Highland Council Scrutiny Report

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On 1 April 2011 the new scrutiny body, the Care Inspectorate took over the work of the Social Work Inspection Agency (SWIA). This report is the result of scrutiny and assessment work carried out by SWIA and completed by the Care Inspectorate.

1. Introduction

The Care Inspectorate decides how much scrutiny a local authority's social work services will need by carrying out an initial scrutiny level assessment (ISLA). This considers potential areas of risk at strategic and service levels. SWIA carried out an initial assessment of The Highland Council's social work services between October 2010 and March 2011. We did so by:

- Scrutiny of 80 case records supported by local file readers and an additional 20 case records read as part of supported self-evaluation of services for high risk offenders, again with local file readers;
- analysis of 339 documents provided by the council or sourced by SWIA;
- analysis of SWIA's performance inspection report (published May 2007) and follow-up report (published November 2008) to track progress made on recommendations;
- analysis of key performance data;
- analysis of the findings of HMIE inspection of services to protect children (published May 2010), Audit Scotland Best Value 2 Pathfinder report (published May 2010), Care Commission findings; and
- participation in shared risk assessment activity led by Audit Scotland which included all relevant scrutiny bodies.

The ISLA focuses on answering nine risk questions:

- Is there evidence of effective governance including financial management?
- Is there effective management and support of staff?
- Is there evidence of positive outcomes for people who use services and carers across the care groups?
- Is there evidence of good quality assessment and care management?
- Is there evidence of effective risk assessment and risk management for individual service users, both in terms of risk to self and public protection?

- Does the social work service undertake effective self-evaluation resulting in improvement planning and delivery?
- Is there effective partnership working?
- Do policies, procedures and practices comply with equality and human rights legislation and are there services that seek to remove obstacles in society that exclude people?
- Are there any areas that require urgent attention and improvement?

2. ISLA findings

Based on the evidence available, four areas presented no significant concerns:

- There were no significant concerns regarding the effective management and support of staff. There were a number of strengths including the Workload Management Framework and Supervision Policies.
- Performance in practice on risk assessment and risk management was generally strong and most files we read contained risk assessments and management plans that were at or above an acceptable standard.
- There were no significant concerns regarding compliance with equality and human rights legislation. The council was meeting its statutory duties and was providing access to services for the various diverse and potentially excluded communities in Highland.
- There were no suspected or actual areas of unsatisfactory/weak performance that required urgent attention and improvement.

In a further four areas the level of risk was uncertain:

- There had been effective governance in children's and criminal justice social work services but there were longstanding issues regarding effective joint management and delivery of some community care services. Far reaching changes in how services will be planned, managed and delivered are being proposed. It is too early to say what the impact of this will be.
- Although the general standard of assessment and care management was good, there were risks to the council's ability to deliver the Mental Health Officer (MHO) service. There were consequent risks to people with a mental disorder regarding assessments for MHO consent to the use of compulsory care and treatment measures under mental health legislation[1].
- While there was ample evidence of the council and its key partners addressing service improvement by using a performance management approach, there was less evidence of self evaluation activity, particularly systematic case file audit.
- SWIA's previous inspection reports had been critical of the state of partnership working between the council and NHS Highland. This was reflected in longstanding difficulties in shifting the balance of care for older people and people with learning disabilities in Highland.

In the remaining area there were significant concerns:

[1] MHOs have statutory duties and responsibilities under The Mental Health (Care and Treatment) (Scotland) Act 2003, The Adults with Incapacity (Scotland) Act 2000 and as specialist consultants on these in relation to Adult Support and Protection legislation.

- There were significant concerns about older people's services. Important outcome measures for older people were amongst the lowest in Scotland, including the provision of intensive home care. There were increasing numbers of people experiencing delays in being discharged from hospital.

SWIA summarised its initial findings in a report that it sent to the local authority in April 2011.

3. Timing of scrutiny

The amount of scrutiny the Care Inspectorate (and formerly SWIA) carries out in a local authority relates to both the assessed level of risk and the size of the local authority. These combined factors mean that the Care Inspectorate could have undertaken up to 35 scrutiny sessions (meetings, focus groups and observations) in Highland. However, our risk assessment resulted in us requesting 25 scrutiny sessions. We also asked the council to identify any areas of service they believed would enhance our understanding of the issues raised in our ISLA risk assessment. The council identified three additional sessions. Our scrutiny included meetings with people who used services, carers, staff, managers, and partner agencies (see appendix 1). We completed it in May 2011.

It should be noted that our scrutiny took place at a very early stage in the work towards the planning for the integration of health and social care services in Highland.

4. Scope of scrutiny

Our scrutiny is targeted and proportionate and does not constitute a full assessment of all social work services. Based on the ISLA we did not scrutinise the following areas of practice:

Effective Management and support of staff

Previous SWIA and other scrutiny had confirmed that the supervision policy had a clear set of standards for all staff and managers to work to, including responsibilities regarding professional development, workload and recording of case work and supervision sessions. All staff had a Personal Development Plan (PDP). There was good guidance for managers and staff to support the completion of PDPs. Significant effort had gone into ensuring positive staff and management engagement in changing professional practice in relation to the implementation of GIRFEC[2]. There was a workload management framework in place which covered allocation, eligibility criteria, handling referrals and staff supervision. It provided clear, practical guidance on the development of the workload management scheme. There was good communication with staff.

