care inspectorate

Healthcare Improvement Scotland

Services for older people in the Western Isles

March 2016

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

HAPPY TO TRANSLATE

Services for older people in the Western Isles
March 2016
Report of a joint inspection

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

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

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- by email
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- on audio tape or CD
- in Braille (English only)
- in languages spoken by minority ethnic groups.

Contents

Purpose

The purpose of this report is to evaluate the progress the Western Isles Partnership was making towards integrated working and whether this progress was impacting on the outcomes for older people who were in need of health and social work services.

Background

Scottish Ministers have requested the Care Inspectorate and Healthcare Improvement Scotland 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 work services from April 2015. This policy aims to ensure the provision of seamless, consistent, efficient and high quality services, which deliver very good outcomes[1] for individuals and unpaid 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.

Between April and June 2015, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services in the Western Isles. The purpose of the joint inspection was to find out how well the services of NHS Western Isles and the Western Isles Council[2] (referred to together in this report as 'the Western Isles Partnership' or 'the Partnership') delivered good personal outcomes for older people and their carers. In doing so, we recognised the stage of development the partner agencies shared at the time of the inspection. 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 and as healthy as possible. We also wanted to find out if health and social care services were well prepared for legislative changes requiring them to integrate[3].

As part of our joint inspection, we met with older people, unpaid carers, and with a range of staff. We read the health and social work records of 101 older people. We also read and analysed policy and strategic and operational information provided by the Partnership.

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

[2] Comhairle nan Eilean Siar: Comhairle nan Eilean Siar is the name of the local authority in the Western Isles. We refer to this as the Comhairle (the Council) in this report.

[3] The Public Bodies (Joint Working) (Scotland) Act 2014: Requires health board and local authority partners to enter into arrangements (the integration scheme) to delegate functions and appropriate resources to ensure the effective delivery of those functions.

Western Isles context

The Outer Hebrides, also known as the Western Isles are an island chain off the west coast of mainland Scotland. The islands are geographically co-extensive with Comhairle nan Eilean Siar, one of the 32 unitary council areas of Scotland. They form part of the Hebrides, separated from the Scottish mainland and from the Inner Hebrides by the waters of the Minch, the Little Minch and the Sea of the Hebrides. Scottish Gaelic is the predominant spoken language amongst older people, although in a few areas English speakers form a majority.

The context for this partnership is a complex and challenging geographical environment. The fundamental challenge is providing accessible and flexible services to a population of 27,400 across an island chain. The islands extend for 140 miles from the Isle of Barra to the Isle of Lewis, with 30% of the population in the Greater Stornoway area and the remaining population scattered over 280 townships. The Comhairle and the NHS Board have coterminous boundaries within which there is a predominantly aging population. By 2037 the Western Isles is projected to have the highest percentage of older people in Scotland, representing 34% of the population. Currently the Western Isles is one of six areas to have people over 65 years representing more than a fifth of the population.

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 (Appendix 1). Our findings on the Western Isles Partnership's performance against the quality indicators are contained in separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector to deliver positive outcomes for service users and their carers. The inspection teams were made up of inspectors and associate inspectors from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors who were carers on each of our inspections. To find out more go to: www.careinspectorate.com/ or www.healthcareimprovementscotland.org/

Our inspection process

Phase 1 - Planning and information gathering
The inspection team collates and analyses information requested from the Partnership and any other information sourced by the inspection team before the inspection period starts.

Phase 2 -Scoping and scrutiny
The inspection team looks at a random sample of health and social work records for 100 people to assess how well the partnership delivers positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. A staff survey is also carried out.

Phase 3 - Reporting
The Care Inspectorate and Healthcare Improvement Scotland jointly publish a local inspection report. This includes evaluation gradings against the quality indicators, any examples of good practice and any recommendations for improvement.

To find out more, go to **careinspectorate.com** or **healthcareimprovementscotland.org**

Summary of our joint inspection findings

Key performance outcomes

We found a number of important weaknesses in the key performance outcomes being achieved for older people. These included a significant proportion of older people who were subject to delayed discharges from hospital and older people having to wait, sometimes for significant lengths of time, to receive care at home support or to access a place in a care home.

The length of time older people had to spend in hospital after they were fit for discharge had been raised in a previous inspection by Healthcare Improvement Scotland. In some instances, it meant that the opportunity for a successful return home was lost.

In comparison with other partnerships, there had been very limited development of reablement and intermediate care services. This meant very few older people had been able to benefit from these.

Self-directed support was being discussed with older people and the take up of this was increasing. However, a number of families and staff told us that, in their opinion self-directed support was not a real choice, but was an alternative to an older person having to wait for an uncertain length of time for a Comhairle care at home service.

These areas of poor performance, their adverse impact on outcomes and the challenges faced by the Partnership was not always evident from national performance data which suggested more positive performance. These included the amount of care at home provided, and the proportion of older people cared for at home rather than in care homes.

The level of emergency admissions to hospital was just below the national average, but this was offset by the above average length of time that older people had to remain in hospital in these circumstances.

Most staff showed an understanding of the need to focus on positive personal outcomes for older people. From our review of health and social work services records, and in common with other inspections, we found that the majority of findings on outcomes for older people were positive

Whilst the Partnership had some plans and was taking some service development actions to improve outcomes for older people, it was going to be some time before older people would be able to benefit from most of these.

Getting help at the right time

Most older people and carers we met were generally happy with the services provided to them in the Western Isles. They felt that these services contributed to better outcomes in respect of health and wellbeing. We saw good examples of older people being supported to remain in their own homes. Having a GP as the physician on-call out of hours had helped avoid hospital admissions for some older people.

However, some older people waiting to return home from hospital had poor personal outcomes. This was due to difficulties in recruiting care at home staff, waiting times for care home placements in some areas, and a very limited availability of intermediate care services

Across the Partnership, there was a well-developed network of condition-specific management services helping older people to achieve good personal outcomes. There was a good focus on self-management.

Both health and social care staff tried to reduce the risk of falls for older people. The number of older people benefitting from telehealthcare/telecare was increasing and there was good palliative care for older people living at home and in the community. There were some technical challenges in the use of video conferencing for medical consultations.

Relatively few people were benefitting from Anticipatory Care Plans. Where plans did exist, they were not always shared amongst professionals.

The Partnership needed to improve access for mental health assessments. It also needed to ensure that older people could benefit from a timely diagnosis of dementia and from post diagnostic support.

Impact on staff

Within the Western Isles, it was clear that front line staff in both health and social work services worked well together. This was supported by feedback from staff in our discussions with them and in response to recent staff surveys. We had a 51% response rate to our staff survey and those who responded, said they felt valued and well supported by their most immediate managers.

Both health and social work staff were committed and well-motivated in their jobs and said that they worked well together. We saw a number of examples where staff had worked closely and imaginatively together to achieve good outcomes for older people.

Staff impressed as being clear about their roles and responsibilities. Most staff we met were positive about the training and development support they received to enable them to do their jobs. Although a challenge, the Partnership tried to provide this in a way which took account of the dispersed nature of its workforce across the islands.

Staff expressed frustration about the constant issues around resourcing care. They said this could have a negative impact on their morale.

The Partnership used different approaches to communicate with staff. Staff, however expressed mixed views about the effectiveness and quality of these approaches. In particular front line staff did not feel well informed on the action being taken to take forward health and social care integration, nor about various service development or redesign initiatives.

Impact on the community

We found little evidence of a strategic approach for community capacity building, nor of a well-established approach to engaging with communities as part of this. Work to develop locality planning and to decide how this would link with health and social care integration needed to be advanced

There was a strong sense of community spirit and engagement, with communities willing to participate in and inform the integration process. The Partnership needed to do more to harness this.

Staff had a good knowledge and appreciation of the various supports and services provided by community groups and organisations. However, as reflected in our staff survey, they had less awareness of the role which they could play as staff and what approaches the Partnership were taking to increase community capacity.

Tagsa Uibhist was a vibrant and local third sector provider which provided a range of well-regarded services in the Uists and Barra communities. It was an important part of the social landscape in the Southern Isles. The Partnership's health and wellbeing group was successfully engaging with the public in Harris around a number of public health initiatives.

Delivery of key processes

Most older people and carers were clear about how to access services. They relied heavily on local knowledge and word of mouth rather than on the Partnership's public information which was of variable quality. The Faire Careline service provided an effective call service and was supported by local staff acting as responders in the more rural areas. Access to services was generally good with the exception of some services, such as care at home and care homes where there were significant resourcing issues. The Partnership needed to ensure that where older people had to wait for services, they were kept informed in the meantime.

Findings from our file reading about the quality of assessments were generally positive with older people having good quality needs assessments in place. Most older people also had care plans in place, although keeping these subject to review was a challenge with a significant backlog in reviews for older people in Lewis and Harris. Improvement was required in the number of carer assessments being completed. Not all staff appeared to understand the potential added value for carers in having their own needs considered and addressed.

There had been some strengthening in the governance arrangements surrounding adult support and protection and the work of the adult protection committee. However awareness-raising on adult protection, the collection and use of management information and self-evaluation activity all required further attention as a matter or priority. There were good arrangements in place to manage risks for older people associated with adverse weather conditions in the Western Isles and its dispersed geography.

The findings from our file reading exercise about involving older people in their care and support were generally positive with the exception of independent advocacy being offered (where appropriate) where the results were disappointing.

Plans and policies

The Partnership had a Joint Commissioning Strategy. Whilst this provided a useful direction of travel it needed to be converted into a detailed plan as a matter of priority. There was awareness across the Western Isles Partnership of the need to move forward with planning and implementing service changes. This was required so that the NHS Western Isles and the Comhairle could more effectively respond as a Partnership to the presenting levels of need and the demographic pressures of an ageing population.

We concluded that the development and implementation of early intervention and support services had been limited, a view echoed by many staff in our staff survey.

Some operational restructuring and strategic planning was taking place. This included significant and important work around care at home, reablement, intermediate care and a review of residential care. However, much of this work was at an early stage or was some way off fruition. The Partnership acknowledged considerable work was required to take this forward now that some of the foundations for change were being put in place.

Some stakeholder engagement had been taking place, but this was limited. The Partnership needed to develop its approach to its involvement of, and engagement with, all stakeholders. Staff at practitioner level felt distanced from the integration agenda.

The Partnership acknowledged it needed to further develop its approaches to quality assurance and self-evaluation and some work was already under way.

There was a pressing need to ensure that priority was given to the development of the joint strategic commissioning plan, and the related financial and resource mapping in consultation with all stakeholders.

Management and support of staff

The Western Isles Partnership was clear about the value of having a motivated and well informed workforce. It had worked hard to ensure that staff were given professional support and opportunities.

Both NHS Western Isles and the Comhairle had clear approaches to address the long-term issues of recruiting and retaining staff. This was a particular issue that they experienced along with other remote and rural partnerships, and they were part of an international group working to address this. The Partnership was also looking at internal measures. These included strengthening links with further and higher education facilities to develop career pathways and to provide continuing professional development opportunities for staff. We did not see much evidence of NHS Western Isles and the Comhairle, until recently, sharing the learning from the

actions which they had taken on a single agency basis to address recruitment and retention challenges. Most staff worked in single agency teams.

