care inspectorate

Healthcare Improvement Scotland

# Services for older people in Fife

January 2015

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

HAPPY TO TRANSLATE

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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.

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# Fife Partnership – summary of our joint findings

## Background

Between April and June 2014, The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services[1] for older people in Fife. The purpose of the joint inspection was to find out how well the health and social work services partnership (between Fife Council and NHS Fife) delivered good personal outcomes for older people and their 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 legislative changes designed to get health and social care services to work closer together.

Our joint inspection involved meeting approximately 100 older people and carers who cared for older people, and around 200 staff from health and social work services, and reading some older people's health records and social work services records. We also studied a lot of written information about the health and social work services partnership and services for older people and their carers in Fife.

In Fife, social work services and most community health services were delivered by Fife Council and NHS Fife. Some 3,400 social care and health staff were asked to complete our online survey with 652 staff responding: 25% from Fife Council, 72% from NHS Fife and a further 2% employed in 'other' sectors. This represented a low figure of approximately 19% of the total workforce in the NHS and council for older people's services and should be remembered when staff figures are mentioned throughout the report.

## Key performance outcomes

The Fife Partnership delivered positive outcomes for some older people and their carers and was able to provide a range of services to prevent avoidable admissions to hospital. For example, the Fife Partnership hospital at home project was supporting older people to stay at home or in a homely setting rather than being admitted to hospital for short-term medical intervention. However, the Fife Partnership's performance on ensuring timely discharge from hospital for older people who were medically fit for discharge was more mixed.

[1] S48 of the Public Services 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

The Fife Partnership had yet to consistently meet the Scottish Government's target for delayed discharges, but it was making major changes to the way services initially responded to older people and their carers. They had introduced discharge hubs, but it was too early to measure whether these changes were making a positive difference to outcomes for older people. Home care services in Fife were delivering some positive outcomes for older people. However, there was a significant issue with home care capacity and this had a negative impact on some older people and their carers due to having to go to hospital or having to stay there longer when it could have been avoided. The numbers of older people going directly from hospital to residential or nursing care was higher than in other areas of Scotland.

Whilst self directed support (SDS) was offered as a positive alternative to adults in Fife receiving a service, it had yet to be promoted for older people. The intention was to offer older people SDS who asked for this and also develop a test site to actively promote SDS for older people within 2014.

## Getting help at the right time

The Fife Partnership had a strong, shared vision of ensuring that people received the right support at the right time, delivered by the right people. Staff demonstrated that they were also committed to this vision, whilst acknowledging that there could be challenges in working towards achieving it.

The Fife Partnership was able to show it was shifting from a culture/approach of service-led provision to one of getting the best personalised outcomes for older people and their carers. For example, it had introduced a number of projects providing community-based supports, which increased choice for older people in Fife. The Fife Partnership acknowledged that it needed to do more work to make sure carers had their outcomes met in a more meaningful way.

New services had been developed which meant that more people could be looked after in the community, rather than in a hospital setting. Some progress was being made in getting people who were in hospital discharged into the community much quicker and as a result improving recovery.

Development of new services had mostly been on single agency lines and capacity issues meant that the pathway through services had been compromised at times. Work still needed to be done to ensure that health and social work services worked better together to ensure older people get the health and social care services they need.

Fife Council was making steady progress with the implementation of SDS with other service user groups and was starting to roll this out within older people's services through pilot projects. The Council was aligning this with work on community capacity building so that communities had more tailored, local services to support flexibility, choice and user control.

## Impact on staff

We undertook a staff survey to get the views of staff working across health and social work services in the Fife 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 good access to training, but most of this was delivered individually by health and social work.

Staff said they were working well together across the Fife Partnership on an individual basis and were confident this was likely to improve as services continued to become joined under integration. However, staff did not think there was sufficient capacity to do preventative work: just over half agreed that services worked well together to prevent hospital admission, and less than half agreed that services had improved in the last year.

Generally, staff did not think that change was managed well and did not think that historically, senior managers communicated well. Senior managers had held recent engagement events with staff about integration.

## Impact on the community

We found there was a good range of community supports for older people in place and further proposals under development, with the Fife Partnership seeking to work productively with older people and the third sector in this regard. The Fife Partnership also had a variety of local community projects to encourage independence and reduce health and social care involvement where appropriate. This meant older people had the opportunity to be supported by local services that were not necessarily managed and run by health and social care, which in turn promoted independence and retention of skills. These projects were supported by the Fife Partnership through a range of funding, including the time-limited Change Fund, which raised issues of sustainability.

## Delivery of key processes

Referrals to social work services had significantly increased through the Social Work Contact Centre. We were told it was easy to refer to this service and the most complex cases were dealt with well. There was effective contact with external agencies. However, people with less serious needs had significant waits for assessment and follow-up action where needed.

There was a range of intermediate care services to prevent hospital admission and support timely discharge and while there had been some improvements, discharge planning was patchy across Fife. This impacted negatively on older people waiting to be discharged from hospital as going home from hospital at the right time could be dependent on where they lived. The main reason for delay was the unavailability of home care services.

The quality of assessments, including assessment of risk produced by the Fife Partnership was varied. We were not always clear how agencies had contributed to the assessment. We were

encouraged to hear that local arrangements were being made to ensure that multi-agency meetings would be taking place more frequently, particularly in relation to discharge planning. Social work services had improved their performance in relation to case reviews, mainly through the appointment of dedicated review officers. The recruitment of specialist staff to address delayed discharges in relation to Adults with Incapacity legislation was also beginning to show positive results.

There were good adult support and protection guidance and arrangements in place. However, we found these were not always followed by operational staff. We were reassured that this issue had been picked up by the Fife Partnership's internal audit process. The adult protection committee had prepared an appropriately focussed improvement plan to address this.

There was very good involvement of older people in directing their own support, although there was some scope for improvement in relation to involving independent advocacy services. This would ensure that older people's views would be represented.

There were significant issues relating to carers assessments, particularly about acting on these assessments. We concluded the Fife Partnership needed to engage proactively with the Carers Centre so that carers received the support they needed to provide good levels of care to the older people they cared for.

### Policy development and plans to support improvement in service

We were concerned that the Fife Partnership had struggled to produce a detailed joint commissioning strategy that took account of service design, delivery and improvement. As a consequence, it now had considerable work to do before completing a strategic plan which would underpin the establishment of a new and effective health and social care partnership.

Despite this, we heard the Fife Partnership had developed some new and effective initiatives and services to better support older people in the community. Local Management Groups had an important role to play in ensuring consistent provision for older people across Fife.

As part of its integration agenda, the Fife Partnership needed to develop more robust integrated approaches to quality assurance and self-evaluation.

Whilst there were some good examples of older people, carers and other stakeholders being involved in strategic planning, this was not consistent. The Fife Partnership needed to develop a comprehensive approach to their involvement as part of its planning for health and social care integration. This will make sure that older people and others receive services and approaches that meet their needs.

## Management and support of staff

Fife Council and NHS Fife were developing joint workforce initiatives to make sure that services could be provided to older people more efficiently by properly skilled and trained staff. Recruitment and retention were difficult in some geographical areas and in some parts of the workforce. The Fife Partnership was working to reduce high levels of absence in older people's services.

Most staff believed that there was good joint working at a local level, but there was little work being done to develop joint posts at the time of inspection.

Staff development and training was largely specific to each of the partners, but staff thought that they had access to training appropriate to their posts and supervision was good. There were several initiatives in place which showed NHS Fife and the council's intention to develop a more collaborative approach to joint training and development. For example, the joint Scottish Vocational Qualifications (SVQ) programme (level 2 Health and Social Care) for Fife Council homecare workers and NHS Fife community-based clinical healthcare support workers.

## Partnership working

The Fife Partnership had operated joint financial arrangements over a number of years and despite issues arising at an operational level, financial management appears to have been robust. There are a number of significant challenges and pressures ahead in the provision of more integrated services, particularly in relation to providing services on a sustainable financial footing and remaining within budgets. The strategic planning process will need to take account of this, particularly in relation to investment and disinvestment.

There was no clear joint information-sharing strategy in place. We were reassured that the Fife Partnership was getting help from the Scottish Government to improve this position through grant funding for a series of projects. There were mixed examples of information-sharing systems. Changes to the client information recording system used by social work services were fairly new and still had to be bedded in. Staff reported this system was cumbersome and time consuming, and did not reflect the amount of information sharing across agencies. Given this was not an information-sharing system and therefore did not address the gap in how information was shared across the Fife Partnership. The social work service was monitoring the roll-out of this and working with staff to refine the system.

There has been a varied approach to partnership working in Fife. External agencies and the Fife Partnership had acknowledged that this needed to be strengthened by external agencies and the Fife Partnership. We noted that this had appeared to be improving over recent months. The housing partnership had played a key strategic role which had a positive contribution on partnership working. However, we concluded the Fife Partnership should engage more effectively with the independent, private and voluntary sector partners. We also

concluded the Fife Partnership was on a stronger footing to move forward through the integrated Health and Social Care Shadow Board and Local Management Groups.

## Leadership and direction

The Fife Partnership had made significant efforts to develop good working relationships between agencies. While there continued to be some tensions, particularly at senior management level, the Fife Partnership operated services based on national policies, such as Reshaping Care for Older People, which were delivered within localities through jointly developed and agreed strategies. The Fife Partnership needs to make sure frontline staff were kept informed of progress and to ensure their views and those of the wider community were taken on board in service development.

The Fife Partnership had responded early and positively to develop an infrastructure for planning for integration of health and social work services. Senior managers and elected members were aware of the need for change and agreed about the direction of travel. While there was still significant amounts of work needed before the Fife Partnership was fully integrated, there was a strong base on which to build through the Shadow Board.

Future success of the Fife Partnership's senior management will be dependent on development of a robust joint commissioning strategy, based on full consultation and collaboration. Key services need to be developed and supported to ensure all parts of the Fife Partnership are connected appropriately, particularly in relation to home care, care home and intermediate care provision.

The Fife Partnership senior management team was going to see significant changes through retirements and other staff movements. This was both an opportunity to bring in fresh talent, but also a risk to continuity and consistency for the new director of integrated health and social care.

## Capacity for improvement

We saw evidence of positive outcomes for some older people and their carers in Fife. The Fife Partnership was at an early stage towards integrating health and social work services. The Fife Partnership needed to better monitor how well this was progressing and the pace of change needed to significantly increase.

We mainly saw constructive working relationships among the leaders we met and they understood the direction of travel required to achieve successful integration. Planned changes in key leadership positions would have to be carefully managed. The preparations for integration were underway, but evidence that the changes were impacting positively on outcomes for older people was awaited.

## Outcomes for older people and their carers

### Areas of good practice and for improvement

Areas of good practice

- Fife had an Integrated Community Assessment and Support Service (ICASS) which was an overarching term to describe a group of services whose aim was to improve the quality of care and outcomes for older people. These included three core areas of work.
- Volunteers and Community Connections for People with Dementia and their Carers – Alzheimer Scotland, Kirkcaldy. They introduced enhanced activities in existing day centres and more community-based outreach groups
- The Tool Shed – The Ecology Centre, Kinghorn. This involved older male volunteers working with young volunteers to restore tools for use by local community groups and in Africa.
- Mind your Mind – Fife Employment Access Trust (FEAT). This charity provided mindfulness training to work in collaboration with NHS Fife psychiatric services identifying and assisting clients within the three main psychiatric hospitals to start working towards supported employment opportunities before they are discharged from the NHS services.
- Maintenance Plus – Furniture Plus. Operating out of Dysart, Inverkeithing and Cowdenbeath, this provided a range of services, including basic DIY to older people in their own home.
- Real Living Network – Link Living. They provided a befriending and support service for rurally-isolated people and their carers. This project won the 'Older People's Project of the Year' at the Herald Society Awards 2013.
- Still Points in a Turning World – Nutshell & ON @ Fife. This outreach theatre project combined creative arts, reminiscence sessions with play writing. Winner of Scotsman Fringe First Award - 'Thread'.
- Fife Voluntary Action – following a successful pilot, this group was developing a third sector based project 'Footcare Fife'. It was being developed as a sustainable social enterprise providing personal footcare using volunteers trained and supported by NHS Fife podiatry services. It aimed to help older people to prolong their physical activity, health and wellbeing.
- The Postgraduate Collaborative Leadership Programme, the first of its kind in Scotland, was an impressive joint initiative. It was delivered in conjunction with St Andrews University. Scottish Government departments were funding stakeholders for the programme as they had an interest in learning from this programme and replicating it nationally.

Areas for improvement

- The Fife Partnership should make better use of statistical and qualitative data to inform the development of more flexible service options for older people. This analysis should also be used to inform the Fife Partnership's strategic plans.
- The Fife Partnership should demonstrate how it will make services available to older people, how they fit with the new models of care which have been developed by the Fife Partnership and how they meet the needs of older people. There should be clarity about the interim home care solution being provided with clear timescales for implementation.
- The Fife Partnership should ensure that all care planning for older people involves and is made available to all relevant people.
- The social work service council should ensure it can manage demand, particularly when older people are being discharged from hospital. It should also ensure there are effective communication processes, which will support the management of referrals both internally and to external providers, including health services.
- The Fife Partnership should ensure that its strategic planning activity for services for older people includes older people currently in receipt of health and social care services and their carers. It should also ensure that the plan is compliant with best practice criteria.
- The Fife Partnership should ensure its independent, private and voluntary sector partners are enabled to make a positive contribution at all levels to providing positive outcomes for older people.
- The Fife Partnership should ensure that the Care Home Programme and the Home Care Services Review are closely monitored and evaluated in terms of performance and outcomes for people who use these services.

## Evaluations and recommendations

| Quality indicator | Heading | Evaluation |
|---|---|---|
| 1 | Key performance outcomes | Adequate |
| 2 | Getting help at the right time | Adequate |
| 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 | Weak |
| 7 | Management and support of staff | Good |
| 8 | Partnership working | Adequate |
| 9 | Leadership and direction | Adequate |

| Recommendations for improvement: | |
|---|---|
| 1 | As a matter of urgency, the Fife Partnership should put measures in place to ensure that older people in Fife are discharged home or to a homely setting when they are ready for discharge. |
| 2 | The Fife Partnership should use the available statistical and qualitative data to jointly evaluate current performance and trends to inform the development of more flexible options for older people. This analysis should also be used to inform the joint strategic plan. |
| 3 | The Fife Partnership should provide a robust plan on how it will support service availability and how older people move through services with the new models of care which NHS Fife has developed. The plan should include the interim home care solution being provided with clear timescales for implementation. |
| 4 | To ensure that older people's needs are met at the appropriate time, the Fife Partnership should ensure that anticipatory care planning involves all appropriate stakeholders. These plans should be made available to all relevant staff groups. |

| | |
|---|---|
| 5 | Fife Council should ensure the Social Work Contact Centre can effectively manage demand (particularly in relation to discharge of older people from hospital) within agreed timescales. It should also ensure there are robust communication processes, which will support the management of referrals onwards so that older people receive the support they need from the most appropriate agency and at the right time. |
| 6 | The Fife Partnership should make sure it takes account of older people and their carers in its public engagement activity on strategic planning for services for older people. |
| 7 | The Fife Partnership should produce its long-term joint commissioning strategy for older people as part of its strategic plan for health and social care integration. It should ensure that the strategy is compliant with best practice criteria for joint commissioning strategies and is explicit in how it will provide positive outcomes for older people. |
| 8 | The Fife Partnership should produce a disinvestment strategy for Change Fund projects as a matter of urgency. This should include evaluation of projects to inform decisions about their continuation and the impact these have on improving outcomes. This is especially important, given that some of the Change Fund has been used to meet the normal recurring costs of service provision, rather than projects that help reduce the number of older people going into hospital and or long-term care. |
| 9 | The Fife Partnership should engage with its independent, private and voluntary sector partners to review its existing partnership working arrangements with them. It should ensure that these partners can make a positive contribution at all levels to providing positive outcomes for older people, particularly in relation to service design and development. |
| 10 | The Fife Partnership should ensure that future modelling of services is done in full consultation with partners and that existing plans, in particular the Care Home Programme and the Home Care Services Review, are closely monitored and evaluated in a timely fashion, in terms of performance and outcomes for older people who use these services. |

# 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[2] for individuals and carers. Local partnerships have to produce a joint commissioning strategy. They are currently establishing shadow 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 Fife Partnership's performance against the 10 quality indicators are contained in 10 separate sections of this report. The subheadings 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 carers. The inspections will also look at the role of the independent sector and the third sector[3] to deliver positive outcomes for older people and their carers.

The inspection teams are made up of inspectors and associate inspectors[4] from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We will have 'lay' inspectors who are carers and also Healthcare Improvement Scotland's public partners[5] 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.

[2] The Scottish Government's overarching outcomes framework for health and care integration is centred on, improving health and well-being, independent living, positive experiences, improved quality of life and outcomes for individuals, 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.
[3] The Third Sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers (Scottish Government definition).
[4] Experienced professionals seconded to joint inspection teams.
[5] Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to ensure that it engages with patients, carers and members of the public.

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

Fife is a peninsula between the Forth and Tay rivers in central Scotland. It covers an area of 1,325 square kilometres and has the third largest local authority population in Scotland. It had a population of 366,000 in 2012. Fife's population is growing and is expected to reach 400,000 by 2033.

Fife's birth rate is rising, as is the number of people reaching pensionable age. Fife's population is ageing much faster than is the case for Scotland as a whole. The Scottish Index of Multiple Deprivation (SIMD) identifies that Fife's share of the most deprived data zones has decreased from eight data zones within Scotland's 5% most deprived band in 2009 to six in 2012.

The Fife Partnership is between Fife Council and NHS Fife and they have a co-terminus catchment area. However, there are three community health partnerships, namely: Dunfermline and West Fife; Glenrothes and North East Fife; and Kirkcaldy and Levenmouth.

The joint inspection of services for older people in the Fife area took place between May and June 2014. It covered the health and social care services in the area that had a role in providing services to benefit older people and their carers.

We scrutinised social work services and health records for 84 Fife older people. Older people in the sample had between two and ten health records, all of which we scrutinised. We scrutinised around 400 health records. 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 the reporting of these records. We analysed nationally published and local statistical data about the Fife Partnership's provision of health and social care services for older people. We analysed the Fife Partnership's policy, strategic and operational documents. We spoke with a sample of individuals and their carers, from the 84 older people whose records we read. We also spoke with other older people who received health and social care services and carers. We spoke with health and social work services staff with leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We are very grateful to all of the people who talked to us as part of this inspection.

## Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

The Fife Partnership delivered positive outcomes for some older people and their carers and was able to provide a range of services to prevent unnecessary admissions to hospital for older people. For example, the Fife Partnership hospital at home project was delivering positive outcomes for older people in supporting them to stay at home or in a homely setting rather than being admitted to hospital for short-term medical intervention. However, the Fife Partnership had yet to consistently meet the Scottish Government's target of no delayed discharges over four weeks' duration. This meant older people who were medically fit for discharge had to remain in hospital longer.

The Fife Partnership was making major changes to the way services initially responded to older people and their carers, for example an integrated discharge hub had been opened in Victoria Hospital, Kirkcaldy. However, it was too early to measure whether these changes were making a positive difference to outcomes for older people.

Whilst home care services in Fife were delivering some positive outcomes for older people, there was a significant issue with home care capacity and this had a negative impact on some older people and their carers. The numbers of older people going directly from hospital to residential or nursing care was higher than in some other areas of Scotland.

Whilst SDS was actively offered as a positive alternative to adults in Fife receiving a service, it had yet to be promoted for older people. The intention was to begin to pilot SDS with a wider client group within 2014.

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

One way to show how successful partnerships are at meeting the aims of Reshaping Care for Older People[6], is measuring how many older people are able to stay independent and well at home and remain out of a formal care setting.

[6] The Reshaping Care for Older People is a Scottish Government initiative aimed at improving services for older people by shifting care towards anticipatory care and preventions.

## Emergency admissions to hospital

An emergency admission is 'when admission is unpredictable and at short notice because of clinical need'.

Emergency admissions for people aged 75 and over living in Fife had been increasing against a national downward trend. This was despite the Fife Partnership's individual actions to reduce avoidable emergency admissions to hospital for older people. The Fife Partnership had been trying to develop a range of alternatives to hospital admission and had established a 'hospital at home' service which provided medical treatment to older people within their own homes or in homely settings. This consultant-led service was being rolled out in a phased approach. Staff from residential care, social work and families spoke highly of this service and its ability to work with individuals to keep people from being readmitted or moved from home to hospital for treatment. Early evaluations demonstrated a 6.5% reduction in hospital admissions for people aged over 75. Feedback from those who had received this service had been positive.

The Fife Partnership was also performing marginally better in respect of multiple emergency admissions in comparison to the Scottish average. This can be seen in Chart 1 below which shows that in 2013 it performed better than the Scotland figure by having fewer multiple emergency admissions to hospital for those aged 65 and over. In turn it had fewer occupied bed days for older people following multiple emergency admissions in all three age groups.

The Fife Partnership submitted unpublished data which indicated that NHS Fife had the sixth lowest rate of all NHS boards in Scotland at September 2013 for emergency admissions for those aged 75 and over. That confirmed the rate of multiple emergency admissions had been consistently below Scotland's average as a whole. We concluded that fewer older people in Fife were being admitted and readmitted to hospital by having their needs met by alternative methods, thus allowing them to remain at home.

