care inspectorate

Healthcare Improvement Scotland

Services for older people in Falkirk

July 2015

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

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The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

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

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Contents

Summary of our joint inspection findings

Between September and October 2014 the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services1[1] for older people in the Falkirk Partnership. The purpose of the joint inspection was to find out how well the health and social work services partnership delivered good personal outcomes for older people and their unpaid carers. We wanted to find out if health and social work services worked together effectively to deliver high quality services to older people, which enabled them to be independent, safe, as healthy as possible and have a good sense of wellbeing. We also wanted to find out if health and social work services were well prepared for the coming legislative changes designed to get health and social care services to work closer together.

Our joint inspection involved meeting over approximately 90 older people and carers who cared for older people, and around 240 staff from health and social work services, reading some older people's health records and social work services records. We studied a lot of written information about the health and social work services partnership and services for older people and their carers in the Falkirk Partnership.

In Falkirk, social work services and most community health services were delivered by Falkirk Council and NHS Forth Valley.

Outcomes for people who use services and their carers

Our joint inspection found that the Partnership provided a range of high quality services to older people and unpaid carers who cared for older people. Health and social work services staff worked well together to deliver these services, which in many instances transformed older people's lives, enabled them to remain in their own homes, kept them safe and as well as possible and maintained their wellbeing. Good examples of early support and intervention services delivering positive outcomes was the Reablement-at-home and Mobile Emergency Care Services.

The Partnership performed in line with Scottish averages in terms of delayed discharges, emergency admissions and multiple emergency admissions. It's performance on ensuring the timely discharge of older people from hospital who were medically fit for discharge varied in the months leading up to inspection with Scottish Government targets not being met consistently.

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

What did people and their carers think?

The Falkirk Partnership was supporting the involvement of service users in the assessment for, and delivery of their own care as well as shaping future services. Their was a clear focus on ensuring that older people were supported to remain as independent as possible, where appropriate and have the care they needed to do this provided by the right people at the right time.

There were some good examples of services providing support to carers. Older people were, on the whole, satisfied with the services they received and the positive outcomes they achieved. The joint integrated carer strategy was central to the progress being made in relation to the above. However, more needed to be done to make sure carers needs were accurately assessed and recorded in the case files.

Impact on staff

We undertook a staff survey to get the views of staff working across health and social work services in the Falkirk Partnership. Staff were generally well motivated and enjoyed their work. There were positive working relationships among practitioners. Staff also thought they worked well together to support older people to live in the community. They had access to training, but most of this was delivered separately by health and social work to their own staff.

Staff said they were working well together across the Partnership on an individual basis and were confident this would be strengthened by health and social care integration. However, staff did not think there was sufficient capacity to do preventative work.

Generally, staff did not feel changes were managed well or that communication was as effective as it could be. Senior managers were planning engagement events with staff and other stakeholders about health and social care integration

Involving the local community

We found that the Falkirk Partnership was committed to engaging with and involving local communities to develop community capacity, a way of supporting communities to enhance their involvement in decisions that affect them. It wanted to work productively with older people and the third sector about this. The Partnership had a number of local community projects to encourage independence and reduce health and social care involvement where appropriate.

The Partnership had been successful in engaging people in local volunteering, in being public partners and in looking at the needs of their own communities. The Stakeholder Engagement Project was an example where the Partnership had made efforts to ensure people understood about local services.

Getting a service and keeping safe

The Falkirk Partnership staff, older people and carers said that they often had difficulties accessing services and that there were some difficulties responding to referrals passed on to duty workers in the community care teams by the Contact Centre which provided a single point of access in to social work services..

The Partnership established a number of services which had an early intervention and preventative focus such as the homecare crisis team, the Frailty Clinic and the anticipatory care plan team.

Staff demonstrated a good understanding of the need to focus on older people's wishes and aspirations and not just on their needs. However, many of the approaches to assessment and care planning were being carried out on a single agency basis. The quality of assessments and care plans produced by the Partnership was variable. It was not always evident from the health and social work services records we read how agencies had worked together and jointly contributed to assessments. There was also a need for the Partnership to improve the frequency of which the care plans for older people were reviewed.

More positively, the needs of older people requiring palliative care were given good attention.

Our findings from the health and social work services records for risk assessment and risk management indicated the need for significant improvement in these areas, including in the production of chronologies that were fit for purpose.

Older people and their families we met said that they felt staff made good efforts to involve them in decisions about their care, treatment and support. The self-directed support (SDS) team and SDS Forth Valley were working hard to increase the awareness and use of self-directed support, but faced challenges in terms of their capacity to handle the volume of work.

Plans and policies

The Falkirk Partnership had a good set of joint plans, policies and procedures for older people's services. Older people themselves and carers who cared for older people had been widely involved in the preparation of plans, policies and procedures for the services that they, the older people and their carers, depended upon.

We found that plans, such as the Joint Strategic Commissioning Plan[2], had been implemented by the Partnership to improve services for older people and to improve outcomes for older people. An example of this was the development of the reablement-at-home service which helped older people who had had some form of crisis, such as a fall and a hospital admission, to regain their confidence, independence and ability to manage comfortably and safely at home.

2 Falkirk Partnership Joint Strategic Commissioning Plan for Older People

Management and support of staff

The Falkirk Partnership were beginning to develop joint work force initiatives in response to health and social care integration to make sure that services could be provided to older people more efficiently by skilled and trained staff. Recruitment and retention was broadly positive and only difficult in some parts of the work force. The Partnership was working to reduce staff sickness absence in older people's services.

Most staff believed that there was good joint working at a local level and there was some evidence of jointly developed posts emerging at the time of our inspection.

Staff development and training was largely specific to each of the partners, but staff said that they had access to training that was appropriate to their post. There were some initiatives in place to promote leadership and tackle the ageing work force issues which was positive. Staff also said they also said they felt well supported by front line managers.

Working together

Staff from health and social work services in the Falkirk Partnership had a history of good working relationships and effective joint working. The creation of the Community Health Partnership had helped to strengthen the existing good relationships and good joint working. The Partnership was getting prepared for the coming legislative changes designed to get health and social care to work closer together. One area for improvement was that information about health and social care integration to all staff needed to improve.

The Partnership had some shared financial arrangements for a number of years and this was strengthened with the delivery of their joint strategic commissioning plan for older people which had a jointly agreed financial budget attached. However, there were a number of challenges and pressures ahead for the partnership in terms of improving integrated services such as implementing sustainable whole system change management and remaining within budgets.

There was no joint information strategy in place but we were assured that the Partnership was getting help from the Scottish Government to improve this position through grant funding for a series of projects. Staff reported that systems were cumbersome and time consuming and did not address the gap in how information was shared across the Partnership.

There was good evidence of partnership working across the third and independent sectors. We saw evidence of this in work to develop the joint strategic commissioning plan, the Bo'ness project and other locality planning and commissioning initiatives. Housing had played a key strategic role which had a positive contribution to partnership working.

There was involvement of older people in directing their own support, although there was some scope for improvement in relation to involving independent advocacy services.

Leadership

The Falkirk Partnership had made significant efforts to develop good working relationships between agencies. This was fostered over many years. The Partnership operated services based on national policies, such as Reshaping Care for Older People, which were beginning to be delivered in localities through jointly developed and agreed strategies. The Partnership needed to do more to make sure frontline practitioners were kept up to date with service developments.

The Partnership had made the expected progress since agreeing their model of health and social care integration. Senior managers, elected members and NHS Forth Valley Board members were aware of the need for change and shared the vision about the future direction of travel. While there was still significant amounts of work needed before the Partnership was fully integrated, there was a base from which to build through the shadow joint board.

The future success of the Falkirk Partnership will be dependent on the development of a robust Joint Strategic Plan, based on a full needs assessment, consultation and collaboration. Key services need to be planned, commissioned, developed and supported to ensure that all parts of the Partnership are joined up appropriately in a 'whole systems' way of working.

Capacity for improvement

Overall the Falkirk Partnership had capacity for improvement. We saw evidence of positive outcomes for some older people and their carers in Falkirk. The Partnership was at an early stage towards integrating health and social work services. The Partnership needed to better monitor how well this was progressing and scale up improvements. The pace of change needed to accelerate.

We mainly saw constructive working relationships among the leaders we met and they understood the direction of travel and vision required to achieve successful integration. Planned changes to key leadership positions were still occurring at the time of the inspection. The preparations for integration were underway, but evidence that the changes were impacting on outcomes for older people was not yet available.

Evaluations and recommendations

We assessed the Falkirk Partnership against the 10 quality indicators. Based on the findings of this joint inspection, we assigned the Partnership the following grades.

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

Evaluation criteria

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

Recommendations for improvement

1 The Falkirk Partnership should put measures in place to meet the Scottish Government delayed discharge targets and to make sure older people in Falkirk are discharged home or to a homely setting when they are medically fit to do so.

2 The Falkirk Partnership should ensure all staff are aware of new initiatives and enable staff to communicate and share information more effectively.

3 The social work service should improve its arrangements for how the public and other agencies access the service through the Contact Centre to the community care team duty system. It should also review the capacity of the locality teams to make sure it can efficiently respond to all the initial enquiries.

4 The Falkirk Partnership should improve on the number of carers' assessments being undertaken and make sure that these, along with support plans, are recorded in the relevant case files.

5 The Falkirk Partnership should take action to make sure their assessment, care planning and review processes are improved to ensure a better shared approach and understanding of older person's needs and wishes.

6 The Falkirk Partnership should ensure that all relevant case records contain chronologies that are fit for purpose and documented as well as jointly developed risk assessments and risk management plans so that the older person's needs are clearly defined and protected. .

7 The Joint Management Group, as the strategic planning group, should use the available data to review and report on progress against the outcomes in the Joint Strategic Commissioning Plan. This is important in order to make sure that 'whole system' change and improvement is evidenced, planned and delivered in a sustainable way.

8 The Falkirk Partnership should incorporate the Joint Strategic Commissioning Plan for older people in to the Joint Strategic Plan for health and social care integration. The plan should be compliant with the Scottish Government's strategic commissioning plan's guidance[3] and be accompanied by a robust delivery plan that is subject to routine scrutiny by the Joint Management Group.

9 The Falkirk Partnership should implement the communication and engagement plan set out in the Integration Scheme as a matter of priority to ensure the work force fully understand the vision and pathways of change.

3 Health and Social Care Integration, Public Bodies (Joint Working))(Scotland) Act 2014 Strategic Commissioning Plans Guidance

Background

Scottish Ministers have requested the Care Inspectorate and Healthcare Improvement Scotland to carry out joint inspections of health and social work services for older people.

The Scottish Government expects NHS boards and local authorities to integrate health and social care services from April 2015. This policy aims to ensure the provision of seamless, consistent, efficient and high-quality services, which deliver very good outcomes[4] for individuals and unpaid carers. Local partnerships have to produce a joint commissioning strategy. They are currently establishing transition arrangements, and each partnership is producing a joint integration plan, including arrangements for older people's services. We will scrutinise partnerships' preparedness for health and social care integration.

It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (see Appendix 1). Our findings on the Falkirk Partnership's performance against the 10 quality indicators are contained in 10 separate sections of this report. The sub-headings in these sections cover the main areas we scrutinise. We will use this methodology to determine how effectively health and social work services work in partnership to deliver very good outcomes for older people and their unpaid carers. The inspections will also look at the role of the independent sector and the third sector[5] to deliver positive outcomes for older people and their unpaid carers.

The inspection teams are made up of inspectors and associate inspectors[6] from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We will have 'lay' inspectors who are unpaid carers and also Healthcare Improvement Scotland's public partners[7] on each of our inspections.

The inspections are comprehensive and each one takes around 24 weeks to complete. We will inspect six partnerships each year.

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

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

6 Experienced professionals seconded to joint inspection teams.

7 Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to sensure that it engages with patients, carers and members of the public.

Our inspection process

Phase 1 - Planning and information gathering

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

Phase 2 -Scoping and scrutiny

The inspection team looks at a random sample of health and social work records for 100 people to assess how well the partnership delivers positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. A staff survey is also carried out.

Phase 3 - Reporting

The Care Inspectorate and Healthcare Improvement Scotland jointly publish a local inspection report. This includes evaluation gradings against the quality indicators, any examples of good practice and any recommendations for improvement.

To find out more go to **www.careinspectorate.com** or

www.healthcareimprovementscotland.org

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

The Falkirk context

Falkirk is located in the heart of Scotland midway between Edinburgh and Glasgow. It is the 11th most highly populated council area in Scotland. The Falkirk Partnership is between Falkirk Council and NHS Forth Valley and they had a co-terminus catchment area. However, there were two other local authorities, Stirling and Clackmannanshire, sharing NHS Forth Valley's boundaries. Therefore, NHS Forth Valley includes three separate Community Health Partnerships.

The population of Falkirk in 2014 was 157,640. Older People aged 75 years of age and over made up 7.8% of the population which was slightly lower than the Scottish average. By 2037, the population of Falkirk is projected to be 173,130, an increase of 10.4% compared to the population in 2012. Over the next 25 year period, the age group that is projected to increase the most in size in Falkirk is the 75+ age group. This is the same as Scotland as a whole.

In Falkirk the number of births has decreased by 7.6% between 2012/13. The number of births across Scotland only fell by 3.5% over the same period. The 2012 Scottish Index of Multiple Deprivation (SIMD) identified that 8% of the population of Falkirk were living in one of the 15% most deprived areas in Scotland. In 2009 this was 9%. Some areas of Falkirk were amongst the top 5% deprived areas in Scotland.

The joint inspection of services for older people in the Falkirk Partnership area took place between September and October 2014. It covered the health and social work services in the area that had a role in providing services to benefit older people and their carers.

We scrutinised health and social work services records of 99 older people. Older people in the sample had multiple records, all of which were scrutinised. However, in most cases the primary case record was held within the social work service file and as such there was a greater focus on reporting of these records. We analysed nationally published and local statistical data about the Falkirk Partnership's provision of health and social care services for older people. We analysed the Falkirk Partnership's policies, strategic and operational documents. We spoke with a sample of individuals and their carers, from the 99 people whose records we read. We also spoke with other older people who received health and social care services including carers. We spoke with health and social services staff who had leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We were very grateful to all the people who talked to us as part of this inspection.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Good

The Falkirk Partnership delivered positive outcomes for many older people and carers. Some older people experienced less positive outcomes, such as a delayed discharge from hospital. However, the Partnership was making every effort to address this by implementing a number of initiatives to ensure that older people who were medically fit were discharged from hospital more promptly.

One such collaborative initiative that had been developed was the 24/7 Team that provided out of hours, short term and crisis interventions. These care at home services provided early interventions and support to older people. We saw evidence that the health and social services involved in the 24/7 Team worked well together and delivered good outcomes for those receiving support.

The Partnership faced considerable challenges making sure care home placements were available to those older people in hospital ready to be discharged. A Delayed Discharge Steering Group had taken account of this and other related issues. There was a detailed plan outlining how they proposed to address the issues.

Senior managers in the Partnership were confident that the measures they were introducing would positively impact on admissions to hospital and delayed discharges. The most recent data we read showed that this was the case in relation to hospital admissions although meeting Scottish Government delayed discharge targets was still challenging.

The Partnership had consistently provided more home care services than the Scottish average but they had delivered less intensive home care services to older people. However, the introduction of the 24/7 Team was likely to positively impact on this in the future.

The Partnership delivered less respite for older people and their carers than the Scottish average. Some carers we met expressed how this made it difficult to continue in their caring role. This was an area the Partnership needed to address.

Over all the Partnership provided good quality regulated services for older people. But we found there was a need for improvement in two local authority care homes.

In this section we look at a range of local and national data to assess the Falkirk Partnership's performance in respect of key outcomes for older people. For example, over time, we would expect to find fewer older people have had an emergency admission to hospital. Where older people have been admitted to hospital, we would expect to find fewer had their discharge delayed.

We also look at how the partnership is providing services to support people at home or in a homely setting, and at how the Partnership is improving the health and wellbeing outcomes for older people and their carers.

1.1 Improvements in partnership performance in both healthcare and social care

Emergency admission to hospital

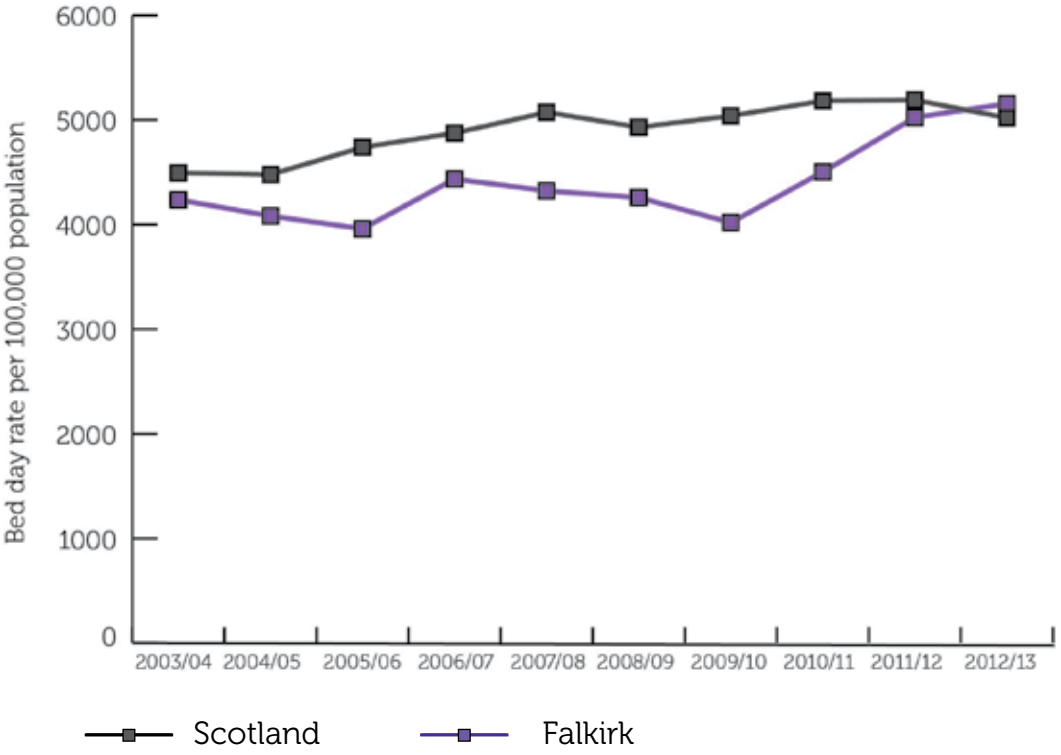
Between 2003/04 and 2010/11, the Falkirk Partnership had performed better than the Scottish average in terms of the number of emergency admissions, multiple emergency admissions, and emergency bed days occupied by patients aged 65 and over.

However, recent data showed that since 2010/11 emergency admissions for people aged 65 and over had rapidly increased. This was against a national downward trend. Nevertheless, the Partnership was still achieving the Scottish average. Similarly, there had been a recent rise in the number of people requiring two or more hospital admissions (chart 1). Occupied bed days for emergency admissions for people 65 and over was just below the Scottish average.

During the inspection we were unable to establish a specific reason for the rise in emergency and multiple emergency admissions. We did note that the timescales aligned to the 2010 opening of the Forth Valley Royal Hospital but there was no evidence to indicate a causal relationship between these two issues.

We discussed the rising trends in emergency and multiple emergency admissions to hospital with the Partnership. A range of services had been developed as alternatives to hospital admission such as the Reablement-at-home Service (ReACH), the Bo'ness Project, the Falls Prevention Programme (including joint working with the mobile emergency care service), and the Frailty Clinic established.

Chart 1: Rate per 100,00 population of patients aged 65+ with 2 or more emergency admissions to hospital. Falkirk Community Health Partnership, 2003/04 to 2012/13



Source: Information Services Division Scotland

Two key areas that can prevent unnecessary hospital admission for older people are anticipatory care planning and effective management of falls.

Anticipatory care planning

An anticipatory care plan anticipates significant changes in an older person's health and care needs and describes action, which could be taken, to manage the anticipated problem in the best way.

Key Information Summaries and anticipatory care plans across NHS Forth Valley had been completed by GPs and these were available in 40% of the health files we read during the inspection. SPARRA data (Scottish patients at risk of readmission and admission) was used to ensure priority was given to those most at risk.

Although there was evidence that progressive work around anticipatory care plans was being undertaken we found that they formed the primary plan in only 1% of the social work and health services files that we read. We concluded that the sharing and use of anticipatory care plans was limited between health and social work services.

Falls management

The Partnership had several projects which aimed to reduce the risk of falls and prevent unnecessary hospital admission. These projects were strategically overseen by the multi-agency Forth Valley Falls Strategy Group. Staff described a project involving the mobile emergency care service and the Scottish Ambulance Service which aimed to prevent people who had fallen but were uninjured being taken to hospital. While this service development was innovative, the performance outcomes in respect of preventing unnecessary hospital admissions could not yet be evidenced.