There were very few co-located or joint teams, although this did not prevent front line staff from working closely and flexibly together. The Occupational Therapy Team was a joint team and operated as an effective and fully integrated team and service. Some broad joint principles had been agreed for the workforce as part of a workstream for health and social care integration. This was at an early stage and further work was required to develop this.

Managers were supportive of staff and recognised the pressures they faced in carrying out their work. Staff recognised this and felt valued. Where appropriate training and support was not available locally in the Western Isles, the Partnership was supportive of this being accessed from the Scottish mainland.

Partnership working

There were a number of significant financial challenges and pressures on the provision of more integrated services, particularly in relation to providing services on a sustainable financial footing and remaining within budgets.

A combined budget for services which would become integrated was still to be agreed. A chief finance officer for the Partnership had yet to be appointed. Some decisions had been reached on the use of the Integration Care Fund in its first year, with decisions for years two and three pending on the completion of the strategic plan. The Partnership was still in the process of managing the transition from the Change Fund to the Integration Care Fund and needed to conclude this quickly.

In common with other partnerships, the Western Isles Partnership faced challenges from having separate IT systems. However, it had taken some actions to address this, including expanding the number of staff from each organisation with access to each other's systems. It was also considering a joint tendering exercise for a client/patient recording system. It demonstrated a keenness to introduce initiatives to improve efficiency and communication for community nursing staff, an example of which was the use of digital pens.

Historically there had been difficulties in partnership working at the highest level between NHS Western Isles and the Comhairle. Senior managers said this was no longer the case and we saw some limited evidence to support this. Staff and third sector organisations retained some scepticism about this

The length of time it had taken before agreement was reached on the model for health and social care integration and then with the subsequent appointment of a Chief Officer meant considerable detailed preparatory work was going to have to be completed in a relatively short timescale.

Leadership

The Partnership had a clear high level vision for older people which was consistent with the reshaping care for older people agenda. However this was not supported by

a detailed plan on how this vision would be taken forward and implemented. This was highlighted in our staff survey which reflected a lack of awareness amongst staff about the service development agenda. The Partnership needed to move quickly to develop its detailed plans for older people as part of its strategic plan for integration.

Historically there had been difficulties in aspects of partnership working between NHS Western Isles and the Comhairle. We could see that these had meant that the organisations had not worked together effectively to develop a range of community services to support older people. They were now facing the consequences of this in high numbers of delayed discharges.

Senior managers, elected members and board members said these difficulties were now in the past. Most staff, third sector partners and other stakeholders we met were sceptical about this.

Initially the NHS and the Comhairle had favoured different models for health and social care integration. They had only agreed on the body corporate model relatively late in the day and this had impacted on the timescale for appointing a chief officer. We also saw this was reflected in the four main workstreams in preparation for health and social care integration which would require a considerable amount of work to be concluded in a short timescale.

Both organisations made good efforts to communicate with staff using newsletters and other means. Staff were generally positive about their line managers and middle managers, but they questioned the visibility of the most senior managers. This was particularly true of staff in the Southern Isles.

The Partnership was working on a number of important service development and redesign initiatives, but for most of these it would still be a significant amount of time before the potential benefits would be experienced by older people and their carers.

Capacity for improvement

The Partnership faced some very significant challenges which could have an adverse impact on the outcomes for and experience of older people and their carers. The fact that our inspection found some important weaknesses in outcomes for older people, in self-evaluation for improvement and in leadership raises concerns about the Partnership's capacity for improvement.

Whilst some service redesign work had been completed, the majority of the major service improvement and redesign activity was still very much work in progress and for a number of these developments it would be some time before the expected benefits would be in place for older people.

The Partnership had a clear high level vision of what it wanted to offer and achieve for older people. However, it had work to do to complete a detailed plan on how to deliver this. Frontline staff considered themselves to be well-supported by their more immediate managers. Senior managers worked hard to communicate with staff; however many staff we met questioned their visibility.

There had been some historical difficulties around partnership working between NHS Western Isles and the Comhairle at the most senior level. In addition the Partnership had left it relatively late before agreeing on its model for integration. It had considerable work to do in order to complete its strategic plan for integration.

The Partnership demonstrated a generally good level of awareness of the challenges it faced. It was aware of the need for it to make a success of health and social integration. Some optimism was expressed that the appointment of the chief officer would help increase the chances of this happening. We concluded that it would also require the chief officer to be supported by the efforts of all key stakeholders.

Evaluations and recommendations

We assessed the Western Isles Partnership against the nine quality indicators. Based on the findings of this joint inspection, we assigned the partnership the following grades.

Quality indicator		Evaluation	Evaluation criteria
1	Key performance outcomes	**Weak**	**Excellent** – outstanding, sector leading **Very good** – major strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important weaknesses **Unsatisfactory** – major weaknesses
2	Getting help at the right time	**Adequate**	
3	Impact on staff	**Good**	
4	Impact on the community	**Adequate**	
5	Delivery of key processes	**Adequate**	
6	Policy development and plans to support improvement in service	**Weak**	
7	Management and support of staff	**Adequate**	
8	Partnership working	**Adequate**	
9	Leadership and direction	**Weak**	

Recommendations

1. The Western Isles Partnership should continue to progress with the strategic and operational improvement actions it has identified to ensure that older people are not delayed in hospital after they are fit to be discharged. The Partnership should ensure that a whole systems approach to delayed discharge is a fundamental aspect of its strategic commissioning plan for health and social care integration.

2. The Western Isles Partnership should complete its redesign of care at home services without delay, including a focus on reablement approaches. The partnership should also press ahead with plans to develop intermediate care services and implement these as fast as possible.

3. The Western Isles Partnership should take action to provide one-year post-diagnostic support for people newly diagnosed with dementia, in line with the national dementia strategy (2013-2016).

4. The Western Isles Partnership should review and make explicit how it can further develop arrangements for third sector and local community involvement in strategic planning. The Partnership should also explore

opportunities to promote inclusion of a wider range of people within the older person's network (co-production activity).

5. The Western Isles Partnership should make arrangements to ensure that older people whose discharge is delayed receive services in hospital that maintain or improve their independence in line with their personal outcomes.

6. The Western Isles Partnership, through its involvement in the public protection chief officers group and the adult protection committee, should ensure that action is taken to improve data collection, its use for improvement purposes and the quality of CareFirst recording. It should also ensure that a clear programme of self-evaluation is undertaken. This should include an audit of the effectiveness of its screening arrangements for adult support and protection referrals.

7. The Western Isles Partnership should take steps to ensure that the draft Joint Commissioning Strategy for services for older people is finalised. A SMART joint strategic commissioning plan should also be developed in consultation with all stakeholders to deliver a range of services to help support older people to remain at home successfully. The plan should include detailed costs based on identified future needs.

8. The Western Isles Partnership should develop a comprehensive and strategic approach to how it involves all relevant stakeholders in its strategic planning activity.

9. As part of health and social care integration the Western Isles Partnership should develop an integrated training strategy. In doing so it should consider ways to jointly develop and provide access to a range of training and education for staff which can be accessed easily and provided in a range of formats. This should be informed by staff views and through a training needs analysis.

10. The Western Isles Partnership should jointly produce and monitor a forward looking combined budget for the services that will become integrated to ensure that the financial monitoring arrangements are bedded in, in preparation for the Integration Joint Board going live. A plan should also be produced for how the Integrated Care Fund will be used for each of the three years of the funds life and this should be jointly monitored on a regular basis.

11. The Western Isles Partnership should ensure that its strategic plan for health and social integration provides detailed and measurable actions of how its higher level visions and objectives for older people will be delivered.

12. The Western Isles Partnership, as it moves into the new integrated partnership, should review how it communicates with its staff and with the wider community.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Weak

We found a number of important weaknesses in the key performance outcomes being achieved for older people. These included a significant proportion of older people who were subject to delayed discharges from hospital and older people having to wait, sometimes for significant lengths of time, to receive care at home support or to access a place in a care home.

The length of time older people had to spend in hospital after they were fit for discharge had been raised in a previous inspection by Healthcare Improvement Scotland. In some instances, it meant that the opportunity for a successful return home was lost.

In comparison with other partnerships, there had been very limited development of reablement and intermediate care services. This meant very few older people had been able to benefit from these.

Self-directed support was being discussed with older people and the take up of this was increasing. However, a number of families and staff told us that, in their opinion self-directed support was not a real choice, but was an alternative to an older person having to wait for an uncertain length of time for a Comhairle care at home service.

These areas of poor performance, their adverse impact on outcomes and the challenges faced by the Partnership was not always evident from national performance data which suggested more positive performance. These included the amount of care at home provided, and the proportion of older people cared for at home rather than in care homes. The level of emergency admissions to hospital was just below the national average, but this was offset by the above average length of time that older people had to remain in hospital in these circumstances.

Most staff showed an understanding of the need to focus on positive personal outcomes for older people. From our review of health and social work services records, and in common with other inspections, we found that the majority of findings on outcomes for older people were positive.

Whilst, the Partnership had some plans and was taking some service development actions to improve outcomes for older people, it was going to be some time before older people would be able to benefit from most of these.

1.1 Improvements in partnership performance in both healthcare and social care

The Western Isles Partnership's performance in respect of its services for older people was variable in relation to its performance plotted against national data. The majority of its performance and outcomes data was in line with or better than the national average. However, in some important areas, including delayed discharge from hospital, it was poor. Some of this data suggested levels of performance which did not reflect the realities of some very significant operational challenges. Older people unable to receive care at home support, or to access a care home placement, were examples of this.

Emergency admission to hospital

An emergency admission is 'when admission is unpredictable and at short notice because of clinical need'. The proportion of older people in the Western Isles admitted to hospital on an emergency basis in 2013–2014 was just below the national average and had been since 2010–2011. It had reduced since 2008–2009.

In contrast, the length of time older people remained in hospital after an emergency admission was just above the national average. While this figure had peaked in the Western Isles in 2008–2009, it had remained consistently above the national average since then. Charts 1 and 2 show information on the rates and length of emergency admissions.

Chart 1 – Rate per 100,000 population of emergency admissions to hospital for patients aged 65 or over. Western Isles community health and social care partnership, 2004/05 to 2013/14.