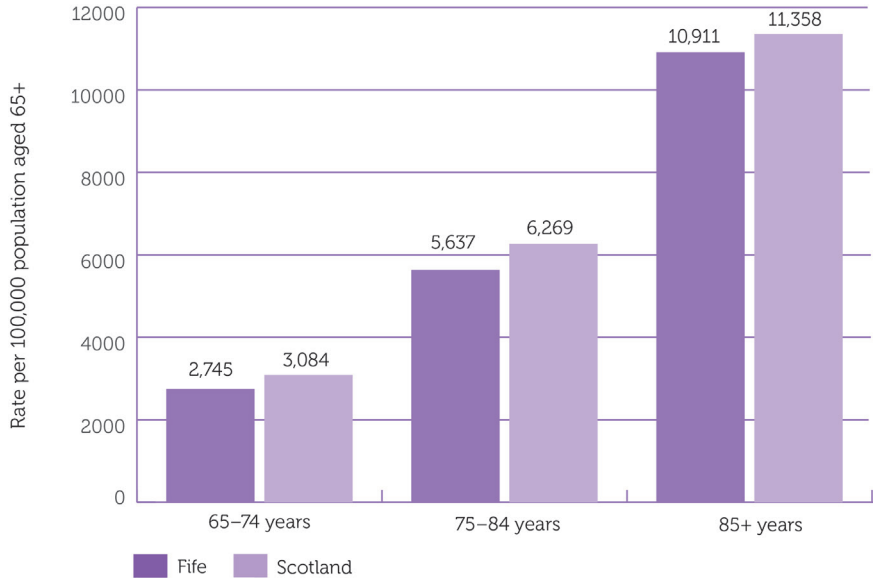
We undertook a survey of staff who were involved, directly or indirectly in providing services for older people across the Fife Partnership. From the staff survey conducted, 54% of those who responded said that services worked well together to successfully prevent avoidable hospital admissions. This was in line with the evidence available as illustrated above.

## Multiple emergency admissions

Chart 1 on the next page sets out Fife's multiple emergency admissions for older people in 2013. Fife numbers across the three age groups remain slightly below the Scottish rate per 100,000.

## Chart 1

Multiple emergency admissions for older people 2013 (rate per 100,000)




(Source: Information Services Division Scotland)

### Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. In April 2013, the Scottish Government set a target that there would be no delayed discharges of over four weeks' duration. This is a two-week reduction on the previous target of six weeks. In 2015, the target will be reduced further to delayed discharges not exceeding two weeks.

When clinically ready to go home from hospital, the necessary care, support and accommodation arrangements should be put in place in the community so that older people can be discharged from hospital in a timely manner. However, there are times when people no longer require hospital inpatient treatment, but they are unable to return home or be transferred to a more homely setting. As the chart below shows, the Fife Partnership performance on preventing delayed discharge against the current four-week target had yet to consistently meet the Scottish Government's targets. Whilst the Fife Partnership's overall performance for delayed discharges showed a slow improvement over time, there remained fluctuations in performance. Although improvements were made in December/January 2014, performance dropped again by the April census with month to month variation over the last year. In Fife, there were 14 delayed discharges of people as at April 2014 which was equal to 0.4 per 10,000 population compared to the Scotland rate of 0.3 per 10,000. This number had doubled from the previous census figures reported in January 2014 where Fife had seven delayed discharges that were outwith the four-week government target. There were a number of reasons given in the statistical report, or identified during inspection for this. For example, home care is

care and support for people in their own home to help them with personal and other essential tasks. A number of health and social work services staff we spoke with told us that the lack of availability of home carers was having a significant impact on their ability to arrange support for older people to return to their homes.

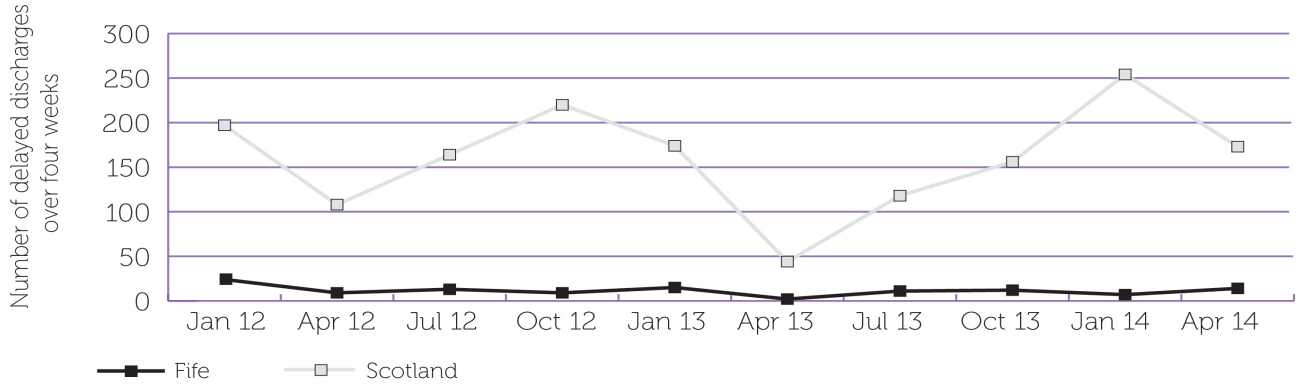
NHS Fife was ranked sixth highest in Scotland in regards to its figures relating to the number of delayed discharges. There was evidence to suggest that the Fife Partnership is making efforts to improve its performance, for example through developments in intermediate care.

**Recommendation for improvement 1 (QI 1.1)**

**As a matter of urgency, the Fife Partnership should put measures in place to ensure that older people in Fife are discharged home or to a homely setting when they are ready for discharge.**

### Chart 2

Number of people waiting for more than four weeks for discharge to appropriate setting in Fife and Scotland, January 2012 to April 2014




| | Jan 12 | Apr 12 | Jul 12 | Oct 12 | Jan 13 | Apr 13 | Jul 13 | Oct 13 | Jan 14 | Apr 14 |
|---|---|---|---|---|---|---|---|---|---|---|
| Fife | 24 | 9 | 13 | 9 | 15 | 2 | 11 | 12 | 7 | 14 |
| Scotland | 197 | 108 | 164 | 220 | 174 | 44 | 118 | 156 | 254 | 173 |

(Source: Information Services Division Scotland)

Delayed discharges can also be due to reasons associated with the Adults with Incapacity (Scotland) Act 2000 and other reasons sometimes deemed beyond the control of the local authority or partners. Code 9 is the term used to describe these complex cases. The major reason for delays where Code 9 had been used was related to patients who lacked capacity to make decisions about their welfare and who required the appointment of a proxy under the terms of the Adults with Incapacity (Scotland) Act.

Fifteen per cent of lost bed days were due to Code 9 delays. This meant that 85% of bed days occupied by older people whose discharge was delayed were not due to complex

legal issues, but more due to services and resources not being available to support timely discharges.

**Recommendation for improvement 2 (QI 1.1)**

**The Fife Partnership should use the available statistical and qualitative data to jointly evaluate current performance and trends to inform the development of more flexible options for older people. This analysis should also be used to inform the joint strategic plan.**

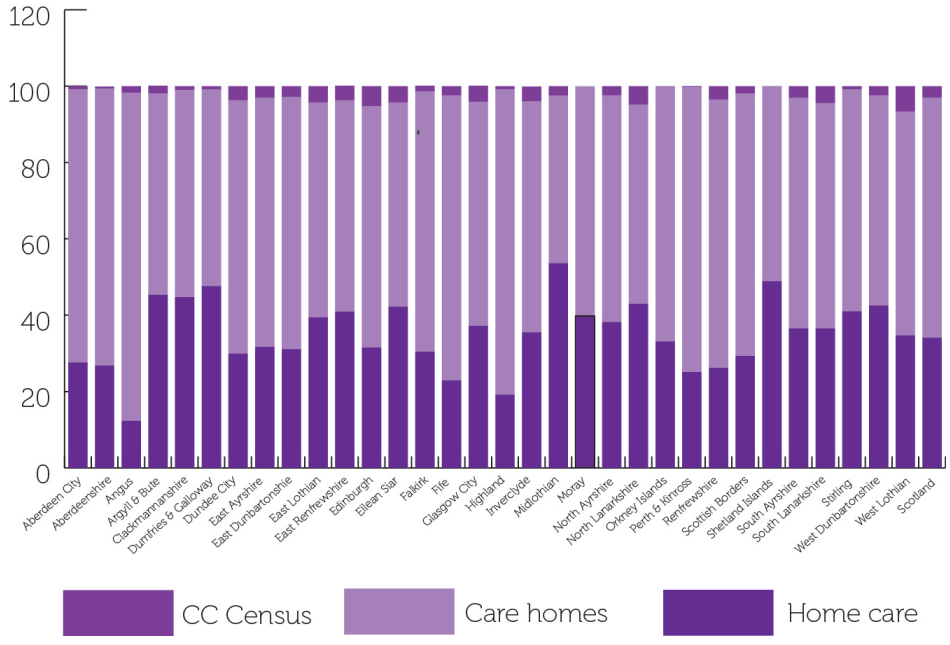
## Provision of home care services

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

These figures indicated that within Fife, the level of home care provision available for older people was significantly lower than the national average.

**Chart 3** shows the Scottish Government's balance of care indicator, which gives the proportion of older people receiving intensive home care as a percentage of those older people requiring significant support in that area (people aged 65+ receiving intensive home care, in a permanent care home place or in an NHS continuing care place). Out of the 32 local authorities in Scotland, Fife had the second lowest rate of older people supported through intensive home care. Fife has consistently remained well below the Scottish national average for the last 10 years.

**Chart 3**
Percentage aged 65 plus receiving 10+ hrs. of care at home, 2013



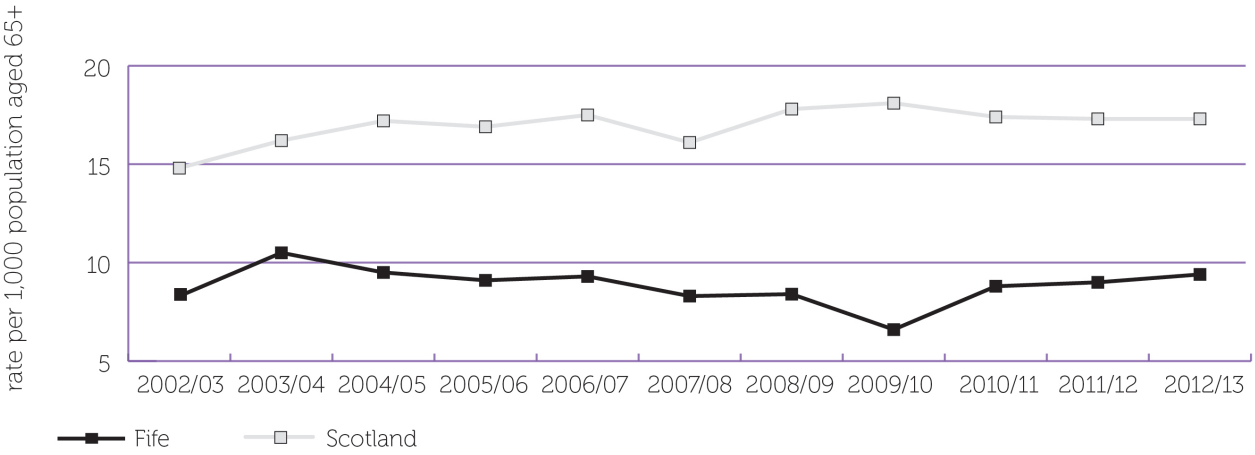

Sources: Scottish Government Quarterly Monitoring, Social Care Survey and Continuing Care Census

**Chart 4** gives the number of people receiving intensive home care (10+ hours each week) in Fife and Scotland as a rate per 1,000 population. It shows the impact of the Fife Partnership's low level of home care provision. This was acknowledged by the Fife Partnership during the inspection. In 2012-2013, there were 630 people aged 65 and over receiving intensive home care (10+ hours per week). This was equal to 9.4 per 1,000 populated aged 65 and over. The Scotland figure was 17.3 per 1,000 population aged 65 and over. This showed that, within Fife, intensive home care was being provided to significantly fewer older people than in other parts of Scotland and well below the Scotland average.

We met with a number of older people and carers who were happy with the service they received, but also heard from older people and their carers waiting long periods of time to access a service. This view was also confirmed by some of the health staff we spoke with. They described no longer expecting care to be provided by social work services timeously and of their attempts to support older people using alternative health resources such as the district nursing service.

### Chart 4

Number of people receiving intentsive home care, 2002-2003 to 2012-2013 (Rate per 1,000 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Fife | 8.3 | 10.5 | 9.5 | 9.1 | 9.3 | 8.3 | 8.4 | 6.6 | 8.8 | 9.0 | 9.4 |
| 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)

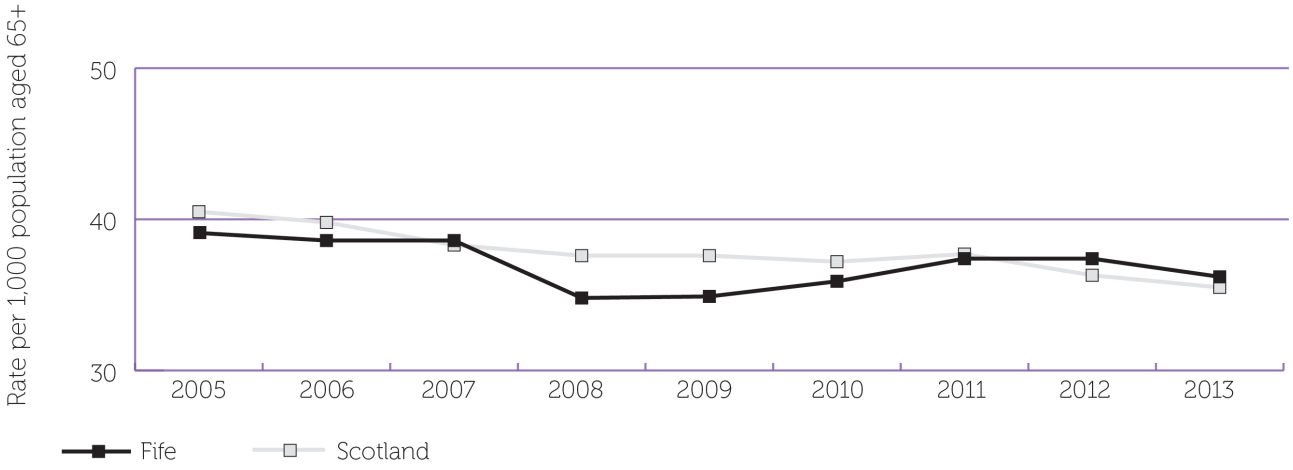
## Care home places

**Chart 5** shows that between 2005–2011 fewer older people were being permanently placed in care homes than the Scotland average. While the rate of older people moving

to live in care homes in Fife was lower than the Scottish average until 2011, the recent increasing trend in Fife saw the Fife rate rise above the Scottish rate in 2012. As of March 2013, there were 2,544 care home residents in Fife. In the same year, there was a slight decrease in the rate of older people in care homes in Fife, although this remains higher than the Scottish average. Our findings suggested that partly as a result of availability of home care and expectations of families, care home options tended to be the preferred option. We were concerned that some of these decisions were being made without the consent of older people who lacked capacity. We discuss this further in Section 5.2.

### Chart 5

Older people in care homes, 2005 to 2013 (Rate per 1,000 population aged 65+)




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|---|---|
| Fife | 39.1 | 38.6 | 36.6 | 34.8 | 34.9 | 35.9 | 37.4 | 37.4 | 36.2 |
| Scotland | 40.5 | 39.8 | 38.3 | 37.6 | 37.8 | 37.2 | 37.7 | 36.3 | 35.5 |

Source: ISD Scotland - Scottish Care Homes Census, 2000-2013)

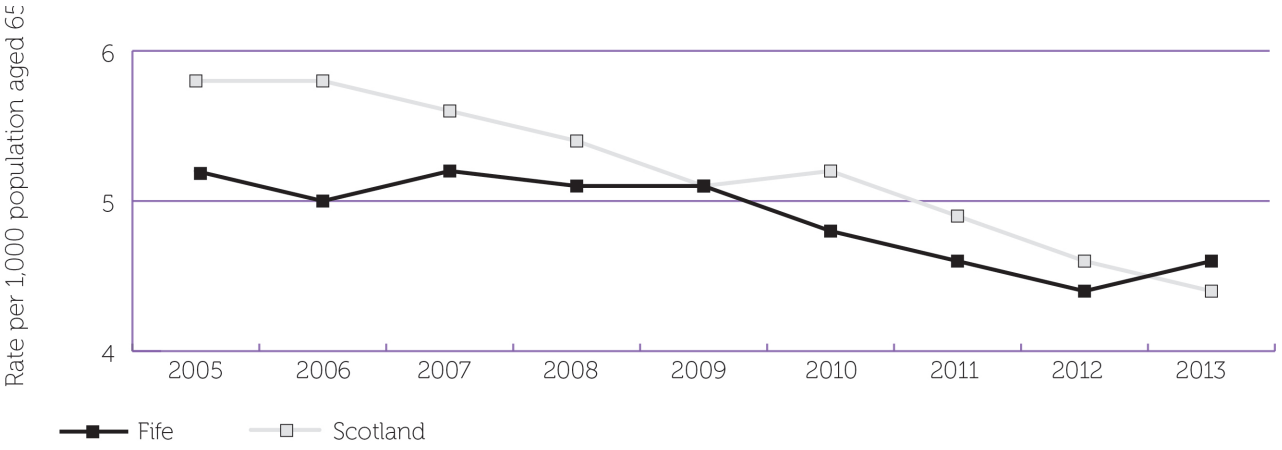
The number of Fife residents in care homes for older people run by the private sector had increased by 31% since March 2000. This was significantly higher than the national increase of only 5%. The decrease in the number of residents in the local authority/NHS and voluntary sector mirrors the steady decline seen nationally, although it should be noted that Fife had experienced a significantly larger decrease in the voluntary sector compared to Scotland overall. The figures were 58% and 23% respectively.

The number of older people in care homes run by the local authority has increased by 1.3% in Fife in the last decade, while nationally there has been a 20% decrease. Within the last year, the number of older residents had increased by 4%, while nationally there has been a 3.5% decrease.

In the last decade, the number of local authority run care homes had remained stable while Scotland overall had seen a gradual decrease as indicated in **Chart 6**.

## Chart 6

Older people in local authority care homes, 2005 to 2013 (Rate per 1,000 population aged 65+)




| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|---|---|
| Fife | 5.2 | 5.0 | 5.2 | 5.1 | 5.1 | 4.8 | 4.6 | 4.4 | 4.6 |
| Scotland | 5.8 | 5.8 | 5.6 | 5.4 | 5.1 | 5.2 | 4.9 | 4.6 | 4.4 |

(Source: ISD Scotland - Scottish Care Homes Census, 2000-2013)

The number of registered places in care homes for older people run by the local authority in Fife had remained stable for the last five years, while nationally there had been a 9.4% decrease in the number of registered places in Scotland overall.

### Performance of regulated care services for older people

The Care Inspectorate inspects regulated services for older people operated by the council and the independent sector. The most recent inspection grades that the Care Inspectorate assigned to services in Fife overall were of a "good" standard, delivering positive outcomes for older people and their carers. During our inspection, the majority of families, carers and older people in care homes we met spoke positively of the level of care and support they received from staff in residential services. Generally, regulated care services for older people operating in Fife, delivered good outcomes for older people and carers.

The table below indicates that the majority of services for older people in Fife were graded 3 or above for the quality of care and support theme. Care homes for older people had a greater number of services rated as good or very good compared to the national average, while support services, which included home care, and housing support services had less services graded as unsatisfactory or poor than the Scottish average, and a higher proportion of services graded as very good or excellent.

The Care Inspectorate grades services on a 6-point scale:

1. Unsatisfactory
2. Poor
3. Adequate
4. Good
5. Very good
6. Excellent

### Grades for Quality of Care and Support theme for services operated by Fife and Scotland as at 31 March 2014

| | | | | Grades | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Care service | Subtype | Number of graded services | | 1 and 2 | | 3 and 4 | | 5 and 6 | |
| Care home service | Older people | 73 | 857 | 1% | 2% | 22% | 17% | 17% | 9% |
| | Respite care and short breaks | 1 | 16 | 0% | 0% | 1% | 0% | 0% | 1% |
| Housing support service | | 38 | 977 | 1% | 0.5% | 5% | 12% | 15% | 19% |
| | Care at home | 41 | 731 | 0% | 0.5% | 7% | 10% | 15% | 13% |
| | Other than care at home | 30 | 513 | 0% | 0% | 4% | 5% | 12% | 11% |
| **Totals** | | **183** | **3,094** | **2%** | **3%** | **39%** | **44%** | **59%** | **53%** |

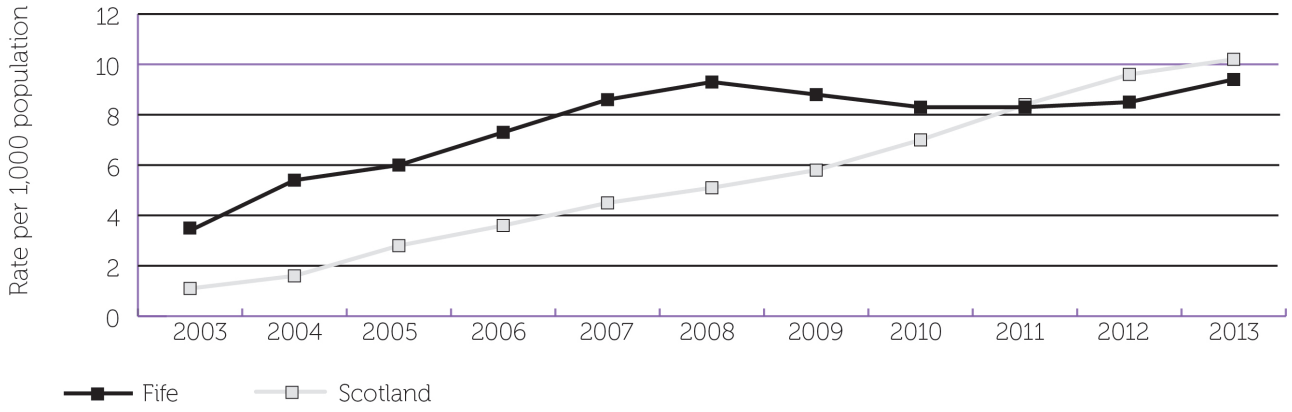
(Source: Care Inspectorate LAN data 31 March 2014))

### 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. **Chart 7** shows that Fife Partnership has over time performed better than the Scotland average in promoting and providing direct payments. However, their performance had deteriorated over recent years compared to the Scottish average, but take-up has increased once more since 2011.