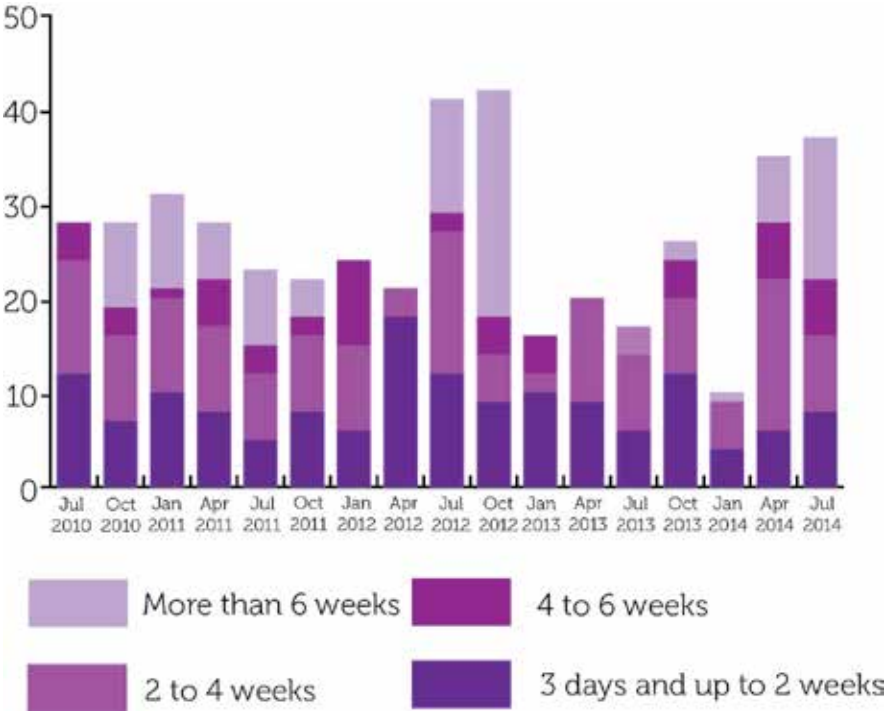
NHS Forth Valley ReACH service, the social work falls coordinator, and the mobile emergency care service team worked jointly to provide a comprehensive falls service. This service undertook falls assessments which considered all the factors, or causes, and recommended strategies to reduce future falls, as well as providing telecare and alarm systems. However, as with anticipatory care plans, staff we spoke to advised of partnership-wide challenges in being able to share such information limiting the effectiveness of the service.

Delayed discharges from hospital

Delayed discharge happens when a patient is medically fit for discharge from hospital, but is unable to be discharged for social care or other reasons. In April 2013 the Scottish Government reduced the previous six-week target to no delayed discharges over 4 week's duration. In 2015, the target has been reduced further to delayed discharges not exceeding two weeks.

As Chart 2 below shows, the Partnership's performance on preventing delayed discharges against the current 4 week target and the previous six week target was inconsistent.

Chart 2: Numbers of Falkirk delayed discharges by length of delay/ performance against Scottish Government targets



Source: Information Services Division Scotland

As can be seen, between 2012 and 2014 there have been significant variations in performance.

The Falkirk Partnership presented a mixed picture in terms of bed days lost to delayed discharges for patients aged 75 and over. Information Services Division (ISD) data showed that the number of hospital bed days occupied by delayed discharges fell sharply below the national average between April 2012 and March 2013. However, this has steadily increased again, and in April 2014 the number of hospital bed days occupied by delayed discharges was sitting just below the Scottish average.

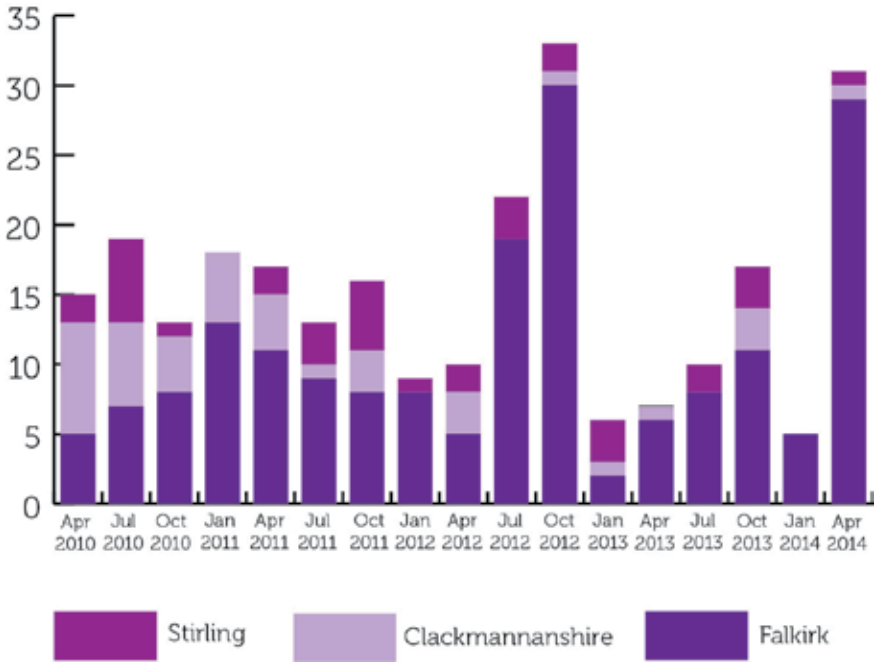
The reason for people being delayed in hospital has varied over time and is different across all the council areas in NHS Forth Valley. A report by Audit Scotland for the Partnership outlined that in April 2014 most of the NHS Forth valley patients delayed were waiting for a residential care home place (31 patients) Chart 3 below shows that of those awaiting residential care home placements, 29 of the 31 waiting for placement were Falkirk Council residents although the chart does not reflect the proportionality of Falkirk's population against the neighboring authorities. However, this was still challenging for the Falkirk Partnership as the number of care home vacancies in the Falkirk area was low, falling from 29 in January 2014 to 11 in April 2014.

Although we found some evidence that the Falkirk Partnership, supported by the Scottish Government Joint Improvement Team, was making use of their developing Choice Policy in order to be able to discharge patients into appropriate interim placements, further work could be done in this area. The Partnership should review the capacity of care home provision, home care and other community services.

Recommendation for improvement 1

The Falkirk Partnership should put measures in place to meet the Scottish Government delayed discharge targets and to make sure older people in Falkirk are discharged home or to a homely setting when they are medically fit to do so.

Chart 3: Number of patients delayed waiting for a care home place to be available, by council, April 2010 to April 2014



Source: Information Services Division Scotland, delayed discharge census, February 2014. Standard delays, excluding delays of 1–3 days

Discharges can also be delayed for reasons out with the control of the Falkirk Partnership such as those associated with Adult with Incapacity (Scotland) Act 2000, or those with complex needs. These are recorded as Code 9 when they are reported to ISD. The major reason for Code 9 delays within the Partnership was related to patients who lack capacity to make decisions about their welfare and who required the appointment of a proxy under the terms of the above Act.

The ISD data showed that the Partnership had a relatively low percentage of Code 9 delays that were contributing to their overall percentage of all delays compared to other

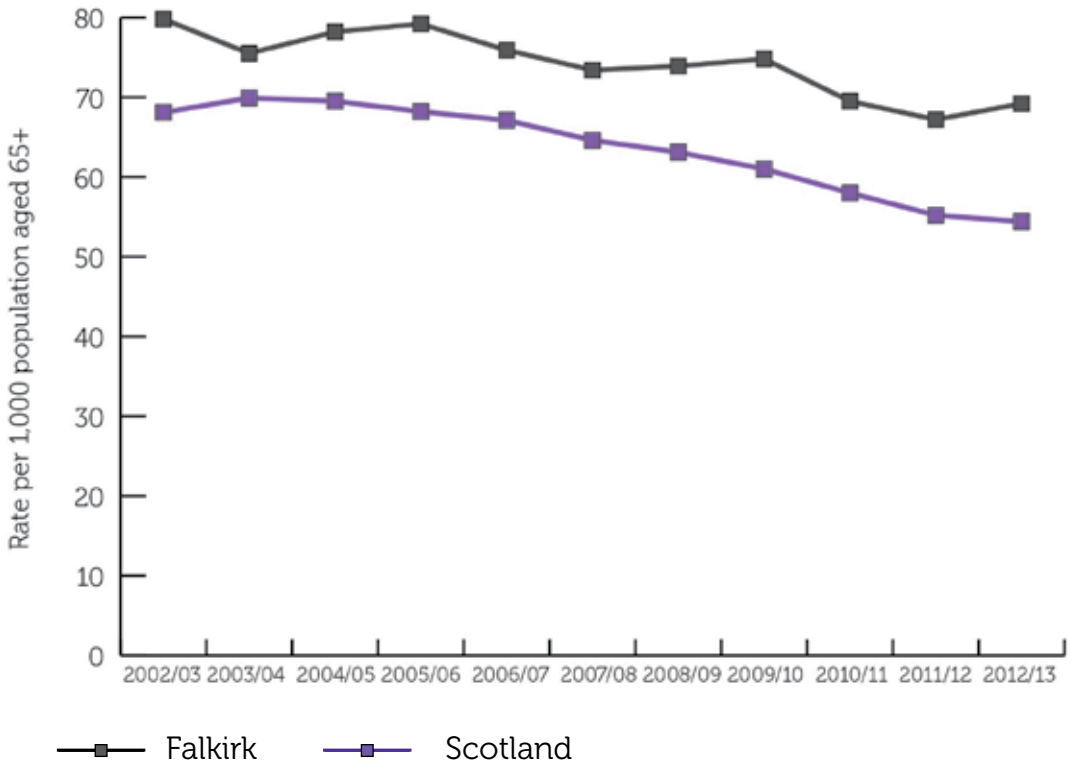
local authorities, ranking five out of 32 local authorities. We saw positive evidence at the delayed discharge steering group that all the appropriate legislative options were being strategically considered including the Adults With Incapacity Act (2000) and 13Za of the Social Work (Scotland) Act 1968 options.

Provision of home care services

Home care is care and support for people in their own home to help them with personal and other essential tasks.

Chart 4 below shows the Falkirk Partnership providing consistently higher than national average figures of home care to people in the locality which is positive.

Chart 4: The number of people aged 65+ supported by Falkirk and Scotland as a rate per 100 population aged 65+ between 2002/3 and 2012/13

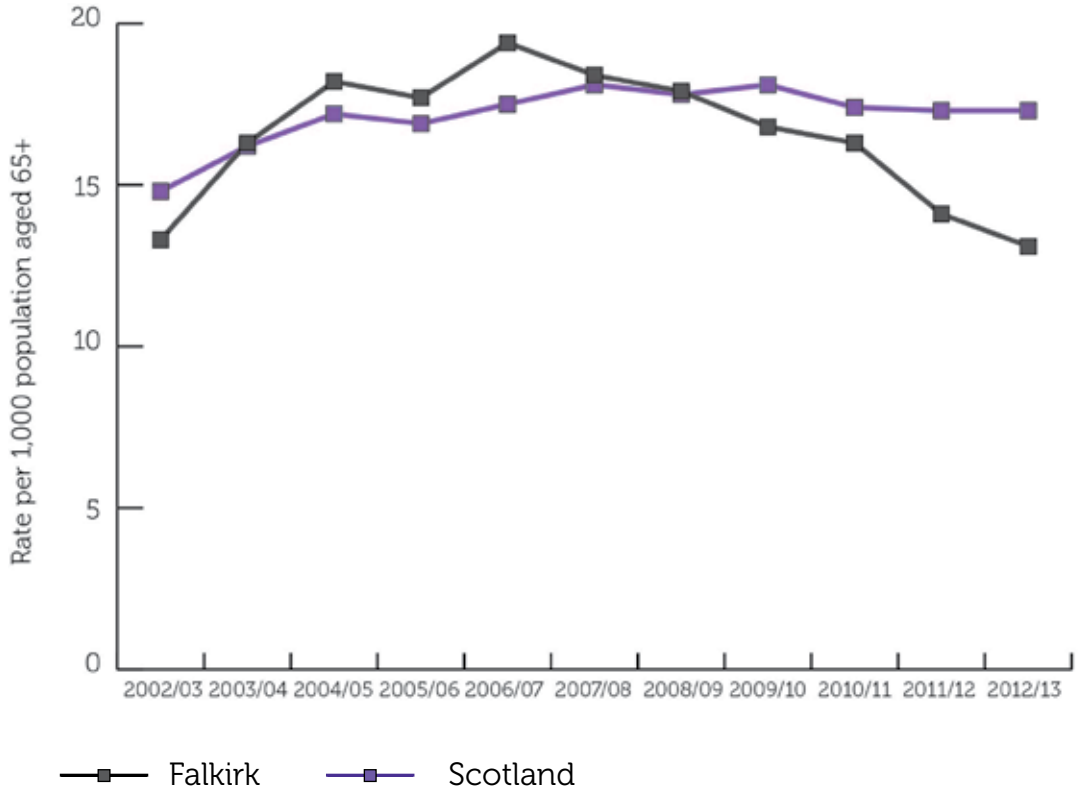


	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Falkirk	79.8	75.5	78.2	79.2	75.9	73.4	73.9	74.8	69.5	67.2	69.2
Scotland	68.1	69.9	69.5	68.2	67.1	64.6	63.1	61.0	58.0	55.2	54.4

Source: Scottish Government Social Care Survey 2013 and Home Care Census

However, although the overall delivery of home care hours provision has been consistently higher than the national average, Chart 5 below shows the Partnership has steadily reduced the number of people receiving intensive home care services (10+ hours a week) since 2008/9 meaning they are now below the national average.

Chart 5: Number of people receiving intensive home care (10+ hours per week) in Falkirk and Scotland, 2002/03–2012/15, as a rate per 1000 population aged 65+.



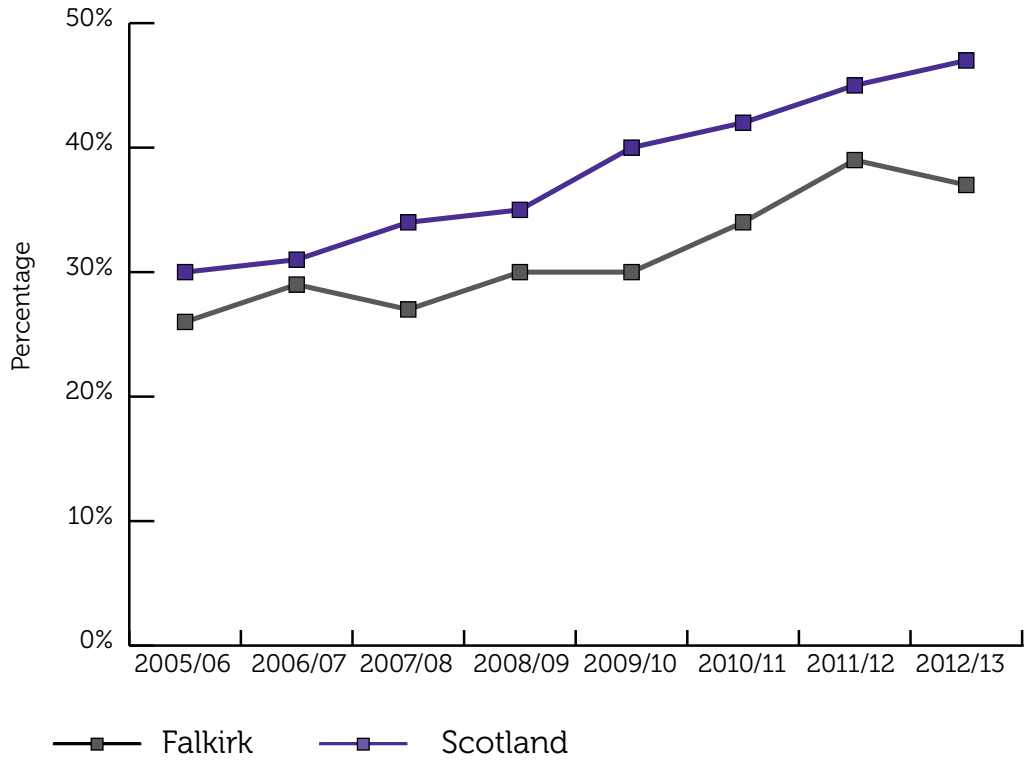
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Falkirk	13.3	16.3	18.2	17.7	19.4	18.4	17.9	16.8	16.3	14.1	13.1
Scotland	14.8	16.2	17.2	16.9	17.5	18.1	17.8	18.1	17.4	17.3	17.3

Source: Scottish Government Social Care Survey 2013 and Home Care Census

Chart 6 below shows there was also similarly declining trends in terms of the Falkirk Partnership's delivery of home care in the evenings and overnight. It was ranked 26 out of 32 local authorities for this indicator (the first ranked providing the most hours of support) and 22 out of 32 local authorities for the delivery of home care services at the weekend.

The Partnership was reviewing its provision of intensive home care and reablement-at-home services to prevent hospital admissions and people staying in hospital longer than was necessary. The introduction of the 24/7 Team and other services was a positive step forward for the Partnership and ultimately the full impact of these services will determine if the current levels of evening and overnight home care provision is adequate or not.

Chart 6: Falkirk home care clients aged 65+ years receiving evenings/ overnight care as percentage of total 65+years home care clients, 2005/06–2012/13



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Falkirk	26%	29%	27%	30%	30%	34%	39%	37%
Scotland	30%	31%	34%	35%	40%	42%	45%	47%

Source: Scottish Government Social Care Survey 2013 and Home Care Census

The Falkirk Partnership delivered care and support at home through three teams.. Firstly, the 24/7 Team which provided crisis care, rehabilitation support, and assessment of new home care referrals and organising the initial six weeks of homecare, known as the Short Term Service. Secondly, the long term team provided in house care and support to those with longer term needs beyond the initial six-week period. Thirdly, the Resource Team managed and quality assured care and support provided whose care was delivered by an external provider. They also managed the in-house meals-on-wheels service, the shopping services and the out-of-hours service. The implementation of these early intervention and support services was positively increasing the amount of home care hours delivered out with core hours as shown in Charts 4 and 5 above.

The 24/7 Team included the:

- out-of-hours service which covers the elements of the Long Term Team, home care and those noted below between the hours of 5pm and 9am on a daily basis including weekends
- short-term service

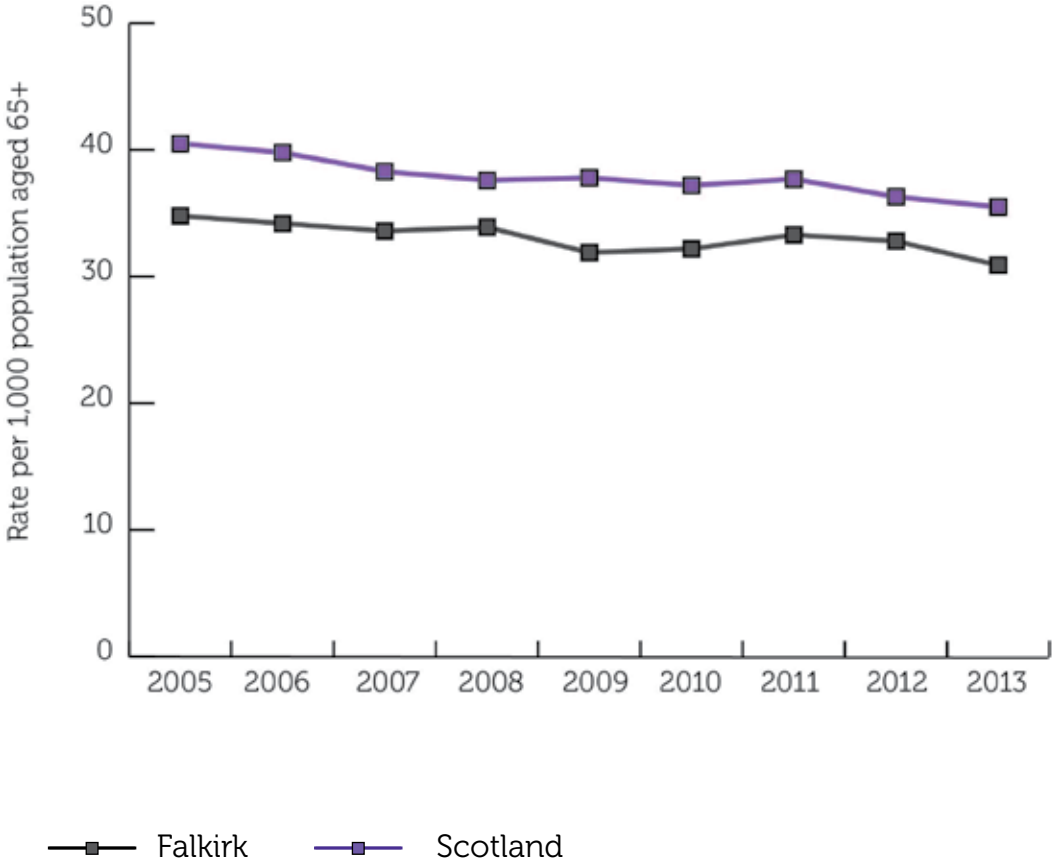
- crisis care service
- reablement-at-home service.

The reablement-at-home service included nursing and allied health professionals and supported hospital discharges for older people in collaboration with ReACH(rehabilitation and assessment in the community and at home). We discuss the positive outcomes this service was delivering later in this chapter.

Care home places

Chart 7 shows that between 2005 and 2013 the Falkirk Partnership had proportionately placed less older people in care homes than the Scottish average. While numbers of older residents in care homes had steadily decreased during that period in both Falkirk

Chart 7: The number of residents in care homes for older people, (aged 65+years), as a rate per 1000 of the population 65+ years, in Scotland between 2005 to 2013



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Falkirk	34.8	34.2	33.6	33.9	31.9	32.2	33.3	32.8	30.9
Scotland	40.5	39.8	38.3	37.6	37.8	37.2	37.7	36.3	35.5

Source: Information Services Division Scotland-Scottish Care Home Census 2000–2013

and Scotland overall, Falkirk's rates have remained consistently lower than the national average. This trend should not necessarily be interpreted as reflective of poor outcomes for older people However, the Partnership should continue to review the level of care home provision along with the provision of care at home services to improve its performance in relation to delayed discharges.