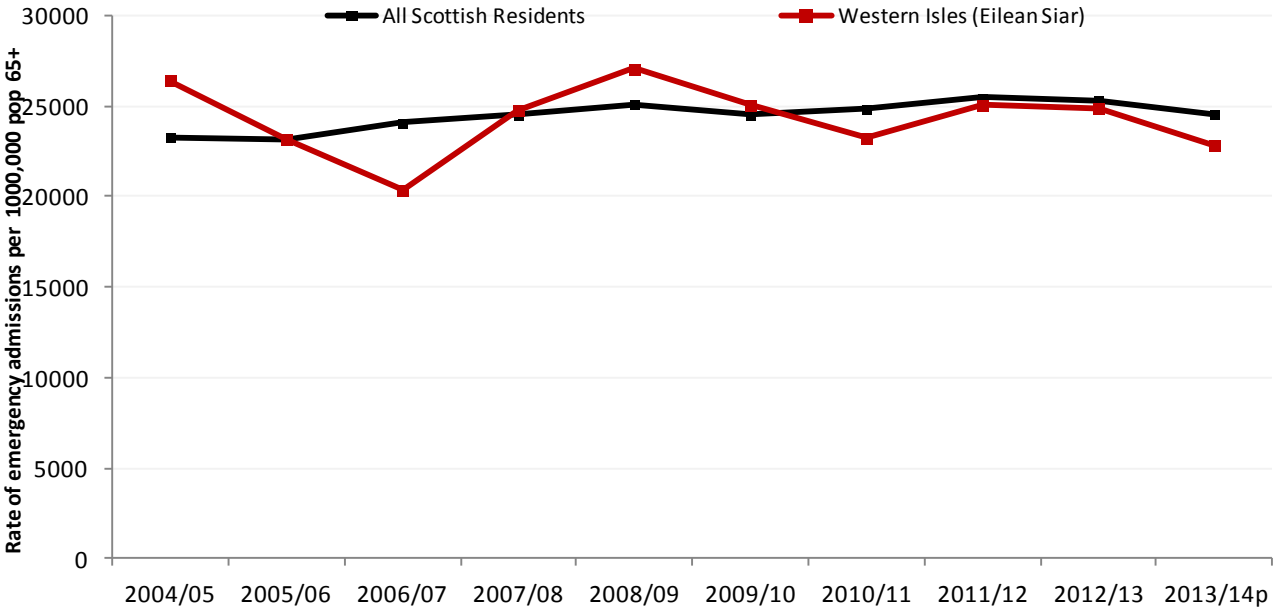
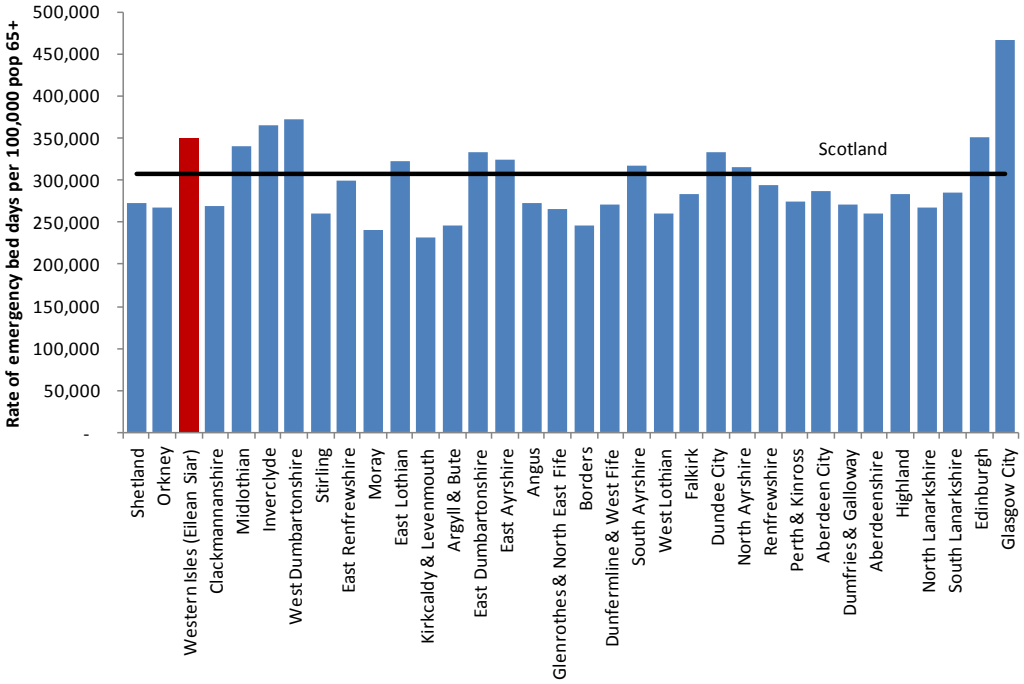


Chart 2 - Rate per 100,000 population of bed days for emergency admissions to hospital for patients aged 65 or over. All community health partnerships, 2012–2013.



The rate of multiple emergency admissions (two or more admissions) in the Western Isles was just above the national average in 2012–2013, but not significantly so. The rate of multiple emergency admissions to hospital for people over 65 years had not changed for the Western Isles over the last 10 years.

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 2015, the Scottish Government reduced its target for delayed discharges in that there should be no delayed discharges of over two weeks' duration. Before this, the target had been four weeks.

There is evidence that the longer an older person spends in hospital when they do not need to be there, the harder it becomes to discharge them home or to an appropriate setting.

As has been seen nationally, the number of bed days occupied by delayed discharge patients in the Western Isles had been increasing. Charts 3 and 4 show Western Isles performance in relation to delayed discharge.

Chart 3 – Bed days occupied by delayed discharge patients aged 75 or over. Data for Western Isles local authority. April 2012–April 2015.

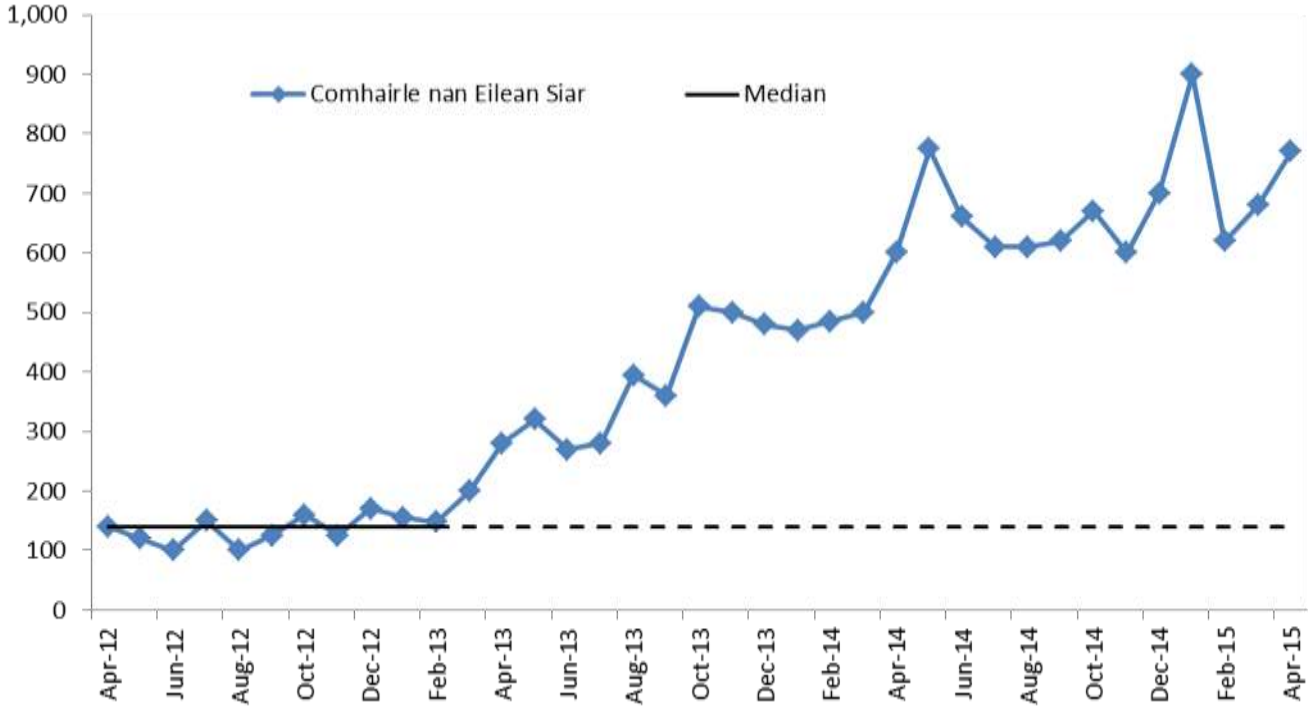
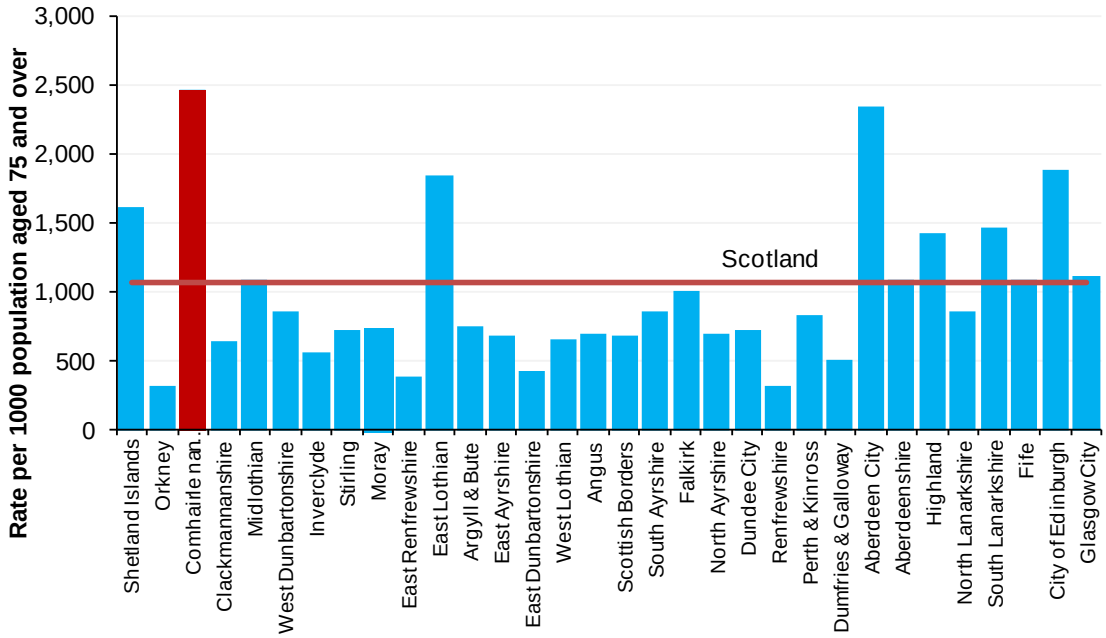


Chart 4 – Bed days occupied by delayed discharge patients per 1,000 population aged 75 or over. Data for local authorities, January 2014–December 2014.



At the time of our inspection, the most recent national delayed discharge census had been published in June 2015. This showed that, in May 2015, the Partnership had a total of 30 delayed discharges. This compared to 23 delayed discharges in May 2014. Of the 30 delayed discharges in May 2015, 11 were standard delays and 19

were Code 9[4] delays. Of the 11 standard delays, nine were in excess of the two-week Scottish Government target.
During the inspection, we heard in detail of the pressure on beds in the Western Isles Hospital in Stornoway. Both families and staff told us of examples of older people whose discharge from hospital had been delayed for several months and, in some instances, over a year.

We attended a meeting of the delayed discharge planning group. This was a multi-agency group which met on a weekly basis to review the discharge planning arrangements for patients. Of the 43 patients considered at this meeting, 25 were waiting for a care home placement and five for a care at home package. We saw that the group communicated and worked well together, but were limited in what they could achieve given the pressure on care home and care at home resources. The group acknowledged the poor outcomes for older people delayed in hospital. This included:

- some older people waiting to be discharged, but whose health then deteriorated so that they required medical treatment and prolonged hospitalisation
- some older people whose potential return to their own home, rather than to another setting, was jeopardised by their delayed discharge from hospital.

Within the existing available resources, the Partnership also had to make decisions on whether to prioritise the needs of some older people in hospital who were fit for discharge against very vulnerable older people in the community who were at risk of hospital admission unless intensive support was provided quickly.

