

# Multi-agency inspection

## Collaborative working across services for older people in Tayside

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# Acknowledgement

We wish to thank everyone who assisted us during this pilot multi-agency inspection. We received a warm welcome from everyone we met and we are grateful to them for the time and effort they took to assist us. We particularly appreciate the way the local co-ordinators provided us with support and information throughout the inspection.

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Chapter 1	Introduction	1
Chapter 2	Summary	2
Chapter 3	Aims, scope and nature of the multi-agency inspection	6
Chapter 4	Context of services for older people in Tayside	7
Chapter 5	Overview of Tayside-wide issues	10
Chapter 6	Angus Council and NHS Tayside partnership	27
Chapter 7	Dundee City Council and NHS Tayside partnership	49
Chapter 8	Perth & Kinross Council and NHS Tayside partnership	76
Chapter 9	Evaluations and recommendations	102
Appendix 1	Model for the multi-agency inspections of services for older people	106
Appendix 2	Methodology for the multi-agency inspection in Tayside	107
Appendix 3	Angus Community Health Partnership structure	109
Appendix 4	Angus Council Social Work and Health structure	110
Appendix 5	Dundee Community Health Partnership structure	111
Appendix 6	Dundee City Council Social Work Department structure	112
Appendix 7	Perth & Kinross Community Health Partnership structure	113
Appendix 8	Perth & Kinross Council Housing and Community Care structure	114
Appendix 9	Resource transfer to councils from NHS Boards, 2003-04	115
Appendix 10	Resource transfer for geriatric continuing care services, 2005-06	116

# Social Work Inspection Agency

## Evaluations

The multi-agency inspections for community care services have adopted the SWIA six point scale. In this multi-agency inspection of services for older people, the inspection team has provided an evaluation for each of the six areas for evaluation, as set out in appendix 1: Model for the multi-agency inspections of services for older people.

The evaluations apply to collaborative working between health and social work services within the partnerships. For this reason, they may differ from the evaluations in the SWIA performance inspections. There are no evaluations given to a single agency or in chapter 5 which considers the Tayside-wide issues.

The evaluation scale

Level	Definition	Description
Level 6	Excellent	Excellent or outstanding
Level 5	Very good	Major strengths
Level 4	Good	Important strengths with some areas for improvement
Level 3	Adequate	Strengths just outweigh weaknesses
Level 2	Weak	Important weaknesses
Level 1	Unsatisfactory	Major weaknesses

## The report format

We collected a very large amount of information during the inspection. This report cannot do full justice to all that we learnt. Instead it draws out the main themes about collaborative working, backed by selected evidence.

Except where the inspection team is expressing an opinion, the report is written in the past tense. Where we use quotes from individuals, they represent opinions we heard widely expressed, not just one individual's views.

The report uses the following words to describe numbers and proportions:

Almost all = over 90%

Most = 75-90%

Majority = 50-74%

Less than half = 15-49%

Few = up to 15%.

The term 'social work services' covers both social work and social care services, either directly provided by councils or commissioned from the independent sector.

## Introduction

In recent years, NHSScotland and local authorities have responded to significant challenges and changes. There have been substantial improvements in health, social work and social care services which have delivered better outcomes for people and their carers. But demographic changes, people's rising expectations and advances in medical technology is placing greater demands on agencies to continue improving services for older people.

In all public services we are making a shift from top-down, target driven performance management to more self-improving systems built around the needs of individuals. Increasingly, collaborative working between health, social work and social care agencies will make a significant contribution to improved services. The overall aim of collaborative working is to give people the best and safest care possible.

Multi-agency inspections support this improvement in several ways. For this reason, they were announced by Malcolm Chisholm, Minister for Communities, in 2006. This first pilot multi-agency inspection focuses on the way that the agencies in Tayside work together, rather than on specific services. In doing so, it promotes collaborative working by highlighting good practice, and making recommendations where change or improvements are needed. It demonstrates to patients and people who use services that joint working can assist them to live independently.

The development of the model and methodology for this multi-agency inspection has been led by SWIA in partnership with NHS Quality Improvement Scotland and the Care Commission. Each has different ways of working but all have an identical focus in assisting agencies to give people the best and safest care possible. They are committed to evaluating all the multi-agency inspections to find out how they can contribute to a simpler system of review, inspection and regulation.

This report gives an overview of collaborative working between health and social work services provided in Tayside. It also sets out the strengths and areas of good practice as well as identifying areas where improvements are needed.

We fully appreciate the co-operation and assistance of the four agencies, NHS Tayside, Angus, Dundee City and Perth & Kinross Councils, which have participated in the first pilot inspection of services for older people. In particular we are grateful to patients, service users, carers, staff and managers who played an active role in the inspection process.

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# CHAPTER 2

## Summary

### 2.1 Tayside-wide issues

There were distinctive differences in the way in which the three Tayside health and social work partnerships approached their strategic and operational responsibilities for services for older people, despite there being one health board, NHS Tayside.

There was no over-arching strategic framework in NHS Tayside for older people's services. Although some local variation is to be expected, we consider that there should be greater consistency of approach on key strategic issues. These include the need to shift the balance of care between acute and primary health services and to shift the balance of care from care homes to home-based care.

About two thirds of acute admissions to Ninewells Hospital in Dundee, which serves all of Tayside, were people aged 65 years or over. It was therefore a major and high cost provider of in-patient services for older people in Tayside. The development of multi-disciplinary collaborative services and intermediate care is a key element of national policy as set out in *'Delivering for Health'*.<sup>1</sup>

Effective services maintain frail older people at home, may often succeed in preventing unscheduled admissions, and can minimise acute stays by promoting early supported discharge with care, rehabilitation and follow up. NHS Tayside needs to address this issue of the balance of care between acute and primary care in a vigorous way, by jointly developing an over-arching and coherent strategy with the three councils.

The three partnerships were fully aware of the need to shift the balance of care from institutional settings such as care homes to providing more home-based care. They had developed plans to do so. However, all the partnerships were finding it difficult to achieve their goals for a number of reasons, of which the most significant was the historical patterns of health delivery, together with the relatively high levels of use of care homes and low levels of intensive home care, as was the case for much of Scotland.

Older people in Tayside were largely positive about the quality of their assessments and the services or treatment they received. They were also largely positive about the way staff from different agencies worked together. However, carers said they were frequently not receiving the support they needed either in relation to their own health needs or from hospital staff when the person for whom they cared was in hospital.

Frontline health and social work staff generally worked together in Tayside in a positive way, with a clear focus on assisting older people to live as independently and safely as possible. This was particularly true of the multi-agency teams in all three partnerships. Multi-agency teams for early supported discharge and prevention of admission provided alternatives to admission and early supported discharge services. These services successfully minimised the acute length of stay and supported older people in their own homes.

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<sup>1</sup> *Delivering for Health*, Scottish Executive, 2005

Staff in all the Tayside partnerships were struggling to cope with the demands made on them by the incompatibility of health and social work IT systems, particularly in relation to single shared assessments (SSAs).

The emphasis in current health and social work thinking stresses the importance of early stage, preventative services for older people and the importance of self care, particularly for people with long term conditions. All the Tayside partnerships were aware of the need for services which enable well being and self care, such as case management and rehabilitation, and were beginning to address this.

There were differences about the way that the three partnerships approached the role of home care and social care staff in prompting and/or giving medication, and this was beginning to be addressed. Some services for people with dementia in Tayside exemplified good practice; others were patchy and there were some shortfalls. This was also beginning to be addressed.

## 2.2 Angus Council and NHS Tayside partnership

The Angus partnership delivered good outcomes for older people through effective collaborative working at all levels. For example, the Manager of the Community Health Partnership and the Director of Social Work and Health jointly demonstrated positive and enabling leadership. The managers from health and social work approached the design and delivery of services in a whole systems way.

Most health, social work and social care frontline staff were committed to working together to ensure that older people and their carers received high quality assessment, care and treatment so that people could live as independently as possible.

There was a wide range of services, and the delivery and management of services, including performance management and continuous improvement, were very positive. There was an up to date joint strategy for older people's services. More work needed to be undertaken on the balance of care in relation to care homes and care at home and the partnership was undertaking this in a variety of ways, for example through a Best Value review and the review of community hospitals.

## 2.3 Dundee City Council and NHS Tayside partnership

The performance of the Dundee partnership in delivering outcomes for older people through collaborative working between health, social work and social care services was adequate. More attention needs to be given by senior managers from health and social work to jointly implementing a whole systems approach to services and collaborative working. The challenges in delivering on a whole system approach in Dundee are considerable because of the local economic and social pressures.



There was evidence that the partnership had analysed its position and developed some proposals to improve outcomes for older people. However, the pace of implementation was slower than the partnership wanted. There was a need for stronger joint leadership in ensuring collaborative working, particularly in relation to joint commissioning and financing. The existing style of leadership was having a serious impact on the partnership's ability to cope with issues such as the levels of delayed discharges.

Most health, social work and social care frontline staff were committed to working together to ensure that people and their carers could live as independently as possible. Their performance in relation to person centred care in assessment, care management and treatment was good. Staff perceived it as problematic when social work resources were not available to implement the outcome of single shared assessments for individuals, particularly in hospitals, or to provide complex or high cost care packages, which then contributed to the level of delayed discharges.

They were also aware of the impact of Ninewells Hospital, a large teaching hospital in Dundee, which served all of Tayside. It provided an acute service to Tayside and northeast Fife and a community service to Dundee. There was a lack of consistent staffing and the 'boarding out' of patients in temporary places within the hospital which led to difficulties in developing working relationships. There was no other large scale community hospital facility in Dundee.

There was a wide range of services, and the delivery and management of services, including performance management and continuous improvement was adequate. There was no published joint strategy or joint commissioning strategy on older people's services, although considerable work had gone into developing them. More work was being undertaken on improving the balance of care in relation to care homes and care at home.

The partnership recognised it needed to increase the pace of change, and was beginning to do so, for example by the council voting for an additional £1.8 million for care at home services for 2006-07. The partnership needs to consider how it should deliver community health services, particularly in relation to the impact of Ninewells Hospital.

### **2.4 Perth & Kinross Council and NHS Tayside partnership**

The performance of the Perth & Kinross partnership in delivering outcomes for older people through collaborative working between health, social work and social care services was adequate. Senior managers from health and social work were giving significant attention to implementing their vision of the way forward. This clearly involved a whole systems approach to developing services and collaborative work. It was set out in their joint council and health committee paper of July/August 2006.

The strategy for older people's services, dated 2002, needs urgent updating in the light of this paper. Work had begun on this, through the establishment of a new Joint Commissioning Group which was overseeing the development of a range of care group strategies, including one for older people's services. It had a deadline of March 2007 for a draft strategy to be in place.

Most health, social work and social care frontline staff were committed to working together to ensure that people and their carers could live as independently as possible. The partnership's performance in delivering assessment, care and treatment was adequate. However, many staff were uncertain of the way forward since the ending of Care Together (an earlier integration of health and social work services) in 2004. The partnership should involve managers and staff in implementing a joint communication strategy about future developments in services for older people. A draft communication strategy has been developed by the CHP which was intending to consult on how this could be effectively introduced across the partnership services.

There was a wide range of services, and the delivery and management of services, including performance management and continuous improvement, was adequate. However, the partnership had agreed how to improve these areas, for example in implementing a joint performance management framework. More work was being undertaken on improving the balance of care in relation to care homes and care at home. New opportunities for community health services were being considered through the redesign of community hospitals.

# CHAPTER 3

## Aims, scope and methodology of the multi-agency inspection

### 3.1 Background

The model and methodology for the multi-agency inspection were developed by the National Health Service Quality Improvement Scotland, the Social Work Inspection Agency and the Care Commission. Each has different ways of working but all have an identical focus on assisting agencies to give people the best and safest care and treatment possible.

### 3.2 The Tayside multi-agency inspection of services for older people

The Tayside inspection was the first of two pilots designed to test the new model and methodology. It took place between June and November 2006, with the fieldwork being undertaken in the three partnerships in October 2006.

### 3.3 Aims of the multi-agency inspection

The aims were to:

- examine the effectiveness of collaborative working between health, social work and social care services in delivering better outcomes for older people
- make recommendations on improving collaborative working in order to improve the care and treatment of older people
- develop a more proportionate and whole systems approach to review, inspection, and regulation
- test out the effectiveness and sustainability of the model and methodology for the multi-agency inspection of services for older people (MAISOP).

See appendix 1: Model for the multi-agency inspections of services for older people.

### 3.4 Scope of the multi-agency inspection

It was agreed that this pilot would:

- focus on multi-agency issues and not single agency services
- not include acute health services except where they impacted on primary health, social work and social care services.

### 3.5 Nature of the multi-agency inspection

The inspection process drew on the methods used by NHS QIS, SWIA and the Care Commission. It included:

- interviews with older people, carers, elected members, managers, and staff
- carer, staff and stakeholder questionnaires
- case file reading of health and social work files
- self evaluation workbooks and advance information.

See appendix 2: Methodology for the multi-agency inspection in Tayside for further details.

## Context of services for older people in Tayside

### 4.1 NHS Tayside

In October 2004, NHS Tayside began a phased transition from the existing structure to three Community Health Partnerships. Each Community Health Partnership (CHP) was strategically aligned to the three Tayside councils, Angus, Dundee City and Perth & Kinross.

The CHPs form the key building blocks for the modernisation of the NHS in Scotland and the implementation of the Joint Future Agenda in Tayside. They provide a route for developing integration between acute and primary health care. They also work closely with the councils to deliver effective services in the community and ensure a locality based approach to the health improvement agenda.

In early 2006, NHS Tayside established a Single Operating Division to facilitate service delivery, reduce duplication and bureaucracy and reinforce accountability arrangements. A Chief Executive was appointed to lead the division, which consists of the acute and primary health services, including the CHPs, for Tayside.

The report covers the three partnerships between NHS Tayside and the three councils, which were formally established through Extended Local Partnership Agreements in 2004, as required by the Scottish Executive.

### 4.2 Angus Council

Angus has a population of about 106,556, most of which is spread across seven towns, while the rest is rural. Accountability and sustainability of services are key factors because of the diverse geography.

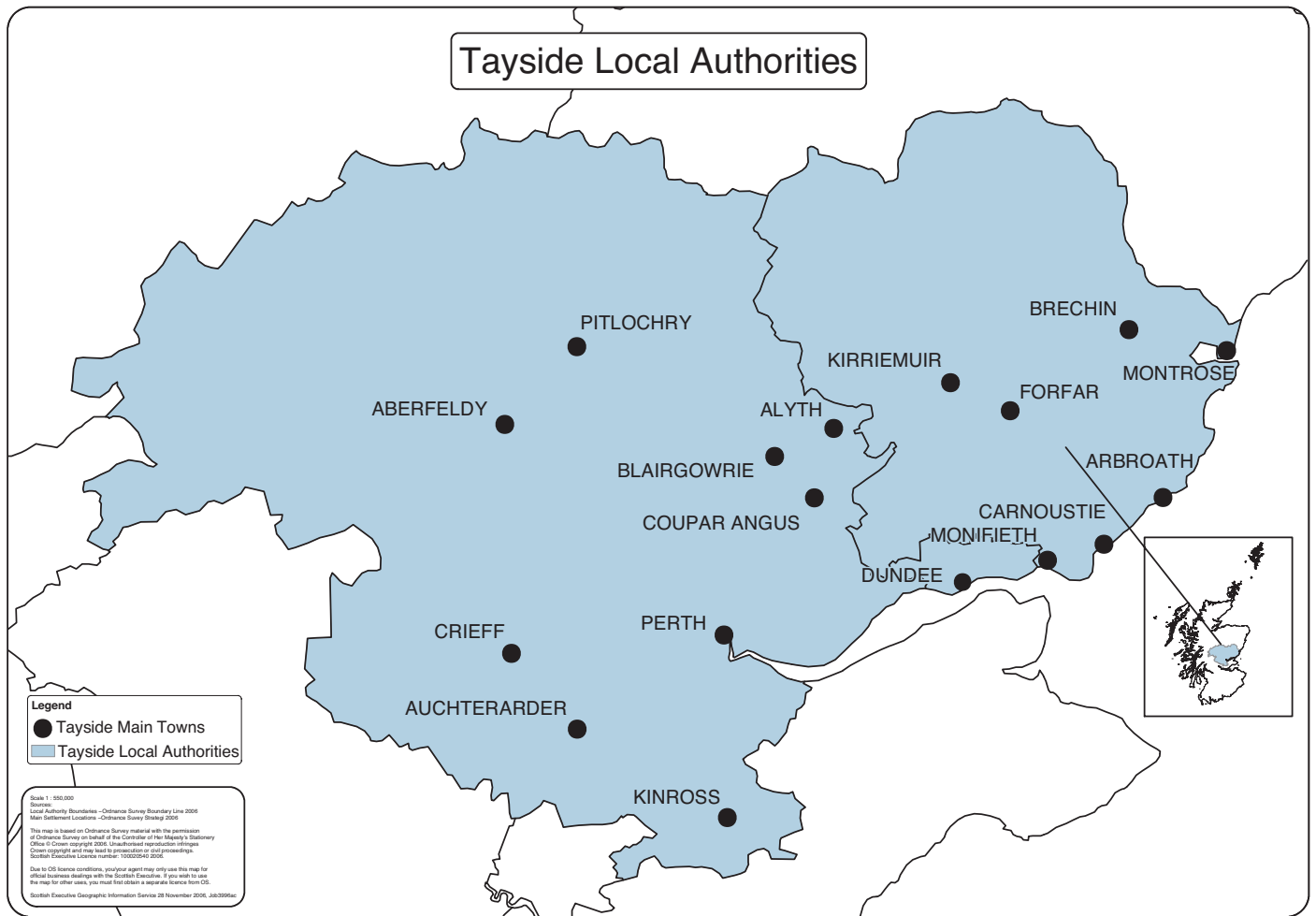
By 2016, the local population is expected to fall by 6%, but with a 21% increase in the older population, which is significantly above the national increase of 17%. It is projected there will be an increase in the older people population from 22% to 29% of the total population by 2024. Angus contains a mixture of relatively prosperous communities based on farming and fruit-growing combined with pockets of deprivation in its main towns, particularly in Arbroath.

Since local government reorganisation in 1996 there has been an integrated social work department, with a Director of Social Work and a Social Work Committee. In 2003, the council renamed the Department, Director and Committee as 'Social Work and Health'.

The council intended that the change would reflect the transfer of responsibility to social work for the health improvement agenda in Angus and would further promote the close working relationship with the NHS in the council area. The Director is not directly responsible for the delivery of NHS services but, along with the Manager of Angus community health partnership, he plays a pivotal role on behalf of the council for developing the co-delivery of health and social care services.

The Angus partnership adopted a lead agency role for key services in 2004 as part of the Extended Local Partnership Agreement. Social Work and Health is the lead agency for older people’s services, including people of all ages with dementia and older people with mental health problems. Angus CHP is the lead agency for adult mental health services.

Fig 1: Map of NHS Tayside, Angus, Dundee City and Perth & Kinross Councils



### 4.3 Dundee City Council

Dundee City Council, which is the fourth largest city in Scotland by population, is the smallest council by geographical area. The overall population of around 142,000 has fallen by 8% since 1991 and is projected to decrease to 121,000 by 2024. Whilst the population is expected to decrease, the population is also ageing. The older people population is projected to increase from 18% to 23% of the total population by 2024. This will affect the level of funding from the Scottish Executive. The associated increase in need for services for older people will create challenges for the council and the partnership.

Its compact nature offers potential advantages to the council in providing services, and some features of the council's context, including the long-term unemployment rate, have improved. Overall though, levels of socio-economic deprivation and associated morbidity are high or very high across the city, which creates very significant challenges for the council in providing services. This is compounded by outward migration, high daytime population, and social exclusion. It therefore has markedly different challenges to face than the other two partnerships.

Dundee City Council has an integrated Social Work Department, with a Director of Social Work and a Social Work Committee.

#### 4.4 Perth & Kinross Council

The Perth and Kinross area is predominantly rural with a population of 138,400 of whom almost a third live in Perth. The percentage of older people, at 22%, is above the Scottish average of 19%. The older people population is projected to increase from 22% to 27% of the total population by 2024. Many of these older citizens live in the rural areas to the north and west. The geography of Perth and Kinross means that the distances involved in providing services are much greater than in the two other partnerships.

Within Perth & Kinross Council, social work services are managed as two separate service areas – Education and Children's Services (ECS) and Housing and Community Care (H&CC). Both services have an Executive Director and Depute Director. The Depute Director of Community Care also has the key role of Chief Social Work Officer (CSWO) for the council.

Social work services provided by Perth & Kinross have undergone significant structural and operational changes in the last few years. The history of these changes provides an important backdrop to this inspection and are briefly summarised below.

In April 2001, Care Together – a pilot partnership between health and community care social care services for adults – was established. In April 2004, following a review, Care Together was disbanded. During the inspection, many health and social work staff talked about the significant impact of these changes on them.

Housing and Community Care (H&CC) was established and all council community care services are now delivered from this department. Within this department, older people's services are provided through the Older People's Services Partnership, which has both social work and some health services. At the time of this inspection, the council was undergoing a strategic review of leadership and management which was due to report in late 2006.

Community care services are led by four Lead Officers, who along with the Depute Director, form the senior management team. One of the Lead Officers, the Senior Partnership Manager (Older People's Services), has responsibility for a range of services and reports jointly to the Manager of the Community Health Partnership and the Deputy Director for Community Care.

Appendices 3-8 contain diagrams of the structure of the CHPs and social work services.

# CHAPTER 5

## Overview of Tayside-wide issues

There are several issues which are consistently shared by the three partnerships and they are brought together in this chapter. Where it is appropriate to give more details about a particular partnership, this is done in the following chapters.

### 5.1 Whole systems approach

#### 5.1.1 The situation in Tayside

There was no over-arching strategic framework for NHS Tayside for older people's services. This means that there was no effective whole systems approach, with a clear vision, supported by milestones and targets, with effective joint resourcing, financial plans and joint performance measurement.

This can partly be explained by the fact that older people use a high proportion of all health services, thus making it difficult to know precisely what services to include in an over-arching strategy.

Moreover, with the establishment of the three Community Health Partnerships (CHPs) the focus in Tayside, at the time of the inspection, was on partnership working between the councils and the CHPs at the operational rather than the strategic Tayside-wide level. There have been some benefits in NHS Tayside's approach to enabling the partnerships to address the care of older people from a local perspective and allowing relationships to develop.

However, there were distinctive differences in the way in which the partnerships approached their strategic and operational responsibilities for services for older people. To some extent this is appropriate, given the need for local partnerships to reflect local needs and circumstances.

Work was being undertaken in NHS Tayside on the future shape of some services, in particular community hospitals, which provided significant elements of care for older people. Work was also being undertaken on long term conditions, unscheduled admissions, and hospital at night. All of this work was being project managed by NHS Tayside. It is essential that councils are fully involved in the discussions and decisions made as these will have a significant impact on the demand for future council services.

The move towards a single operating division, renamed the Delivery Unit, which included both acute and primary health services, should provide the opportunity for NHS Tayside to develop a coherent strategic and financial framework for older people's services. The newly appointed Chief Executive of this Unit was committed to working with the councils, to resolving some existing tensions and to providing collaborative solutions. He had the support and confidence of partners across Tayside in this task.

There are several key issues which need to be jointly addressed:

- Shifting the balance of care between acute and primary health services
- Shifting the balance of care between residential care and home-based care in the community
- A coherent strategy for health and social care services for older people in Tayside
- An effective funding strategy which fairly reflects level of need.

### 5.1.2 Shifting the balance of care between acute and primary health services

About two thirds of acute admissions to Ninewells Hospital, Dundee, were people aged 65 years or over. It was therefore a major, high cost provider of in-patient services for older people in Tayside. Its location and the lack of community hospitals and intermediate care alternatives in Dundee, as well as health referral practices, meant that relatively more older patients from Dundee were admitted than from the other two partnerships in Angus and Perth & Kinross. This has contributed to the fact that there were more unscheduled admissions and more delayed discharges from Dundee.

This needs to be set in the context that NHS Tayside has been seeking to address the issue of unscheduled admissions. Over the last five years it had some success in reducing the increase in unscheduled admissions, although more recently there was an upward trend.

The development of multi-disciplinary intermediate care and integrated services is a key element of current policy as set out in the *'Kerr Report'*<sup>2</sup> and *'Delivering for Health'*. An undue reliance on the acute sector can manifest itself by providing costly care in an inappropriate place, sometimes for too long. It can also mean a neglect of in-hospital rehabilitation, a failure to optimise arrangements for discharge and support, and the use of resources that could potentially be used more cost-effectively in intermediate and integrated care services.

The optimal care of older people who are necessarily in acute care can also minimise their length of stay and dependency. Both quality and health economics considerations support a shift in the balance of care from acute to primary health services.

The Angus, Dundee and Perth & Kinross partnerships present three examples of varying challenges and achievements in shifting the balance of health services.

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<sup>2</sup> *Kerr Report-National Framework for Service Change in the NHS in Scotland*, Scottish Executive, 2004



### *Angus partnership*

The history and development of health services for older people in the Angus area were of particular interest. Of the three areas inspected, Angus was, on the evidence available, the best example of what can be done in managing the shift in the balance of care from acute to primary and community services. Significant factors were:

- Relatively compact geography, with small town/rural mix and no large scale urban deprivation
- History of confident and coherent community services prior to recent developments
- Improved and increasingly harmonious council/NHS relationships
- Systems and structures which were relatively simple and innovation-friendly
- The closure of inpatient acute facilities at Stracathro Hospital, Brechin, has been successfully achieved, despite earlier concerns. Local services have risen well to the related challenges, assisted by the resource transfer arrangements.

The resulting pattern of local services, robust alternatives to admission and discharge services, combined with the more distant acute facilities in Ninewells Hospital, can be regarded as embracing all the principles of the *'Kerr Report'* and *'Delivering for Health'*.

### *Dundee partnership*

Collaborative working between health and social work services for older people in Dundee presented different challenges. Although there were examples of collaborative working, in a city with historical patterns in the provision of health service delivery, combined with significant deprivation, multi-agency working in the provision of services for older people needs to be further developed. Significant factors were:

- The impact of Ninewells Hospital, a Tayside facility, which has a disproportionate impact on Dundee, with local services overshadowed by a very large teaching hospital
- The threshold for admission for older people to acute care appeared to be the lowest encountered in the three areas inspected
- Primary care had still to demonstrate its full potential in the emerging role and involvement of the CHP's services and structure
- Imaginative and high quality community services such as home care which worked hard and appeared to deliver well, given their resource constraints
- Intermediate services (step-up and step-down) appeared inadequate
- Difficulties over resource transfer for older people's services
- The impact of not having Tayside issues worked out was greater in Dundee.

### Perth & Kinross partnership

In broad terms, the balance of care across health services for older people in the Perth & Kinross partnership appeared to represent a stage of development intermediate to that of the two other partnerships. There were social and geographical challenges, with urban and rural deprivation, and a minority of patients in very remote areas. Significant factors were:

- The changing use of Perth Royal Infirmary (PRI), a district general hospital, had impacted on local services
- The ending of the Care Together experience had been difficult for many health and social work staff
- There was not yet a clear strategic way forward, jointly owned by clinicians, health and social work professional staff
- A geriatric medicine service which was actively and imaginatively engaged in service developments and collaborative projects
- A major concern amongst some clinicians about the role of NHS Tayside, which they called '*Tayside centralism*'. This was seen as a lack of recognition and encouragement of local developments, while at the same time developing Tayside-wide solutions not felt to be locally owned
- There seemed to be a robust tradition of rural general practice that embraced change and technology while continuing to provide at or near home services for frail older people, who in other circumstances might have been admitted, with significant long term implications, to an acute hospital.

#### 5.1.3 Shifting the balance of care towards care in people's own homes

The three partnerships were fully aware of the need to shift the balance of care from institutional settings such as care homes to providing more home-based care. They had developed plans to do so, for example:

- The Dundee partnership's papers on '*The Balance of Care and Service Development in Dundee: An Integrated Approach, 2003 and 2006*', and the Dundee City Council committee report on '*Older People Services, June 2006*'
- The Perth & Kinross partnership had set out their plans in the joint committee paper entitled '*Developing the Partnership Approach to Better Outcomes – Shifting the Balance of Care*', July/August 2006, which outlined the partnership's approach to modernising services and closer, more effective joint management processes
- The Angus partnership had a fully developed '*Older People's Strategy, 2005-2008*'.