Performance of regulated care services for older people

We reviewed the local authorities self-reporting on its regulatory inspection quality of care and support grades. We found that while most registered services were receiving good grades, there were differences across the six Council care homes for older people.

There were two care homes being consistently evaluated with lower grades from the regulatory inspections carried out by the Care Inspectorate. The local authority was undertaking work to rectify this.

Older people living in the local authority care homes generally reflected positive feedback to the Care Inspectorate inspectors and inspection volunteers who recorded positive outcomes from service user participation sessions in the care home inspections.

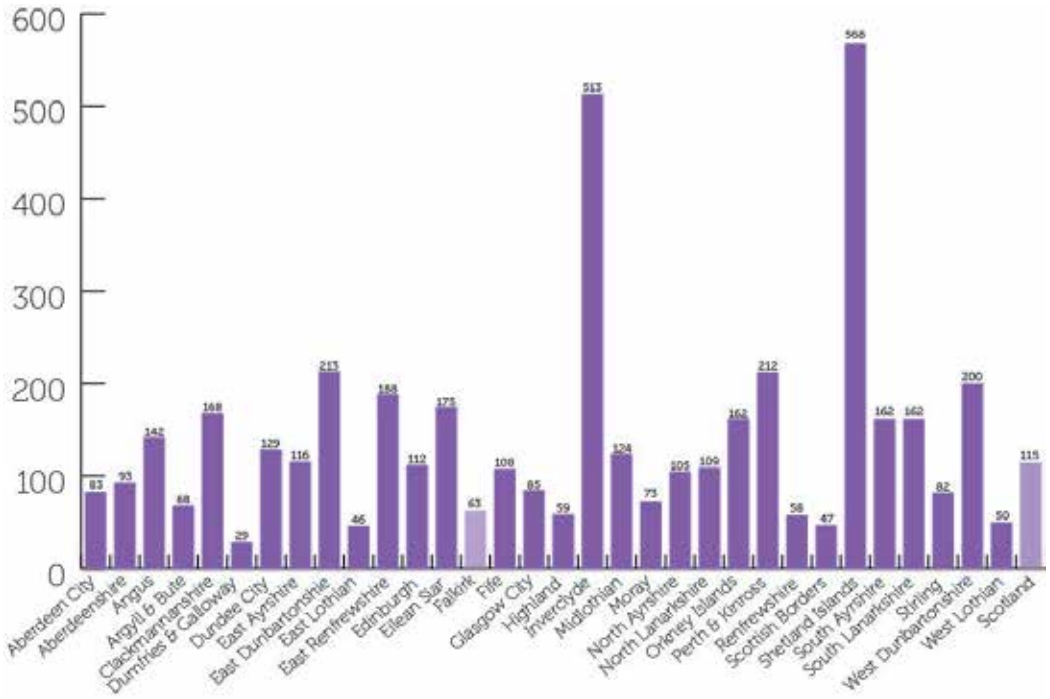
Respite care for older people and their carers

Chart 8 below shows that the Partnership is delivering significantly less respite to service users than the Scottish average. Some older people and carers told us that respite had not been available to them when they were in crisis.

We spoke to staff who advised us that respite is provided by the local authority in three of its care homes, with private sector care homes providing most planned and unplanned respite. The Partnership should consider where it could make improvements to the availability of respite provision for weeks provided, overnight, and daytime.

We noted that there were day service and accommodation based service reviews under way, as well as the strategic service planning review of high end care provision. The Partnership have linked these reviews to support them to address the low rates of respite delivery, and quality of care issues relating to the two care homes discussed.

Chart 8: Falkirk and Scotland respite for service users, (rate per 1000 population 65+ years), 2012-2013)



Source: Audit Scotland Statutory Performance Indicators data 2006–2008, Scottish Government 2009–2012

Telehealthcare and telecare

Telehealthcare may be video-conferencing, patients' remote consultations with health professionals or environmental monitoring devices installed in patients' homes. Telecare is equipment and services that support older people's safety and independence in their own home. Examples include personal alarms and smoke sensors.

The Falkirk Partnership received funding from the Scottish Government to develop Telecare in the Falkirk Area. There was evidence in reports submitted to the Falkirk Partnership strategic planning groups that these services are well developed In addition, a comprehensive Joint Working Action Plan for telehealthcare, falls, and medication provided good evidence of collaborative working across the Partnership.

We reviewed the Partnership's self reported performance information for the above initiatives which demonstrated some positive outcomes. For example, from 01 April 2013 to 31 March 2014, it was reported that telecare had prevented 44 unplanned admissions to hospital and, saved 150 hospital bed days.

Examples of good practice

The Falkirk Partnership's care home liaison psychiatry service was established in January 2006. This was for ongoing support and education for all care home staff to increase their capacity to assist older people with mental illness or dementia. Due to its success in Falkirk, this service was expanded across other areas of Forth Valley in October 2012.

The aim of the service was to provide continuity of care, improve communication with all professionals involved in the residents' care, reduce admissions to hospital (for psychiatric inpatient care) reduce out of hours contact and support all care home staff, through enhancing skills, knowledge and understanding, therefore improving delivery of care.

GPs and care home managers can refer to this service.

The role of the care home psychiatric liaison nurse was to provide patient and staff focused six-weekly clinics based within the care home to keep older people's mental health under close review. These clinics provided the opportunity to assess, plan and manage conditions more effectively.

The liaison nurse also delivered needs-led teaching, training and education programmes to care homes to increase their awareness of mental health issues.

Prior to the service being established admissions of patients to the acute psychiatric inpatient wards was approximately 20 per year. Following the establishment of the service in 2006 the yearly admission rate has dropped significantly to between three and five patients per year since and has not risen in the last eight-year period.

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

Reablement and intermediate care

Reablement is a range of services focussed on helping someone maximise their independence or re-learn skills they need to stay at home and confidently carry out the activities of daily living. Reablement services are often delivered with intermediate care services. Intermediate care can include a wide range of short term interventions or rehabilitative services which will help promote independence, reduce the amount of time someone might spend in hospital, or help to avoid unnecessary admissions to hospital. Intermediate care can be provided in hospital, people's homes or in a special unit, such as a care home or day centre.

The Falkirk Partnership had adopted a reablement approach focused around the reablement-at-home service. The ReACH team, NHS Forth Valley and the Falkirk Council Social Work Services 24/7 team worked together to provide the reablement-at-home service.

Prior to June 2012, the reablement-at-home service worked with 12 patients and two early supported discharge patients for up to four weeks. This was increased in June 2012 to 24 patients plus two early supported discharge patients for up to six weeks. This generated an additional capacity of 12 patients at any one time for referrals from the community to reablement-at-home.

Since its introduction, the reablement-at-home service has delivered the following outcomes for people using the service.

- 2010/11 57% of those receiving the service did not need additional home care following the reablement-at-home service input.
- 2011/12 84% of those receiving the service did not need additional home care following the reablement-at-home service input.
- 2012/13 80% of those receiving the service did not need additional home care following the reablement-at-home service input.
- But 2013/14 had seen a significant reduction to only 55% following the reablement-at-home service input.

The outcomes for older people following the input of the reablement-at-home service were positive, with on average 69% of patients over the last 6 years having been discharged early and not requiring any additional ongoing home care input. However, the Falkirk Partnership needs to monitor the 2013/14 reduction and aim to re-establish the higher levels of positive outcomes. We met older people and carers who had benefited from the reablement-at-home service. They told us they felt it had assisted them to be more independent than they might otherwise have been. The service also undertook a customer satisfaction survey which mainly generated positive responses.

We saw that carers had been involved in the development of the Forth Valley Carers' Strategy[8] which was formally launched in 2012. We read in the position statement submitted to us by the Falkirk Partnership that this was the first integrated carers strategy in Scotland. We also read a comprehensive action plan within the Carers' Strategy progress report that reflected some very positive achievements between the beginning of April 2013 and the end of March 2014. Examples included carer support workers making one-to-one contact with 214 carers during hospital discharge, which was important to seek their views about discharge arrangements and 108 carers being referred for welfare benefit advice in order to ensure their income was maximised at critical times during their support. We noted many other significant achievements.

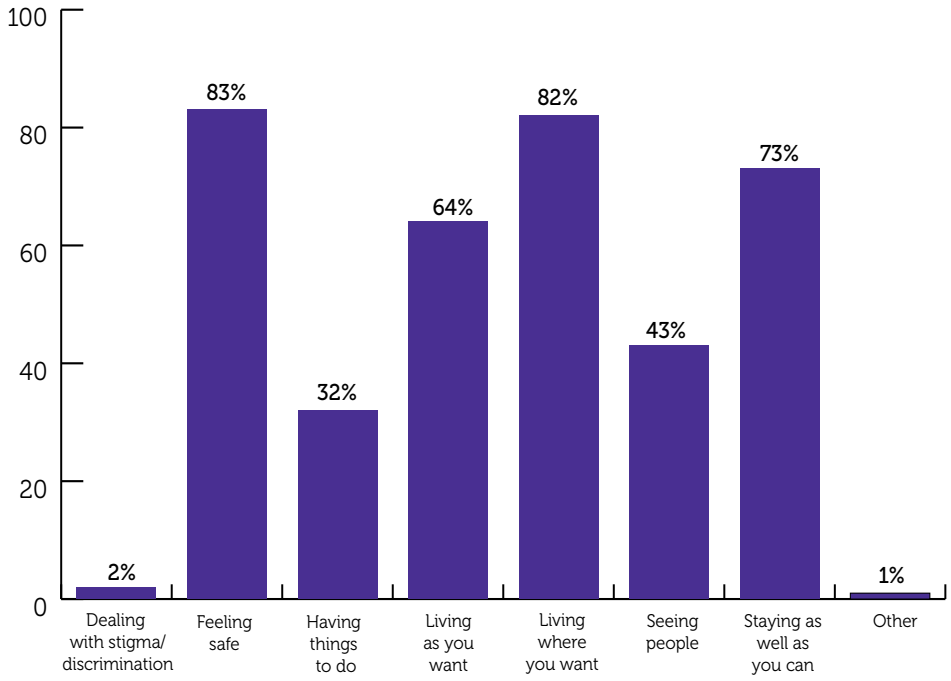
8 Forth Valley, Integrated Carers' Strategy 2012-15

Undertaking a caring role can have a detrimental effect on the carer's physical and emotional health. The Community Care and Health (Scotland) Act 2001 gives carers the right to have their own needs assessed independent of the person they are caring for. Some carers we spoke with said they had received a carer's assessment. This assessment considered the needs of the carer and how they could be assisted by the Partnership to support the relevant older person they were caring for. It was clear from our review of health and social work services records, that where formal carers' assessments were undertaken, the outcomes were very positive. However, we saw little evidence of carers' assessments in social work and health services files we read. This is discussed in more detail in Chapter 5.

Outcomes for older people

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

Chart 9: Positive personal outcomes for service users delivered by the Falkirk Partnership, September 2014



Source: Care Inspectorate/Healthcare Improvement Scotland

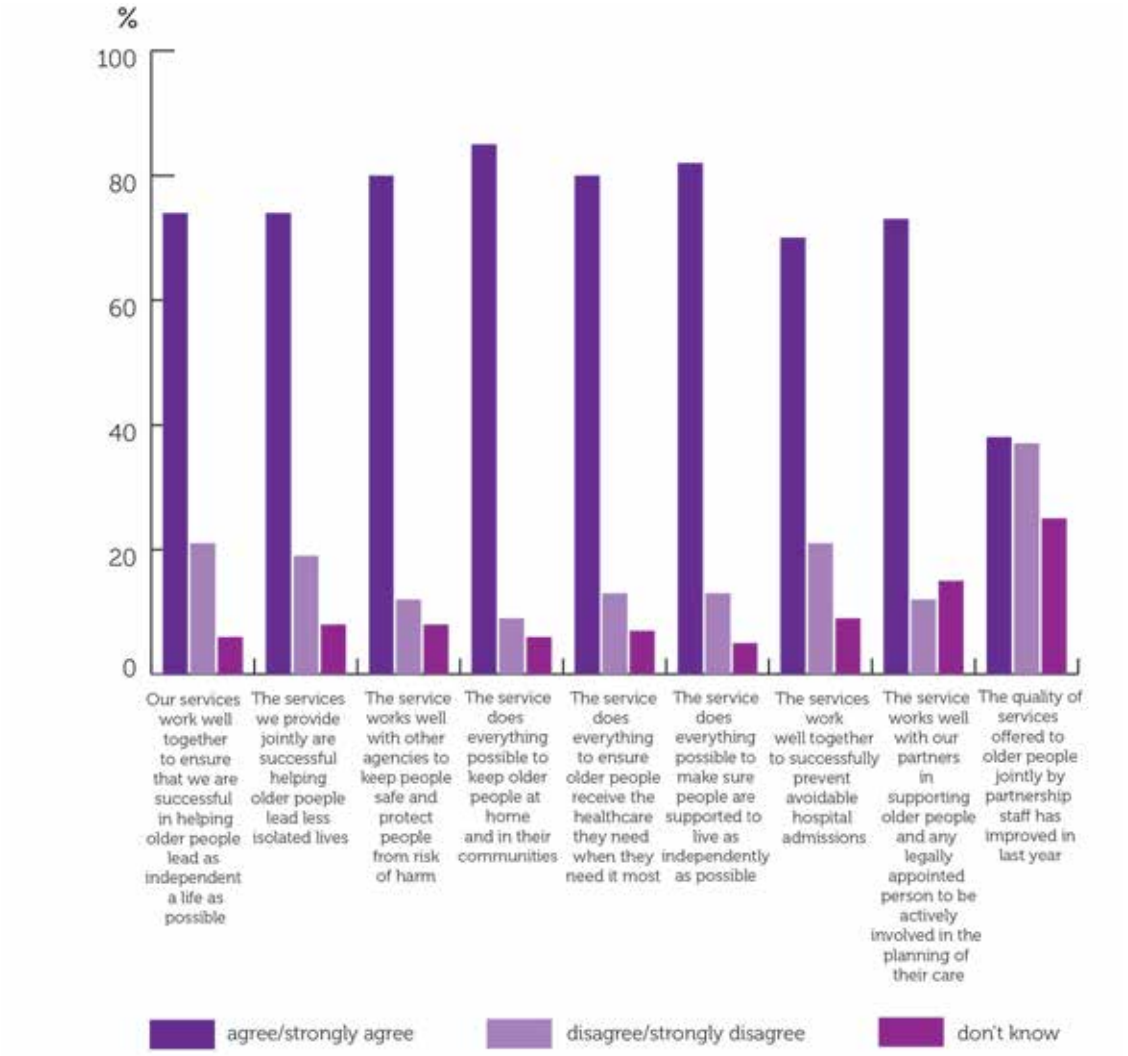
Chart 9 shows the range of good outcomes delivered for older people by the Falkirk Partnership. We saw evidence of this from the health and social work services records we read.

Forth Valley, Integrated Carer's Strategy 2012-15

Of the social work and health services files we reviewed we were further encouraged that positive personal outcomes were achieved for almost all individuals (94%).

During our inspection, we met with a number of older people and carers. They told us that, as a result of the health and social work services they received, they felt safer, well supported and listened to. However, only 22% of care plans clearly set out the older person's desired outcomes.

Chart 10: Positive personal outcomes for service users delivered by the Falkirk Partnership, September 2014



Source: Care Inspectorate/Healthcare Improvement Scotland

Chart 10 shows the results of our survey of health and social work services staff about the delivery of positive personal outcomes for older people and their carers. Overall, the staff survey results relating to outcomes were positive. However, less positive responses were received to the question on the quality of services offered to older people jointly by the

Partnership in the last year. Only 38% of staff completing the survey agreed that there had been improvements made in the last year.

Health and social work managers suggested that the large scale changes to service structures and delivery may have contributed to the comparatively negative responses from staff.

Complaints handling and learning from complaints

One of the areas we look at when considering how partnerships are improving outcomes for individuals and their carers is how well partnerships handle and learn from complaints.

The social work services had been collecting good performance data about complaints across all service areas including older people. They told us that areas for improvement were factored in to service plans such as the introduction of real time monitoring of home care services.

In accordance with the Patients' Rights Act (2011) NHS Forth Valley produced an annual report that was a public facing document outlining how feedback, comments, concerns and complaints were used to improve service delivery and outcomes for their patients.

To conclude the Falkirk Partnership has developed a number of early intervention and support services that have demonstrated good outcomes and positively impacted on the admission to hospital trends. The trend data is showing that the upward trend for hospital admissions has steadied. However, in terms of timely discharges more work is required particularly to ensure care home placements are available for older people who need that service.

Rehabilitation services are being provided at the right time and despite pressure on the capacity of services like the 24/7 team good outcomes for older people were evident.

There were high quality regulated services in the main within Falkirk. Two local authority care homes required some improvement and the Council was working with the Care Inspectorate to achieve this.

More work was required to ensure that anticipatory care plans were being shared across the Partnership more effectively and that there was a greater availability of respite care.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation - Good

The majority of older people and carers we spoke to during the inspection said they were very happy with the services they received.

The Partnership had worked well together to produce its Integrated Carers' Strategy with an accompanying action plan. This highlighted a range of good initiatives such as early contact with a high volume of carers following an older person's admission to hospital and also with community advice services to ensure their income was maximised. However, some carers we spoke to felt communication between agencies could still be improved to avoid having to tell their story repeatedly.

The Partnership was also strengthening its links between carers and GP practices. There were a number of good projects being developed that took account of the physical and emotional wellbeing of carers. Similar good work was happening at the Sensory Centre for older people and carers with a visual impairment. The older people and carers we talked to during the inspection told us that they experienced good outcomes as a result of attending these services.

The Partnership had developed a number of early intervention and prevention services to support older people. We spoke to older people who attended the Sensory Centre following a stroke who talked very positively about the positive outcomes they achieved.

Services for older people with dementia were developing well but some carers we spoke to told us that post-diagnostic support was not as accessible as it could be. The Partnership had established close working links with Alzheimer's Scotland to strengthen their commitment to this agenda.

We saw good collaboration between community and hospital based services. The Psychiatric Nurse Liaison Team was a particularly good example of a service that worked with patients presenting with confusion on hospital wards. There was good evidence they co-produced subsequent interventions with older people and carers. In addition the palliative and end of life services were providing good outcomes for patients and carers and had put their views at the heart of their service review and improvement processes.

While many of the early intervention and support services were working well there were some examples where communication and sharing of information could be improved in areas such as anticipatory care planning, the Frailty Clinic and some falls prevention activity.

This chapter looks at whether the Falkirk Partnership has an integrated strategy and approach at the most appropriate time to promote and maintain the older person's health, safety, independence and wellbeing. It considers the joint action taken to support the older person's capacity for self care including those with increased frailty and long-term conditions.

It also considers if systems are in place to gather older people's and carers' feedback about their experience of services and if they have been supported to make decisions about the care they need.

We comment on the Partnership's information and whether or not it is readily accessible.

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

An integrated approach

The majority of health and social work services records we read showed that assessments carried out took in to account individuals needs and choices. Our health and social services records review indicated that 94% of cases we read (99) took account of the older person's needs and 91% took account of their choices. We found that in the majority of cases the older people we spoke to during our inspection were happy with the care they received and with the staff who delivered this.

Chapter one highlighted that the Falkirk Partnership was not meeting the national targets for delayed discharge. We found there were challenges in respect of effective discharge planning across both acute and psychiatric settings. For example, where social work services staff were involved in hospital ward reviews, this helped with more effective discharges and care planning. However, there was a disparity with social work involvement in hospital ward reviews across the Partnership.

The Falkirk Partnership's Joint Strategic Commissioning Plan for Older People (2014-2017) outlined its intention to move from a model of reactive care to preventative care.

Two examples of where an integrated approach between health and social care was providing improvement in outcomes for individuals and there carers were the Frailty Clinic in Forth Valley Royal Hospital and the Bo'ness Project.

The Frailty Clinic

The Frailty Clinic was set up in Forth Valley Royal Hospital to provide older people living in the community with access to a specialist comprehensive older people's assessment. The aim of the service was to reduce avoidable hospital admissions and support patients being cared for in the community. Health services worked in partnership with the local

authority home care service to design a package of care that was agreed and delivered following the older person's assessed needs being identified. The assessment would also link in with all other relevant rehabilitation health services needed to support the older person at home. Older people were assessed by the multi-disciplinary health team on the day of referral or the following day. We read about the outcomes in the information submitted to us by the Partnership for some the patients attending this clinic. They told staff involved that the service provided prompt appointments, that staff working there were very helpful and attending for a single appointment prevented them and their family from attending numerous other appointments. There was also positive outcomes for the Partnership as admissions to hospital for patients following this intervention were diminishing. It was also anticipated that in time this service would also impact positively on in-patient numbers, length of stay and occupancy levels.

Unfortunately, the demand for the Frailty Clinic had been lower than anticipated. Although referrals were increasing the clinic was only running at 60% capacity. Some staff groups we spoke with said they were not fully aware of the referral processes to the Frailty Clinic or the purpose of it. Increasing staff awareness could increase the numbers of people benefiting from this service.

The Bo'ness Project

The Bo'ness Project (phase 1 for people aged 85+ with dementia or complex needs) was an example of a locality approach that considered those people in the Falkirk population likely to have both complex and overlapping health and social care needs.