In order to address the issues surrounding delayed discharges, the Partnership had a number of important service improvement initiatives and developments under way. These included:

- funding for an additional 12 care home beds in the Western Isles which were anticipated to come on stream in November 2015
- the Erisort Project which would allow for the provision of intermediate care in a range of settings. We were told it might be two years before this would become fully operational, and
- the continuing implementation of the care at home redesign exercise.

While these were all potentially positive developments, senior managers acknowledged that they were only a partial solution and it would still be some time before their impact would be felt. We say more about these initiatives and developments in Chapter 6.

[4] Code 9 patients are those whose discharge will take longer to arrange and therefore the standard maximum delay is not applicable. These cases would include patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

We read reports which provided updates on the delayed discharge position to the Health and Social Care Committee and to the Western Isles NHS Board. These included a report which reviewed the position from January 2011 to May 2014. It contained a number of improvement actions. These included:

- adopting estimated discharge dates for all appropriate patients
- the use of key information summaries in the Western Isles Hospital which included information from anticipatory care plans
- the establishment of multi-agency teams to support a consistent approach to assessment and care management
- the operation of a delayed discharge 'Hub' in the hospital in advance of the establishment of the multi-agency teams
- implementation of the 2013 Scottish Government guidance on choice in relation to care home placements for older people moving there from hospital[5]. This guidance included the need for the use of interim care home placements and robust consideration of capacity issues, including the use of the provisions of Section 13Za of the Social Work (Scotland) Act 1968.

Senior health managers acknowledged that there needed to be a more formalised way of working in the admissions wards. This would ensure that older people were provided with an estimated discharge date on admission to hospital, and that structured and frequent ward rounds took place. Limited progress appeared to have been made with setting up the multi-agency teams. Both staff and managers told us there could be significant delays in progressing guardianship applications for older people. All of these factors led us to conclude that the Partnership needed to take urgent action to take forward the improvement actions listed above.

Action needed to improve delayed discharge performance had been an area of difficulty going back a number of years. In October 2012, Healthcare Improvement Scotland carried out an older people in acute hospitals (OPAH) inspection in the Western Isles Hospital[6]. This found that a number of older patients, who were ready to be discharged home, were having to stay in hospital as there were no care at home packages available for them in the community. At that time, five out of twelve patients on one ward were delayed from being able to go home from hospital.

Recommendation for improvement 1

The Western Isles Partnership should continue to progress with the strategic and operational improvement actions it has identified to ensure that older people are not delayed in hospital after they are fit to be discharged. The Partnership should ensure that a whole systems approach to delayed discharge is a fundamental aspect of its strategic commissioning plan for health and social care integration.

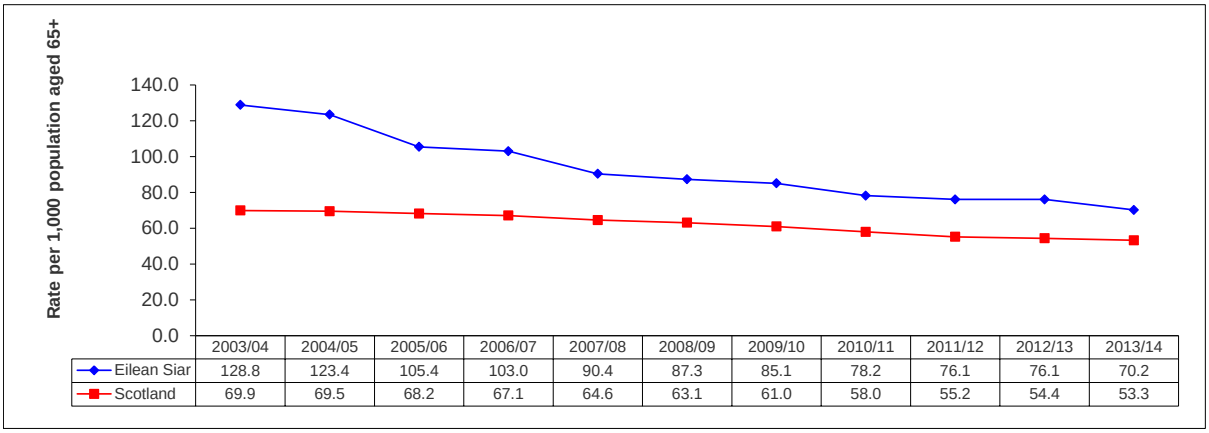
[5] Scottish Government Guidance on Choosing a Care Home on Discharge from Hospital December 2013 mels/CEL 2013 (formatting of reference, eg MELs/CEL in full)
[6] Healthcare Improvement Scotland: Western Isles Hospital – care of the older people inspection report: November 2012

Provision of care at home services

Care at home is care and support for people in their own home to help them with personal and other essential tasks. It is a key service in supporting older people to remain at home.

Comhairle nan Eilean Siar (the Comhairle) was by far the largest provider of care at home services in the Western Isles. Chart 5 shows that the level of care at home provision had been declining steadily in Scotland over the last 10 years. However, the level of care at home provided by the Comhairle had remained consistently higher than the national average. In 2013–2014, the level of care at home provided by Western Isles Comhairle was 70 per 1,000 older people compared with 53 per 1,000 older people for Scotland.

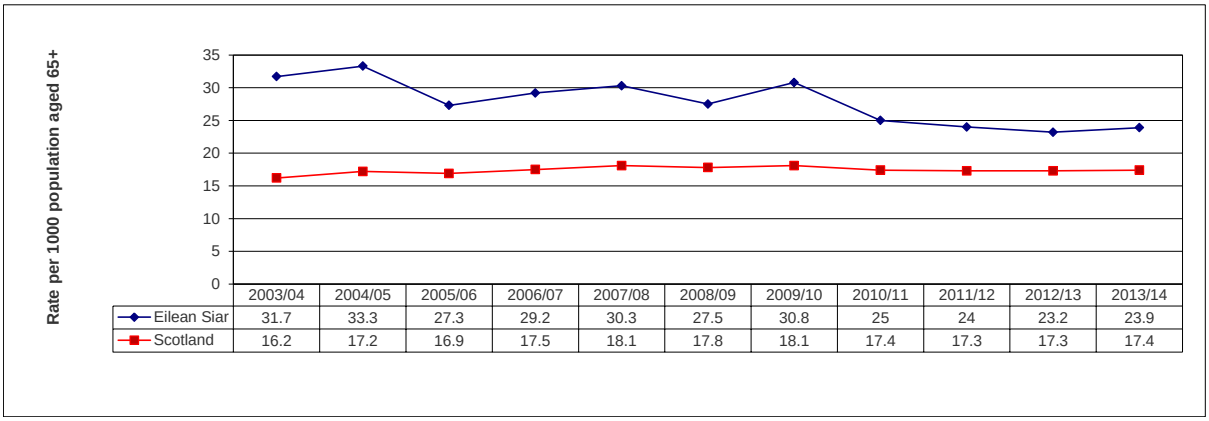
Chart 5 - Number of people aged 65+ supported by local authority in home care, 2003/04 – 2013/14 (rate per 1,000 population)



	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Eilean Siar	128.8	123.4	105.4	103.0	90.4	87.3	85.1	78.2	76.1	76.1	70.2
Scotland	69.9	69.5	68.2	67.1	64.6	63.1	61.0	58.0	55.2	54.4	53.3

Chart 6 shows that the level of intensive care at home (10 hours or more of care at home each week) provided by the Comhairle was also well above the national average. The Comhairle's performance for the provision of care at home in the evenings/overnight and at weekends was more mixed. In 2012–2013, it was ranked twenty-third of the 32 local authorities in Scotland for evenings/overnight care and sixth for the provision of weekend care.

Chart 6 – Number of people receiving intensive home care, 2003/04 to 2013/14 (rate per 1,000 population aged 65 or over)



	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Eilean Siar	31.7	33.3	27.3	29.2	30.3	27.5	30.8	25	24	23.2	23.9
Scotland	16.2	17.2	16.9	17.5	18.1	17.8	18.1	17.4	17.3	17.3	17.4

However, despite the relatively high level of provision, the Comhairle faced a significant challenge in meeting the assessed need and demand for care at home services. We met older people and their families who were either waiting for, or who had waited significant lengths of time for, a care at home package. This had placed them under considerable pressure. This could be a problem across the islands, but was most acute in some of the most remote and rural areas and could be exacerbated by care at home staff having to travel very large distances to visit older people.

Staff told us that some families, faced by their parent being on a waiting list for a care at home service for an uncertain length of time, had chosen to try and recruit and employ their own carers as an alternative and as part of self-directed support. We met a number of families who had done this. This had resulted in better outcomes for some older people and their families than others. However, they all indicated that having to wait for a care at home service from the Comhairle had been a significant factor in their decision to pursue self-directed support.

At the time of our inspection, the Comhairle was carrying out a significant redesign exercise of its care at home services. Senior managers acknowledged that a previous redesign exercise had not been 'particularly successful'.

The redesign exercise was being taken forward on a staged basis with an initial focus on the most heavily populated areas of Stornoway and Broadbay. It included the use of Call Confirm Live, a workforce scheduling and monitoring system. A benchmarking exercise carried out by the Comhairle showed that use of this system was having a positive impact. The Comhairle now ranked among the highest performing local authorities with a relatively low proportion of the workforce's time not fully accounted for. Managers also described how a change in the out-of-hours management arrangements for care at home staff was leading to reductions in the need to provide care at home cover for older people due to staff sickness. We say more about the redesign exercise in Chapter 6, but concluded that the implementation of the care at home redesign should lead to more consistently improved outcomes for older people.

Eleven care at home services were registered with the Care Inspectorate. Six were part of the Comhairle's care at home service, four were provided by voluntary or not for profit providers and one by a private sector provider. As part of the inspection, we looked at the grades awarded by the Care Inspectorate from its inspections of regulated services. This showed that the majority of grades awarded, including for the quality of care and support, were graded as 'good' or better.

As stated earlier, the Comhairle provided the majority of care at home services to older people. Generally, the Comhairle would purchase a care at home service from another provider when it was struggling to provide the service itself due to staffing pressures. It did this on a 'spot purchasing' basis. While this helped meet the immediate needs of the older people concerned, it did little to enable other service providers to increase their service capacity and to provide a greater element of choice for service users

Reablement

Reablement is the delivery of intensive and specialist care at home support, often combined with intermediate care services such as physiotherapy, occupational therapy and rehabilitation. This is normally delivered for a prescribed period of up to six weeks and it aims to help people regain confidence, and focuses on skills for daily living. It can enable people to live more independently and reduce their need for ongoing services and supports.

We met a number of staff, in particular allied health professionals such as occupational therapists and physiotherapists, who said that their focus on rehabilitation and maximising independence for older people was consistent with the provision of reablement.

However, no established and dedicated reablement service was in place at the time of our inspection. A reablement project had been agreed as part of the Change Fund[7]. This was designed to support early discharge from A&E and the Acute Assessment Unit. It included a focus on falls prevention and rehabilitation in the community. However, this project had not been fully staffed by the time its funding ceased. A decision had also been taken that the main mechanism to provide reablement would be through the redesigned care at home service. Staff and managers would have a specific remit and focus on providing reablement. We read the 2014 service specification for the care at home service. This anticipated that six older people each week would start to receive a reablement service. At the time of our inspection, this was not yet happening as the staff concerned had not yet completed the necessary training.