## Chart 7

Clients receiving self directed support (direct payments) 2003-2013 (Rate per 10,000 population)




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Fife | 3.4 | 5.4 | 6.0 | 7.3 | 8.6 | 9.3 | 8.8 | 8.3 | 8.3 | 8.5 | 9.4 |
| Scotland | 1.1 | 1.8 | 2.8 | 3.6 | 4.5 | 5.1 | 5.8 | 7.0 | 8.4 | 9.6 | 10.2 |

(Source: Scottish Government Social Care Survey 2013)

Since April 2014, councils have had a statutory duty to offer the four self directed support options to older people as well as other adults who require social work services. The self directed support options are:

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

The Fife Partnership had focussed its efforts in promoting self directed support within adult services and had undertaken pilot projects to support adult groups. Given the success of these pilots and the implementation of the self directed support (Scotland) Act 2013, self directed support was now being rolled out on a mandatory basis to include older people. However, older people have been able to access direct payments for some time. For example, of the 344 people who had received direct payments (which is one of the four options) in Fife in 2013 these included 37 older people who will be directing their own care towards achieving their personal outcomes.

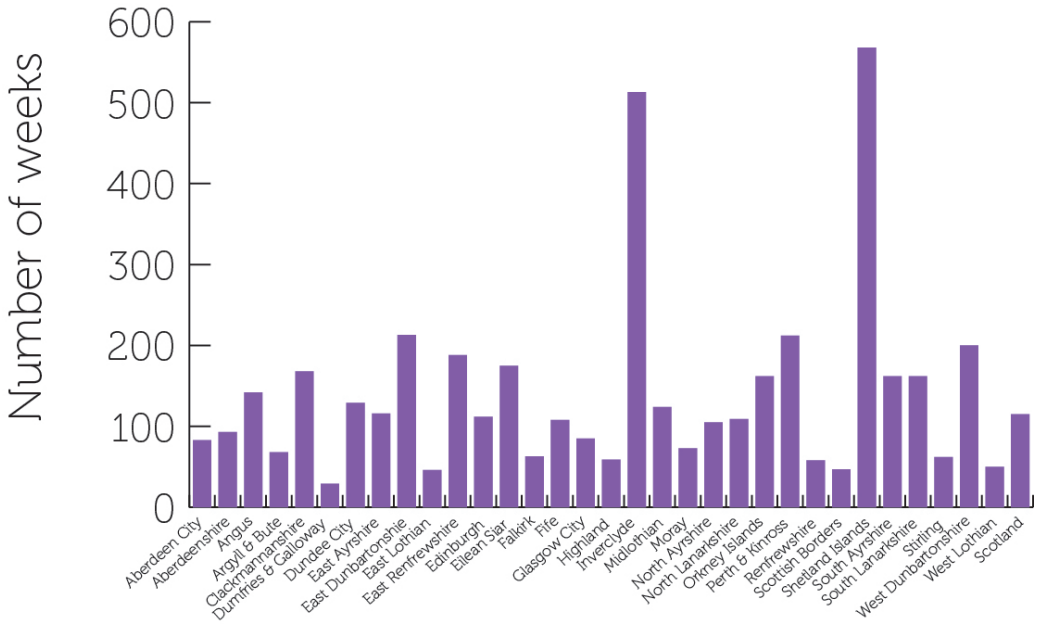
We met with very enthusiastic staff responsible for implementing self directed support who confirmed that they were about to focus and give priority to promoting self directed support within older people's services. It will be important to continue to monitor and accelerate progress and implementation of self directed support with older people as the roll-out progresses.

## Respite

Fife provided a total of 7,240 respite weeks to older people aged 65 and over in 2012-2013. Of the 7,240 respite weeks, 2,750 were overnight respite weeks and 4,490 were daytime respite weeks. These figures were all slightly below the national Scottish average for the same period. Overall, these figures showed that the Fife Partnership delivered slightly less respite to older people and their carers than the Scotland average. During our inspection, we met with some older people who received respite and they spoke positively of their experience. Carers were enthusiastic about the break it gave to them.

### Chart 8

Total number of respite weeks provided to older people, 2012-2013 (Rate per 1,000 population aged 65+)




(Source: Audit Scotland SPI data 2006-2008, Scottish Government 2009-2012)

## 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 sometimes 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 people might spend in hospital or help avoid unnecessary admissions to hospital. Intermediate care can be provided in hospital, people's homes or in a specialist unit, such as a care home or day centre.

Fife had an Integrated Community Assessment and Support Service (ICASS) which was an overarching term to describe a group of services whose aim was to improve the quality of care and outcomes for older people. These included three core areas of work:

- hospital at home
- intermediate care and
- reablement approach.

There were local variations in Integrated Community Assessment and Support Services across Fife localities dependent on what services already existed. The short stay assessment and rehabilitation (STAR) beds were located within five units across Fife providing a new model of support for older people who wanted to continue to live in their own homes. We found early indications to show that these services were having a positive impact on supporting older people remain at home, but these had yet to be thoroughly evaluated by the Fife Partnership. Some staff we spoke with said that because of pressure on resources, the STAR beds and respite resources were vulnerable to being used interchangeably which was having an adverse affect on their abilities to meet service objectives.

We were told about the positive impact the introduction of the integrated discharge hub in August 2013 had in decreasing the delayed discharge figures. The discharge hub was one of the positive outcomes following scrutiny activity by Healthcare Improvement Scotland in 2013. The initial hub was opened in Victoria Hospital, Kirkcaldy. The aim of the discharge hub team is to assess the care needs of older people to enable a planned, supported, timely and co-ordinated discharge to an appropriate care setting. The team also assesses the needs of older people who require support from a multidisciplinary team or other agency. Older people are seen by the team within four hours of referral. Older people referred to the team must be medically fit for discharge, or have a predicted discharge within 48 hours and require support from a multidisciplinary team or other agency. The Fife Partnership intended to roll this model out across Fife over the remaining months of 2014.

## Telecare

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

[7] Source: Scottish Government Social Care Survey 2013 and Home Care Census.

According to the latest statistics published by Scottish Government[7], the Fife Partnership was mainly providing community alarms and more general telecare equipment rather than using more telehealth initiatives. This means older people are accessing services directly rather than from their own home which may be less convenient for them. As of March 2013, 6,313 people, of which 5,466 were aged 65 and over, were receiving community alarm or another telecare service supported by Fife Council. This was equal to 17.24 per 1,000 population, slightly less than the national figure of 21.5 per 1,000 population.

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

### Outcome-focussed care plans

Outcomes are the changes in individuals' lives that are a result of the services they receive. Outcome-focussed assessments and care plans emphasise the desired positive changes the individual wants and the provision of services is designed to achieve. We found from the health and social work services records we read that, overall, there were positive personal outcomes for the older people in the sample.

Of the health and social work services records we reviewed, we considered that 68% of all the care plans were outcome focussed. Staff we met were working hard to implement a more outcome-focussed approach. We concluded there was room for improvement in ensuring that older people's outcomes were considered in the assessment process.

Only 35% of records we read supported the prevention of the individual having to go into hospital whilst in 65% of cases it did not.

In 89% of the older people whose health and social work services records we read, there had been an improvement in their circumstances. There was strong evidence of positive outcomes for the individual as a result of health and/or social work involvement. These positive figures confirmed what we heard from people who used services and their carers we met during the inspection.

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

Summary

Evaluation – Adequate

The Fife Partnership had a strong, shared vision of ensuring that people received the right support at the right time, delivered by the right people. Staff demonstrated through the staff survey and our meetings held with them that they were also committed to this vision, whilst acknowledging that there could be challenges in working towards achieving it.

The Fife Partnership was able to show it was shifting from a culture / approach of service-led provision to one of getting the best personalised outcomes for older people and their carers. The Fife Partnership acknowledged that it needed to do more work to ensure carers had their outcomes met in a more meaningful way.

Whilst acknowledging the Fife Partnership still had a lot of work to do to improve discharge planning, it was clear that it was committed to strengthening a collaborative approach to provide more efficient care pathways. New services had been developed, which meant more people could be looked after in the community rather than in a hospital setting. Some progress was also being made in getting people who were in hospital discharged into the community much quicker.

Development of new services had mostly been on single agency lines and capacity issues meant that the pathway through services had been compromised at times. Work still needed to be done to ensure that health and social work services worked better together. This would make sure older people would receive the help they needed at the right time.

Fife Council was taking a phased approach to the implementation of self directed support with other care groups and was starting to roll this out within older people's services. The Council was aligning this with work on community capacity building so that communities had more tailored, local services in communities to support flexibility, choice and user control.

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

### An outcome-focussed approach

The majority of health and social work services records we read showed that assessments carried out to identify people's needs were good. Outcomes were identified as opposed to services and most outcomes were met. Most of the older people we spoke to were happy with the care they received and with the staff who delivered this. Most of the carers felt they had been included at key points in the care pathway. We saw some good examples of health and social work services working well together and with older people and their carers to provide support at times of crisis.

### Improving care and support for frail older people

We saw good examples of service delivery, such as the Jean Mackie Centre, Dunfermline, which provided good daytime support to older people. We concluded this was a very good resource which used a person-centred approach, individualised assessments and care plans. It had robust systems in place to review individual care needs. There was evidence of the service seeking feedback and responding to concerns raised by older people. They also had on-site support from occupational therapists and linked closely with GP surgeries. There was very positive feedback from older people about this service, with high levels of satisfaction expressed.

We spoke with a number of people who had been unhappy with the discharge process from hospital. Many of these people referred to a lack of access to equipment to support discharge as an issue and we talk about this later in the report. Carers also raised some concerns about whether the training that paid carers received to use this equipment was sufficient.

Older people's experience of support varied at times when they lived in the most rural areas of Fife. Some experienced difficulty in getting services due to their geographical location and this proved particularly problematic if they wanted to use self directed support. We saw local variations and approaches to service delivery as different areas had different needs. However, we were unable to determine if there was a strategic overview in relation to locality planning and there was no evidence that learning from good local service provision or lessons learned from others were being shared across Fife. This also made it difficult for us to assess whether all older people received a similar and consistent response in terms of service delivery, reflective of their needs.

### Supporting carers

Some carers we spoke to said they had received a carer's assessment. This assessment considered the needs of the carer and how they could be assisted by the Fife Partnership directly or through a third party to support the relevant older person they were caring for.

However, most of them expressed dissatisfaction with the support provided following this assessment. It was clear that services had been provided to support the cared for individual and to indirectly support the carer. However, carers said they had received little in the way of personal support. We saw little evidence of assessments in files we read, which would have helped them continue with their caring responsibilities. The carer's assessment had been described as 'cumbersome' by many staff and we were told that social work and the Fife Carers Centre were looking at simplifying the process. Based in Kirkcaldy, Fife Carers Centre describes its aims to support family carers throughout Fife, helping them to sustain their role without compromising their own health and wellbeing. There was universal praise for the Fife Council funded Carers Centre for the support they gave to carers as well as being a source of advice and training to carers.

A number of the carers we spoke with felt that the role and contribution of carers and their needs required to be more fully acknowledged and strengthened. Many felt they had been offered limited consultation opportunities and limited involvement in things that mattered to them. A number of the carers spoke enthusiastically about carer events in the past, but it appeared there had been very few in recent years.

Carers had been involved in the development of the Fife Carers Strategy[8] which was formally launched in 2012. They were also members of the Strategic Implementation Group responsible for implementing the strategy. The Fife Partnership was currently working on linking this strategy with other strategy groups such as the Older People's Strategy Group and the Dementia Strategy Group.

Whilst an action plan was developed to help deliver the strategy, there was little evidence that this had an impact on the life of carers. The Fife Partnership should consider how it can refresh the action plan and ensure that the plan truly reflects the voice of the carers in Fife.

We saw a comprehensive proposal for a more integrated and person-centred approach to transport with this being linked to the discharge processes as transport was raised as an issue by carers during inspection. The proposal would ensure that transport arrangements acknowledged the changing demographics and met the needs of older people and their carers. The proposal also contained a focus on a person-centred approach to discharge transport for older people with complex discharge planning needs in the proposal. This was a comprehensive proposal which would support the integrated discharge hub which opened in Victoria Hospital in August 2013. We look forward to seeing if this is achieved.

The quality of service experienced by older people and their carers was variable and this was mirrored by how staff felt about the quality of services that people received. Of those staff who responded to the survey, 54% agreed/strongly agreed that the quality of services offered to older people jointly by partners/staff had improved over the last year; 46% disagreed/strongly disagreed.

[8] Fife Carers Strategy 2012-2015

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

The Fife Partnership had done a lot of work at a strategic level to develop services that would ensure people got help at the right time and receive care in the right place. Most of the services were single agency, that is provided separately by either social work services or NHS services. This had an impact on the overall quality and choice of care for older people within the hospitals and in the community. A recurring theme within our interviews with staff, older people and their carers was that care at home packages were sometimes difficult to get. This resulted in some discharges from hospital being delayed and some people being admitted to hospital because they could not get a care at home package to keep them safely within their community. Some work had been done to improve this situation. For example, a new integrated discharge hub had been developed in the Victoria Hospital. This hub was having a positive impact on older people being discharged from hospital faster and a reduced length of stay for them. However, health staff did report however that there continued to be some problems with availability of home care packages, affecting discharges negatively.

Fife Council proposed a one-year solution from its budget which would provide more care at home staff for this winter, where traditionally, demand is higher. We were told that care at home models will be highlighted within the joint commissioning strategy and will be taken forward in the resultant strategic plan.

Despite a change to models of care, senior medical and nursing staff reported that Victoria Hospital still had about 25% of patients who did not need to be there. It was felt that this was mainly due to a substantial reduction in home care provision.

We concluded a lot of work still needed to be done to ensure that health and social work services worked better together to ensure older people received the help they needed at the right time.

**Recommendation for improvement 3 (QI 2.2)**

**The Fife Partnership should produce a robust plan on how it will provide effective support to prevent avoidable admission to hospital or support timely discharge home for older people with the new models of care which have been developed by NHS Fife. The plan should include the interim home care solution being provided with clear timescales for implementation.**

### Supporting people with long-term conditions

There were an increasing number of people living with long-term conditions, such as diabetes and asthma in Scotland. This presented a major challenge for health and social care partnerships.

Senior managers told us the Fife Partnership's approach to the management of long-term conditions over the past five years had become more collaborative. There was a focus on more self-management, supported care and caring for people with complex care needs. This change in approach was linked to the Reshaping Care for Older People agenda. The Fife Partnership was trying to make better use of resources and to put better management arrangements in place to support the change.

Health staff told us about a number of services using multidisciplinary staff groups to improve outcomes for people with long-term conditions. For example, we were told about district nurses who provided treatment to older people in their own homes which would previously have only been provided in hospital meaning a reduction in hospital admissions. The Fife Partnership was also targeting areas of deprivation to ensure it captured everyone who needed its support. It was clear that the management of long-term conditions and the importance of a multi-agency approach to this was becoming embedded across all service provision.

We were told about the work of the managed care networks who led the work on long-term conditions. Each managed care network looks at a specific long-term condition and focusses on how high quality services can be provided to older people. There was a lot of positive work being undertaken by these groups and there was evidence of them giving advice and support to other agencies. However, none of the managed care networks had social work or social care representatives sitting on them and in terms of effectiveness, we would expect the Fife Partnership to consider extending its membership to other agencies.

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

We looked at how well the National Standards of Care for Dementia[9] were being implemented in Fife.

The Fife Partnership faced some early challenges with the delivery of the Government HEAT target to deliver expected rates of dementia diagnosis for people. The Fife Partnership sought assistance from the Scottish Government Performance Support Team during 2012–2013. This had led to progress being made to encourage and support GPs to diagnose older people where the dementia was straightforward. There was also an increased focus on building capacity for diagnosis within primary care.

NHS Fife had produced a focussed action plan with clear leads and timescales for delivery. The Performance Support Team was to monitor the implementation of the action plan every two months. Early indications showed the Fife Partnership was progressing well with meeting this target.

The target to ensure that all people newly diagnosed with dementia received a minimum of a year's Post Diagnostic Support by 2015–2016 was also at an early stage.

[9] Standards of Care for Dementia in Scotland: Action to support the change programme, Scotland's National Dementia Strategy June 2014.

At the time of inspection, Post Diagnostic Support was reported to be happening on a small scale with plans to fully implement Post Diagnostic Support hubs across Fife over the next three to four months. Three hubs will be established and will provide a consistent model of Post Diagnostic Support based on Alzheimer Scotland's "5 & 8 Pillars" Model of Community Support[10]. The core functions of the hubs would be to co-ordinate, signpost, report and provide support for people with dementia and their relatives. The hubs would have multi-agency staffing. When fully up and running the target response time for Post Diagnostic Support to commence would be seven to ten days from formal diagnosis.

These hubs would develop the Post Diagnostic Support programme in association with other parties, including medicine for the elderly, psychology, Alzheimer Scotland, Carers' Trust Scotland (formerly the Princess Royal Trust for Carers), people with dementia and their families or carers and other relevant parties.

Recruitment of staff to the hubs was under way and they were expected to be operational by the end of 2014. When fully operational, a named skilled practitioner will lead the care, treatment and support for the person with dementia and their families.

Whilst still in its early stages, we considered that the Post Diagnostic Support hubs would be a robust model of trying to establish locality-based services and meet dementia standards as well as the HEAT target.

Occupational therapists were able to articulate clearly where they could contribute to meeting the dementia standards. They had a unique role in the dementia strategy as allied health professionals (AHP) consultants. We noted positive work was being undertaken to carry out in reach and outreach work and support post diagnostic work. The occupational therapists had developed close links with Fife Carers Centre and had been involved in developing and rolling out training.

A lot of Post Diagnostic Support was being provided by Fife Carers Centre. Carers told us they viewed this as a good resource to learn more about dementia and to meet and share experiences with other carers.

[10] Delivering Integrated Dementia Care: The Eight Pillars Model of Community Support. September 2012.

We saw some other good examples of services to people with dementia:

- The Montrave service was a redesign from Queen Margaret Hospital, Dunfermline in patient model to a local community model. This model meant people were cared for in the community as opposed to as a patient within a hospital. This service was almost fully implemented and was embedded within Integrated Community Assessment and Support Service, as well as the emerging Post Diagnostic Support services to ensure a whole systems approach to delivering the 5 and 8 Pillar models of community support.
- The enhanced assessment and support team was jointly funded and included multi-agency staff. The service provided an intensive, specialist needs assessment service for people with dementia in their own home to avoid admission to hospital. The service covered north east Fife.
- A central assessment and support team was run by a specialist mental health team. This was a short-term, home-based assessment, treatment and support for people over 65 with mental health difficulties including dementia of a complex nature and younger people with an established diagnosis of dementia.

Staff had been appointed to specialist dementia champions or ambassadors posts and this had been rolled out in health and social care to act as a catalyst for change. Staff we spoke with were generally positive about the service. This was reflected in the staff survey where 62% of respondents agreed/strongly agreed that their service did all it could to make sure that older people received a timely diagnosis of dementia. Forty-nine per cent of respondents agreed/strongly agreed that older people were able to access timely Post Diagnostic Support. Fifty-one per cent disagreed/strongly disagreed and this probably reflects the number of pathways that were previously in place. With the establishment of the Post Diagnostic Support hubs and new services, this perception should change.

### Palliative and end-of-life care

The Fife Palliative Care Group was taking forward a comprehensive action plan. This should ensure that people with cancer, chronic illness and life-limiting illness get the support they require at the right time from skilled knowledgeable staff. The group was a high level multidisciplinary strategic group reflecting the clear multidisciplinary approach the Fife Partnership wanted to see in the care and support being given to older people at point of care.

A number of options to further develop cancer services had been drawn up following a recent seminar allied to the Scottish Government, Macmillan Cancer Support and NHS Scotland Transforming Care After Treatment initiative. The Fife Partnership was explicit in the action plan that in order for successful implementation of the action plan, all partners needed to be involved. They also linked outcomes from the options to reducing hospital admissions and providing a clearly defined palliative care pathway.

A wide variety of training and support in relation to palliative care was offered to all levels of staff from health, social care and the third sector. There was very positive evidence of strong engagement with GPs, with a high number of GPs attending a yearly study day offered by NHS Fife.

The Fife Partnership had become more co-ordinated in recent months in how it was addressing palliative care and providing better outcomes for people and have identified where it needs to continue to develop.