[2] The 'Getting it right for every child' integrated approach to providing services for children.

There had been absence management issues. The Positive Attendance Strategy was implemented across the council in April 2009 to reduce staff absence by 20% by March 2010. Absence actually rose by 8.9% during this period. Across social work there had been increases in absence compared with the rest of the council. The council recognised that this could be better managed. A task group had been established to monitor the situation and support teams. Since then the average days' absence per quarter had decreased throughout 2010/2011, and by end June 2011 absence was 35% lower than it had been in March 2010.

Effectiveness of risk assessment and risk management

Scrutiny activity undertaken by other bodies confirmed low risk here. The six gradings reported by HMIE on its' joint inspection of services to protect children and young people were five 'very good' and one 'good'. The report was published in May 2010. There were effective public protection arrangements in place and good multi-agency working on child and adult protection.

There was evidence of good performance in the case file reading for high risk offenders, children and adults. We assessed performance on the basis of protective and /or non-protective risk.

An independent analysis (Edinburgh University) of the impact of GIRFEC on professional practice and culture noted some very positive changes including a reduction in the rate of child protection registration, better conversion rates and numbers of referrals falling, as children's needs were met earlier in the process. Repeat registration began to fall in 2008 and similar impact on youth offending was indicated.

The Adult Protection Committee was meeting regularly and all members were in place. It linked into the wider 'Safer Highland Public Protection Arrangements' (child protection/alcohol & drug partnership/ MAPPA/ violence against women/youth justice). The social work service plan had a risk register which was regularly reviewed via the Chief Executive's quarterly review process. The Chief Executives of the Highland Community Planning Partnership had issued guidance on structure and process for the best strategic arrangements to support public protection. These linked to key single outcome agreement areas. The group met every four months to consider key issues and performance reports.

Equality and human rights

Our initial assessment concluded that the service was complying with equality legislation and was alert to the need to ensure that it tackles obstacles that exclude people.

The Social Work Service Plan 2010/2011 made general commitments to fulfil the council's duties to promote equality under the Single Outcome Agreement. The proposed service redesign for community care also assessed for potential discriminatory impact and included the views of 'a range of equalities groups' to assess likely impact.

There were increasing numbers of people receiving Direct Payments and people opting for self-directed support. These funds could also be used to increase inclusion, for example by funding driving lessons and other forms of tutoring that promoted greater independence.

A joint national audit by the Scottish Council on Deafness and ADSW[3] showed Highland performing particularly well on delivering training in BSL[4] and other related training to support staff working with people with a hearing impairment. For Highland's Children 3[5] was also producing action plans for deaf and visually impaired children.

5. Scrutiny findings

Governance and financial management

Reason for scrutiny

Previous SWIA inspection activity (May 2007 and November 2008) identified difficulties in achieving effective partnership working on community care. This confirmed the Council's own analysis of its performance at that time, which also indicated that there was considerable room for improvement in shifting the balance of care for older people and in improving and modernising services for people with learning disabilities.

The council and NHS Highland were planning to embark on a significant restructuring of the governance and operational management of adult community care and children's services[6]. They will continue to share responsibility for specifying outcomes and allocating resources, but the NHS will take lead responsibility for community care and the council will lead on children's services.

As had been the case throughout Scotland, resource mapping undertaken so far had raised difficult questions about the consistency and equity of current allocation. The Council had been involved in the development of the Integrated Resource Framework model, designed to identify such variation and inconsistency.

The extent of these changes was very ambitious, as was the proposed timescale which committed partners to having completed a detailed strategic plan by May 2011, to be delivered by May 2012. Given that it was proposed, for example, that around 1400 staff currently working for the council would shift to the employment of the NHS, and 230 NHS staff would transfer to the council, the scale of the potential challenges facing partners was considerable.

[3] Association of Directors of Social Work
[4] British Sign Language
[5] For Highland's Children is the Integrated Children's Services Plan for children, young people and families in Highland. The plan is linked to all relevant local planning arrangements and aligned with the NHS Health Improvement Targets (HEAT), the Highland Council Programme for Administration (Strengthening the Highlands) and the Single Outcome Agreement with the Scottish Government (SOA).
[6] At their most recent joint meeting on 23 June 2011 The Highland Council and NHS Highland decided to proceed with their plans to integrate health, education and social care services.

There was a continuing priority to shift the balance of care from institutional settings towards community and home based services, with increased use of anticipatory care, reablement and rehabilitative models, and short term and focussed interventions. This will require a significant shift in the funding model of services and close engagement with other council services and NHS Highland. The proposals were also predicated on significantly increasing community capacity to bolster preventative approaches and to meet less acute need.

Scrutiny findings

There had been a significant improvement in the quality of partnership working between the council and NHS Highland.

