more on patient feedback and employing real time information in the form of patient stories to inform change and the development of services. We also noted that as part of the Change Fund, an overarching survey about growing old in Perth and Kinross was under consideration.

When we met with some of the older people (whose files we had read) and their families we heard mixed views about their experiences in terms of accessing information about what supports and services might be available for them. Some, but not all of them were aware of how and who to contact for information or to access services, for example the Access Team.

We saw a number of good examples of work which had been undertaken to provide public information. This included information on self-directed support and an agreed role for Heartland Radio at times of severe weather conditions. We read the Older People's strategy and the Community Capacity Building Action Plan and noted that these had both identified the need for the improved availability of information, and especially local information.

The Council was in the process of introducing self-directed support (SDS). It recognised the need for the development of local and micro providers to extend the provision and choice in local areas for service users. The Council was initially focusing its efforts to support capacity building in the Pitlochry area. It planned to review its approach to SDS once 100 people were in receipt of it. At the time of our fieldwork in February 2013 there were seventy people in receipt of SDS and senior managers said take-up had started to increase significantly (the figure had increased to 70 from 28 in the previous month).

A number of staff we met had received training on SDS and they were generally supportive of this approach. Some cautioned that its success was closely linked to the extent that new alternative forms of supports and service were developed. We refer later in the report to the work which was being done by the Partnership to develop these. At a focus group, staff told us that an elderly couple who lived together (and whose file we had read) were now in receipt of SDS which was used for the provision of overnight care. This support had provided a positive outcome in that his choice was to remain at home rather than be admitted to a care home as had originally proposed while he was in hospital.

In our file reading we saw little evidence of anticipatory care planning, although in one of the cases we followed-up, a daughter described how staff had involved her and her elderly mother in discussions on end of life arrangements. Throughout the inspection we heard from staff and managers that anticipatory care planning by the NHS in Perth and Kinross was still in its early stages. At focus groups some health staff said they had some anxieties about discussing their longer term needs and wishes with older people. They were concerned about raising expectations which might not subsequently be able to be met due to resource limitations. Staff in the delayed discharge team said they were hindered by the limited information available to them about anticipatory care plans (ACPs).

This form of care planning was further developed in some specialist service areas. Marie Curie staff said they worked closely with NHS colleagues and that they had recently begun the process of ensuring all of their service users had an ACP.

Managers said that the initial lack of an electronic system for ACPs had been a challenge, but one had recently been attached to the NHS MIDAS system which had supported the roll out of ACPs for 600 care home residents as part of the Change Fund Programme. The GPs we met said that given their contractual arrangements,

they expected to see an increase in the number of ACPs in 2013/14. A Blairgowrie practice for example was expected to complete 60 ACPs in 2013 and 120 in 2014.

Our discussions with staff suggested that the Partnership needed to do more to ensure that the purpose and benefits of anticipatory care planning were more widely understood. It also needed to give further consideration to how the important information contained within individual ACPs is shared or accessible to relevant staff working across health and social care.

A number of service developments had taken place designed to improve outcomes for older people. A reablement service had been introduced on a pilot basis in 2010 and then rolled out in 2011. It was seen as having an important first stage role in providing assessment and support to ensure people were enabled to become as independent as possible. The former Social Work Inspection Agency had undertaken telephone survey in 2010 of reablement service users who spoke very positively about their experience. A performance report for 2011/12 showed that a reduction of an average two hours per week from seven to five in the number of home care hours provided before and after involvement with the reablement service.

Most of what we heard about the reablement service during the inspection from service users, carers and staff was very positive and Hospital OTs said that the action taken to allow them direct access to the service had helped facilitate hospital discharge. However, there were some pressures on the service which was designed to be provided for up to six weeks. If there was a continuing need for care at home at this stage, this should then be provided either by the Council's own "mainstream" homecare service or by an independent sector provider.

We heard from a range of staff that staffing issues in these services meant that they were not always in a position to pick up the older person's care at the six week stage and this had to be delayed. This could impact on the reablement service's own capacity to take on new service users. Reablement service staff said their default position had normally been to assume people were suitable to receive a reablement service unless there were clear reasons why they would not be (e.g. lack of capacity). Despite this we saw that a lot of staff time and effort was committed to screening meetings. We attended one of these meetings which are held on a twice daily basis. A number of the referrals were being sent back to the referrer as they lacked sufficient information. This resulted in duplication of effort and could delay the speed with which the reablement service was put in place. Partly in order to address this, the ACCESS Team which oversaw the reablement service was about to start piloting the receiving of referrals and completion of assessments over the telephone. We concluded that the Partnership needed to maintain a focus on ensuring appropriate, effective and speedy entry into and exit from the reablement service for older people in order to avoid bottlenecks in the service.