However, all the partnerships were finding it difficult to achieve their goals for a number of reasons which are set out in the following chapters. The most significant one was the relatively higher levels of use of care homes and lower levels of intensive home care, as was the case in most of Scotland.

Even when the partnerships took steps to reduce the use of care homes, increase the level of intensive home care, prevent emergency hospital admissions and reduce delayed discharges, the balance of care remained weighted towards the use of care homes. Dundee City Council had agreed in June 2006 to commit an additional £1.8 million for 2007-08 for intensive home care, which was a very significant step towards addressing its balance of care.

Overall NHS Tayside met all the delayed discharge targets set by the Scottish Executive. However, there was a marked difference in the speed with which each of the three partnerships could set up care packages to facilitate discharge from hospital. This was related both to available funding and available services. We urge NHS Tayside and its partners to respond to the national drive to reduce delayed discharges by promoting the development of new infrastructures and services, such as intermediate care, rather than channelling resources into existing services.

Partnerships were developing some ways of supporting older people at home, for example through joint developments with health, social work and housing, assistive technology, in housing with care, telecare and telemedicine. These are essential routes to supporting more older people at home. We particularly welcome those targeted at supporting more frail people at home.

### 5.1.4 A coherent strategy for health and social work services for older people in Tayside

The national vision for the NHS in Scotland, as set out in the *'Kerr Report'* and *'Delivering for Health'*, replaces traditional ideas of primary and secondary care with community care teams, including sometimes complex care, at or near the patient's home, and with acute care limited to those whom it will most benefit. The national vision for social work is set out in *'Changing Lives'*.<sup>3</sup>

The principles of these documents were widely accepted in Tayside, although there were challenges in following through on implementing the national vision for health services and different rates of progress. The greatest challenges were clearly in the Dundee partnership which had the most extensive changes to deliver, and where there did not always appear to be a shared understanding about how to implement the national vision.

*'Somewhere in the great scheme of things I feel that the most important people, the patients, have been forgotten about.'* (quote from NHS staff member in staff survey)

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<sup>3</sup> *Changing Lives: Report of the 21st Century Social Work Review*, Scottish Executive, 2006

The overall impression of strategy and delivery of multi-agency services for older people in Tayside was therefore one of an uneven landscape. There did not appear to have been strategic consideration of the differing levels of services across Tayside which would address the way that services had been developed historically. It is not clear whether what existed was a resulting postcode lottery of services or was a reflection of different levels of need in the three partnerships (although it is likely to have been both).

In terms of acute care provision and use, the Angus partnership appeared to have made good progress, having absorbed the closure of acute inpatient care at Stracathro Hospital and adapted to a lower volume use of more remote acute care at Ninewells Hospital. Good multi-agency working was apparent in Angus at all levels, such as the designated links between the three community mental health teams and the Psychiatry of Old Age at Sunnyside Royal Hospital, Montrose.

In Perth & Kinross, it appeared to be an appropriate time to consider reducing inpatient care and to providing local specialist outpatient and day case services at Perth Royal Infirmary. Consideration could also be given to making more use of high-volume acute and specialist services in Ninewells Hospital.

However, Ninewells Hospital will be unlikely to fulfil its potential as the major provider of Tayside-wide acute, complex and high-technology care, if it continued with its existing level of unscheduled admissions which can turn into delayed discharges.

NHS Tayside should also consider the staffing and tasking of specialist geriatric medicine services, in which a Tayside-wide variance was seen. While the Royal Victoria Hospital, Dundee, provided high quality geriatric services for a small proportion of older people, geriatric medicine in Dundee appeared insufficiently engaged on two important fronts. Much closer involvement with other specialists in the acute care of older people, and a much more extensive and imaginative engagement with primary care in the CHP were required.

The Perth & Kinross geriatric medicine services commendably demonstrated both acute and community involvement in a way that served to maximise their impact on the care of older people.

We were informed during the fieldwork that a Tayside-wide strategy was going to be developed by NHS Tayside by June–July 2007.

### Recommendation – Tayside-wide number 1

NHS Tayside and the three councils should jointly develop and implement a coherent Tayside-wide framework for older people's services. This should set out an agreed strategic and financial framework for meeting the challenges of implementing the national policy directions as set out in *'Delivering for Health'* and *'Changing Lives'*. The framework should adopt a whole systems approach to achieving the required shifts in the balance of health and social work services.

Within this framework each partnership should develop and implement a clear strategy, including a joint action plan, financial plan, timescales and commissioning plan, which sets out how it will meet the need for local service developments.

#### 5.1.5 Financial resources

This section covers areas, such as resource transfer for older people's services, which were common to each of the three partnerships with NHS Tayside. Resource transfer funding was provided by NHS Tayside to each of the three Tayside councils to cover the costs of providing services for older people in the community following the closure of hospital beds. Comparative levels with other NHS boards and councils are set out in appendices 9 and 10.

The history of resource transfer agreements was relevant to the current availability and pattern of services for older people in the three partnerships. Separate resource transfer agreements had been reached between each council and NHS Tayside. We received comments that there had been a lack of transparency or equity between NHS Tayside and the three councils, and that this had resulted in disparities across councils. We did not have the capacity to examine these issues in detail.

### Recommendation – Tayside-wide number 2

There should be more joint discussion between NHS Tayside and the three councils regarding future funding arrangements including resource transfer. Future NHS Tayside funding arrangements should take account of imbalances created by resource transfers agreed to date.

The three councils were clear that they faced or would face financial pressures in relation to services for older people, because of demographic changes, people's rising expectations and advances in medical technology. All of these place greater demands on partnerships to continue improving services for older people.

Fig 2: Budgets for services for older people within the three partnerships, 2005-06.

Source of funding	Angus partnership	Dundee partnership	Perth & Kinross partnership
Council	£30.7 million	£31.3 million	£29.6 million
NHS Tayside	£12.6 million	£28.4 million	£12.7 million
Total	£43.3 million	£59.0 million	£42.3 million

The 'NHS Tayside Local Delivery Plan, 2006-09' (dated June 2006) included targets to reduce the number of people waiting to be discharged from acute hospitals into a more appropriate care setting. However, the Plan noted that the major risk was that the targets were dependent upon funding provided by the councils for ongoing placements. The Plan also noted that, during 2005-06, the partner councils had been unable to continue to provide the same level of new placement activity as in previous years. However, Perth & Kinross had increased their placement activity from 251 in 2005-06 to 276 in April-December 2006.

Nevertheless, we consider this to be a risk that will continue in future, because of the increasing pressures on funding for older people's services, particularly in Dundee. We have made a recommendation earlier in this report (Recommendation: Tayside-wide number 1) about the need for a fully costed Tayside-wide strategy for services for older people in order to effectively and jointly manage this issue.

Of particular concern was the absence of medium term financial planning. All three partnerships were unable to produce financial plans for the following two years 2007-08 and 2008-09. Medium term financial plans are essential to the process of forward planning and they should be prepared and agreed based upon policies and objectives in force at the time of preparation. They can thereafter be adjusted accordingly, on a rolling basis, if required. This would be assisted by NHS Tayside aligning its budget setting timetable with those of the three councils, as is currently being done by NHS Lothian to assist joint financial planning.

### Recommendation – Tayside-wide number 3

The partnerships should prepare medium term joint financial plans and review them on a rolling basis in order to inform the process of forward planning of services for older people. NHS Tayside should consider aligning its budget setting timetable with those of the three councils.

## 5.2 Person centred care

### 5.2.1 Single Shared Assessments and IT

The staff of all the Tayside partnerships were struggling to cope with the demands made on them by the incompatibility of health and social work IT systems, particularly in relation to single shared assessments (SSAs). Angus was piloting the eCare system for SSA in the early supported discharge and prevention of admission schemes.

During the inspection we saw an SSA being emailed from Ninewells Hospital to a shared office in Kirriemuir, for the simultaneous attention of a number of different staff, including a community nurse, social worker, occupational therapist and home care manager. Once fully integrated IT systems are in place, they will bring about significant improvements to inter-agency working.

### 5.2.2 Preventative and self care services

The emphasis in current health and social work thinking, as set out in *'Delivering for Health'* and *'Changing Lives'*, stresses the importance of early stage, preventative services for older people. Current thinking also stresses the importance of self care, particularly for people with long term conditions. All the Tayside partnerships were aware of the need for services which enable well being and self care.

NHS Tayside had initiated a project in each partnership to identify patients with long term conditions (LTC) and to support them effectively in the community through case management. There was a Long Term Conditions Strategy for each area of Tayside. The councils were, however, being faced with difficult decisions about their ability to fund and provide early stage, preventative services because of the increasing demands on their budgets. They were committed to continuing to provide these services, Dundee especially so, but managers acknowledged that it might not be possible to do so.

## 5.3 Delivery and management of services

### 5.3.1 The interface between the delivery of health and social work services

We noted the positive way in which frontline health and social work staff generally worked together in Tayside. This was particularly true of the multi-agency teams in all three partnerships.

In Angus and Perth & Kinross, multi-agency teams for early supported discharge and prevention of admission provided alternatives to admission and early supported discharge services. These services successfully minimised the length of acute stay and successfully supported older people in their own homes.

Comparable teams in Dundee also provided similar services, but had more difficult challenges because of the shortage of home care services, which was below the national average level. As a result, the option of acute admission of frail older patients with sub-acute or minor acute illness seemed to be more common. It is doubtful if this can be explained simply on grounds of geography or deprivation levels, and it seems possible that other factors such as levels of intermediate services and referral patterns in primary care in Dundee also contributed to this situation.

There were many examples of strong collaborative working between health and social work staff in the community, for example home care staff in Dundee spoke very highly of community nurses and the support they received from them. In Perth & Kinross, health and council staff, together with other organisations, reduced the incidence of falls (see Good practice – Perth & Kinross number 2).

### 5.3.2 Medication

Regular and consistent handling of medication for people at home is a litmus test of multi-agency collaboration, because it is essential if people are to be supported in staying in their own homes.

#### Good practice – NHS Tayside number 1

The pharmacist in the Community Liaison Team in Perth Royal Infirmary, whose role was to assist people leaving hospital to know how to take their medication regularly, was clearly enabling older people to manage their move from hospital to home more safely.

There were differences about the way that the three partnerships approached the role of home care and social care staff in prompting and/or giving medication, and this was being addressed. Although prompting by home care and social care staff was the policy of the three councils, it was not always implemented by staff. The Perth & Kinross partnership was training staff to prompt and had a training plan in place for this. Angus had a clear policy for the administration of creams although this was not consistent across Tayside.

The issue of the appropriate assessment of patients' ability to manage their own medication, together with the capacity, professional and drug stability issues for pharmacists meant that there were some problems with this area of service provision. For example, there were problems with some pharmacists who were unwilling to fill more than a certain number of 'nomads' (small plastic containers for pills) or fill them for more or less than a specified number of pills. However, many community pharmacists were working at full capacity.

The staff survey and the focus groups showed that most staff did not believe that there was effective assessment of older people's ability to manage their own medication safely, regardless of where they lived. This question attracted the highest level of negative responses in the staff survey.



More problematic was the situation when people needed more than prompting. The three partnerships' policy was that home care and social care staff were not allowed to administer medication. This can put additional pressures on community nurses who may be unable to undertake the number of visits required to ensure regular medication.

The inspection team noted the strenuous efforts being made to develop and implement a policy to enable home care and social care staff in Angus to administer medication. At the time of the inspection, the Angus partnership was considering whether NHS Tayside funded pharmacy staff could deliver medication training to social care staff. Their aim was to enable competent trained staff of all grades to deliver optimal care to patients and prevent duplication of effort across the partnership.

The partnerships were considering whether this policy, when agreed in Angus, could be rolled out across Tayside. The Perth & Kinross partnership had linked closely with Angus to avoid duplication and share good practice for the administration of medication.

### Recommendation: Tayside-wide number 4

Managers should ensure that policies and procedures on medication (drugs, creams, etc) for older people receiving services are clear and are energetically promoted with all staff, including pharmacists, to ensure consistency of practice. A subsequent audit should be carried out to monitor implementation.

### 5.3.3 Dementia services

Several issues arose during the multi-agency inspection in Tayside in relation to dementia services. There were good services such as Beech Hill House in Angus which provided a range of services including day care and respite, the specialist dementia nurse in the Community Liaison Team in Perth and the model of small teams of home care workers in Dundee providing a consistent service.

### Good practice – Angus partnership number 1

Angus partnership had a joint Early Stage Intervention Service for People with Dementia, which provided support and information in a clear and helpful manner. This kind of service is particularly important because of the predicted growth in numbers of people with dementia and the fact that about 30% of those with the illness are in the early stages.

Shortage of respite was consistently mentioned, although some available services were not fully used. In Dundee, in particular, there were limited respite services which were flexible and could manage people with challenging behaviour. In Perth & Kinross there were shortfalls in respite and suitable day care, particularly for people with dementia whose needs became greater as their condition advanced.

Many systems of home care provision throughout Tayside resulted in what one carer called a *'traffic of strangers'* into the homes of people with dementia and this issue did not appear to be systematically tackled.

Carers of people with dementia generally did not feel that they were valued as partners in overall care. In Perth & Kinross and Dundee they felt they had to find out about and press for services they needed. However, many carers spoke about the good support of community psychiatric nurses (CPNs).

From discussions with staff, interviews with older people with dementia, and the observations within care home and hospital settings, we identified a lack of understanding, knowledge and confidence among a significant number of staff involved in working in this area. A number of staff expressed a desire for specific training in dementia.

Angus had devised more joint training in recognition of this need, which was extended to carers and included representatives from Alzheimer Scotland. Perth & Kinross have developed training for nursing auxiliaries within community hospitals and were looking to extend this to home care staff.

#### Recommendation: Tayside-wide number 5

All partnerships should develop training plans or progress their existing plans to ensure that all social care and health staff working with people with dementia are provided with training on the skills and expertise needed for working with people with dementia.

The *'Tayside Managed Care Network for Dementia – service mapping project, 2006'*, which highlighted aspects of good practice across Tayside and areas of shortfall, was a useful basis for further multi-agency service development. When this is acted upon, some differentials in service provision would be remedied and the quality of services undoubtedly improved.

## 5.4 Outcomes for people who use services and their carers

In summary, older people were largely positive about the quality of their assessments and the services they received. They were also largely positive about the way staff from different agencies worked together. However, carers said they frequently did not receive the support they needed in relation to their own health needs or from hospital staff when the person for whom they cared was in hospital.

### 5.4.1 Views of older people on services

The majority of older people selected to be interviewed were living at home in the community and were receiving fairly intensive services. About half had been admitted to hospital at some point during the previous 12-18 months. The majority of those interviewed knew what services they were receiving, although some of those with dementia were not sure and had to be prompted to remember.

Almost all of the older people were very positive about the quality of services which they received, rating them as either excellent or good. Almost all commented that the services which they received helped them live a more independent life and also feel safer.

Equipment and technology were viewed by the older people as playing a crucial role. The community alarm service was identified by many of the older people as giving them a great sense of security and re-assurance. Two older people who had undergone surgery for below knee amputations were anticipating the arrival of electric wheelchairs. A number commented on how walking aids had not only helped with their mobility indoors, but had also increased their confidence to venture outside again.

Most of the older people were aware that an assessment of their needs had been done, although less than half were clear about who had done this and when. Only a few were aware of having received anything in writing about their assessed needs and the services which they would receive. Most knew both whom to contact about their services and how to do so.

The extent to which older people considered that they had been active participants in, rather than recipients of an assessment and care planning process, varied considerably. Less than half were clear that they had been asked about their needs, when the assessment had been done, or whether they had been asked their opinion about services which would help them. However, almost all said they were happy with the outcomes of the assessment.

It is very positive that almost all of the older people were happy with the services which they received. Partnerships should continue to consider ways in which older people, including older people with dementia, are helped to make decisions throughout their treatment and care experience.

We were impressed that in a number of the homes visited for the interviews there were information packs which included details of the services to be provided (especially home care and community nursing services) and details of who to contact about them. The packs did not necessarily include a copy of an assessment and care plan. The Perth & Kinross partnership's policy was to keep individuals' records for community nursing and home care in their homes. All partnerships should ensure that older people receive a copy of their own assessment and care plan.

It was evident that a number of older people were unclear about what written information they had received, whether they had kept this and, if so where. Given that this could include important information about whom to contact in an emergency, partnerships should give consideration to how they give written information, especially emergency contact details, to older people.

Several different mechanisms were used in Angus, such as a section in the home care information booklet for recording emergency information. Angus Care and Repair issued emergency information through a 'message in a bottle' which was kept in the fridge. All partnerships should consider different ways of providing emergency information, for example in a laminated sheet or magnetic format to attach to fridges.

#### Recommendation: Tayside-wide number 6

All partnerships should ensure that every older person receives a copy of their own assessment and care plan. They should consider the ways in which they provide written information to older people so that it can be easily identified and located within older people's homes.

Almost all of those interviewed said that the services which they received from health and social care services were well co-ordinated. None of those who had been discharged from hospital raised any concerns about the arrangements surrounding their discharge from hospital. Although one individual had not been able to leave hospital for a period of six weeks after her assessment had been completed, because of a lack of home care services, almost all said that they received the equipment which they needed when they needed it.

Older people and carers interviewed did not raise concerns with us about the co-ordination of services, which is also positive. However, we saw some practice which suggested that there is scope in Tayside for multi-agency working to become more co-ordinated and integrated. For example, when older people received services from community nursing and care at home services, sometimes from both the council and independent sector, there were multiple service folders in the house.

Moreover, intensive care packages could mean that the number of social care and health staff coming to the house was very large. For example, one man discharged from hospital had a combined care team of 27 staff attending his home on a regular basis, although this was exceptional. Managers should consider how best to monitor these situations and make changes where necessary.

### 5.4.2 Views of carers on services

Although most of the carers who responded to the survey said that their own health was reasonable or good, the majority said their health had worsened because of their caring responsibilities. This is consistent with the findings of many carers surveys. It is of particular concern, especially given that most of the respondents reported problems with stress or worry, 76% with lack of sleep, 33% with back pain and 24% reported other problems including heart problems, high blood pressure and psoriasis. The majority said that their health problems had affected their ability to care and about half said that these problems had gone on to affect the person for whom they cared.

Although most of the respondents had spoken to their GP about their caring responsibilities, only 19% had been offered a health check by their GP practice in their capacity as a carer. Most carers thought that it would help them if they were offered an annual health check. The majority of carers who responded were themselves over 60 years of age.

Perth & Kinross CHP has provided all practices with guidance on working with carers including onwards referral to both social work and voluntary agencies. Some practices have identified carers champions. Given the crucial role which carers play, all partnerships should give more attention to the health needs of carers. A clear strategy is needed for ensuring that this is appropriately addressed, particularly within primary care.

#### Recommendation: Tayside-wide number 7

Partnerships should develop systems for monitoring the number of health checks offered and provided to carers and should set annual targets for increasing these.

The survey had encouraging findings in respect of carers assessments. The majority of respondents had been informed of their right to a carers assessment and had had their needs assessed. Performance in this area is higher than average compared to SWIA performance inspections, but varied across the three partnerships. Also encouraging is that most of those assessments had been completed during the previous 12 months, although, again, performance varied across the three partnerships.

Most of the carers who had received an assessment said that it had helped them. The majority had then received support services for themselves, and a similar percentage had received support services for the person for whom they cared. Most of the respondents had had a break from caring during the previous year with about two thirds of this respite being provided by agencies and one third provided from other sources, such as family, friends and neighbours.

Carers views about the effectiveness of multi-agency working were generally positive. However, they were not positive about their experiences when the person they cared for was admitted to hospital. For example, only 37% of respondents said their views and input were sought on admission to hospital, only 27% were informed of their rights to a carers assessment and only 38% were involved in planning when the person they cared for was discharged from hospital.

The satisfaction levels of carers about the provision of information and of feeling valued and listened to were significantly lower in respect of hospital staff, than for both health professionals in their local GP practice and social work staff.

#### Recommendation: NHS Tayside number 1

NHS Tayside should give attention to improving how health staff communicate with carers and how they acknowledge the role of carers of older people. This should be done in partnership with carers organisations and be supported by the introduction of feedback mechanisms and improvement plans.

#### 5.4.3 Outcomes for service users and carers from the viewpoint of staff

File reading was one of the ways that the inspection team collected objective evidence about outcomes for people and their carers. Both health and social work files were read and the findings set out below are drawn from them. The conclusions of the file reading were positive overall, although there were some important findings.

On the positive side we found that there was evidence that the objectives in the care/treatment plan had been, or were in the process of being, achieved in 98% of cases. In almost all of these cases, this could be attributed to effective collaboration between services. Furthermore, where there had been no improvement in the individual's circumstances, this could only be attributed to a lack of collaboration between services in less than a third of the cases. In almost all cases (91%), there was evidence that the views of the individual were taken into account.

The level of multi-agency intervention was judged to be proportionate to the assessed needs in almost all (92%) of the cases and this was also the case irrespective of whether individuals had become more or less dependent on services during the period under scrutiny. Services had worked together to provide care in times of crisis in most cases. They facilitated hospital discharge in 88% of cases and prevented hospital admission in 33% of cases.

## Chapter 5: Overview of Tayside-wide issues

For those individuals who had been admitted to hospital during the previous year, the quality of the care package put in place to meet their needs upon discharge was judged to be good, very good or excellent in most (78%) cases.

The most significant findings from the file reading related to unplanned hospital admissions and delayed discharges. In 90% of the cases of older people who were admitted to hospital during the previous 12 months, the admission was unplanned. It was also notable that the subsequent discharge from hospital was delayed in 21% of cases to allow services to be put in place. The file reading suggested that services were more effective at times of crisis in facilitating discharge from hospital rather than preventing admission.

## Angus Council and NHS Tayside partnership

### 6.1 Person centred care

There were well established processes for assessment, care management and treatment in social work and community health services. The experience of people receiving services was fully taken into account when delivering or developing services. Enabling well being and self care was also being undertaken effectively, for example through the Early Stage Dementia service. There were a number of effective mechanisms to ensure access to services, such as an excellent range of leaflets. Performance in this area was very good.

#### 6.1.1 Assessment, care management and treatment

##### *Assessment*

There was a well established inter-agency single shared assessment (SSA) process which fully considered individuals' needs and preferences. The Angus partnership was piloting the eCare system for its joint assessment and care management documentation to ensure easy exchange of information between health and social care staff, and we saw an impressive example of it in use. Their SSA incorporated the IoRN, a national tool to measure levels of dependency and assist in the long range planning of services.

There was a Carers Self Evaluation Tool, which was being piloted as carers preferred this to a carers assessment form. Carers were encouraged to use this to consider their needs and then to discuss with a member of the social work team what could be provided. Nearly three quarters of carers who responded to our survey in Angus said that they had been informed about their right to an assessment and over half had had their needs assessed. Of these, three quarters had received support services. There was good feedback from carers, especially about care management. A project to locate carers through GP practices was well established, and had identified over 500 new carers.

The full SSA included the possibility of a wide range of assessments, such as physiotherapists, occupational therapists, and dieticians. There was integrated care pathway documentation used by the Angus Medicine for the Elderly service. Although the full SSA was not part of it, the SSA level 1 form for referral, initial assessment and screening was included. This pathway was designed to ensure that a prompt initial screening and assessment was carried out on admission to hospital and to involve other agencies where appropriate.

Systems were in place to identify and respond to the needs of groups and individuals, for example the SSA asked about ethnic needs or considerations. There was access to the interpretation and translation service run by Dundee City Council. The '*NHS Tayside Race Equality Scheme Action Plan, 2005 – 2008*' was a positive document. Some developments were in hand, for example discussions were underway with the Chinese community and there appeared to be efforts to ensure that services were culturally appropriate in Angus, which had about a thousand people from ethnic minorities and an unknown number of gypsy/travellers.



### *Care management and treatment*

Social work staff in Angus were fully committed to enabling people to live independently supported by the care management process. The file reading showed that care plans with clear goals and timescales were agreed and signed by service users and reviewed regularly. This was not always so for people receiving low levels of home care, because of pressure of work.

Older people were enabled and supported to make their own decisions, and advocacy and information were readily available to assist them do so. A care manager located in Ninewells to improve transfer of care on discharge has demonstrated real improvements and initial feedback from service users suggested that the service was highly valued.

#### Good practice – Angus partnership number 2

An older person moved to a care home and then, at the review six weeks after moving, she expressed a strong desire to live in her own home. This preference was taken seriously and the social worker found and furnished a flat as well as providing a great deal of support.

This commitment was not quite so evident in health services. The hospital patient discharge sheet did not mention taking account of users or carers views but other paperwork made it clear that patients and carers could be involved in the discharge planning meetings. There were some basic leaflets, for example on the community nursing service and pulmonary rehabilitation as well as leaflets on exercises given out by physiotherapists. Individualised compliance charts and guidance from clinical pharmacists were provided on discharge from hospital.

Information sharing between agencies to ensure care was seamless was underpinned by several policies and protocols such as the NHS Code of Practice and consent forms as part of the SSA process.

There was an impressive range of developments to improve care and treatment within the last 12-18 months and to meet the needs of older people, such as the Angus Joint Equipment and Loan Service (AJELS), an equipment trial service, rapid access chest pain clinics, Parkinson's review clinics, and a stroke rehabilitation unit. Evaluations such as the Rapid Response Scheme Evaluation Report demonstrated high levels of satisfaction with these new services.

### 6.1.2 Experience of people and carers when receiving services

This section looks at how the experience of people receiving services was used in service delivery and development. This was evidenced through an impressively wide range of systems to obtain feedback about the experience of people and carers when receiving health and social work services. For example service user and patient reviews, feedback surveys, audits, complaints, carers surveys, and focus groups for specific topics were in place.

The feedback systems included the Whitehills Health and Community Care Centre comments and suggestions feedback system, the Angus counselling service client satisfaction evaluation report, the diabetes day service evaluation, weight management service evaluation, and the GP patient experience study. The development of the Patient Public Forum will further strengthen the inclusion of views of service users in improving health services.

Our survey of carers showed that the majority of carers for older people felt valued and listened to by social work staff. It was also clear that action was taken to improve services, for example consultation on the Angus Carers Strategy showed that carers wanted more flexible home-based respite and a new short break scheme had been set up in response to this.

There was good provision of advocacy, for example through the Independent Angus Advocacy Service, funded by the partnership, and the Clients Right Service, provided by the council. The training programme being developed for care management will include advocacy skills.

### 6.1.3 Enabling well being and self care

There were active partnerships between formal and informal care to promote and maintain health and independence. These included training programmes for volunteers, carers and staff on palliative care and care of stroke patients.

Agencies actively supported older people's capacity for self care particularly for long term conditions, for example the Early Stage Dementia Service. One community mental health team, besides providing a range of therapeutic interventions, had set up a support group in a rural area to overcome problems associated with isolation.

The Angus Gold Project had been set up to promote healthy living and disease prevention. A Health Shop had been set up in Montrose to provide information and advice about health improvement for older people, with a second planned in Forfar.

The new stroke rehabilitation unit in Stracathro Hospital had a strong focus on both rehabilitation and promoting well being and self care.

A pilot study had also been set up by NHS Tayside involving two GP practices to look at addressing the needs of people with long term conditions. A number of patients had been identified who would benefit from ongoing support to enable them to manage their conditions more effectively.

Regular reviews were normally being undertaken for older people by health and social work staff, within six weeks of receiving a service and at least annually, as appropriate, whether in hospital, care home or at home. These were multi-disciplinary or multi-agency as required. Service user and carer involvement in reviews was considered by Angus social work staff to be essential.

### 6.1.4 Access to services

#### *Information about services*

A range of excellent council leaflets was available, for example clearly explaining that people would be assessed and the council would decide whether they needed services. Information was widely provided on both health and social work services, for example through GP surgeries, the internet, libraries, the Carers Centre, the AMAZE Directory of Services and out-patient departments.

All health leaflets had contact information in several languages and a contact telephone number for translation. All council leaflets had the crystal mark for plain English and information for older people was available on request in a range of mediums.