There was a great deal of enthusiasm for the planned changes amongst the various stakeholders we met. Senior council and NHS officials, elected members and members of the NHS board strongly supported the proposals. Many middle and front line managers, some staff, and external providers of commissioned services were in favour of the proposed integration of services. The senior officials we met with maintained they had a clear sighted and realistic vision about the single agency plan, and were confident that it would proceed and that it was workable.

The consultation process was still at an early stage when we were in the area. Despite the significant efforts being made by the Council and its partners to consult and communicate with stakeholders about the planned changes, concerns were expressed by groups of people who use services, carers and some staff that we met during the period of our scrutiny. Of those who were aware of the proposals, many saw the changes in terms of threats to services and resources, and in the context of wider national financial austerity measures.

Although most of the changes to strategic governance arrangements had been agreed in principle there were significant issues and challenges that the Council and NHS Highland were working to resolve, including:

- Community Health Partnerships (CHPs) remain a requirement of current legislation but the partners had yet to resolve the place of the CHP(s) in the new arrangements. Audit Scotland recently carried out a national review which showed that progress in developing the performance of CHPs since they were established in legislation in 2004 has been limited[7].

- The council charges for certain services whereas NHS services are free at the point of delivery. Arrangements regarding how charges will be set and applied by the NHS were still required.

- There was agreement that criminal justice social work services would remain the responsibility of the council but revised senior management and governance arrangements had not been finalised.

[7] Review of Community Health Partnerships, Audit Scotland, June 2011

- The future role of the Chief Social Work Officer (CSWO) was not yet clear. Statutory guidance requires the appointment of a professionally qualified CSWO to support local authorities and elected members, to provide governance and to ensure professional leadership and accountability. The scope of the role relates to all social work and social care services, whether provided directly by the local authority or in partnership with other agencies.

- The council has statutory duties and responsibilities under mental health, adults with incapacity and adult protection legislation, including the provision of the Mental Health Officer (MHO) service. This legislation confers exclusive duties and responsibilities on council officers. For example, any new arrangements would have to ensure the continued governance of the MHO service through the local authority and the independence of MHO assessments.

- There were unresolved issues regarding the future arrangements for social work out-of-hours services which currently cover both children and adults.

- Decisions regarding who will employ and manage other key staff groups, such as specialist nursing services and staff providing paediatric health services, had not yet been made.

The Council and NHS Highland were well aware of these and other challenges that they faced. They had developed a joint risk register that identified key risks in the process and evaluated them in terms of likelihood, impact and level of risk. The risk register also outlined mitigating actions and was regularly updated with commentary on the status of the risks identified.

Other potentially hazardous areas included the oversight and monitoring of externally provided services commissioned by the council and a budget of £90 million for adult care. In addition, there will be a key role in managing and developing the social care market in Highland to ensure good quality provision and to maximise choices for local people. NHS Highland's financial contribution to the cost of adult care is £23 million (excluding in-patient care). As these and other difficult issues require resolution the leadership and resolve of council elected members and health board members will be tested.

Senior officers in both the council and NHS Highland acknowledged that there were still significant challenges regarding governance, but they remained committed to the model and were optimistic about the prospects of success. They were very clear that this process was not a 'pilot' and did not want it to be referred to as such.

Council and NHS senior officers, elected members and health board members all acknowledged the ineffectiveness of previous partnership working, but were keen to emphasise the strength of the current partnership, which was much improved. They recognised the need to develop a strategy to meet the needs of a rapidly growing demographic change in the number of older people living in Highland. Demographic predictions estimated that there would be a 57% increase in the number of older people aged 85 or over by 2018. While there was a widespread understanding that only a minority of this section of the population will have acute health and care needs, they knew that services as they were currently configured were not fit for purpose, particularly in terms of the balance of care.

From their perspective, the council Chief Executive and the Director of Social Work had already recognised the need to better integrate health and social care in Highland, prior to the joint decision to propose moving to the single agency model. They acknowledged that previous attempts to reorganise had not been successful. The significant improvements in joint working between health and the council, and better outcomes for adult service users that had been envisaged, had not been achieved.

The social work service established the Transformational Change Programme for Community Care in early 2010, with a planned implementation over two years. The Community Care Partnership agreed 15 separate workstreams and has been making good progress with these. These were consistent with the approach articulated in the Joint Community Care Plan. The programme sought a clear pathway for people through services, with a single point of access and clarity about the roles of different agencies and professionals. This led to a number of the workstreams becoming policy, including:

- revised and devolved resource allocation processes;
- self directed support;
- modernising care at home service;
- adult support and protection;
- transitions;
- modernisation of care homes; and
- reablement.

The achievements of this initiative predated the single agency plans.

The council and NHS Highland increasingly took the view that the debate between their respective agencies had become sterile, and stalled around issues of resource transfer. There was also recognition that the pace of change in adult services was too slow. They decided to look at more radical solutions and then committed themselves to developing proposals for the current single agency model.