The 'package' being tested in Bo'ness was a combination of initiatives that included:

- identifying older people in partnership with GPs who were at high risk of needing health and social care services and would most benefit from this approach
- developing an anticipatory care team made up of district nurses to implement anticipatory care plans for the group of older people identified
- signposting people as required, for example for medicines review or additional equipment
- proactive community involvement to help people manage through a variety of support approaches and a 24/7 telephone support line provided by district and night nursing.

We read detailed data which provided good baseline measures for future comparison. Previous audit work the Partnership undertook showed that there was an opportunity for up to 30% of patients who stay longer than 14 days in hospital to have been cared for on an outpatient basis or by an admission of less than 48 hours. By the Partnership's own acknowledgement this suggested that there were opportunities to significantly reduce avoidable hospital admissions.

There were active plans to expand this project to include people over 65 years of age.

Supporting carers

The Falkirk Carers' Centre aimed to support family carers throughout Falkirk and Clackmannanshire Council by helping them to sustain their role without compromising their own health and wellbeing. The carers we spoke to talked very positively about the Carers' Centre for the support, and in particular the dementia training provided. However, some also felt the Partnership needed to improve communication between health and social work. They said they were frustrated about having to "tell the same story time and time again"

The position statement we received from the Partnership prior to inspection stated that the Carers' Centre had developed and implemented 110 carer support plans with carers. The carers we met at the Carers' Centre certainly said they were offered an assessment but that they were not always repeated meaning their value could be diminished throughout the journey of the cared for person's illness.

During our inspection we found areas where the Partnership was being proactive in their approach to supporting carers. Here are two examples of this.

- The Richmond Practice, where GPs were inviting known carers for a health check, during which the impact of the caring role on their health was discussed. The GP or other staff could then provide information to carers about other services such as the Carers' Centre

- An innovative project established by the Partnership to help carers understanding of the functional impact of visual impairment. The use of an interactive electronic application to simulate the diagnosis of visual impairment had recently started to be used in the Falkirk Sensory Centre. Carers told us that their interactions with those being cared for benefited from improved levels of anxiety and stress because carers were developing an improved understanding of the impact of visual impairment thus increasing their ability to continue in their role.

While we found there was good involvement at an individual project level, a number of the carers we spoke with felt that the contribution of carers at a more strategic level required to be more fully acknowledged and their needs more supported. Those attending the Carers' Centre felt they had been offered limited consultation opportunities and limited involvement in things that mattered to them. However, we did note that there were examples where carers were heavily involved in such activities such as the Joint Dementia Initiative Service review where, they told us, they felt they had played an important contributory role.

2.2 Improvements in the health and wellbeing and outcomes for people, carers and families.

An increasing number of people are living with long-term conditions, such as diabetes, asthma and dementia. One of the key roles of health and social work professionals in supporting people who are living with a long-term condition(s) is to build their self confidence and capacity for self-management, and to support them to be as independent as possible .

In the majority of the health and social work services records we read we found evidence that older people had been supported to self-manage their condition. This was consistent with the view of those completing the staff survey where 74% of staff felt that the service worked well together to support people's capacity for self-management.

Within the Partnership, some services were using multi-disciplinary staff groups including the third and independent sector organisations to improve outcomes for older people with long term conditions. One such example was the Change Fund initiative linked to the Bo'ness project linking physiotherapists working in health services with Active Forth, a physical activity referral scheme. The aim of this service was to provide a sustainable approach to engagement in exercise following participation in OTAGO, (a strength and balance falls and injury prevention programme). Another example was where occupational therapists working in health liaised with Red Cross volunteers to design a programme of community confidence building by developing graded exposure sessions.

Example of good practice

The Falkirk based Forth Valley Sensory Centre is a partnership with all Forth Valley local authorities, Royal National Institute for the Blind Scotland, NHS Forth Valley and Action on Hearing Loss.

The Centre was involved in a project to support people with visual impairments following a stroke. Visual function was assessed by a rehabilitation worker from the sensory impairment team and optometrist on the acute stroke unit. This collaborative approach between health and local authority colleagues ensured that older people got an early diagnosis and their post discharge rehabilitation planned.

Older people we spoke to told us of the positive personal outcomes for them as they were provided with specialist therapy to learn to adjust to the visual impairment. They were also provided with support to rebuild their confidence to help them to be safe and engaged in their local communities.

Implementing Scotland's National Dementia Strategy 2013-2016

We looked at how the Falkirk Partnership was implementing the National Dementia Strategy. A dementia steering group had been established to take forward a broad approach in delivering the dementia strategy. Regular NHS Forth Valley benchmarking exercises had been undertaken to monitor improvements and identify key achievements, and challenges while implementing the strategy.

Dementia champions (people with additional training in dementia care who work to affect change, improve experiences, care, treatment and outcomes for people with dementia and their families) had been identified in both health and social work services. We were told most hospital wards had a dementia champion. It was positive to hear that wards strived to ensure that dementia patients were admitted to the right bed at the right time, in an attempt to avoid unnecessary moves as this could cause stress and distress. Forth Valley Royal Hospital also used the 'Butterfly Scheme' to identify individuals with dementia. The Butterfly Scheme invites family and friends of an adult with dementia to complete a carer sheet which offers hints and tips about how the individual likes to be treated. If the older person with dementia was admitted to hospital a butterfly symbol indicated to staff that they were part of the scheme. Staff then knew to refer to the person's carer sheet.

The Partnership recognized that the delivery of post diagnostic support at the current rate was challenging and had created increased demand on services in terms of delivering Commitment 2 of the National Dementia Strategy. Commitment 2 aims to ensure everyone newly diagnosed with dementia receives at least one year's post diagnostic support. The Joint Management Group were exploring short and longer term additional support options. A collaborative approach to deliver a year's post diagnostic support in line with the National Dementia Strategy was being adopted. For example, Alzheimer's Scotland care workers were involved in providing post diagnostic counselling and carer support. We visited the Maples Day Centre in Falkirk and heard about the positive impact of this role from staff working there and older people in attendance.

However, we were advised by staff that this service was approaching capacity but no plan to expand the service had been made. We noted that as a consequence of the above, Alzheimer's Scotland had initiated a waiting list for this support. We also heard from some carers that post diagnostic support was limited. They said that services were introduced in response to a crisis rather than as a preventative measure.

The Joint Dementia Initiative was established in 1991 however, this was under review at the time of the inspection.

This initiative aimed to support older people living with dementia by offering:

- home-to-home support
- drop-in café

- one-to-one service
- time-to-share service.

The home-to-home service provided up to four people with dementia the opportunity to attend day care at a volunteer's house. This part of the service was extremely well received by everyone who attended. We were told this service model had attracted both national and international interest.

We heard that the drop-in café was particularly effective in signposting people to services. It had also developed a useful booklet written in collaboration with Alzheimer's Scotland and other organisations. Carers and older people attending the drop in café told us that they felt these services were of real value to them. They were providing carers with the chance to meet people in the same situation and develop support networks. It provided a venue for health workers to visit and undertake necessary mental health checks and it also provided a point of contact where effective signposting was taking place about dementia services. The people we spoke to said this service coordinated their care needs and linked them effectively to health and social work services.

Example of good practice

The extended psychiatric nurse liaison team was screening older people admitted to acute or community hospitals with signs of delirium. As a result of this service, approximately one-fifth of all elderly acute in patients received a full cognitive assessment similar to that provided in the Older People's Community Mental Health Service memory clinic.

Where appropriate, a diagnosis based on the patient's presentation was being made and details of this fed back to the patient, carer and GP. Appropriate referrals were then made to the Community Mental Health Teams, Social Work Services, Alzheimer's Scotland and the Princes Royal Trust Carer's Centre.

As a result, the Falkirk Partnership reported that 144 people with dementia had been diagnosed in the acute hospital in the past 12 months. These people may not have received an early diagnosis and the support and intervention if this service was not available.

The Falkirk Partnership also reported that all the patients reviewed by the extended psychiatric nurse liaison team who had carers, were involved in their assessment. Approximately 70% of these assessments were face to face interviews. The rest were conducted by telephone.

Palliative and end-of-life care

Access to palliative care in the community was underpinned by the Falkirk Partnership's standards for patients with a limited prognosis. Clinical Leadership and support from a Managed Care Network was also supporting improvements and sustainability of palliative and end of life care.

The Partnership was providing specialist care, extending out with traditional hours, to prevent hospital admission for individuals at the end stages of their lives. In partnership with MacMillan and Marie Curie, a weekday overnight service and a weekend evening service were provided, as well as psychosocial therapies including cognitive behavioral therapy and community based social support, for example, coffee mornings. These were good examples of health care agencies working with the third sector to deliver services. We read the evaluation of this service and the feedback described practitioners as caring and compassionate staff who made a positive difference in difficult circumstances. This service positively supported 87% of those with end of life care needs to die in their preferred place.

The Partnership had recognised the important role of care homes in the provision of palliative and end of life care and demonstrated a commitment to enabling people to remain in the care home at the end stages of illness. A care home project was undertaken with nine private and five local authority care homes to deliver training in collaboration with the Strathcarron Hospice in Denny. The focus of the training included the development of anticipatory care plans to help ensure that people could remain in the care home to die rather than being admitted to hospital. Very positively, we noted there were also reviews of each individual who died in hospital to make sure the correct decision had been taken and to ensure further learning and continued development.

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

Self-directed support means the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. Since April 2014, councils have a statutory duty to offer the four self directed options to older people and other adults who need social work services. The self-directed support options are:

- Option 1. direct payment
- Option 2. the person chooses and directs the available support
- Option 3. the local authority arranges the support
- Option 4. a mix of the above.

The Falkirk Partnership had elected to initially offer self-directed support to new individuals referred for assessment. People already in receipt of community social care

services were to be offered self-directed support at a scheduled review, or in the event of a change of circumstances.

Since 1 April 2014, Falkirk Council had commissioned 29 packages of care using self-directed support and were processing a further 12 using self-directed support assessment tools. Staff we met said that the Partnership still had some work to do before being in a position to deliver on option 2. This option allows the service user to tell the council what services they want them to buy on their behalf to meet their assessed support needs. The Scottish Government expects that all relevant self-directed options should be made available to older people. We were satisfied that the self-directed support project board was progressing this.

The Partnership had developed an information leaflet about self-directed support, and how to access it and who to contact to seek support. However, feedback from a range of people including the Citizens' Panel, and older people and their carers, suggested that few had heard of self directed support and others had found information about it difficult to access.

Although the Partnership was making progress with the implementation of self-directed support, it may wish to consider further developing the information available, and support given, to enable older people and their carers to make an informed choice about the most suitable options for them.

One area where the Partnership was demonstrating an innovative approach to informing older people and their carers of resources and services was in the Living It Up project. This was an online self-management hub which his was being developed in conjunction with older people. The web-based project aimed to provide an interactive guide to local services, peer support for individuals with long term conditions and self management tips. This included medical support from NHS Forth Valley to make sure health information was helpful and accurate.

In summary, we found good initiatives to ensure people in the Falkirk area are getting help at the right time. However, although there were a variety of initiatives of a preventative and early intervention nature, we found that not all staff were aware of how to access those initiatives. Also, key information that should have been shared was either unable to be shared, or when it was shared, some key staff were not sure on how to use the information to support the older person. An example being social care staff not knowing how they should use anticipatory care planning information, or anticipatory care planning sitting with GPs and not being accessible to community staff.

Recommendation for improvement 2

The Falkirk Partnership should ensure all staff are aware of new initiatives and enable staff to communicate and share information more effectively.

Quality indicator 3 - Impact on staff

Summary

Evaluation – Adequate

The staff survey we sent out prior to inspection showed that the Falkirk Partnership staff were well motivated, supported by their managers, felt valued and enjoyed their work. These positive attitudes were also reflected to us when we met staff during the inspection.

However, although there was evidence of positive attitudes in the staff groups, we met some staff who advised us that they were working to capacity and that they were unable to carry out early intervention work as a consequence and this was impacting on staff morale.

Pressures in some front line services were being compounded by sickness absence but the Partnership were putting positive measures in place to address the issues arising.

The Partnership acknowledged it had redistributed it's resources to support new initiatives it had developed but was proactively recruiting back in to areas where pressure was high on staff groups like district nurses.

Health and social work service case records we read, staff survey results and meetings with staff all reflected positive levels of communication between agencies. However, the communication of policy and strategic developments needed to be improved.

We concluded that there was good access to training and development opportunities but some staff we spoke to told us that because they were working to capacity it was difficult to make time to attend.

In this chapter we considered if staff were motivated and committed to delivering high quality services. We also considered if they were well supported, managed and provided with the capacity to undertake their work well. We comment on whether staff felt there was good joint working, understood organisational priorities, had good opportunities for organisational development and contributed to change management.

3.1 Staff motivation and support

Motivation

We considered a range of evidence, including the Falkirk Partnership's training plans and the staff survey we conducted as part of the inspection. We were advised that a social work services community care survey had been undertaken recently but it was too early to obtain results. We found no other evidence of any staff surveys conducted by the local authority. However, we were provided with a highlight report for NHS Forth Valley from NHS Scotland Staff Survey 2013[9]. This survey was not exclusive to staff working in services for older people.

We met with approximately 242 health and social work services staff over the duration of the joint inspection. Just over 1,300 health and social services staff were asked to complete our online survey with three hundred and fourteen (314) staff responding. This broke down to:

- 65% from Falkirk Council
- 34% from NHS Forth Valley
- 1% employed in 'other' sectors, such as GP practices.

This represented a figure of approximately 23% of the total older people workforce in both the NHS and council which is in keeping with the figures of other inspections we have undertaken.

Staff in health and social work services who responded to our staff survey indicated a positive level of motivation. Results of our survey showed that:

- 87% of staff who responded agreed/strongly agreed that they enjoyed their work
- 75% of staff who responded agreed/strongly agreed that they were well supported in situations where they may face personal risk
- 66% of staff who responded agreed/strongly agreed that they felt valued by their managers (26% disagreeing).

We found similar results in the focus groups we held with health and social work services staff we met during the inspection.

Almost half (47%) of staff who responded, disagreed that there was sufficient capacity within their team to carry out preventative work, while just over a third of respondents, (36%) agreed. The majority of staff agreed that their workload was managed to enable them to deliver effective outcomes to meet individual needs.

Only 38% of staff who responded agreed that changes which affected services were managed well, with 50% disagreeing, and 12% saying they didn't know. Only half of

9 NHSScotland Staff Survey 2013, highlights report for Forth Valley. Report prepared by Information Services Division, NHS National Services Scotland. November 2013.

respondents agreed that senior managers communicated well with frontline staff. Staff from both health and social work services advised there had been some changes at service manager level which may have impacted on the level of feedback to frontline staff. They said they had not been provided with any real information or briefings on plans for integration. Staff also said that generally they received little information or communication about policy and strategy developments that affected them. Senior managers in health and social work services were at an early stage of planning joint information sessions for staff about integration. We saw the timeline for this outlined in the draft health and social care integration scheme.

We met with a number of frontline social work staff, including home care staff. Generally they said they enjoyed their jobs and were motivated to do the best they could. However, they said they were dealing with considerable workload pressures, and had little opportunity to be involved in anything but reactive and crisis work. This was not helped by having to cover for staff sickness and compromised their ability to cope with capacity issues. Staff did not appear to think that the re-organisation of the local home care social work teams had been successful; particularly the recently established home care coordinator role which they felt had not helped make the service any more efficient.

Some frontline health staff we met reported that morale was low. They said they, "loved their job and were committed to their patients but the pressure of the workload was extremely difficult".

District nurses advised that team numbers had been reduced a number of years ago but that demand on the service had increased. This they said had raised the pressure on them. They said they were at crisis point and felt colleagues on the frontline in social work were at the same stage. They were concerned they were unable to properly monitor the health needs of older people as a result. They also said night nurses were undertaking aspects of social care duties to maintain older people at home.

At the time of inspection, the Partnership was recruiting to eight new permanent district nurse posts in response to an awareness of increasing workload pressures. This was a positive step towards dealing with the challenges around that particular service.

Teamwork

Staff we met told us there was good day-to-day communication and working relationships between health and social work services staff. Much of this was informal and staff stressed that they saw these links becoming stronger as social work and health staff would increasingly be working together. For example, of those who responded to the staff survey:

- 72% agreed/strongly agreed that their service worked well with its partners
- 74% of respondents agreed/strongly agreed they felt valued by other practitioners and partners when working as part of multi-disciplinary or joint team

- 80% agreed/strongly agreed that their service worked well with other agencies to keep older people safe and to protect older people, from risk and harm
- 72% agreed/strongly agreed that their service worked well with partners in supporting older people and any legally appointed person to be actively involved in the planning of their care
- 73% of staff who responded agreed/strongly agreed that they worked well together to ensure they were successful in helping older people live as independent a life as possible
- 84% of staff responding agreed/strongly agreed that services did everything possible to keep older people at home and in their local communities.
- 69% of staff responding agreed/strongly agreed that services worked well together to successfully prevent hospital admission, with 21 % disagreeing.

However, some staff told us about concerns they had about access to services and service improvement. This was reflected in the response to our staff survey findings where 37% disagreed that older people are able to access a range of preventative and enabling services when they need them.

Learning and development

Most staff reported that they were able to gain access to appropriate training and development in their respective professions. However some thought that there was less access to training than previously. In our survey, 76% of respondents agreed that they had good opportunities for training and professional development. Some frontline social work staff told us they had generic posts and when required, they received appropriate training to meet the needs of older people in their care. For example, there has been training to assist staff to manage stress and distress, which appeared to be an issue for a number of older people with complex needs and who were receiving services.

NHS Forth Valley staff told us there was lots of training available, but it was often difficult for staff to attend due to operational priorities. They said there was a focus on making sure all mandatory training was completed on time, for example, fire safety awareness, management of aggression and moving and handling. However, we were informed about a district nurse education event where there was over 90% attendance showing that there are more positive examples of voluntary attendance.

Adult support and protection and outcomes focused training were being delivered jointly Some staff thought that more self-directed support training needed to be rolled out as a matter of urgency.

In conclusion, the majority of staff who responded to our survey and who we spoke with during our inspection enjoyed their work. There was good evidence from staff that they worked well with partners and that communication between teams was good. Although some front line district nurses stated morale was low, the evidence from our inspection

does not suggest this is widespread across the partnership.

However, staff were less positive about the impact they were having in the delivery of preventative services and felt that more could be done to prevent older people being admitted to hospital.

Staff had good access to training and in Adult Support and Protection this was delivered jointly to health and social care staff. Staff told us that they needed more training in self-directed support.

We would encourage the Falkirk Partnership to focus on how they enable staff to focus on prevention, particularly on prevention of hospital admission. Providing staff training in self-directed support would support the Partnership to increase awareness and in the implementation of the self-directed support options.

Quality indicator 4 – Impact on the community

Summary

Evaluation - Good

The Falkirk Partnership had separate communication and engagement strategies that were underpinning good work in this area of practice. The approach was impacting positively and third sector lead officers we met said they were feeling more involved in planning and delivering services than they had previously. The Joint Strategic Commissioning Plan was a particularly strong example of good public engagement and this was reflected in positive attendance and participation at locality events.

Other initiatives like the Stakeholder Engagement Project had been initiated and were being well supported to scale up across Falkirk and strengthen community capacity building principles.

There was also evidence of good involvement and co-production with the third sector linked to commissioning exercises such as the Public Social Partnership and Partnership Innovation Fund initiatives. These were providing the third sector with opportunities to play a key role in new service developments.

We found that both the Stakeholder Engagement Project and the Public Partnership Forums were making excellent use of public partners and volunteers to support initiatives the Partnership was involved with.

However, despite some good initiatives the staff survey results reflected that less than half of staff agreed that the Partnership recognised and engaged well with diverse communities. This highlights a need for the Partnership to do more work about keeping staff updated on the positive work they are undertaking.

In this section we looked at how the Falkirk Partnership worked to promote positive community capacity and engagement. We looked at evidence that the characteristics of the local communities were understood and that there was evidence of community partnership.

4.1 Public confidence in community services and community engagement

Engaging with the community

Both Falkirk Council and NHS Forth Valley had independent and current policies in place to engage and communicate with a range of stakeholders involved in health and

social work services. NHS Forth Valley had its Communication Strategy (2009-14)[10]. Although this was a single agency document it had a commitment to partnership work embedded within it. It detailed a variety of tools available to NHS Forth Valley to support communication with its external and internal stakeholders.

Likewise, Falkirk Council had its own Plan for Local Involvement[11] and its Participation and Engagement Strategy[12]. These were framed around the principles of 'we asked, you said, and we did', and the national standards for community engagement, and took account of equality and diversity issues. They were supported by a communication and engagement toolkit.

It was clear from our meetings with senior health and social work managers, as well as third sector representatives, that they recognised the need to develop community capacity. They placed importance on the role that local communities and community organisations could play in providing support to older people.

We met representatives from the third sector who said that they felt included in the planning, commissioning and implementation of services as a result of their involvement in the development of the joint strategic commissioning strategy.

Some of the Falkirk Partnership's other measures to increase involvement included:

- the Chief Executive of CVS Falkirk and District (third sector interface organisation) was a member of the Joint Management Group and played an integral role in representing this sector at an executive level
- an independent sector review officer being recruited from Scottish Care to represent this sector at the Reshaping Care for Older People Group
- the introduction of independent sector partnership meetings
- implementing a public social partnership approach
- the Stakeholder Engagement Project work
- the Joint Strategic Commissioning Plan work where, out of 140 stakeholders, 19% were from the independent sector and 34% from the third sector.