The reablement service had been established in advance of the Change Fund. This had contributed significantly to a number of other service developments, including an Immediate Discharge Service, a Rapid Response Service and the use of care home beds to provide step-down or step up care. The first was to support hospital discharge and the latter two were to provide alternatives to hospital or permanent care home admission at times of crisis. Information provided showed that between April – August 2012, 152 patients had received support from the immediate discharge service of whom only eight had required to be re-admitted to hospital. The use of care home beds as a step-down arrangement from hospital was allowing continued rehabilitation to be provided for older people who might previously have been admitted to a care home on a permanent basis direct from hospital. At the time of the inspection 37% of those older people who had accessed step-down care had then been able to return home.

These services and approaches were largely managed on a centralised basis and based in Perth. Most of the comments we heard about the services were positive. However, some health staff talked about difficulties in being able to get access the Rapid Response Service, as the service was already fully committed. A number of health staff we met were also unaware of the Immediate Discharge Service. GPs said whilst they recognised the benefits of these community support services, it was in some respects easier and quicker for them to access a hospital bed than these services. They said that if they made a referral, they would not receive feedback confirming that the required community support services had been put in place. As a consequence, they were uncertain if services would always be put in place as required. In order to provide easier referral arrangements for community health practitioners, a direct telephone line to the ACCESS Team had been established. As a means of further improvement, we concluded that Housing and Community Care should consider whether it would be possible for feedback to be provided to GPs when they make referrals for community support services as alternative to a hospital or care home admission, on the outcome of the referral.

Based on its experience to date in trying to prevent unplanned hospital admissions and to support effective hospital discharge, the Partnership was taking action at the time of the inspection to:

- Review the prevention of admission and hospital discharge planning pathways.
- Develop a hospital at home model which would be supported by an increase in the level of input available from community consultant geriatricians.
- Focus more on flexible step up care, rather than step-down provision.

In addition the council was exploring the possibility of committing additional financial resources to help alleviate the pressures associated with hospital admissions and effective discharge arrangements. The council had taken similar action on previous

occasions, in the form of additional expenditure on both home care and on the purchase of care home beds. During 2012/13, for example, it had committed an additional £244,000 to supplement home care provision specifically to support the discharge of older people from hospital.

The health and social care staff and managers we met during the inspection said that the community hospitals were a good resource which provided good local care for older people. GPs also said they played an important role and that they considered admission to or involvement with a community hospital as an alternative to admission to Perth Royal Infirmary. They were aware of the plan to increase community geriatrician capacity and considered this could be equally as helpful to the community hospitals as to the staff supporting older people at home. The older people we met who had experience of a community hospital and their families all appreciated being able to be treated in their local community, rather than a city hospital.

Dementia

One of the Partnership's key objectives was to improve the quality of care and treatment for people living with dementia and their families. We saw in the documentation provided that a number of initiatives had been taken in support of this objective. These included:

- The completion of a dementia pathway. A report for the Change Fund Board showed that the Partnership had exceeded the HEAT[9] target in 2011/12 for the number of people placed on the dementia register.
- The recruitment of three Alzheimer's Scotland dementia link workers. Their involvement was primarily aimed to be with older people in the earlier stages of dementia in a local area co-ordination role. To assist them in this role they had access to the SWIFT system. A review of the role of the link workers was in progress, including consideration of them having more involvement in post diagnostic support and locality focussed work.
- A pilot project using a GPS device to support and promote safe walking by older people with dementia. Whilst there were some issues with the pilot in terms of signal strength, the findings were largely positive. This included a reduction in carer anxiety.

The Partnership had established a national demonstrator project – the Strathmore dementia project in Blairgowrie. The project was developed to reflect the principles of the national dementia strategy and in particular to demonstrate the benefits of a local strategic support to the provision of community based support. To do this, resources

[9] HEAT: HEAT targets and standards which contribute towards delivery of the Scottish Government's Purpose and National Outcomes; and NHS Scotland's Quality Ambitions. The targets cover, Health Improvement, Efficiency, Access to Services and Treatment.

were shifted from a hospital based dementia assessment unit which had a relatively low demand to the community and attached to the local community health team.

The project aimed to develop better and more integrated services for people with dementia living at home, in care homes or who were in hospital. It had four main components, building based support within a sheltered housing complex; a dementia information café; outreach and carer support and community group support sessions. The project was subject to evaluation which included feedback from people who used the services and from carers. We saw that this feedback was positive. We met with a number of service users and carers as part of the file reading follow-up and our fieldwork. They all spoke very positively about the support and services provided. In terms of improvement a number said they would like the opening hours of the dementia café to be extended. Staff told us that there had been only one admission to Murray Royal Hospital in the previous eighteen months from the area covered by the Strathmore service and this was a significant reduction on previous admission levels.

The Murray Royal hospital was subject to a focused visit by the Mental Welfare Commission at the time of our inspection. The visit was to the three old age psychiatry wards which are part of a new build hospital facility at Murray Royal. Whilst the Mental Welfare Commission did identify some areas for improvement, the findings of the visit were largely positive. This included the environment in the wards, the standard of physical health care and the provision of activities.