Senior council officers also acknowledged that they have to find savings in the current financial climate, in common with colleagues across the country. A budget for 2012/2013 had been set. Approximately £4 million in savings had to be found in an overall budget of £600 million. Although the council had invested £1 million per year in home care since 2007 they recognised that this could not continue and that new ways of working, and making savings, had to be considered. Their single agency plans, including the consolidation of health and social work budgets, were one way of doing this.

This initiative had been financially supported by the Scottish Government and in January 2011 ministers allocated £450,000 to support the developments and changes. Money from the Change Fund[8] (£3.4 million) will also be directed to the proposed new arrangements. As formal agreement was reached on 23 June 2011, the positions of existing staff currently leading on transformation will now be formalised and a transformation team put in place. The aspiration is that with the government's financial support the process will be cost neutral.

[8] Reshaping Care for Older People: Change Fund – COSLA/The Scottish Government/NHS Scotland, 2011 - 2021

There were a range of substantial strategic objectives for the planned integration of health and social care that remained at a very early, conceptual stage at this point. Until more work has been done to begin delivering on these objectives it will not be possible to evaluate their impact, particularly in terms of improved outcomes for people who use services and their carers, improved joint working between health and social care services, and more effective and efficient use of financial and other resources.

There was a strong commitment to achieving these aspirations at all levels in the council and in NHS Highland. Although significant efforts were being directed towards widespread consultation, other stakeholders, including people who use services and their carers, were yet to be convinced. The consultation process was at an early stage and there were many people, including some council staff, who did not have enough information about the plans. They need a better understanding of these plans and their potential impact on access to and availability of services, and any potential impact on jobs.

Recommendation 1 –The council should continue to work with NHS Highland to ensure that information about the process of integration and progress with implementation is available to hard-to-reach groups who may have difficulty in attending public events or in accessing other forms of communication.

Outcomes for people using services and carers

Reason for scrutiny

The council had amongst the lowest spend on older people's services per head of population (30th out of 32 councils). It provided amongst the lowest numbers of people aged 65+ with care at home, and was showing a poor performance for the provision of numbers receiving 10+ hours. Lower than average numbers of people were receiving weekend, evenings and overnight care. There were just above average numbers of people in care homes, and rates of emergency hospital admissions were around average. There were, however, increasing numbers of people whose discharge from hospital was being delayed.

There had been a significant older people's population growth over the last two years. The Council had also been reviewing and addressing the impact of the initial failed reorganisation of care at home services in 2008/2009.

Modernisation of care at home services was underway and additional investment had been made, and had achieved some local improvement. However, there was still much to be done and the overall position of older people's services relative to the rest of Scotland, and outcomes achieved, was an area of significant concern.

A review of day and community services for older people and for people with learning disabilities was also underway as part of a wider transformational change programme in community care services. This was linked to service improvement, but was also clearly linked to achieving identified efficiency savings, including required savings in the current financial year of £1.4m in day services for older people.

There were proposals to rationalise day and community support services for older people in Inverness. The plan was to offer a tiered model of service provision with intensive support to people who live at home, who are at the higher end of need. There will be a range of provision below that with 'modest' funding going to the voluntary sector and community based groups. This would support a framework of response to need with formal reablement services for those with the most complex needs, to developing community capacity to respond to less pressing need. The proposal stated there will be savings that will make funds available to provide grant support to building community capacity. Progress had also been made with initiatives aimed at realigning the balance of care in Fort William, Raasay and Assynt.

Scrutiny findings

Improved partnership working had seen the development of a range of approaches being taken forward to improve outcomes.

Senior managers in NHS Highland acknowledged that currently outcomes for older people could be better in Highland. They wanted to see more responsive, integrated, holistic services that were more community based. They were well aware of the cycle of unnecessary admission to hospital followed by delayed discharge for want of adequate community based services. They were keen to impact on this, as had been done elsewhere in Scotland. They emphasised the need for a stronger and more available home care service which would include health and social care workers. A more flexible workforce was required that could function in a variety of settings.

In the two years prior to the decision to proceed with plans for integration, the Council had already begun to establish components that are central to an integrated community care service, for example, devolved decision making and the reorganisation of home care. Given that these important changes had already been made, it may be difficult to determine that improved outcomes (if they can be measured) are a consequence of the move to the more recently agreed single agency model.

Managers of community care services acknowledged that while they will be able to measure what they deliver under the new arrangements, they may not be able to measure the impact of assessments that filter people out. They acknowledged that they would not know what the outcomes will be in cases that are assessed as not meeting criteria for the more intensive services that they will manage.

They also welcomed the delegation of decision making and budget management into their districts. This brought decision-making much closer to front line staff. This practice will continue under the new arrangements but may need to be reviewed to encompass NHS governance requirements.

Home care managers explained that the main changes resulting from the review of their services were new rates and rotas for service users and carers. They believed these ensured a consistent approach across the whole of home care. Rotas were in place in some areas, but in others they were still recruiting, although the response to the advert had been good. They were hoping to progress on this fairly soon. In those areas where access to home care was not good there was unmet need of approximately 570 hours. This was either due to the need to increase hours or because new services were required. However, they were confident that most of this unmet need will be eradicated when appointments have been made and the new rotas are in operation.