A good example of how the Partnership was engaging and working with the local community, and third and independent sector partners was demonstrated in their approach to developing the joint Strategic Commissioning Plan for older people. The consultation and engagement plan was central to this work.

The Partnership's Joint Strategic Commissioning Plan was informed by a wide scale review of care and support that included CVS Falkirk and District and Scottish Care (independent provider representative organisation), community groups and private sector providers. The purpose was to gather information about the priorities and how services could improve over the three-year period of the Joint Strategic Commissioning Plan.

10 NHS Forth Valley Communication Strategy 2009-2014
11 Falkirk Council Have Your Say: A Plan for Local Involvement 2011-2014
12 Social Work Service Participation and Engagement Strategy 2012-2015. We Asked, You Said, We Did.

As part of the Joint Strategic Commissioning Plan consultation between March and May 2013 the Partnership organised two large events and five smaller locality based discussion groups across the Falkirk area. Approximately 170 people took part in these events. The Partnership gathered views through online and paper-based questionnaires and presented information to various forums across the Falkirk area, for example the Community Care and Health Forum. Using these approaches allowed the Partnership to make good use of events at which the public were consulted about services and their future design.

Although we found evidence of good community engagement , when we asked about community involvement in our staff survey, only 41% of those who responded agreed the service recognised, and consulted with, diverse local communities about levels, range, quality and effectiveness of services. Similarly only 34% of respondents agreed there were joint strategies to promote and expand community involvement and change.

The Falkirk Partnership should find more effective ways of communicating these developments with the workforce.

Community initiatives – the development of community supports

Health and social work services worked together to develop new models of service delivery. For example, the Stakeholder Engagement and Co-Production Project which was supported by the change fund and facilitated by a corporate policy officer and a stakeholder engagement officer. The steering group included seven volunteers. A wider network of key contacts had also been established, including local ministers, teachers, community councilors, community group leaders and a care home manager.

The model had four key elements.

- Community profiling: comprised of statistical data collection and analysis.
- Stakeholder analysis: identification of key stakeholders.
- Action research: reflective process to bring about change comprising of research.
- Theory of change: a logic model or process map of activities and outcomes that need to be fulfilled to reach a long term goal.

Over 80 members of the local community were engaged in the Stakeholder and Co-production Project during the first year. Participants took part in focus groups and solution circles, receiving feedback on the progress of the project. Thirty two participants discussed NHS Forth Valley issues and came up with potential solutions to identified problems. Participants had also joined up with other council and partner engagement activities such as the Joint Strategic Commissioning Plan consultation and self directed support events.

The second year of the project was spread more widely throughout the Falkirk Council area with clear outcomes. These outcomes built upon the findings from the first year of the pilot. There was evidence of good progress, such as:

- joint work with the MacMillan Charity to set up coffee shop drop-in pilot sessions - further work was then undertaken with GP practices to maximise their awareness of these pilot sessions and encourage effective signposting for patients who may have benefited from such support
- the co-delivery of a heritage project with Friends of Kinneil Falkirk Community Trust
- sheltered accommodation services - we saw evidence of the Stakeholder Engagement and Co-Production Project's involvement in many other locality projects.

The Falkirk Partnership and CVS Falkirk and District worked jointly to develop a Public Social Partnership approach. This is a strategic partnership arrangement through which the Falkirk Partnership worked with the third sector to share responsibility for designing and commissioning services around the needs of older people. We noted that learning from earlier models piloted in children's services was applied to this approach.

The Public Social Partnership had three stages.

- Third sector organisations work with public sector purchasers to set a service specification and design a service together.
- A prototype service is put in place which allows testing of the agreed model.
- The service is further developed to maximise community benefit before being competitively tendered.

We saw evidence that this positive approach had been implemented to inform and shape the next framework agreement for care at home and housing support services. The council was taking forward two tenders to replace the single framework with two separate frameworks - one for homecare and the other for care at home and housing support.

The presentations that were delivered at these events clearly highlighted the need for change and the process all stakeholders were being invited to engage in. This really helped to set the scene and lay the foundations for joint working in this area.

Through the Reshaping Care for Older People agenda the Falkirk Partnership also established a Partnership Innovation Fund in 2011 with a substantial annual investment of £317,500 for three years. The purpose of this fund was to support third sector organisations, either working individually or in partnership with others, to seek innovation in the delivery of services for older people within the locality. This was to include a focus on shifting care towards anticipatory care, prevention and supporting older people to enjoy full and positive lives in their own homes or in homely settings.

The fund was managed jointly by CVS Falkirk and District and demonstrated good partnership working. A panel that had representation from Falkirk Council, NHS Forth Valley, CVS Falkirk and District and a Community Interest Group considered and made a collective decision on all applications.

A key condition on application to the fund was that any award would be limited to a period of 12 months. Whilst initiated in good faith, we read that the complexity of individual project disinvestment and the timescales over which it might effectively take place were underestimated. The uncertainty over the scope for and routes into health and social work services mainstream budget funding, and the impact on planning for continuation of service delivery, had caused some concern for some third and independent organisations. This was reflected in focus groups we had with providers who said this was leading to year-to-year service planning and delivery making sustainability challenging.

Engaging the community – community involvement and impact

NHS Forth Valley had a very well attended and positive Public Partnership Forum. We noted that Falkirk Council did have representation at some of these meetings which helped to strengthen the Falkirk Partnership's position. We saw that forums had been planned up until November 2014 with agreed involvement topics set out on agendas for the public. These agendas were all relevant to person centered planning, involvement and designed to keep communities, including older people, well informed about current topics impacting on the Partnership's and delivery of services. Joint presentations were delivered and the minutes of the meetings were well designed to ensure people who attended could understand the content and feedback captured. Some very encouraging feedback from those who attended the meetings was reflected in these minutes. From the minutes of the meetings it was evident that there were a high number of attendees, reflecting good participation.

The Falkirk Partnership had six representatives on the Public Partnership Forum Co-ordinating Group. NHS Forth Valley had allocated three places for public partner representatives and three to the voluntary sector including CVC Falkirk, British Red Cross and the Princess Royal Carer's Centre.

Volunteers have worked with NHS Forth Valley on various projects such as the Design and Project Board for the new Forth Valley Royal Hospital. NHS Forth Valley was awarded 'Investing in Volunteers Quality Assessment Standard' in 2010 and successfully renewed this Award in 2014 for a further four years' duration.

To conclude The Falkirk Partnership had up-to-date communication and engagement strategies in place. These were being applied effectively. Third and independent sector leads told us they felt more involved now than they had been in the past and they were represented on a number of key strategic meetings. The joint strategic commissioning

plan was a particularly strong example of good communication and engagement and this was reflected in the Scottish Government Joint Improvement Team's feedback to senior managers in the Partnership. There was good innovation around the use of the Public Social Partnership and Partnership Innovation Fund. The Stakeholder Engagement Project was strengthening community capacity building and was being scaled up well across other Falkirk localities. Both this project and others like the Public Partnership Forum were making good use of volunteer services.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation - Adequate

The Contact Centre provided a single first point of contact into the social work service for people in the community and other agencies.

However, Partnership staff, older people and carers said that they often had difficulties accessing social work services.

The Partnership established a number of services which had an early intervention and preventative focus such as the homecare crisis team, the Frailty Clinic and anticipatory care plan team.

Staff demonstrated a good understanding of the need to focus on older people's wishes and aspirations and not just on their needs. However, many of the approaches to assessment and care planning were being carried out on a single agency basis. The quality of assessments and care plans produced by the Partnership was variable. It was not always evident from the health and social work services records we read how agencies had worked together and jointly contributed to assessments. There was also a need for the Partnership to improve the frequency of which the care plans for older people were reviewed.

More positively, the needs of older people requiring palliative care were well met.

Our findings from the health and social work services records for risk assessment and risk management indicated the need for significant improvement in these areas, including in the production of chronologies that were fit for purpose.

Older people and their families we met said that they felt staff made good efforts to involve them in decisions about their care, treatment and support. The self-directed support team and Skills Development Scotland Forth Valley were working hard to increase the awareness and use of self-directed support, but faced challenges in terms of their capacity to handle the volume of work.

This chapter focuses on the extent to which all staff recognised that an individual is in need of care and support. It considers how well information was shared between partners and was used to make decisions. It looks at the timeliness and effectiveness of the help and support provided in preventing difficulties arising or increasing including anticipatory care planning, reablement, rehabilitation and self-management.

5.1 Access to support

In its position statement submitted to us at the initial stage of inspection, the Falkirk Partnership said that the social work contact centre had significantly improved access

to social work services. It provided a single point of telephone contact for members of the public and referring agencies. It said that its performance in terms of answering and dealing with calls was good with an 85% response rate to public inquiries. It said the number of complaints from members of the public about difficulty in contacting the social work service had dropped significantly with only four such complaints being made the previous year. However, the Partnership were aware that there could be problems when the Contact Centre was passing referrals onto the locality teams.

The Contact Centre passed any calls which it was not able to fully conclude or resolve to the duty team in the relevant locality office. Whilst arrangements varied slightly across the teams, the general approach was for there to be social work staff on duty each day on a rota basis. It was clear from numerous comments we received from older people, carers, social work staff and staff from other agencies that the locality teams faced difficulties in always being able to respond to duty calls.

Comments we heard included:

- staff from other agencies wanting to make a referral or to speak to social worker being advised that the duty workers were "currently unable to take calls"
- messages having to be left which went unanswered for several days
- carers struggling to get through to a duty worker on behalf the older person they cared for.

Some district nurses said they had to be very insistent when phoning in relation to an urgent matter. However, they acknowledged that their own work pattern could prove problematic in terms of duty workers trying to call them back when they were out visiting patients themselves.

Recommendation for improvement 3

The social work service should improve its arrangements for how the public and other agencies access the service through the Contact Centre to the community care team duty system. It should also review the capacity of the locality teams to make sure it can efficiently respond to all the initial enquiries.

The Partnership developed a number of procedures and care pathways to ensure the best outcomes and experiences for older people. A significant focus of these procedures and pathways was that of early intervention and prevention.

An example of this was the intermediate care service aimed at maximising the older person's level of independence at home provided at Tygetshaugh Court extra-care housing service. This was a positive development, however, staff told us when we visited Tygetshaugh that it was not uncommon for older people to stay beyond the expected 'up to six weeks period' in order to achieve a positive return home. The Partnership should

monitor this as extended stays could impact on intermediate beds being available to both prevent hospital admission and facilitate hospital discharge.

A review undertaken with support from the Scottish Government Joint Improvement Team had identified that the Partnership did not yet have the full range of preventative services in place. To address this, the Partnership had decided to concentrate on intermediate care and at the time of our inspection a further six intermediate care beds were about to come on stream at Summerford Care Home.

Home care can be a key service in both preventing hospital admission and in facilitating hospital discharge. In common with many areas in Scotland, there was considerable pressure on the home care service in meeting demand. Staff told us of examples, especially recently of difficulties in providing new home care packages. Falkirk Council (unlike a number of councils) provided a crisis home care service which was able to provide an overnight service for up to ten days. This was a valued service in preventing admission to hospital or a care home. However, it was operating at full capacity and was not always able to respond to new referrals. Emergency residential respite provision was in a similar position.

The mobile emergency care service was piloting an extended service from 10pm until 7am to take forward a redesign of overnight provision to include proactive personal care services to help prevent admissions to hospital and support early discharges.. NHS Forth Valley also provides a night nursing service. There was a positive joint protocol agreed between the managers of these two services enabling them to communicate out of hours, making sure effective decisions were being made about the older person's care needs and determining which service was best placed to respond.

In its position statement submitted prior to inspection the Falkirk Partnership stressed it continued to provide services to those who fell within all four categories of need and could support this with performance data. The social work service operated the standard four-level eligibility criteria, based on:

- critical
- substantial
- moderate
- low needs.

However, this contrasted with comments we heard from some staff who said that, in the main, services were only provided to older people with critical and substantial needs. The council was aware that the criteria needed to be reviewed to take account of self–directed support and this work was under way.

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

In the sample of the social work and health services files we reviewed, we saw assessments in both the social work and the health records. In 94% of the 99 case files we read the primary assessment was in the social work file. The rest were in health files. Our findings on assessments were mainly positive in that:

- 98% of social work and health service files we read contained an assessment of need and the majority of these were up to date
- 94% of the assessments took account of the older person's needs.

The Partnership had invested in training to help promote a person-centered and outcomes approach. This had included the Talking Points[13] approach and we could see the evidence of this in assessments we read, especially those we evaluated as being good or better. We evaluated half of the assessments as good or very good. However, the fact that half of the assessments were evaluated as no better than adequate (including 11% evaluated as weak or unsatisfactory) indicated there was significant room for improvement in the Partnership's ability to perform consistently well in identifying older people's needs, wishes and aspirations.

Sharing information to assist the assessment process was not helped by limitations in information being able to be accessed and shared electronically between (and in some instances across) health and social work services. The Partnership acknowledged this in the position statement submitted to us prior to inspection. It also acknowledged that the Single Shareable Assessments completed by health staff largely acted as referral documents to the social work service.

Health and social work staff we met also confirmed this. However, they were clear that they did speak to each other when completing assessments. This was either by telephone or on a face to face basis, especially where staff were co-located. In our staff survey there were almost equal levels of agreement and disagreement in responses to the question whether information systems support frontline staff to communicate effectively with partners. Staff also said that if a health or social work colleague asked for a copy of their assessment they would share a paper copy with them. However, when we raised this in our focus groups, this practice did not appear to be routine.

As indicated in chapter 1, We looked at carer assessments in the health and social work files we read.. Carers have a legal right to have their own needs assessed if they so wish. We were concerned that in 47% of applicable social work and health services files we read there was no evidence that the carers had been offered an assessment. Social work staff and managers questioned this finding as they said SWIS (Social Work Information System) included a mandatory field which staff had to complete to confirm that a carers assessment had been offered. However, more positively, carer assessments had been

13 Talking points: a widely used organisational personal outcomes approach which is evidence based.

completed for all those carers who had been offered and accepted an assessment. There was also evidence that in most instances the assessments had contributed to the carer feeling better supported in their caring role. We concluded that the Partnership should make sure that carer assessments are being offered where applicable and that this is robustly recorded on electronic systems.

Recommendation for Improvement 4

The Falkirk Partnership should improve on the number of carers assessments being undertaken and make sure that these along with support plans are recorded in the relevant case files.

Our social work and health service case file reading results in respect of care planning was mixed. Virtually all (95%) of the 99 files we read contained a care plan, although the primary plans, almost all of which were social work care and support plans were not found to be SMART (included realistic and measureable targets, deadlines for reviewing progress and measuring what staff set out to do) in just over half (56%) of the plans. Only a quarter of the care plans were comprehensive. This was in part a reflection of the fact that most of the care plans we saw were either single agency or single discipline. As with assessments, care plans were not routinely shared. This meant that information about the range of an older person's health and social care needs, and how these would be met, was often not recorded and held independently in a single agency case file..

It was recognised within the Partnership that their ultimate aim was to provide end-of-life care with dignity and respect regarding the patient's preferred place of care. With this in mind, an important exception to the paragraph above was DNACPR plans (Do Not Attempt Cardiopulmonary Resuscitation). Action had been taken to ensure that these were shared and recorded on the GPs' EMIS system, the Council's call centre IT system and were consistently recorded in care homes. Some similar actions had been undertaken with anticipatory care plans, but the extent to which these were widely shared was variable. For example, as well as some communication issues we outlined with social work services in section 2.2, nursing staff at Forth Valley Royal Hospital and pharmacy staff we met both said they had no access to anticipatory care plans.

We noted the commitment to high quality palliative and end-of-life care planning in Falkirk. We met with a group of staff who were working closely in partnership with the Marie Curie and the Macmillan Nursing service. The Partnership was using an interim care planning tool, having stopped using the Liverpool Care Pathway[14] in line with national policy, and were looking at ways of improving overall palliative care planning. The Partnership was focusing on improving service delivery to the place where the older person chose to die. In addition, it was seeking to learn from a review which looked at the circumstances of people who had died at home during 2013.

14 Liverpool Care Pathway: A UK wide care pathway covering palliative care options for patients in the last days or hours of life.

We saw that the Partnership had taken action to receive feedback from the families of older people who had received a palliative care service. The following quote was typical of the positive feedback provided:

"I couldn't fault the service; we received both emotional and practical support in an extremely kind manner. The support given helped my family cope with the last few days of my father's life. All I can say is thank you very much".

Despite the limitations in the sharing of information electronically between health and social work staff, it was clear from our various meetings with staff that in the main they worked well together and shared information at a local and operation level. This was highlighted by staff:

- undertaking joint visits to older people
- coming together to respond to crisis situations
- the attendance of social workers at 'gold standard' meetings held in GP practices to discuss older people with complex needs.

In the files we read, the support provided completely or mostly met the needs of the older person in 87% of the cases.

Our social work and health service file reading also showed that, in 82% of the files, there was evidence that the health and social care support of the older people was subject to regular review. However, evidence from our inspection fieldwork was more mixed. Whilst reviews held by the mobile emergency care service and the Falkirk Council's care homes for older people were taking place as scheduled, there was a backlog in a significant number of reviews within the locality teams and the home care service. Actions had been taken by the Partnership to address this, including the appointment of specialist reviewing officers and freeing up some staff time so that they could undertake a cluster of reviews. However, these actions had been unable to fully address the problem of outstanding reviews. Most review activity was still being done on a single agency basis. We concluded that the Partnership needed to take action to ensure that the needs and care plans of older people are reviewed in line with procedures and jointly where appropriate.

Frontline social work services staff said that the completion of reviews and assessments was not helped by the SWIS system which they described as being cumbersome and time consuming. During our review of social work and health service records we noted that review reports were essentially add-ons and updates to the initial assessment. Not only was this cumbersome for staff, it also made it difficult to easily obtain an up-to-date picture of an older person's needs.

As part of health and social care integration, the Partnership was considering how it could address some of the challenges surrounding its ICT systems.

Recommendation for Improvement 5

The Falkirk Partnership should take action to make sure their assessment, care planning and review processes are improved to ensure a better shared approach and understanding of older person's needs and wishes.

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

Well structured governance arrangements were in place for adult support and protection. Many of these operated on a Forth Valley wide basis where there was a history of partnership working around adult protection. These were supported locally by the Falkirk adult support and protection strategy and planning group, chaired by the Falkirk Council Chief Executive.

There was also a comprehensive set of Forth Valley adult support and protection procedures in place. In our staff survey, most staff (81%) either strongly agreed or agreed that there were clear guidance and processes in place to support them in assessing and managing risk.

In our discussions with the independent convener and members of Forth Valley Adult Support and Protection Committee it was confirmed that they were receiving good performance data and analysing their priorities accordingly. Strategic planning links were beginning to form with other service areas such as mental health around issues like distress and self harm.

Our review of health and social work services records examined risk assessment and risk management practice. The findings of this were variable and in some aspects concerning. We found that operational practice was not always consistent with the Partnership's own procedures and best practice. For example, in the 11 files of older people with adult protection type risks (current or potential issues regarding adult protection or protection of the public) we found that:

- four of the 11 social work and health service files, which should have included a risk assessment, did not have one
- of the seven social work and health files which included a risk assessment, we evaluated three of these assessments as weak
- five of the 11 social work and health files did not include a risk management plan.

Some caution needs to be exercised with the findings given the small sample size.

Forth Valley adult support and protection committee's self-evaluation activity included an annual multi-agency case audit. Within Falkirk, social work team managers undertook a review of a number of adult protection cases as part of their staff supervisory

arrangements. A reporting arrangement was in place to aggregate the findings of the reviews. These were then considered at a performance management meeting chaired by the head of community care. We recognised this was a positive approach and were confident this work will drive improvements in those areas of practice highlighted by this inspection.

The completion of risk assessments and risk management plans are essential parts of adult protection practice. We concluded that the Partnership needed to ensure that these are completed when appropriate.

We also heard from the chair of the adult support and protection committee that a safeguard had been built into the screening arrangements for adult protection referrals. This meant that a multi-agency initial referral discussion took place whenever a third referral was received for the same older person. This was a positive quality assurance mechanism.

However, there was a much larger sample of social work and health service files (73) with non-protection type risks (such as a frail older person at risk of falling and sustaining an injury). The findings for these files were better, but still indicated room for improvement in that:

- whilst 61 of these social work and health files included a risk assessment, 12 did not
- while we evaluated 20 completed risk assessments as good or better, 41 were evaluated as adequate or worse
- while 48 of the social work and health service files which should have had a risk management plan did have one, 38 did not.

One factor which contributed to some of the poorer findings was the significant extent to which much of the risk assessment and risk management activity was being done on a single agency basis. We found that risk assessments had not been informed by the views of multi agency partners in four out of the seven protection type risk assessments, and in 38 of the 61 non-protection type risk assessments. Whilst there were exceptions, and in particular in the higher risk cases, health and social work staff we met during the inspection also reflected this view. A common observation from staff was that risk assessments were done separately and that these, and any subsequent updates, were not routinely shared.

In the staff survey, most staff (75%) agreed that there were a range of risk assessment tools which they could use. At focus groups staff confirmed the existence of risk assessment tools, but their comments about the quality of these were more mixed. Staff in the older people's mental health service used a joint risk assessment form, but they were an exception. Home care providers said each agency has to carry out a risk assessment and had a separate plan in place. The multi-factorial risk assessments completed by the mobile emergency care service were shared with the ReACH service, but not with other health or social work services.