There were systems to determine eligibility and priority and these were transparent, fair and equitable, for example the priority categories for occupational therapy services and the specific criteria for community alarms. Revised draft eligibility criteria for social work services were awaiting approval by the council. The new intake system for social work would ensure a single point of access for all new referrals.

#### *Improving access to services*

Obstacles caused by factors such as disability and geography were positively addressed in a number of different ways. Transport was provided for day services users, all public access buildings were compliant with disability legislation, and a loop system was available in all minor injury units.

Other organisations were positive about health and social work services. Partner organisations such as WRVS and the Salvation Army assisted with transport using volunteer drivers. One of the national voluntary organisations was particularly enthusiastic about the range of services available to older people and the extent to which these were constantly improved.

There was good guidance available on some aspects of collaborative working such as the Tayside joint health and social care adult discharge protocols.

Older people could be referred, as required, to specialist services such as sensory impairment and allied health professionals (AHPs). There was a wide range of training available to staff to ensure they were kept up to date with the needs of older people with impairments, for example continence training.

High quality equipment and Care and Repair services were available in Angus with equipment being delivered to older people from the joint equipment store on the same day if necessary. Direct access by older people to community alarms, some AHP services and equipment services was being progressed.

A major redesign was being undertaken in relation to community hospitals, community medicine and rehabilitation services. This will support a shift in the balance of care and provide easier access to some services.

## 6.2 Key outcomes

Positive outcomes for older people and their carers are a key indicator of effective collaboration between agencies. Good outcomes for older people were achieved from services provided by the Angus partnership. They commented on the commitment and the contribution made by both the social care and health staff to their care arrangements, both when they were at home or when being discharged from hospital.

This section should be read in conjunction with chapter 5 which covers outcomes for older people and carers on a Tayside-wide basis. The SWIA performance inspections have found that all social work services across Scotland need to develop better ways of recording and measuring outcomes for people who use services. Without these, it has not been possible so far to evaluate outcomes as very good.

### 6.2.1 Views of older people

It was clear from the inspection that older people in Angus experienced good outcomes. This included older people who had been effectively supported to prevent hospital admission at a time of crisis and also older people who were successfully being supported at home after a period of time in hospital. A number of older people commented on the commitment and the contribution made by both the social care and health staff to their care arrangements. Even a low level of assistance could make a significant improvement in their quality of life and was much appreciated:

*'I stopped going out; well I was afraid I would fall, but getting my zimmer lets me go out for wee whiles.'* (quote from an older person in an interview)

Outcomes for older people and carers were largely seen to be positive, for example:

- An older person spoke very positively to us about the quality and importance of the community meals service. It had been reviewed and developed taking into account research highlighting the importance of good nutrition, so that people could be provided seven days per week, twice a day, with hot meals rather than frozen meals
- A person with Parkinson's disease who attended the day hospital at Stracathro Hospital told us about how much she valued being able to return there regularly for checkups
- A number of older people had successfully been supported to move from a care home environment to an adjacent very sheltered housing facility with the outcome that they were enabled to live more independently
- One older person who was being supported at home after an above knee amputation in August 2004, but who had since fallen at home twice, was still being visited at home on a weekly basis by her GP

- A carer who was interviewed together with his elderly mother commented on how the day care service not only benefited his mother, but also supported him in his caring role by allowing him to continue working.

Less positively:

- Several carers considered that the difficulties of being a carer were often not recognised. They said during interviews with us and their focus group that both home care and community nursing staff were sometimes reluctant to make use of carers detailed knowledge of the person for whom they cared
- There was sometimes a lack of co-ordination around the discharge of older people from Ninewells Hospital to community hospitals in Angus. This meant that an older person might not necessarily be discharged to the resource best suited to meet their needs and might have to be transferred a second time
- In an interview with an older person who had attended her local hospital earlier that week and was sent home with various medications for a urinary tract infection, the interviewer became concerned about the woman's capacity to self-medicate safely.

The findings from the case file reading exercises were that the social work files in Angus were of very high quality and that in almost all cases the objectives in the care plan either had been or were in the process of being met. In most cases the level of intervention was seen as proportionate to meeting people's needs.

### 6.3 Whole systems approach

The partnership's use of a whole systems approach in relation to the range and quality of services, joint planning of these services and joint financial management was very good. There was a wide range of health and social work services, and a very collaborative approach was taken to joint planning and financial management.

#### 6.3.1 Range and quality of community based services

##### *A whole systems approach to delivering services*

Health and social work staff and managers in Angus demonstrated a positive approach to whole systems thinking for services for older people. For example, the Manager for the CHP and the council's head of service for community care services were co-located in Forfar and demonstrated effective leadership across council and CHP boundaries.

We saw many examples of good joint working and co-ordination between services during the inspection. There was generally good collaborative working between GPs, community nurses and social work staff at grass roots level. For example, GPs and community staff were involved in provision of care such as the Gold Standard in palliative care. There was particular emphasis on delivering integrated care at points of crisis, which often prevented admission to hospital.

The Angus partnership is developing access to services across the range of agencies with recent agreement to extend access to community alarms to the community nursing service. The Forfarshire Society for the Blind and the special needs housing assessors in the council had direct access to the community alarm service and plans were being developed to include the Macmillan nursing service. Providers spoke of good collaborative working between health and social work services within day services, including links to pharmacy and podiatry.

In the staff survey, Angus showed the highest level of positive responses (86%) to the question about a whole systems approach to service delivery. We met staff groups and service providers who were very positive about well co-ordinated working and communication. Most of the case files we read recorded specialist or multi-disciplinary working.

### *Broad range of quality services*

There was a broad range of quality services to support people in their own home. Many of these are described throughout the report and include jointly managed and integrated services. There was also a range of residential, housing and assisted living, and day care options, which were either provided directly by the council or commissioned from the private or voluntary sectors. Almost all the staff who responded to the survey thought that a good range of quality services was provided.

Services to people with dementia were of a very good standard, with a significant improvement in recent years. The newly re-opened Beech Hill House complex offered a range of residential and day support services to people with dementia and their carers. The early stage dementia project for people with dementia is of particular note in terms of support to carers. Plans were in hand to increase availability of day services at weekends.

There was a clear link to the health improvement agenda. Elected members highlighted their community meals service and its role in delivering good quality hot meals to service users across the council area and in providing informal monitoring of isolated individuals. This service was seen by staff as key to maintaining people in their own homes.

The multi-agency community mental health teams not only provided support to individuals but the support workers worked alongside other agencies, for example advising on good practice in day care. The teams also provided training to staff in residential settings about working with people with dementia or challenging behaviour.

### Good practice – Angus partnership number 3

People who use services, their carers and staff in a range of agencies all spoke positively of the work of the Early Supported Discharge/Prevention of Admission (ESD/PoA) teams. The teams showed very effective practice in sustaining people in the community or enabling early discharge from hospital. Staff were achieving measurable results including reductions in re-admissions to hospital.

The referrals management centre being developed by NHS Tayside was welcomed as an opportunity to streamline discharge planning, to increase the use of step down facilities, and to direct patients to the most appropriate resource. The management of Medicine for the Elderly services in Stracathro Hospital through the CHP structure, rather than acute services, was seen as a positive advantage to service delivery.

The jointly commissioned Independent Intermediate Care Scheme offered nursing and rehabilitation in care homes in Angus. It was successfully providing step up and step down facilities to support or prevent inappropriate hospital admissions.

### *Service commissioning*

Service commissioning, whether single agency or joint, should take a whole systems approach to achieving agreed strategic objectives. A joint commissioning plan for older people's services in Angus was set out in the Older People Care Group Strategy. The council planned to develop a more detailed commissioning strategy from the recommendations of the Best Value review of older people's services. One of the factors being considered in this review was that the majority (about 80%) of home care services were provided in-house and the majority of care home services were provided by private providers.

However, this review was looking only at council services. Appropriate health services should also be considered and links should be established with the review of community hospitals.

Discussions with the Care Commission did not indicate that there were issues of quality in the services provided by the independent sector. We were made aware by the Care Commission of the trend in which large provider organisations were purchasing small local care homes. Such shifts in the market can lead to a reduction in choice for individuals.

### 6.3.2 Planning, policy development and partnerships

#### *Strategic planning is informed by a whole systems approach*

The 'Older People Care Group Strategy, 2006' was an exemplary strategy for older people's services and was the key planning document for older people's services across Angus. It addressed longer term planning for older people's services, for example taking into account demographic trends, and it set out timeframes, responsible officers, targets and progress. It formed a good basis for the delivery of joined up services and sought to include all appropriate partners. Outline agreement on the funding of commitments was included in the strategy.

#### Good practice – Angus partnership number 4

The Angus housing strategy for older people was based on a 20 year vision for housing suitable for older people. It commendably recognised the diminishing demand for sheltered housing in its current structure and proposed a range of options including 'virtual' sheltered housing that would enable individualised solutions to supporting individuals in their own community.

The planning structure had good cross-agency involvement including representatives from the voluntary and private sectors. Service providers in the voluntary sector spoke of improved communication and involvement in planning services, although this view was not shared by private providers.

Managers worked hard to ensure that there was full involvement of all stakeholders. Responses to the stakeholders' survey indicated that the voluntary sector felt fully involved. Trade union representatives spoke positively of joint working and involvement in the planning of services.

We were told that service user and carer representatives were involved in all the strategic planning groups but the carers we spoke to did not feel engaged in the process. This suggests a need to review carer involvement to make it more rewarding to them.

The outcome of the review of community medicine and rehabilitation services (including community hospitals) will have an impact on how services are delivered in the future, in terms of available resources, including buildings and finances. We stress that the partners should ensure that the possible impact of this review is taken into account in joint planning and make clear links between this review and the Best Value review of older people's services.



### *Implementation of joint vision, policies and strategy*

The implementation of the joint vision, policies and strategy was undertaken through the development of operational and business plans. The CHP had a Delivery Plan for 2006-07 and the council a Service Plan. Both of these take account of national strategies, the Joint Performance Information and Assessment Framework (JPIAF) performance indicators and Local Improvement Targets (LITS). Individual units and teams develop specific action or business plans which reflect the vision and strategy.

Staff working in joint teams were involved in the development and delivery of joint policies, for example in the community mental health teams. There was also increasing involvement of primary care and housing staff in the prevention of admissions approach. A team of housing staff had been trained in the single shared assessment process to ensure that a holistic view of an older person's needs was taken into account when assessing an individual for accommodation.

Operational staff, both health and social work, were involved in a range of planning groups and staff spoke of how this had helped them to have a clearer understanding of the strategic direction. This had been supported by good monitoring and reporting to staff on planning activity.

The partnership was supported by a Joint Strategic Support Unit which was established four years ago to develop and monitor a range of policies and strategies, including local targets.

There was a clear commitment by the partners to measure the delivery of the key planning objectives. As part of the submission to JPIAF, the partnership was working to move from process to local outcome measures. The Joint Improvement Team from the Scottish Executive was working with the partnership to develop an evaluation framework for joint working.

The Director of Social Work and Health and the Chief Executive of the council were both members of the CHP board which ensured strong linkages between council and health delivery on policies. Several people spoke of the advantages of managers of both services being based within the same building thus facilitating communication and collaborative actions.

Management reports showed that realistic targets were set and reviewed. There was a clear performance reporting structure in place which set out timescales and identified the responsible managers for delivering on both performance and performance information.

### 6.3.3 Financial and resources management

#### *Financial planning*

The Angus Council 2006-07 budget for services for older people was £30.7m which, when added to the NHS Tayside budget of £12.6m for the Angus area, resulted in a total budget provision of £43.3m. Consistency in budgeting within the partnership was achieved through the Joint Management Group.

At the time of the inspection, there were no financial plans available for 2007-08 and 2008-09 as these would depend on the review of strategies which were being undertaken. We make a recommendation about this in chapter 5.

The linking of financial plans to the strategic objectives had been lacking, to a degree, in the past, but efforts had been made to improve these in 2006-07 and managers advised us that this should be fully addressed by 2007-08. Additionally, the Older People Care Group Strategy illustrated the movement of funds from bed-based to community-based services and across services to support service development in older people's mental health services.

The ratio of financial input by the partners was not a pre-agreed percentage. Rather, it depended on the provision of services by each partner and varied from year to year. For example, podiatry services were being included from 2006-07. Elected members of Angus Council said they did not concern themselves with health resource allocation in the other two Tayside areas as long as they felt that Angus was obtaining a reasonable level of resources. They generally expressed satisfaction with the resource allocation and with their relationship with NHS Tayside.

#### *Financial management*

The Joint Management Group was provided with budgetary control reports only once a year. The reason given for this was that the budgets were aligned and well controlled within each partner organisation. Each partner produced its own budgetary control information for its own officers on a monthly basis. Managers advised that, if any significant budgetary problems were to arise during the year, they would be reported to the Joint Management Group.

#### Good practice – Angus partnership number 5

Angus partnership had a 'buddying' system between health and social work finance staff to ensure sound financial joint working. There were two designated financial officers from health and social work services who worked together and supported the work of the Strategic Planning Group for older people's services.

There had been some joint capital expenditure in recent years, for example the Whitehills Health and Community Care Centre and the Beech Hill House complex, which was a PFI development. Capital expenditure requirements were dealt with by using the partners' corporate methodology.

Managers advised us that, due to demographic influences, financial commitments for older people were growing at a rate that was putting increasing pressures on the partnership's limited resources.

### 6.4 Delivery and management of services

Day to day planning and resource management between health and social work were effectively undertaken and monitored at a local level across the partnership. There was also a range of joint operational management mechanisms such as groups which met regularly to oversee all joint projects and initiatives. There were increasing levels of co-location, for example in Whitehills Health and Community Care Centre, with resulting benefits in sharing information, problem solving and responses to need. Performance in this area was very good.

#### 6.4.1 Day to day planning and resource allocation

##### *Operational management and planning*

We were impressed with the joint operational management and planning which we observed in Angus. There were good inter-agency relationships, characterised by a positive and problem solving approach. In a joint interview two middle managers demonstrated this when they said: *'We can't control all the difficulties we face, but we can manage them.'*

Managers met regularly in a variety of well established joint operational forums to ensure that there was consistency and alignment with the partnership's agreed joint plans and priorities. The implementation of the Action Plans for the community mental health teams demonstrated this in an exemplary way.

There was clarity in joint teams about which kind of cases should be allocated to staff who had the most appropriate skills and experience. Allocation was done at weekly multi-agency meetings.

The partners set a high standard in monitoring and managing capacity issues in relation to hospital discharges. Multi-agency teams met regularly to ensure that care packages were set up before individuals leave hospital. The discharge co-ordinator from Ninewells Hospital attended the Joint Planning Group to ensure that operational issues were properly understood at the strategic level and solutions found.

The CHP previously had three managers who managed services within geographical areas on a 'cradle to grave' basis. At the time of the inspection, there were three managers with functional remits, and senior managers said this had enabled a much more effective approach to the management and delivery of services.

Social work managers had adopted a system of 'hot spot monitoring' which required managers to track key performance information, for example about assessments, on a monthly basis and take prompt action as required.

### *Workload management systems and waiting lists*

Workload management systems for individual social work practitioners were in place. We were not made aware of any significant problems with workloads except for two areas. Home care assessors said they had difficulties completing reviews and community nurses said they no longer had time to 'check on' patients as opposed to undertaking active nursing duties. However, the inspection team understands that nursing duties nationally are now more focused on active interventions.

Day to day management of workloads appeared effective with staff meeting targets such as those for service delivery set out in the Local Improvement Targets (LITS). There were no significant delays in the provision of most social work services. Where there were some delays, such as home care, they existed mainly on the basis of availability of service rather than the ability to obtain funding. There were no delays for Direct Payments.

However, there were significant waiting times for community rehabilitation services, in particular physiotherapy and occupational therapy. The CHP viewed this as a priority for investment as part of the proposed reconfiguration of community hospitals.

Part of the reason for the limited waiting lists was the strength of the joint working in Angus at all levels. For example, community nurses in rural areas had good links with social work staff and both were proud of their flexibility in responding to need and taking action. Managers met regularly, for example community care team leaders and home care managers did so to inform each other about and monitor the needs of people who were using or may need to use their services.

Community nurses spoke of the good access to minor home modifications such as grab rails which could be instantly provided by direct referral to Angus Care and Repair. Both health and social work staff saw the joint equipment store as providing a quick and effective service. Community nurses were a major source of referrals for home care and praised the speedy assessments undertaken by home care assessors (although there were knock on effects in some reviews not being carried out).

Good practice – Angus partnership number 6

The community mental health teams (CMHTs) were set up in 1999 with social work as the lead agency, to provide a care management service to people over 65 who had mental health problems. Clear eligibility criteria were established from the start. Joint meetings with the service manager, the older people's care management teams and CMHT managers were held regularly to ensure consistency and appropriateness of work. The allocation of work between the CMHTs and the care management teams for older people was being made on the basis of a shared understanding about the complexity, presenting problems and the need for multi-disciplinary working in cases being referred.

Intake and allocation systems should effectively screen and prioritise work, and priorities set at team/unit level should reflect joint priorities. Following SWIA's performance inspection in 2005-06, which highlighted concerns about the intake system, a new social work intake system was being developed, and was to be fully operational by November 2006.

In addition, Angus was responding to concerns in that report about the absence of clear and robust eligibility criteria. At the time of the fieldwork, a draft protocol for eligibility criteria was with the elected members for approval. It was designed to support the partnership's aim of providing a wider range of services, especially preventative services for the over 50s, rather than restricting services to people with priority needs.

However, staff and managers told us they were working with effective eligibility criteria in relation to older people's services, and they thought there was clarity about how to screen and prioritise work. For example, 40% of referrals from Ninewells Hospital for the early supported discharge scheme were screened as not suitable because the individuals did not have short term needs or were clinically unstable.

The council was also developing more effective resource allocation systems for access to care homes and priority systems for home care. The joint Local Capacity Group had been established to monitor and effectively manage discharges from hospital.

### 6.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Established multi-disciplinary arrangements for the protection of vulnerable adults should be in place. These should include a fully implemented inter-agency policy and procedure for the reporting of abuse of vulnerable older people.

#### *Arrangements*

A Tayside-wide policy had been put in place in 2005 for the protection of vulnerable adults. Further work, such as leading workshops, was being undertaken by the national Joint Improvement Team (JIT), to improve the implementation of the protocol. This should also ensure greater consistency about the threshold for intervention assessment and management of risk across Tayside, although managers in Angus thought that they had general agreement about when it would be appropriate to intervene.

A multi-agency Adult Protection Committee had been established in Angus. A generic risk assessment tool had also been developed and implemented within social work. Community nurse managers said that nurses also assessed their patients for risk.

Managers said that robust multi-agency training had been developed and was to be delivered locally in Angus. The care management training to be implemented following the new Scottish Executive guidance will also include risk assessment and the protection of vulnerable adults.

#### *Accountability for risk management*

Risk management and monitoring of risk assessments was undertaken through multi-disciplinary case conferences, supervision, care and case management processes and case file audits. Staff and managers were clear that if home care staff had concerns they would raise these with them. They recognised that it can be difficult to assist older people with dementia to remain in their homes but that it could be achieved through collaborative working.

There was an appropriate balance between risk management and the right of people to make their own decisions. Within the partnership a number of staff had undertaken the Adults with Incapacity Act training which covered issues of self determination, advocacy, and the rights of individuals. Angus Council also had a contract with an independent agency that offered advocacy to individuals.

We were impressed with the way that social work and health staff and managers discussed together the way they would support older people at home, rather than going into hospital, even though this might involve some risks. They clearly respected the rights of older people to take decisions about remaining at home and were supportive of this, but emphasised that the decision should be multi-agency and agreed with the GPs.

### 6.4.3 Management and support of staff

#### *Training and staff development*

There was a very positive approach to joint training, although there were no overall joint training strategies. Both health and social work had training managers who worked together on the joint training remit. However, managers accepted that the training programmes could be better linked, and could be more closely related to joint service priorities and less 'condition linked'. Training, appraisals and continuous personal development (CPD) were still agency specific, for example the council had a good supervision booklet and supervision was effectively undertaken for social work staff.

There were a number of local inter-agency initiatives, example for mental health awareness training, moving and handling, and medication management. There was also a joint training initiative between health and social work to improve collaborative working with people with dementia and stroke care. A pilot joint leadership programme was completed in April 2006. The CHP had frequent training days and social work staff attended these.

Of particular interest, the partnership had developed training and a protocol for home care and social care staff to assist people to take prescribed medication. It was poised to roll this out. Housing staff were trained to and did carry out SSAs, an approach which exemplified the holistic approach and good relationship with the housing services. Independent providers were able to access some joint training and training provided by the council.

Some professionals raised some concerns about whether all staff were adequately trained to meet the needs of people with dementia or other complex needs. They also said that there were training issues about some staff who were sometimes reluctant to listen to carers views and recognise their contribution to the care of older people, and that there were inconsistent levels of communication across agencies.

There were a number of leadership programmes in place such as Stretch (partnership), and Leading to Deliver (council). The council was introducing a performance management system, to be rolled out in housing first, and then in social work. This could be used in the CHP at a later stage, with the CHP Manager stating that there was definitely scope for this to be integrated into health performance systems.

#### *Joint workforce planning*

Workforce planning had not been a priority when establishing the new CHP arrangements but managers now wanted to look at more integrated workforce planning. They were particularly interested in looking at the need for generic workers who could combine the duties of nursing assistants and social care assistants. There was also a major issue, in common with the whole of Tayside, about the age of the workforce, both nursing and social work. Since many staff were over 50 years, their retirement would have a significant effect on the delivery of services.

The difference between the terms and conditions of staff in joint teams was not a significant issue in Angus. Union representatives said that while they recognised the issue, staff in joint teams tended to accept and work round these. Although there were some difficulties in filling posts in rural areas, absence levels and recruitment were generally not problematic in either social work or health services and there was good support from human resources staff in both organisations.

Checks on qualifications and registration requirements were made at the recruitment stage, including Disclosure Scotland checks in both health and social work. Staff had personal development plans that took account of their CPD requirements for accreditation purposes.

### *Staff support and morale*

The partnership was fully committed to supporting staff at all levels in the organisation through a range of good practices. There were well established systems in both the council and the CHP for induction, supervision, appraisal, management competencies, continuous professional training, and personal development, leadership programmes. The council has achieved the Investors in People (IIP) award. Service plans and work plans were in place for all teams within the partnership. CHP staff were in the process of being assimilated into Agenda for Change and the incorporation of the National Knowledge and Skills Framework into personal plans/job outlines was underway.

Staff in both health and social work services spoke highly of the support they received from their managers and their morale was generally very high. Creativity and innovation was encouraged by managers.

*'The winters in the glens have led to staff supporting each other. And, as managers, we try to be flexible and supportive of staff in rural areas.'* (quote from a manager in an interview)

We were impressed by the consistency and frequency with which staff in older people's services spoke positively of the way their work was valued and how they were able to make a real difference to the lives of the people they assisted. Union representatives also spoke very positively of joint working and the support for staff right across Angus, although there was no joint staff forum.

### *Policies that guide how staff communicate*

There were documents and protocols about communication between staff, and managers said that they intended to develop more appropriate information for staff and the public on older people's services. They wished to do so to support transformational change within the partnership, for example in relation to proposals about the future of community hospitals in Angus.



However, we saw many examples of very good communication between staff in joint teams who were working well together and trusting each other. Beech Hill House staff said that they worked well with staff from community health services: *'We have moved on in leaps and bounds since we moved back together into the new high dependency complex'*. The staff in Stracathro Hospital day hospital said they worked well with other staff in the hospital and community, including social workers. In rural areas, community nurses had good links with social workers.

The Early Supported Discharge/Prevention of Admission (ESD/PoA) service was an example of excellent joint working in virtual teams. Members were not co-located but worked well together. They were positive, highly motivated, and fully engaged in their work. The workforce was stable and enjoyed high job satisfaction. A physiotherapist said: *'You see people getting better with good mutual support from different staff'*.

We were impressed by the way that health and social work managers in Angus recognised the difficulties that could exist for staff in communicating across professional and organisational boundaries and worked to minimise these. The council's older people service had produced a communication strategy and a multi-agency working group was developing an electronic resource directory.

### Good practice – Angus partnership number 7

The Manager, Augmented Care, and Community Nurse Manager demonstrated good collaborative working. They said that, although so many initiatives were emerging from the Scottish Executive, and although staff had different values, terminology and ways of doing things, staff in both health and social work wanted the best outcomes for patients and users. They thought that this could be greatly helped by working together on small steps, for example direct access for community nurses to community alarms. Achieving joint successes for staff, patients and service users was the best way forward for them and their staff.

#### 6.4.4 Performance management and continuous improvement

##### *Joint performance reporting*

This is undertaken through the Scottish Executive reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). This contains annual returns by partnerships on performance indicators based around four national outcomes. These are underpinned by Local Improvement Targets (LITS), which are set by the partners themselves to measure progress and improvement.

The Executive rated the partnership in 2005-06 as making good progress on single shared assessment. This was in terms of the number of older people with completed community care assessments and an average timescale of 19.9 days between the first contact date and the start of the first service.

The partnership was making steady progress in relation to cross-agency access to resources as a means of enabling faster access to services for older people. A joint resourcing agreement and joint eligibility criteria were being developed.

The partnership met most of its LITS for 2005-06. It has consistently met the targets for reductions of delays in discharging people from hospital. It was meeting or was close to meeting its targets for rapid response services and better services for carers. It fell short of its target on the provision of intensive home care.

Although the partnership had developed its targets for 2006-07, including for example the length of stay in care homes as a means of measuring their performance in supporting people to remain at home for as long as possible, its targets were evaluated by the Scottish Executive as requiring substantive development.

The overall JPIAF feedback was that the partnership was making steady progress. However, the Angus partnership's opinion was that this did not reflect the true position, as good progress was being made. For example, the number of older people supported in care homes reduced from 776 in 2004-05 to 720 in July 2005. The target for older people receiving intensive home care of more than 10 hours per week was 120 in 2005-05. The actual number was 95, but if other services are factored in, this rose to 235 people receiving more than 10 hours care per week.

The partnership had well established systems in place to monitor performance, both as individual agencies and jointly. The Joint Project Development Group for older people's services monitored key areas of older people's services, for example through a strategic calendar of proposed events. The partnership indicated that it needed to concentrate on outcomes rather than outputs and intended to further develop the LITS.

The Chief Officers Group for community planning was developing a joint performance management framework, and a joint reporting system was being developed. The council's Excelsis system was being made available to health. However, managers and staff recognised that the difficulties with using different IT systems in relation to single shared assessments, and therefore with information sharing, meant that further work was needed to generate good quality performance information.

There were a number of mechanisms where the partners individually monitored performance, for example the Service Improvement Model was being applied to services for older people. The CHP used the Quality Improvement and Clinical Governance reporting structure and calendar which is used throughout NHS Tayside, reporting on these at six-monthly intervals.

Through these joint and single reporting mechanisms the partners were able to demonstrate improvements such as the fact that people discharged from Ninewells Hospital to the intermediate care service in Arbroath, where they received rehabilitation services for four weeks, had a very low rate of re-admission (1.9%). The Early Supported Discharge service (ESD) had re-admission rates of 9%. The level of admissions for the Prevention of Admission (POA) rate was 19%, and this had fallen from 23% in the previous year. There was a Tayside-wide discharge planning group that monitored delayed discharge targets and addressed issues of concern.

Both partners regularly reviewed older people's services, for example the council was in the process of undertaking a Best Value review of older people's services with particular emphasis on the way services were commissioned from the independent sector.

### *Continuous improvement*

We were impressed with the way in which staff in the partnership consistently owned and worked towards continuous improvement. User/patient feedback was sought regularly in order to improve performance. For example, patient satisfaction surveys were carried out in a number of services such as weight management and pulmonary rehabilitation. Staff in the Augmented Care Services were working on process mapping of admissions to permanent care in order to improve this process for service users by identifying areas of good practice and by highlighting blockages and duplication.

Staff and managers were open to ideas and innovation, for example proposals from staff in joint teams for the Project Development Group, and freedom to test and evaluate service innovations using the 'Plan, Do, Study, Act' methodology, originally a health approach but now crossing the divide into social work.

There was also strong leadership from senior managers in promoting continuous improvement, for example health managers described how they had contacted other partnerships such as Lanarkshire to learn about case management.