There had been changes in levels of responsibility for staff, particularly at manager level. They acknowledged that the period of change had been very difficult and challenging, but they were also confident it was worthwhile as they were now heading in a better direction. They were still in transition and had done some scoping and recognised the imbalance in resource allocation. They were now addressing this, but different areas were at different stages as a result.

The rota provided more consistency of care and service users now knew who was attending on what days. Adjustments were based on service user and staff feedback and they managed to accommodate this, for example in relation to start times and contacts.

We met with people using services for older people who clearly enjoyed what was on offer at the centre they attended. They said these were “first class” and “fantastic”. They praised the quality of support and assistance they got from staff. Attending the centre meant they kept safe, active mentally and physically (as far as possible) and felt connected to their communities. They said attending the centre had improved their lives.

Their carers echoed these comments, describing the day centre as a ‘lifeline’. They all wanted more days. They would like to see the respite aspect of the service further developed and also greater availability of respite at home to allow them to spend time away. There was little knowledge of self directed support amongst this group and they were keen to know more.

There had also been a recent drive towards more personalised arrangements for people with learning disabilties. The social work service had developed a strategy to re-design services to meet the needs of:

- people placed out of area or who may be at risk of this following transition;
- people living in isolated tenancies with intensive care packages; and
- people living with families where this arrangement was no longer sustainable.

The strategy was clear that it would be possible to establish high quality personalised care in the Highlands at significantly lower costs than existing out of area placements and some of the most expensive home care packages. The enthusiasm and commitment of senior managers and staff was clear. The revised approach included some shared tenancies and tenancies in clusters, use of community resources, and removal of 2:1 care packages and other staff economies. These were regarded positively and with a sense of achievement by staff.

We met people who used learning disability services. Most were unaware of the forthcoming planned changes to some services. A few had experienced a reduction in service with their support focusing more on housing support activity rather than social support. They were positive about the range and level of support that they received within their homes . Most were also involved in activity in the community including using council run day services. They were unaware that these services were likely to change in the near future with the reduction in the number of available places.

Some were supported by a settled staff group but others had experienced changes. They wanted consistency in the staff who provided their support. Most had been supported well by their social worker.

We met with participants in the Self Directed Support (SDS) pilot project. This was developed in partnership with Scottish Government, with Highland as one of three national test sites, to build experience in the use and development of Self Directed Support. The project aimed to provide more flexibility and less bureaucratic access to opportunities for young people in transition, and their families, to manage their own care arrangements. As at January 2011 the number of people receiving Direct Payments had grown by 17% from 165 to 200, and 23 people were receiving SDS packages.

All were generally very positive about SDS and acknowledged big improvements in outcomes and quality of life for themselves or the people they cared for. The emphasis on choice and control was cited as a key difference to services previously received. Service users and their parents talked about lives being transformed, they now had 'full' lives and were enjoying purposeful, meaningful activities.

Several of the parents we met were very critical of earlier experiences of transitions from childrens to adult services. Some had nothing in place even after their child had left school. One service user who did not have a learning disability was put into a learning disability service. She described herself as 'bored and scared' at that time. The consensus view was that children's services in Highland were 'good' but the sudden loss of good respite support on reaching age 18 was not uncommon. They saw as perverse the allocation of resources to support the development of an individual's independence and autonomy, only to undermine them by removing access to the services that support this. They also identified a need to make access less restrictive in terms of carers' circumstances, and said that respite was only available if the carer was in employment.

They believed that SDS could be better promoted by social work staff. They believed that social work staff were reluctant to promote personalised approaches because of the potential impact on care budgets. However, the users and carers saw SDS as more cost effective, as they took responsibility for the administration and organisation of care, including the financial aspects. The council was building on its use of community connectors to increase opportunities for self directed support. Their workplan had built in a support structure for staff to develop their approach to SDS.

Recommendation 2 – The social work service should ensure its guidance to staff emphasises the positive promotion of more personalised approaches and self directed support.

Representatives of independent advocacy providers told us that there were a number of key issues about which they consistently heard from service users. People using learning disability services were concerned about the introduction of fees for attendance at day centres and the withdrawal of support for transport costs (a significant issue in Highland). They were unhappy about lack of consultation on these changes.

Similar concerns were expressed by people with mental health difficulties. Some people using mental health services suggested that it would be better to be made subject to a Compulsory Treatment Order because they could then not be charged for services. The independent advocacy providers were worried that charging might deter people from asking for help.

Some concern was also expressed about numbers of MHOs and their ability to meet the demand for their service. We met with mental health service users on Skye. Some had been told by staff that there were likely to be cut backs in service provision, whilst others had experienced this already. Many group members had not felt able to challenge decisions to reduce service levels and were concerned about the possible negative effect on their physical and mental health.

They really valued the day centre they attended, which was open 365 days a year and was a safe refuge for many of them. They were very concerned about the future of the centre's funding, as the budget had been cut by 2.5% this year (2001/2012) and a further cut was planned for next year. This budget reduction had been applied to the majority of commissioned services in Highland. They understood that savings had to be made. There had been discussion between staff and service users about how to do this. One option being considered was to use the money that had previously been collected for service users' outings.