### Anticipatory care planning

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

Anticipatory care plans had been completed by GPs. People prioritised for these plans were people who were at moderate and high risk of emergency admission. These anticipatory care plan s were kept with key information summaries. The summary was a way for health professionals to record and share important information about people with complex care needs or long-term conditions. This information could be shared with others such as NHS 24, Scottish Ambulance Service and out-of-hours service. Although social work services staff were unable to access the key information summaries, health staff advised that information could be shared if requested.

The Fife Partnership was trying to improve how it shared information. However, there was little evidence of anticipatory care planning in the files we read, although we were aware that numbers reported by NHS Fife were relatively high. The majority of older people and their carers we spoke with had neither heard of nor had any conversations with staff about any support they might need in the future. The exception was some carers whose GPs had discussed end-of-life and palliative care issues with them.

**Recommendation for improvement 4 (QI 2.2)**

**To ensure that older people's needs are met at the appropriate time, the Fife Partnership should ensure that anticipatory care planning involves all appropriate stakeholders. These plans should be made available to all relevant staff groups.**

We saw very little preventative work being undertaken when we looked at social work case files and a number of carers stated that they would have liked to have had a discussion with staff about what might inform choices in the future. There was a Carers Emergency Card Scheme where plans made by carers could be implemented should there be an emergency or crisis for the carer, but this was not widely used by the carers we spoke with. Preventative and anticipatory care needs to be wider than just this type of scheme.

Staff survey findings in this area were mixed. Forty-nine per cent of respondents agreed/strongly agreed that older people are able to access a range of preventative and enabling services to suit their needs when they need them. Fifty-one per cent disagreed/strongly disagreed. Whilst there were preventative and enabling services available, without improved awareness of these services and identification of these needs, these services would not be accessed by those who might need them in the future.

Older people and their families, whilst generally happy with the services that they received, had mixed feelings about prevention, early identification and intervention at the right time.

'He doesn't get the appropriate service at the right time. It is normally just too late'.

'There has been no discussion about future care'.

'You are given the care that is available, rather than what the individual needs. They have a "cabinet of support". You cannot get anything that is outside of it'.

Social work and social care services should consider how they can take a more preventative approach to their work with older people and their carers. Early and effective pathway planning should be considered by social work and social care to support prevention and this should be clearly evidenced in assessments and reviews.

### Intervention at the right time

We saw some positive changes to ensure that staff could give care and support at the right time and to make sure people were seen by the right professionals to get the support needed. Examples of this included:

- The development of reablement units at two of Fife Council's Care Homes; Alan McLure House, Dunfermline and Valley House, Cowdenbeath.
- Allied health professionals adopting a seven day work pattern including evenings to improve responsiveness, to improve the quality and choice of service for older people by providing support to people at the times they needed, it both within the hospital and in the community. Early indications showed that length of stay in hospital had reduced by one day on average per patient since this started in 2013.
- The adoption of a reablement approach by home care service to all older people as a means of improving or retaining their independence and allowing them to retain or regain control of their lives. The home care training team had also delivered training in reablement approaches to a number of care homes in the independent sector.
- A more timeous response to referrals by using the Social Work Contact Centre. The Contact Centre was able to successfully triage, screen and prioritise all new contacts with referrals screened and prioritised on the day of referral.

Allied health professionals welcomed their developing role. They felt they were now being recognised for the services they could provide and their role in supporting people to remain in the community and helping people with more timely discharges from hospital.

However, allied health professionals were expected by management to meet hospital time standards in the community. We were told that dietetics staff had been put under pressure due to an increase in care home beds. This meant there were more people for them to see, but there had been no increase in their staffing levels.

The Fife Partnership had a community joint equipment store which had been making good progress between 2012–2013 delivering an integrated service which would contribute to the prevention of admission to hospital. This service was jointly funded by Fife Council and NHS Fife and provided a range of aids and equipment to older people in the community. While this service reinforced the Fife Partnership message on prevention of admission to hospital, increased demand meant that equipment was not always provided when it was needed. The increased demands were due to staff being better trained, therefore identifying more people who required support. This was compounded by the changing demographics of an ageing population and increasing complexity of need. The development of the Integrated Community Assessment and Support Service had also led to an increase in the volume of requests to the store. As a result, the Fife Partnership identified a funding gap to maintain the service and cope with increasing demand.

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

Fife Council had made steady progress in implementing self directed support. It was clear that implementation of self directed support was challenging, but many positive steps had been taken. The roll-out of self directed support had started with adult services and was then planned to move on to children and families and then older people's services.

We were confident that self directed support options were being offered. We spoke with a number of people who had accessed self directed support and they spoke positively about how this allowed them to get more flexible services at times that suited them and from service providers other than Fife Council. Fifty-eight per cent of staff agreed or strongly agreed that their service worked well with partners to promote the implementation of self directed support with 42% who disagreed or strongly disagreed. However, there was still a lot of work to be done to ensure that staff were championing self directed support. The Fife Partnership acknowledged that, while there had been mandatory awareness training and assessor training for the pilots, the older people's staff groups' awareness of self directed support was patchy at the moment. This training was being rolled out and while staff had been slow to undertake self directed support assessor training, this was steadily improving. A self directed support resource pack had been developed by social work services and was available for all staff. A link to an Open University personalisation course which was aligned with the self directed support approach had been sent to all staff.

The Fife Partnership had identified risks associated with moving forward with self directed support including the potential risk of abuse to carers from an older person as an employer, particularly in terms of ensuring suitable terms and conditions, training and support. Other risks identified included financial and budgetary risks and the risk of an inconsistent approach to service choice and quality. However, there needed to be more clarity about how the Fife Partnership would mitigate these risks. Whilst the NHS in Fife does not legally have to make self directed support payments to older people, there will be implications for the NHS because of the future pooling of budgets. It is important that these risks are clearly addressed by the Fife Partnership.

We noted good practice in the self directed support assessor training where older people who had been through the self directed support process contributed by sharing their real-life stories to reinforce the positive messages from personalised outcomes for future participants of self directed support .

There was a self directed support and Older People Advisory Group which was a multi-agency group. Membership included day care providers, the independent sector, the Scottish Care Workforce Development and Advocacy forums. There was evidence of Fife Council regularly updating external agencies on the progress of self directed support and involving them in self directed support and Community Capacity Building events.

There had been a self directed support conference held in the Rothes Halls, Glenrothes in March 2012 and there were a lot of good, informative leaflets for older people about self directed support. Feedback from older people and practitioners stated that, along with the single shared assessment and the resource allocation system, the self directed support process was too bureaucratic, repetitive and lengthy. Work was continuing to streamline the process. The updated assessment and support planning paperwork would use the Talking Points approach making it more outcomes focussed and accessible for older people. The Talking Points framework classifies the outcomes important to individuals into three broad categories: quality of life; process; and change.

The Fife Partnership was in the early stages of making the link between self directed support and Community Capacity Building and it should continue to develop this and ensure that there are local alternatives to the services that had traditionally been available to people. There had been investment in local area co-ordinators based both in the self directed support team and in the Fife Elderly Forum to extend links into the community and help build up low level service, usually through self-help or voluntary input. This was a very positive move. The Fife Elderly Forum had contacts across Fife and provides information and advice on issues which affect older people and their relatives. They also provide a professional independent advocacy service to older people. As well as providing this service, they also act as a voice on older people's issues, consulting with older people and feeding back their concerns and issues to the Fife Partnership.

Consultation with local communities, older people and carers should continue to ensure new services meet the needs of those communities. Asset Mapping (which is a visual and participatory approach to documenting a range of strengths, assets, talents and resources within individuals, organisations and communities) had started and this mapping exercise was carried out to enhance the self directed support experience and outcomes for people by developing an increased knowledge of what communities could offer, particularly those socially isolated.

The Fife Partnership should build on its work with the third sector and private providers and set out its direction within the strategic commissioning plan.

# Quality indicator 3 – Impact on staff

Summary

Evaluation – Adequate

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 good access to training, but most of this was delivered individually by health and social work.

Staff said they were working well together across the Fife Partnership on an individual basis and were confident this was likely to improve as services continued to become joined under integration. However, staff did not think there was sufficient capacity to do preventative work. Just over half agreed that services worked well together to prevent hospital admission, and less than half in our survey agreed that services had improved in the last year.

Generally, staff did not think that change was managed well nor that historically, senior managers communicated well. Senior managers had held recent engagement events with staff about integration.

## 3.1 Staff motivation and support

### Motivation

We considered a range of evidence, including employee surveys carried out by the Care Inspectorate and Healthcare Improvement Scotland, and a range of training plans. We were provided with no evidence of any staff surveys conducted by local partners.

We met with approximately 200 health and social care staff over the duration of the joint inspection. Some 3,400 social care and health staff were asked to complete our online survey with 652 staff responding: 25% from Fife Council, 72% from NHS Fife and a further 2% employed in 'other' sectors. This represented a low figure of approximately 19% of the total workforce in the NHS and council for older people's services.

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

- 90% of staff said they enjoyed their work
- 84% agreed they were well supported in situations where they may face personal risk
- 69% said there were positive working relationships between practitioners at all levels
- 78% felt valued by other practitioners and partners, and
- 69% of staff agreed that they felt valued by their managers (31% disagreeing).

These results were also confirmed in the focus groups of health and social care staff we met during our fieldwork. However, some district nurses expressed concern about the future of district nursing.

Less positively, only 26% of staff agreed that there was sufficient capacity within their team to carry out preventative work; it was lower (20%) for council staff. The majority of staff agreed that their workload was managed to enable them to deliver effective outcomes to meet individual needs, 33% disagreed.

Only 34% of staff agreed that changes which affected services were managed well, with 56% disagreeing and 10% saying this was not applicable to them. Only 47% of respondents agreed that senior managers communicated well with frontline staff. At the time of the inspection, senior managers in health and social care were running a series of joint information sessions for staff about integration.

We met with a large group of frontline health staff who were positive about coping with the many challenges connected with the introduction of new initiatives, for instance the discharge hub and STAR beds. However, their limited access to communication about these initiatives was shared by a group of frontline social work staff who expressed similar concerns about changes and communication about them.

Social work managers told us about recruitment difficulties in some areas of staff to undertake care at home work. Whilst a recent review of staffing had resulted in some improvements through changes to work patterns and contracts, difficulties were still being experienced. These difficulties were presenting difficulties for front line staff. The new arrangements were not delivering the support required when needed. This meant there were staff with down time at key periods when there was a need for home care to be provided.

The interim Head of Service was undertaking a review of the Fife Council home care service with a view to maximising its capacity to ensure it was more able to respond to the growing demands in an efficient and effective way. In the meantime, recruitment of home

care staff had ceased completely. This service had waiting lists of older people waiting for a home care service. The review was aimed at achieving more flexibility in terms of when staff could support people, the ability for staff to work across health and social care settings; a pay review and better career structure for staff. This was currently with trade union groups for discussion. We hope this latest review activity will be more successful as this group of staff will provide the framework for providing care in people's homes and maintaining more people in the community. However, a lot of work needed to be done to plug the gaps in care at home provision.

### Teamwork

Staff we met told us there was good day-to-day communication and working relationships between health and social care 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:

- 69% agreed that they felt their service had excellent working relationships with other professionals
- 73% agreed that their team worked well with other agencies to keep people safe and to protect older people from risk and harm
- 66% 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
- 60% of staff agreed that they worked well together to ensure they were successful in helping older people live as independent a life as possible, although 70% agreed that their own service did everything possible to make sure people were supported to live as independently as possible, and
- 69% agreed that services did everything possible to keep older people at home and in their local communities. When asked to give an example of a joint initiative in Fife which had successfully helped to improve outcomes for older people, the most common service mentioned was Hospital at Home, followed bythe Integrated Community Assessment and Support Service.

However, there was some staff uncertainty about what the future integration of health and social work services might mean for their work. This was reflected in our staff survey findings.

- Only 59% agreed that the support they provided jointly was successful in helping older people lead less isolated lives.
- Only 54% agreed that services worked well together to successfully prevent hospital admission, with 35% disagreeing.
- Only 40% agreed that the quality of services offered to older people jointly by partners had improved over the last year, with 34% disagreeing and 26% indicating that the statement was not applicable to them. When asked for an example of a joint initiative that would improve outcomes for older people in Fife, the most common replies identified improved communication, more joint working and integrated teams.

### Learning and development

Most staff reported that they were able to gain access to appropriate training, development and supervision in their respective professions, although some thought that there was less access to training than previously. In our survey, 77% of respondents agreed that they had good opportunities for training and professional development. Seventy-eight per cent of staff agreed that they had access to effective line management, including regular profession-specific clinical supervision within the Fife Partnership.

The provision of joint training was less clear. We would expect more adult support and protection training to be delivered jointly despite logistical issues around volume and geography. However, staff we met reported this training was largely delivered separately within health and social work. Staff told us there was some other joint training available and some staff thought that self directed support training needed to be rolled out, particularly for health staff.

## Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

We found a good range of community supports for older people in place and further proposals under development, with the Fife Partnership wanting to work productively with older people and the third sector about this. The Fife Partnership also had a variety of local community projects to encourage independence and reduce health and social care involvement where appropriate. These were supported by the Fife Partnership through a range of funding, including the Change Fund. However, this raised issues of sustainability as this short-term funding would cease.

There was less evidence of engagement and Community Capacity Building from a more strategic perspective. It was not clear where this sat in broader organisational or partnership plans. Although recently agreed by the Shadow Board, there was no detail about a planned or structured strategic approach within older people's services.

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

It was clear from the meeting with elected members, senior managers and staff we met that they recognised the need to develop community capacity that is the scope, range and availability of services for older people in the community. They placed significant importance on the role that local communities and community organisations could play in providing support to older people.

Fife's third sector led the development of a Community Capacity Building programme to assist with preventing avoidable hospital admissions work as part of the Reshaping Care for Older People initiative. Their focus was on tackling social isolation for older people, helping them to have an active and healthy retirement and to live independently in a homely setting. It also sought the third sector's participation in the design of services and activities that impact on them. To support this financially, the Community Interventions Fund (CIF) had been launched in January 2012 to fund innovative third sector projects.

Examples of projects were:

- Volunteers and Community Connections for People with Dementia and their Carers - Alzheimer Scotland, Kirkcaldy. They introduced enhanced activities in existing day centres and more community-based outreach groups
- The Tool Shed - The Ecology Centre, Kinghorn. This involved older male volunteers working with young volunteers to restore tools for use by local community groups and in Africa.
- Mind your Mind – Fife Employment Access Trust (FEAT). This charity provided mindfulness training to work in collaboration with NHS Fife psychiatric services identifying and assisting clients within the three main psychiatric hospitals to start working towards supported employment opportunities before they are discharged from the NHS services.
- Maintenance Plus - Furniture Plus. Operating out of Dysart, Inverkeithing and Cowdenbeath. This provided a range of services, including basic DIY to older people in their own home.
- Real Living Network – Link Living. They provided a befriending and support service for rurally isolated people and their carers. This project won the "Older People's Project of the Year" at the Herald Society Awards 2013.
- Still Points in a Turning World – Nutshell & ON @ Fife. This outreach theatre project combined creative arts, reminiscence sessions with play writing. Winner of Scotsman Fringe First Award - "Thread".

We read how these innovative projects were meeting or exceeding their target and were having a positive impact on the lives of people in the community. They were generally in a position to grow, but struggling to plan for this due to the uncertain financial climate at the time of inspection. There were concerns from service providers that the community resources and services which had been developed might not be sustainable and that the momentum which had been built up in Community Capacity Building would be lost.

A number of other initiatives established within the voluntary sector had been funded from the Change Fund[11], including the following:

The Shine project had 30 staff trained and a network of 15 micro-providers established. The project aims were to:

- support staff to have conversations that focussed on personal outcomes for older people, and
- build the infrastructure to sustain this model within the Fife Partnership through integrated working with Fife Council, third and Social Enterprise sectors, support the development of the micro-provider sector – growing the capacity to work flexibly with older people in ways that are legal, safe and sustainable.
- The Fife Elderly Forum was a very positive joint initiative. Local area co-ordinators were appointed by the forum. From when they began in 2011, they had been proactive in developing their role with older people in Fife. Their remit was to bridge gaps by supporting partner agencies to develop new strands to their service. They were also given the remit to map out existing provision and were responsible for launching an online service for an older people directory which went live in summer 2013. During November 2012–November 2013, they had received 313 referrals and had worked with 424 older people with an average age of almost 80 years. Local area co-ordinators in the self directed support team were assisting with capacity planning issues and making good use of the NHS directory of community resources system. Intelligence was being collated and capacity planning issues were to be progressed one locality at a time.

The local area co-ordinator team had also helped develop a framework to support the Blether Together initiative, whose objective is to provide telephone contact for local people who may be cut off from friends, family and the wider community. This is supported by volunteers. The co-ordinators' work also included securing funding to support sustainability and offer advice to older people, informing and signposting to other services across Fife. Whilst we were impressed by the positive initiatives within the voluntary sector, we saw there was limited evidence of current and robust evaluation of all these projects or evidence of long-term plans to support their development.

The Fife Partnership told us it was committed to involving the public in policy and service development. We saw some good examples where people who used services and the wider community had been consulted through engagement events, for example in developing the new advocacy strategy, new care home re-provision, Let's have a blether

[11] As part of the Reshaping Care for Older People agenda, £230 million Older People's Change Fund was made available to Health and Social Care Partnerships from the 2011-2012 financial year. A further £70 million will be available for the 2014-2015 financial year. NHS Boards and their local authority partners submitted change plans, detailing how they proposed to spend this funding.

event and People's Panel survey. Fife People's Panel was a group of people who had volunteered to help improve Fife by giving their opinions and observations on a variety of public issues. Launched in June 2006, the Panel was organised by Fife Partnership - which combines Fife Council, NHS Fife, Police, Fire Service and the voluntary sector.

The Fife Advocacy Strategy 2013–2017 and action plan, which encompassed all service users including those with mental health issues, was developed in partnership with service users, carers and voluntary sector service providers and approved by the Health and Social Care Partnership in November 2013.

We were told about the review and redesign of the advocacy services in line with the aims for the new advocacy strategy. The local independent advocacy forum comprised providers, service users and other key stakeholders. However, advocacy services for older people were yet to be fully established. We say more about Blether Together in Quality Indicator 6.

A Long-term conditions reference group to influence and guide service delivery and design, consisting of health and social care staff, patients and members of the public representatives had been established, but it was too early at the time of inspection to evaluate progress.

The Dunfermline and Levenmouth Local Management Group had worked with the voluntary sector via Fife Voluntary Action to develop a footcare service where volunteers had been recruited, trained and supported by NHS podiatry staff to provide basic footcare to people in the community. We saw this as a very positive Partnership and community initiative.

**Examples of good practice**

**Following a successful pilot, Fife Voluntary Action was developing a third sector-based project "Footcare Fife". It was being developed as a sustainable social enterprise providing personal footcare using volunteers trained and supported by NHS Fife Podiatry. It aimed to assist older people to prolong their physical activity, health and wellbeing.**

Adult protection newsletters provided information that promoted safe and healthier lifestyles and promotion of use of community resources. They also mentioned community interest banks which collected views and experiences of inequality from the community and equality groups in Fife. We would encourage the Fife Partnership to ensure the valuable information collated should be used to inform future design of services.

Fife was beginning to make good progress in their approach to locality planning. The membership of the Local Management Groups had been reviewed to include representatives from the independent and voluntary sectors. Each Local Management

Group had its own action plan and a development budget of £130K. One Local Management Group had been looking at transport options; another had secured access to some scatter flats for people discharged from hospital with no immediately/ready accommodation with volunteers available to provide assistance by switching on power/ heating and buying groceries for example. We say more about Local Management Groups in chapter 6.

The Fife Partnership acknowledged it needed to do more to measure the outcomes of community supports, embed good practice and to find out how well regarded its own services were by the wider public. The Shadow Board approved work to develop a more joined up approach to community capacity building. The draft joint commissioning strategy included a number of development areas that would support this, including:

- progressing the development of social enterprise;
- supporting development of low level interventions as informed by older people, such as time-banking (a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants 'deposit' in a time bank, perhaps by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they themselves are in need) and befriending;
- developing a sustaining network of community supports; and
- increasing the capacity of the third sector interface.

Service providers told us they were anxious about the decentralisation of the council into the proposed seven locality areas and the review of grant funded projects. Their concerns related to the consistency, quality and availability of third sector funding under this proposal across geographical divisions. Whilst this was a valuable exercise we would have expected the review of grant funded services to have taken place well in advance of planning for integration. We make a recommendation for improvement about this in chapter 9.

We read the NHS Fife volunteer guide for staff and Fife Council volunteer policy. Although the council's policy was out of date there were positive moves to engage and meaningfully involve volunteers. There was a volunteer development co-ordinator with a specific remit for community care-related volunteering activity. Documentation we read showed that there were 70 volunteers providing a diverse range of support from befriending, gardening and assistance with IT. In 2012, there had been 188 requests for volunteers of which 150 had been met.

Older people who used services and their carers valued the Real Living café community resource in High Valleyfield, which enabled individuals to come together and participate in meaningful activities. It was viewed as a lifeline by a number of older people and their carers that we met and was particularly valued by those who lived alone. It was run by Link Living a charitable organisation and had been operational for two years. Volunteers

facilitated and ran the café with two paid staff employed by the charity. We think the Fife Partnership should consider rolling out this model across Fife as the older people and their carers we spoke to said this was a very important part of their life. Older people said they enjoyed meeting people and socialising, including trips organised by Link Living. Carers were happy to meet other carers and interestingly stayed with the older person for the entire session.