Medication management

During our fieldwork, it became clear that there were was some staff uncertainty and anxiety about medication management and the role which social care staff could and should play in this. In part, this appeared to be prompted by a local pharmacy chain moving their supply of medicines from multi-compartmental compliance aids to original packs. Social care staff were unclear about what implications this might have for their roles.

This issue was being addressed by the Medication Administration Steering Group which had been established by the Partnership during 2012. This group was looking more broadly at medication management. In 2011, a pilot was conducted involving some of the council's own homecare staff. To support the pilot and in response to a number of incidents where staff were assisting service users with medication, the Partnership had issued "Guidelines for Social Care Officers Assisting Older Service Users with Medication" in April 2011. However, the pilot did not continue beyond the pilot stage. Senior managers told us this was due to a number of practical difficulties, including the securing of appropriate MARS sheets to support the administration of medication.

The Partnership was now planning to embark upon a Test of Change exercise in the Blairgowrie. This would be on a larger scale. As part of this, health staff would review

the medication of older people to ensure that they were receiving appropriate medication. Social care staff would be trained to administer medicines where this was needed. The pilot would also explore:

- the potential of direct administration to reduce the amount of prescribed administration; and
- the extra costs (to the council) of its staff administering medication given the additional staff time involved in this.

We considered that the establishment of the Steering Group provided a useful joint opportunity to take forward what can be a complex issue. Given the uncertainty expressed by both health and social work staff about the implications of the recent changes in how medication was supplied, we concluded that the Partnership needed to ensure that staff were kept informed of the pilot and its progress. We also concluded that the Partnership should determine from the outcome of the Test of Change exercise the most appropriate arrangements for the administration of medication to older people who need support with this.

Carers

The evidence about carer support from our file reading was mixed. In 80% of the files we read and where there was a carer, there was evidence that support had been provided to support the carer to continue in that role. However, it was not clear from some files whether carers had been offered a carers' assessment and/or advised about carer support and advocacy services. Not all the carers we met in the file reading follow-up said they had been offered a carers' assessment. A lot of the documents and evaluation reports referred to how the various initiatives taken by the Partnership had helped to provide increased support to carers and to reduce carer stress. For example, part of the role of the Alzheimer's Scotland link workers was to provide pre and post diagnosis to carers and one of the link workers was involved in running support groups as part of the Strathmore dementia service.

A number of the documents included quotes from carers and whilst these were generally positive, sometimes the positive conclusions drawn by services from the quotes were in our view, somewhat over-stated. We only met or spoke on the telephone to a small number of carers during the inspection. Their experiences impressed as being more mixed than those referred to in the documentation. Positive comments centred on responsive and caring staff. Critical comments were mainly in relation to lack of communication and problems with care at home staff not arriving as scheduled. The latter point also featured in the findings of inspections of regulated care at home services (both services provided by the independent sector and by the council). We analysed these as part of preparation for this inspection.

Senior managers said that the carers' strategy needed to be reviewed and updated as this was now eight years old. They planned to develop the Carer's Centre into a Multi- Agency Carer's Hub in Perth City which would have a broader role and a business case to allow this had been developed. The Partnership recognised the

need for Hub to be linked to the provision of more support to carers in rural areas, including as part of an increased focus on health checks for carers.

4.3 Impact on staff

The staff we met demonstrated a strong commitment to their jobs and there were good local joint working relationships. The lack of joined up IT systems was a widespread source of frustration. Most staff we met in the localities said that they felt empowered to develop and improve local services and a number identified their involvement in Action Learning Sets as having played a part in this.

During the inspection we met with a significant number of health and social care staff, some 150 in total. Most were based in the Highland Perthshire and Strathmore areas. A smaller proportion were based in Perth City and provided services across Perth and Kinross. We were impressed with the motivation and commitment of the staff we met. They wanted to be able to provide high quality services and it was evident that staff working at the front line level had strong joint working relationships. This was particularly evident where staff were co-located or working in close proximity with each other. Generally they considered that their organisations, at the senior level, had a clear vision and commitment to health and social care integration and broader Partnership working as a vehicle for improving outcomes for older people and their carers. At focus groups, some NHS staff said this vision and the commitment to it at operational middle management level sometimes seemed less strong.

The morale of staff we met was good and although they said they were busy, concerns about workload were not raised at focus groups. This said, it was evident that those staff trying to manage the demand on beds at Perth Royal Infirmary were under considerable pressure at the time of the inspection. In addition, the lack of joining up between the NHS and Council's IT systems was a widespread source of frustration and was described as the biggest impediment to effective joint working.

We read the documentation submitted by the Partnership on communication with staff. This included the use of electronic messages being "cascaded" down the organisational structure to staff. At focus groups, health staff said that this tended to be the primary form of communication with them. Social work staff said there was a more varied approach to staff communication, including team meetings and newsletters. They were positive about this mixed approach. We saw little joint communication and considered that the Partnership should develop this as part of health and social care integration.