Most members complained about the waiting times to get a service. Their specific concerns about council cuts added to wider anxieties about perceived threats to their financial circumstances. Although not a council issue, many were also obviously very concerned and increasingly anxious about their benefits being reviewed and the prospect of having to attend a DWP tribunal.

Quality assessment and care management

Reason for scrutiny

The overall quality of assessment and care management was evaluated as 'good' or better in most of the case files we read, across children's, adults and criminal justice social work services. Most case files had an assessment on file and most of these were rated as 'good' or 'very good'. Very few fell below an acceptable standard. There had been an improvement in performance on care and/or supervision plans in most case files from when we last audited files in 2007. There was evidence that plans were subject to regular review and that there was no unreasonable delay in receipt of services in almost all cases. There was evidence that service users' views were sought and taken into account in most case files.

However, there were issues about the availability of assessments by the Mental Health Officer (MHO) service which was impacting on the rights of people who could potentially be subject to compulsion under mental health and related legislation.

The council recognised risks in its' capacity to deliver statutory duties and responsibilities in relation to the MHO service. The Director had reported a number of significant issues to committee. There was an uneven distribution of MHOs across the region with shortages in key areas and a lack of out-of-hours cover across most of the region. There was a steadily increasing statutory workload. The number of Guardianship orders in Highland was considerably higher than the national average with obvious implications in terms of MHO service capacity. The Social Work Service Plan 2010/2011 identified the risk of not being able to meet statutory duties under mental health legislation as a key risk to the social work service. The council had strengthened the service by increasing the number of full time MHOs by three posts and ensuring the existing number of non-dedicated staff was maintained and that capacity was evenly distributed across the Highland area.

Scrutiny findings

Most mental health service users had experience of contact with the MHO service. They were aware that MHOs had stopped doing out of hours calls because of issues about their terms and conditions. One island-based service user told us about an experience of consent to her emergency detention being sought by a local GP over the phone to Inverness. It is difficult to see how this could have been a person-centred assessment and how any possible local alternatives to compulsion could have been considered.

The MHOs we met were concerned that the demands of their statutory roles in relation to the Mental Health (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 were impacting on their other roles as care managers and social workers. Because of these pressures the MHO contribution to non-statutory mental health social work was limited. This is an issue across the country. We were also aware of some commendable support and development work delivered by MHOs in rural areas.

There was no out of hours MHO cover across Highland although there was a rota for Inverness and the Inner Moray Firth. For other areas, the current arrangement for social work out of hours was from a single hub and may have included MHOs, if they were on the rota in their role as social workers, but this was not guaranteed. There were plans to move to a fully staffed service, however.

The arrangements for the management and deployment of MHOs, and the allocation of their work, were confusing. The relationships between their roles in community mental health teams, the management of guardianship work, staffing the out of hours rota and their role with Care First and other information recording was not clear. Although each individual in the group understood their specific role and function they had little knowledge of what their peers were doing and seemed uncertain about where authority lay. They were unclear about lines of communication and used our focus group, in part, to catch up with each other about what was going on. MHO Forum meetings were now rare and arrangements for mentoring were patchy.

The MHOs we met expressed concerns about their lack of seniority and additional pay for their MHO training and work. It appeared that some staff had opted out of MHO work.

They were also unclear about the nature and implications of the single agency for adult services and did not seem to have understood the potential implications in terms of the governance of their service and the independence of their assessments.

Service managers told us that although they thought they had enough MHOs overall, there were difficulties in optimally deploying them. Some were based in criminal justice and community care practice teams and their capacity was restricted by the demands of their substantive posts. There were four members of staff who had been approved for MHO training but, even if they all successfully complete, they will not be available for deployment for another year. The service is currently using a number of recent retirees to enhance MHO capacity.

The Director explained that wider community mental health services will be delivered through a single NHS manager under the single agency model, but there will be a senior social work practitioner attached to the team.

Recommendation 3 – The council must ensure that it meets its statutory duties and responsibilities, as laid down in the National Standards for MHO Services[9], in relation to the roles and management of MHOs under the single agency arrangements.

Self Evaluation and Improvement Planning/Delivery

Reason for scrutiny

Although we were provided with substantial evidence of an extensive performance management approach by the council and its key partners, there was less evidence of qualitative self evaluation activity in relation to social work services.

The analysis of SWIA's case file reading data indicated that for high risk offenders 30% of files had evidence of first line manager scrutiny. No files had evidence of senior manager scrutiny. For adults and children 10% had evidence of first line manager scrutiny and 4% of senior manager scrutiny. Case file audit is a key component of self evaluation activity.

The Chief Executive's Quarterly Review process focused on the Social Work Service Plan objectives. Service plan objectives were derived from recommendations made in SWIA's performance inspection report (May 2007) and on evaluations made by HMIE in their successive CP reports. This activity indicated the need to:

- increase numbers of older people who could be supported in their own homes;
- achieve up-to-date SLAs and contract monitoring arrangements for voluntary organisations;
- meet statutory duties under mental health legislation, including MHO cover across the region; and
- increase levels of self-directed support across Highland.