Older people and their carers we met were generally positive about the community support services available for older people. However, they said that in some areas there was an absence of suitable public community transport. This gap could be a significant factor in preventing older people from connecting to their communities and engaging with centre based services outside their local community.

We asked about community involvement in our staff survey. The results from those that responded were as follows:

- 37% who agreed/strongly agreed that their service recognised and consulted diverse local communities about levels, range and quality and effectiveness of services
- 0% who agreed/strongly agreed that there are clear joint strategies to promote and expand community involvement and community change; and
- 43% who agreed/strongly agreed that there is a strong positive engagement between partners and local community and voluntary groups. (With NHS staff being slightly more positive in their response generally to these questions.)

We found NHS staff were more positive about engagement between partners, community and voluntary groups. However, at our focus groups with frontline staff there was still limited awareness amongst them that health and social work services had an important role to play in developing community capacity.

## Quality indicator 5 – Delivery of key processes

The Contact Centre was the first point of contact for people in the community and other agencies and there had been a significant increase in referrals.

We heard it was easy to refer to this service and the people with most complex needs usually received a prompt response. There was effective contact with external agencies. However, people who did not meet the criteria of having critical or substantial needs had significant waits for assessment and follow-up action where needed. There was a range of intermediate care services to prevent hospital admission and support timely discharge. While there had been some improvements, discharge planning was patchy across Fife. This impacted negatively on older people having to wait to be discharged from hospital. The main reason for delay was the unavailability of home care services.

The quality of assessments produced by the Fife Partnership was varied. It was not always evident from the records we read how agencies had contributed to the assessment. We were encouraged to hear that local arrangements were being made to ensure that health and social work staff were beginning to meet more frequently, particularly to plan individuals' discharge from hospital. Social work services had increased the number of people whose needs were regularly reviewed, mainly through the appointment of dedicated review officers. The recruitment of specialist staff to help plan for those individuals whose discharge was delayed due to their lack of capacity was also beginning to show positive results.

Good adult support and protection guidance and arrangements were in place. However, we found these were not always followed by operational staff. We were reassured this issue had since been picked up by the Fife Partnership's internal audit process and were beginning to address this. The quality of risk assessments was varied. However, there was very good involvement of older people in directing their own support. There was some scope for improvement in the involvement of independent advocacy services to ensure older people needing this service had an opportunity to have their views heard.

There were significant issues relating to carers assessments, particularly about acting on these. We concluded the Fife Partnership needed to engage more proactively with the Carers Centre.

## 5.1 Access to support

Since December 2012, the social work service had operated a Contact Centre. This aimed to:

1. provide a single point of access for new enquiries (service user and professional)
2. improve outcomes for service users by enabling the delivery of a seamless and joined-up service
3. improve consistency and quality of service by providing a focussed approach to service user contact across the service, and
4. help to meet the service efficiency savings through better use of staff time and resource; supporting a corporate approach to delivering more services at first point of contact.

We found that there were elements of good practice within this system. Clear guidance and service standards underpinned the operational delivery of this service. Additionally, clear communication standards with referrers were also embedded in all key processes. In addition, all referrals were cross referenced with health to determine their involvement or seek their advice.

The service was handling approximately 100 more referrals a month than the previous year. Contact Centre staff took account of the social work service's eligibility criteria, which in line with national practice, were set out in terms of critical, substantial, moderate and low needs. Contact Centre staff completed an initial screening of enquiries. Staff directed people to community resources where they considered that the person's needs could be met by the community resources, rather than by a council or health service.

The Contact Centre operated a referral 'Ladder' system which was a means of prioritising the response to all new referrals. We were advised that on average this would have about 50 referrals on it at any one time. Contact Centre staff said that they were able to deal with referrals for people screened as being in critical or substantial need within 24 hours or a number of days. However, people screened as moderate/low they should be signposted / diverted by the Contact Centre. We heard these people could have to wait up to four weeks before having an initial assessment of their needs by the Contact Centre staff. It could then take up to a further six months before any required follow-up was provided by locality teams.

NHS staff we spoke with said all new referrals had to go through the Contact Centre and that this could cause delays in obtaining a social work response. Social work managers acknowledged this, but said where a social work staff member was already involved with an older person, direct contact could be made with that staff member.

We saw that planning for the Contact Centre had included a proposal to review its operational effectiveness. Such a review had not commenced at the time of inspection.

Given the challenges faced by the Contact Centre in responding to referrals for individuals with seemingly moderate or low level needs, we concluded that the planned review should be undertaken as a matter of priority. We also concluded that the review should include a focus on the Contact Centre's role in dealing with the key issue of hospital discharge planning.

**Recommendation for improvement 5 (QI 5.1)**

**Fife Council should ensure the Social Work Contact Centre can effectively manage demand (particularly in relation to discharge of older people from hospital) within agreed timescales. It should also ensure there are robust communication processes, which will support the management of referrals onwards so that older people receive the support they need from the most appropriate agency and at the right time.**

The Fife Partnership had developed a number of intermediate care services such as the Integrated Care Assessment Support Service. This service provided a wide range of services including prevention of admission, early supported discharge, community falls response, rehabilitation, long-term conditions, palliative care, dementia, day hospital and Hospital at Home.

Intermediate care teams, covering a range of integrated services to provide rehabilitation to promote faster recovery from illness, prevent unnecessary hospital admission, support timely discharge and maximise independent living. The intermediate care teams were part of the Integrated Community Assessment and Support Service. The other services in this service were Hospital at Home of which early data are showing an impact in the prevention of hospital admission; Community Hospital Beds; Day Assessment Treatment and Rehabilitation and Reablement Services. These services worked in collaboration to ensure that the older person received the right care at the right time. Senior medical staff were cautious about celebrating the success of these services too soon and stressed that there needed to be a systemic change which would be the focus of the models of care analysis currently being undertaken by a Shadow Board working group.

In order to prioritise and ensure home care availability, reablement team leaders had started to attend Integrated Community Assessment and Support Service allocation meetings every Thursday. The waiting lists for this service had reduced significantly, with this standing at two people in one Community Health Partnership area. However, it was acknowledged by social work managers that home care managers were tackling this differently across Fife. Difficulties recruiting staff had led to some people from these areas having to remain in hospital until carers became available to support them at home.

The development of a frailty screening tool and an assessment tool which were being used in accident and emergency and two assessment wards. Use of tools such as: Comprehensive Geriatric Assessments, Delirium Pathway and Cognitive Impairment

Pathway would ensure that the right professionals from the multidisciplinary team would provide interventions to the older person.

Occupational therapists and physiotherapists had been brought together with the rapid assessment discharge team to support effective discharge. There was evidence of podiatry staff and speech and language therapists consulting with older people and their carers to see if extended hours or weekend working was something that they wanted - to provide services at a time that was best for them.

Third and voluntary sector staff told us they were aware of the pressure on the council's care at home service. They had created their own resource directory and were informing individuals of independent providers' response to this.

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

We noted positive findings about needs assessments from the health and social work services records we read. Most of the assessments we evaluated were located in the social work files.

- In almost all cases we looked at (95%), there was an assessment of need on file.
- In two thirds of cases considered, there was indication that information from a range of professionals had contributed to the assessment.
- 56% of assessments we rated were good or better. None were rated unsatisfactory.

In a third of the records we read, where assessments indicated a range of services was required, the assessment did not include information from other professionals such as allied health professionals. However, it was evident from interventions taken that joint working was taking place.

We also identified, that multi-agency case conferences were not routinely taking place as part of hospital admission and discharge planning. We talked to families and staff who confirmed that case conferences were not routinely planned and implemented. Some families told us they wanted their relative to be admitted to a care home because they could no longer cope and said they had argued strongly with health staff to achieve this. Social workers advised that, for some people, the need for care was pre-determined before their involvement. Multidisciplinary and multi-agency meetings, including case conferences, can provide important opportunities to meet, reflect and take account of all necessary assessment information as part of making care and treatment plans, particularly in relation to delivering care to people with complex care needs. Partnership managers indicated the new-locality based multidisciplinary and multi-agency "Verification Panels" could effectively address these issues. The Fife Partnership should satisfy itself that this is the case.

We had mixed findings on the planning and delivery of care and support from the health and social work services records we read.

- 60% of files had a comprehensive care and support plan. In 33% of files, the plan was not comprehensive and 7% did not have one in the file.
- In 86% of files we considered, the primary care plan completely or mostly addressed the individual's identified needs or risks.
- Almost 60% of care plans were not SMART[12]. In almost all of the files we read, there was no delay in the individual being assessed for key services or receiving key services following assessment.

We concluded that following assessment, services were responsive and delivered timeously. However, this was not always the case as outlined in the section relating to cases referred through the Contact Centre.

The social work service had a number of dedicated review officers whose main role was to undertake annual reviews of older people receiving services. They had been appointed to address a backlog in reviews for older people, although we found they were not deployed equitably across the localities. Care Inspectorate inspections of home care and care home services in Fife confirmed that the social work service had made good progress in completing reviews. Older people subject to Adults with Incapacity Act legislation remained the responsibility of the social workers in area teams on an ongoing basis. This included the responsibility for making sure these cases were reviewed.

In just over half of the files we read, there were concerns about the person's capacity to make decisions about their welfare. A formal assessment of capacity was available in less than half of these files (43%). The Fife Partnership needed to take urgent steps to ensure that assessments of capacity were completed to ensure that individuals are appropriately supported in making decisions about their future care and support. We have already highlighted the high proportion of older people subject to the Adults with Incapacity Act who were delayed in hospital when medically fit for discharge.

The Fife Partnership had taken some recent action to begin to address this through the Community Flow Improvement Group and the appointment of a strategic Mental Health Officer. In the few months before our inspection, this had contributed to the number of delayed discharges relating to Adults With Incapacity Act legislation reducing from 18 to 10. We were advised there was to be an additional 0.5 WTE development post planned to further support this work. Although the Fife Partnership had made some positive developments to begin to address issues for older people who lack capacity, more could be done to improve performance in this area through earlier intervention and anticipatory care planning.

[12] SMART - Specific, Measurable, Agreed upon, realistic and Time-based

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

Well structured and governed adult support and protection arrangements were in place. The Fife Partnership had well-written multi-agency adult support and protection guidance, including a formal Partnership agreement on information sharing.

However, the findings from our review of health and social work services records about adult support and protection were not as positive and suggested that operational practice was not always in line with service policy and procedure. For example, in relation to protection type cases, where there may be current or potential issues regarding adult protection or protection of the public:

- Only two of the 12 protection type cases (current or potential issues regarding adult protection or protection of the public) considered captured the views of multi-agency partners.
- Just under half of the protection type cases had risk assessments we rated as good or better than good. More positively, over three quarters of the protection type files had a risk assessment and in most of these, the timing of the most recent assessment was in keeping with the needs of the individual.

We were assured to note that these areas of poorer performance had also been identified by the Fife Partnership following a recent self-assessment audit. The APC had prepared an appropriately focussed improvement plan to address this.

Our findings in relation to non-protection type risks such as the risk to a frail older person who is at risk of falling and suffering an injury or the risk to an adult with dementia who is at risk of wandering and suffering harm was also variable:

- 83% of relevant files had a risk assessment on file
- almost half (48%) of assessments written had no evidence of multi-agency input in to the risk assessment, and
- only 36% of the risk assessments we rated were good or better than good.

The council told us it was aware of these issues through internal case file audits conducted every three months. We found this process was robust and comprehensive. There were clear recommendations and analysis to this process, but we were unclear how this performance management information and improvement was reported, managed and followed up, particularly if themes relating to protection type risk emerged.

We found that how risk was recorded and managed was inconsistent in files. This was despite clear guidance being published by the head of adult and older people's services in 2013. By not establishing robust risk assessment and risk management arrangements, older

people may not be supported to achieve personal outcomes, such as living at home or living with the person they wish to.

We also found that, where risks were identified, there was an overall lack of analysis of risks and mitigating factors to reduce them. The case file audit undertaken by social work between October 2013 and December 2013 found that some of the risk management tools they used were not helping staff to enter data in a reflective way. The Fife Partnership should review both protection and non protection risk assessment and risk management processes including documentation and electronic recording systems to improve how risk is managed or enabled. They should include feedback from older people who have been involved in the ASP process to help inform their decision to make sure older people are protected from harm and are supported to take appropriate risks.

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

We found positive results for the extent to which the Fife Partnership involved older people in discussions and decisions about their care and treatment. For example, in all of the relevant files (79 in number), there was evidence that practitioners actively sought the views of the individual at the assessment stage (94%), at the care plan stage (89%) of files and at the review stage (95%) of case files.

This was confirmed by the older people and their carers we met who told us they felt very involved in the assessment of their needs and the formation of their care plan. However, we found the take up of independent advocacy could be better due to low levels of the service being offered.

- In 17% of files we read we considered the individual should have been, but was not, offered independent advocacy.

Circles Network Independent Advocacy Service, which is part of a national charity and has offices in Glenrothes, Cupar and Dunfermline produced monthly reports and these showed 98 referrals in the month of January 2014. Of these only 36 were in relation to older people and only 15 of those related to older people with dementia. Only 32 of the total were referred from frontline social work and health services.

We concluded that there was scope for some improvement in the extent to which Partnership staff (especially health staff) made older people aware of the availability of independent advocacy services. We saw an important role for the new strategic MHO post holder in monitoring these data and evaluating any emerging trends to inform targeting of advocacy support. This would help to make sure independent advocacy services are fully used and directed towards individuals who need it most, including people delayed in hospital under the Adults with Incapacity Act.

Staff at Fife Carers Centre advised us that progress on implementing recently agreed pathways for providing carers assessments had stalled. They also said there was significant confusion about who should complete carers assessments, where these should go when completed and the value they add to the carer's outcomes.

- Of the records we read where there was a carer, only about half (49%) of the carers were offered a carer's assessment.
- Of those offered the carer's assessment, only 22% of the carer's assessments offered were completed.

We concluded that the Fife Partnership needed to engage proactively with the Carers Centre to ensure there was clarity for both carers and staff about:

- the important purpose of carer assessments in supporting carers in their role, and
- the process for completing these assessments and how they will provide support.

Self directed support was being underpinned by a suite of very good assessment, care planning and review tools. They were consistent with the principles of the legislation and fully supported the person-centred philosophy. However, these were yet to be rolled out to those working alongside older people. Staff working in the self directed support team said Fife Council had taken legal advice and decided against offering self directed support option 2. The council will need to monitor the impact of this approach.

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


Summary

Evaluation – Weak

The Fife Partnership had struggled to produce a detailed joint commissioning strategy. As a consequence, it now had considerable work to do before completing a strategic plan which would underpin the establishment of a new and effective health and social care partnership. The Shadow Board should monitor progress and make sure this is completed.

Despite this, the Fife Partnership had developed some new and effective initiatives and services to better support older people in the community allowing them to remain at home longer or return home from hospital at the right time. Local Management Groups had an important role to play in balancing being responsive to local needs whilst better joining up these service developments and ensuring consistent provision for older people across Fife.

As part of its integration agenda, the Fife Partnership needed to develop more integrated approaches to quality assurance and self-evaluation to ensure that older people in Fife receive the best services possible.

Whilst there were some good examples of older people, carers and other stakeholders being involved in strategic planning, this was not consistent. The Fife Partnership needed to develop a comprehensive approach to its involvement as part of its planning for health and social care integration.


### 6.1 Operational and strategic planning arrangement

The Fife Partnership said in its position statement, as part of the inspection self-assessment process, that it was in a state of transition in terms of its key strategic plans. The main joint plan for older people had been contained within the Fife Health and Social Care Partnership Service Delivery Plan 2012–2015[13] which was being replaced by the joint commissioning strategy (sometimes referred to as the joint plan for strategic commissioning). The work to develop this commissioning plan was now being taken forward by the Fife Partnership as part of the preparation of the strategic plan which it was required to complete for April 2015 as part of its preparation for health and social care integration.

[13] Fife Health and Social Care Partnership: Service Delivery Plan 2012–2015.

We concluded that the Fife Partnership needed to move quickly and effectively in order to develop an integration plan as well as a detailed and fit for purpose strategic plan for older people.

The service delivery plan contained a number of appropriate strategic objectives for older people and other care groups. It was clear from our inspection and a progress report of the plan for 2013–2014 produced by the Fife Partnership that considerable service development activity had been taking place. What was not clear was how this activity was connected as part of a single overarching strategic plan for older people. The progress report listed the various objectives and action taken, but it did not say how the objectives were to be achieved and how these would be measured. This was reflected in the progress report where some 45 objectives relating to older people were listed, all of which were evaluated as being on track and as being low risk. Given the pressures, including the financial pressures faced by the Fife Partnership, it was not clear how these evaluations had been reached. We were also unclear how this activity played into the joint commissioning strategy.

The Fife Partnership's 2011 Change Fund Plan provided a good higher level account of key changes to be achieved over the next five years and of areas of strategic intent. Respective examples of these were developing a reablement approach in home care and reducing the rate of unplanned care episodes. It included reference to The Fife Reshaping Care Delivery Plan. However, we were not provided with a copy of this and it was not mentioned to us during the inspection.

The joint commissioning strategy was only approved by the Fife Partnership in June 2014, having been a considerable time in production. Whilst it provided a good statement of high level objectives, it lacked detail of how these were to be taken forward and implemented. It was not supported by a financial framework and Fife had not used the Integrated Resource Framework[14] in developing its strategy. We concluded this would affect the Fife Partnership's ability to outline its long-term plans for investment and disinvestment. The plan also contained little reference to workforce considerations and lacked a housing contribution statement. It also referred to the Older People's Strategic Implementation Group as having a governance role for the delivery of the Change Fund Plan. We met with the implementation group and it was clear and acknowledged by the group that this had become (at least by the time of the inspection) primarily an information sharing forum, albeit a useful one. The Fife Partnership needed to revitalise the governance role of the Older People's Strategic Implementation Group.

Given the above, we were left unclear about what exactly was the detailed strategic plan which brought together the various activities and service developments which had been taking place under the reshaping care umbrella. When we met with the Shadow Board they confirmed that, at the time of inspection they did not have a written plan in place,

[14] IRF - The Integrated Resource Framework which by mapping cost and activity data aimed to inform partners of the current distribution of their resources to enable them to make better informed and equitable resource investment decisions.

although they planned to have a draft completed by April 2015. The Fife Partnership should also ensure that its timescales for producing the joint plan allows sufficient time for consultation with key stakeholders.

The strategic plan was identified by staff, managers and Board members we met as being the vehicle for taking forward key activities in future. Four work streams had recently been established to undertake the work for the strategic plan. These were analysis, models of care, capacity building, and user and carer involvement. At the time of our inspection, the work streams were still very much works in progress and we were provided with little information on the detail of progress they had made.. They were still to be concluded and pulled together into a strategic plan.

Given this, it was not possible to assess how well advanced the Fife Partnership was in its detailed strategic planning for older people. However, given the lack of such detail contained within the recent joint commissioning strategy, the Fife Partnership clearly faced a significant challenge in this area. We make a recommendation about this later in this section of the report.

The key groups for taking forward operational and strategic planning were the Fife Partnership Management Group and the three Local Management Groups which covered the three community health partnership areas in Fife. The group brought together the relevant senior managers in an overarching and co-ordinating role. The Local Management Groups, reporting into the Fife Partnership Management Group brought together local managers both to implement and manage service developments, but also had a degree of autonomy to do so in a way which reflected local needs and circumstances.

We had the opportunity to attend both the Fife Partnership Management Group and a Local Management Group meeting during the inspection. We concluded their effectiveness was variable. The Fife Partnership Management Group was described as playing an important role in the development and implementation of a range of service development initiatives, such as Hospital at Home and intermediate care (STAR) beds. However, we also heard about some difficult historic and current joint working relationships. At the time of our inspection, the Fife Partnership had invoked the dispute resolution process to resolve a funding shortfall for aids and equipment.

Given the large geographical area and population of Fife, Local Management Groups were described as providing a more meaningful way of engaging with localities and promoting Community Capacity Building than could be achieved centrally. We saw for example how the Dunfermline and West Fife Local Management Group played a key role in the operation of the discharge hub at the Victoria Hospital, which was making improvements in achieving timely discharge from hospital.

The Fife Partnership had recently recognised the need to review the Local Management Groups and as a consequence had taken action to strengthen its partnership working

by introducing co-chairs from both health and social work for each Local Management Group. The Local Management Groups were also now including social work representation at service manager level to facilitate their ability to make decisions. Staff and managers involved in the Local Management Groups told us that a further intention was to enhance the engagement between Local Management Groups with GPs, lead clinicians and hospital consultants. One criticism we heard from staff about Local Management Groups was they contributed to variable and inconsistent service development across Fife. The Fife Partnership should set out clear performance frameworks for the operation of Local Management Group.

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

The Fife Partnership said that the Reshaping Care for Older People strategy and the Change Fund had provided a significant catalyst for a renewed focus on prevention of avoidable hospital admission and reablement for older people. While we did not see the strategy document, we found there was a strong focus on developing or redesigning services which provided care and support at home and in the community. These included:

- providing support, including financial support to voluntary organisations to allow them to focus on lower level support
- comprehensive geriatric assessment services
- a move from a reablement approach being provided by a specialist team to all older people who use home care services and receiving reablement as a "mainstream" part of home care provision
- developing Integrated Care and Assessment Services and Hospital at Home services, and
- a community joint equipment store strategy and the use of assisted technology.