We saw a 2012 employee feedback survey from twenty social work staff in the Highland Perthshire and Strathmore areas. The responses about levels of motivation and job satisfaction provided a very positive picture and were also reflected at our

focus groups which were largely comprised from staff in these areas. We had limited opportunities to meet staff from other areas. Those staff we met based in Perth City impressed as equally well motivated.

We read some documentation which covered Perth and Kinross Partnership area. These included the 2012 Employee Survey for Housing and Community Care and the 2012 NHS Tayside audit of clinical supervision for Allied Health Professionals.[10] The former found that:

- 81% of respondents were positive about the commitment of themselves and their team to their jobs and were clear (84%) what was expected of them at work.
- 75% of respondents said they were giving the freedom to solve problems. This was a positive finding given that empowering staff was seen as being important in achieving better outcomes for older people.
- 68% of respondents were positive about having the right tools to help them to do their work, although fewer (45%) were positive about receiving recognition on their work performance.

The NHS audit found that:

- 92% of respondents took part in clinical supervision and 75% of these were either very satisfied or satisfied with its quality.
- 49% of respondents had never accessed any training about clinical supervision.

Housing and Community Care senior managers said arrangements were in place for staff to receive regular supervision and for employee development. Nearly all the social care staff we met confirmed this was the case. The NHS was in the process of rolling out Team Vitality Tools which aimed to promote a positive working culture, team engagement and empowerment. Only a few health staff we met had so far used these tools and awareness of them amongst health staff seemed limited.

Senior managers told us that they saw empowering front line staff and encouraging local joint working as being essential if better outcomes for older people were to be achieved. A number of both health and social work staff we met at focus groups said that they did feel "empowered" and that there was a culture which encouraged them to work together to improve and develop services. This was particularly evident amongst staff who had been involved in the Action Learning Sets[11]. They described three key benefits arising from their involvement:

[10] These two documents both cover a wider staff group than staff working with older people in Perth and Kinross

[11] Action Learning Sets – A small group of people who meet regularly to support one another in their learning in order to take purposeful action on work issues.

1. By spending a concentrated period of time with their health or social work colleagues they were able to develop a much better understanding of each other's roles and responsibilities and the organisational context within which they worked. It had also resulted in improved communication between them.
2. By working together as a group to try and resolve problems which impacted on the quality of service which they could provide in their locality or service area. The introduction of direct access to reablement by OTs had been an example of this as was the introduction of some telephone assessments by the ACCESS team.
3. The opportunity to have direct contact with senior managers and a sense of being entrusted by them to develop new approaches and solutions.

Health staff working in the community hospitals said they had a good degree of autonomy and that in the absence of doctors on site they were entrusted to make some important decisions, for example that an older person was well enough to return home.

4.4 Impact on the Community

The Partnership demonstrated a strong commitment to engaging with the community and to community capacity building. Its approach built on the work which had already been done as part of the Healthy Communities Collaborative. It was developing a framework of locality based working and supporting structure to facilitate this approach.

The Partnership said it was committed to the development of models of integrated service delivery and community planning at locality level, informed by effective community engagement and involvement. Co-production/ Community Consultation and Engagement was one of the five workstreams being taken forward by the Partnership under the change Fund and in 2012/13 this workstream was allocated 10.7% of the total monies available via the Change Fund. We read the Communications and Engagement Plan 2012 which included a detailed activity plan for working with communities across all five Change Fund workstreams.

We were provided with a considerable amount of evidence which reflected a lot of commitment to and activity by the Partnership in taking forward this approach. Staff and managers we met acknowledged that part of the impetus behind the approach was recognition that statutory services alone would not have sufficient resources or capacity to meet the needs of the growing elderly population. However, there was also a positive sense of enthusiasm about services seeking to re-engage closely with and work in Partnership with local communities and some of the benefits which could accrue from this for older people.

Housing and Community Care was in the process of re-structuring and moving to a structure built around five localities where staff would have increased autonomy and responsibilities for local joint working and community development. The CHP was also making some adjustment to its locality and line management arrangements to provide consistency with Housing and Community Care. We say more about this at Section 4.6 on the management and support of staff. Senior managers said that a key driver for the changes was to provide a structure which better supported locality working and community involvement.

Much of the Partnership's work in this area had been developed in Highland Perthshire and Strathmore (centred around Pitlochry and Blairgowrie respectively). A community capacity building team leader and two community capacity building workers had been recruited who initially concentrated on the Highland Perthshire area and on identifying, meeting and bringing together local groups. Through this activity they had identified some 130 local community groups or initiatives operating in the Pitlochry and surrounding area. A number of specific consultation and engagement events had taken place, involving local groups, third sector representatives such as PKAVS, and NHS and Council staff. An example of this had been a 2012 "Winter Watch" event which was attended by 30 people and looked at what local arrangements could be put in place to support older people at times of severe adverse weather.