Individual Development Plans for staff were used well with a rate of 94% in the council and 75% in health (a rise from 64% last year). Senior managers of older people's services in Angus wanted to build on the positive attitude of staff to continuous improvement. For example, they wanted to see staff development actively linking into the LITS but recognised that this may take time to achieve.

The Angus partnership demonstrated that performance management and continuous improvement was soundly embedded at all levels, strategic and operational, and that these factors drove up the quality of services in order to deliver better outcomes for people and their carers.

## 6.5 Leadership and direction

The Angus partnership demonstrated very good leadership of people and change. The senior managers modelled good partnership working in action, and enjoyed the confidence of staff. The key achievements and priorities set by the partnership were in line with '*Delivering for Health*' and have already delivered better outcomes for older people in relation to delayed discharges and unscheduled care. They were clear about the next steps in their local improvement and development agenda and had already initiated action to address shortfalls in intensive home care and NHS community rehabilitation services.

The Chief Executive of the council described a coherent relationship between the community planning partnership and the CHP, in which issues related to older people were addressed through a number of relevant and cross-cutting themes. These included demographic change, supply of carers, deployment of migrant workers and rural economy issues. Subsequent agreed actions were all subject to an electronic performance management system which the partnership had agreed to put in place to ensure tracking and delivery. The community planning partnership tried to ensure all plans were outcome focused and SMART.

The Director of Social Work and Health and the CHP Manager consistently presented a model of mature, cooperative leadership, in which each displayed an understanding of the pressures and challenges within the other's organisation. The CHP Manager was impressive in her approach to work with elected members. She had built on her previous contact and since the inception of the CHP saw herself as the local 'face' of NHS Tayside in Angus. She described herself as the first point of contact for the council on health issues and also as the local accountable officer.

This perception was confirmed by the Chief Executive of the council. In the past, NHS Tayside was often regarded as 'remote and unresponsive' by the council but the CHP Manager had done much to improve this view, by enabling elected members to air any misgivings and concerns they had and to have them addressed. This was particularly important in relation to service redesign.

With regard to the overall change agenda in Angus, the council and NHS Tayside were aware of future proposals which might prove controversial, particularly concerning community hospitals. The approach, as in the past, would be for the local partnership to make the case for change robustly and transparently.

A key issue for local leadership, as in all three Tayside partnership areas, was the working out of an appropriate relationship with NHS Tayside acute services, to enable as much health care as possible to be devolved to the local area. This was described by the CHP Manager as a 'maturing process' which was being developed through the Tayside-wide Capacity and Flow workstream and the Pharmacy workstream.

To support this, a financial framework is essential to ensure local confidence in relationships with centrally-based services and to demonstrate equitable distribution of resources. We make a recommendation about this in chapter 5.

Senior partnership managers conveyed enthusiasm about how the Chief Executive of NHS Tayside's Delivery Unit might progress the devolving of services to the local areas. There was evidence of forward thinking and planning about future integration of services as well as tackling the improvement agenda. Senior managers were clear about what needed to be done and had, in some cases, already initiated action.

A key issue for the council was the reported low levels of intensive home care and for NHS Tayside the need to significantly enhance the capacity and coverage of AHP services and rehabilitation skills generally.

Integrated workforce planning was at an early stage in this partnership, although joint training was well established. The next major step would be to move towards generic workers, which staff themselves had said would be a desirable development.

### 6.6 Capacity for improvement

**The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services and their experiences, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.**

**We found that significant achievements had been made to improving outcomes and experiences of people using services. Senior managers recognised the importance of quality assurance and performance and had ensured that good systems were in place. There was a strong culture of continuous improvement which was well embedded at all levels in the agencies. The leadership of the Angus partnership was very good. Overall, there was very good capacity for improvement.**

In order to maintain progress there are a number of positive factors which will underpin and support these developments.

We found a clear vision for partnership working in the Angus partnership which was firmly based on improving outcomes for older people. This was grounded in the strategy for older people's services, produced in 2006. There was sound financial planning and monitoring. Good support from the council and stable organisational arrangements also facilitated robust partnership working. Both health and social work staff were highly motivated and determined to enable older people to live as independently as possible.

## Dundee City Council and NHS Tayside partnership

### 7.1 Person centred care

There were well established processes for assessment, care management and treatment in social work and community health services. The experience of people receiving services was taken into account when delivering or developing services. There was a strong ethos in Dundee of enabling well being and self care and the council prided itself on the availability of lower level supportive services. Performance in this area was evaluated as good.

#### 7.1.1 Assessment and care management

##### *Assessment*

There was a well established inter-agency single shared assessment (SSA) process which fully considered individuals' needs and preferences. Dundee health and social work staff were particularly concerned about the difficulties of sharing SSA information with other agencies and said they had to fax copies to each other which took a considerable length of time. Like some other councils, Dundee's intention was to incorporate the IoRN, a national tool to measure levels of dependency and assist in long range planning of services, into the SSA when IT systems were developed.

The full SSA form was not generally used within hospital records. It was used by community health staff when making referrals. It was partially used by the council occupational therapy (OT) service and was well used by home care staff. It included health and social information. Rehabilitation plans were found in just over a third of files – in very few council files but in the majority of NHS files. The case file reading found that community care needs were recorded in three quarters of council files, and also in the majority of NHS files.

Dundee recognised the importance of carers assessments and had developed a form that carers could complete themselves if desired. Evidence from the case files and carers focus group showed that it was not well known about or widely used. The low completion rate was being addressed by the carers strategy group and the Princess Royal Trust centre. However, evidence from case files and the survey showed that about half of the carers were having their needs identified and addressed. This suggests good practice in that although staff were not widely using the form, they were discussing carers needs with them.

Some service users have very particular needs. The SSA required details of 'ethnic group and cultural background' and included a sheet for relevant details. Information about the needs of minority groups was also obtained from representative groups. The '*NHS Tayside Race Equality Scheme Action Plan, 2005 – 2008*' was a positive document. There were some services such as the Dundee City Council interpretation and translation service and the Chinese lunch club, but culturally sensitive services for ethnic minorities generally appeared to be limited.

Research on minority ethnic groups suggests that they want the same services as British older people but they want them to be culturally sensitive. The work on setting up an acceptable meals service in Dundee demonstrated this. There were no users from minority ethnic groups in the council's day centre for older people and it might have been possible to widen access to include them, with more flexible opening hours if necessary, as was done with Alzheimer Scotland. The department was working with a multicultural working group to develop a new multicultural day service.

### *Care management and treatment*

Dundee social work staff were committed to the care management process to enable people to live independently. The analysis of case files showed that over two thirds of files contained care plans (although these were very often home care service plans), and over two thirds had evidence of reviews. Home care staff drew up exemplary care plans for their service which were then kept in folders in the houses of service users and were available for other staff. In addition, many services, such as the day centre, the day hospitals and residential homes, had their own documentation.

Involvement of service users was strong – all documentation required the signature of the user, and users were involved in care planning meetings. Advocacy was available and a review of advocacy services was almost complete. Direct Payments were available and of the 33 people receiving them, nine were older people. Case file analysis showed evidence that the views of individuals were taken into account in nearly all cases. Care home placements and housing with care usually had to be allocated on the basis of need or availability rather expressed preference. The limited availability meant that first choice was not always a possibility.

An interesting feature of Dundee was that people retained their GP and therefore also the community nurses when they moved house. This was usually an advantage for the older person, if not for staff from other agencies who worked on a locality basis and had to relate to many different GPs and community nurses. Consistency in personnel was identified as a key issue by the Tayside Managed Care Network for Dementia, and it was helpful that GPs could maintain contact.

Although clearly there were problems with hospital discharges, practical arrangements made by frontline staff seemed to work satisfactorily, for example with most equipment arriving when required. This seemed to be a result of a really strong motivation of both staff in the hospital and staff in the community who said they wanted to '*get it right*'. Thus, for example, when a commode was not ready for a recently discharged woman, the social care worker got one for her from the store.

### Good practice – Dundee partnership number 1

A married couple moved to Rockwell Housing, a new partnership arrangement between a housing association and the Social Work Department, with a social care team on site. The facility included a number of flats for two people as well as one person flats and this enabled the couple to remain together. The husband was able to continue caring for his wife who had significant personal care needs, with additional support from the care team on site.

Information sharing between agencies to ensure seamless care was underpinned by several policies and protocols such as the NHS Code of Practice and consent forms as part of the SSA process.

There was an impressive range of developments to improve care and treatment within the last 12-18 months, such as the redesign of the Intensive Care at Home Service, the Lochleven intermediate care facility, the Chinese lunch club, Rockwell housing with care and the planned joint equipment store.

#### 7.1.2 Experience of people and carers when receiving services

This section looks at how the experience of people receiving services was used in service delivery and development. The Dundee partnership worked hard to obtain feedback from users and carers, for example a survey of home care staff and service users had just been completed. A telephone survey was ongoing in relation to the First Contact Service, which provided the first point of contact with council services. There had been a patients' satisfaction survey of the intensive care at home and rapid response services and an evaluation of the Parkinson's clinic group therapy.

Dundee had also just completed a carers survey which provided useful views on respite. These had been fed into the ongoing development of a carers strategy and the review of respite. Action had been taken to increase the care at home respite service to about 600 hours service per week. Action was also being taken to improve services such as the change to SSA forms to include the views of carers. However, our survey of carers showed that only about half of carers for older people in Dundee felt valued and listened to by social work staff.

There was provision of advocacy, for example through Age Concern, Alzheimer Scotland and DIAS which has a specific remit to cater for people with dementia and mental health problems. Managers recognised that advocates give a mixed feedback to them about services and that more advocates were needed. They were reviewing advocacy services and would incorporate views of individuals, carers and staff in this.



### 7.1.3 Enabling well being and self care

There was a strong ethos in Dundee of enabling well being and self care. Dundee prided itself on the availability of lower level supportive services such as the shopping service, the handyman service, the domiciliary meals service, the community alarm service and the home care service. All these services assisted people to remain independent and we recognise the value of these services. There must, for people with dementia, be issues about all these services being delivered separately. Managers should consider this and seek to make improvements if possible.

Dundee had an international reputation for its exercise programmes for older people, which have been the focus of a great deal of research. The Princess Royal Trust centre was funded to provide information, support and education for carers, which was much appreciated by the carers interviewed. An Alzheimer Scotland support worker was also funded.

A pilot project had been set up by NHS Tayside with two community nurses to identify and assist people with long-term conditions who would benefit from ongoing support through case management to enable them to manage their conditions more effectively.

The intensive care at home care service (ICAHS) had a strong rehabilitative ethos where the aim was to help older people increase their confidence and independence by encouraging them to do as much as possible for themselves. The day hospital for older people also had a strong rehabilitative approach, which ran throughout their assessment, treatment and discharge processes.

Regular reviews were normally undertaken for older people on a six monthly or annual basis, as appropriate, whether in hospital, care home or at home. These would be multi-disciplinary or multi-agency as required. Service user and carer involvement in reviews was considered to be essential by Dundee social work staff.

### 7.1.4 Access to services

#### *Information about services*

In the staff survey more than three quarters said there was information available to older people about health and council services. The partnership had a draft internal Service Directory, which helpfully set out a very wide range of both health and social work services but it was being updated and had not been published. When this was completed a service user booklet would be produced. There appeared to be few NHS leaflets, although there were joint leaflets on the Intensive Care at Home Service and confidentiality of patient information. The voluntary organisations had leaflets, such as the Tayside Association for the Deaf leaflet about their befriending scheme, and the Princess Royal Trust (PRT) centre leaflets.

The Dundee carers focus group members said they had found out about services from other carers or the PRT which was funded to provide information on behalf of the department. However, they agreed that health centres were definitely improving as sources of leaflets. There was a general view amongst the carers who said that *'you had to be clear about what you wanted and strong enough to ask for it'*. Managers should consider what range of information is required and take action to ensure it is widely available to the public.

The council had a First Contact Team which accepted referrals in all formats and was very accessible as it was in the centre of town. The team had no waiting times for referrals and assessments. The occupational therapy service accepted self referrals.

### *Improving access to services*

The social work committee had approved eligibility criteria, and over two thirds of all staff surveyed said that council systems were transparent, fair and equitable. Under half said the same about NHS systems. However, evidence showed that older people did not know about or understand the eligibility criteria for services. New leaflets for services were being developed. They should include information about eligibility and priority.

There was guidance available on some aspects of collaborative working such as the Tayside joint health and social care adult discharge protocol, but there was no multi-agency guidance on referrals and transfers between health and social work services.

There was a range of specialist services, such as the Dundee Blind and Partially Sighted Society, community rehabilitation therapy (CRT), a memory clinic, and podiatry. The involvement of Alzheimer Scotland in the Oakland day centre meant that the centre could provide for any degree of challenging behaviour, which was impressive. Access to the community health teams was through self referral, which was seen as very helpful, as well as through GPs.

Staff received regular training on sensory impairments but the council acknowledged that this was an area for improvement. Older people consulted felt that if people had needs that related to both physical and mental health problems they might have difficulty obtaining an appropriate service.

## **7.2 Key outcomes**

Positive outcomes for older people and their carers are a key indicator of effective collaboration between agencies. The evidence showed a mixed picture. Some people whom we spoke to said they were satisfied with their services, but others were not. The findings, for example from the case file reading, showed that there were issues around achieving successful outcomes for older people, both when they were at home or being discharged from hospital. The partnership's performance was evaluated as adequate in this area.

This section should be read in conjunction with chapter 5 which considers outcomes for older people and carers on a Tayside-wide basis.

### *Views of older people*

It was clear from the structured interviews which we undertook in Dundee that the older people interviewed were generally satisfied with the services they received. This included older people who had been effectively supported to avoid hospital admission at a time of crisis and also older people who were successfully being supported back at home after a period of time in hospital.

*'I had a problem with my legs and my sheltered housing warden spoke to my GP and made an appointment for me to see him. I got some pills and I'm coping much better now. She would do anything for you.'* (quote from older person in an interview)

During the fieldwork, good outcomes were demonstrated but some issues were also highlighted. On the positive side:

- An older woman who had spent a lengthy period in hospital after a below-knee amputation was secured suitably adapted alternative accommodation very quickly from a housing association. She and her husband were clearly delighted with their new housing. They also spoke positively of the Taxicard provided by the council which allowed her to maintain a degree of independence by giving her access to adapted taxis at a subsidised rate
- The positive working relationships between the hospital social work team and hospital staff ensured that older people approaching the point of being fit for discharge from hospital were able to have their needs quickly assessed
- We found a strong commitment from some staff, including those working in the Intensive Care at Home Service, to promoting older people's independence and their ability to self care.

Less positively:

- Less than half of the Dundee carers surveyed thought there was good communication between health and social care staff (although a similar proportion expressed no opinion). Less than half felt that they had involvement or input into the planning of care when the person for whom they cared was admitted to hospital. We heard a number of concerns from carers about the level of availability of respite services to support them
- We also heard a number of comments which suggested that there was a lack of clarity about the respective roles of social care and health staff in the community in the administering of medication. We observed some practice involving older people with dementia where inadequate consideration appeared to be given to their ability to retain and follow guidance on medication, given their cognitive impairment.

The findings from the case file reading exercise showed a more mixed picture than the other partnerships. For example, older people were on a waiting list for a service(s) in 25% of all the files read, but this figure was higher (33%) in NHS files in Dundee. However, most older people who are waiting for a service were already in receipt of a service, even though they were waiting for other services or a higher level of service.

Although there were only a small number (5) of cases in Tayside where the dealings with the individual were judged not to have adequately taken into account potential barriers arising from difference in culture or beliefs, all these related to NHS cases in Dundee.

## 7.3 Whole systems approach

There was a wide range of health and social work services. The partnership was committed to using a whole systems approach in relation to the range and quality of services, joint planning of services and joint financial management. However, there were significant issues within the partnership in relation to implementing this approach. Work needed to be undertaken on further developing clear milestones and targets, effective joint resourcing, joint financial plans, a joint commissioning strategy and joint performance measurement. The partnership had taken steps to improve this situation, for example by agreeing to implement a joint performance framework. The partnership's performance in this area was evaluated as weak.

### 7.3.1 Range and quality of community based services

#### *A whole systems approach to delivering services*

There was a mixed picture in Dundee about the commitment of health and social work staff to a whole systems approach to delivering services. We saw examples of good collaborative working, particularly between community nurses and social work staff at the grass roots level. However, the position about delayed discharges and the relative lack of resources impacted on joint working, with staff attributing responsibility to each other agency's use of funding and management of resources.

#### *Broad range of quality services*

Dundee council had a wide range of services to support older people in the community. Many of them demonstrated joint working in the delivery of care services for older people. These include the Intensive Care at Home Service, the Rapid Response service and the Supported Discharge Service, all of which provided additional support to people to either prevent hospital admission or support discharge.

However, the council's committee report '*Older People Services*' in June 2006 stated that there were significant issues about the range of services, in relation to the level of home care, intensive home care, respite care and intermediate care. The partnership has worked to improve this situation. Its policy, following the Balance of Care report in 2003, has been to improve the level of home care, and in particular intensive home care packages, while maintaining the level of care home places. It supported this by developing more services such as housing with care, rehabilitative and respite care.

The Audit Scotland indicators for 2005-06 showed that the number of hours of home care provided in Dundee was below the national average and Dundee was ranked 19 of 32 local authorities. (It had improved from 25th in 2004-05.) In 2005-06 there was an improvement in evening and overnight care, moving Dundee from a ranking of 29 in the previous year to 26 of 32 local authorities.

The Audit Scotland figures showed that Dundee had a higher rate of service users aged over 65 years than the national rate. The June 2006 committee report stated that, in total, '*151 people are awaiting 1230 hours of service. Of these people, 31% are awaiting a service of over 10 hours per week*'. The majority of hours were therefore awaited by people who require more than 10 hours of service a week, though they were getting some service.

Managers in Dundee stated that there was an '*issue of pace*' in improving the home care situation and the council has agreed an additional £1.8 million to assist in this, particularly in developing intensive home care packages of more than 10 hours per week. The committee report in June 2006 set out the issues for developing health and social work services generally across the partnership. For example, some development of housing with care had been achieved but not as much as proposed. This had added to the pressure of increasing supported care in the community and an improved balance of care.

The development of the new CHP structure in Dundee was a potential opportunity for improving the balance of care. For example, collaborative working was being developed through addressing cross-professional issues in virtual teams. However, the full potential does not yet appear to have been realised.

There were some developments which were positive. The joint equipment store, (which was at the design stage) should deliver more streamlined services but limitations in the range of equipment which can be accessed by health or social work staff would continue to limit the effectiveness of the service. There were no plans for arrangements for emergency provision of equipment or for evening access, although there were plans for weekend access.

Meeting the needs of people with dementia was mixed. Some pockets of good practice were seen particularly in the range of support from the joint community mental health teams but an overarching approach to meeting the needs of people with dementia or challenging behaviour was needed. This is also considered in chapter 5.

Dundee had a large supply of sheltered housing and there was a Best Value review of the sheltered housing service in 2005. Service user and staff surveys conducted at the time confirmed there was considerable satisfaction with the sheltered housing provided. The review also confirmed that strategic consideration had been taken of the amount required for the future. This was being taken forward as part of the Housing Strategy for Dundee.

However, we were told that much of the sheltered housing no longer met the needs of very frail or disabled older people. Many schemes had stairs to all flats which limited older people's ability to participate in community activities, although the 'Friendly Bus' service provided transport for older people so that they could travel to other sheltered housing units and community resources. Older people pointed out to us that while they liked their homes, sub-optimal sheltered housing meant they would have to move to get the care they needed and they might need a care home because their home was inaccessible.

#### Good practice – Dundee partnership number 2

The home care service had been re-organised so that there were small self managing teams of staff who provided the care of several older people within the team. This ensured greater continuity of care for older people and reduced the number of staff to whom they had to relate. Home care staff were able to go out with an occupational therapist when a discharge package was being planned so that there would be a good shared understanding of what was appropriate help for the older person.

The Oakland Centre provided day care for older people including older people with dementia. There were mixed views on this service. Several people saw the service as inflexible in terms of access and transport arrangements, and thought that the quality of the experience for individuals attending was limited. We were later informed that issues on access and actions to improve this had been identified by managers, who were also looking at the processes of referral and service delivery. However, during the inspection staff, service users and carers spoke positively of the support for people with dementia which was provided at the centre in conjunction with Alzheimer Scotland.

Day services for older people were also provided within a hospital setting at Ashludie and Kingscross hospitals. These services were designed to meet specific needs on a short-term basis. The Oakland Centre was seen as the base for development of day support services for older people, forming part of the continuum of support involving day hospitals.

It was not clear how these services would be jointly developed and other agencies expressed some frustration at the delays by the council in maximising the use of this resource. It was also not clear how the day support needs of older people with functional mental health problems will be addressed. However, discussions had taken place about developing day services and this would be further considered by the partnership at the Strategic Planning Group for Older People.

There were protocols and systems in place for hospital discharge planning with clear timescales for response. There was good discharge planning in the Royal Victoria Hospital and in the medicine for the elderly wards at Ninewells Hospital, but staff across agencies identified gaps in links with orthopaedic and other medical wards. The discharge process was also affected by the movement of both staff and patients in Ninewells Hospital, including the ‘boarding out’ of patients in temporary places within the hospital, and the subsequent lack of continuity.

Many staff in both health and social care services said that there were low levels of referrals from GPs to the teams which could support early identification of people at risk and prevent admission. This was a very significant issue since inappropriate admission to hospital can lead to a lessening of an individual’s ability to cope in the community and make discharge more problematic. It should be addressed by the partnership by developing more intermediate care services.

### Good practice – Dundee partnership number 3

The local manager had responsibility for mainstream home care as well as intensive home care, and the rapid response services. She had good links with combined care at home and the community rehabilitation team. This structure allowed significant flexibility in providing home-based services.

Services to support carers were patchy, particularly in the evenings and at weekends. Respite services were being developed with a plan to provide these within a dedicated respite unit. Respite for individuals was planned on annual basis and some carers found this to be unresponsive to their needs.

We spoke to staff who were very positive about the services they provided and service users who spoke highly of the services they received. A range of networks existed to include service users. We met with organisations which were developing services for minority ethnic groups and heard of involvement of service users in activity planning in sheltered housing schemes.

### *Service commissioning*

In considering a whole systems approach to the development and delivery of services it is necessary for councils and health services to communicate well with each other and have sound commissioning strategies which show engagement with providers at an early stage.

A number of reports in Dundee had identified the imbalance in relative spending in care home places and home care, and the need to change this. This included the ‘*Balance of Care Report, 2003*’ which was commissioned by the Strategic Planning Group for Older People and had been reviewed in 2006. It set out the strategy position in terms of a commissioning framework and direction. There was an outline joint commissioning framework in place against which the partners have assessed their progress.

It was being further developed through the Best Value review led by the Chief Executive of the council, with full participation of all stakeholders, including voluntary organisations. However, there was still no agreed joint commissioning strategy for both health and social work services for older people.

Independent service providers said that there was limited contact with them both in relation to care at home and care homes, except for contract management and monitoring of services already provided. We did not find significant evidence of thinking about how the care at home market might be developed or which services were to be commissioned to promote a shift in the balance of care. Voluntary organisations said they did not feel they were treated as partners in providing services. Social work managers told us there were regular meetings with independent service providers.

Service users and staff we met were positive about the quality of home care and care home services provided by the council. The reports from the Care Commission supported this view but were concerned about the proportionately high number of complaints received about services in the private care home sector. The introduction of the national contract for care home provision will be used by the council to work with providers to deliver quality services to meet their contractual requirements.

The Best Value review of services for older people which just begun by a multi-agency group and led by the council's Chief Executive should give real impetus to developing a joint and innovative commissioning strategy. It is essential that NHS Tayside assists this process by working collaboratively to put in place a joint strategy and financial framework within which priorities for older people's services are agreed.

### 7.3.2 Planning, policy development and partnerships

#### *Strategic planning is informed by a whole systems approach*

A multi-agency strategy for the Dundee partnership should have an overview of service provision, show medium to long term forecasts of service needs, and be supported by a financial framework. These should be accompanied by clear action plans with achievable objectives within agreed timescales and a joint commissioning strategy. It should take account of the review of community hospitals and the development of intermediate care services.

The implementation of service planning and development of older people's services in Dundee was devolved to the Joint Strategic Planning Group (SPG) through the Health and Local Authority Management Group. The SPG had not been meeting for some time, whilst the CHP was being set up, although it was in the process of being reconvened.

The partnership's performance had therefore been affected by delays in strategic planning. We make a recommendation about this in chapter 5.



At the time of the inspection, there was no joint strategic document which set out what health and social work community care services such as community nursing, home care and AHP services were being provided and should be developed. Nevertheless, we acknowledge that the partnership has undertaken a very considerable amount of work to develop a joint strategy.

The '*Dundee Joint Community Care Plan, 2005-08*' outlined the proposed direction for health and social care services in the partnership, including those for older people, but it no longer appeared to be in line with the latest thinking within the partnership. It had been informed by the '*Balance of Care and Service Development Report, 2003*', which set out an approach for older people's services and proposals for providing services. This was fully reviewed in January 2006 and specified the need for further strategic work and a full joint commissioning strategy.

### Recommendation: Dundee partnership number 1

The Dundee partnership should urgently collaborate on implementing a whole systems approach at all levels of both organisations. It should produce a strategy which includes a joint action plan, financial plan, timescales and commissioning strategy, and which sets out how the partnership will meet the need for local service developments. It should also set and monitor timescales for delivering tangible results.

Both health and social work services had their own plans for services. They reflected priorities across both the CHP and council services. Dundee City Council has a detailed '*Social Work Service Plan, 2003-2007*', which clearly set out services, lead officers, performance measures, funding, and target end dates, but it did not reflect the latest thinking within the partnership.

### *Implementation of joint vision, policies and strategies*

The implementation of joint policies and strategies was taken forward in a number of ways such as the Health and Local Authority Management Group, which oversaw service delivery and development. Joint working with housing services has informed the development of the housing strategy, including housing with care and the redevelopment of sheltered housing.

The joint priority allocation meeting, which we attended, focused on care home placements, with limited discussion about how to meet the needs of people within the community requiring high level care packages. However, we also saw some positive examples of people returning to the community, after being in hospital, with increased support while awaiting the care home of choice.

There were mechanisms for involving providers in strategic planning and development of services, for example they had been offered places in strategy and service planning groups. The involvement of service users and carers in service planning was undertaken through planning processes such as Celebrate Age Network, the OPEN Project and the NHS Tayside Public Partnership Forum. There were plans to involve existing and future service users in developing new housing services. Managers said that the performance management framework was being developed to ensure that users and carers were involved more robustly.

### 7.3.3 Financial and resources management

#### *Financial planning*

Dundee City Council's budget for older people's services (and other services such as learning disability and substance misuse) was £31.3m in 2006-07 which, when taken together with the NHS Tayside budget of £28.4m for the Dundee area, resulted in a total budget provision of £59.7m. These budgets are aligned, not pooled.

The broad financial framework contained in the Community Care Plan set out the respective contributions to achieve joint planning commitments. This was further developed in the *'Balance of Care Review, 2006'*. At different stages the council and health service have committed additional funding to meet these commitments on an interim basis, but there did not appear to be a longer term resource allocation from either agency.

The financial framework for older people's services was contained within the Extended Local Partnership Agreement (ELPA) which set out the resources for 2004-05 and the financial framework to be operated. There was not a detailed up to date financial plan. The Agreement indicated that resource transfer would be managed by the partner agencies in accordance with the *'Tayside Resource Transfer and Bridging Finance Procedures, 1999'*. We were advised, however, that this document was due to be updated.

The links between the partnership's health and social work services financial plans and strategic objectives require improvement. The construction of each year's budgets was mainly historically and incrementally driven rather than through specific links to current joint policies and objectives. The partnership ratio of financial contributions can change, to a degree, depending on the incremental construction of the budgets and whether savings are required from either partner.

We noted the debate that took place between senior managers during two meetings with us about the adequacy of resource transfer levels and the use of potential resource transfer for efficiency savings. There was discussion about the use of underspends by NHS Tayside to assist with effective management of resources.