Intermediate care (sometimes referred to as step-up and step-down care) is another means by which hospital admission can be prevented for older people. We found that intermediate care was not well developed in the Western Isles. The Partnership acknowledged this. It had an agreed plan to develop intermediate care services operating in and from the Erisort ward in the Western Isles Hospital. A 'virtual team' would provide treatment and care to older people in the ward, in local care homes and in older people's own homes. However, the service was still under development, and was not expected to be fully operational until 2016.

The development of reablement and intermediate care services plays an important role in supporting older people in their own homes and communities, and in preventing admission to and delayed discharges from hospital. The lack of development and availability of reablement and intermediate care services in the Western Isles, coupled with the challenges facing care at home services, meant that some older people had experienced poor personal outcomes as a consequence. These included older people having to be admitted to hospital in the absence of an available community alternative and older people whose discharge from hospital was delayed.

[7] The Change Fund is a Scottish Government grant to health and social work services partnerships, which aims to help the partnership develop services for older people and carers who care for older people.

Recommendation for improvement 2

The Western Isles Partnership should complete its redesign of care at home services without delay, including a focus on reablement approaches. The partnership should also press ahead with plans to develop intermediate care services and implement these as fast as possible.

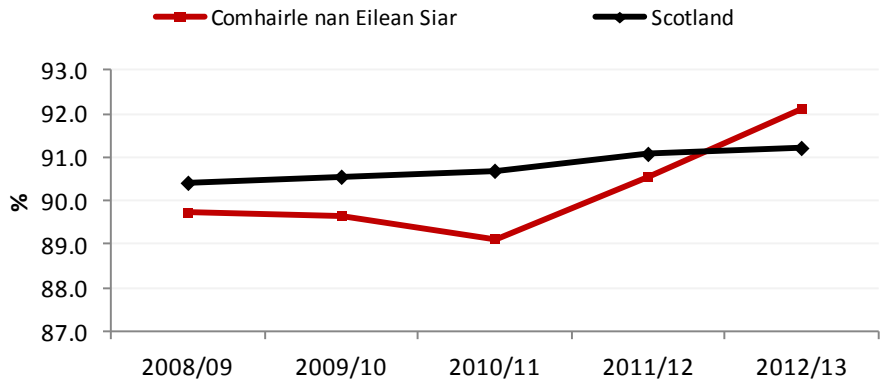
Palliative care

The proportion of older people in the Western Isles who had spent the last six months of their life at home or in a community setting had increased. By 2012–2013, this was higher than the proportion for Scotland as a whole.

The Partnership had a procedure in place that when an older person in Lewis or Harris was recognised as needing palliative care, their family was put in touch with the community unscheduled care nurses. This approach helped avoid calls to NHS 24 or presentation at hospital, and helped to minimise stress for the older people and families concerned.

While the palliative care support and treatment provided to older people in the community was good, this contrasted with the experience for some older people in hospital. Staff told us of some older people with palliative care needs whose expressed wish was to die at home, but who had died in hospital as appropriate care in the community had not been put in place.

Chart 7 – Percentage of last six months of life spent at home or in a community Setting. Data for all local authorities 2008/09 - 2012/13.

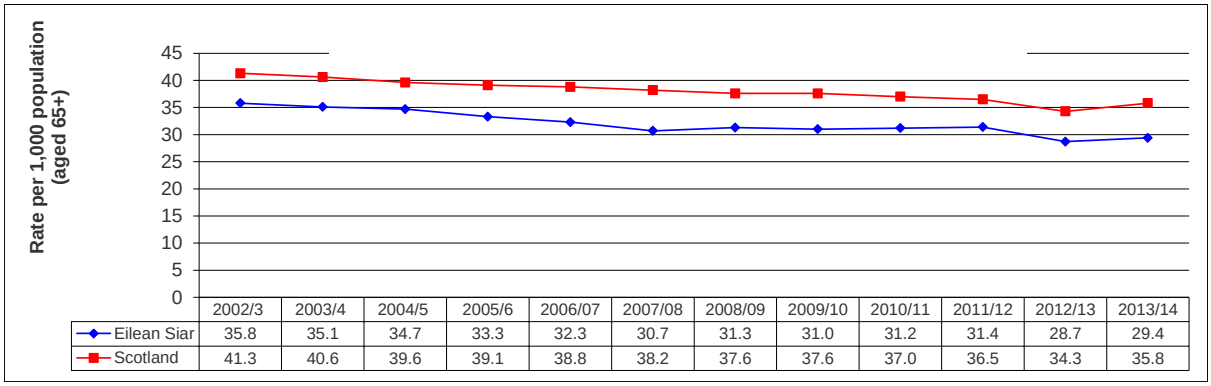


Care homes

Chart 8 shows that the proportion of older people in care homes in the Western Isles was below the national average. This had consistently been the case over the last 10 years. Combined with other good performance data, this would be indicative of a Partnership achieving a positive balance of care position. However, we found that the Partnership faced significant pressures on care home bed availability in Lewis and Harris (although not in the Uists and Barra). Both staff and managers said the lack of care home beds was a major factor in the level of delayed discharges. We

read a Health and Social Care Committee report which said the lack of available care home placements was a factor in 18 of the 19 Code 9 delays in May 2015.

Chart 8 – Long-term stay care home residents aged 65+ supported 2002/03-2012/14



	2002/3	2003/4	2004/5	2005/6	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Eilean Siar	35.8	35.1	34.7	33.3	32.3	30.7	31.3	31.0	31.2	31.4	28.7	29.4
Scotland	41.3	40.6	39.6	39.1	38.8	38.2	37.6	37.6	37.0	36.5	34.3	35.8

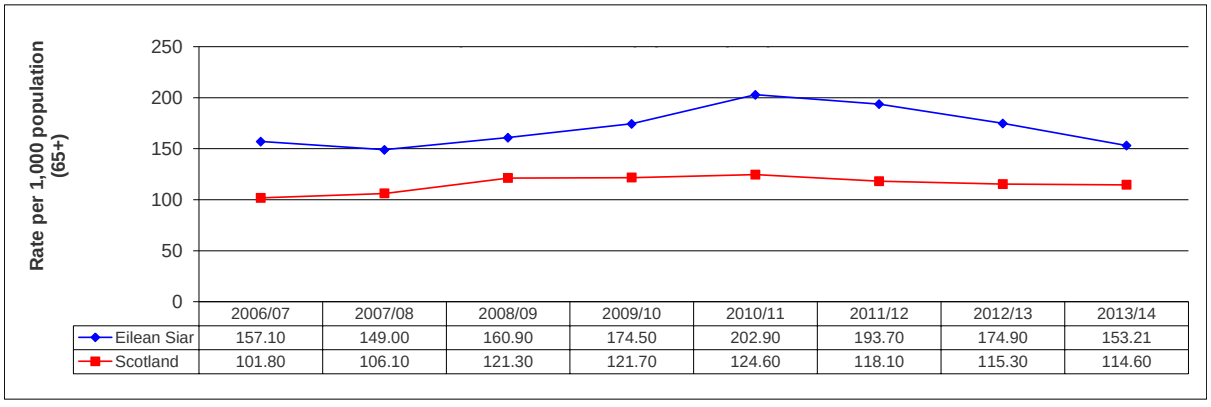
In order to address the pressures on the care home capacity, the Partnership had built a new 16-bedded care home in Harris. It had also commissioned an additional 12 care home beds to service the Lewis and Harris areas.

We looked at the grading information from the most recent Care Inspectorate inspections of the nine care homes in the Western Isles. Six of these care homes were run by the Comhairle. Most of the grades given were 'good' or better.

Respite care for older people and their carers

The Partnership provided a high level of respite for older people. This had been consistently well above the national average. In 2013–2014, it provided 153 respite weeks per 1,000 65+ population compared with 115 per 1,000 population nationally. The majority of the respite provided was overnight respite care rather than day time respite care.

Chart 9 – Total respite weeks provided for older people 2006/07-2013/14



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Eilean Siar	157.10	149.00	160.90	174.50	202.90	193.70	174.90	153.21
Scotland	101.80	106.10	121.30	121.70	124.60	118.10	115.30	114.60

A number of older people and their families spoke positively to us about the respite care they had received. However, we heard from some staff that pressure on respite beds was growing, especially in Lewis. Respite beds were increasingly being used on an emergency rather than a planned basis. This was to avoid admission to hospital or admission to a care home on a permanent basis. Senior managers

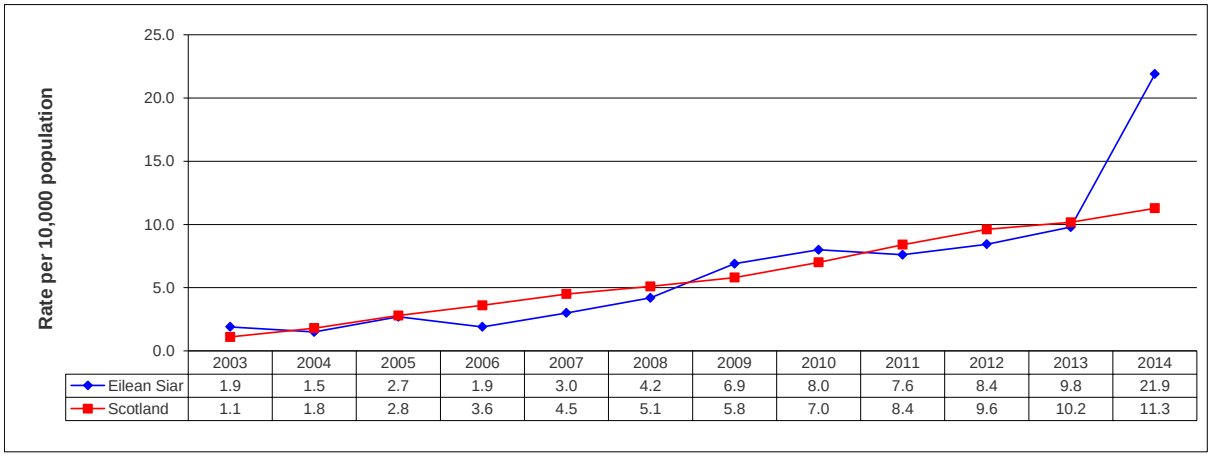
advised that an overview was maintained of respite beds to ensure that they were used in a flexible manner to meet need.

Self-directed support

Self-directed support means the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. Since April 2014, councils have a statutory duty to offer the four self-directed options to older people and other adults who need social work services. The self-directed support legislation was enacted in April 2014, so most of the current available national data relates to one element of self-directed support, namely direct payments and is not specifically in relation to older people.

In 2014, 60 people in the Western Isles were receiving direct payments compared with 27 people in 2013. Chart 10 shows the provision of self-directed support, including this significant increase.

Chart 10 – Clients receiving self-directed support (direct payments) 2003–2014 (rate per 10,000 population)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Eilean Siar	1.9	1.5	2.7	1.9	3.0	4.2	6.9	8.0	7.6	8.4	9.8	21.9
Scotland	1.1	1.8	2.8	3.6	4.5	5.1	5.8	7.0	8.4	9.6	10.2	11.3

In its position statement submitted to us before the inspection, the Partnership stated that during 2014–2015, there had been a further increase in the uptake of direct payments. A total of 75 people were now using this option to direct their own support in 2014–2015. Thirty of these were over the age of 65 and four of those managed their own direct payments.