In Strathmore, there had been local community involved in the developments surrounding Blairgowrie Community Hospital and the Strathmore dementia service. This included the establishment of the dementia information café.

This approach to community engagement aimed to build on the existing work which had been started as part of the Healthy Communities Collaborative. This had supported a range of community initiatives, such as lunch clubs and safe walking groups. We read the 2010 evaluation of the Collaborative which contained many comments from older people on how their involvement had improved their sense of health and well-being. Whilst the findings of this and other evaluations and of our inspection were generally positive about the approach being taken towards community engagement, they did raise a number of challenges. These included:

- How to involve members of the public beyond those people who were already actively involved in existing community and volunteering activity.
- How to measure the impact of these community based initiatives.

Working with community partners, the Partnership had also implemented and supported a number of specific initiatives. These included:

- Timebanking which was operating in Coupar Angus, Aberfeldy and Pitlochry with plans progressing for a fourth service in the Stanley area. This was seen as a positive example of how communities could take action to support themselves. Five thousand hours of support had so far been provided via the

existing Timebanks and staff we met were positive about the model as a means of low level/preventative support. Staff we met estimated that only about a quarter of the support provided to date had been for older people and some questioned the extent it would be able to support more vulnerable older people to remain living at home. Information provided by senior managers for the Timebanking development in Stanley showed that some fifty people attended the first local event, including quite a number who had not previously been involved in community activity of this type. Thirteen people had gone on to act as befrienders for older people. The information also showed that older people in Stanley represented the largest potential user group. These looked to be encouraging developments.

- The provision of tested self management classes through the third sector in Highland Perthshire as part of its approach to supporting people with long term conditions. This involved the Disability Information Service in Perthshire (DSIP) providing a six week course to older people to increase their confidence and skills in managing their long term conditions. They aimed to provide four courses to a total of forty older people. Initial feedback was mixed in that those older people who attended were positive about the course, although the actual take up of the course by older people had been less that hoped for. In an attempt to rectify this, consideration was being given to offering the course via Telehealth which would offer the opportunity for older people to participate from their own homes.
- The development of small micro businesses had been identified as a means of trying to address the problems faced by both the Council and the independent sector in providing care at home to older people in the most remote parts of the area. Community capacity building staff had started to engage with Growbiz, based in Blairgowrie and who had experience in developing small social enterprises of this type. They had done some analysis and concluded that a viable option would be, for example, a single person operation providing support to four or five older people in a remote rural area

At the time of our inspection staff and managers involved in the community engagement approach were in the process of putting a more formal framework in place to support this. This was to include a Community Led Forum which would have one representative from each of the local community groups and which would meet on a quarterly basis. The forum would engage with and be part of a Locality Network at which the statutory agencies, the third sector and the community forum would work together in looking at how supports and services could best be provided to the local population, including older people. The first meeting of the Community Led Forum for Highland Perthshire was scheduled to take place in March 2013 and it was planned that the framework being adopted there would provide an appropriate model for the other localities.

It was too early to be able to see how big an impact there would be arising from the time and effort the Partnership was investing in trying to develop community capacity and community supports. However, we were impressed with the real commitment and enthusiasm demonstrated by the Partnership in this area. This included its efforts to adopt a strategic approach to community engagement and capacity building

4.5 Delivery of key processes.

Many of the file reading findings in relation to assessment and care management practice were very positive. Many of the assessments were focused on personal outcomes and this provided an approach which could usefully be further developed within care plans and reviews. The lack of joined up IT systems made it difficult to obtain a holistic picture of older people's health and social care needs without accessing a range of different records.

Whilst the delivery of key processes was not a primary focus of this pilot inspection, our scrutiny activity and in particular our file reading and focus groups generated some pertinent information.

As indicated at section 4.1, we read 30 files of older people who were in contact with both health and social care services. The relatively small sample size meant that the finding should be regarded as indicative, rather than as statistically significant.

Many of the findings from the file reading were positive. For example:

- 90% of files contained an assessment and these were all timeous. The quality of the assessments was evaluated as very good or good in 84% of cases.
- 90% of files included issues about risk, and in nearly all of these, there were up to date risk assessments and most had risk management plans. The quality of risk assessments and management plans was good – overall it was better for protection type risk than non- protection type risk.
- 81% of files included a care plan and in 80% of these, the care plan was evaluated as mostly or completely addressing the service user's needs. In 90% of files there was evidence that the support provided to the individual was subject to regular review.
- There was little evidence in files of the older person having to wait to have their needs assessed or for services to be provided.
- There was evidence of multi-agency working in 87% of the files. In 24 of the files we read, the older person and their family had been under very considerable pressure. In 21 of these files there was evidence that services had worked together to provide care at this time.