The health board subsequently announced its intention of developing a Tayside-wide strategy for older people's services. We welcome this, but would stress the importance of developing it in full collaboration with the three councils.

At the time of our inspection, there were no medium term financial plans available for 2007-08 and 2008-09. We were advised that it was difficult to prepare such plans when decisions had yet to be taken about the Dundee City Council and NHS Tayside budgets. We make a recommendation about this in chapter 5.

### *Financial management*

A crucial issue for the Dundee partnership was that the resources invested in older people's services, or the way they were utilised, appeared insufficient to meet the current needs of its ageing population. This was apparent from the waiting lists for services and continuing delayed discharges. This situation existed despite the fact that Dundee City Council spent 4% over the GAE level on all social work services in 2005-06.

Staff and managers in the other two Tayside partnerships told us that it was generally considered that the Dundee partnership received a proportionately higher allocation of health funding for older people's services, in order to meet shared pressures such as delayed discharges (see Fig. 3). Although council managers considered that their budgets were generally sufficient for the services that had been planned, they agreed that they were not sufficient for the unmet need.

Senior council and CHP managers clearly recognised the scale of the problems they were facing. A council committee report in June 2006, and subsequent reports, had set out the extent of unmet need for older people. It should be noted that this report provided information on numbers of older people waiting for different types of services, but did not include details of the significant amount of recurring revenue which would be required to fully address the problem. This report had also been discussed in the CHP committee, which was a positive step towards ensuring joint ownership of the problem.

The joint Health and Local Authority Management Group met monthly and financial monitoring reports were submitted to the Group on a quarterly basis. The regularity and quality of financial information provided to budget holders each period was satisfactory. Budget holders appeared to be experienced and adequately trained.

The information provided to elected members at committee meetings and the discussions that took place at the meetings appeared inadequate. However, we were advised by officers that members were also briefed, as required, prior to committees and therefore more detailed information was informally provided to them than in committee reports.

Partnership capital expenditure was minimal, apart from the provision of a joint equipment store. This was projected to cost almost £2m, with funding being provided by the Scottish Executive (£1.5m), Dundee council (£0.25m) and NHS Tayside (£0.16m). Capital expenditure requirements were dealt with by using the partners' corporate processes.

### *Information systems*

These should support frontline staff effectively, and a new council IT system, called Event Recording System (ERS) had been developed in-house and introduced in July 2005 to do this. About 550 staff were using it to record a range of event types such as referrals, assessments and phone calls. SSAs could only be held as attachments, which limited the potential to draw statistical summaries from them. It did not assist inter-agency communication because it was an in-house only system.

Staff in Dundee were particularly concerned about the problems with the interface of health and social work systems. They spoke of their considerable frustration in the delays in achieving co-ordination between systems, the duplication in recording for both systems and the fact that they had to fax lengthy documents to each other. Developments were underway to link the health and social work IT systems and the Dundee Data Partnership was monitoring this. Staff were not aware of an agreed timescale for achieving the links between the two systems.

There were several joint and council groups which worked to ensure that joint and single agency information systems were developed and implemented. These included the Dundee Data Partnership and the Social Work Department's Service Information and Technology Group.

## **7.4 Delivery and management of services**

The effectiveness of day to day planning and resource management between health and social work varied considerably within the local services. It was most positive in those services focused on discharging individuals from hospital and in the relationship between home care staff and community nurses. Staff perceived it as problematic when resources were not available to provide complex or high cost care packages for individuals, particularly when leaving hospital, which then contributed to the numbers of delayed discharges. Performance in this area was evaluated as adequate.

### **7.4.1 Day to day planning and resource allocation**

#### *Operational management and planning*

Health and social work managers considered that the systems in place to support the day to day planning and delivery of services were very good. These systems were designed to ensure that services were provided in line with agreed joint plans and priorities. For example, the Health and Local Authority Management Group jointly oversaw management and planning of services.

Individual, unit and team service plans set out their respective objectives and the links to the council's departmental service plan. Service managers for older people's services had defined operational and functional responsibilities, including areas of joint responsibility, and these were directly linked with service plans.

We agree that there were some sound internal mechanisms. For example, we were impressed with the fact that senior home care managers were not involved in day to day planning and resource allocation but had empowered middle and front line managers to deliver the service. Health managers were implementing nurse-led discharges giving ward based staff more responsibility in patients' journey of care in hospital.

### Good practice – Dundee partnership number 4

Ward based nurses were being encouraged to take responsibility for individual patient's care journey and discharge arrangements from the point of admission. They identified lead workers from either discussions with the family or from contacting social work and then worked with them to provide seamless care. This can be difficult to manage in Ninewells where patients may be 'boarded out' to other beds.

The First Contact team screened and prioritised social work referrals in Dundee and this service worked well – referrals were generally handled within half a working day. If not resolved within six weeks, cases were then passed to long term teams. Guidance was in place for firstline managers and practitioners that included eligibility criteria, devolved budgets, direct access to resources, the joint SSA process, and care and assessment standards.

We were not convinced that there were consistently strong managerial and staff links between the agencies in relation to day to day planning of services, case allocation and joint planning for the care of individuals. Some social work staff and managers said they did not know details of waiting lists for services, although we saw electronic evidence of waiting lists that have been available and circulated to staff for 18 months and for four years in the case of delayed discharges. Their statement was in line with our concerns that health and social work managers, until recently, have not been proactive in jointly managing waiting lists for some services for older people. These services include crisis, rehabilitative, respite and home care.

### *Workload management systems and waiting times*

Dundee City Council had effective mechanisms for workload management of social work in place and we were not made aware by staff of any significant problems with workloads. However, day to day joint management of workloads was not wholly effective, as targets such as those set out in the Local Improvement Targets (LITS) were not all being met, although there were other factors contributing to this.

In June 2006, the Social Work Department reported to committee that there were 145 older people waiting for care at home. Of these, 19 people had been waiting less than six weeks and 70 people had been waiting more than six weeks for a home care service. The report states *'although the majority have some service, those awaiting high levels of service are very vulnerable to arrangements breaking down'*. In addition, 79 people were waiting for care home placements. In October 2006, there were 39 older people who had been waiting in hospital for discharge for over six weeks and 15 for less than six weeks.

Health staff such as GPs, consultants, hospital and community nursing staff said it was difficult to know where decisions on waiting lists were made and were particularly concerned about the waiting times for residential homes and the availability of respite.

There were limited waiting lists for community equipment and the relevant manager stated this positive situation existed because the occupational therapists (OTs) employed by the council did not undertake care management and could focus on providing their service. Health staff said there was an immediate response by community OTs to their faxed referrals for same day discharge of patients in acute care when returning home.

Waiting times for health services, such as physiotherapy, within the CHP were rigorously monitored and actions taken if national waiting times targets were to go unmet. There was no waiting list for Ashludie Day Hospital; staff there allocated days for patients and decided the appropriate treatment.

There were different mechanisms within the partnership for handling the allocation of services. An inter-agency group prioritised the allocation of resources to meet individual needs for complex or high cost care packages such as care home places. There were regular functional frontline management meetings in social work that considered the information in relation to the capacity and workload at team and service level.

However, many staff thought that if a service was not available or there was a waiting list, then social work staff filled in unmet needs forms and accepted the fact that a service would not be available. We were aware that unmet need was reported to committee and that additional resources had recently been allocated to alleviate pressure on waiting lists.

Joint working was most positive in those services focused on discharging individuals from hospital. There was a very strong partnership between the Intensive Care at Home Service (ICAHS), the Crisis Team and the discharge co-ordinators in Ninewells Hospital. The ICAHS manager had considerable autonomy in identifying what service users needed and could manage services flexibly and positively to provide it quickly and effectively. Preventative and rehabilitative social work staff said they had excellent relationships with health colleagues in acute services but there were difficulties when there were not enough services to meet individuals' needs.

There were also strong relationships within joint teams. The Crisis Team described itself as ‘*a coherent team – we’re good at dealing with things ourselves – we work through our difficulties*’. They had developed innovative work patterns to maximise coverage. Home care staff said they worked very closely with community nurses who would take referrals from them and respond within one day: ‘*We work closely with the district nurses*’.

Concerns were expressed by social work staff about the fact that there were very different referral patterns from GP practices in Dundee, together with a growing sense of detachment and distance between them and the GPs. They said: ‘*It is not going to get any better*’. They believed that the new GP contracts and out of hours arrangements meant that doctors were being called out to see patients whom they did not know and would be more likely to admit to hospital.

They identified GPs as potential allies and thought that closer joint working would help to prevent inappropriate admissions to hospital. They also recognised that it was essential to have good preventative and crisis services for older people in the community if this was to happen. We were concerned to find a perception by front line staff that working relationships with GPs were deteriorating and consider that the partnership should take action to reduce barriers to closer co-operation.

Both health and social work had appropriate systems for monitoring demand and unmet needs. This information was collated and distributed regularly, for example Citystats were regularly reviewed by NHS Tayside and waiting times were regularly reported to Dundee City Council.

However, there were occasions during the fieldwork when we were concerned that some managers in both agencies seemed to have lost sight of what it meant for the individual older person who was waiting for services. Figures for waiting lists and delayed discharges were quoted without conveying to us a sense of urgency to act together at a strategic level to address the issue.

Senior managers were clear that this was not so, stating that they monitor, review and report service provision and waiting lists. Moreover, they said that they have frequently conveyed the urgency of the situation and it is in recognition of the problems that a Best Value review was being undertaken.

### 7.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Established multi-disciplinary arrangements for the protection of vulnerable adults should be in place. These should include a fully implemented inter-agency policy and procedure for the reporting of abuse of vulnerable older people.

### *Arrangements*

A Tayside-wide protocol had been put in place in 2005 for the protection of vulnerable adults. Further work, such as leading workshops, was being undertaken by the national Joint Improvement Team (JIT), to improve the implementation of the protocol. This should also ensure greater consistency about the threshold for intervention, assessment and management of risk across Tayside.

A multi-agency Adult Protection Committee was being established in Dundee. Several risk assessment forms had developed by health and social work, for example by Ashludie day hospital and Oakland day centre.

Managers said that comprehensive multi-disciplinary training was delivered locally in Dundee. The care management training to be implemented following the new Scottish Executive guidance will also include risk assessment and the protection of vulnerable adults.

### *Accountability for risk management*

The accountability for risk management and monitoring of risk assessments was undertaken through multi-disciplinary case conferences, supervision, assessment, care and case management processes and case file audits. For example, assessment documents included triggers for identifying and responding to risk.

Dundee managers and staff said they took a person-centred approach to assessment and care planning to ensure that each person had a care package appropriate to their needs. This included carers support services and advocacy services funded by Dundee. In this way an appropriate balance between risk management and right of people to make their own decisions was ensured.

However, they also told us that there were issues in Dundee about individuals being admitted to Ninewells Hospital, rather than being supported in their own homes, for a number of reasons. There was a local expectation by carers and families that individuals would be admitted, for example in emergency situations or when carers were having difficulty coping. This was reinforced by the relative ease of access to Ninewells Hospital, for example by GPs, and less readily available home-based support services, both health and social work, in Dundee. These issues require a whole systems approach by the partnership if they are to be resolved.

## **7.4.3 Management and support of staff**

### *Training and staff development*

Under the leadership of the Director of Social Work, the department has worked very hard to improve the staffing situation, including training and support. There had been some significant successes, such as reductions in levels of sickness, staff turnover and vacancy levels.



Emphasis was placed on both supporting and enabling staff, for example through personal folders, achieving the Scotland's Health at Work (SHAW) silver award and through actively promoting healthy living for staff. Independent counsellors, leaflets, emails, notice boards and the non-smoking policy all reinforced the message about the value of staff and the importance of their good health.

Training and continuous professional development (CPD) were largely agency-specific. There were no overall joint training strategies and no indication of close joint working between the training managers in health and social work. In discussions with social work managers, they focused on the improvements that had been made in social work training and staff matters.

There were a number of single agency training developments. A revised induction programme for all community care staff which would complement the existing two week induction programme for home care staff had been devised and will be implemented. An induction programme for care home staff had been introduced. A social work development framework was in place and an implementation plan for this specifically for community care was being progressed.

There were some local inter-agency initiatives such as joint induction programmes for health and social care staff in joint teams. The earlier SSA training involved health and housing (specifically homeless services) staff. A new single shared assessment training programme had been devised and will be implemented. The joint care management training development group had planned for and will implement the national care management training framework. Home care managers were proud that they had undertaken joint training between home care staff and community nursing staff in a move towards greater sharing of duties and eventually more generic workers.

There was a specialist mental health induction for community mental health and social care staff alongside specialist palliative care and rehabilitation training. Staff in Ninewells Hospital were to have a laminated and easy-to-read card for the discharge pathway and trained nurses would walk the wards advising people about the pathway.

The independent sector said that access to the council's training was very limited. The council had recognised that there were deficits in the quality of some independent care homes in Dundee and had developed in-reach work to train and support staff in the delivery of services to older people with challenging behaviour.

There were excellent opportunities for unqualified staff to access training through the Healthcare Academy and the Social Work Academy but these were only open to health or social work employees respectively. They appeared to be targeting the same workforce.

### *Joint workforce planning*

Joint workforce planning did not appear to have been considered by the partnership. However, issues, such as demographic trends and the age of the workforce, indicate that the partnership should begin to undertake joint planning.

Managers from health and social work spoke of the great difficulty they envisaged in progressing to becoming a single employer, but they had held joint interview panels for some joint posts. Managers said there were multi-agency teams in Dundee which were working satisfactorily but they stressed the importance of staff being clear at the start of setting up a joint team, or when joining it, about factors such as holidays and conditions of service.

Single Status and Agenda for Change have led to some diversion between the agencies about differing health and social work job descriptions. Managers were trying to streamline these where appropriate, for example for the multi-agency and multi-disciplinary staff working in the joint equipment store.

Checks on qualifications and registration requirements were made at the recruitment stage, including Disclosure Scotland checks in both health and social work. Staff have personal development plans that took account of their CPD requirements for accreditation purposes.

### *Staff support and morale*

The Social Work Department has worked hard to promote the health and well being of its staff through a range of activities such regular health events, information about smoking cessation, and health checks in working time. It achieved the Scotland's Health at Work (SHAW) silver award in April 2006 and was working towards the gold award.

The emphasis on improving staff morale, led by the Director, was particularly effective in home care, with staff often going the 'extra mile'. The department's arrangements, for example access to stress management and back care, have led to a significant reduction in days lost through sickness. In home care, a combination of these and the positive effect of small self-managed teams have reduced the sickness level to 3%, which is very commendable.

There were good relationships in the multi-agency teams, such as the Intensive Care At Home Service (ICAHS) where working relationships were very positive and there was a clear commitment to sound multi-agency working. Team members described themselves as *'one team, committed and confident about the services we provide'*.

### *Policies that guide how staff communicate*

The department was developing a Communication Framework to improve the way staff communicated with each other, mainly within the council, and engaged with service users and their carers. We were not made aware of a similar initiative in the CHP.

Communication between staff in the Dundee partnership appeared to be variable. The majority of staff surveyed agreed that services worked well together to deliver services. We met with staff based in both hospital and community settings, for example in the Crisis Team, who could evidence positive collaborative approaches to support discharge from hospital and support individuals in the community. But some staff in preventative and rehabilitation services said they had mixed relationships with health colleagues in acute services. There was a lack of consistent staffing and the ‘boarding out’ of patients in temporary places within Ninewells Hospital had led to difficulties in developing working relationships.

Many council staff said that poor communication from health, and particularly from colleagues in the acute sector, was affecting the quality and speed with which some referrals about discharging older people from hospital were being made to them. They said training and guidance on moving patients from hospital appeared to be lacking for health staff, again particularly in acute services.

*‘It is becoming increasingly difficult to engage effectively with GPs and district nurses. We have seen a dramatic drop in referrals from district nurses since the inception of SSA.’* (quote from Dundee staff survey)

Staff generally found it difficult to understand the delays in putting care packages, especially complex ones, in place. They were very aware of the implications of this for older people themselves, and for them as staff being able to offer a service to other older people. In the staff survey, 79% of social work staff in Dundee agreed that multi-agency discharge arrangements are successful in preventing inappropriate admissions but only 53% of NHS Tayside staff agreed.

Home care staff said their teams met every morning to discuss workloads, for example on how to handle emergencies, sickness cover and training and they were more positive about joint work with health colleagues, saying they worked very closely with district nurses who would take referrals from home care staff and respond within the day.

*‘We are proud of the work we do with our colleagues in housing and health. We have good links with the hospitals and we work hard at keeping relationships going.’* (quote from Dundee staff survey)

Union representatives said that links between health and social work unions tended to be arms-length in Dundee and there was no joint staff forum, although there had been one in the past. They said that relationships between health and social work staff were not generally as good as elsewhere in Tayside, although there had been good joint working in the development of the joint equipment store.

### Recommendation: Dundee partnership number 2

The partnership should work to develop a more integrated approach to training, workforce planning and methods of communicating with staff about services for older people.

#### 7.4.4 Performance management and continuous improvement

##### *Joint performance reporting*

Joint performance reporting was undertaken by the Joint Performance Management Group through the national reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). This consists of annual returns by partnerships on performance indicators based around four national outcomes. They are underpinned by Local Improvement Targets (LITS) which are set by the partners themselves to measure progress and improvement.

The Scottish Executive requires reports from local authorities and the NHS about how they are working in partnership and what outcomes are being achieved as a consequence for older people. In response to the partnership's JPIAF submission for 2005-06, the Executive rated the partnership as making steady progress overall.

The partnership was rated as making good progress on single shared assessment in terms of the number of older people with completed community care assessments and an average timescale of 19 days between the completion of assessments and start of first service. The evaluation identified the need for further work to be done on IT systems and the need for further involvement of a broader range of assessors, for example housing staff.

The partnership was rated as making steady progress in relation to cross-agency access to resources as a means of enabling faster access to services for older people. A joint resourcing agreement and eligibility criteria were being developed.

In terms of whole systems working, the partnership was evaluated as below average on the comparative model. Whilst there had been improvements, for example a reduction in hospital admissions and an increase in intensive home care, there had been an increase in multiple emergency admissions to hospital and delayed discharge targets had not been met.

The evaluation concluded that whilst the balance of care was improving, *'there is still a long way to go'*. This was evident from the fieldwork where we saw that the partnership was continuing to fall short of its delayed discharge targets. It also became clear that the partnership would have to overcome significant financial pressures if it was to make further progress in shifting the balance of care.

Overall, the partnership was evaluated as falling short of its Local Improvement Targets for 2005-06. Whilst there had been improvements in performance on reducing emergency admissions and intensive home care, performance in these areas still fell short of the targets which it had set. Its new targets for 2006-07 were evaluated as being sufficient.

The Social Work Department has already used the EFQM model, which is closely aligned to SWIA's Performance Inspection Model (PIM), to assess its own performance. The partnership had agreed to use the PIM as the basis for the Joint Performance Management Framework, which would be managed by the Joint Performance Management Group. The Framework was still at an early stage and the partnership was further developing it, for example by holding a second joint strategic planning event in November 2006.

There were a number of mechanisms through which the partners individually monitored performance. The CHP used the Quality Improvement and Clinical Governance reporting structure and calendar which is used throughout NHS Tayside. It reported on these at six-monthly intervals. Particular attention was being given to waiting times.

Through these joint and single reporting mechanisms the partners were able to demonstrate improvements such as an increase in the number of people receiving intensive home care (more than 10 hours per week) and the need for further improvements, for example in reducing delayed discharges and the number (about 50) of people not receiving an intensive home care service, as at June 2006.

### *Continuous improvement*

There was evidence of continuous improvement. The Intensive Care at Home Service, (ICAHS), heard of older people being admitted inappropriately to Ninewells Hospital. Team members '*walked the job*' for two weeks, including out of hours and at weekends. Although they had found little evidence to substantiate the statement, they had established a closer relationship with the A&E department, which included a co-ordinator visiting A&E on a daily basis as well as screening referrals from there.

Both partners regularly reviewed older people's services, for example the council was in the process of undertaking a Best Value review of older people's services, due to be completed in January 2007. It was being led by the Chief Executive with wide ranging and multi-agency representation. There had also been a review of sheltered housing. The review of occupational therapy services in 2005-06 had led to a number of improvements including revised targets to reduce waiting times for adaptations.

The use of community hospitals was being reviewed by NHS Tayside. The partnership also intended to review single shared assessment processes and documentation.

There were some examples of best practice being jointly identified and rolled out, for example in relation to the joint equipment store, where managers had looked at other stores in Scotland in order to learn about the critical success factors.

Service user/patient feedback was sought, for example in the home care service and by the Crisis Service and Early Supported Discharge Team which used a tick box form for regular, city-wide surveys of patients. These demonstrated high levels of satisfaction. The EFQM model has customer results as one of its main drivers and should promote a user focus when the Joint Performance Management Framework is well established.

Overall we did not find that there was a culture of joint performance management or continuous improvement fully embedded in staff and managers' thinking. The Audit of Best Value and Community Planning carried out by Audit Scotland in 2005 stated that: *'the department has made strong efforts to drive a new culture of performance management that is beginning to show encouraging results'*. We recognise the significance of the recent adoption of a shared Joint Performance Framework and the two development events in June and November 2006. These should have a significant impact on co-ordinating efforts to deliver better services and support partnership working.

## 7.5 Leadership and direction

The leadership of the Dundee partnership was evaluated as adequate. There were many good quality services which had been planned and delivered on a joint basis and which reflected well on the partnership leaders. There was commitment and enthusiasm amongst frontline staff for their work, despite some low morale. Some initiatives planned jointly by the council and the CHP were a positive sign of improving strategic leadership.

The need for improvement in this area mainly reflects the problems in meeting the needs of older people, the difficulties in jointly resolving these issues by the council and NHS Tayside and the quality of relationships and communication amongst some of those at the most senior levels.

Elected members in Dundee City Council, whom we met during the inspection, clearly valued the social work services provided for older people and stated a strong commitment to meeting the needs of older people. Members also saw the CHP as a key mechanism for linking the local authority in to the health inequalities agenda.

The Convenor of Social Work has had a long standing personal interest in this area and was also a member of the NHS Tayside board, though she was uncertain about the usefulness of this role. Members (and some senior officers in both health and social care) did not convey a sense of strong partnership between the council and NHS Tayside at the most senior level. There was some evidence that relationships at this level were not always marked by mutual trust.

The council had taken the bold step several years ago of reducing its in-house residential provision from ten units to five. They have approached the modernisation of the home care service at a slower pace. Members also acknowledged that some of their sheltered housing needed to be upgraded or replaced to ensure it was suitable for older people with greater levels of need. They described a strategic approach to all social work services that had a strong emphasis on low-level preventive services and health and well-being.

Senior council and CHP staff clearly recognised the scale of the problems they were facing. The council committee report in June 2006, and subsequent reports, had set out the extent of unmet need for older people, although it should be noted that this report provided information on numbers of older people waiting for different types of services, but did not include details of the significant amount of recurring revenue which would be required to fully address the problem. This report had also been discussed in the CHP committee, which was a positive step towards ensuring joint ownership of the problem.

Other ways in which the partners were trying to develop a more joint strategic approach included agreement by the council and the CHP to a joint performance framework, the joint development of intermediate care, and a proposal to bring community planning and community care planning closer together. The CHP Manager confirmed that there had been improved relationships with many council departments since the inception of the CHP and a greater understanding of council functions. He also thought health issues had a bigger profile within the council.

There was a very significant resource shortfall in council funding of older people's services which was leading to lengthy waiting times for most services and to increased delayed discharges. The council attributed this to the need to fund children's services above the indicative GAE level from the Scottish Executive. The council had made funding of £1.8m available to alleviate the problem in older people's services. The council had also taken the positive step of initiating a Best Value review of older people's services, led by the Chief Executive.

However, many meetings which we attended were dominated by discussions about funding shortfalls and which agency had responsibility for solving the problem. On two occasions there was debate amongst senior managers about funding arrangements such as previous levels of resource transfer, together with the use of underspends by NHS Tayside to assist with the effective management of resources.

These discussions and other related matters raise serious concerns about the transparency of arrangements, particularly around resources, between the two organisations and the capacity of the leadership to resolve these problems.

One senior council officer acknowledged a lack of collective vision for older people, which was confirmed by the results of the staff survey and in focus groups. Acute services staff from Ninewells Hospital strongly expressed a view that there was no agreed vision for older people in the hospital and that they were seen as a low priority. Other health staff also expressed concerns about the commitment to the care of older people within Ninewells Hospital.

All senior staff and clinicians agreed that there was an urgent need for a joint older people's strategy for the Dundee partnership, underpinned by an investment strategy. Strong and visible leadership on the part of both organisations will be required if this is to be achieved.

## 7.6 Capacity for improvement

The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services and their experiences, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.

We found that there were generally good outcomes for people using services. Senior managers recognised that quality assurance and performance management needed more attention and had agreed how this would be undertaken. The joint leadership of the Dundee partnership was not as strong or as positive it could have been and we therefore evaluated the capacity for improvement as adequate.

In order to maintain progress there are a number of positive factors which will underpin and support these developments. Both health and social work staff were motivated to work together to provide the best possible outcomes for older people and their carers and wanted to see improvements being made where there were difficulties. There was very strong support from the council which valued social work services highly. There was a strong ethos in Dundee about enabling well being and self care and the council prided itself on the availability of lower level supportive services.

The partnership in Dundee faces very significant challenges and therefore requires strong leadership and high levels of commitment. These challenges, including the financial ones, should not be allowed to get in the way of achieving better outcomes for older people. There is evidence of some good collaborative working between NHS Tayside and the council, but it is essential that the two organisations make sure this is universal and that priority is given to resolving difficult issues as quickly as possible. Only through this can everyone be assured that the needs of older people will be met in the most effective way possible, in line with *'Delivering for Health'* and *'Changing Lives'*.



# CHAPTER 8

## Perth & Kinross Council and NHS Tayside partnership

### 8.1 Person centred care

There were well established processes for assessment, care management and treatment in social work and community health services but there were some weaknesses in carrying out care management. The experience of people receiving services needed to be taken into account more fully when delivering or developing services. There was a strong focus generally on enabling well being and self care in the Perth & Kinross partnership and on joint working to promote it, such as through the falls prevention project. Information to ensure information about services, such as leaflets, needed to be improved. Performance in this area was evaluated as adequate.

#### 8.1.1 Assessment and care management

##### *Assessment*

There was a well established inter-agency single shared assessment (SSA) process, which fully considered individual needs and preferences. The Perth & Kinross partnership had experienced difficulties because the council had changed its electronic systems from eCare to SWIFT, making information sharing problematic. However this was being remedied at the time of the inspection and all assessments were to be done on eCare and passed between staff electronically. The SSA incorporated the IoRN, a national tool to measure levels of dependency and assist in the long term planning of services.

Carers were entitled to separate assessments of their needs. Evidence from local file reading and focus groups showed that carers assessments were not being widely promoted or understood. Carers often mentioned community psychiatric nurses as the people who supported them and acted as their advocates.

Hospital admissions presented a particular challenge to assessment and care management because there seemed to be several systems at work. The SSA was used by staff in hospital specialist units such as Care of the Elderly and was to be rolled out to the acute sector. Old Age Psychiatry and Care of the Elderly wards have multi-disciplinary processes integral to their assessment and discharge planning, and would begin a generic assessment of need on admission.

Some service users have very particular needs so within all assessment documentation there were sections for identification of needs. The SSAs had Specialist Assessment Request forms. Both the Chinese population and the Eastern European population in the Perth and Kinross area were growing. An ethnic monitoring form has been introduced in the SSA. The *'NHS Tayside Race Equality Scheme Action Plan, 2005 – 2008'*, the CHP Equality and Diversity action plan and the council's Race Equality Scheme promoted general awareness of individuals' needs. However, culturally sensitive services for ethnic minorities appeared to be limited, but the CHP and council had submitted a joint bid for funding for two minority ethnic access development workers because they were committed to jointly developing appropriate services.

### Care management and treatment

Perth & Kinross social work staff were committed to the care management process to enable people to live independently and to working together to achieve this.

#### Good practice – Perth & Kinross partnership number 1

An older person with mental health difficulties had been provided with intensive health and social care services to help support him at home. Unfortunately a sudden and significant deterioration in his condition meant that he could not safely remain at home and he required emergency respite to be arranged on the eve of a public holiday. His son said that this had been a traumatic experience for the family but he spoke very highly of the manner in which the social worker and community psychiatric nurse had worked together to meet his father's changing needs.