Staff in social work locality teams had an important role in completing risk assessments. Staff and team managers said that the SWIS assessment template included a section for risk assessment, but as this had no sub-headings or guidance, it resulted in variable quality in its completion. There was a specific risk assessment tool for adult support and protection which the staff said was good. However, they added that this was only available in paper format. As such, it was not readily available to staff in other agencies or in full, to the emergency duty team.

Chronologies are an important tool in bringing together information to inform and refresh risk assessment. We saw a significant number of social work case file chronologies and we evaluated 52% of these as being an acceptable standard. Only 18% of the case files that should have contained a chronology did not. Also, nearly half of the chronologies were not of an acceptable standard. Often one of the reasons for this was that the chronologies were a list of health and/or social work activities which lacked reference to the older person's significant key life events. The fact that these were often automatically generated by the IT system did not help in the good quality chronologies being produced by staff. The director of social work said the social work service had done some improvement work on chronologies and was aware that it needed to do more.

At the time of the inspection, there were some plans to extend risk assessment practice. For example, the falls team was working with district nurses so they would identify older people at risk of falling. This would trigger a detailed falls risk assessment and management plan. The team also planned to take action to extend information sharing across agencies on older people at risk of falls.

The mobile emergency care service was in discussion with health colleagues with a view to a copy of their risk assessments being placed on the MIDIS[15] (Multi - Disciplinary Information System) system.

The self-directed support team had included a specific section on adult protection risk in relation to self-directed support in its training programme.

Recommendation for Improvement 6

The Falkirk Partnership should ensure that all relevant case records contain chronologies that are fit for purpose and documented as well as jointly developed risk assessments and risk management plans so that the older person's needs are clearly defined and protected.

15 MiDIS: Multi-Disciplinary Information System mainly used by community nursing staff.

5.4 Involvement of individuals and carers in directing their own support

From our review of health and social work services records, we found that services had involved older people and their carers in discussions about the care, treatment and supports they needed were mainly very positive. This was evidenced by:

- the views of older people or their representatives being actively sought and taken into account at the assessment, care plan and review stages in 93%, 86% and 93% of social work and health service files respectively
- support for the older person to contribute to their care plan in 91% of the social work and health service files
- in 84% of applicable files of any potential barriers to the older person being able to contribute their views being addressed.

Most of the older people we met during the inspection reflected these findings and said they felt involved in discussions about their support needs and how these would be met. Family members also endorsed this view and we saw examples of how services had used social media and e-mail to engage with family members who lived at a distance or overseas.

Staff also highlighted "involvement" as an area where they considered practice was good and well established in Falkirk. In our survey, the majority of staff (73%) agreed or strongly agreed that their service communicated well with older people, although a small proportion (19%) disagreed with this. Forth Valley Royal Hospital staff said that open visiting arrangements had helped family involvement. We heard some particularly positive comments about how the staff in the Joint Dementia Initiative were able to invest time and effort into their engagement with older people with dementia and their families.

We met with the self-directed support team and learned about the work they were doing to support the implementation of self-directed support. This included the resource materials they had prepared for both the public and for staff. They were also working in close partnership with all the necessary stakeholders. Both had a clear commitment to spending a considerable amount of time with people considering self directed support options and, especially Option 1, the provision of a direct payment. This was to ensure that people were clear of what they were taking on. In the 12 social work and health service files we read where self directed support was in place, we evaluated this as being effective in nine of them. However, the self-directed support team was small and they acknowledged that this impacted on their role and the extent to which they alone could directly increase awareness of self- directed support. We concluded this may account for the carers views we received outlined in Chapter 2.

Staff were also positive, although slightly less so, about how they engaged with carers. Sixty-six per cent said that the views of carers were fully taken into account. As indicated in section 5.2, our file reading indicated scope for some improvement in this area,

in relation to offering carer assessments. Also, whilst 53% of carers had been offered information about aids and equipment for the person they cared for, 19% had not.

From our review of health and social work services records we saw that where advocacy was provided this had helped the older person to articulate their views (nine of the eleven older people concerned). However, based on our review there was scope to improve staff awareness on the role of advocacy. In 12 of the social work and health files we read, the older person had not been offered advocacy where this would have been appropriate. As with many other areas in Scotland, the provision of advocacy in Falkirk was targeted on statutory work (for example mental health detentions) rather than broader welfare issues. Advocacy staff we spoke to said they felt there was variable use of their service across the Falkirk area by both health and social work services and felt more could have been done to strengthen the role they undertake in work with older people who require their help.

For some older people there can be issues in relation to their legal capacity to make decisions. Of the social work and health service files we read, 20 older people lacked capacity and it was positive that 14 of them had made decisions about granting power of attorney. However, of the 79 older people who still had capacity, concerns about the extent of their decision making abilities existed in 35 cases. Only 13 of these 35 older people had taken proactive action and granted power of attorney. This suggested that staff in their dealings with older people should encourage them to give early thought to decision making arrangements should they lose capacity in future.

Mental health officers have an important contribution to make in relation to some situations of older people who lack capacity. They can also provide advice in some complex adult protection cases where mental health concerns have been identified. We heard that the mental health officer service was under considerable pressure in Falkirk due to recruitment and retention issues. This restricted the contribution which mental health officers could make in these areas. Staff we met told us that they were involved in discussions with the senior managers in social work services to rectify this. This progress will need to be monitored in light of the critical role this staff group plays for people who cannot make decisions for themselves.

In terms of access to services we concluded that there were some difficulties with the management of inquiries going from the contact centre to local social work duty teams. A number of older people, carers and staff we met expressed this view. Additionally, access to intermediate care had been identified by the Scottish Government Joint Improvement Team prior to the inspection and this was being addressed. There were some good examples of accessible services, including the care-at-home 24/7 Team providing crisis care at night, the mobile emergency care service and night nursing service.

In terms of assessment, care plans and review processes there were examples of some good work as well as less positive areas of practice. While good communication amongst

agencies was evident, the sharing of information to enhance key processes was not always evident.

Finally, we concluded that the Partnership ensured that older people were involved in the decisions affecting how support was being provided. However, for some older people who might not be able to express clear views, the involvement of advocacy services could have been made earlier.

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

Summary

Evaluation - Adequate

The Falkirk Partnership had recently restructured its operational and strategic planning arrangements for health and social care integration. However, the Partnership needed to develop a more integrated and whole system's approach to performance reporting, quality assurance and self evaluation to ensure that older people in Falkirk received the best joint services possible.

There was an up-to-date joint commissioning plan for older people in place. Through one of the workstreams supporting health and social care integration, work was progressing on the development of a financial framework that would set out the process by which the joint planning, resourcing, reporting and monitoring would be carried out. Mutual relationships between the workstreams needed to be strengthened so that they came together in a more planned and coherent way.

The Partnership's Community Equipment Provision Review had shown little evidence of progress since 2011.

The Partnership demonstrated a strong and effective commitment to Involving older people who use services, carers and stakeholders in developing and evaluating services.

We noted some innovative commissioning programmes such as the Strategic Services Planning Review.

This chapter comments on the organisational and strategic management across the partnership and the extent to which the strategies and plans reflected the vision of the service. It also considers how purposefully the Partnership involved individuals and carers in service development. It also covers quality of services and how quality management drives improvement.

6.1 Operational and strategic planning arrangements

The Falkirk Partnership position statement stated that they were faced with key strategic challenges. In order to address these the Partnership had a well established governance structure in place. The Community Planning Partnership had a Leadership Board which was the key high level strategic decision making body for the Partnership. Below this group in the structure was the Community Health Partnership's Partnership Board which included both elected members and NHS Forth Valley Board members.

The Partnership's Joint Management Group reported directly to the Partnership Board. The Joint Management Group's responsibilities were to plan, manage, review and monitor the delivery of all, services, plans and strategies for older people across the Partnership area. It was co-chaired by social work services and health. In 2013, this group took the proactive step of undertaking a Planning and Delivery Structures Review. We read that the previous structure had been in place for some time but the Partnership had identified it lacked consistency in communication and connectivity, transparency and accountability.

For this reason, The Joint Management Group recommended that there should be two new older people specific groups reporting to it. Firstly, the Older People Implementation Group, which was an existing group that was re-aligned to oversee the delivery of priorities detailed in the Joint Strategic Commissioning Plan.

Secondly, the Reshaping Care for Older People (RCOP) Planning, Commissioning and Monitoring Group which supported the subsequent service developments such as workforce development and performance management. This group had outcome-based reporting mechanisms in place and had effectively overseen the 36 projects funded through Reshaping Care for Older People's Change Fund. (The Change Fund was money that was made available by the Scottish Government to partnerships across Scotland from the 2011/12 financial year).The Reshaping Care for Older People Programme was the Partnership's strategic policy driver for older people's services in Falkirk.

The Partnership's Change Fund Monitoring Sub-Group had carried out reviews of all the 36 change fund projects in June 2014. Reports to the Joint Management Group indicated that many of Falkirk Change Fund Projects were meeting or exceeding their target outcomes.

The Partnership had also implemented a Strategic Joint Commissioning Plan for older people focused around the Reshaping Care for Older People Strategy. This aimed to improve services for older people by shifting care towards anticipatory care and prevention. This plan took full account of national and local policy and planning, other relevant care group strategic plans and had a jointly agreed financial budget.

However, as the Partnership had not adopted a SMART approach to developing the plan or its supporting position statement, it was unclear how the work would be prioritised, or who was responsible for its delivery.

The Bo'ness Project and locality planning group were also featured in the Joint Strategic Commissioning Plan position statement and there was evidence of some positive developments. However, unlike the 36 change fund projects, we saw no evidence that the outcomes in these areas had been fully evaluated by the Joint Management Group although we did note that this group were being routinely updated on the progress of this project. Furthermore, while the Partnership reported that they had refined their Joint Performance Management Framework we did not see evidence of this either in projects

being scrutinised using this framework, or when we attended the Joint Management Group.

We concluded that, without a delivery plan to support the Joint Strategic Commissioning Plan, or evidence that the joint performance framework was being used effectively, the Joint Management Group, as the strategic planning group, should address this.

Recommendation for Improvement 7

The Joint Management Group, as the strategic planning group, should use the available data to review and report on progress against the outcomes in the Joint Strategic Commissioning Plan. This is important in order to make sure that 'whole system' change and improvement is evidenced, planned and delivered in a sustainable way.

In May 2014, the Partnership agreed that it would adopt the body corporate model for health and social care integration (where the health board and the local authority delegated functions to a joint board headed by a joint chief officer. This triggered joint working on the integration scheme (sets out the key agreements that need to be reached developing the integrated arrangements), including a detailed timeline of significant events aligned to the Scottish Government's requirements, and the progression of work across six key workstreams:

- governance
- finance
- workforce and organisational development
- participation and engagement
- clinical and care governance
- planning and operations.

This work was being co-ordinated across the Forth Valley by the health and social care integration core group made up of senior managers from the Falkirk area.

Work had not yet commenced to develop the health and social care partnership's Joint Strategic Plan that was required to be delivered by health and social care integrated joint boards. The timescale for that is April 2016 and it was envisaged that this would be driven by both the Health and Social Care Integration Joint Chief Officer once appointed, who will be responsible to the Integrated Joint Board. The Joint Strategic Plan would provide an overarching plan for all joint commissioning plans including all details regarding financial budgets and other resources.

The Partnership had agreed which services would be the responsibility of the Integrated Joint Board once established. Staff we spoke to said that the Joint Commissioning Strategy would support integration and the future development of the Joint Strategic Plan which will include a robust financial framework. The Core Group was overseeing these developments.

In the draft Integration Scheme submitted by the Partnership it was stated that the appointment of the Health and Social Care Integration Joint Chief Officer would not be taken forward until January 2015, with a likely appointment in March the same year. This means the Partnership will face significant challenges in having everything prepared for health and social care integration formally commencing.

We noted that the Partnership had very recently appointed a full-time programme manager to oversee the workstreams and link with the Joint Chief Officer (on appointment) to shape the Joint Strategic Plan. We considered this to be a positive step although it would have been advantageous to the Partnership if this appointment had been made sooner.

Senior managers we met said that the Reshaping Care for Older People agenda had provided very helpful learning opportunities for taking forward health and social care integration. They also said that they acknowledged the challenges of scaling up the new service initiatives that were developing. The Partnership should embed the learning from their work on Reshaping Care for Older People as they progress health and social care integration to improve whole system working across planning, reporting and governance arrangements.

The Partnership was preparing an application for their share of the Integrated Care Fund announced by the Scottish Government in July 2014. This Fund of £100m builds upon the Reshaping Care for Older People's Fund which will come to an end in April 2015. In order to secure the indicative allocations that have been announced for 2015/16, partnerships were required to submit an integrated care plan by 12 December 2014. We noted that the timing of this was challenging for the Partnership as it preceded the completion of the Joint Strategic Delivery Plan. The indicative allocation to the Partnership was £2.88 million.

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

The development of partnership services for older people had a strong emphasis on supporting older people to remain at home. This included developments in both health and social work services including reablement and rehabilitation services. The Partnership said that the Reshaping Care for Older People Strategy and the Change Fund had provided the catalyst for the renewed focus on anticipatory care services. In order to achieve this, Falkirk Partnership's Joint Strategic Commissioning Plan set out clear priorities including:

- preventative and anticipatory care
- proactive care and support at home
- effective care at times of transition
- hospital and care homes

- a framework of systems and supports to facilitate change
- cross-cutting themes.

There has been a long-standing and well embedded partnership culture in the Falkirk area. The Reshaping Care for Older People's Group and the Older People's Implementation Group, both of which were multi-agency, were key to the planning and implementation of joint services.

In Chapter 1 we noted the very positive outcomes that the care home liaison service was delivering in terms of early interventions to avoid admission of older people residing in care homes to psychiatric hospitals. Additionally, in chapter 2 we also considered the positive outcomes of the Extended Psychiatric Nurse Liaison Team and the benefits they were having on the care pathways for older people who presented with cognitive difficulties in acute hospital wards.

The anticipatory care plan team was also beginning to show some positive developments, as was the Frailty Clinic and other services such as ReACH and reablement-at-home. However, staff we spoke to said they did not feel these initiatives were as joined up as they should be.

The mobile emergency care service established a joint initiative in collaboration with the Scottish Ambulance Service. This identified a number of older people who had fallen, who were classified as being uninjured and having no medical issues, but were admitted to hospital. Despite noting that this initiative did not have the impact that was hoped for it led to multi agency developments such as those identified gaining access to a fast-track therapy screening service, mobile emergency care service, telecare, or crisis care input.

Additionally, the mobile emergency care service had a falls management service which, at the point of referral, would link with health colleagues and arrange support, or signpost to community services where appropriate, such as occupational therapists, physiotherapists or GPs.

In November 2010, NHS Forth Valley and the three local authorities enlisted the assistance of the Joint Improvement Team in utilising a self-evaluation tool for a whole system review of community equipment provision across Forth Valley.

A position paper written at the end of 2012 outlined numerous options and recommendations to improve equipment provision. We met staff who said that despite the success of the test-of-change site, access to equipment still varied across Falkirk. The joint equipment store steering group shared a joint vision but staff we spoke to said the test of change site had still to be evaluated, that there were no clear timescales for delivering change and no sense of overall direction or achievement.

Staff and managers we spoke to recognised there were some challenges surrounding the development of these new initiatives and services developing predominantly around

Reshaping Care for Older People. In particular, they highlighted the following.

- How the developments of a number of initiatives had been variable. This meant it could be difficult for staff to know what particular services were available across the partnership area.
- The difficulty faced by the Falkirk Partnership in having the capacity and resources to meet the level of existing and growing demand for its services given the pressures it faced in these areas around supporting hospital discharges
- There was widespread support for the anticipatory care approach being a mainstream part of the homecare service. However, we heard from staff and managers that pressure on the service meant that this work could not always be provided.

These challenges were being addressed through the Joint Management Group. As previously discussed (recommendation 8), the Falkirk Partnership should adopt a whole systems approach to addressing these issues.

6.3 Quality assurance, self evaluation and improvement.

NHS Forth Valley and Falkirk Council both had systems in place which appropriately allowed them individually and jointly to review the performance of their services. The Community Planning Partnership had set out their joint vision for Falkirk in their Single Outcome Agreement[16]. The Falkirk Partnership's performance against the single outcome agreement was reported to the Community Planning Partnership's Leadership Board three times a year and the Partnership Board and joint management group more regularly.

The Partnership's Joint Strategic Commissioning Plan position statement stated they had recently undertaken work to refine their joint performance management framework which is linked to the Single Outcome Agreement. Measures within the framework included:

- national measures
- local pre-established social work services indicators
- housing indicators
- Change Fund project measures
- HEAT indicators
- Talking Points.

In addition, performance measures were included for the third and independent sector, particularly in relation to those activities delivered via the Partnership Innovation Fund.

However, we did not see any evidence of the performance management framework being used, either when we visited the Joint Management Group, or in any of the information we read.

16 Falkirk Community Planning Partnership, Single Outcome Agreement 2013-2015

Examples of joint quality assurance.

Some joint quality assurance measures were in place. We saw positive evidence that the recently introduced strategic groups such as the Reshaping Care for Older People group regularly reviewed the work for which they were responsible. Reports were then sent to the Joint Management Group on progress either with action plans or a review of performance. The Change Fund monitoring sub-group provided the first line of quality assurance for all the 36 reshaping care for older people projects. Detailed reports that were, analytical, outcome focused and framed in financial terms to assist with decisions about investment and disinvestment were evident.

Reporting was focused on performance of specific pathways outlined in the Reshaping Care for Older People programme which in turn were aligned to the Joint [Strategic] Commissioning Plan and Single Outcome Agreement.

Another example of joint quality assurance activity in the Partnership was the delayed discharge steering group meeting. We attended this meeting and observed the Falkirk Partnership present joint performance information and a strategic action plan for taking change management and improvement forward across the whole system through a more comprehensive use of Information Services Division (ISD) data. The Partnership was consulting ISD about this at the time of the inspection to determine how data could be utilised. That proposal will assist the Falkirk Partnership to develop their needs analysis and use the intelligence to inform locality planning around issues relating to delayed discharges.

Examples of single agency quality assurance

A good example of single agency quality assurance work was the social work services application of the REFLECT self-assessment programme (a three-step improvement framework that helped unlock the collective knowledge of people involved towards a common goal of lasting improvement in public services) within a Public Services Improvement Framework for both the care and support at home and residential care services. The residential improvement plan resulting from the self assessment was robust and reflected that a care home audit system had been implemented to address the quality of care issues we highlighted in Chapter 1.

There was also a social work services community care quality assurance and improvement group that was responsible for driving the Continuous Improvement Framework. We noted that they were applying a Community Care Services Quality Assurance and Improvement Framework which had been developed to complement existing frameworks used at either a corporate or social work level.

The community care service management team had oversight of the implementation of the Framework through quarterly meetings and developed an action plan where issues were identified.

The Forth Valley Community Health and Social Care Partnership's Quality Improvement and Risk Group agreed and progressed the priorities for a programme of work across the three community health partnerships linking to service and health improvement for their populations. This group's role was to support the Forth Valley community health partnerships in coordinating, prioritising, approving, assigning support to, monitoring and reporting on the Community Health Partnership Quality Improvement Programme, using agreed processes to support delivery of person centred services.

Examples of individual service quality assurance

We also found that operational managers had reviewed the performance of some individual services. The review of new service users to the care and support at home 24/7 service was a good example. With the introduction of personal outcome plans using 'Talking Points' as well as the use of a Single Shared Assessment, a new and more conversational approach was being introduced and used by home care managers in the 24/7 Team from 2012.

For those not subject to the above review, senior home care workers were undertaking audits of the care plans. There was also evidence of quality assurance 'spot check' visits to older people's homes by senior home care workers.

We were told by staff that all Council-commissioned projects that received over ten thousand pounds of funding, were reviewed against their project plan, in monitoring review meetings every three months. We noted that while review meetings were being recorded in accordance with 'Following the Public Pound', and that there were annual reporting statements covering aims, outcomes and value for money commentary, there was inconsistency in the level of detail and subsequent scrutiny. This needs to be more equitable across all services.

Examples of practitioner-level quality assurance

In terms of quality assurance, self evaluation and improvement at an individual practitioner level, evidence from the health and social work services records we read indicated that only 52% (of 99 cases) showed that decisions or discussions for staff supervision were recorded. Only 30% of the 99 cases showed that managers had periodically read the case file records. However, social work staff we met said that supervision took place regularly with only some exceptions.

We were advised that a case file audit tool for community care social work staff had been introduced in 2013. This was used in supervision and kept in the practitioner's file as opposed to social work electronic records. This may account for the very low figures highlighted. However, while the detail of discussions and decisions may sit in another file, the electronic system should be updated to reflect key decisions and the manager's involvement.

6.4 Involving individuals who use services, carers and stakeholders.

The Falkirk Partnership showed a commitment to involve individuals and their carers, the third and private sector, other stakeholders and communities in developing and evaluating services.

The Partnership was working towards developing an area-based approach for the planning and delivery of services. The Partnership had clearly decided to use local involvement within the scope of their participation and engagement strategies for all this work.

The Joint Strategic Commissioning Plan was a good example of co-production across a range of stakeholders through consultation events. The consultation and engagement plan reflected the views of the people from the local community who took part. Adjustments to the consultation and engagement plan were made as the result of these events. Both elected members and NHS Board members were involved in groups locally and in receiving feedback at these consultation events.

We read that the 2013/14 GP contract offered the Partnership the opportunity to consider two significant pieces of work for whole system collaboration and service improvement. These were the Quality Improvement and Productivity section of the Quality and Outcomes Framework and secondly the Whole System Working Project. Both sought to establish greater engagement across primary and secondary care in the context of health and social care integration.