A number of these developments were still being evaluated at the time of the inspection, but we heard positive comments about them from both older people in receipt of the services and from staff. A number of older people we met said the support they received had helped them remain living at home and to retain a good degree of independence. Every week, 60 older people were receiving a Hospital at Home service at the time of our inspection and both this and the integrated discharge hub at Victoria hospital were attracting interest from other Partnerships. It was not clear how the Fife Partnership was going to replicate this approach across Fife.

Staff and managers we spoke to recognised there were some challenges surrounding the development of these services. In particular, they highlighted the following:

1. How the development of a number of the initiatives had been patchy. This meant it could be difficult for staff to know what particular services were available in different

parts of Fife. In the staff survey, 50% of health staff and 56% of social work staff either disagreed or disagreed strongly that there was a fair geographic coverage of services to support older people.

2. The difficulty faced by the Fife Partnership 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. For example, pressure on the homecare service could result in older people having to remain in hospital for a period after being medically fit for discharge. It also had implications for older people at home.

3. Whilst there was widespread support for a reablement approach being a mainstream part of the homecare service, we heard from staff and managers that pressure on the service meant that reablement work could not always be provided. In addition, the application of the eligibility criteria meant that older people with moderate needs were rarely provided with a homecare service. This meant a potential opportunity was lost to help this group of older people with input to help them live independently.

4. Further work was required to make sure that all parts of the Fife Partnership were joined up and supporting the various developments. A number of managers commented on the need for actions not to be taken in one part of the system without careful consideration of how this might impact on the whole system. The need to better align Integrated Community Assessment and Support Services and the homecare service was also identified.

The Fife Partnership was fully aware of these challenges and was taking a range of measures to try to address them. This included the work being done on models of care and community capacity building to inform the strategic plan and a further review of the homecare service which was nearing completion. Some short-term action was also being taken at the time of the inspection, with the NHS providing the council with £500K for the provision of low level community support. The Fife Partnership had tested a number of ways of working and improving how they delivered services. Managers should evaluate the test sites and produce a coherent plan to set out which services would be commissioned in the future.

### 6.3 Quality assurance, self-evaluation and improvement

Within the Fife Partnership, both health and the social work service had a range of quality assurance and improvement targets linked to core datasets. We found there were some areas where the partners were working together to develop more integrated approaches to quality assurance, performance management, self-evaluation and improvement. Some elements of these were more developed than others.

Appropriately, some quality assurance activity remained single agency and the social work service had recently established a Quality Assurance Unit to help ensure compliance with

appropriate quality and professional standards. We saw that some individual services had arrangements in place to receive feedback from older people as a means of quality assuring the service they provided. The Hospital at Home services and Fife Elderly Forum were examples of this, as was the Community Alarm and Telecare service which sent out an annual satisfaction questionnaire to all people who use this service. However, it was not clear whether there was a systematic expectation that all services would seek to quality assure themselves in this fashion.

We met with representatives from private and voluntary sector providers and they indicated that the Fife Partnership only involved them to a limited extent in measuring the quality of services. They said they had internal quality assurance systems in place, but had not been asked to share their findings with the Fife Partnership.

Some joint quality assurance arrangements were in place. Planning for hospital discharge was an example of this with relevant managers from social work and health services coming together weekly at a meeting to discuss improving quality and choice of service in each Community Health Partnership area and to review discharge arrangements, including delayed discharges. This had changed recently from a centrally-based activity to one undertaken in each of the three Community Health Partnerships. There were some indications at the time of our inspection that this was having some positive impact on reducing the number of steps in the care process and making the best use of available capacity in health and social care systems.

As in other areas in Scotland, the Fife Partnership faced challenges in trying to develop joint performance management information as most data had to be extracted from different IT systems. However, a joint Data Management Group was in place to help address this. We saw examples of performance reports produced by the Data Management Group. This included a monthly core report which contained a range of information, including data on emergency admissions, delayed discharges and care home placements. This was reported to both the Fife Partnership Management Group and the Fife Partnership Management Board. The Health and Social Care Integration Governance Group were looking at further plans for information sharing and a joint performance framework, building on the Scottish Accord on the Sharing of Personal Information[15].

The Edison[16] system was used to help in the performance and reporting management of delayed discharges. Managers looked at this at a weekly verification meeting and said that this proved useful in providing an accurate overview of the number and range of delayed discharges. Some staff and managers said there were some issues still to be ironed out with the use of Edison concerning the timing of when older people were either added or removed from the system.

[15] The Scottish Accord on the Sharing of Personal Information is intended as a potential national framework which agencies across Scotland can agree and sign–up to. The Scottish Accord on the Sharing of Personal Informationoffers a mechanism for Scottish agencies to transition from multiple and diverse regional agreements to a single consistent, clear and accessible national framework.
[16] Edison – Electronic Discharge Information System Online Nationally. A system to provide "real time" information on delayed discharges.

Within both health and social work, there was a considerable amount of self-evaluation and improvement activity taking place. There were numerous test sites within health and the European Foundation of Quality Management[17] (EFQM) approach was widely used within the council. However, it was not clear whether a joint model for self-evaluation had been or was being considered. As a result, we were not sure that the Fife Partnership was using this information to make measureable improvements for older people.

Reshaping Care for Older People and the Change Fund had also provided an important opportunity for the Fife Partnership to consider its self-evaluation and improvement agenda. This was reflected in the significant service improvement initiatives which had been undertaken or were under way, including those initiatives referred to in Section 6.2. Many were or had been introduced initially on a test basis or incrementally. For example, not all Community Health Partnership areas in Fife had a community hospital and these areas were therefore selected for the initial development of Integrated Community Assessment and Support Services and Hospital at Home services. We concluded that this was a sensible approach.

The Fife Partnership demonstrated a willingness to enlist external support to assist with its improvement agenda. For example, a health economist had recently been commissioned to undertake some whole system mapping and analysis. The Joint Improvement Team was involved in the independent evaluation of the STAR beds.

A number of developments were still being evaluated. The Fife Partnership should use a standard evaluation tool to measure the impact of service developments.

## 6.4 Involving individuals who use services, carers and other stakeholders

We were provided with information and saw some positive feedback from participants at a number of consultation and engagement events. These include the following:

- The Montrave Project which was a redesign from a hospital inpatient model to a community model for older people with dementia and frailty within Cameron Hospital, Windygates. A significant number of carers of older people in the hospital had been involved in the redesign and members of the Carer's Strategy Group said that the carers had played an active role in driving the change forward. The revised service was able to be provided in a manner consistent with the Pillars of Care model of community support supported by the national dementia strategy.

[17] EFQM – European Foundation of Quality Management. An excellence model to help organisations to achieve higher levels of performance.

- The Re-provision of Care for Older People Programme. Extensive public consultation had taken place regarding the development of new care homes for older people. Consultations included full public meetings; face to face meetings in care homes; online consultations; and involvement with other stakeholders, such as Fife Elderly Forum and the People's Panel.
- The Self Directed Support Reference Group which included representatives from housing, the voluntary and third sectors. This was a positive group in terms of how it engaged positively with a range of stakeholders. It engaged with people who used services to learn from their experiences.

Consultation and engagement activity had also taken place as part of the development of the joint commissioning strategy. This included questionnaires to groups with an interest in older people, such as the Fife Users Panel. Workshops were held with independent sector providers as part of their development day in February 2013.

"Blether events" had also been held in three Community Health Partnership areas. These were designed to allow a more localised and less formalised approach to engaging with the public in local communities about their aspirations and wishes for how the needs of older people should be catered for. The Fife Partnership used the Community Engagement Standards[18] to allow it to measure the success of the events and we saw that the events had scored highly against these standards. Unfortunately, we did not meet any of the older people who had participated in these events. More blether events were being planned at the time of the inspection.

It was not clear whether these and other engagement events, such as the Older People and Carer Engagement Forum held in February 2014 were part of an overarching strategy for older people, carer and public engagement or constituted a series of largely one-off activities. We did not see any such engagement strategy. It is important that the Fife Partnership created and implemented an engagement strategy as part of an integrated approach to user and carer engagement.

A Public Reference Group had been established in October 2012 and elderly forums were in place. Both were positive attempts to engage with the public, including older people. We met with members of the Fife Elderly Forum who spoke positively about how their attendance at the forums helped reduce their sense of social isolation. However, few of those present were significantly involved as users of social care and health services and the group we met did not consider they had been involved in any consultation about the future development of these services.

We met with representatives of private sector providers and the voluntary sector and heard some mixed views about the extent of their involvement by the Fife Partnership in

[18] Scottish Executive National Standards for Community Engagement.

strategic planning issues. The private sector representatives were more critical. Whilst acknowledging that Scottish Care[19] had some involvement, they considered there had been few opportunities for them to be involved in the Reshaping Care for Older People agenda. They felt their experience and knowledge as private providers was not made best use of by the Fife Partnership. The representatives of the voluntary sector were generally more positive and indicated that the Fife Partnership's engagement with it had improved. The Local Management Groups were identified as having played a positive part in this.

We concluded that the Fife Partnership had taken positive steps to engage with the public in planning for future service provision. It needed to ensure that this was happening as part of a broader engagement strategy and one which included involving older people and their carers currently in receipt of health and social care services.

**Recommendation for improvement 6 (QI 6.4)**

**The Fife Partnership should make sure it takes account of older people and their carers in its public engagement activity on strategic planning for services for older people.**

## 6.5 Commissioning arrangements

Joint strategic commissioning means all the activities involved in the Fife 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 development of commissioning strategies for older people had proved challenging in Fife over a number of years. In 2010, Social Work Inspection Agency[20] commented on the impact of Fife Council's delay in the production of a commissioning strategy and how this represented an ongoing weakness in commissioning practice.

We found that these challenges had continued with the joint commissioning strategy. The Scottish Government and the Convention of Scottish Local Authorities (COSLA) had issued guidance stating that Partnerships should have these strategies ready for the financial year 2013–2014. A draft joint commissioning strategy was completed and presented to the Health and Social Care Partnership in June 2013. This was remitted for further information and the final draft strategy was not presented to and approved by the Fife Partnership until June 2014.

As stated in section 6.1, we examined the joint commissioning strategy and its predecessor, the service delivery plan. Both provided good detail of high level objectives

[19] Scottish Care – a national representative organisation for health and social care independent sector providers.
[20] Social Work Inspection Agency: FIFE COUNCIL SCRUTINY REPORT. December 2010.

and the delivery plan included information on improvement and redesign activity which had been initiated or undertaken. However, both documents came some way short of meeting the suggested Joint Improvement Team Government criteria of a fully comprehensive joint commissioning strategy.

The Fife Partnership explained that this was partly due to the work required to further develop the strategy was now being taken forward as part of the work streams for the broader strategic plan required for health and social care integration. This required to be completed for April 2015.

We found some indication and evidence that the Fife Partnership was making progress in some areas. For example whilst the final joint commissioning strategy had not included a housing statement, we saw that Fife Housing Partnership had completed a final draft of an approach to older person's housing for 2013–2016. The Scottish Government's Joint Improvement Team was also supporting the work streams. Given the previous difficulties surrounding commissioning, we concluded that the Fife Partnership needed to progress and conclude this work as a matter of urgency.

**Recommendation for improvement 7 (QI 6.5)**

**The Fife Partnership should produce its long-term joint commissioning strategy for older people as part of its strategic plan for health and social care integration. The plan should be compliant with best practice criteria for joint commissioning strategies and explicit how it will provide positive outcomes for older people.**

We read and heard about two other issues during the inspection which related closely to joint commissioning. The first was the Care Village programme which included the building of three new council run 60 bedded care homes in Fife. The first of these was under construction at the time of our inspection. Social work staff and managers we met advised that there was no lack of capacity of care home beds in Fife and described the decision to go ahead with new care homes as 'a political one' by the current administration. This decision was confirmed by an elected member. Meetings we held with the Fife Partnership indicated that this decision had not been part of a joint approach to commissioning.

The second issue related to the home care service. Managers had implemented a review of the service, including revised contracts for home care workers at the end of 2013. However, it was already evident that the revised service was not fit for purpose in an important element. This was because the contracts of the staff and their deployment were not consistent with the care needs of many older people. There was a lack of clarity on the level and type of home care service that would be commissioned and who would deliver this service. We say more about these two issues in chapter 9.

## Quality indicator 7 – Management and support of staff

Summary

Evaluation – Good

Fife Council and NHS Fife were developing joint workforce initiatives. Recruitment and retention was difficult in some geographical areas and in some parts of the workforce. This affected the quality and numbers of staff available to some older people who needed services. The council was working to reduce high levels of staff absence in older people's services.

Most staff believed that there was good joint working between health and social work staff at a local level, but there was little work being done to develop joint workforce plans, job specifications and posts at the time of inspection.

Staff development and training were largely specific to each of the partners, but staff thought that they had access to training appropriate to their posts and supervision was good. There were several initiatives in place which evidenced the intention of NHS Fife and the council to develop a more collaborative approach to joint training and development.

### 7.1 Recruitment and retention

We found that resource allocation and deployment of staff was still largely at an individual agency level.

We read a range of relevant and clear documents produced by the council and NHS Fife on recruitment and retention, and on human resources. The Fife Partnership produced separate documents on equality and diversity and retrospective PVG checking policies, although both were fit for purpose.

In almost all interviews and focus groups we carried out, we were told by frontline and senior staff that recruitment in home care was a major issue. They said it was affecting the delivery of services, including new projects introduced because of the Change Fund and was influencing prevention of admission to and discharge from hospital. Council staff told us that home care had not been able to recruit for some time and posts were frozen when staff left. A new contract had been introduced and rotas had been changed resulting in staff having unused direct care hours. We also heard from staff that the recruitment of district nurses could be difficult. There had been recruitment difficulties in mental health occupational therapists, but recent documents indicated that a recruitment drive had positive effects. There had been some issues in the community joint equipment store in relation to retention of staff. There seemed to be problems

about the numbers and skill mix of staff in the store impacting on occupationa therapists time, which was spent in the store ensuring the correct equipment was being arranged, and the delivery of services. However, this appeared to have been resolved just before the inspection.

The Shadow Board had identified the recruitment difficulty in some areas and was looking at planning to have a workforce, which would be structured differently and work across care home, community and hospital, and have career progression. The Shadow Board should produce a workforce plan that reflects the proposed improvements. They should identify clear steps to achieve the changes to staff deployment, monitor progress and ensure this positive initiative is delivered.

NHS managers told us that recruitment across a range of disciplines in North East Fife was problematic because the area consisted of small remote villages. External providers of services also reported difficulties in recruiting in rural areas, for both nursing and social care staff, with particular difficulties in recruiting nurses.

At the time of the inspection, a Director of Integrated Health and Social Care had just been appointed and was due to start in September 2014. A recruitment pathway had been agreed by NHS Fife and Fife Council which resulted in the secondment of two Change Managers, one from each partner, reporting to the Director. A recent paper "Together We Can (March 2014)", which outlined the jointly agreed organisational development approach, identified "a newly established Transition Team comprising seven senior managers who each spent approximately 50–80% of their time supporting Health and Social Care Integration".

The jointly agreed organisational development approach included a focus on supporting workforce development and also leadership development. The Shadow Board had a workgroup on Workforce and organisational development, supported by a long established joint organisational development group. They had an organisational development group of council and health staff to deliver joint learning and organisational development activities. However, workforce development managers we met reported a disproportionate cut in their budget. They feared this would adversely impact on current and future joint work.

As part of the work of the group, consideration was being given to jointly delivered induction andorientation arrangements for staff newly employed in the Fife Partnership.

In workforce development, the Fife Partnership had recently concluded a joint pilot programme to enable staff to acquire appropriate qualifications. A jointly accredited programme was being run for health and social care support workers and more joint programmes were planned as a result.

Sickness and unplanned absence can have an impact on service delivery. Both social work and health had clear strategies to bring down absence levels, reported regularly on them, and were closely monitoring progress.

Social work had the highest absence rate in the council, and within social work, older people's services had the highest rate. A social work attendance management plan had the objective 'to drive down absence levels and achieve an annual absence figure of no more than 15.01 work days lost per full time effective for the period 2013/14'. Social work was ahead of this target in the first three quarters of 2013–2014.

While NHS Fife did not report on sickness levels for staff in older people's services, specifically, sickness levels in services which treated older people were below 5% for 10 of the 12 months before our inspection. In a June report NHS Fife stated that the reduction in levels had meant that it had spent £1.8 million less on absence costs in 2013–2014 than in 2012–2013. NHS Fife had a well-attended absence management training programme and Local Attendance Management Groups.

## 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. There were some co-located teams across the Fife Partnership such as the Integrated Response Teams and the integrated discharge hub at Victoria Hospital. However, these had been newly developed and we were not made aware of any pre-existing joint and co-located teams. Integrated Response Teams support early discharge from hospital, preventing delayed discharge and prevention of admission. Integrated Response Teams provide intensive, short-term rehabilitative support (up to two weeks) to people in their own home. The teamconsists of Home Care Manager, Charge Nurse, Occupational Therapist, Physiotherapist, Social Worker, Secretary and 12 Rehabilitation Care Assistants. The team was jointly managed by a Senior Nurse (Health) and a Team Leader (Social Work).

Most job descriptions were specific to each of the partners, apart from the newly appointed director and the manager of the joint equipment store. Almost all staff we met were clear about their roles and responsibilities.

We found positive aspects of joint working from the health and social work services records we read. There was evidence in many cases of multi-agency working (77%) and that services worked together to provide care at times of crisis (76%). On the whole, information was shared between professionals and recorded in their files (60%). Positive comments were recorded by staff during the file reading on staff deployment. Some older people we met who received services from both health and social work services spoke of good experiences of joint working between the partners to provide care. However, there was evidence that multi-agency partners' views informed risk assessments in only 52% of cases.

From our staff survey, we found that 69% of respondents agreed/strongly agreed that there were positive working relationships with other professionals. Frontline staff as well as health and social care managers we met during fieldwork reported good working relationships with colleagues across the services. They also said there was an increased focus on outcomes for older people evolving as a result. However, frontline social work staff indicated that there was confusion about developments such as the discharge hubs and the purpose and function of initiatives such as the STAR beds.

Staff we met and those who responded to our survey from both health and local authority were generally positive about the support they received from their line managers.

### 7.3 Training development and support

The NHS and council operated separate arrangements for individual supervision and annual appraisal.

The council told us it did not have a formal appraisal system in place. However, its supervision policy allowed for an element of appraisal within the context of performance management, skills development and training, and focus on outcomes. They said evaluation was also carried out through electronic case file audits. We noted that small numbers (26%) of Partnership files read recorded decisions and discussions from supervision, and that 15% of cases had been read by line managers. We read a supervision evaluation document that indicated there was inconsistency across social work in terms of the frequency and quality of supervision, with home care and older people's residential care being two of the services where this was a significant issue. In older people (Operations) services, a quarter of staff did not have a supervision contract; in home care services, one third said they did not have a supervision contract; and in occupational therapy over a third were not sure if they had a supervision contract.

NHS Fife used the national Knowledge and Skills Framework to ensure staff (apart from medical staff who have a different appraisal and revalidation system) were clear about their responsibilities and had appropriate supervision and training. A recent report (April 2014) identified that 75% of staff had engaged in the Knowledge and Skills Framework process and 60% had fully completed PDP reviews and appraisals at February 2014. This figure was an improvement on the previous year's figure. Engagement in the Knowledge and Skills Framework process was identified as a priority in the learning and development section of the NHS Fife workforce modernisation and development strategy and as a key action in the staff governance action plans being taken forward by Local Partnership Forums.

A wide range of training opportunities were available to staff, including examples of joint initiatives. Housing staff were included in training in areas such as dementia and adult support and protection.

Fife Council and NHS Fife each had extensive and detailed plans for workforce planning and professional development, and action plans for each organisation detailing training available and who the training was for. We met with senior managers from health and social care who were responsible for workforce planning, and they were taking forward arrangements to develop joint training and qualification initiatives. This included the joint SVQ programme (level 2 Health and Social Care) for Fife Council home care workers and NHS Fife community-based clinical healthcare support workers. This was further tested with a view to training further cohorts.

Staff said the Adult Protection Committee had taken account of a recent training needs analysis to inform the future planning of joint adult support and protection training and that the proposals had been implemented to address the issue of 12 cancelled adult support and protection training sessions the previous year.

We also heard about the NHS Fife e-learning provision. This was originally only for health staff, but was being rolled out to give partners access to an extensive range of training opportunities.

Yet another collaborative approach was the suite of training designed by the MacMillan Palliative Care Team, the NHS Palliative Care Counsellor and the Workforce Planning and Development Section for all staff working in adults and older people's social work service.

**Example of good practice**

**The Postgraduate Collaborative Leadership Programme, the first of its kind in Scotland, was an impressive joint initiative. It was delivered in conjunction with St Andrews University. Scottish Government departments were funding stakeholders for the programme as they had an interest in learning from this programme and replicating it nationally. The admission criteria for the programme included middle or senior managers with partnership working experience, although voluntary organisation participants were encouraged and financially supported to participate. The programme began in March 2011 and 19 participants from across Fife Partnership organisations successfully completed the first programme. The second cohort had recently completed the programme. An independent evaluation indicated positive impact was being achieved at service delivery level as well as equipping participants with the skills to achieve effective partnership working. This programme received a national award from COSLA. At the time of the inspection, funding had not been identified to support the 2014–2015 programme.**

In our staff survey, 77% agreed that they had good opportunities for professional development.