There were some weaknesses in the care management of people in Perth & Kinross and managers had already identified areas for improvement. For example, the proportion of files containing SSAs, the proportion with continuous recording, and the proportion including a chronology of key events, was lower than in other areas. In addition, several of the files examined had care plans completed or updated more than 12 months ago.

Of the four carers interviewed, one had a care plan. Another carer interviewed had been helped by a specialist Parkinson's nurse but she had had to make the contact herself. The interviews showed differences in the effectiveness of ways that staff assisted people, for example the carer of a man who had had two emergency hospital admissions was unaware of any extra help being available.

Information sharing between agencies to ensure care was seamless was underpinned by several policies and protocols such as the NHS Code of Practice and consent forms as part of the SSA process. However, several staff talked to us about their concerns about confidentiality in relation to sharing information between health and social care systems, and managers should explore why staff believed there were problems.

A number of service developments had been made in order to meet need, such as a Managed Care Network for dementia and the specialist dementia nurse in the Community Liaison Team. Of particular note is the improved service in all the council care homes following the involvement of carers in designing flexible, high quality day, respite and emergency care in Dalweem, a care home set in a rural area.

### 8.1.2 Experience of people and carers when receiving services

This section looks at how the experience of people receiving services was used in service delivery and development. The partnership was clearly aware of the importance of feedback from users and carers and was planning to develop mechanisms for this. The Age Matters Consultation Event in December 2005 obtained useful feedback from people and their carers and led to a draft action plan. There was a 'Which Way to Diagnosis?' conference about dementia and a Psychiatry of Old Age event in early 2006. A public symposium was to be held in November 2006 by the CHP to gather the views of the public on health services.

There was a range of ongoing mechanisms for feedback, such as complaints, home care questionnaires and service reviews. A Stakeholders Conference had been held and an action plan developed to take forward agreed priorities. However, there did not seem to be ongoing processes for carers and users of services to feed their experiences and views into the service planning system. One voluntary organisation that was funded to receive and collate such information said it had no mechanism to pass this to the community planning processes as the planning group was not then meeting.

The shortage of advocacy services was subject to the review of the service level agreements ongoing at the time of the inspection. One advocacy service was jointly funded by NHS Tayside and the council. Advocacy was not mentioned at any of the meetings with staff or carers, but it was clear that community psychiatric nurses were perceived to have this role by some families. There were some good respite services in one council home and in two private homes which incorporated the flexibility which carers really valued and had requested.

### 8.1.3. Enabling well being and self care

There was a strong focus generally on enabling well being and self care in the Perth & Kinross partnership and on joint working to promote it. There were 'quality of life' workers within wards in Perth Royal Infirmary and sheltered housing to promote healthy living. Chronic obstructive pulmonary disease classes were being run by allied health professionals (AHPs) to educate and improve well being for patients with long term conditions.

#### Good practice – Perth & Kinross partnership number 2

The Scottish Healthy Communities Collaborative project had a significant impact in reducing the number of falls amongst older people. The falls prevention project brought together a range of social care, health professionals such as GPs and community pharmacists, and community members. They worked together to identify risk factors for falls and ways to reduce the incidence of falls. This included advising older people on sensible footwear, reviewing medication and promoting regular exercise. There had been reduction of falls by about 60% in a three month period in 2006 compared to the same period in 2005.

A pilot project had been set up by NHS Tayside to meet the needs of people with long term conditions, whereby people in two GP practices were provided with case management to enable them to manage their conditions more effectively. A project involving motivational coaches for similar cases had not yet started, but staff such as AHPs and nurses were involved in developing this, as well as Arthritis Care. Exercise classes were being initiated by Perth & Kinross Leisure. A pilot project for multiple sclerosis patients was underway.

We were impressed by the work and the enthusiasm shown by the Active Living Group in promoting health and well being. The group provided training about chair exercises for home care staff to be used with older people. Similar training had also been provided for sheltered housing wardens.

However, there were some limitations to the services promoting well being. Day care was limited in Perth, but additional support was provided through lunch clubs, WRVS, and volunteer transport services in rural areas. People involved in the voluntary sector felt they were being called upon to support carers because statutory services were over-stretched, but increased funding was not provided to them.

There were good systems for reviews in Old Age Psychiatry and Medicine for the Elderly. In principle, there were six-monthly reviews for all people receiving home care and annual reviews for all social work service users. However, evidence suggested that this was not always the case. No carer said they had had a review of their services. Over half of the files examined had no evidence of periodic reviews, although one user interviewed had an exemplary record of reviews, for which there was a legal requirement since he was the subject of a guardianship order.

#### 8.1.4 Access to services

##### *Information about services*

There was a range of council leaflets and they were available in a range of language and formats. The council had a website which would not be easily accessible to many older people and their carers, and did not provide information about available services. The council has identified that it needed to improve the quality of its information, both paper and web-based. However a majority of older people surveyed as part of the SWIA performance inspection said that they found it easy to obtain information about services. There were published systems for determining eligibility and priority which were transparent, fair and equitable.

Work was in progress to provide more written material about health services, and a CHP website. NHS Tayside was developing a carers information strategy to seek to improve collaborative work with carers but there had been delays in completing this.

### *Improving access to services*

Perth and Kinross is a predominantly rural area. Access to social work services was provided through a single point of entry in Perth and through rural offices. Access was more problematic for people living in rural areas, but services were being developed to ameliorate this, for example the flexible respite services in Aberfeldy and Crieff. Collaborative working in rural areas also seemed to be overcoming some of the problems of service delivery. Transport had had significant resources invested in it and was praised by users and carers.

The case file reading showed that in most of the cases where an individual was from an ethnic minority or had a disability, there was evidence that the services provided for the individual did take into account the potential barriers arising from this. Work was being undertaken to develop links and services to the gypsy/traveller population in Perth and Kinross. For example, a health needs assessment on the gypsy/traveller site had been undertaken and an action plan devised.

Access to specialist services within the NHS was through referrals by GPs to Medicine for the Elderly. There was open access to the community mental health teams. Rehabilitation was available in the community through AHPs who worked in both the Intensive Care at Home Services and health community rehabilitation services. Referrals for these services were made via GPs or other health professionals. Social workers can directly refer to rehabilitation services or specialist AHP services following completion of a single shared assessment.

The Joint Equipment and Loan store was located in a single fully functional building, and this joint service had improved the supply of equipment. Health and social work equipment was stored together and, while cross-referrals were required to access the other agency's equipment at the time of the inspection, work was being undertaken on enabling direct access. The council's occupational therapy service has a clear priority system with emergencies and hospital discharge receiving immediate attention. Their leaflet was at the printers at the time of the inspection.

There was no inter-agency guidance on care planning and care management but this was being developed. There was inter-agency guidance for health and council staff on sharing information and there was the Tayside joint health and social care adult discharge protocol. Independent providers said that health staff were very poor at passing information about individuals to them. Managers said that work was being undertaken on improving information sharing with the independent sector, for example through electronic information sharing.

### Good practice – Perth & Kinross partnership number 3

The Perth & Kinross Carers strategy, published in June 2005, clearly set out details about what services were available to carers, including carers emergency cards, and an Action Plan for 2005-08.

## 8.2 Key outcomes

Positive outcomes for older people and their carers are a key indicator of effective collaboration between agencies. The evidence in Perth & Kinross in relation to outcomes for older people and their carers was mixed. Some people whom we spoke to said they were satisfied with their services. Some interviews and findings, for example from the case file reading, showed that there were issues around outcomes for older people, such as the geographic variations in the provision of services for older people. The partnership's performance was evaluated as adequate in this area.

This section should be read in conjunction with chapter 5 which looks at outcomes for older people and carers on a Tayside-wide basis.

### Views of older people

There was a mixed picture about outcomes for older people in the Perth & Kinross partnership. The structured interviews showed that the older people were generally satisfied with the services which they received and were experiencing good outcomes. The interviews included older people who were being successfully supported back at home after a period of time in hospital.

*'If it wasn't for the care staff I wouldn't be here. They are good for encouragement; they help you so far, but you have to help yourself – the physiotherapist provided me with a sheet of exercises.'*  
(quote from an interview with an older person)

During the fieldwork, good outcomes were demonstrated but some issues were also highlighted. On the positive side:

- One older person had been discharged home three weeks before the interview and a good balance was being struck between providing enough support to avoid re-admission to hospital and encouraging the recovery of as much independence as possible
- Two of the council's care homes provided emergency respite which can be accessed directly by GPs. Initial evaluation indicated that this was helping prevent hospital admissions.

Less positively:

- There were geographic variations in the provision of some services for older people which could impact on outcomes, for example there is not a Community Liaison Team (CLT) in each of the community hospitals, although the CLT in Perth Royal Infirmary oversees discharge planning for the whole partnership area. There were also some difficulties in providing home care packages in rural areas
- Some carers also spoke about the number of staff involved in some care at home packages. When there was a lack of consistency, this could prove disruptive for the person for whom they cared

- Some carers, whilst acknowledging the positive role provided by day care and respite services, highlighted the fact that they perceived there was limited availability and the impact this could have on them in terms of stress.

It is important to stress that Perth & Kinross have a higher rate of respite for total respite nights and total day time respite hours than was provided across the rest of Tayside. The council also provided a higher rate of overnight respite provision than for Scotland.

The findings from the case file reading exercises were that the social work files in Perth & Kinross needed attention. For example, 42% of care plans had been completed or updated more than 12 months ago compared to 9% in Tayside as a whole. However, in most cases the objectives in the care plan either had or were in the process of being met. In most cases the level of intervention was seen as proportionate to meeting people's needs.

A lower proportion of single shared assessments in the case file audit had been completed in this partnership than elsewhere in Tayside (38%, compared to 67%). There was also less evidence that the views of older people were taken into account. More positively, where carers needs had been assessed, at least some of these needs were judged to have been met in all cases.

### 8.3 Whole systems approach

The partnership's use of a whole systems approach in relation to the range and quality of services, joint planning of these services and joint financial management presented a mixed picture. There was a wide range of health and social work services, but joint planning and financial management needed considerable attention. Performance in this area was evaluated as adequate.

#### 8.3.1 Range and quality of community based services

##### *A whole systems approach to delivering systems*

There was considerable scope for a whole systems approach to be taken because many health and social work services were delivered through the Perth & Kinross Older People's Services Partnership. The post of Senior Partnership Manager was jointly funded by NHS Tayside and the council, was jointly managed, and reported to both organisations. However, the potential of the arrangements had not yet been realised for a number of reasons, such as the re-organisation following the end of Care Together and the long term absence of two of the key senior managers.

Services within the Partnership were largely aligned rather than being integrated as they had been in Care Together. The council and NHS Tayside had decided that this was the right way forward after the Care Together experience. We recognise that this is an appropriate way and commend the commitment of the Chief Social Work Officer (CSWO) and the Manager of the CHP to work collaboratively to ensure positive outcomes for older people and their carers. This commitment had been set out in committee papers and in meetings with staff.

Some significant joint developments were being implemented or discussed. These included a single point of access to services for older people, following the model initiated in Angus.

### *Broad range of quality services*

There was a range of community based services to support older people in the community but there were also some issues about service provision. For example there was clearly an imbalance in provision with a relatively high level of people cared for in residential care homes and lower than average levels of home care and day care services.

In 2004-05, Perth & Kinross was the lowest performing council in terms of total hours of home care provided. However, the situation is improving. Between April 2005 and October 2006, the council increased the number of home care users from 1,068 to 1,085 and the number of home care hours from 6,237 to 7,732. Home care users now have an average of 7.13 hours home care compared to 5.9 in April 2005.

A Best Value review of home care services had sought to provide more responsive services to support older people at home by increasing the number of skilled staff providing personal care services. The implementation of the review was successful in meeting its original targets. However the provision of home care remained problematic because of the increase in demand, lack of resources and difficulties in recruiting in some areas. There has not been a clear commissioning strategy for home care which could promote independent sector providers.

The Local Improvement Targets showed a significant increase in the number of intensive home care packages. There was an increase in people over the age of 65 receiving intensive home care (more than 10 hours per week) from 199 in 2005, to 256 in 2006. This is highly commendable although the partnership acknowledged that this number was below its targeted level. Access to home care in rural and more remote areas presented a range of challenges for services. However, redressing the balance of care was further achieved by the reduction of people in care homes, from 1,162 people in 2005, to 1091 in 2006.

The joint Resource Allocation Group had been set up to provide a more flexible approach to rebalance care and to actively redesign home based services. Its members included nursing and AHPs to ensure a holistic approach to meeting the needs of people with intensive care needs. The group was designed to ensure that health services could be targeted for those in crisis or to support prevention of admission to longer term care. This step is welcomed. Further consideration should be given to how staff could be helped to think about alternatives to care homes at as early a stage as possible in the care management process.



Services were in place to support discharges from hospital. The Community Liaison Team in Perth Royal Infirmary had a multi-agency staff group of both social work and health staff, including occupational therapists and physiotherapists. It co-ordinated hospital discharges and transfers to community hospitals. The team saw clear benefits in the range of disciplines within the team and this was reflected in their high level of multi-disciplinary single shared assessments.

Hospital discharge planning was supported by having access to step down facilities in community hospitals, with plans to arrange direct access by social workers to community hospital beds. We saw the quality of services available in Beechgrove rehabilitation unit for crisis and prevention of long term admission to care.

There was a range of services in place to support alternatives to hospital admission. These included services such as one-stop community clinics, links to specialist nursing services including stroke and Parkinson's nursing services. A night sitter service was available to support carers of people with dementia. Service users and carers spoke positively about the flexible respite scheme in operation in a care home in Aberfeldy. This was being rolled out to all the council care homes.

A review of community hospitals was underway, in order to provide more appropriate local health services, and plans were being discussed about building a new integrated health and care partnership project, involving NHS Tayside, social work, GPs, primary care, and the private sector, in Pitlochry. There were some interesting and innovative options being considered.

### *Service commissioning*

The absence of an up to date joint strategy for older people's services meant that there was no document setting out a commissioning plan, including the existing provision of services and the supply of services to meet future need. The plan should take account of the demographic changes, both in the ageing population and changes in the workforce. It should be accompanied by an action plan that addressed how providers would be engaged to deliver services.

Senior managers have recognised the urgency of progressing this. The Perth & Kinross partnership was revising and developing their joint planning and commissioning structures. Clearly agreed remits and membership of joint planning teams had been agreed. A commissioning group had been set up. It was formulating a joint commissioning plan to ensure that a substantial shift in the balance of care was achieved and to commission a wider range of provision within available resources in order to maintain the functioning and independence of frail older people. The commissioning group intended to meet every six weeks and its role would include monitoring of Local Improvement Targets and the JPIAF requirements. A clear reporting format was being developed to ensure progress.

Commissioned services had been evaluated through the detailed review of service level agreements which had been reported to and agreed by committee. However, better partnership arrangements should be considered when commissioning services. Responses to the stakeholders' survey indicated that they perceived services for older people to be limited and that they were not being involved in delivering a wide range of services, largely for financial reasons.

Providers who had service level agreements with the council said these were mostly agreed on an annual basis. Although their funding was increasingly linked to performance targets, there was no linked review of funding agreements. The stability of providers is dependant on the security of funding arrangements and attention should be given to this issue.

Discussions with the Care Commission did not indicate that there were issues of quality in the services provided by the independent sector. We were made aware by the Care Commission of the trend in which large provider organisations were purchasing small local care homes. Such shifts in the market can lead to a reduction in choice for individuals.

### 8.3.2 Planning, policy development and partnerships

#### *Strategic planning is informed by a whole systems approach*

There was no up to date strategy for older people's services – the previous one was developed in 2002. During the fieldwork we were told about the partnership's commitment to producing a comprehensive strategy by March 2007, which we welcome. However, there were a number of documents that set out the direction of travel. The joint council and CHP paper entitled '*Developing the Partnership Approach to Better Outcomes – Shifting the Balance of Care*', July/August 2006, set out the partnership's approach to modernising services and closer, more effective joint management and planning processes.

We found that in the Joint Commissioning Group there appeared to be reservations as to how the new arrangements for older people could be made to work successfully. It will be important therefore for the CSWO and CHP Manager to give ongoing leadership and support to this team.

The Corporate Plan clearly stated the priorities and links between health and social care services through the Strategic Health Partnership and the Health Improvement Strategic Forum.

#### **Recommendation: Perth & Kinross partnership number 1**

The Perth & Kinross partnership should progress its work on updating its strategy for services for older people. This should include a joint action plan, financial plan, timescales and commissioning strategy. It should also set and monitor timescales for delivering tangible results.

### *Implementation of joint vision, policies and strategies*

Although the strategy for older people's services produced in 2002 had, amongst its first objectives, the shift in the balance of care towards the provision of community based support services, progress to date had been limited. That strategy, while setting out a range of activities to deliver on, had few measurable targets or timescales. As a result of this and other reasons such as the organisational changes, there has been drift in implementing the strategy.

However, there had been a number of positive initiatives. Primary care staff spoke of developments being taken forward in unscheduled care, development of the use of community hospitals, and chronic disease management. Included in these developments were pilots for nurse-led discharges and, very significantly, discussions on social work access to community hospitals for crisis admission and planned admission in the management of long term conditions.

A framework was in place for the use of a range of settings for intermediate care, for example places in community hospitals and a unit in Beechgrove care home. The liaison between staff at Perth Royal Infirmary and community hospitals was considered to be working well. Plans for the future development of services include the development of telecare and the use of telemedicine technology.

#### Good practice – Perth & Kinross partnership number 4

The involvement of an occupational therapist from the Community Liaison Team in assessing people in A&E in Perth Royal Infirmary was a positive step in preventing inappropriate admissions, by providing advice and arranging support services.

There has been a considerable impact on delayed discharges through several measures such as improved discharge planning between services, for example a clear pathway between hospital based staff, the Intensive Care At Home Service (ICAHS) and other community based services.

However, some clinicians and staff in primary care expressed concern that local initiatives may be difficult to reconcile with NHS Tayside developments, particularly in relation to community hospitals. In contrast to Angus, the development of a referrals management centre for Tayside hospitals was seen by them as a disincentive for local solutions.

There was limited provision of day care services and we observed practice in a day care centre which continued to offer support to older people with dementia beyond the remit and criteria for the service, because there was no service geared to meeting their needs. The Tayside Managed Care Network has carried out a mapping exercise of services and has identified gaps in services for people with dementia. This information will be used to inform the Mental Health Strategy for Older People.

Many staff were clearly not engaged in implementing the vision for older people's services. Frontline staff in both health and social work services spoke of feeling cut off from the decision making processes. Staff said there was little sense of consultation about or rationale for services. This was at odds with the strong message from the senior managers who, although they acknowledged difficulties in preceding years, thought that matters were greatly improved.

Senior managers gave evidence of staff involvement and engagement in agreeing the vision and priorities, including a stakeholder event in December 2005, staff briefings and discussion sessions in December 2005 and January 2006, and a partnership conference in June 2006. However, they should consider again how staff could be involved in the planning and development of services in order to ensure positive engagement during a time of considerable change. We make a recommendation about involving staff later in the chapter.

We heard about several good examples of partnership working and involvement of key stakeholders. Consultation has taken place with some ethnic minority groups to gather their views on their future service needs.

#### Good practice – Perth & Kinross partnership number 5

The Age Matters Consultation Event in December 2005 brought together service providers, people who use, or future users of, services as well as carers and key public agencies. It obtained useful feedback from people and their carers and led to a draft action plan. This was a seminal conference which will have a major impact of the development of the strategy for older people's services.

A carers task group has been set up with wide representation, including carers, the Princess Royal Trust centre, health, social work, and the independent sector, to be involved in the development of the carers strategy. The development of the flexible respite service was in response to carers views. However, in meetings with carers who spoke positively about care at home staff involved with the person they care for, they expressed concern about the limited range of support services on offer.

Responses to the stakeholders' survey indicated that non-statutory organisations did not feel properly involved in the planning process. Service providers also told us they were not involved in planning or delivering services. Consideration should be given to the development of a more strategic approach to the relationship with providers in planning and delivering services.

### 8.3.3 Financial and resources management

#### *Financial planning*

The Perth & Kinross Council budget for older people's services in 2006-07 was £29.6m which, when added to the NHS Tayside budget of £12.7m for the area, resulted in a total budget provision of £42.3m.

The responsibility for planning services for some health and social work services for older people was held by a postholder in the Older People's Partnership who was located in the CHP headquarters in Perth Royal Infirmary. There were aligned budgets, which were managed by the Senior Partnership Manager.

As is the case with the other two areas in Tayside, the budgets were aligned, rather than pooled, and therefore each agency was responsible for its own financial control. However, on a day to day basis, accountability lay with the Senior Partnership Manager.

Community care service priorities were listed in the council's Business Management and Improvement Plan (BMIP) for 2005-06. These included implementing the home care service priorities, shifting the balance of care, supporting more people at home and reducing delayed discharges. Within the plan, there was no indication of the financial resources required to achieve the objectives. The council is committed to introducing policy led budgeting and the BMIP guidance for 2007-08 includes the requirement to cost objectives and key priorities.

Perth & Kinross Council was reviewing its resource allocations across all social work services in order to address the gap between its expenditure on adult care and the grant aided expenditure (GAE) recommended level. It was projecting to spend 2% under GAE in 2006-07. The main pressure had been on free personal care and that this had been addressed by additional funding of £0.8m in 2006-07.

The CHP Work Plan, 2005-06, which detailed the strategic objectives and performance targets for the CHP, together with details of the responsible officers, contained no information regarding the resources required to achieve the objectives, nor any links to any other financial plans.

Financial plans were prepared by each partner individually but in consultation with each other. No financial plans were available for 2007-08 or beyond. The council is facing recurring revenue pressures in funding free personal care over the next two years. We make a recommendation about financial plans in chapter 5.

The strategy for older people's services was out of date and was not aligned with financial plans. Therefore, the partners could not be sure that the budgets were sufficient to meet their objectives but there was joint agreement to progress the strategy by March 2007. Although the strategy was in the process of being updated, the partnership had been prioritising its work to meet the national outcomes for shifting the balance of care, reviewing community hospitals, supporting long term conditions and unscheduled admissions to hospital.

Agreement has been reached to integrate the CHP Business Plan, the Balanced Scorecard and the BMIP to order to align the business processes of the partners. An officer group had been set up to deal with finance, human resources issues and organisational development, and agreeing financial frameworks was considered to be a priority.

### *Financial management*

Monthly reports were provided for budget holders, and the council (but not NHS Tayside) produced budgetary projections to the financial year-end. A system of 'hot spot' reporting is used. The council's *'Community Care Budget Scrutiny Summary to August 2006'* detailed projected expenditure pressures of £1.231m and potential savings of £0.684m, leaving a projected £0.547m overspend. The report included other services (such as learning disabilities) in addition to older people's services. It was not clear in the report what action was being taken to resolve the forecast overspend of £0.547m. Managers were however taking action within their services and regularly monitoring their budgets.

The partnership had no capital budget of its own. Capital requirements had to be bid for from the council and NHS Tayside under their normal capital planning procedures. There was significant capital expenditure planned for older people's services by NHS Tayside at the time of the inspection, such as the Medicine for the Elderly redesign, stroke services, the outline business case for Psychiatry of Old Age and the Bobbin Mill development.

The partnership arrangements were covered by the Extended Local Partnership Statement (dated January 2005) which superseded the Local Partnership Agreement, April 2003, and which included provision for services in addition to older people's services. Further amendments have since been made to this Statement, financial details for 2004-05 having been incorporated in March 2005.

### *Information systems*

As the previous IT system was no longer fit for purpose, the council introduced a new social work system to cover the range of social work activities. The decision to implement the SWIFT system provided a challenge for social work services and created duplication of effort from staff, who had to use both it and eCare. A significant amount of work had been undertaken to resolve issues of information recording and sharing and, since the SWIA performance inspection in 2006, agreement had been reached on using the eCare system for information sharing with health colleagues. Staff were being trained on the eCare system to support implementation. Staff in housing services had integrated eCare into their assessment processes.

SWIFT was the main tool for providing management information for council services. The range of management information was still being developed. The links between management information and performance reporting were still at an early stage.

The next stage was to develop joint performance reporting mechanisms with a joint information store being proposed by March 2007.

## 8.4 Delivery and management of services

Day to day planning and resource management were adequately undertaken and monitored at a local level. The situation for the delivery of older people's services in Perth & Kinross was different from the two other councils in Tayside because there was an integrated Older People's Services Partnership for many of the relevant services, but its potential had not yet been realised. Managers need to improve communication about the future developments of services with both health and social work staff.

### 8.4.1 Day to day planning and resource allocation

#### *Operational management and planning*

Partnership senior managers considered that day to day planning and management by operational managers was undertaken effectively, based on a shared vision which had been developed with team leaders. Team plans were developed from the wider Business Management and Improvement Plan (BMIP). Priorities were monitored through the senior management team (SMT). Partnership managers for localities oversaw and managed their staff groups to ensure conformity with the agreed joint plans and priorities.

The situation for delivery of older people's services in Perth & Kinross was different from the other two councils in Tayside because there was an integrated Older People's Services Partnership for many services, although some, such as the community nursing service, were line managed by CHP managers. This meant that there was potential for a more holistic approach, especially as some staff were not sure which services were managed by the Older People's Services Partnership or the CHP, but thought it did not matter.

However, the partnership faced a range of challenges because of the complexity of the roles of managers who had to work across health and social work. There is no doubt that the absence of two senior managers, through long term sick leave, and the difficulty in recruiting to other senior posts had placed considerable burdens on the managers responsible for day to day delivery as well as front line staff. There were particular pressures on the managers in the home care service.

The restructuring of senior posts at the time of the inspection should facilitate recruitment and provide much greater impetus and energy to delivering services to older people.

### *Workload management systems and waiting lists*

Team leaders monitored the progress of work by viewing the workflow activity using the SWIFT electronic system. Work was underway to develop effective workload management, part of which would identify when work was due and overdue so that the situation could be addressed. Caseload management tools for individual staff caseloads were being considered by the Assessment and Care Management Review Group, with planned implementation in the next few months. Some health and social work staff, particularly home care, expressed concern about their workloads, but the majority agreed their workloads were manageable.

Waiting lists were collated monthly and were discussed as part of the monthly performance reports to both council and health senior management teams. Both strove to manage these proactively. However, there were waiting lists for some services. For example, a lack of resources has resulted in difficulties for the Early Supported Discharge (ESD) team, which offered short term services to enable people to leave hospital. When the mainstream home care service could not offer a service, the ESD became blocked and was then not able to facilitate discharges.

There were effective mechanisms in place for handling referrals and allocating work. Team leaders or their deputies screened and prioritised work on a daily basis to ensure that critical care and protection issues were dealt with on the same day/within 24 hours. The SWIFT system provided information about length of time from assessment to delivery. There was awareness of the waiting times for non-urgent occupational therapy assessments (six months for one of the users interviewed).

Eligibility criteria for older people's services were clear and well understood by staff. Authorisation for resources was sought through the Resource Allocation Group (RAG) to meet complex care needs or through the Partnership managers, if action had to be taken prior to the next meeting of the group. Delayed discharges were monitored and reported to the RAG. The figures reported on the EMPTAYADD system showed that there was a total of 59 delayed discharges on 31 August 2006. Actions to remedy this were being discussed at locality and senior management meetings.



Managers intended to implement a single point of entry, similar to the Angus model, for older people needing a service, particularly to prevent emergency or repeat admissions to hospital. The model had not been finalised as it may be appropriate to have virtual teams in rural areas and co-located teams in Perth. This should assist in the screening and prioritisation of referrals.

### 8.4.2 Risk management and accountability

This section deals with risk management and accountability specifically in relation to inter-agency working regarding individuals. Organisational risk management issues were not covered in this inspection. Established multi-disciplinary arrangements for the protection of vulnerable adults should be in place. These should include a fully implemented inter-agency policy and procedure for the reporting of abuse of vulnerable older people.

#### *Arrangements*

A Tayside-wide protocol had been put in place in 2005 for the protection of vulnerable adults. Further work, such as leading workshops, was being undertaken by the national Joint Improvement Team (JIT) to improve the implementation of the protocol. This should also ensure greater consistency about the threshold for intervention, assessment and management of risk across Tayside. However, the Perth & Kinross guidelines had been favourably commented on by the JIT.