In Forth Valley they elected to use the Whole System Working Project funding to support practices in the development of anticipatory care planning and delivery of high quality and safe care with particular focus on:

- mainstreaming the use of the Key Information Summary
- improving patient safety with focus on the 'Safer Medicines' workstream of the Scottish Patient Safety Programme
- the Health and Social Care Integration agenda
- locality development
- improved communication at the interface of healthcare services
- optimising management of long-term conditions.

All GP practices in Forth Valley participated in the work with locality coordinators. These coordinators organised six workshop events that were attended by over 150 GPs with participation from a wide range of other professional groups.

As well as sharing good practice the aim was to develop more consistent standards of integrated working, effective networking and models of care throughout NHS Forth Valley.

However, other frontline staff we spoke to said they did not think they had much opportunity to be involved in shaping policy developments. They said workload pressures made it difficult for them to attend working groups and make a contribution.

We concluded that the Partnership had taken positive steps to engage with the public in planning for future service provision. There are also other examples where this has occurred, outlined in all the other sections of this chapter. However, it needed to ensure that this was happening as part of a broader joint engagement strategy that included older people currently in receipt of health and social work services.

6.5 Commissioning arrangements

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

The Scottish Government and the Convention of Scottish Local Authorities (COSLA) had issued guidance stating that partnerships should have strategic plans ready for the financial year 2013–2014. The Partnership agreed their Joint Strategic Commissioning Plan in December 2013. The plan had been produced with the support of a number of partners and acted as the driver for commissioning across health and social work services within Falkirk to support the planned integration of health and social care. The Partnership was clear about how this informed the Joint Strategic Plan.

In respect of the Joint Strategic Commissioning Plan, the Partnership agreed a joint budget of £120.43 million based on Integrated Resource Framework data from 2010-11. The Joint Strategic Commissioning Plan provided detail of the vision, objectives and priorities. The Falkirk Partnership had used limited information to help shape its plans. The integrated resource framework was used but, at the time of inspection, the Partnership had not been able to use other data available to them such as relevant ISD data. However, an integrated information sharing protocol was agreed to allow for health and social work services data to be shared and analysed to assist the needs assessment work. The Joint Strategic Commissioning Plan position statement dated February 2014 a detailed account of progress at that time.

The Partnership was also able to link in with national and local drivers such as corporate plans, housing and poverty strategies and the single outcome agreement. A report to the Falkirk Partnership Board highlighted positive comments made by the Scottish Government Joint Improvement Team who considered the strengths of the Joint Strategic Commissioning Plan lay in engagement and the housing statement that was included in the plan. The plan was focused around sound community capacity building principles and locality planning.

However, while the Partnership had undertaken to deliver the Joint Strategic Commissioning Plan, as previously discussed, we found no evidence of a SMART implementation plan across the Partnership. This made it difficult to determine what was actually being prioritised, who was leading on key aspects of work and the timescales for delivering outcomes.

Recommendation for Improvement 8

The Falkirk Partnership should incorporate the Joint Strategic Commissioning Plan for Older People into the Joint Strategic Plan for Health and Social Care Integration. The plan should be compliant with the Scottish Government's Strategic Commissioning Plans Guidance[17] and be accompanied by a robust delivery plan that is subject to routine scrutiny by the Joint Management Group.

Managers we met advised us that the full resource contribution aligned to the Joint Strategic Plan had not yet been finalised and that the health and social care integration core group focusing on finances was the vehicle for further scoping and analysis of joint budgets. At the time of our inspection, this group was progressing work around a financial framework that would set out the process for joint planning, resourcing, reporting and monitoring. They further told us that this group was ahead of other workstreams and that this would be challenging for the Partnership as resources should be dependent on the outcome of the other workstreams.

At the time of our inspection, it was difficult to determine how the Partnership was going to plan for and implement priority services across the whole system, if the needs assessment work undertaken in the workstreams was not tying together. However, we saw evidence of good work in the health and social care integration core group meetings and the recent appointment of the programme manager to oversee the development of the workstream groups should enable the Partnership to make more coordinated progress.

The Council's Corporate Plan 2012-17 sets out the financial context for this period. A medium-term financial plan had also been agreed.

In the interim, the Falkirk Council's budgeting process was being undertaken annually. This had significant implications for the third sector. Senior representatives from the third sector told us of the difficulties recruiting staff on one year contracts meant that frequently staff are under notice of redundancy before the next years funding is confirmed. We were told that there are plans for the council to move towards three-year budgeting plans but there was no set timescale for this. Progress here would support more effective forward planning and commissioning in the third sector.

17 Health and Social Care Integration, Public Bodies (Joint Working))(Scotland) Act 2014 Strategic Commissioning Plans Guidance

The allocation of Change Fund monies was being overseen by the Joint Management Group. The Partnership received funds averaging £2million per year between 2011 and 2015. There was a balance remaining in the 2014-2015 financial year. From the Partnership's financial reports, we could see that this money was being appropriately prioritised and redirected to reablement, rehabilitation and services to support effective hospital discharges.

The Partnership had made a successful bid to the North East Territory Board, a national initiative set up by the Scottish Government as a way to increase the scale of joint service working, increase opportunities for strategic asset management and maximise community and stakeholder engagement. They received capital to take forward redesign work relating to the high end service provision (residential care and housing with care for older people).

The Partnership had commissioned Hub East Central Scotland Limited (a joint partnership between public and private sector organisations aimed at developing and delivering better local services across East Central Scotland) to support, develop and deliver a sustained programme of investment in high-end service provision.

This strategic service planning review (Service Review) was the first of four proposed sequential steps which will incrementally build a picture of future service provision. These steps included a:

- strategic service planning review of high end care provision and strategic analysis of existing Council and NHS service delivery locations and premises across Falkirk
- strategic review and analysis of non-Council owned service provision and service delivery locations and premises across Falkirk
- feasibility review on the viability of potential new or remodeled service delivery facility(ies) within Falkirk
- detailed validation of feasibility study assumptions leading to a business case and hub new project request.

The outcome of this service review will be a strategically developed view of housing with care provision on a Falkirk wide basis. The result of this work was not available at the time of the inspection.

To conclude, the Falkirk Partnership had the foundations of a good strategic planning and delivery structure in place. It had delivered a joint strategic commissioning plan for older people although it was not clear how progress was measured. Preparation for health and social care integration was a priority for the Partnership. They were closely linked in to Forth Valley wide workstreams and had appointed a programme manager to oversee the coordination of the work. However, the Partnership had still to agree the scope of both services and joint budgets included within integration which was impacting on the workstream synergy.

There was evidence of good partnership working across all stakeholders although communication and sharing of information in a whole systems way could be improved as discussed in Chapter 2.

We saw good examples of single and multi agency quality assurance work and recognised that work was still required to deliver a joint performance reporting framework.

The Joint Strategic Commissioning Plan provided a focus around early intervention and support services and budgets were being appropriately aligned to these priority services.

Quality indicator 7 - Management and support of staff

Summary

Evaluation - Adequate

The Falkirk Partnership had separate workforce plans in place but had identified that a joint strategy was needed. Key elements had been identified in a framework to take this work forward. We also considered the recent appointment of two organisational development posts as a positive step in advancing the necessary work in this area.

Staff recruitment was being carefully managed with replacements only being made where operationally necessary. Recruitment was a challenge for some services, and although there were few joint posts, at present, there was evidence of new approaches to service delivery through a range of projects and schemes. Of particular note was the positive approach the Partnership had taken to meet the challenges around consultant vacancies.

The Partnership were also taking all the necessary steps to manage its sickness absence issues and was working to identify and address hot spots across service areas. There are good examples of this highlighted in this chapter.

Resource allocation and deployment of staff were still largely at an individual agency level. However, there was evidence that frontline staff from health and social work services worked hard to ensure a joined up approach to provide positive outcomes for older people.

We noted that there were challenges for social work services around the governance of supervision and appraisals in terms of regularly undertaking this work and also making sure there was an up-to-date framework guiding managers in the services. Health staff were evidencing more positive outcomes in terms of exceeding their targets on similar supervisory and development processes.

This chapter comments on how staff are supported and managed within the workforce. It also looked at how staff were supported to learn and develop in their roles and in the context of a changing culture how the partnership approached joint workforce planning and deployment of staff.

7.1 Recruitment and retention

The Falkirk Partnership operated two separate strategic workforce plans. Senior human resource managers told us recruitment processes were, in the main, separate to each agency and most job descriptions were specific to each of the partners. There were some encouraging signs of joint recruitment as a joint programme manager post had been

filled as well as two further organisational development posts.

The Joint Chief Officer post for health and social care integration had yet to be recruited. They planned for this to be advertised by January 2015 with the successful applicant in post by end of March 2015.

The Partnership's Joint Strategic Commissioning Plan for Older People and supporting action plan set out the priorities for organisational development and human resources for 2013–2016 and included:

- development of a communication and consultation strategy about integration
- identification of the scope of resources
- development of a joint workforce education and training framework covering all partner agencies
- review of employment practices to support a partnership model
- establishment, co-ordination and monitoring of relevant task groups to deliver agreed actions.

This framework and action plan, which formed part of the planning towards integration, included substantial work that would take significant resource to complete.

We read a range of documents produced by Falkirk Council and NHS Forth Valley on recruitment and retention and spoke to a number of health and social care staff. The only areas across the Partnership found to have difficulties with recruitment and retention were in home care services, mental health officers and Band 2 healthcare assistant staff..

Human resources managers told us that the positive levels of staff retention had a negative effect within NHS Forth Valley as it also meant they had an ageing workforce. Forty per cent of NHS staff in Forth Valley were eligible to retire in the next 10 years. For this reason, one of the priorities was to up skill staff in Bands 5 and 6 nursing posts.

Recruitment within NHS Forth Valley followed strict vacancy management protocols. Local service redesign was considered when a vacancy arose rather than automatically filling like with like. Senior manager approval was required before a post could be filled. NHS Forth Valley had a 12-week vacancy-to-recruitment target. In order to meet the 12 week target, the recruitment process could start before the staff member left their post. We were told that apart from a small number of positions, NHS Forth Valley met the 12 week target.

NHS Forth Valley, as with the rest of Scotland, faced major problems in recruiting to consultant posts. To address this, they were taking a proactive approach by introducing "proleptic appointments". This meant that the senior doctors were recruited in advance of a consultant retiring, guaranteeing them the consultant post when the vacancy arose. This was dependent on the senior doctor successfully completing their Certificate of Completion of Training.

Falkirk Council operated a similar process to NHS Forth Valley for managing vacancies, with managers considering local service redesign when a vacancy arose, and approval to fill vacancies needed at service directorate level.. This allowed extra time for service managers to decide whether or not it was essential to fill vacancies. However, more positively, we were told social work services vacancies were exempt from the 12-week holding time.

The target for staff sickness absence in NHS Scotland is 4%. In 2013-2014 NHS Forth Valley achieved 5.18%, which although higher than the overall Scotland figure of 4.76%, was an improvement on the previous year's achievement of 5.70%. NHS Forth Valley was adopting a range of strategies to improve absence management including benchmarking, profiling, stress management, staff surveys and attendance management training.

Falkirk Council and the social work service had benchmarked nationally and drew up a proposal to consider setting more realistic absence targets for frontline social work staff (5.5%). At the time of our inspection the proposal was out to staff for consultation.

The social work services sickness absence rate was 6.5% for social work staff, 7.5% for home care and 5.14% across a range of disciplines.

A range of actions were being considered by the social work services to manage absence including:

- new online absence management course for managers
- reviewing physiotherapy service
- working with occupational health to identify priority cases
- purchasing new software to provide better information on absence rates to managers
- introducing new performance indicators to monitor long-term absence
- a corporate trigger process to manage absences was to be applied.

We heard that the Partnership had been in touch with other partnerships about the home care recruitment issues to see what was happening elsewhere. They expanded their modern apprentice scheme taking on 20 people each year, giving a total of 40 since this started. The aim was to make sure each apprentice secured a job in the care sector. Although this was achieved it was not clear how many had secured jobs in homecare services.

7.2 Deployment, joint working and team work

We found that resource allocation and deployment of staff were still largely at an individual agency level. We spoke to organisational development staff from across the Partnership. They said there had been a good history of NHS Forth Valley and Falkirk Council organisational development sections working together on particular projects. Examples included the NHS Forth Valley Coaching Programme which was shared with the three Forth Valley councils, and a joint leadership programme. NHS Forth Valley had made use of the Council's work around customer focus and services, whilst the Council

had used NHS Forth Valley training material on dealing with violence and aggression.

Examples of integrated teams operating across the Partnership included the learning disability and adult community mental health teams The learning disability team had been in existence for 10 years and appeared to be working well. The older people's community mental health service was under review and had not yet reported on outcomes. The home care short term care team had been co-located with the hospital team but had to move following building works. There were no plans to return this team to the hospital. NHS Forth Valley was looking at aligning occupational therapy services with Falkirk Council but this was at an early stage.

The multi-agency complex care panel met regularly to consider complex cases and discuss how the individual's needs could be met. This was a joint meeting with NHS Forth Valley and the three local authorities to agree jointly funded care packages.

We found positive aspects of joint working from the health and social work services records we read. From our staff survey, 73% of respondents agreed or strongly agreed that services worked well together. There was evidence of multi-agency working (64%) and more positively, that services worked together to provide care at times of crisis (74%). On the whole, information was shared between professionals and recorded in the social work and health service files (55%).

We noted many positive comments about staff during our review of health and social work services records. Some older people we met who received services from both health and social work services spoke of very good experiences of joint working between the partners to provide care to them. However, there was evidence that multi-agency partners' views only informed risk assessments in 43% of cases. It was clear that frontline staff across the Partnership were working together to provide positive outcomes for older people. However, this was not always evident from the health and social work services records we looked at during the inspection.

From the staff survey we found that only 56% of respondents agreed or strongly agreed that there were positive working relationships with other professionals. However, almost all frontline staff as well as health and social work services managers we met during fieldwork reported good working relationships with colleagues across the services.

7.3 Training, development and support

NHS Forth Valley and Falkirk Council operated separate arrangements for individual supervision and annual appraisal.

Social work services had an Annual Employee Development Review[18]. However, managers we met said that performance targets in relation to this had not been consistently met.

18 Annual Employee Development Review - Guidance Notes and Summary and Action Plan. Revised 2006.

There was an expectation that supervision for staff should be in place. In our discussions with organisational development staff, we were told that supervision on an individual basis was difficult to achieve. For this reason, the social work service they were looking at making more use of group supervision for home care staff.

We noted that only a small number (30%) of social work case files we read recorded decisions and discussions from supervision, and similarly that only 30% of cases had been read by line managers. Frontline staff told us they felt supported by immediate management but had little contact with middle, and senior management.

Clinical supervision was not mandatory in NHS Forth Valley and took place mainly in the community teams. These arrangements were usually informal and arranged at a local level. District nurses also told us about group supervision sessions for Band 6 nurses, although these had not been happening recently due to time constraints.

In NHS Scotland, the NHS Knowledge and Skills Framework (KSF) applies to all staff who are employed under Agenda for Change terms and conditions. NHS Forth Valley used the electronic Knowledge and Skills Framework (eKSF) to support the personal development planning and review.

Human resources managers told us that they had met their draft workforce plan target of 80% of NHS staff have having had their annual appraisal on the eKSF system, but organisational development colleagues were aware they needed to concentrate more on the quality of the appraisal process.. The governance framework for this strategy was led by the staff governance committee and the area partnership forum. Both the staff governance committee and the NHS Forth Valley Board received regular progress reports.

A wide range of training opportunities were available to staff and the Partnership provided us with detailed training programmes. Self-directed support awareness training, including outcomes focus was being made available to all frontline social work service staff. However, the staff we spoke to said it was difficult to be released for training due to capacity issues, but that it was crucial for them to undertake their work effectively. They also said health services staff should be included in this training. We concluded that while some joint training was available improved coordination across the Partnership was needed to make sure appropriate uptake of the training.

Social work services operated a successful Scottish Vocational Qualification (SVQ) assessment centre which was visited annually by the Scottish Qualification Authority to examine the quality of service provided. We were told by social work managers that these reports had been consistently positive.

To conclude we saw evidence that Falkirk Partnership was actively promoting some joint posts such as the Programme Manager and in the area of occupational development. However, crucial posts like the Chief Officer remained vacant. Recruitment issues were

well managed with some good initiatives introduced to tackle specific areas of concern like the appointment of consultants.

The Partnership was responding to sickness and absence issues and had implemented measures to address the challenges it faced. An example of good practice is described below.

Social work services were facing some challenges around overseeing staff supervision and appraisal which they will need to consider but the health staff were performing well on their eKSF targets.

Example of good practice

Home care managers told us they were managing teams that were dealing with increasingly more complex individuals with more physical needs. Added to the ageing population of the workforce, this contributed to high levels of sickness absence. The service introduced an absence management officer who provided a link between the human resources section and the home care service. This individual made sure the absence management policy was consistently implemented and undertook 1:1 sessions with repeat absentees. This had made a significant improvement in reducing absences by 2%.

Quality indicator 8 – Partnership working

Summary

Evaluation - Adequate

The Falkirk Partnership had operated on the basis of joint financial arrangements over a number of years. It was managing resources adequately despite the financial pressures on services. Appropriate steps to manage costs and review spend. There was a number of significant challenges and pressures ahead in the provision of more integrated services, particularly in relation to providing them on a sustainable financial footing and continuing to remain in budget.

The Partnership saw the transition year as an opportunity to better understand the financial impact and undertake the necessary scoping to plan for jointly delivered services. However, we found the workstreams were out of step. We were not clear how priority services were being strategically evidenced, prioritised and planned without the activity of the other work streams feeding in. The Partnership needs to make sure it scopes in all the necessary joint services and produces a robust financial framework to ensure effective monitoring and reporting.

There was no clear joint information-sharing strategy in place. We were reassured however, that the Partnership was taking all the necessary steps to improve this position through a number of projects and initiatives. There were a number of examples of information-sharing systems. However, across the Partnership we found that there was a general level of frustration among staff about the efficiency of the IT systems in place.

This chapter comments on how finances and resources were managed across the partnership and whether there was a whole systems approach. It also considered whether areas such as business support and ICT supported the delivery of outcomes for individuals and respective members of the partnership.

8.1 Management of resources

The Falkirk Partnership told us they have historically worked well together as the Falkirk Community Planning Partnership (CPP) and in the management of pooled budgets for pockets of integrated services.

The Partnership had opted for a body corporate model for health and social care integration with delegation to the new Integrated Joint Board, which itself will be jointly accountable to both NHS Forth Valley and Falkirk Council. The Joint Strategic Commissioning Plan was agreed in December 2013 by a partnership comprising Falkirk Council, NHS Forth Valley, CVS Falkirk and District, and Scottish Care in order to support

the planned integration of health and social care. This strategy will inform the Joint Strategic Plan which the new board must have completed by January 2016. This plan will include a financial context on what was to be collectively spent by the Falkirk Partnership. However, more analysis was to be carried out around the agreement of scope and indicative budgets before this was agreed. This will be carried out by the Health and Social Care Integration Joint Chief Officer, once appointed, with initial oversight from the Joint Management Group.

The Partnership's shadow joint board will comprise of elected members from Falkirk Council, as well as NHS Forth Valley Board members. Both the NHS Forth Valley Board members and Falkirk Council elected members told us they received regular update reports on the progress of health and social care integration. The Joint Management Group reported progress directly to the Partnership Board.

The Partnership intended for 2015/16 to be a transition year for health and social care integration, with the aim of implementing full integration from April 2016. The transition year was to be used to better understand costing of services to be provided and as a period to narrow down costing and scoping of services.

As discussed in Chapter 6 the finance workstream was developing a financial framework which was to set out the process by which resourcing was to be agreed. This was expected to be agreed in November 2014. For this reason it would be important that the Partnership progress more quickly with the other workstreams.

A sum of £0.364 million was made available to NHS Forth Valley following a successful bid to the Scottish Government. This funding was to support the development of transitional arrangements. An integration programme manager had been recruited to each Partnership area (Falkirk and Stirling and Clackmannanshire). It was expected that the remaining funds will be allocated equally across the Partnership areas as the need arises for capacity within workstream areas.

Financial performance of Falkirk Council and NHS Forth Valley

The Council's Corporate Plan 2012-17[19] sets out its financial context for this period. In the interim, the Council's budgeting was carried out annually. The financial management of the Council had been considered as part of Audit Scotland's annual joint shared risk assessment process. This had identified no specific concerns in relation to the financial management and planning of the Council.

The social work services budget within Falkirk Council was £89.7 million for 2014/15. In a report to Falkirk Council's executive committee on 30 September 2014, the director of social work reported that, as at 31 July 2014, an overspend of £2.4 million (2.7%) was projected. This was in contrast to an under spend of £0.97 million in 2012/13 and an

19 Falkirk Council, One Council, One Plan, Corporate Plan 2012-2017

over spend of £0.60 million in 2013/14. Pressures included home care, which projected a £0.895 million (7.8%) overspend, and 24-hour care, which projected a £1.212 (4.3%) overspend for 2014/15.

The projected overspend was largely due to the increased demand and need for the service. The Partnership reported that there was the potential for the over spend to increase as the year progressed. During 2014/15, there had been a 4% increase in the number of people aged over 65 receiving home care services and a 12% increase in the number of hours of care purchased. There had also been an 18% increase in the number of people aged over 65 requiring home care during evenings and weekends. Although some of the over spend had been offset against savings in staff costs due to vacancies, there had been an increase in agency costs and home care external purchasing.