Senior managers from health and social care had been engaging in an "action learning set" to support the development of effective relationships, a positive environment, and determine how they would work together to bring about service improvements. They told us this had been very useful in understanding each other's roles.

## Quality indicator 8 – Partnership working

Summary

Evaluation – Adequate

The Fife Partnership has operated joint financial arrangements over a number of years and despite issues arising at an operational level, financial management appears to have been robust. At a strategic level, there were gaps in the process and we were unclear as to how the Fife Partnership was taking forward investment and disinvestment. There are a number of significant challenges and pressures ahead in the provision of more integrated services, particularly in relation to providing services on a sustainable financial footing and remaining within budgets. Financial governance arrangements such as the questions of handling underspends or overspends, accounting timeframes and audit arrangements also needed to be considered. More guidance from the Scottish Government on these issues should assist the integration process.

Like other Partnerships there was no clear joint information-sharing strategy in place. We were reassured that the Fife Partnership was getting help from the Scottish Government to improve this position through grant funding for a series of projects. There were mixed examples of information-sharing systems. The client information system used by social work services was fairly new and still had to be bedded in. Staff reported this was cumbersome and time consuming, as well as not reflecting the amount of information sharing across agencies.

There has been a varied approach to partnership working in Fife. There has been an acknowledgement that this needed to be strengthened by external agencies and the Fife Partnership. We noted this had appeared to be improving over recent months. A driving factor in this was the need to deliver on the integration agenda. The housing partnership had played a key strategic role which had a positive contribution on partnership working. However, we concluded the Fife Partnership should engage more effectively with the independent, private and voluntary sector partners. We also concluded the Fife Partnership was on a stronger footing to move forward through the Shadow Board and Local Management Groups.

### 8.1 Management of resources

Fife Council and NHS Fife have operated joint financial arrangements for many years. In response to the proposed legislation for the new health and social care partnerships in 2013, they established a Shadow Integrated Health and Social Care Board based on a

'Body Corporate' model. This is the delegation of functions and resources by NHS boards and local authorities to a Body Corporate which will be managed by a joint board with an appointed Chief Officer who will be jointly accountable to both Chief Executives.

The Fife Partnership did not have a robust joint commissioning strategy, underpinned by a financial framework in place. However, the Fife Partnership was aware of this and was at the early stages of beginning to address the issue. Before finalising the financial arrangements of the Fife Partnership, chief finance officers were awaiting more guidance from the Scottish Government following the consultation period for the draft Scottish Statutory Instruments scheduled to end in August 2014.

The Fife Partnership identified an indicative integrated revenue budget of £293.9 million (£142.6 million from Fife Council and £151.3 million from NHS Fife) based on the 2014–2015 budgets for the services considered to be within scope of the Fife Partnership. The indicative budget reflected only direct service costs, excluding some overheads and support service costs.

The proposed Fife Council contribution to the new integrated budget covered adult services, older people's services and an element of housing services, for example housing adaptations. The proposed NHS Fife contribution covered all the current community health partnership budgets plus direct clinical budgets for elderly medical services in acute services. However, there remained some uncertainty about some of the NHS services to be included within the integrated budget, particularly around budgets that were broadly designated as unscheduled care.

The indicative budget was seen as a starting point and subject to further review as service integration evolves. The Shadow Board and senior managers appeared committed to the formation of a truly integrated budget and facilitating the process of moving towards a more community-based, integrated care services model. At the time of inspection, the 2014–2015 budget had not yet been approved by the Shadow Board as the Fife Partnership intended to get a fuller understanding of the delegated functions as set out in the draft Regulations Relating to Public Bodies (Joint Working) Scotland Act 2014[21]. The General Fund Revenue Budget 2015–2018 which was presented to Fife Council Executive Committee on 9 September 2014 reported a potential funding gap in 2017–2018 of £77.2m.

### Financial performance of Fife Council and NHS Fife

The council, as a whole, had reviewed its funding levels and found a potential funding gap of up to £92.6 million for the period to March 2018. However, the council showed an understanding of the financial challenges it faced and was effectively planning to minimise the risks. The council's three-year rolling financial budget 2014–2017 was agreed at a full council meeting in February 2014. However, it was too early to assess how effective these plans would be in bridging the funding gap.

[21] Regulations Relating to Public Bodies (Joint Working) Scotland Act 2014

NHS Fife produced a Local Delivery Plan (LDP) which aligned its Board's strategic priorities with financial plans, workforce plans and asset plans. The NHS board's five-year financial plan for the period 2014–2015 to 2018–2019 indicated a break-even position in each of the five years. The plan assumed annual efficiency savings ranging between £16.7 million and £18.1 million in each of the five years, totalling £87.1 million over the five-year period.

The economic environment meant most councils and NHS boards were experiencing financial pressures in delivering their services and, as a result, the longer term financial plans of both Fife Council and NHS Fife remained at risk of not being affordable and presented a significant challenge moving forward.

A social work budget overspend of £13.3 million in 2013–2014 was reported to the Education, Social & Communities Scrutiny Committee on 10 June 2014 (7.4% of their total social work revenue budget of £178.2 million). Included within the £13.3 million, was an overspend of £4.1 million that was attributable to the services provided by the council under the Fife Partnership (2.9% of the council's element of £139.9 million included within the Fife Partnership budget). The report to the committee recognised that the council faced significant challenges in relation to a number of areas within its social care budgets (both within adult social and children's social care).

The main causes of the £4.1 million overspend were:

Adult and Older People's Services

- £1.3 million overspent, mainly due to a shortfall in the savings that were anticipated from the council's reshaping of social work programme
- 1.5 million overspent, mainly due to a shortfall in the savings that were anticipated from the council's reshaping of the social work programme. This resulted primarily from a material increase in the demand for social care across all client groups and an over-optimistic estimate of £5.7 million for the savings target
- £4.2 million overspent within the home care budget, due to increased demand for external care packages and an overspend on home carers and agency staff pay

Offset by

- £2.9 million released from the Older People Change Fund (we discuss this later in this chapter).

NHS Fife was required to meet various financial targets set by the Scottish Government and to remain within its budget. The 2013–2014 financial statements showed that NHS Fife met all of its financial targets for the year and achieved a small surplus of £0.3 million in the

year. Despite achieving an overall surplus, NHS Fife incurred an overspend of £0.6 million against its budget contribution to the Fife Partnership (0.36% of their £166.9 million budget contribution), mainly as a result of a £0.8 million overspend on acute elderly medicine.

To make sure that older people receive the services they need in the future, it is important that budget overspends are resolved and realistic. Affordable financial plans need to be put in place to put the Fife Partnership on a sustainable financial footing going forward.

### Joint financial reporting arrangements by the Fife Partnership

A joint financial monitoring report was presented to the Shadow Board in May 2014, excluding capital spend. The report provided separate outturn figures for the council and NHS revenue spending streams. We had been advised that capital spend was outwith the scope of the Fife Partnership's direct responsibility. However, decisions on capital spending can have an impact on future revenue expenditure.

Budget setting and monitoring arrangements were not truly integrated, with each organisation setting and monitoring their own funds. A Joint Finance Group had been established led by NHS Fife's Director of Finance to manage this process of developing an integrated budget and the pooling of a broad range of resources. Again, the timing of this inspection meant it was too early to review progress.

### Financial arrangements

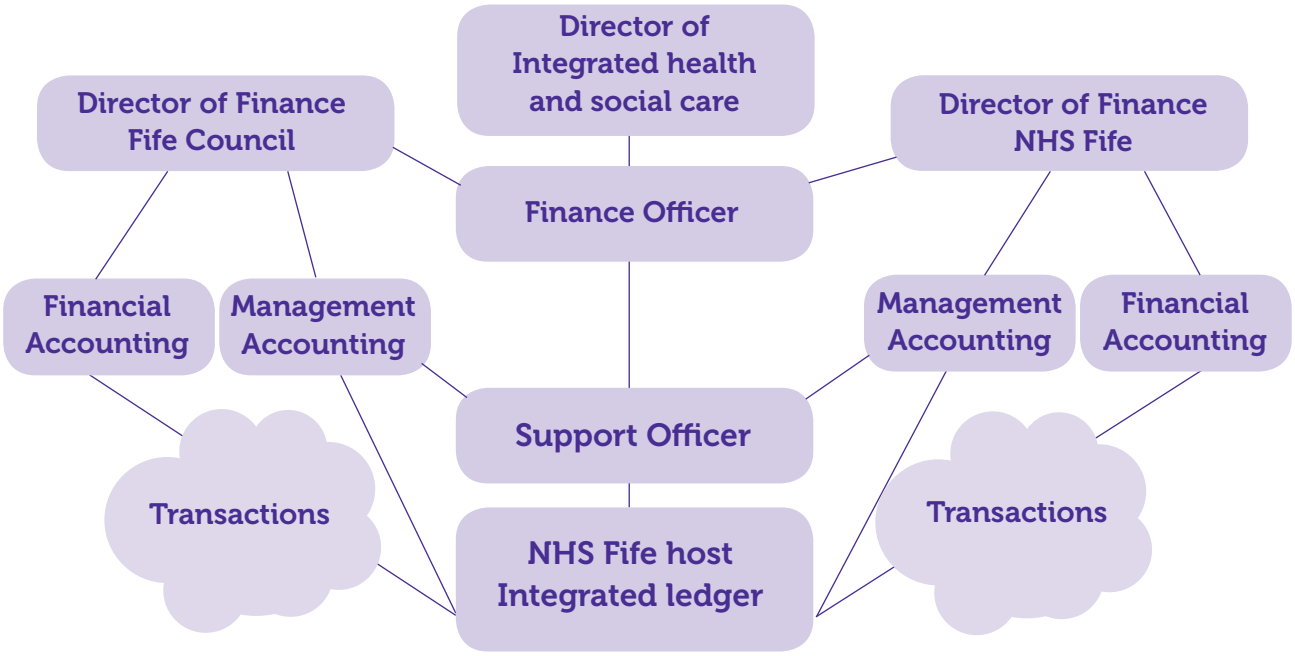
The Integrated Resources Advisory Group set up by the Scottish Government had provided guidance on the financial requirements. Further detail had also been provided in Draft Regulations Relating to Public Bodies (Joint Working) Scotland Act 2014. The financial requirements included financial regulations, financial planning, financial management and reporting, accounting requirements and systems, insurance and risk management, internal and external audit, asset use issues and the treatment of underspends and overspends. Finance officers from both organisations continued to meet to identify and agree practical solutions to deliver the financial information. Finance officers advised us that although good progress was being made in this area, they required more guidance and clarity from the Scottish Government.

The Shadow Board also highlighted the need for discussions to take place between Fife Council and NHS Fife to agree the process in the event of future overspends by the Fife Partnership as well as the use of any built-up reserves.

Chief finance officers were developing an implementation action plan to ensure that all finance-related requirements were identified and completed to support full integration. This work involved looking at individual roles, systems, regulations and the compilation of the integrated budgets. Despite initially intending to use the Integrated Resource Framework which was used by some other partnerships, this has not been used by the Fife Partnership.

The Fife Partnership should identify a robust quality assurance approach to cost and quality implications for local decision-making on health and social care.

The chart below illustrates a model which both chief finance officers agreed would meet the needs of the integrated body.




The chief finance officers believed that an existing member of staff could fulfil the role of the finance officer at no additional cost. If the Fife Partnership followed this route, it would be important for the role to be given the status and resources required to effectively assist the Director of Integrated Health and Social Care to manage the financial resources.

## Change Fund

Since 2011–2012, the Scottish Government provided specific funding to the Fife Partnership to assist the move to more community-based care through the Change Fund. The Scottish Government expected the Change Fund to be used as 'bridging finance' to enable the redesign of services and facilitate achievement of national policy. It also expected the use of the fund should influence decisions on the nature of Partnership spending with a significant shift to anticipatory and preventative approaches to achieve and sustain better outcomes for adult care including older people.

The funding was received by NHS Fife from the Scottish Government who then distributed part of the funds to Fife Council through agreement by the Shadow Board. By the end of the 2014–2015 financial year, the Fife Partnership should have received a total amount of £21 million comprised as follows:

| | 2011/12 (£million) | 2011/12 (£million) | 2011/12 (£million) | 2011/12 (£million) | Total (£million) |
|---|---|---|---|---|---|
| Fife Council | 2.4 | 2.4 | 2.4 | 2.0 | 9.2 |
| NHS Fife | 1.9 | 2.4 | 2.2 | 1.9 | 8.4 |
| Joint funded projects | 0.6 | 0.8 | 1.0 | 1.0 | 3.4 |
| **Total** | **4.9** | **5.6** | **5.6** | **4.9** | **21.0** |

The two main categories of expenditure from the fund were NHS Fife's Hospitalsat Home scheme and Fife Council's reablement scheme which accounted for £7.2 million and £7.7 million, respectively, over the four-year period. We were concerned that significant sums from the council's Change Fund expenditure had been used to meet the normal recurring costs of adult social work care rather than for projects that help reduce the number of older people going into hospital and/or long-term care.

The funding from the Change Fund will be stopped after 2014–2015 and the Fife Partnership intended to consider its disinvestment strategy from Change Fund projects as part of a wider review of its joint commissioning strategy. However, at the time of inspection, this process was at a very early stage.

**Recommendation for improvement 8 (QI 8.1)**

**The Fife Partnership should produce a disinvestment strategy for Change Fund projects as a matter of urgency. This should include evaluation of projects to inform decisions about their continuation and the impact these have on improving outcomes. This is especially important, given that some of the Change Fund has been used to meet the normal recurring costs of service provision, rather than projects that help reduce the number of older people going into hospital and/or long-term care.**

## 8.2 Information systems

We found that the Fife Partnership did not have a joint strategy that supported the sharing of information at both an individual and strategic level.

However, the importance of making progress in this area was widely recognised by the Fife Partnership, especially to underpin the effective integration of health and social care services. The Fife Partnership's Information Sharing Board had prepared and submitted a funding request to the Scottish Government. There were two phases to the proposed work. The first phase would involve the necessary scoping work to be completed. The second stage would focus on the delivery and implementation of systems to deliver multi-agency access to relevant health and social care data by practitioners. The outcome of the funding bid was still awaited. In the meantime, a number of IT integration projects were under way. These included:

- a joint working group which was developing an information-sharing policy
- the social work service's user records were being populated with NHS patient CHI numbers to facilitate better linking of social care and health information
- permission for authorised council staff to access the NHS MiDiS system (Multi Discipline Information System), and
- reciprocal permission for authorised NHS staff to access older people's records on the council's SWIFT system.

We found that some service areas across the Fife Partnership were more advanced than others in their approach to information sharing. One of the most positive examples had been the very clear and detailed information-sharing protocol developed and agreed by the Adult Protection Committee. The protocol took full account of the Scottish Accord on the Sharing of Personal Information (SASPI).

In other areas, performance was more mixed. For example, at the community joint equipment store we found there was very good electronic access to the store by both health and social work staff. However, the stock control system was not working well and staff said a more robust system was required. Independent sector providers we met said that the council had recently made changes to its electronic invoicing system which was causing significant delays in payments being made to providers and other organisations. Council managers acknowledged this temporary problem and said that urgent action was being taken to resolve it.

Staff we met at various levels expressed a number of frustrations with the operation of IT systems and the limited extent that these were joined up and able to "talk to each other". From the health and social work services records we read it became clear that information was being shared between staff both within and across agencies at a higher level than was reported by staff.

Within social work, a new system AIS linked to SWIFT was being rolled out. A number of staff said they found the systems "clunky" and that inputting information on the AIS system was very

time consuming. Managers were aware that some staff, despite being trained on AIS were continuing to use SWIFT as they felt more familiar and comfortable with it. A number of health staff said that they had as much difficulty accessing information from other health disciplines as they did from social work colleagues.

In our staff survey, 58% of staff who responded either disagreed or strongly disagreed that information systems support frontline staff to communicate effectively with partners. The results for health and social work staff were 56% and 62% respectively.

Work was being and had been undertaken to ensure that information systems were able to provide good means of clearly identifying and recording the needs of older people and the care and treatment needed to meet these. An example of this was within social work where considerable work had been done to develop a care plan and review documents which were compliant with the National Minimal Information Standards for community care services[22].

At the time of inspection a national review of nursing documentation was being undertaken. This hoped to produce a national assessment and discharge document for use across all NHS boards. The final national documentation will be a three-day admission to discharge acute care booklet and testing will begin in a number of NHS boards over the next few months and is called the National Admission Assessment and Personal Care Record. This was the record of the care and treatment for the older person from their initial assessment on admission and for up to three days stay in hospital. Additional documentation for longer stays can be added. The nursing process reflected in the documentation is the:

- initial and ongoing assessment to identify older person's needs
- care planning to meet those needs
- implementation, and
- evaluation of the care given.

All risk assessments, person-centred care planning, evaluations of care, multi disciplinary recording, communications with older people and carers and discharge planning will be covered within this one document.

At the large scale staff briefing events held by the Fife Partnership for health and social care integration, IT had been identified as a major challenge to both effective integration and for the development of an integrated workforce. Senior managers we met understood this and needed to ensure that it was given sufficient priority in the planning for integration.

[22] The Regulation of Care (Scotland) Act 2001 ('the Act') set up the Care Commission, which registers and inspects all the services regulated under the Act, taking account of the national care standards issued by Scottish Ministers.

## 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.

Effective partnership working is essential to meet the intentions of health and social care integration. During our inspection, we heard and saw from senior managers a recognition that they needed to see themselves as being part of a single entity, rather than as part of two bodies working together. We say more about health and social care integration and the Fife Partnership's approach and preparedness for this in Section 9.2 of this report.

The history of partnership working between NHS Fife and Fife Social Work Service had been somewhat mixed according to a number of staff we spoke with. The report of the 2010 Social Work Inspection Agency performance improvement inspection referred to good joint working at most levels. However, it reported the consensus view amongst managers was that partnership working at senior level could be more strategically focussed and decision-making accelerated. The potential to progress the development of co-ordinated and integrated services had not been fully realised despite the apparent advantages of co-terminous boundaries. The report included a recommendation for the need for Fife Council and NHS Fife to strengthen partnership working across care groups.

Audit Scotland's 2011–2012 Assurance and Improvement Plan (AIP) for Fife Council identified partnership arrangements as being an area of uncertainty due to the outstanding challenges posed by service modernisation, delayed hospital discharge and budget reductions.

During our inspection, we heard comments from a range of stakeholders which suggested some difficult partnership working relationships at a senior level in preceding years. However, we heard equal comments that this had been improving quite significantly in the last year or so. Various explanations were offered which included:

- the Change Fund providing a positive impetus for joint service development and redesign
- the establishment of the Shadow Board had provided an opportunity to refresh and refocus the membership, and
- a recognition and response to health and social care integration which meant that the current partner bodies simply had to work and plan together very closely. This included jointly confronting areas of financial pressure.

As indicated in Section 6.5, we saw evidence that there had been growing recognition of the important role of housing options to meet the needs of older people. The Fife Housing Partnership was now showing itself to be a key partner and contributor whose role was attracting positive, national interest. It had been asked to present as an example of

positive integrated working to a national event in July 2014 on the opportunities to housing providers arising from health and social care integration.

Our meetings with private and voluntary sector partners and representatives presented a mixed picture of partnership working. Overall, the Fife Partnership tended to have a somewhat more positive view of the joint working arrangements and relationships than the third sector itself. Private providers felt they were not always given a fair opportunity to tender for new areas of service provision, such as the care home replacement programme, which was tendered on a Transfer of Undertakings Protection of Employment (TUPE) basis. TUPE refers to the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014". The TUPE rules apply to organisations of all sizes and protect employees' rights when the organisation or service they work for transfers to a new employer. In addition, they felt they were not treated as having an important contribution to make. Voluntary sector representatives said their frontline services had good relationships with health and social care practitioners and contracts officers. However, they felt the Fife Partnership could improve how it meaningfully engaged with the sector at the strategic level. The third sector makes an important contribution now and will need to play a greater part in future. Given this, we concluded that the Fife Partnership should ensure that it had robust arrangements in place for third sector involvement as part of health and social care integration.

**Recommendation for improvement 9 (QI 8.3)**

**The Fife Partnership should engage with its independent, private and voluntary sector partners to review its existing partnership working arrangements with them. It should ensure that these partners can make a positive contribution at all levels to providing positive outcomes for older people, particularly in relation to service design and development.**

### Compliance with integration delivery principles[23]

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to review and evaluate if the planning, organisation or co-ordination of social services, services provided under the health service and services provided by an independent health care service is complying with the integration delivery principles.

Audit Scotland's assurance and improvement plan (AIP) for 2014–2015 concluded that integration planning was progressing reasonably well and that good relationships were apparent between Fife Council and NHS Fife. It also referred to the Shadow Board having overseen the development of integrated performance arrangements, ahead of a number of other Partnership areas. However, we concluded from our inspection that early arrangements that had been established had not made significant progress, and in some areas, such as joint commissioning, the pace will need to be picked up significantly.

The Fife Partnership Board, the Fife Partnership Management Group and the Local Management Groups were key groups within the Fife Partnership. We had the opportunity to read reports and attend meetings of all three. Based on observation, the working relationships at these meetings looked positive and constructive. Some reports we read seemed to lack a level of detail, but we noted that elected members from the council and executive officers from NHS Fife were not slow to ask pertinent and detailed questions. The Fife Partnership was still determining what the locality structure would be for the new Partnership. The indications were that this would likely be based around seven localities. This would not significantly impact on the existing three Local Management Groups. As indicated in Section 6.1 we considered that the Local Management Groups provided a solid foundation, especially following their recent review, for good localised partnership working moving into the new Partnership. This had resulted in co-chairs from both health and social work services for each group.