[9] National Standards for Mental Health Officer Services, Scottish Executive, Edinburgh 2005

Scrutiny findings

Heads of service and service managers said that for children and families they were improving how they gathered and analysed performance information. They acknowledged that until recently reporting had been ad-hoc and had usually been reactive to requests for information. Proposed changes to the base information gathered and reported had been agreed with elected members. They said the approach had changed and would become more outcome focused for the next iteration of the plan for integrated children's services, For Highland's Children 4.

For community care they acknowledged that they were mostly reporting outputs but were working on processes to measure and report on outcomes. They were also intending to design some self-evaluation activity linked to the impact of reablement but had yet to clarify outcome measures.

Criminal justice social work services were also planning to develop an outcome based model and were piloting service user questionnaires in community service to try to evaluate the impact of the service on people gaining employment.

Case file audits were not routinely carried out and evaluated, although team leaders were expected to have an oversight of case records to ensure their quality. CareFirst had been enhanced to allow better recording of this activity. However, findings were not aggregated, collectively recorded or reported. There were periodic reviews across given themes, for example of health needs recorded in child's plans. Children's services had recently agreed a more systematic approach to recording and review of audits.

Recommendation 4 – The council should develop more systematic and productive arrangements for case file audits.

Registered services carried out some self-evaluation of their services in reporting to the regulatory arm of the Care Inspectorate, but this did not as yet fit into a wider focus on continuous improvement.

There was a gap in terms of awareness of the need for basic data about people currently using learning disability services and moving on from them. For example, there seemed to be no readily available data on the numbers and characteristics of those who had left day centres and what their current alternative service was, if any. The collection of The Same As You (or similar) data did not seem to take place on a regular basis.

In learning disability services planned arrangements for evaluation of performance and outcomes were promising. Providers were considering more rigorous methods of recording outcomes and evidence for change, acknowledging that previously neither they nor the local authority had addressed this. There had also been a lack of scrutiny and monitoring of the components and outcomes of many of the high cost packages of care, especially those out of area. Managers said that services that were funded, for example specialist interventions from health care services, were not always in place.

The need to make savings had also prompted some re-evaluation of good/best practice, for example questioning whether 2:1 support and individual sleepovers were actually required. While plans to measure and evaluate improvement seemed well embedded in the new care arrangements, there was no evidence of this for the service overall.

There was a corporate framework for the use of PSIF which was at an early stage. A staged roll-out was planned with adult support and protection scheduled for August 2011, support services in the autumn and children's services and criminal justice social work services for November 2011. Staff had been trained as assessors. The process of evaluation will be led by someone external to the service, for example the review of looked after and accommodated children will be led by a colleague from NHS Highland.

There had also been various attempts to gauge people's experience of services or transitions, usually by questionnaire, simple interview or individual reviews. We did not see any systematic analyses of these. Senior managers should be cautious about reliance on such information as a bulwark of evaluation without systematic data gathering, and only if reviews take place regularly, are thorough and are properly recorded.

We were assured that a comprehensive evaluation was planned. However, it was not clear how the original objectives of the transformation programme (planned prior to the current single agency arrangements) were progressing, and with what outcomes. Without baseline data on current performance it will not be possible to judge what difference the proposed single agency model will make to service access, delivery and outcomes. The service based outcomes of some key parts of the transformation programme will not be known, even in quite basic terms. For example, the numbers and characteristics of those who lost services, whether they were replaced and, if they were, with what. Similarly, the consequences for the vacated resource will also be unknown, i.e. whether it was used for someone else with higher needs or as part of a service closure or reduction plan.

Recommendation 5 – The new single agency arrangements entail the delegation of service provision across a range of providers, as well as the council and NHS Highland. The council should:

- work with NHS Highland to ensure that robust outcome measures are developed for community based, non-NHS services, including those that are part of the capacity building initiative; and

- identify and measure outcomes on the impact of its' Transformational Change Programme (pre-single agency)

Partnership Working

Reason for scrutiny

Our Performance Inspection and follow-up reports were critical of the state of partnership working between the council and NHS Highland. The strategic oversight, planning and development of community care services had been the responsibility of The Highland Council/NHS Joint Leadership and Performance Board. There was recognition (supported by inspection findings) that a significant system and business change was required in the organisation and delivery of community care services, in order to address partnership performance issues.

Adult care was being modernised through the Transformational Change Programme and joint leadership and governance arrangements had been in place for some time. However, in 2010, a joint report by the Council and NHS Chief Executives acknowledged that although partners believe co-ordinated management was improving, engagement processes such as community care planning and direct feedback from service users and carers had indicated that "…improvements have not delivered the quality and effectiveness of services that people want."