Multi-agency procedures and guidelines were in place in Perth & Kinross. A multi-agency Interim Adult Protection Committee, chaired by the Chief Executive, had been established. It acted as a strategic planning and monitoring group to ensure the effectiveness of the local procedures.

Over 1,500 staff from all agencies and from the private and voluntary sectors were trained. Social work managers had training in chairing of adult protection case conferences and courses were planned with the police in terms of forensic interviewing. A strategic group was examining risk assessment and management across all social work care groups. The adult protection procedures clearly outlined the roles and responsibilities of all health and social work staff.

#### *Accountability for risk management*

The accountability for risk management and monitoring of risk assessments was undertaken through multi-disciplinary case conferences, supervision, assessment, care and case management processes and case file audits. Management oversight of protection plans was undertaken by the Lead Officer (Adult Services) to ensure consistency and performance management. The ongoing monitoring by the Lead Officer had led to high standards of work in this area.

Deciding on the appropriate balance between risk management and the right of people to make their own decisions is a complex process. Perth & Kinross worked, through their procedures, to ensure that there was a balance between an individual's self determination and risk management. In all instances, they ensured that older people had access to independent advocacy. Service users and families were involved in discussions. The issue of balance between risk and rights was regularly examined by managers. However, the use of guardianship orders, for various reasons, meant that the council had a higher than average level in progress and this had impacted on the delayed discharge figures.

### 8.4.3 Management and support of staff

#### *Training and staff development strategy*

There was a very positive approach to joint training within the partnership. Some extensive joint training had taken place, for example 400 health and social work staff had been trained to use the SSA electronic version. Health and social work had delivered about six joint training sessions on long term conditions and self care.

In social work there was a Learning and Development Plan which set out the training programme and priorities. Professional supervision and development was managed by each organisation individually for their staff through supervision, meetings, and personal development plans (PDPs).

There was an area of concern, in common with other parts of Tayside, about home care staff who said they had poor training for working with people with dementia. However, Blairgowrie Hospital was developing a dementia training programme for nursing auxiliaries, and the partnership proposed that this should also be made available to social care staff.

#### *Joint workforce planning*

Joint workforce planning had not been a priority but this will need to be addressed by the partnership, because of several issues. There is a major issue, in common with the whole of Tayside, about the age of the workforce, both nursing and social work, and the problems that may arise if significant numbers of staff over 50 years retire at about the same time.

Concerns around the different terms and conditions of health and social work posts were raised, partly because staff had become very aware of this issue from Care Together. In joint teams, staff tended to accept and work round these but there were issues where colleagues were on a different pay structure.

We were told that there had been difficulty in recruiting to some posts, because of the issues around the ending of Care Together. This had also led to some staff leaving to work elsewhere.

*'Some managers have struggled with the culture of working across boundaries and some people have personally suffered as a result, leading to long term absences and staff leaving NHS Tayside.'* (quote from meeting with GPs and consultants)

There was some difficulty in recruiting home care in rural areas such as north of Dunkeld, and these staff recruitment issues would make it difficult to extend some home care in the rural areas. However, the reality was that the social work vacancy level was 5%, compared to the national average of 9.5%.

Checks on qualifications and registration requirements were made at the recruitment stage, including Disclosure Scotland checks in both health and social work. Staff had personal development plans that took account of their CPD requirements for accreditation purposes.

### *Staff support and morale*

Staff in both health and social work frequently expressed to us a need for more support and information about the direction of travel for services for older people. Staff said that most change was top down, with little sense of consultation or rationale being given, thus causing a lot of uncertainty. They said they felt cut off from the decision making process. Many health and social work staff whom we spoke to said they did not know exactly what the CHP was and who led it. Most staff thought that there was very little evidence of high level joint management or joint services and that they were working in silos.

The SWIA staff survey carried out for the performance inspection showed that most staff in the council's Housing and Community Care enjoyed their jobs, but about half the staff did not think that services had improved in the last year. The stakeholders' survey indicated that the stakeholders perceived that there were high stress levels amongst managers, a high staff turnover and a loss of continuity which impacted on the ability to provide continuity of service. There was a general sense that developments in older people's services had stalled over a difficult two year period.

*'The transition from Care Together meant that health and social work staff felt pressured, and suffered from lack of clarity, with no direction. Social work staff also felt that their professional social work role and identity was diminished in Care Together. We had a staff conference recently. Now we ensure that the appropriate professionals manage the right professional staff – now there is a new energy.'* (quote from senior manager in an interview)

We saw positive attempts by senior managers to tackle this issue and to clarify the future for older people's services. A joint council and CHP paper, dated July/August 2006, clearly set out proposals for services and joint working. We attended a meeting with managers at which these proposals were fully articulated by the Chief Social Work Officer (CSWO) and CHP Manager. Managers have also been holding briefings, carrying out visits and providing information through newsletters.

Managers were very aware of the need to ensure that professional staff received supervision and consultation from professionals in their own discipline and were making strenuous efforts to ensure that this happened. Staff thought this would ensure better support to them and would lead to improved morale and quality of work.

### *Policies that guide how staff communicate*

The partnership was developing new and better methods of communicating with staff in older people's services. Perth & Kinross CHP had a draft Communication Strategy. There was also a draft Older People's Services Communication Strategy in preparation for the redesign of intermediate care services.

The council had recently upgraded its intranet site to improve the level and type of information services for staff. The council's community care staff survey group was a reference group to feed information across the organisation. Community care policies and procedures were being reviewed by a staff group and would be posted on ERIC, the staff intranet site.

There was generally a commitment amongst frontline staff to good communication, much of which was derived from the Care Together experience. Staff were clear that in Care Together they had worked in localities and had developed respect and understanding for each other.

*'The legacy of Care Together is that frontline practitioners on the ground still work well together.'*  
(quote from staff focus group)

The Community Liaison Team (CLT) in Perth Royal Infirmary was an enthusiastic and self managing team and had developed good links with A&E staff through the outreach work of one occupational therapist who had been successful in preventing inappropriate admissions to hospital.

Good communication was also seen in rural areas where there was a lower turnover of staff, so that staff knew each other better and reported a greater tendency to trust each other's assessments. In northwest Perthshire, there were regular meetings of GPs, district nurses, social workers, physiotherapists, occupational therapists and community psychiatrist nurses who met every four weeks in each practice to discuss community care. In Perth there were similar meetings approximately monthly.

However, there had been a lack of communication from managers to staff in older people's services overall in a period of many changes. Union representatives said that communication between health and social work staff in Perth & Kinross was not as transparent as it had been in the past. There was no joint staff forum for health and social work. We saw limited formal communication between staff from different agencies within the files we read.

### Recommendation: Perth & Kinross partnership number 2

The partnership should involve managers and staff in implementing a joint communication strategy about the developments in services for older people.

#### 8.4.4 Performance management and continuous improvement

##### *Joint performance reporting*

This is undertaken through the Scottish Executive's reporting mechanism, the Joint Performance Information and Assessment Framework (JPIAF). This contains annual returns by partnerships on performance indicators based on four national outcomes and underpinned by Local Improvement Targets (LITS), which are set by the partners themselves to measure progress and improvement. The Executive rated the partnership in 2005-06 as making steady progress overall.

The partnership was rated as making as steady progress on single shared assessment in terms of the number of older people with completed community care assessments, and an average timescale of 22 days between the completion of assessments and start of first service. The evaluation identified the need for further work to be done on IT systems and for the involvement of a broader range of lead assessors, for example from housing and voluntary organisations.

The partnership was rated as requiring improvement in relation to cross-agency access to resources as a means of enabling faster access to resources for older people. The partnership was still developing its access to resource protocols.

In terms of whole systems working, the partnership was evaluated as requiring improvement on its understanding and its application of the holistic approach. There was an increase in emergency admissions from 4,299 in 2005 to 4,467 in 2006, and in multiple admissions from 701 in 2005, to 828 in 2006. There were 59 delayed discharges in August 2006. The balance of care remained over dependent on care homes, rather than home-based care, although the partnership was achieving real improvements in redressing the situation.

The partnership was evaluated as falling short of its Local Improvement Targets for 2005-06. It was evaluated as meeting or being close to meeting its targets on single shared assessments and better support for carers. Intensive home care and rapid response services were evaluated as requiring improvement. Its new targets for 2006-07 were also evaluated as requiring improvement.

In a report to the council's Housing and Health Committee, dated 16 August 2006, the partners fully committed themselves to further extending their partnership activities and to meeting the challenges for performance management as set out by the Scottish Executive, NHS Scotland and COSLA in their paper '*Joint Future: The Outcomes Approach – The Next Steps, January 2006*'.<sup>4</sup>

<sup>4</sup> *Joint Future: The Outcomes Approach – The Next Steps, January 2006*, Scottish Executive 2006

They noted that this would require '*strong commitment at every level to systematic recording and scrutiny of performance*'. In order to achieve this, the partners had agreed to regenerate the single shared assessment process and enable the use of the information sharing system, eCare, by all health, housing and social work professional staff. We welcome this in view of the fact that the staff to whom we spoke expressed concerns that the existing data collection and information sharing systems were not easy to use or robust. They also said they were therefore not confident about effective joint performance management.

The partners had committed themselves to developing a Joint Improvement Framework across local community care services in order to set and monitor joint targets and performance indicators. They agreed that these would be part of the remit of the proposed CHP Performance Management Sub-Group (PERTHSTAT).

The Framework would involve more regular monitoring of performance in relation to delayed discharges, such as providing forward projections of performance and run-charts to ensure that the predicted modelling of improvement was delivered, with clear targets for each service involved in the process of hospital admission and discharge. It would also include the development of a joint public reporting mechanism on the key performance indicators. We welcome these developments.

The partnership monitored progress on a regular basis for example through the '*Older People's Strategy Report May 2006*' which detailed services, future plans, timescales, and responsible officers. There were also a number of mechanisms by which the partners individually monitored performance, for example the council's noteworthy Business Management and Improvement Plan (BMIP) for community care services, together with its monthly/quarterly activity reports. The CHP had a Quality Improvement Framework, which included a systematic review of services and a walk-about programme. The CHP was also in the process of developing a balanced scorecard approach to encourage continuous improvement of services.

Through these joint and single reporting mechanisms the partners were able to demonstrate improvements such as the increase in home care hours (from 6932 in 2005 to 8560 in 2006), the increase in numbers of assessments completed in 28 days (96% in 2005-06) and the time taken to start social work services after assessment (56.6% within 7 days against a target of 45%). The falls prevention project had been successful in preventing accidents and falls and in supporting people at home – there was a reduction of 34% in reports of falls to the ambulance service.

### *Continuous improvement*

Both partners reviewed older people's services, for example a Best Value review of home care was undertaken in 2003. The home care improvement plan arising from this had been implemented and was being monitored through the Home Care Project Board and Task Group. A strategic review of sheltered housing and housing options for older people to ensure these services were fit for the future was being undertaken at the time of the fieldwork. The use of community hospitals was also being reviewed by NHS Tayside. User/patient feedback was sought although it did not appear that this was regular or consistent.

Performance management systems and a positive approach to continuous improvement at the strategic levels were being actively pursued by the partnership. Although this approach did not yet consistently run through the way staff worked, managers were aware this needed further development, and were taking very positive steps to achieve this.

### **8.5 Leadership and direction**

The leadership of the Perth & Kinross partnership was evaluated as good. The impact of the ending of Care Together is beginning to lessen, with the focus being on the future rather than the past within both health and social care. There is a clearly set out agenda for change. In relation to older people's services specifically, one of the main challenges facing leaders in social work and the CHP was the task of instilling a new sense of confidence and purpose in partnership working. The principles of joint working had been clearly restated by the partnership leaders, but ownership of the future vision for older people still had to be evidenced at the next levels of management, where partnership working had to be delivered.

Elected members, senior officers and clinicians in the Perth & Kinross partnership provided a convergent view of the position on vision and direction for the partnership in relation to older people's services. The Chief Executive of the council was strongly committed to community planning and work was in progress corporately to improve the integration of partnership working on older people's services (and other care groups) into community planning themes. An elected member had been appointed as an Older People's Champion.

There was a general sense of cautious optimism, with strengthened leadership in the council and the inception of the CHP. Many people told us that the ending of Care Together had had a damaging impact on inter-agency relations and on staff. Inevitably, there was a perception that many developments had stalled in the intervening period, with the consequent need to make up lost ground.

The partnership team charged with leading the older people's services strategy had been among those most directly affected by the changed arrangements, since the Older People's Services Partnership was what remained of the previous integrated structure for community care services. The CSWO and CHP Manager stated that they had learned important lessons from the experience, which were reflected in changed partnership arrangements for governance and management accountability.

Pooled resources had obviously become politically challenging, mainly because of audit issues, but also because the previous arrangement had failed to address significant gaps in social work services. The focus on alignment rather than pooling of resources and activities had begun to restore confidence at political and senior officer level. This was confirmed in a number of contacts throughout the inspection.

It was also recognised that ambiguity about professional responsibilities and accountability had been unhelpful. This was being redressed by ensuring that professional leadership was provided to respective professional groups whilst adhering to the overriding objective of delivering seamless services.

There had also been some benefits from the previous experience and much to build on. One example of this described by a consultant was better working relationships with a range of council services, including housing. There were also examples of positive initiatives which had roots in Care Together partnership working and these provided a foundation on which to build forward looking, joined up services for older people. Optimism for the future and a clear sense of direction were not shared throughout older people's service areas. We found morale to be low amongst some staff in both health and social work, with communication from senior management being seen as particularly problematic. There was a sense of staff in older people's services being disconnected from senior staff. This was raised in focus groups and in the staff survey.

The Older People's Services Partnership was recently reviewed and restructured, with the intention of modernising and improving services. Changes of this nature can sometimes lead to short term loss of morale. We observed a meeting of key managers and clinicians charged with leading the new joint planning structures at which the CSWO and the CHP Manager gave very clear and supportive messages about the future direction of travel.

We noted that in the Joint Commissioning Group there appeared to be reservations as to how the new arrangements for older people could be made to work successfully. It will be important therefore for the CSWO and CHP Manager to give on-going leadership and support to this team. There also needs to be more attention given by senior staff to a joint communication strategy which will ensure that how the vision is to be achieved is better understood.



Relations between the local area and the NHS board, and particularly acute services, were a significant issue for local partnership leaders. Local hospital consultants considered they had excellent working relations with the CHP, GPs and with social work colleagues, but were concerned about the future role of NHS Tayside in the planning and delivery of older people's services. There was unease about the future planning for community hospitals and the proposed referrals management centre, which they believed would detract from the ability of local staff to deliver the best, most flexible care.

The CSWO and the CHP Manager had a generally positive view of the NHS Tayside Delivery Unit and what it might achieve, which was seen as not detracting from the local CHP. There was however concern about NHS Tayside and the issue of equitable distribution of resources across the three council areas, with the need for more transparency being emphasised.

A joint report by the CSWO and the CHP Manager on '*Shifting the Balance of Care, July/August, 2006*' demonstrated good joint leadership to drive the local joint agenda forward, with clear actions and timescales being set. It recognised the shortfalls in the council service and in joint services. It also set out what needed to be done. It is important that this is followed through into a more comprehensive joint commissioning strategy for older people services, which clearly aligns joint strategic objectives with the financial plans and priorities of the council and NHS Tayside. The Joint Planning Team has been asked to produce this, and an ambitious timescale had been set for the strategy to be completed.

The two managers were clear about staff development priorities being adult protection and support, and leadership development. A coaching and mentoring scheme for partnership leaders and all staff has been underway for well over a year.

## 8.6 Capacity for improvement

The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services and their experiences, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.

We found that some achievements had been made to improving outcomes and experiences of people using services. Senior managers recognised that quality assurance and performance needed more attention and had agreed how this would be undertaken. Overall, the leadership of the Perth & Kinross partnership was good, and there was good capacity for improvement.

In order to maintain progress there are a number of positive factors which will underpin and support these developments. The impact of the ending of Care Together was beginning to lessen, with the focus more clearly being on the future rather than the past within both health and social work services. There was a clearly set out agenda for change. Managers acknowledged that they needed to communicate more effectively with staff in services for older people. Both health and social work staff were highly motivated to work together to provide the best possible outcomes for older people and their carers.

# CHAPTER 9

## Evaluations and recommendations

### 9.1 Evaluations for the Angus partnership

Area for Evaluation	Evaluation
Person centred care	Very good
Key outcomes	Good
Whole systems approach	Very good
Delivery and management of services	Very good
Leadership and direction	Very good
Capacity for improvement	Very good

### 9.2 Evaluations for the Dundee partnership

Area for Evaluation	Evaluation
Person centred care	Good
Key outcomes	Adequate
Whole systems approach	Weak
Delivery and management of services	Adequate
Leadership and direction	Adequate
Capacity for improvement	Adequate

### 9.3 Evaluations for the Perth & Kinross partnership

Area for Evaluation	Evaluation
Person centred care	Adequate
Key outcomes	Adequate
Whole systems approach	Adequate
Delivery and management of services	Adequate
Leadership and direction	Good
Capacity for improvement	Good

## 9.4 Recommendations for the three partnerships

### Recommendation – Tayside-wide number 1

NHS Tayside and the three councils should jointly develop and implement a coherent Tayside-wide framework for older people's services. This should set out an agreed strategic and financial framework for meeting the challenges of implementing the national policy directions as set out in *'Delivering for Health'* and *'Changing Lives'*. The framework should adopt a whole systems approach to achieving the required shifts in the balance of health and social work services.

Within this framework each partnership should develop and implement a clear strategy, including a joint action plan, financial plan, timescales and commissioning plan, which sets out how it will meet the need for local service developments (page 16).

### Recommendation: Tayside-wide number 2

There should be more joint discussion between NHS Tayside and the three councils regarding future funding arrangements including resource transfer. Future NHS Tayside funding arrangements should take account of imbalances created by resource transfers agreed to date (page 16).

### Recommendation: Tayside-wide number 3

The partnerships should prepare medium term joint financial plans and review them on a rolling basis in order to inform the process of forward planning of services for older people. NHS Tayside should consider aligning its budget setting timetable with those of the three councils (page 17).

### Recommendation: Tayside-wide number 4

Managers should ensure that policies and procedures on medication (drugs, creams, etc) for older people receiving services are clear and are energetically promoted with all staff, including pharmacists, to ensure consistency of practice. A subsequent audit should be carried out to monitor implementation (page 20).

### Recommendation Tayside-wide number 5

All partnerships should develop training plans or progress their existing plans to ensure that all social care and health staff working with people with dementia are provided with training on the skills and expertise needed for working with people with dementia (page 21).

### Recommendation Tayside-wide number 6

All partnerships should ensure that every older person receives a copy of their own assessment and care plan. They should consider the ways in which they provide written information to older people so that it can be easily identified and located within older people's homes (page 23).

### Recommendation: Tayside-wide number 7

Partnerships should develop systems for monitoring the number of health checks offered and provided to carers and should set annual targets for increasing these (page 24).

## 9.4.1 Recommendations specifically for NHS Tayside

### Recommendation: NHS Tayside number 1

NHS Tayside should give attention to improving how health staff communicate with carers and how they acknowledge the role of carers of older people. This should be done in partnership with carers organisations and be supported by the introduction of feedback mechanisms and improvement plans (page 25).

## 9.4.2 Recommendations specifically for the Angus partnership

None

### 9.4.3 Recommendations specifically for the Dundee partnership

#### Recommendation: Dundee partnership number 1

The Dundee partnership should urgently collaborate on implementing a whole systems approach at all levels of both organisations. It should produce a strategy which includes a joint action plan, financial plan, timescales and commissioning strategy, and which sets out how the partnership will meet the need for local service developments. It should also set and monitor timescales for delivering tangible results (page 60).

#### Recommendation: Dundee partnership number 2

The partnership should work to develop a more integrated approach to training, workforce planning and methods of communicating with staff about services for older people (page 70).

### 9.4.4 Recommendations specifically for the Perth & Kinross partnership

#### Recommendation: Perth & Kinross partnership number 1

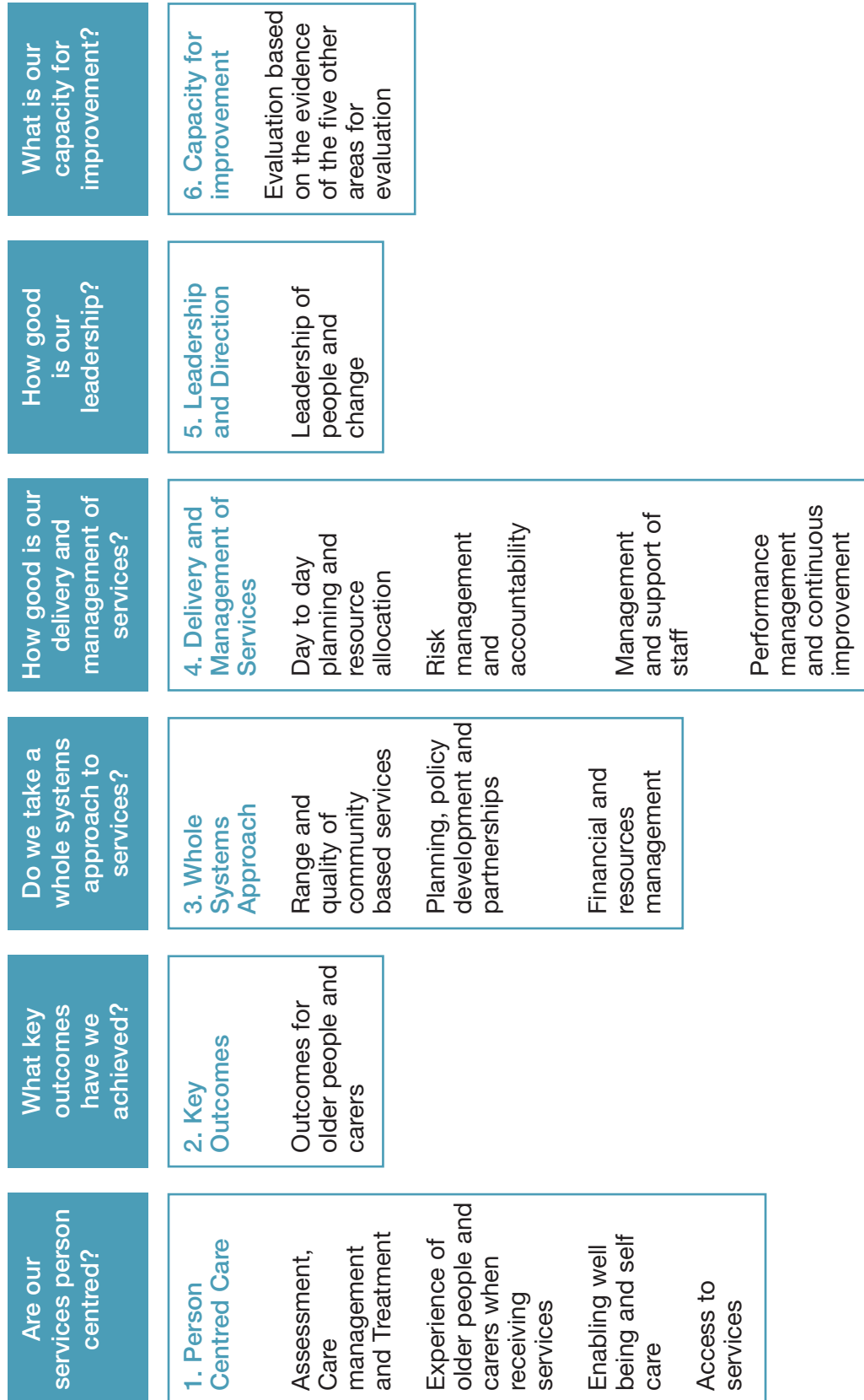
The Perth & Kinross partnership should progress its work on updating its strategy for services for older people. This should include a joint action plan, financial plan, timescales and commissioning strategy. It should also set and monitor timescales for delivering tangible results (page 85).

#### Recommendation: Perth & Kinross partnership number 2

The partnership should involve managers and staff in implementing a joint communication strategy about the developments in services for older people (page 96).

# Appendix 1

## Model for the multi-agency inspections of services for older people



### Methodology for the multi-agency inspection of services for older people in Tayside

The multi-agency inspection methodology was devised by a Task Group, comprised of representatives from NHS QIS, SWIA and the Care Commission. The group built upon:

- NHS QIS draft standards for services for older people and the peer review process
- SWIA's performance inspection model and methodology
- The National Care Standards and the Care Commission's inspection and regulatory processes.

The multi-agency inspection of services for older people (MAISOP) model and methodology were endorsed by the national Strategic Group for Community Care Inspections in 2006.

The development of the detailed inspection process was undertaken by staff within SWIA and other inspectors. A multi-agency team was brought together by the Task Group and included:

- SWIA Chief Inspector, full time and sessional inspectors
- Three NHS QIS peer reviewers, including a GP and consultant in the health care of older people
- Associate inspectors from two other councils
- Care Commission officer
- Lay reviewer
- Statisticians, project manager and administrative staff.

The methodology included:

- analysing the self assessment workbooks and advance information submitted by the partnerships
- case file reading of health and social work files
- carer, staff and stakeholder questionnaires
- structured interviews with service users and carers
- a fieldwork programme including focus groups, interviews, and meetings with stakeholders such as voluntary and private providers.

Full details are set out in the MAISOP Handbook which will be made available on the SWIA website, [www.swia.gsi.gov.uk](http://www.swia.gsi.gov.uk).

We were mindful of the fact that Angus had a SWIA performance inspection in 2005 and Perth & Kinross in 2006. We therefore used information already gathered during these inspections and did not undertake as many inspection activities in both the pre-inspection and the fieldwork phase in those partnerships, in order to lighten their workload.



For example, we issued 300 staff questionnaires, 100 each to staff employed by Angus, Dundee and NHS Tayside. No questionnaires were issued to staff in Perth & Kinross since they had recently had a questionnaire as part of their performance inspection. Nearly 200 questionnaires were returned and this equates to a response of about 65%, which is a higher response rate than that seen in the performance inspections. These responses and the relevant ones for staff working with older people in Perth & Kinross have been used for the report.

We thought that it was essential to speak to older people directly in order to obtain their views about services and the outcomes for the services they received. We decided not to use a postal survey. Experience to date has shown that questionnaire return rates from older people are low. Older people are reluctant to respond critically to questionnaires about services which they receive. Given this and also the pilot nature of this inspection and its focus on multi-agency working, it was agreed with the three partnerships to undertake a series of structured interviews.

SWIA commissioned the Dementia Services Development Centre (DSDC) at Stirling to prepare an interview format and structure which would be suitable for use with older people, including older people with dementia. The format was also designed to enable the interviews to focus on older people's views on the effectiveness of multi-agency working.