[23] 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.

## Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Adequate

The Fife Partnership had made significant efforts to develop good working relationships between agencies. While there continued to be some tensions, particularly at senior management level, the Fife Partnership operated services based on national drivers, such as Reshaping Care for Older People, which were delivered within localities through jointly developed and agreed strategies. The Fife Partnership needs to make sure frontline staff are kept informed of progress and to ensure their views are taken on board in service development.

The Fife Partnership had responded early and positively to develop an infrastructure for integration of health and social care. Senior managers and elected members were aware of the need for change and agreed about the direction of travel. While there was still significant amounts of work needed to see the Fife Partnership fully integrated, there was a strong base on which to build through the Shadow Board.

Future success of the Fife Partnership senior management will be dependent on development of a robust joint commissioning strategy, based on full consultation and collaboration. Key services need to be developed and supported to ensure all parts of the Fife Partnership are connected appropriately, particularly in relation to home care, care home and intermediate care provision.

The Fife Partnership senior management team was going to see significant changes through retirements and other staff movement. This will be both an opportunity to bring in fresh talent, but also a risk to continuity and consistency for the incumbent Director of Integrated Health and Social Care.

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

The joint health and social care strategies for older people in Fife, Health and Social Care Partnership Service Delivery Plan 2012–2015[24] and Joint Health and Social Care Strategy for Older People in Fife 2011–2026[25] clearly set out how the Fife Partnership intended to develop joint working. The documents highlighted the importance of health, councils and the voluntary and independent sectors working better together to meet the Fife Partnership vision. The Fife Partnership stated their strategy will be instrumental in

[24] Health and Social Care Partnership - Health and Social Care Partnership: Service Delivery Plan 2012–2015
[25] Joint Health & Social Care Strategy for Older People in Fife 2011–2026.

providing the pathway to "promote the health and wellbeing for older people and reshape care and services for those with more complex needs".

"The Strategy underpins Fife's Health & Social Care Partnership's commitment to providing services for older people in the future and is a significant step in preparing for the implementation of Health and Social Care Integration in response to the current Scottish Government Consultation".

The Strategy recognised national legislation and local policy drivers and set these within a context of demographic changes, increasingly complex care needs, the need for more efficient use of resources and key health issues which impact upon both health and social care, such as long-term conditions and dementia. This was clearly linked to the impact on acute care and the demand for hospital beds, the redesign of models of care to support the change in direction, the need to reduce admission to hospital where it can be avoided and also reduce delays in discharge for older people in hospital.

Fife's Council Plan 2017[26] provided good headline figures and information outlining future demographic pressures on services and how they could be addressed through the integration of health and social care services. The report highlighted a number of challenges, namely:

- improving performance of council services to meet demand
- shifting services to prevention of admission to hospital and early intervention
- decentralising services and enabling employees
- involving customers and empowering local communities in delivering locally valued services
- working together and integrating services.

Fife's Community Plan 2011–2020 set out their vision to strengthen Fife's future to make Fife, "...a great place to live, work, visit and invest." This community plan aimed to highlight current and future challenges; empower communities to respond to these challenges and set out the wider Fife Partnership's plans through a single outcome agreement. These are agreements between the Scottish Government and Community Planning Partnerships which set out how each will work towards improving outcomes for the local people in a way that reflects local circumstances and priorities, within the context of the Government's National Outcomes and Purpose.

Similar to the council's strategic documents, this took into account national priorities and translated them into locally determined outcomes, acknowledging the difficult financial context. This information was updated annually through the Fife Community Plan: The State of Fife[27]. The 2012–2013 version was still in draft at the time of inspection and had limited information about outcomes for older people.

[26] Fife Council Plan 2017.
[27] Community Planning Achievements: the State of Fife 2012–2013.

While social work services and NHS Fife mainly operated services separately to each other, there was evidence through reading and following up case files and speaking with staff during scrutiny sessions that frontline staff were collaborating to achieve positive outcomes for older people in Fife. This was supported insofar as 82% of staff respondents indicated joint working was supported and encouraged by managers. However, only 42% of staff felt there were effective partnerships which focussed on delivering key policies and plans for older people.

There was evidence of partnership working at senior management level and from attendance at high-level meetings and throughout sessions attended in the scrutiny week. However, it was clear from discussions with senior management from the Fife Partnership this had not always been the case. During our inspection, the Council invoked dispute resolution procedures due to an inability on behalf of the Fife Partnership to agree funding arrangements for a particular joint service. While senior officers were tasked with working through this difficulty, this provided us with a valuable insight into how the Fife Partnership was functioning. It was reassuring therefore, to find evidence from discussions with senior managers and in meetings we attended that the Fife Partnership leaders had a clear appreciation for the need to change and seemed to have a shared understanding of priorities.

The Fife Health and Social Care Partnership Service Delivery Plan, in use at the time of the inspection, set out the approach for service delivery, supporting and developing the joint resourcing and joint management arrangements. This document was to be replaced by the joint commissioning strategy. The Fife Partnership had been working hard to develop this document for a significant period and we tracked progress through minutes of meetings provided by the Fife Partnership. It was clear the Fife Partnership appeared to find this a challenging exercise. This issue was raised and confirmed during the June Older People's Strategic Commissioning Implementation Group meeting. The strategy gained final approval from the Fife Partnership in June 2014. It was unsurprising that over a third of those staff who responded to our staff survey disagreed there was a clear vision for older people's services with a shared understanding of priorities.

## 9.2 Leadership of strategy and direction

In the absence of a coherent joint commissioning strategy, the Fife Partnership having decided to await the outcome of the financial regulations from Scottish Government work to prepare for integration was initially well developed through the Integration Programme Board. This group met throughout 2012–2013. An interim Director of Integrated Health and Social Care was appointed, two integration managers, one each from NHS Fife and Fife Council (with dedicated time to progress the integration agenda) and a Shadow Board was established in June 2013.

The Fife Partnership opted for a Body Corporate approach and we were interested that the Fife Partnership's Shadow Board was configured differently to other Partnerships. The main

difference was that the NHS Fife contingency was derived mainly of executive officers rather than NHS Board members. The membership from Fife Council consisted of: Chief Executive; Interim Director of Health and Social Care Integration; Communications Officer; Chief Legal Officer all (Fife Council and no voting rights). The Board was chaired by one of eight local elected members from Fife Council. NHS Fife was represented by: Community Health Partnership Chair; Chairman of NHS Fife; Chief Executive; NHS Fife Board member; Director of Nursing; Interim Chief Executive; Director of Organisational Development; Director of Public Health (all voting members). In attendance from NHS Fife were Employee Director and Integration Programme Manager. Finally, there were two individuals from outside the statutory agencies, namely Scottish Care and Fife Voluntary Agency.

The Shadow Board appeared mostly cohesive in relation to agreeing the way forward in terms of vision towards personal outcomes for older people. Members appeared alert to the challenges the Fife Partnership faced and demonstrated an awareness of the information needed to comment on issues raised. It seemed clear the Shadow Board was well placed to provide a solid foundation on which to progress to full Board status.

The Integration Work Plan, which was set out in a work programme format was led by the Interim Director for Integrated Health and Social Care and included a number of key work streams, namely:

- Governance
- Finance
- Workforce and Organisational Development
- Joint Commissioning Strategy, and
- Communications

Despite early action to create an infrastructure to support integration, it was difficult to evaluate the pace of progress in relation to development of the Integration Work Plan due mainly to the lack of evidence available. The Fife Partnership acknowledged that pace of progress was steady, with a wish, according to the Interim Director to, "do it right first time." Based on guidance issued in February 2014 by the Joint Inspection Team[28] we felt there remained a substantial challenge to ensure all parts of the integration programme were completed and in place on time.

We noted positively that the Joint Improvement Team had significant involvement in supporting the Fife Partnership with planning for integration and were providing hands-on support to a number of the above work streams.

[28] Strategic Planning (Joint Strategic Commissioning) Joint Improvement Team Advice Note February 2014.

As key strategic partners, housing appeared to have become involved in the process at a late stage. However, we saw a very positive contribution from them in the senior management meetings we observed. We saw evidence of housing taking a lead on a number of strategic projects in support of integration, such as provision of extra care housing (including the 60 bedded care homes) as part of the Care Village programme. We also saw that Fife Housing Partnership had completed a final draft of an approach to older people's housing for 2013–2016.

A Public Reference Group was formed in October 2012, chaired by a member of the Shadow Board with a remit to:

- develop a two-way dialogue for views gathered from personal experience and local networks
- assure account is taken of community, patient and public involvement
- provide a forum for the development and management of related information
- advise and assist in the development of communication materials.

Membership came from a range of Fife residents and individuals as well as representatives from community organisations such as the Fife Elderly Forum, Alzheimer Scotland, Age Scotland and the People's Panel. The Public Reference Group was supported by the Communications work stream. As with a number of areas of work it was difficult to evaluate progress in this area with the lack of evidence available. We read progress reports from this group and while these were at an early stage of the group, we noted the main communication flow came from council officers. We would expect this to change to a more involved approach in the future.

We saw strong clinical leadership in Fife with good examples of health-led initiatives, such as Hospital at Home, Local Management Groups and a demonstrable attempt to engage with the wider Partnership. This had not always been the case but it was acknowledged that the relationship between health and social work at a senior level had improved significantly, particularly over the period leading up to the inspection.

Senior medical and nursing staff told us they were able to describe their strategic direction, not only in the context of Community Health Partnerships and NHS Fife, but quite clearly where this sat within the Fife Partnership. It was evident that changes to how acute services beds would be released and changes to how acute services would be run were being explicitly planned with a view to where the council would be integral to these changes.

A particular challenge for the Fife Partnership was the planned implementation of the Care Village programme, which saw plans for the development of three 60 bedded care homes plus additional services, such as day care and extra care accommodation, on various sites in Fife. This model was driven and approved by elected members, but was out of kilter

with national strategic direction, which is seeking to reduce dependency on care home provision, promoting support for older people to remain at home for as long as possible. This would likely create more problems for the Fife Partnership in terms of addressing the existing significant shortfall in funding for home care services. The Fife Partnership had acknowledged they would need to work together to ensure these developments were fit for purpose and provided positive outcomes for the people of Fife. We were encouraged by clear evidence that elected members were engaged in the integration agenda and future plans for service developments and care models would be informed by the Fife Partnership. They cited examples of how these developments might operate services in the future, including respite, intermediate care and specialist complex care provision.

The home care services had been reviewed just before the inspection, having been significantly over budget in successive years. However, the service was still unable to deal with a full scale change to service provision that could offer flexibility and options to older people. However, we acknowledged that another review was being undertaken to resolve identified gaps in service provision. Whilst it was not known how significant the investment will be to change this service, it would be made more challenging given the investment that is being made in the Care Village programme. We would expect to see this clearly articulated in the joint commissioning strategy.

There was an interim Head of Service for Older People's Services, who had been in post for around six months at the time of the inspection and the Head of Adult Services was due to retire in September 2014. There were three Community Health Partnership General Managers; one held an interim position and another was due to move out of the area imminently to a different post. These changes in senior management could potentially impact upon the stability required to move forward with the wholesale change to service delivery and culture. However, we were aware this was being done with an eye to giving the new Director of Integrated health and Social Care a 'clean slate' on which to get the best people for the jobs. While this could be seen as an opportunity, the Fife Partnership should acknowledge the risks that can come with key, senior staff leaving and new staff coming in and the impact this may have on the strong relationships that will be required to deliver on their strategic plans.

We were advised by the Interim Director that the incumbent Director of Integrated Health and Social Care, who was appointed in June 2014, would take up post in September 2014.

At the time of the inspection, it was not clear what the future NHS Fife management configuration was going to be. However, there will need to be sufficient management input to support the integrated services and existing services, such as Local Management Groups to ensure they continue to work towards seamless services across Fife. The potential move to seven localities will be an opportunity to shape the future management structure and we hope this will be reflected in the council management appointments.

**Recommendation for improvement 10 (QI 9.2)**

**The Fife Partnership should ensure that future modelling of services is done in full consultation with the wider partnership and that existing plans, in particular the Care Home Programme and the Home Care Services Review are closely monitored and evaluated in a timely fashion, in terms of performance and outcomes for older people who use these services.**

## 9.3 Leadership of people across the Fife Partnership

We saw mixed examples of interaction between senior managers and leaders from within the Fife Partnership. A number of joint reports and papers were submitted as part of the inspection process and it was evident the Fife Partnership had contributed to the content. We observed the Fife Partnership working through challenging issues, such as joint funding arrangements and these were addressed during the meetings we observed, but did not always achieve agreement. However, the staff survey indicated that almost 60% of staff agreed that high standards of professionalism are promoted and supported by all professional leaders, elected members and Board members. A Professional Reference Group had been established, chaired by a medical professional from NHS Fife. The role of this group was to lead in increasing and strengthening engagement and involvement of key clinicians, including GPs, mainly through the Organisational Development Plan. We read update reports from this group to the Shadow Board and spoke with senior health staff, who confirmed that progress was being made in terms of engaging clinicians and in particular, GPs in the integration agenda.

The Fife Partnership had organised a number of events to publicise, consult and inform on integration. A handbook entitled Guide to Health and Social Care Integration in Fife[29] was produced for staff and the general public and we saw these in social work reception areas during the inspection. There were a series of themed workshops for staff and care providers to comment and provide their perspective on the implications of integration and how they could contribute.

However, staff told us they did not feel their views had been taken into consideration and when they had participated in events or questionnaires, there was little evidence that staff had been consulted and their views had been used to influence change. This was highlighted in the staff survey that showed almost 60% of staff disagreed that the views of staff were taken into account fully when planning services at strategic level.

Service providers told us they did not feel their views were valued by the Fife Partnership and were not fully consulted on a number of key issues. One group said they heard about the final plans for the Care Village plans through the local newspaper. Providers

[29] Guide to Health and Social Care Integration in Fife – Fife Council and NHS Fife.

also told us the agencies in the Fife Partnership worked well separately and provided good outcomes for people, but the only reason they were integrating was, "because they have to". We heard this message in a number of different sessions during the inspection. Our conclusion was that agencies could have worked better together in the past despite providing good outcomes. Therefore the Fife Partnership will need to demonstrate to these partners that they are indeed working in partnership to instil confidence in how they move forward in the future.

### 9.4 Leadership of change and improvement

Fife Council developed a 'Fife Excellence Model' as part of the self-assessment. The Council reported to the council's Extended Management Team in November 2013 on key areas, including: leadership; service planning; people; Partnership and resources; service processes; customer results; people results; social responsibility results; and key performance results. The document identified a number of strengths and areas for development. The main areas for development included: address inconsistencies in leadership behaviours and approach, especially in relation to:

- performance
- managing performance
- service planning, and
- measurement of outcomes.

It was positive that the Council had made arrangements for self-evaluation and identified areas for improvement. However, we did not see evidence of where this information was being shared within the organisation and across the Fife Partnership.

Senior managers from the Fife Partnership told us they had undertaken a number of visits to other Partnership areas and as a result had been able to develop the Fife Partnership's intermediate care services and implement the integrated discharge Hub. Following further benchmarking activity, with another Partnership with similar demographic makeup and size, they told us they had applied the learning to the financial planning for integration. For example, they learned the other council area was spending twice as much on home care services as Fife Council and disinvesting in care home provision. While this was at odds with the Fife strategy, they were aware of the direction of travel required in the future and how this was being taken forward elsewhere.

The Fife Reshaping Social Work Programme was responsible for the implementation of a number of significant change projects across the social work service during 2011–2014. The programme identified that business processes within the service needed to change and be streamlined to meet changing needs and expectations. The key projects delivered through the programme comprised:

- office rationalisation
- mobile and flexible working
- improved access to services
- home care review, and
- redesign of service processes based on lean principles.

While a number of these projects appeared to have progressed, there were some that appeared in other work streams, particularly in relation to home care. The Fife Partnership was undertaking a number of initiatives and projects and needs to be clear how these are being monitored, managed and reported.

We noted the management and strategic planning structure from advance information and the position statement provided by the Fife Partnership. We also made sure we heard from Local Management Group leads and observed a Partnership Management Group meeting as these were the mechanisms in place to implement the high-level strategic decisions. Health and social work services were represented as well as the third sector. They dealt quite rightly with locality issues and should have fed back up the way in terms of issues and successes so there should be a constant loop in terms of information filtering up and down in terms of leadership and direction.

However, the feedback up the way was not always effective with limited strategic overview in relation to how effective these groups were. We also noted there was limited scope to roll out good practice from one locality to another. The Fife Partnership should review these groups as they should be a powerful means of providing the foundation for change, but in reality do not deliver to their potential.

[30] The core idea is to maximise customer value while minimising waste. Simply, lean means creating more value for customers with fewer resources.

## Quality indicator 10 – Capacity for improvement

Summary

We saw evidence of some positive outcomes for some older people and their carers in Fife. The Fife Partnership was at an early stage towards integrating health and social care services and needed to better monitor how well this was progressing. The pace of change needed to significantly increase, particularly but not exclusively in the area of joint commissioning.

We mainly saw constructive working relationships among the leaders we met and they understood the direction of travel required to achieve successful integration. Changes in key leadership positions would have to be carefully managed. The preparations for integration were under way, but evidence that the changes were impacting positively on outcomes for older people was awaited.

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

#### Improvements to outcomes and the positive impact services have on the lives of individuals and carers

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

Despite reportedly high numbers of anticipatory care plans being in place, we saw little evidence or knowledge of these during the inspection. The focus on reablement had shifted from service specific to an integrated approach. We were not convinced this had been fully planned and implemented. However, we were aware that the Fife Partnership had made some important progress through developments in relation to intermediate care such as Hospital at Home and discharge hubs. They were also committed to trying to make sure older people received the right support at the right time.

The Fife Partnership also needed to make improvements in relation to the quality and choice of services for older people, meeting Scottish Government delayed discharge targets, providing increased access to home care, self directed support, and responding to carers' needs more consistently.

While there remained a number of single agency developments, a theme we found that ran across the Fife Partnership, there were some signs the Fife Partnership had begun to try to address these issues but at the point of inspection it was too early to assess how successful this was.

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

The Fife Partnership had established a planning infrastructure for integration at an early stage. However, this initial impetus appeared to have slowed and from the evidence available, progress was not being made at a pace one would expect. Commissioning and service provision was generally based on single agency. The absence of a robust joint commissioning strategy will significantly delay progress and needs to be addressed as a matter of urgency.

We were reassured that the Fife Partnership had undertaken significant work on identifying and agreeing financial resources and had broadly agreed the range and scope for inclusion in the future. However, we were also keen to ensure there were appropriate measures put in place to monitor and manage an integrated budget.

### Effective leadership and management

There was not a stable management team in place due to several senior positions being interim or about to be vacated. Working relationships at top level between the Fife Partnership had historically been difficult, but there was general acknowledgement that this had improved over the preceding months before the inspection. From discussions with a range of staff, we concluded leaders needed to work harder at taking staff views into account and sharing with staff the merits of integration.

The Shadow Board and senior officials acknowledged the need to concentrate their efforts on engaging and involving staff more. The partners recognised that sustained and focussed effort would be needed if a shared vision was to be developed and implemented to meet future challenges and the necessary resources found to realise their intentions. Good frontline working needed to be built upon by senior managers.

The Shadow Board demonstrated a good understanding of, and general agreement on the way forward for integration and this should act as a solid base on which to proceed.

### Preparedness for health and social care integration

The Fife Partnership had a strong history of providing single agency services, working jointly when needed. Their relationships with the third sector and the independent sector had been mixed and could be strengthened. The Fife Partnership was at the early stages of developing a positive culture of working together. Leaders in Fife understood the future

challenges in delivering joined-up services for older people in Fife. Constructive plans were in early stages of preparation to develop more integrated health and social care services so that older people and their carers would have a more positive experience of these services. There needed to be a shared approach to the development of a joint commissioning strategy for older people to help deliver a joint understanding of the needs and expectations of the older population in Fife and the commissioning of services to meet these.

Our conclusion was that some of the building blocks to achieve better integration were being put in place, but the pace of change needed to be accelerated. The partners needed to be clearer about the sustainability of some of the processes in place, particularly those funded through the Change Fund. The Shadow Board and its subgroups were positive developments, but again needed to pick up the pace. Leadership and preparation for integration were in place, but evidence that the changes required were being delivered was awaited.

## What happens next?

We will ask the Fife 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**

January 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<br><br>**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<br><br>**2.2** Prevention, early identification and intervention at the right time<br><br>**2.3** Access to information about support options including self directed support | **5.1** Access to support<br><br>**5.2** Assessing need, planning for individuals and delivering care and support<br><br>**5.3** Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks<br><br>**5.4** Involvement of individuals and carers in directing their own support | **6.1** Operational and strategic planning arrangements<br><br>**6.2** Partnership development of a range of early intervention and support services<br><br>**6.3** Quality assurance, self-evaluation and improvement<br><br>**6.4** Involving individuals who use services, carers and other stakeholders<br><br>**6.6** Commissioning arrangements | **9.1** Vision ,values and culture across the Partnership<br><br>**9.2** Leadership of strategy and direction<br><br>**9.3** Leadership of people across the Partnership<br><br>**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<br><br>**7.2** Deployment, joint working and team work<br><br>**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<br><br>**8.2** Information systems<br><br>**8.3** Partnership arrangements | |
| What is our capacity for improvement? | | | | |

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