Telehealthcare and telecare

Telehealthcare assists the self-management of patients' conditions and may include video-conferencing, patients' remote consultations with healthcare professionals or environmental monitoring devices installed in people's homes. Telecare is equipment and services that support people's safety and independence in their own home. Examples include community alarms and smoke sensors.

As at March 2014, 710 people in the Western Isles had a community alarm or other telecare service. This equated to 26 per 1,000 population compared to the national figure of 21 per 1,000 population. Of the 710 people, 640 were over 65 years of age.

At the time of our inspection, the Partnership told us that the number of people receiving telecare had increased further to 875.

Benchmarking

The care at home services redesign and the outcome-focused assessment tool were examples where the Partnership had looked in detail at how other partnerships had tackled this exercise as part of its service improvement agenda. However, from the documentation provided by the Partnership or during the inspection as a whole, we saw little evidence that it used benchmarking of its performance on key outcomes for older people against other Partnerships in Scotland, and used this systematically as a tool to drive improvement.

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

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

During our review of health and social work services records, we looked at the personal outcomes being achieved for older people. We considered a broad range of personal outcomes such as living as you want, seeing people, and staying as well as you can. Given this, it was quite common for the files to contain a mixture of positive and poor personal outcomes. We found that 87% of files contained evidence of positive outcomes being achieved and 31% of files contained evidence of poor outcomes. Good partnership working was identified as a key contributory factor in 51% of the files with positive outcomes. A lack of partnership working was identified as a key contributory factor in only 10% of the files with poor outcomes. Chart 11 shows the individual personal outcomes we looked for and the extent to which we found evidence of them.

Chart 11

Positive personal outcomes	Frequency	Percentage
Dealing with stigma/discrimination	2	2%
Feeling safe	59	67%
Having things to do	16	18%
Living as you want	65	74%
Living where you want	76	86%
Seeing people	37	42%
Staying as well as you can	69	78%
Other	2	2%
Total	**88**	**100%**

Only a small number (five) of the older people records we looked at contained evidence that a carer assessment had been offered, accepted and completed. For three of these, we saw evidence that the support provided as a result of the assessment had led to improved outcomes for the carer of the older person concerned. We did not see similar evidence in the other two records.

Outcome-focused care plans

The Partnership was developing a bespoke outcome-focused assessment tool which would reflect the principles of the Social Care (Self-directed Support) (Scotland) Act 2013. The intention was that the new tool would make sure that support options were fully embedded in practice. Staff were to receive further training on 'Talking Points'[8] to supplement existing training before the new tool was implemented. This training was scheduled to begin in August 2015.

Even though the Partnership was still in the process of developing this new outcome-focused assessment tool, health and social work staff we met demonstrated a reasonably clear understanding of individual and positive personal outcomes for older people. This was reflected in our staff survey.

- 77% of staff agreed or strongly agreed that services worked well together to ensure that they were successful in helping older people lead as independent a life as possible.
- 72% of staff agreed or strongly agreed that their service did everything possible to keep older people at home and in their local communities.

This was also reflected in our review of health and social work services records, where 75% of the care plans set out the desired personal outcomes for the older people concerned. This finding compared favourably with a number of other inspections to date. Overall, whilst our review of health and social work services records identified some older people with poorer personal outcomes, for the majority the personal outcomes had been positive.

[8] Talking Points: Personal Outcomes Approach is an evidence-based, organisational approach that puts people using services and their carers at the heart of their support.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Adequate

Most older people and carers we met were generally happy with the services provided to them in the Western Isles. They felt that these services contributed to better outcomes in respect of health and wellbeing. We saw good examples of older people being supported to remain in their own homes. Having a GP as the physician on-call out of hours had helped avoid hospital admissions for some older people.

However, some older people waiting to return home from hospital had poor personal outcomes. This was due to difficulties in recruiting care at home staff, waiting times for care home placements in some areas and a very limited availability of intermediate care services

Across the Partnership, there was a well-developed network of condition-specific management services helping older people to achieve good personal outcomes. There was a good focus on self-management.

Both health and social care staff tried to reduce the risk of falls for older people. The number of older people benefitting from telehealthcare/telecare was increasing and there was good palliative care for older people. There were some technical challenges in the use of video conferencing for medical consultations and in supporting older people in hospital who wanted to die at home.

Relatively few people were benefitting from Anticipatory Care Plans. Where plans did exist, they were not always shared amongst professionals.

The Partnership needed to improve access for mental health assessments. It also needed to ensure that older people could benefit from a timely diagnosis of dementia and from post-diagnostic support.

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

An outcome-focused approach

From our review of health and social work services records, we saw evidence of good personal outcomes and positive changes for older people arising from their involvement with health and social work services and with the third sector. This included good examples of older people being supported to remain in their own homes with appropriate and responsive levels of care and support in place. Older people and their carers told us they felt supported and involved in decision making about their care provision. However, in common with findings from other inspections,

a number of older people also told us they could be asked for the same information by different care providers and that this information was often not shared between the services. The Partnership should improve its communication between services to reduce duplication of information gathering and assessments for older people.

Improving care and support for older people

Appropriate and timely specialist multidisciplinary assessment for frail older people has been shown to improve health outcomes, reduce dependency and length of stay in hospital and improve patient and carer experience.

One way in which the Partnership had attempted to prevent older people from being admitted to hospital in an emergency had been by redesigning the out-of-hours service in Lewis and Harris. This involved having specialist community unscheduled care nurses as the first point of contact for patients who needed a visit at their place of residence. These nurses were highly trained and experienced practitioners who were able to deliver an enhanced level of healthcare provision to older people in their own homes. For example, this included giving intravenous (IV) antibiotics. Previously, this had only been available to hospital inpatients.

An arrangement had also been put into place where an experienced GP would be the physician on-call overnight for the accident and emergency department. As an alternative to a formal hospital admission, the GP had the option of allowing the older person to spend the night in a medical assessment unit. This allowed the older person's needs to be properly assessed. If they did not need ongoing hospital care, it also allowed time for appropriate community supports to be organised to enable the older person to return home the following day.

NHS Western Isles had carried out an evaluation of this arrangement. This showed a 17% reduction in overnight admissions (during the pilot period) and a reduction in calls to the physician on-call. It reported that the GPs on-call knew their patients and their local communities and that this, combined with involvement from the community unscheduled care nurse and the mobile overnight support service (overnight social care provider) made it possible to get people home.

Good practice example: GP involvement as physician on-call out of hours

The Partnership had put an arrangement in place whereby a GP acted as the physician on-call overnight for the accident and emergency department. As an alternative to a formal hospital admission, the GP had the option of allowing the older person to spend the night in a medical assessment unit. This allowed the older person's needs to be properly assessed. If they did not need ongoing hospital care, it also allowed time for appropriate community supports to be organised to enable the older person to return home the following day. NHS Western Isles had carried out an evaluation of this arrangement. This showed a 17% reduction in overnight admissions.

It was encouraging to see that the Partnership was working to move away from traditional out-of-hours provision. This was being done in a way which was achieving some improved experiences for older people as they were seen quickly either in their own homes or in hospital allowing an early assessment of their needs.

The Uists and Barra had their own local arrangements for access to overnight medical emergency support. This was provided on a rota basis by district nurses and GPs. The Partnership told us that, due to GP vacancies, the service was being supported through the use of locum GPs. Whilst it meant that out-of-hours provision was maintained, it could also mean that older people would not experience consistency of staff or the reassurance of having a GP who knew them and their care needs.

Across the Partnership, we found a well-developed network of condition-specific management services was helping older people to achieve good personal outcomes and self-manage their long-term conditions. These included:

- the nurse-led heart failure service supported patients with heart failure by providing education to enable patients and carers to self-monitor and self-manage their condition. The service had also begun work with a local GP practice to provide IV diuretics in the community to reduce the number of patients admitted to hospital with heart failure
- the cardiovascular disease prevention and rehabilitation service, Hebrides Healthy Hearts, offered a menu-based rehabilitation programme. This was provided to patients with acute coronary syndrome or angina, or following cardiac surgery, heart transplant or device implantation, as well as supporting individuals who were at high risk of developing cardiovascular disease. The core team consisted of a cardiac rehabilitation nurse, dietician, physiotherapist and Comhairle exercise specialists, with referral to other specialists for specific input.

NHS Western Isles had recently appointed a Multiple Sclerosis and a Parkinson's disease specialist nurse. This was a potentially positive development which could allow for the provision of consistent and coordinated care, and for older people to be given information and support to manage their own conditions.

The Partnership had also implemented a range of tools and resources from the Scottish Patient Safety Programme in Primary Care[9]. We saw that the dietetic service was working with district nurses to support self-management nutrition tools for patients within the community. The Partnership also said that hospital staff and the district nursing service both used the Malnutrition Universal Screening Tool (MUST)[10]. This was also a positive development as malnutrition can have a wide-ranging impact on people's health and wellbeing. Screening for the risk of malnutrition enables early and effective interventions.

[9] The Scottish Patient Safety Programme (SPSP) is a national programme aimed at improving the safety and reliability of healthcare and reduce harm, whenever care is delivered.
[10] The MUST (Malnutrition Universal Screening Tool) is a five-step screening tool to identify adults that are malnourished, at risk of malnutrition, or obese. It also includes a management guideline that can be used to create a care plan.

As well as training for staff, information leaflets had been produced designed to help older people and their carers to reduce the risk of malnutrition and to increase their ability to self-manage their nutritional intake. Guidelines on the management of those at risk of malnutrition and the use of prescribable oral nutritional supplements had also been developed. Fast access to a dietician for those at high risk of malnutrition had been put in place.

Care at home staff had also received training on nutritional care. Information leaflets had been produced which helped older people and their carers to reduce their risk of malnutrition and self-manage their nutritional intake. Guidelines on the management of those at risk of malnutrition and the use of prescribable oral nutritional supplements had also been developed. Fast access to a dietician for those at high risk of malnutrition had been made available.

All Comhairle residential care homes were using the NHS Scotland pressure ulcer and safety cross screening tool. If a resident was assessed as being at risk or they had a pressure ulcer, screening was carried out daily and scored. A protocol was in place with the community nursing team to enable a visit to the older person within 24 hours.

We found good examples from both the Comhairle and NHS Western Isles where they had actively sought to obtain feedback from people who used services and from their carers. This was mainly done on a single agency basis with separate systems in place to obtain feedback on service provision. NHS Western Isles promoted Patient Opinion[11] as one of the main ways to provide patient feedback. We saw that this was advertised in local newspapers, on the local radio station and that posters were displayed throughout the hospitals and other healthcare premises. Managers said that promoting Patient Opinion was successful in encouraging patients to let the NHS Western Isles know their views and opinions on its services. We looked at the Patient Opinion section of NHS Western Isles' website and saw that patients were using this to tell their story and saw examples where this had helped lead to improve services. Action taken to address the shortage of rheumatologists was an example of this.

Supporting carers

The Partnership faced challenges in identifying carers and in trying to ensure that they received the right help and support to enable them to continue in their caring role. Frontline staff said the main difficulty was the reluctance of some carers to see themselves in that role and as deserving of support. As such, they could be hesitant to accept help and support. Most carers we met told us they felt supported with their own healthcare needs and this enabled them to continue in their caring role. We saw a number of good examples where services had worked together to support older carers by providing aids and adaptations and putting supports in place not only for the older person but for the carer themselves.