To manage these budget pressures, the service was focusing on actions to:
- prevent higher levels of need developing
- manage expenditure more efficiently
- robustly make decisions about high cost care packages.

For example, budget pressures were being partially offset by mechanisms in place to ensure that all commitments to care packages of more than £200 per week were being scrutinised by senior managers. This was to make sure that resources were being aligned to the level of need consistently. This scrutiny ensured that necessary eligibility and priority criteria had been met and aimed to eradicate the provision of care packages to those who were not fully eligible.

There was also a transport review taking place across social work services that was reviewing the eligibility criteria for those currently receiving free transport and who will be able to do so going forward. At the time of inspection, it was anticipated that savings would be identified when this review was completed..

NHS Forth Valley is funded through the Scottish Government, whilst there was some flexibility in determining local priorities; these had to be set in the context of national priorities and targets. NHS Forth Valley's board had seen increasing pressures in the acute sector. An area of particular pressure was the more complex needs of older people.

The overall NHS Forth Valley budget of £511.836 million for 2014/15 was approved by the Board in April 2014 and, as at 30 September 2014, a break-even position was projected for the year end. This can be compared to a £0.209 underspend in 2013/14. Audit Scotland reported in their 2013/14 Annual Audit Report for NHS Forth Valley[20] that financial management remained strong. Robust budget setting processes and challenge evident in agreeing and monitoring the financial position of the Board.

Within the Falkirk Partnership's draft Integration Scheme's timeline, a shadow joint board to take forward health and social care integration was not going to be formally

20 Audit Scotland Annual Audit Report for NHS Forth Valley, 2013/14

established until March/April 2015. However, there was an established partnership board in place that required shadow status in January 2015 as a transitional board that was providing an appropriate transitional framework for joint reporting arrangements to be implemented before health and social care integration was fully operational in April 2016.

Finance officers agreed that more public debate was needed to establish what was important to them in terms of service provision for older people. Work was then needed to agree achievable priorities for delivering services within the financial pressures that the public sector was facing. The Falkirk Partnership faced difficulties going forward with increased demand on services being delivered with reduced financial and workforce resources.

There needed to be more analysis around the agreement of scope and indicative budgets regarding those services included under the health and social care integration arrangements. As a consequence there was no financial framework in place for integration and it was not yet clear how the joint budget was going to be comprised, managed and reviewed either by the shadow joint board prior to April 2016 or the Integrated Joint Board after April 2016.

The Change Fund

Since 2011/12, the Scottish Government provided specific funding to the Falkirk Partnership to assist the move to more community based care through the Change Fund. This fund was provided by the Scottish Government to support Reshaping Care for Older People. The allocation of Change Fund monies was managed by the Joint Management Group and was supported by finance officers from Falkirk Council, NHS Forth Valley and the Falkirk Community Health Partnership. The Partnership received funds averaging £2 million per annum between 2011 and 2015 and Change Fund resources remaining as at 30 September 2014 amounted to £0.836 million. We were assured to note that the priorities for this remaining resource were reablement projects as well as funding support towards reduction in delayed discharges. The projects funded by the Change Fund focused on the delivery of community and home based care services that were enabling a shift in the balance of care from NHS Forth Valley acute sector provision, and jointly recruited posts designed to lead and take the work forward had been recruited to.

Scrutiny of Change Fund spending was undertaken by the Joint Management Group who robustly monitored and evaluated individual projects and jointly developed reporting processes were established. Staff told us that initially this was fragmented due to the number of representatives attending the group and participating in scrutiny. Staff also said this was now a more focused group and advised that scrutiny was now more effective than in the early stages of the Joint Management Group's existence.

The Falkirk Partnership had the opportunity to bid for a share of the Integrated Care

Fund which was announced by the Government in July 2014. This Fund builds upon the Reshaping Care for Older People's Fund which is due to conclude in April 2015. It will be accessible to local partnerships to support investment in integrated services for adults and was intended to focus on prevention, early intervention and care and support for older people with complex and multiple conditions. The Partnership's indicative allocation was £2.88 million. However, the timing was challenging as an integrated care plan was required to be submitted by 12 December 2014, which preceded the delivery of the Joint Strategic Delivery Plan to be finalised in April 2016.

8.2 Information systems

Data sharing between health and social work services is a challenge throughout Scotland. We saw that the partners did not have a joint information communication technology (ICT) strategy that supported the sharing of information at both strategic and individual levels in the planning, management and delivery of services.

An overarching Forth Valley joint data protection officer group was responsible for coordinating information governance at a partnership level. A 'Forth Valley Accord for Sharing Personal Information' supported the sharing of information between health and social care services.

In its position statement submitted before the inspection, the Falkirk Partnership told us that there was not a single information system in place and that, to date, electronic sharing of information has not been achievable. The Falkirk Partnership recognised the challenges that services faced when information systems did not fully support integrated service delivery.

As part of our staff survey, we asked whether information systems supported frontline staff to communicate effectively with partners; 37% of respondents agreed or strongly agreed that information systems supported frontline staff to communicate effectively with partners and 44% disagreed or strongly disagreed.

As in many parts of Scotland, we saw that IT systems are complex and that both health and social work services had multiple IT systems. Staff we met at various levels expressed frustration with the lack of efficiency and operation of IT systems and the limited extent to which these were joined up and able to talk to each other - even within single agencies. For example, acute inpatient services, GP services and district nursing services all use different ICT systems with limited joint access. Some teams have access to respective IT systems, such as the integrated learning disability and adult mental health services.

An example of where accessing a single NHS IT system worked well was in the Macmillan 1:1 project where the use of a shared record was stated to improve communication between community nursing, oncology nursing and the 1:1 project team.

Within social work services, the Social Work Information Service (SWIS) was used across services to record assessments, care plans and reviews. It was being developed to record outcomes for people who use services. Recording of outcomes currently varied across services. Information was gathered through the single shared assessment process and the sharing of information between partners either in writing or verbally was commonplace.

The Falkirk Partnership was exploring options to improve information sharing, including:

- securing funding from the National Information Sharing Board to complete analytical work on information sharing priorities in order to develop a Forth Valley IT plan and strategy
- developing case-based information through a single shared assessment and a shared partnership-wide approach to recording and monitoring personal outcomes
- adopting the priorities within NHS Forth Valley's eHealth Strategy for 2012-17[21] including: developing an electronic community health record to support multidisciplinary team working; a clinical portal for sharing patient information; and electronic sharing of information amongst partner organisations
- work on developing a high-level information sharing protocol (ISP) for use in sharing information specifically between health and social care services was ongoing. It was anticipated that the finalised ISP would be included in the integration scheme
- working with Scottish Government and the Information Services Division (ISD) to develop data-sharing with a focus on linking social care records with patient data
- working with Scottish Government and ISD in relation to data linkage for key information for assessment and service planning for individuals in the Bo'ness Project.

Both NHS Forth Valley and Falkirk Council used Covalent (a performance and governance software application) to manage and monitor performance. However, both performance management systems and requirements were separate. A joint performance management framework including data collection and reporting arrangements had yet to be finalised.

8.3 Partnership arrangements

The Public Bodies (Joint Working) Scotland Act 2014 requires NHS boards and local authority partners to enter into arrangements (the integration plan) to delegate functions and appropriate resources to ensure the effective delivery of those functions.

Compliance with integration delivery principles

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) Scotland Act 2014[22] to review and evaluate if the planning, organisation or co-ordination of social services, services provided under the health

21 NHS Forth Valley EHealth Strategy 2012-2017

22 Section 31 of the Public Bodies (Joint Working) Scotland Act 2014 states in summary: high quality integrated, effective, efficient, and preventative services should improve service users' wellbeing, take account of their particular needs and characteristics, where they live (locality), their rights and dignity, keep them safe, involve them and engage with their communities.

service and services provided by an independent health care service is complying with the integration delivery principles.

Health and social work partnership arrangements have historically been well established through the Falkirk community care and health partnership. The Partnership's journey towards integration, via a body corporate model, could be described as slower than other partnerships. The Partnership consistently stated that they have taken a very considered approach to this large scale change. However, this gave the Partnership time to work through issues and any disagreements and come to an agreed model. The model had the full commitment of all stakeholders.

The Partnership did appreciate that initially they had been less advanced than other partnerships in respect of their integration planning but they do have a detailed integration scheme in place with key milestones identified. The implementation of the scheme and the associated milestones are overseen by the Joint Management Group who had overall responsibility for operational delivery.

We were reassured within the Falkirk Partnership that the Integration Scheme and Strategic Commissioning plans are closely linked to the Community Planning Partnership through the Joint Management Group.

The Partnership was working well with agencies from other sectors as described in Chapters 4 and 6 predominantly. There were established collaborative working groups which were represented and well attended by representatives from the local authority, NHS Forth Valley, voluntary sector and Scottish Care. The purpose of these groups was to ensure all sector inclusion in developing 'the vision' and shared action planning. There were some very clear focus areas where partnership working was being strengthened including delayed discharges and adult support and protection.

Partnership working with housing colleagues was well established. There was a detailed housing contribution aligned with the Joint Strategic Commissioning Plan.

Research had been completed to identify future housing need and demand to assist the ongoing development of the strategy.

To conclude, the Falkirk Partnership had a well established history of joint working. The Joint Strategic Commissioning Plan was a good example that also had a jointly agreed budget. However, more work needed to be done to build on the synergy and progress under health and social care integration to ensure that services, budgets and priorities were being appropriately scoped out.

Shadow Integrated Joint Board arrangements were in place and there was evidence of good preparatory work with all stakeholders including elected members and NHS Board members.

The Partnership was finding ways of meeting the financial pressures upon it but mostly through single agency resolutions and needed to strengthen the collaboration in this area through the relevant health and social care integration workstream.

IT issues were identified during this inspection that hampered joint working. This is in keeping with what is happening nationally. The Partnership had strategic plans to take the issues forward and address.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation - Adequate

The Falkirk Partnership had assumed a very pragmatic strategic approach to health and social care integration. This approach had been adopted to take account of the continued and significant amendments to regulations within the associated legislation and guidance.

The Partnership had a shared vision and strategy as outlined in Council committee and NHS Board reports, as well as being clearly set out in their draft Integration Scheme. A joint management structure was in place to take the work forward and provide the necessary governance in the form of the Joint Management Group and Partnership Board.

We identified that the Partnership had much work to do in a very short timescale. The Joint Chief Officer will be the key driver of this agenda accountable to the Integrated Joint Board but this appointment had not been made despite tight timescales.

Communication about health and social care integration was not being effectively delivered to front line staff across the Partnership. This was leading to uncertainty among the staff. Senior managers needed to address this as a matter of priority.

Staff were being encouraged to work jointly and the Partnership was supporting new ways of working and innovative practice. While this was positive the change management structures and processes were not cohesive. This was leading to improvements in some areas of practice but not across the whole partnership in a sustainable way.

This chapter comments on the quality of leadership and the contribution of corporate leadership to drive the vision, culture and communication with the workforce and wider population. It also considered the effectiveness of the leadership around strategic and cultural change and improvement.

9.1 Vision, values and culture across the Partnership

It was clear that the Falkirk Partnership's senior staff collectively understood the need for a change in the strategic delivery of older people's services. This was captured in the Partnership's vision statement which was "to enable people in the Falkirk Council area to live full and positive lives in their own homes or, when this is not possible,

within homely settings within supportive communities". That vision was shared by all the community planning partners. We found a shared understanding that planning and delivering services in different ways was needed if they were to be successful in terms of the demographic challenges and shifting the balance of care away from institutional care towards community care settings. There was evidence of the culture shifting in relation to localities work in the Bo'ness Project and the Reshaping Care for Older People initiatives.

The Partnership had published its Joint Strategic Commissioning Plan in 2013. While we found senior managers in the Partnership understood the vision outlined in the Joint Strategic Commissioning Plan, we found that operational staff felt less well informed . In our staff survey, 32% of staff who responded felt their views were not taken into account when services were being planned and provided and only 42% agreed that the vision was set out in comprehensive joint strategic plans. Despite this, staff surveyed felt the Partnership was committed to delivering joint services.

Recommendation for improvement 9

The Falkirk Partnership should implement the communication and engagement plan set out in the Integration Scheme as a matter of priority to ensure the workforce fully understand the vision and plans for change.

9.2 Leadership of strategy and direction

In common with the rest of Scotland, the Partnership was working towards putting in place arrangements to take forward health and social care integration. They had agreed to adopt the 'body corporate' model. Transition Board arrangements were still being developed during the inspection.

The Partnership Board and Joint Management Group oversaw progress and provided the high level strategic governance of the Falkirk Partnership's integration plan. We attended a meeting of the Joint Management Group and observed evidence of good working relationships between the social work services, NHS Forth Valley and third sector representatives. The meeting was well attended with broad representation and the reports on health and social care integration were detailed, up to date, clear and concise.

Senior staff across the Partnership described the preparatory work that was planned for the proposed shadow joint board members. This was being framed in a development programme for the members with training being planned to be tailored to members' own experiences and background.

Senior managers in the Partnership felt strongly they had adopted a very measured and systematic approach to the integration of health and social care, and that this had avoided any unnecessary work or confusion for staff during the time when the draft regulations to

support the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 were going through the Parliamentary Process.

There was a Forth Valley-wide health and social care integration core group. The Falkirk Partnership was an integral member of this group and had appointed a programme manager to oversee the development of these groups and help shape the Joint Strategic Plan.

9.3 Leadership of people across the Falkirk Partnership

Feedback from our staff survey provided evidence that more work was needed to make sure there were joint strategies to communicate change to staff. At focus groups we asked staff if they felt well informed about health and social care integration. Only some senior staff responded positively. The Partnership's position was that this was deliberate as it wanted to avoid any confusion amongst staff arising from the various amendments to the regulations. The view of senior managers was that this could have caused further uncertainty and fostered greater doubt and anxiety across the workforce.

We concluded that the Partnership was overly cautious in terms of informing their workforce about developments and could have been more proactive in doing so. While there was no communication and engagement strategy for this we acknowledged there was a proposed plan within the Integration Scheme that took account of this issue. This should be focused around:

- increasing the workforce's understanding of the vision
- informing them about the integration pathway and milestones
- sharing progress reports from the health and social care integration core group workstreams
- informing them of third and independent sector developments
- involvement and consultation processes.

From our staff survey 66% of respondents agreed/strongly agreed they felt valued by their managers and 87% agreed/strongly agreed that they enjoyed their work. This reflected a strong commitment to the operational management of the workforce.

9.4 Leadership of change and improvement

The Partnership had established a joint management structure overseen by the Partnership Board. In the absence of a health and social care integration joint chief officer, the Partnership Board and Joint Management Group were accountable for taking forward the Scottish Government's integration agenda. The Falkirk Partnership was confident about the legislative timescales but we remain cautious about the volume of preparatory work that remains to be undertaken without a joint chief officer to take the lead and steer the vision.

While there was an ethos of partnership working in Falkirk, senior managers felt that Reshaping Care for Older People had fundamentally changed how they planned and delivered joint initiatives. This had proved extremely beneficial in the lead-up to integration. We found that examples of good practice were being proactively encouraged by the Joint Management Group. They fell into three main areas which were localities work, the Bo'ness Project, and Reshaping Care for Older people (Change Fund).

However, what was less clear was how all the various strands of this work fitted together strategically or were self evaluated, quality assured and governed. The senior managers acknowledged to us that the Joint Management Group was not delivering the outcomes as coherently as they wished at that time.

We found evidence of this lack of a cohesive approach amongst staff groups across the Partnership who consistently said they were unsure how their service interfaced with other service areas and developments. This was also evident in the staff survey which found that only 38% of those who responded agreed that changes which affect services are managed well.

We attended a delayed discharge steering group meeting and noted some positive areas of leadership around change and improvement. Meetings were held frequently and attended by the Scottish Government Joint Improvement Team. A range of innovative practice was evident from this group which was being well coordinated and supported by a SMART action plan.

The Partnership was clearly engaged in the planning and delivery of new ways of working in line with the principles of the Scottish Government's health and social care integration, as well as the 2020 Vision for healthcare in Scotland. Elected members, NHS Board members, the medical directors and the senior management team were in general agreement about the future vision for joint services in the Partnership. There was evidence of community engagement that involved the third sector, local communities, service users and carers using a range of innovative approaches.

The challenge for the Partnership was to ensure that there was capacity created to analyse the learning from all the recent innovation around joint working. The senior managers we met acknowledged that this was an essential component of moving the integration agenda forward in a sustainable way. It is also crucial that the Partnership strengthens the role of the Joint Management Group in order to effectively self assess, quality assure, plan, implement and deliver new ways of working. This would strengthen the links to the Joint Strategic Delivery Plan and assist the Partnership in aligning budgets to initiatives with the biggest impact and best outcomes.

To conclude, we found evidence that the Falkirk Partnership had a clear vision and commitment to delivering change although scaling up the changes in a 'whole systems' way remained a challenge for them. There was a strategic planning and delivery structure

in place, governing the change. Preparatory work for health and social care integration was well under way with workstreams in place, programme management posts appointed to and integration schemes entering the final stages of agreement. However, the Partnership faces very tight deadlines if it is to meet the Scottish Government's deadlines in relation to health and social care integration, particularly without the Joint Chief Officer in place to steer the developments.

Quality indicator 10 – Capacity for improvement

Summary

Capacity for improvement

We saw evidence of positive outcomes for most older people in and their carers in Falkirk.

The Falkirk Partnership was actively preparing for health and social care integration but needed to strengthen the coordination of how well this was progressing. Their was evidence that the Forth Valley-wide core group was working to align the different agendas. Additionally the positive appointment of the Partnership's Programme Manager post would assist with this and support the needs analysis work for the Joint Strategic Plan.

We mainly saw constructive working relationships among the leaders we met. They shared a vey strong commitment to the health and social care integration vision. Leaders also showed commitment to new ways of working and Reshaping Care for Older People was the driver for this. The Partnership should carry the learning from this forward towards integrating health and social work services and better monitor how well this was progressing using a 'whole systems' approach.

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

We do not award an evaluation grade to this quality indicator. From our evaluations against each of the quality indicators 1–9, we look at how confident we are that the Partnership has the capacity for improvement.

We concluded that although the Falkirk Partnership had been at an early stage it was now moving towards health and social care integration and the pace of change was now accelerating. In considering our confidence in the Falkirk Partnership's capacity for improvement, from our findings, we looked at the extent to which the Partnership demonstrated:

- improvements to the outcomes and the positive impact services have on the lives of individuals and their carers
- effective leadership and management
- effective approaches to quality improvement and a track record of delivering improvement
- preparedness for integration.

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

Our findings identified a number of initiatives the Partnership had implemented to improve outcomes for older people. These included the Frailty Clinic at Forth Valley Royal Hospital, the Bo'ness Project, and the extended psychiatric liaison team.

In some cases, for example the Frailty Clinic, we found that not all staff were aware of, or knew how to access new initiatives. In others, such as falls management, more could be done to enable staff to share information.

We found that the Partnership was committed to providing the right support to the right person at the right time. However, we found areas where further improvement is required, for example to reduce the numbers of delayed discharges, improve access to residential care and respite facilities for those who need them, and be consistent in responding to carer's needs.

Effective leadership and management

The senior management teams within the Falkirk Partnership had a positive relationship and a clear, shared vision. However, from discussions with a range of staff, we concluded that the vision was less well known amongst frontline staff groups. More could have been done to take staff views into account and keep them informed of strategic developments in health and social care integration.

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

Falkirk Partnership leaders actively promoted service redesign and change in keeping with the principles of Reshaping Care for Older people. However, while this encouragement was positive, we found that the 'whole systems' approach to change management, planning and commissioning could have been strengthened. For example, there could have been more scrutiny of the individual service developments and consideration of how the impact in one area was influencing other aspects of service delivery.

We found evidence that senior managers within the Partnership had identified areas of learning from implementing Reshaping Care for Older People that would be taken forward into health and social care integration. They also acknowledged the challenges in spreading small scale improvement initiatives throughout the Partnership.

Preparedness for health and social care integration

The Falkirk Partnership had established a new planning and delivery infrastructure in 2013

to integrate health and social care. Although progress had initially been slow, the Falkirk Partnership was now making progress and, in terms of their preparedness for integration, was at a stage we would expect to find at this time.

At the time of reporting, recruitment was under way to appoint the Joint Chief Officer. We were assured that Shadow Joint Board members had been identified and that work was being undertaken to make sure they were aware of their developing roles. In addition, the Falkirk Partnership had recruited a programme manager to manage the health and social care integration change processes.

The Partnership had undertaken significant work on identifying and agreeing financial resources attached to the Joint Strategic Commissioning Plan for Older People. However, as discussed in Chapter 8, work had yet to be undertaken in delivering the jointly agreed financial resource framework and factoring the work of other workstream into this process.

The Partnership had agreed the Integration Scheme in principle which included a timeline of key events. This timeline was very tight with little or no room for slippage on any aspect.

In conclusion, most of the building blocks to achieve health and social care integration were either in place or being put in place. The pace of change needed to be further accelerated and had been. However, the Shadow Joint Board and Joint Chief Officer will face significant challenges before 1 April 2016 in terms of coordinating the workstream activity and delivering a coherent Joint Strategic Plan ready for implementation on that date.

What happens next?

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

July 2015

Appendix 1 – Quality indicators

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

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If you wish to comment about any of our inspections, contact us by emailing **enquiries@careinspectorate.com**, or write to us at the Care Inspectorate, Compass House, 11 Riverside Drive, Dundee, DD1 4NY.

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