There were some findings from the file reading which were less positive and we discussed these with staff and senior managers during the inspection. This indicated that the Partnership needed to consider improvement activity in the following areas:

Chronologies: 90% of files contained a chronology, but 74% of these were evaluated as not being of an acceptable standard. This was primarily because most were not actually chronologies of significant life events. Rather they were lists of recent service involvement. Chronologies are an important means of helping to aid assessment and especially assessment of significant risk. As such, it is not appropriate or necessary for all files to include a chronology. The fact that 90% of files included something headed up as chronology suggested there was some confusion about what constitutes a chronology and what constitutes a service history or summary. Both are legitimate, but they should not be confused. Senior managers in the Partnership said they were aware that the purpose and use of chronologies needed to be clarified and they planned further training for staff to address this.

Outcome focussed assessment, care planning and review: Fifty six percent of the care plans were not SMART. Many of these lacked sufficient detail, were too high level and did not include timescales. Some for example indicated that identified needs and outcomes would be met by "daily support". In section 4.1, we referred to how Housing and Community Care had introduced an outcome focused assessment framework. A significant proportion of the social work files we read contained these assessments. Whilst some would have benefited from being a bit more detailed, it was positive that individual personal outcomes were being discussed and agreed with the older people concerned. However, this was not always reflected in care plans or in reviewed care plans. The focus of both of these tended to become narrower and more service or task based. We concluded that the Partnership should consider how the positive progress that has been made on outcome focused assessment is sustained into care planning and review practice. A few health staff had completed the outcome focused assessment training. The Partnership should consider extending this to other health staff, especially given their move away from Single Shared Assessments.

Information systems and recording: Whilst not an issue in any way unique to Perth and Kinross, it was evident that there had been little or no integration of IT systems. Not only were NHS and Council systems largely separate, health staff were also only able to access some NHS systems. At focus groups staff and team managers regularly identified "systems not talking to each other" as a significant frustration and an impediment to effective joint working. They also referred to the resultant duplication of effort. The local file readers said that the files we read only reflected a small proportion of the communication and joint work which actually took place involving heath and social care staff. To get round this, staff said they "pick up the phone" or seek out colleagues. Whilst this had benefits in terms of joint working relationships, staff acknowledged that this was easier where staff were co-located

and that important information, although shared between individual staff, was not always recorded on file.

A further consequence of the lack of a joined up system meant that it was difficult to obtain a holistic picture of an older person's health and social care needs and how services were working together to meet these. Senior managers acknowledged that the lack of integrated IT systems was problematic and presented challenges. The Partnership had an Information Sharing Board which had some specific plans to develop and link up joint chronologies and to link up anticipatory care planning with outcomes focused assessment. However, it was not clear what plans were in place to address the broader issues surrounding the IT systems, although greater access to SWIFT for health staff was being considered. We concluded that the Partnership needs to give consideration as a matter of priority to how the problems arising from the lack of joined up IT systems can be overcome.

4.6 Management and support of staff

The Partnership had a stable workforce. It had however faced longstanding difficulties in recruiting staff to work in the most rural areas. Its focus on community capacity building was partly aimed at addressing this. Only a small proportion of staff were co-located, but senior managers were looking at opportunities for this to happen. Health and Community Care was introducing a locality management structure which would dovetail with what the CHP already had in place. The majority of training was still provided on a single agency basis, although staff made each other aware of relevant training and staff from the third sector said that the Partnership was good at providing them with access to its training.

The Partnership said that historically and overall it had not faced major recruitment and retention difficulties. National data showed that the vacancy rate for social work staff in Perth and Kinross was below the national average. However, a significant exception was in the recruitment of staff, and especially homecare staff to work in the most rural areas. The work which had recently started to support the development of some small micro providers was partly an effort to address this longstanding problem.

Earlier in the report we referred to how the change fund had been used to support a number of service developments and some of the benefits arising form this. A number of these had included the employment of additional staff, but this was often on one year temporary contracts. This was a downside of the change fund monies, as being viewed as a short-term source of funding meant that some staff employed on this basis had left to secure alternative permanent positions. The development of the joint strategic commissioning plan should begin to address the longer term planning for services and the workforce to support these.

We met a group of Human Resources (HR) officers and managers from the NHS and the Council. They said that the change fund had been a great catalyst for joint working. Senior managers advised that they had agreed a joint set of principles for joint workforce planning and that this would be taken forward as part of the planning and preparation for the new health and social care Partnership.

The health and social staff we met considered that they worked well together. Although they acknowledged that co-location does not itself result in effective Partnership working, staff who were co-located said that this certainly had helped. The Pitlochry staff were one of the few teams who were co-located at the time of our inspection. The senior management teams were in the process of co-locating in Perth and they were keen to take further opportunities for staff to be co-located as these arose. Staff in the delayed discharge team in Perth Royal Infirmary were the only staff we met in a joint team and a number of them were only partially deployed in this team. All staff were managed either via the NHS or the Council and there were no jointly appointed managers.