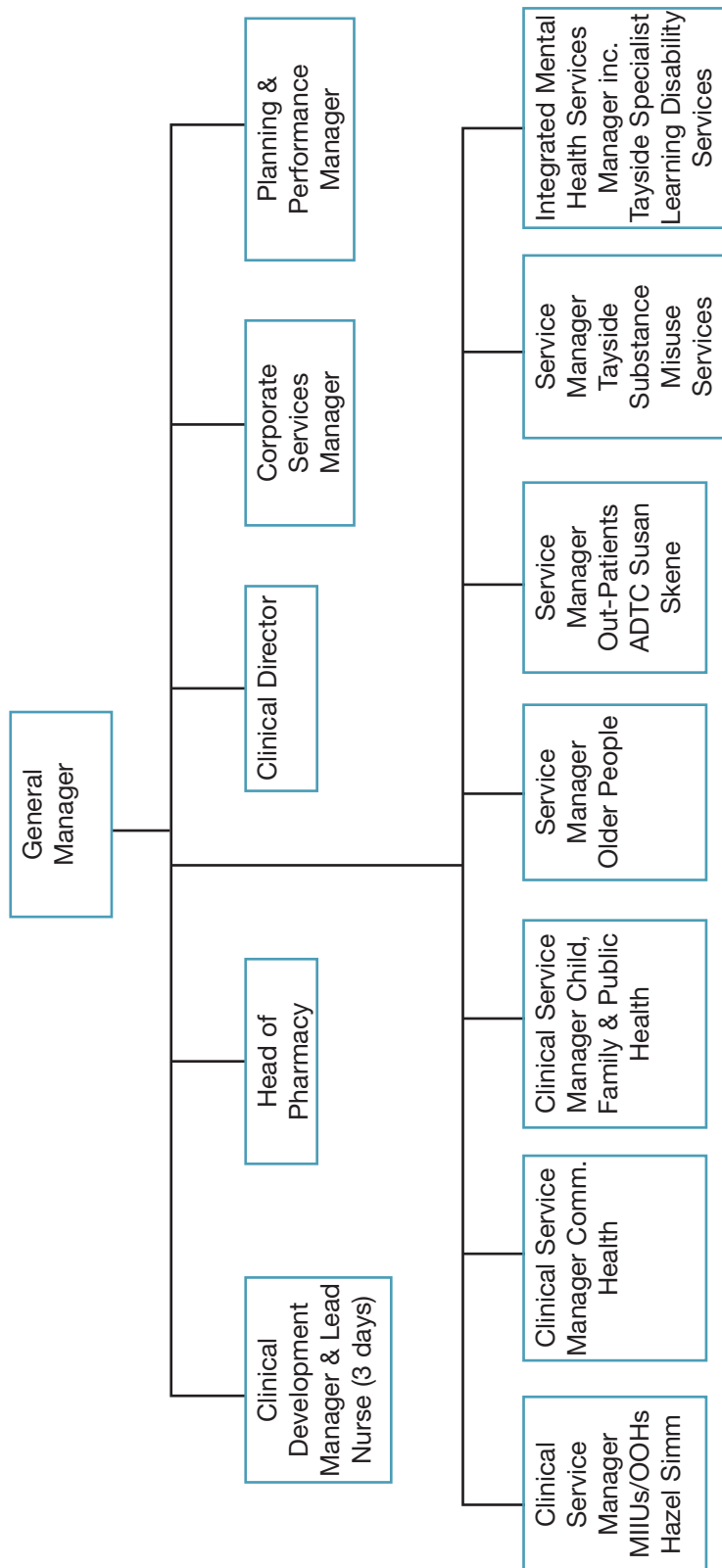
In total 26 interviews were undertaken across the three partnership areas (14 by DSDC and 12 by SWIA inspectors). Some of the older people interviewed were identified from the file reading exercise and the remainder were chosen by the inspection team from a list of older people drawn up by the local authorities where it was known that both health and social care services were involved. Six of the interviews involved carers, rather than older people due to their unavailability at short notice. We appreciate that this was a small number of interviews but it was an essential step in developing the new methodology for the multi-agency inspection methodology. The interviews provided high quality data about older people's views and experiences, rather than statistical data.

As part of the inspection a survey was undertaken of carers of older people in the Angus and Dundee Partnership areas, but not in Perth & Kinross. Carers there had been surveyed separately as part of the performance inspection of that council's social work services earlier in 2006. A small number of health and social work files were read in Angus because several older people's files were read as part of the SWIA performance inspection undertaken in 2005.

It was difficult to assess what health budgets and costs were applicable specifically to older people's services. Financial monitoring reports normally included all CHP figures covering not only older people's services, but also services such as learning disabilities and substance misuse. Additionally, the NHS in Scotland does not specifically identify costs relating to older people's services. The financial data in this report should therefore be treated with a degree of caution.

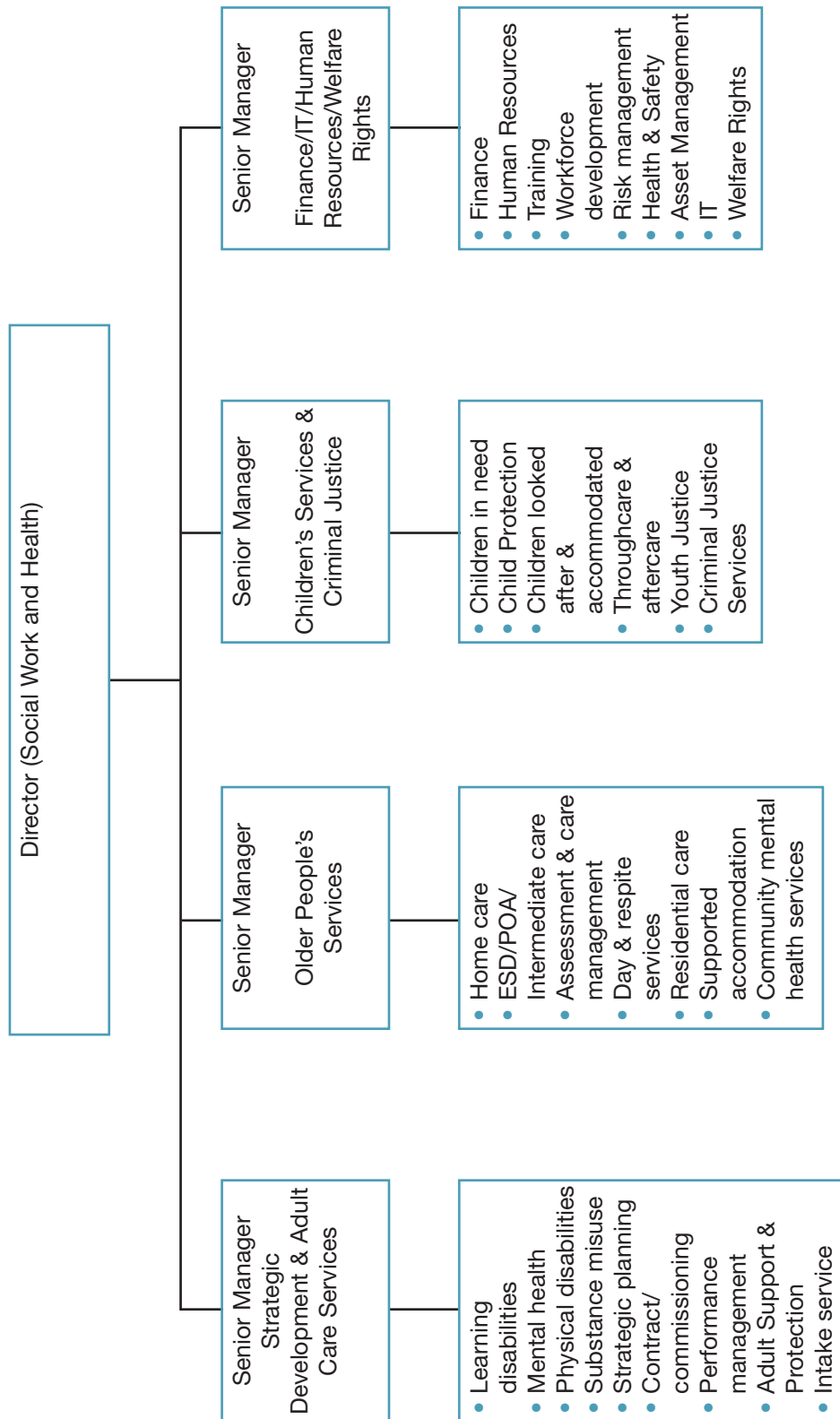
We will build on the experience of using earlier inspection data to assist us to make future inspections more proportionate. We may also make changes to the MAISOP model and methodology after this first pilot in Tayside.

Angus Community Health Partnership structure

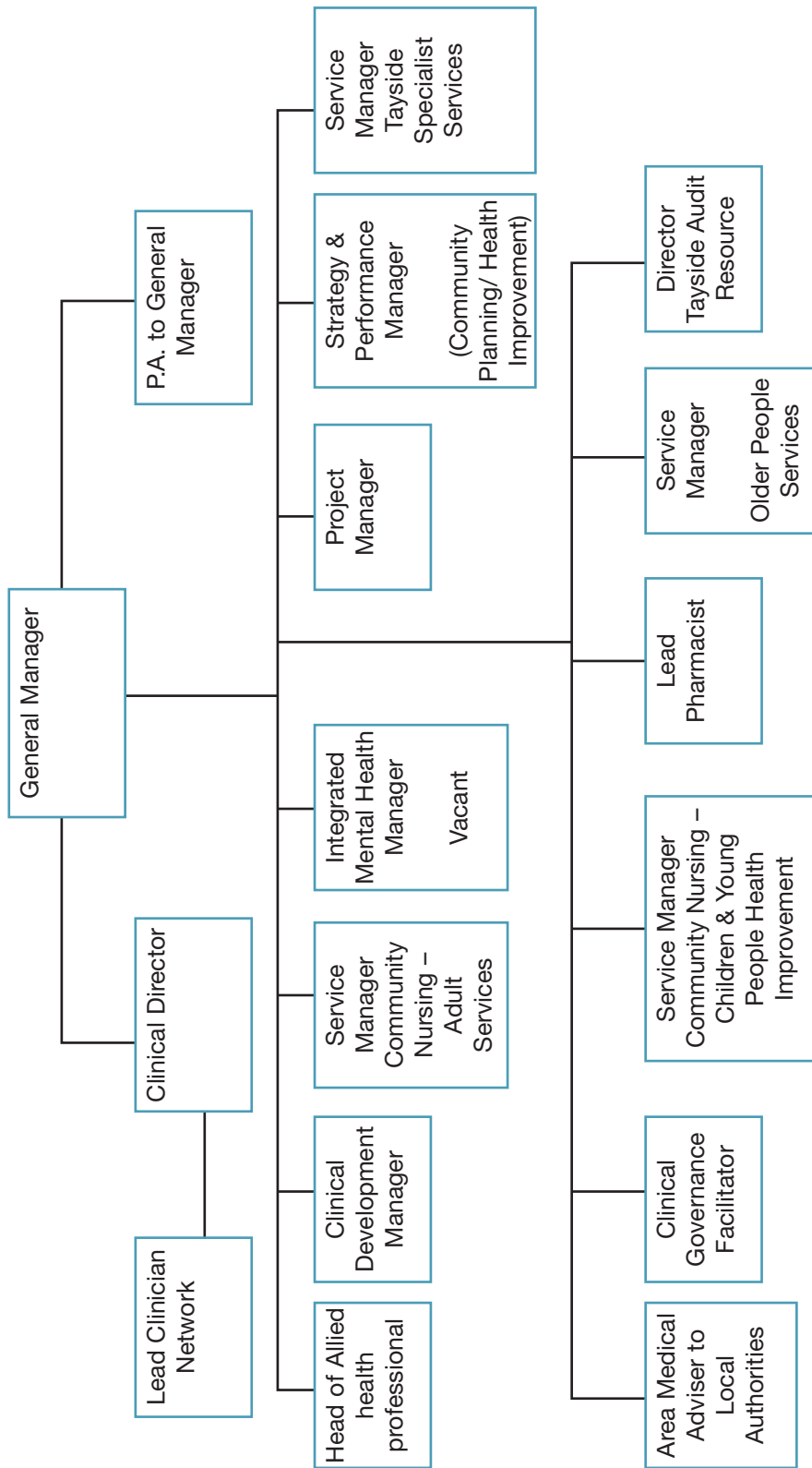


# Appendix 4

## Angus Council Social Work and Health structure

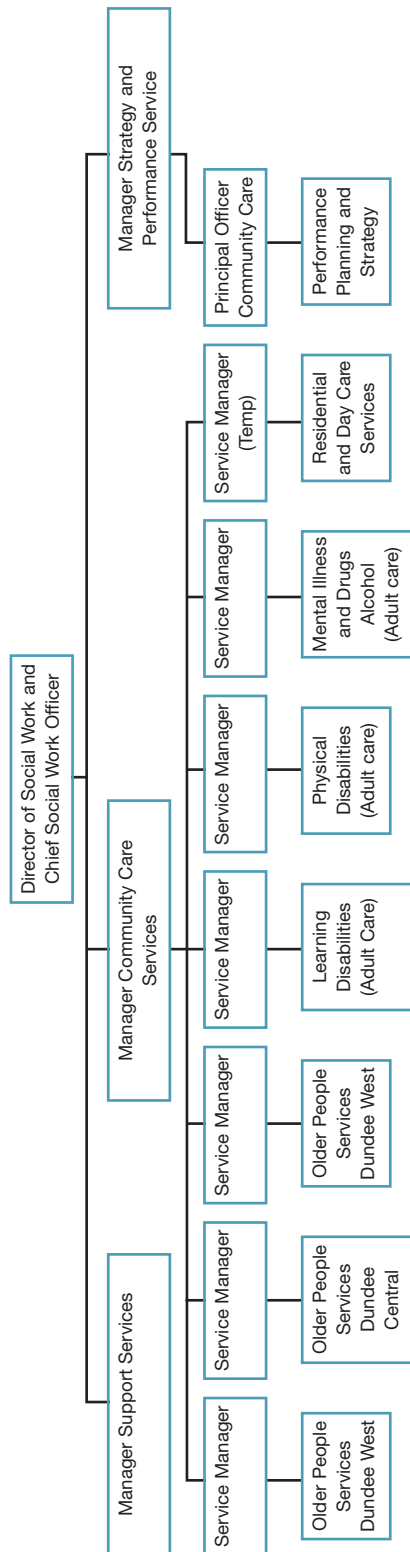


Dundee Community Health Partnership structure

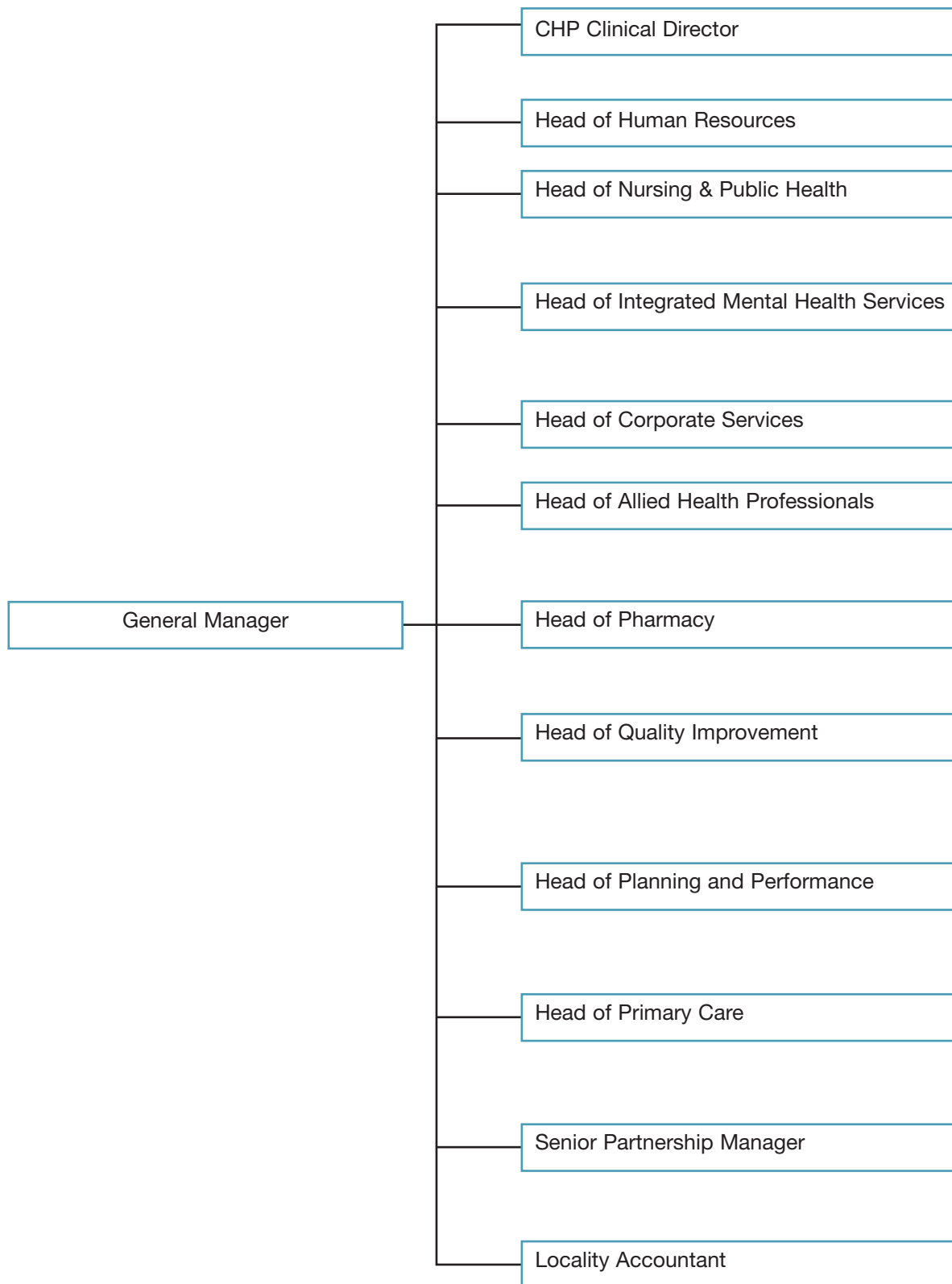


# Appendix 6

## Dundee City Council Social Work Department structure

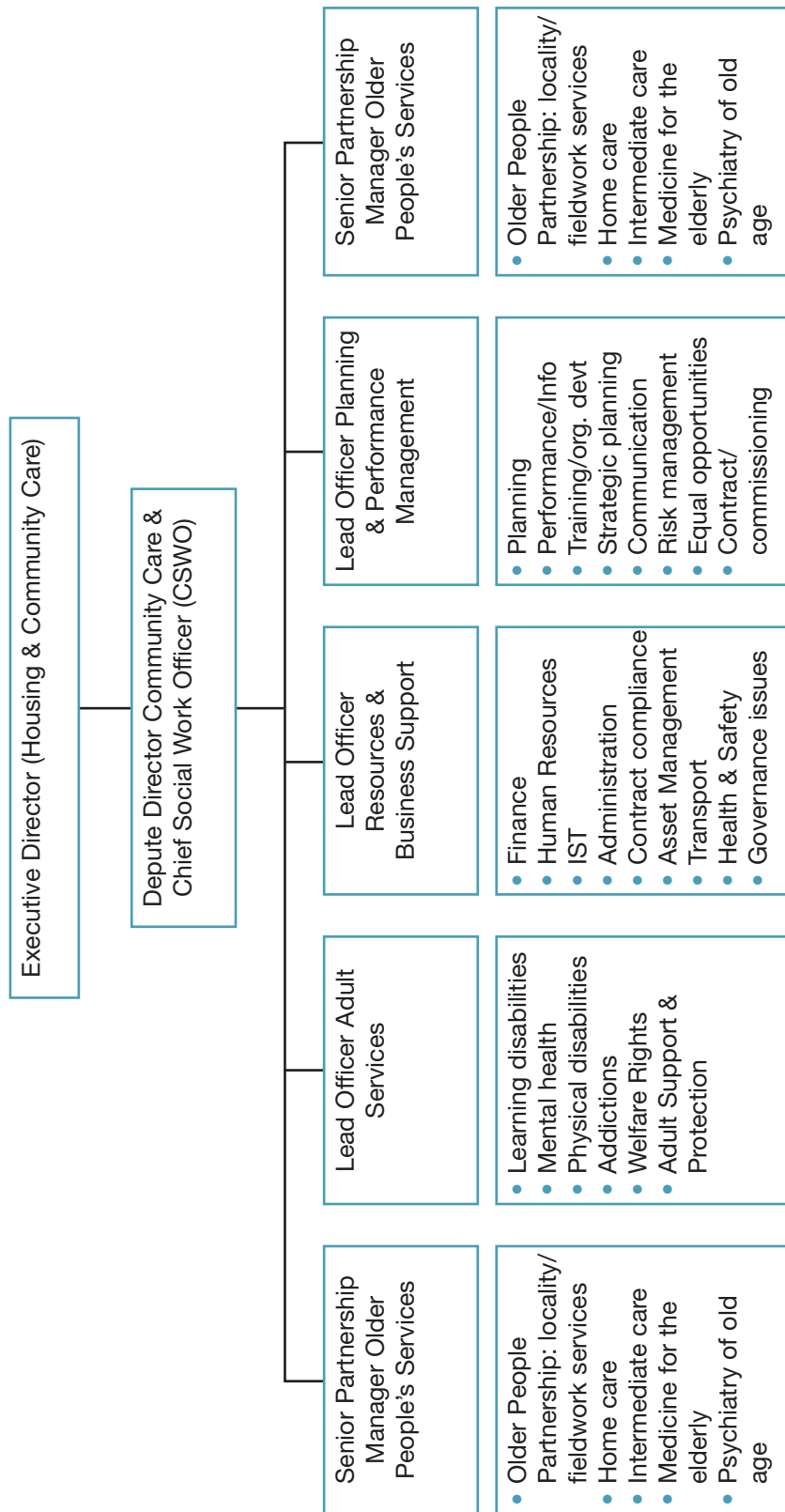


Perth & Kinross Community Health Partnership structure



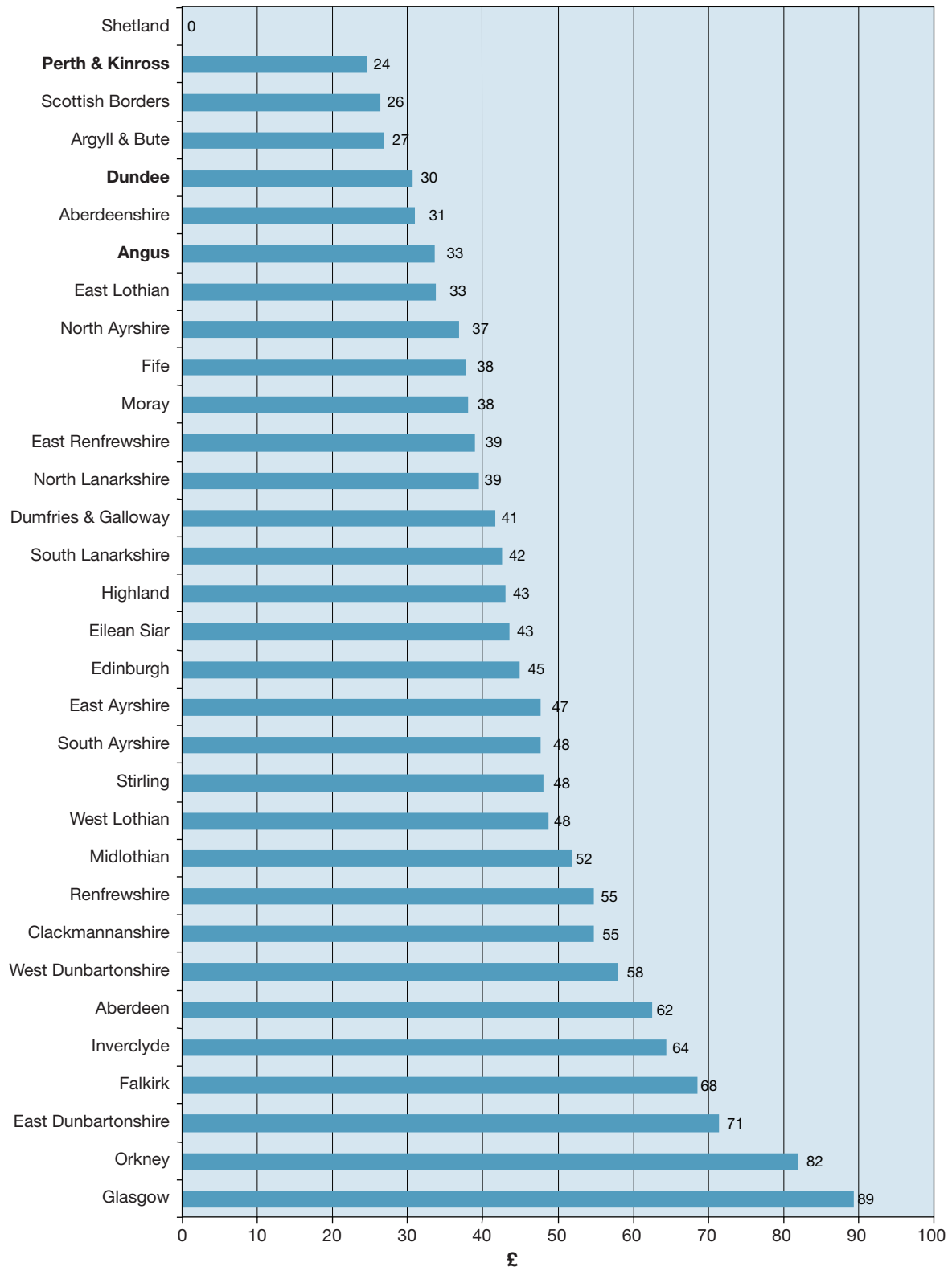
# Appendix 8

## Perth & Kinross Council Housing and Community Care structure



## Resource transfer to councils from NHS Boards, 2003-04

(Source: CIPFA Social Services Statistics 2003-04 Actuals)

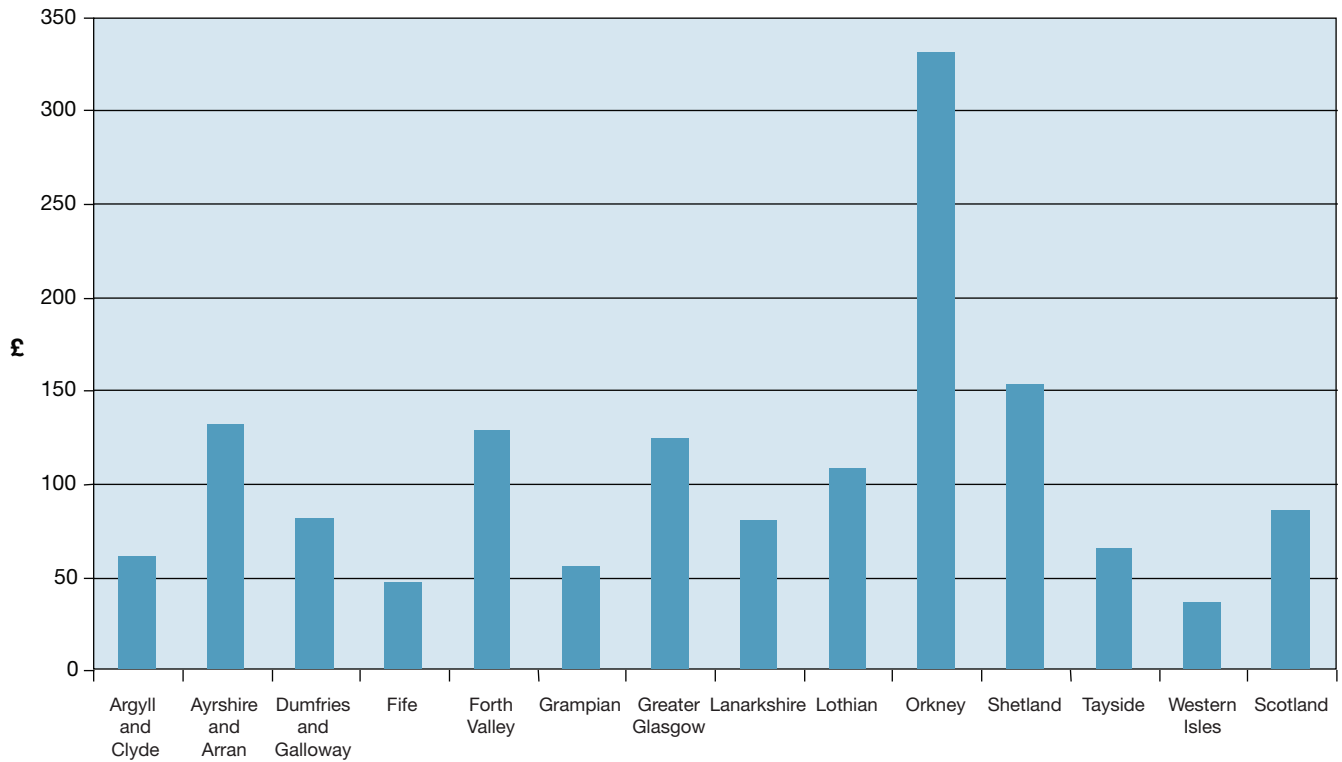




# Appendix 10

## Resource transfer for geriatric continuing care services by NHS Board, per adult aged 65 and above, 2005-06

(Source: Scottish Executive Health Department)



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