[11] Patient Opinion: A website which allows patients to rate the care they have received on the NHS and which is formally supported by the Scottish Government.

Across the Western Isles, we found that the third sector had an active and important role in providing support to carers. The Western Isles Community Care Forum (CCF) was a voluntary care organisation which represented the interest of carers and people who use services throughout the Western Isles. It maintained a register of carers and actively attempted to keep this up-to-date by liaising with GPs and the local community to encourage carers to register.

Carers who did register could access a range of services and supports. These included information and advice, income maximisation, emotional support, short breaks, training and peer support

Following assessment, the CCF also referred carers directly to services such as physiotherapy, occupational therapy and to social services for advice and assistance for self-directed support. A newsletter was produced every three months to keep carers and people who used services in touch with what was going on and to inform them of articles which may be of interest to them. The CCF was also a way for the Partnership to disseminate information to the voluntary and independent care sector.

Carers, people who used services and staff told us that access and demand for respite provision was variable depending on where people lived. We were told there was a high demand for respite in the Southern Isles. To address this, Tagsa Uibhist, a voluntary care provider, was providing two additional respite beds. Tagsa Uibhist was an important provider of support and services in the Southern Isles. It also provided care at home services, overnight emergency support and cancer care at home in partnership with Macmillan Cancer Nurses and Marie Curie. Some staff said that demand for respite in Lewis and Harris was not as great. Overall older people and carers told us they were pleased with the level of access and quality of service provided.

2.2 Prevention, early identification and intervention at the right time

Approaches to reablement and intermediate care were still in the early stages of development. The impact of this was that some older people were unable to return home, from hospital as soon as they were medically fit to do so. In respect of undeveloped intermediate care, this meant that there was little alternative to hospital admission.

Although there was no dedicated reablement team or service, we heard positive stories from some older people and their carers of being supported by the same occupational therapist. This included being seen throughout their care journey from the point of admission to hospital to their discharge home. The approach used by the occupational therapy staff in these circumstances was consistent with a reablement approach. Older people told us that this staff continuity was important to them as they did not have to retell their story to different staff. They also felt supported and reassured by having the same staff member throughout their contact with services.

The Partnership was working on developing preventative resources that would meet a wide range of needs. NHS Western Isles in partnership with the local libraries had developed a project aimed at supporting people to take more control of their health and wellbeing. This involved offering a wide range of books and information on

health and medical issues, all available through the local public and mobile libraries. *Dr You* were locally available books which provided advice on a range of common conditions to help people better understand their health. Some titles included information to help people cope with daily issues such as stress, anxiety and low self-esteem. This service was introduced following a review of people who used the libraries. This showed that 72% of mobile library users were over 65 years old and 10% were over 85 years old. As a new initiative, the project was to be evaluated to assess its effectiveness. This would include how valued it was by its users, including older people and their carers.

The 'Slàinte Mhath!' ('Good Health') initiative encouraged the use of sports centres. Feedback on the initiative showed that it was seen as being very successful and accessible due to its low cost membership. Approximately 430 individuals over the age of 60 were part of the 'Slàinte Mhath!' scheme, of whom 240 were over the age of 65.

The health information and resources service provided a range of materials free of charge to older people. Materials included: leaflets and booklets; models; books; older people project boxes; posters and charts; and CDs. The information and materials available complemented work in many settings across the region, for example schools, workplaces and voluntary community groups. The older people project boxes were available for loan by residential care homes and by older people community groups. They had also been made available to older people in their own homes. The boxes contained reminiscence materials, board games and soft play items for improving memory retention.

The Partnership had also developed a number of other positive preventative inititaives. These included:

- *Nutrition screening*: As well as for hospital and community-based health staff, training on the use of a screening tool had also been provided to care home staff. Training on nutritional care had been provided to care at home staff and public information leaflets had been produced aimed at reducing the risk of malnutrition
- *Outpatient Intravenous Antibiotics and Alternative Therapies (OPIAAT)*: A local review highlighted that a significant number of hospital bed days were being used to provide antibiotic therapy for patients with cellulitis. The OPIATT project allowed the infrastructure to be put in place to allow patients to be treated in a location suitable to them in the community without the inconvenience and costs associated with hospital admission.
- *Poverty Action Group*: We saw that fuel poverty was a significant issue facing older people in the Western Isles. The Poverty Action Group was chaired by an elected member and worked closely with the local energy advisory service to reduce energy usage, cutting high energy bills and therefore support those most in need.

Implementing Scotland's National Dementia Strategy 2013–2016

At the time of our inspection, we found that older people newly diagnosed with dementia did not receive a post diagnostic support service. Previously, post-diagnostic support for older people in Lewis and Harris had been funded by Change Fund monies. However, this service had been paused when its funding ended in March 2015. As a consequence, older people who were receiving post-diagnostic support found that they no longer received this support. Similarly, arrangements for post-diagnostic support in the Southern Isles, where older people had been able to receive up to 7.5 hours support each week had also ended in March 2015. GPs and frontline staff told us there was an urgent need to deliver an appropriate level of post-diagnostic support. They said that the previous, albeit limited provision had been greatly valued by those older people who had received it. However, they also said that the former level of provision had been inadequate. Senior managers advised that the Partnership had agreed to recommence the dementia link worker project as part of the post Change Fund arrangements.

Since March 2015, Alzheimer Scotland had experienced an increase in referrals to its service. This had resulted in longer waiting times for older people. Older people recently given a diagnosis of dementia by a consultant psychiatrist told us that they had then been 'discharged' with no post-diagnostic support offered from mental health services.

We found that people living in the Southern Isles who were considered as likely as having dementia were often not well supported. They could wait for a lengthy period of time to receive a clinic appointment with a consultant psychiatrist. Staff said that GPs could be reluctant to diagnose older people with dementia due to the cost and potential distress for the older person in travelling for further investigations to Stornoway or mainland Scotland. GPs told us that, given these circumstances, they treated older people showing clear signs of dementia as if they had a formal dementia diagnosis even though they had not actually been diagnosed.

Senior managers told us that a new model for the delivery of post diagnostic support was under development. They said this would provide a better and fairer distribution of staff. The Uists and Barra would have their own full-time worker and GPs would be better supported to make a timely diagnosis of dementia.

Recommendation for improvement 3

The Western Isles Partnership should take action to provide one year post-diagnostic support for people newly diagnosed with dementia, in line with the National Dementia Strategy (2013–2016).

Anticipatory care planning

An anticipatory care plan anticipates significant changes in a patient (or their care needs) and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals.

Anticipatory care planning is more commonly applied to support those living with a long-term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well.

As part of our review of health and social work services records, we saw few anticipatory care plans. However, in our discussions with community healthcare staff and GPs it became evident that these plans were being completed. Access to this information was restricted to some healthcare staff including NHS 24. Anticipatory care plans were being completed for people with palliative care needs and this was to be rolled out to people with long-term conditions.

When we met with older people and their carers we found that, although they were unfamiliar with the term 'anticipatory care plan', they had been involved in discussions about future planning and the provision of care.

Where there were anticipatory care plans, these were being held on the GP electronic system with key information summaries. These summaries are how healthcare professionals record and share information about people with complex care needs. Social work services staff confirmed that they had limited involvement in anticipatory care planning and they could not access the plans. The Partnership should consider widening access to anticipatory care plans to all care providers as they are an important component of shared care and support.

Palliative and end-of-life care

We found that services worked well together to support older people with palliative care needs to remain at home. We heard from staff across the Partnership that there was good planning for end-of-life care, so that medications and equipment were in place as needed.

We saw that the revised checklist for embarking on end-of-life treatment (CELT) tool was being introduced in all care settings. This would help clinicians with decision making in recognising when someone was nearing the end-of-life. Social work referrals which related to end-of-life and/or palliative care were given the highest priority in terms of allocation, assessment and the provision of support services.

In contrast, some staff referred to delays getting people out of hospital so they could be supported to die at home. This was linked to the limited availability of care at home staff. Some of the frontline staff we spoke to said this was distressing for both the older person and for their families.

Intervention at the right time

The Scottish Government's Prescription for Excellence programme funded a polypharmacy[12] pilot project in the Western Isles. This project covered four GP Practices in Stornoway, North Uist and Benbecula where the pharmacist would hold telephone interviews with patients prescribed with multiple medications. GPs said

[12] Polypharmacy is the concurrent use of multiple medications.

this had achieved positive outcomes for older people through improved health and lower prescribed amounts of medication. It was hoped that it would be rolled out to other GP practices in the Western Isles.

Some older people and their carers we met from the more remote and rural areas said they had difficulty obtaining blister pack medication. Some older people with no family or friends to support them had to rely on local taxi drivers to collect their medication from their GP surgeries.

A joint protocol for medication management was in place between the Comhairle and NHS Western Isles. This allowed care at home staff to prompt, but not to administer, medication. We were told that this could contribute to an older person being admitted to long-term care if they were unable to take their own medication. Plans were under way to ensure that care at home staff received the right support and training to administer medication where appropriate.

Falls prevention and management

Although the Partnership did not have a dedicated falls team, it had a joint falls policy. This had clear and explicit referral and response pathways for older people who were at risk of falling or who had fallen. A dedicated falls website was available with information for staff and the public. Frontline staff showed a good awareness of the falls policy. They had a collective understanding of their roles in falls prevention and management. We saw that falls screening was completed routinely with older people. When we met with older people, it was evident that they had been assessed for the risk of falls, and had been given appropriate advice and support to reduce the risk of falls.

Telecare

Telecare was provided by the Faire Careline Service (Faire). This was operated by the Comhairle's social and community services department. The service accepted referrals directly from members of the public as well as from health and social work services staff. For more complex referrals, occupational therapy staff would carry out a joint assessment with the Faire Service.

Community alarms were widely used to support people to remain at home safely. Faire had carried out a telephone survey with 15 service users to ask for feedback on the community alarms. Feedback was positive and included comments about older people feeling more confident and carers feeling reassured by the presence of the alarms. We saw some good outcomes for older person using the telecare service. Older people were enabled and assisted to continue to live at home, by using falls pendants, bed sensors and door sensors. Older people told us there was a quick response time in being assessed for aids and adaptations like these. They also said that there was a quick response time for receiving aids and adaptations or getting them installed in their homes.

Due to the geographic remoteness of some areas, local community nursing and social work services staff, rather than the more centrally based Faire staff, were often the call-out response staff through the night. It was mainly the community nurses who would be called out if a person needed help and support. For older

people, this meant that they already knew the local staff which helped to provide consistency of care.

The Partnership had received feedback from older people that where possible they would prefer to receive treatment as close to home as possible. The Partnership was mindful of the need to try and reduce off-island and inter-island travel had piloted some video conferencing specialist healthcare clinics with patients, including some older people. This was a positive development and we heard some positive examples of the impact this for some older people. For certain medical conditions, video conferencing, when it worked, was seen as being invaluable. It enabled a quicker diagnosis of some conditions and enabled the older person to start treatment without having to travel to Stornoway or mainland Scotland for a specialist consultation. However, we were also made aware of some technical teething problems which needed to be addressed in order that the full potential benefit of the use of video conferencing could be achieved. Some staff also highlighted the fact that some older people would not be comfortable by this form of consultation.