Housing and Community Care was in the process of moving to a locality management structure on the basis that this would better support Partnership and integrated working. Appointments to the service manager posts in the locality were pending. Although this was primarily a Housing and Community Care Development, senior managers said that they had done this in consultation with their health colleagues. It was also based on work in Highland Perthshire where staff had not only been co-located in Pitlochry, but had also been involved in action learning sets and a locality development group. The latter was a multi agency forum charged with taking forward Partnership working, including community involvement and capacity building in the locality. Group members said it had taken them some time to work out an appropriate remit, including how they could best engage with the local community.

Some other reviews of staff roles and responsibilities were underway. This included a review of the occupational therapy service. Whilst staff and managers recognised the potential for integration, the review had already been underway for some time and we read a June 2012 progress report which identified a number of problem areas which still required to be resolved. Separately consideration was also being given to GP support to older people in care homes. The CHP had a preferred model of an enhanced service by GPs which would mean each care home being supported by a single GP practice, rather than a range of dispersed GPs (normally the GPs at the time of admission). CHP managers considered this would allow for an improved and more consistent level of GP support to be provided to care homes and their residents.

Whilst we heard many positive comments about care at home staff, as indicated in section 4.2 we also heard comments from a range of sources about staff not always arriving as scheduled. Our inspection, including the analysis of inspection reports of

the regulated care at home services suggested a number of reasons for this and in particular:

- How effective local managers were at managing staff workloads.
- Travelling distance and whether the provider paid staff travel costs.

This is not a problem unique to Perth and Kinross and deploying a large and dispersed workforce is challenging, and especially in rural areas. Senior Managers said that in recognition of this, Perth and Kinross Council paid one of the higher hourly rates for home care in Scotland to the providers, and also a higher rate for rural areas. They said they had engaged on a detailed "GIS Mapping" exercise designed to assist their providers reduce travel costs by focusing their services within particular geographic areas. We concluded that was important that the Partnership and the independent sector providers retained a strong focus on development in this area. This was both in terms of the effective operational deployment of staff, but also in their joint approach to strategic commissioning.

Staff we met said that most of the training they had received was provided on a single-agency basis, although there were areas where joint training took place, for example adult and child protection and drug and alcohol awareness. In addition, individual staff said they shared their training calendars with their colleagues and if they were interested in attending training provided by the partner agency, there was not a problem with this. Information provided by the Partnership indicated that joint training was now more common place. This included dementia training via the national programme for Promoting Excellence, reablement training and multi-disciplinary training to support the discharge pathway planning process. Staff we met from the third sector said that the Partnership was good at providing it with access to its training.

A further example of a joint approach was in the Action Learning Sets. As indicated earlier, staff we met who had been involved spoke very positive about their involvement and the benefits of this. They involved a significant commitment by staff involved. Although some staff we met questioned whether the Action Learning Sets would be rolled out more widely, senior managers confirmed that they were fully committed to doing so.

4.7 Leadership and direction.

Senior managers exhibited a strong commitment to Partnership working and to service improvement. The Change Fund was playing an important part in developing their approach and there were sound governance arrangements in place to support this. The Partnership could usefully develop a more systematic approach to how it obtains feedback from older people who use its services and from their carers.

Whilst leadership and direction was not a primary focus of this pilot inspection, our scrutiny activity generated some relevant information.

From the written documentation we received and from our inspection activity, we could see that the Partnership had a clear vision for the future. Its objectives were firmly tied to the need to reshape care for older people. This was based on a recognition that not only were the existing models of providing care and support unsustainable, but also that there was considerable need and scope for change if better and more personalised outcomes for older people were to be achieved. The health and social care staff we met impressed as sharing this vision and they saw senior managers as being very committed to achieving it. We had some contact with the Council's Chief Executive and NHS Tayside's Depute Chief Executive who expressed a shared view of the importance of Partnership working in meeting the needs and aspirations of older people in Perth and Kinross.

The Change Fund had provided a considerable impetus to how the Partnership was taking forward its agenda for older people. This involved a considerable amount of service improvement and development activity. This was divided into five workstreams which were overseen by an Operational Group which reported to the Change Fund Board. As well as the statutory bodies, both included representation from the voluntary and the private sector. We considered this provided an appropriate framework within which this development activity could take place. Whilst, there had been a focus on service improvement prior to the Change Fund (e.g. the hospital discharge and reablement services), it was noticeable that some of the developments introduced using Change Fund monies in Perth and Kinross (e.g. rapid response and intermediate care) had already been in place prior to this on other parts of the country. This might partially explain why some of Perth and Kinross' balance of care performance indicators remained below the national average.

In February 2013, the Partnership had completed its draft joint commissioning strategy for older people which was being issued for consultation. The Partnership saw the strategy as being a key vehicle in the development of its medium and longer term sustainable models of care. We read the strategy and concluded that it provided a useful basis upon which joint commissioning could be taken forward. However, this would also require the development of detailed and appropriately targeted action plans and these were not due to be developed until after the consultation period ended in June 2013. Given the longstanding difficulties faced by the Partnership in recruiting staff to work and provide support in the most rural areas, we concluded that it would be important that the action plan provided a detailed and strategic approach to address this.