There was a longstanding and well established partnership responsible for the planning, delivery and strategic oversight of integrated children's services. Highland was a 'pathfinder' council for GIRFEC and as the integrated working model had evolved effective partnerships had been established in children's services. The report by HMIE on its' joint inspection of services to protect children and young people reflected effective partnership working across all agencies, including the council.

It was also evident the partnership between Highland and the other local authorities and partners in the Northern Community Justice Authority (NCJA) was working well.

Scrutiny findings

There had been a significant improvement in the quality and effectiveness of the partnership between the council and NHS Highland during the period that had elapsed since our previous external scrutiny activity in the area in 2008. It was evident that a strong partnership had been established to improve joint health and social care services in Highland. Elected members, health board members and senior officials from both agencies spoke about partnership working in very positive terms.

Front line community care staff were very positive about their relationships with housing services, particularly in the development of core and cluster housing. They also valued relationships with community mental heath services and with GP practices. They thought that the revised joint community care plan was a more dynamic document that recognised the need to work more directly with communities. They believed that there was a greater commitment from partner agencies.

Community development workers had been employed by social work and health to support communities and to enable them to build capacity. They were hoping to build on existing community and voluntary sector provision as well as to create partnerships with local private leisure services. They were also looking at developing social enterprises and gave examples of developed community based support services in Assynt, Kinlochbervie and at the Kyle centre. These communities had created alternatives following withdrawals of services or reductions in funding by the council.

Their work had the potential to deliver community based support that met the identified needs of local communities by mobilising volunteer activity across the generations. They were working with communities to attract resources to deliver services using some existing council funding and by seeking new money.

Other initiatives included broadly preventative options such as the development of walking groups and other interest groups to keep the active older members of the community stimulated, and mentally and physically fit. It was too early to say if the initiatives had longer term sustainability, although initial support had been enthusiastic.

The North Kessock Project had achieved an excellent partnership between social work, health services, housing and independent providers. The provision of various forms of council housing was particularly significant given the longstanding pressures on this sector.

The reshaping of day care services had been carried out in partnership with carers and people who use services. Managers were generally positive about the future shape of service delivery offered by the lead agency model. They thought it was building on what was already working well and offered opportunities through streamlined decision making. However, they recognised that a number of questions remained unanswered, including issues about charging for services and balancing preventative and statutory work.

Officials and members across both the council and NHS Highland all conceded that their previous partnership working had not been effective. Senior council officers recognised this and had begun to address the issue of improving integration, before the joint decision to propose moving to the single agency model.

Representatives from the Joint Leadership and Performance Board were in agreement that the single agency changes they were planning were necessary and would be positive in the long term. There had been considerable reorganisation of services within the council over the last ten years and although there had been a working partnership with health services, the group agreed they were not delivering consistently good outcomes. The structural divide was getting in the way and a more radical approach to service delivery was required. The development of the Joint Integrated Community Care Plan had been a key step in moving forward the group’s thinking on what needed to be done.

The plan was not solely about improving home care to meet the needs of an ageing population. They expected to see a number of positive outcomes from the single agency model including quicker access to services, more co-ordinated support, and thereafter greater independence amongst many service users.

Senior NHS managers acknowledged the risks of making easy assumptions that the single agency model will remove all barriers to effective partnership, and will encourage collaboration and diminish professional rivalries. Although they saw genuine commitment and enthusiasm from key partners they recognised that human resource issues such as potential job losses, changed terms and conditions and professional management and accountability issues may continue to create barriers to partnership, at least in the short term.

There was commitment across both agencies to take forward the integration agenda and a shared conviction that this was the best solution for Highland.

People using services and their carers were less concerned about who delivered their services or how they were operationally managed. Their concerns remained focused on issues of access, quality, consistency, flexibility, involvement and good outcomes. As implementation proceeds, the requirement to evidence measurably better outcomes for people using services and their carers will be a key task for the Joint Leadership and Performance Board.

It was too early to say what the impact of the proposed changes will be. As well as the human resource issues already referred to, there were a range of legal, cultural and professional barriers that had to be overcome. Commitment to effective partnership had been reinvigorated on all sides but there were numerous major challenges ahead which will be a huge test of the leadership and resolve of strategic partners.

6. Next steps

We ask the council to take note of the contents of this report and to provide an action plan to address the recommendations made. Further information about this will be provided by the link senior inspector who will maintain regular contact with the council to monitor the impact of new arrangements and new developments and to monitor progress in implementing the action plan. The link senior inspector will also continue to offer support for self-evaluation activity.

Information from the scrutiny report will feed into the annual review of the local authority's assurance and improvement plan as part of the shared risk assessment process.

30 September 2011

Appendix 1

Number and type of scrutiny sessions

Scrutiny Activity	Number of sessions undertaken
Focus groups with people who use services *	4
Focus groups with carers *	3
Meetings with front line staff, first line managers & middle managers	10
Meetings with senior social work managers	3
Meetings with partner agencies	5
Meetings with external providers	1
Meetings with independent advocacy providers	2
Meeting with Elected Members, Health Board Members and Joint Leadership and Performance Board	3
Observations of meetings and events	2

* We have double counted some meetings where both people who use services and carers were present.