In preparation for the Scottish Government's proposals for health and social care integration the Council and NHS had established a Transitions Board which was to become a formalised shadow Board from April 2013. They had been working on a

“route map” on how they would proceed further towards integration, including the supporting governance arrangements. Some final decisions were still to be made about which services would be included in the new health and social care Partnership. Indications at the time of our inspection were that it would not incorporate children’s services.

Staff we met seemed fairly relaxed about health and social integration. Senior health and social work managers appeared to have good joint working relationships. Joint coaching sessions were taking place involving senior health and social work managers. We attended a meeting of the Change Fund Operational Management Group. This was attended by a large group of health and social work managers and also managers from other partner agencies. The working relationships presented as being well-established and productive.

Structural change in itself does not guarantee improved outcomes for people who use services or better Partnership working. The move to strengthen management arrangements and responsibilities on a locality basis seemed to be primarily a Housing and Community Care, rather than a joint initiative. This said, during our fieldwork senior managers confirmed that this had been the subject of discussion to ensure an outcome whereby the new locality boundaries for Housing and Community Care would be aligned with the CHP localities. CHP services had been delivered within localities for some time and CHP Senior Managers were re-aligning some management arrangements (e.g. for the District Nursing service) to better support locality working. Given, the need to focus on and develop co-production and community capacity building, we concluded that the approach being taken to strengthen locality working was a sensible one.

The Partnership had undertaken some positive joint work as part of the Integrated Resource Framework which had allowed it to produce an impressive range of data covering health and social care activity and expenditure. This had provided the basis against which variations in practice and performance could be explored with the intention of learning and rolling out best practice. The Partnership was in discussions with the Scottish Government around a ‘Programme Budgeting Marginal Analysis’ approach on care pathways to better identify how areas of investment/disinvestment could potentially affect service outcomes. In addition we saw that the joint commissioning strategy included examples of how IRF data had been used positively to inform various investment decisions.

We did not focus closely in this inspection on performance management and quality assurance. Whilst the findings of this inspection are generally positive, we heard as many critical as positive comments from the service users and carers we met (albeit a relatively small number) about their experience of services. In addition some of the internal evaluations we read had tendency to over accentuate the positive. This would suggest that the Partnership could usefully review whether it is systematically

seeking and acting upon feedback from older people and carers who use its services.

We were provided with a good amount of documentation which showed that a lot of the services, especially the newly developed services were subject to evaluations. Some, but not all of these, related to initiatives subject to Change Fund monies and reporting arrangements. There was also a strong commitment to a PDSA (Plan,Do,Study,Act)[12] approach and one which was based from learning from "small steps of change". Whilst some of the internal evaluations we read might have benefited from some external verification, we concluded that the Partnership had a positive commitment to service improvement. This, as well as its willingness to entrust staff via Action Learning Sets were indications of good leadership.

Conclusions and capacity for improvement.

The fact that this pilot inspection did not include scrutiny of all the areas for evaluation meant that our conclusions about capacity for improvement had to be tempered to a degree.

We identified a number of areas for improvement and the key ones are identified below. However, in reviewing the findings of the inspection and having reflected upon its current position, inspectors concluded that the Partnership's capacity for improvement was good. In particular, this conclusion was based upon:

- The Partnership's clear vision and sense of direction.
- The work which had been done in preparation for health and social care integration, including around the Integrated Resource Framework.
- The more recent evidence of service development and the strong focus on community engagement and capacity building.
- The strong commitment of the workforce and their positive approach to Partnership working.

Areas for improvement

Inspectors concluded that the Partnership should take account of the need to:

- Determine from the outcome of the Test of Change exercise the most appropriate arrangements for the administration of medication to older people who need support with this.
- Identify effective and practical solutions to the problems arising from the lack of joining up between the existing IT systems.

[12] PDSA - a continuous quality improvement model based on four repetitive steps for continuous improvement and learning.

- Give further consideration to developing strategic solutions to the challenges posed by providing services and support in rural areas. It should do likewise in considering how the positive progress it has started to make in community capacity building can be sustained.
- Consider whether the existing performance management arrangements are sufficiently robust and systematic to confirm that the actual experiences of older people and their carers are as positive as the Partnership would wish them to be.

What happens next?

As this is a pilot inspection, there will be no publication of this report by the Care Inspectorate or Healthcare Improvement Scotland. However, we expect that Perth and Kinross Partnership will consider the findings of the report and ensure that the areas for improvement identified as a result of the inspection are addressed within its improvement action plans,

The Care Inspectorate and Healthcare Improvement Scotland will continue to offer support for improvement through their linking arrangements.

August 2013