A community frozen meals service had recently been introduced. This ensured high quality, nutritional and economically affordable food was provided throughout the Western Isles. The meals were produced by a local provider. This not only provided benefits to the local economy, but also increased use of locally sourced produce. In its tendering process, the Comhairle, on behalf of the Partnership, had included a requirement for healthy meals. Frontline staff told us the introduction of the service had freed up the time of care at home staff. They said that overall feedback from older people and their carers about the frozen meals was positive. However, some older people found the choice of meals available restrictive and had preferred having their meals prepared for them.

As indicated in Chapter 1, the Partnership faced challenges in providing care at home. Health and social work staff told us that older people on the waiting list had to compete with very vulnerable older people in the community who were admitted to care home beds in an emergency. Often these older people were admitted on an emergency respite basis, but their placements then became permanent. Staff also said that, if an older person’s needs increased and they required additional support, there could be significant delays in this being provided. Families told us there could be regular changes in the care at home staff attending their homes. They said this could be very unsettling for older people, especially for older people with dementia.

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

From our review of health and social work services records, and our meetings with staff and older people, we were able to see that self-directed support options were being discussed and offered to older people. We found that a range of information was available for the public about self-directed support. This included information on the Comhairle's website, answers to frequently asked questions, a booklet and a users’ handbook.

However, some families and staff we met referred to there being a general perception that self-directed support was being promoted when the Comhairle could not itself provide care at home services. In this situation, the older person and their

family would be asked to consider self-directed support as an alternative way of getting the care they needed. As there was no brokerage agency in the Western Isles, this placed a considerable emphasis on the families themselves to find and recruit carers. In the absence of a brokerage service, the Partnership sought to assist by the provision of support with a payroll service. Staff also provided guidance on advertising and recruitment processes.

Some families we met had employed carers who also worked as care at home staff for the Comhairle. They indicated that this could prove problematic as whereas the carers were paid for travel costs when working for the council, these costs were not included in the self-directed support payments paid to families. This matter had been raised with the Comhairle which was considering its capacity to assist with travel costs, and in particular for families living in the most remote areas and where travel costs could be considerable.

Results from our review of health and social work services records showed that self-directed support options had been offered in 79% of the cases which was a high number compared with other inspections to date. Of these, 49% of the individuals had opted for support directed by the local authority, with a further 23% choosing to take up direct payments.

Staff raised concerns with us that older people were afraid of using self-directed support as they would struggle with the responsibility. We saw that support networks were in place to support people through the self-directed support process. We saw good examples where voluntary services helped and supported older people with recruitment, financial management and paperwork.

Concerns were also raised by some older people that some information about support options provided by the Partnership was not readily available or accessible as it was only available online. Not all the older people we met had access to a computer, or had the knowledge or skills to navigate the web to access the right information.

We found that the Older People's Partnership had developed a website dedicated to people over the age of 55 living in the Western Isles. This website provided information about clubs aimed at older people operating within each locality, and also events and activities which may be of interest.

The community care forum produced a directory of services every year. This was sent to carers on their register. We found this was a good and reliable source of information for carers. Information in the directory was detailed and relevant to each geographical area across the Partnership. However, only carers known to the community care forum would receive this information.

Overall, we found that older people and their carers knew about information on services and how to access them. However, the Partnership could usefully ensure that all information on resources available to older people could be accessed in numerous ways and not solely on line.

Good practice example: Outpatient intravenous antibiotics and alternative therapies (OPIAAT)

OPIAAT was set up to identify and deliver a safe and effective way to provide intravenous antibiotics to patients in primary care, initially for those with cellulitis. A local review had highlighted that a significant number of hospital bed days were being used to provide antibiotic therapy for patients with cellulitis. Patients had expressed a desire to have this therapy delivered at home. Therefore, the group set out to work collaboratively to allow patients' wishes to be met.

Guidelines were published to ensure all healthcare providers were providing the same evidence-based practice to patients in primary care. In line with the aims of national strategies such as the quality strategy and shifting the balance of care, the project had provided the infrastructure to allow patients to be treated in a location suitable to them in the community, without the inconvenience and costs associated with hospital admission. The project had also strengthened the links between community and hospital staff to the benefit of patient.

This was an innovative new practice that had greatly enhanced patient choice and taken forward the Scottish Government aim to provide appropriate hospital services at home.

Quality indicator 3 – Impact on staff

Summary

Evaluation – Good

Within the Western isles, it was clear that front line staff in both health and social work services worked well together. This was supported by feedback from staff in our discussions with them and in response to recent staff surveys. We had a 51% response rate to our staff survey and those who responded, said they felt valued and well supported by their most immediate managers.

Both health and social work staff were committed and well-motivated in their jobs and said that they worked well together. We saw a number of examples where staff had worked closely and imaginatively together to achieve good outcomes for older people.

Staff impressed as being clear about their roles and responsibilities. Most staff we met were positive about the training and development support they received to enable them to do their jobs. Although a challenge, the Partnership tried to provide this in a way which took account of the dispersed nature of its workforce across the islands.

Staff expressed frustration about the constant issues around resourcing care. They said this could have a negative impact on their morale.

The Partnership used different approaches to communicate with staff. Staff, however expressed mixed views about the effectiveness and quality of these approaches. In particular front line staff did not feel well informed on the action being taken to take forward health and social care integration, nor about various service development or redesign initiatives.

To gain a picture of staff views, we met with health and social work services staff who carried out a range of roles within NHS Western Isles and the Comhairle. We also undertook a staff survey which achieved a response rate of 51% (involving responses from 87 staff). This response rate was higher than in the surveys undertaken in other inspections to date. This was notable as both NHS and Comhairle staff had recently completed internal staff surveys. Of the respondents to the survey, 61% were employees of NHS Western Isles and 33% were employed by the Comhairle.

Motivation

We found that staff in both health and social work services were committed to providing a good service in order to achieve positive outcomes for older people. Both staff groups were well motivated and worked hard to provide the best service they could.

Results from a number of surveys in both health and social work services showed that staff felt positive about their jobs. For example, two recent staff surveys had been carried out by the Comhairle and NHS Western Isles. In the Comhairle's social and community services department, 72% of staff said that they were very satisfied with their jobs. Similarly, 72% of staff responding to the NHS survey said that they were able to do the job to a standard that they were personally pleased with, and 64% of staff were pleased with the sense of satisfaction that they got from their work.

Our staff survey had similar findings, with 91% of staff stating that they enjoyed their work. Staff also felt valued and well supported by their managers, with 79% of staff agreeing or strongly agreeing with this statement.

From focus groups and other meetings we held, staff agreed with the results from these surveys. Staff were very motivated to deliver good supportive services to older people, in line with their wishes. Older people and their carers we met were generally very appreciative of their efforts. Staff said that first line and middle managers were well informed and supportive about their day-to-day work and the pressures they faced.

Teamwork

Frontline staff said they worked well together, making positive links with colleagues across health and social work services and with key organisations in the voluntary sector. Results from our survey showed that:

- 81% of staff agreed that they had excellent working relationships with colleagues, and
- 86% of staff felt that they were well supported in situations where they might be at risk.

However, staff said they faced a number of challenges in their work. This included how workloads were managed and their limited ability to be able to provide preventive supports and services for older people due to the lack of such resources. Results from our survey showed that:

- 69% of staff felt that their workloads where sufficiently managed to allow them to support positive outcomes for older people, 29% of staff either disagreed or strongly disagreed that this was the case
- 29% of staff agreed or strongly agreed they had sufficient capacity to undertake preventative work, 55% disagreed or strongly disagreed.

These findings were also reflected in our discussions with staff. They expressed frustration about the outcomes of assessments, giving examples of the difficulties in accessing care at home services or care home placements to facilitate hospital discharge. Some staff said there were occasions when they felt they were going through the motions by identifying the needs of older people as part of the assessment process, but knowing the resources and services to meet these needs would not then be available. Staff understood the pressures on resources and were aware of the gaps in services to support older people. For example, they were aware

of issues around the recruitment of care at home staff. Managers had a clear set of systems to prioritise and progress the need for care packages. Nevertheless, staff continued to be concerned that the best outcomes for older people were not always met and said this could have a negative impact on their own morale.

Staff were clear about their own roles and responsibilities. Eighty-five per cent of staff said that they felt valued by other practitioners when working as part of a multi-disciplinary team. Generally, staff spoke very positively about their working relationships with colleagues. They gave examples where they worked flexibly and imaginatively to support colleagues and to achieve good outcomes for older people. We saw and were told about some good examples of joint working on issues such as falls assessment, prevention and management. Nursing staff who supported older people in crisis especially out of hours had developed good working relationships with home care staff.

Local solutions were often created, especially in the more remote and rural areas. Staff and carers often went the extra mile to ensure that services met the needs and supported desired outcomes for older people, for example extended working to support older people receiving end-of-life care.

Our review of health and social work services records showed that much of the involvement and engagement with older people by health and social work services was taking place on a single agency basis. Records showed that, while informal discussions often took place between staff for the benefit of the older people they were working with, health and social work systems did not support this. Consequently, joint work was not recorded in a consistent and helpful manner. Staff recognised that they did not have access to written assessments that were carried out by other professionals. As a consequence, staff generally communicated through local networks, by personal contact or through telephone conversations.

Training and development

Staff felt there were good opportunities for training and development. In our survey, 78% of staff said that they had good opportunities for development. Managers told us that staff were supported to access training on the Scottish mainland. Good links were in place with other local authorities and NHS boards to enable this. Staff were also supported to gain qualifications from colleges and universities. Work was ongoing with the University of the Highlands and Islands to support further training for staff in gaining Scottish Vocational Qualifications (SVQ).

A number of staff had benefited from training provided by local colleges in specialisms such as dementia and palliative care. However, some staff, particularly those in the Southern Isles, said they were less able to access training than colleagues based in and around Stornoway.

Staff had mixed views about how involved they were in helping to formulate the development of services and local policies. This had been identified as an area for improvement in the recent Comhairle and NHS staff surveys. It was also reflected in responses to our staff survey, with only 56% of staff feeling that their views were taken into account when planning services. Staff from NHS Western Isles felt slightly better informed than staff in the Comhairle.

Managers from both organisations told us they made real efforts to make sure that staff were kept up-to-date. They gave examples of team meetings and regular emails as methods of communicating with staff. NHS Western Isles also produced a staff magazine every three months. However, some staff felt this did not have as much useful information in it as they would have liked. Generally, frontline staff felt poorly informed about the progress of various service redesign and service development projects.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Adequate

We found little evidence of a strategic approach for community capacity building nor of a well-established approach to engaging with communities as part of this. Work to develop locality planning and to decide how this would link with health and social care integration needed to be advanced

There was a strong sense of community spirit and engagement, with communities willing to participate in and inform the integration process. The Partnership needed to do more to harness this.

Staff had a good knowledge and appreciation of the various supports and services provided by community groups and organisations. However, as reflected in our staff survey, they had less awareness of the role which they could play as staff and what approaches the Partnership were taking to increase community capacity.

Tagsa Uibhist was a vibrant and local third sector provider which provided a range of well-regarded services in the Uists and Barra communities. It was an important part of the social landscape in the Southern Isles. The Partnership's health and wellbeing group was successfully engaging with the public in Harris around a number of public health initiatives.

4.1 Public confidence in community services and community engagement

Engaging with the community

Whilst we saw evidence to confirm that a strong sense of community spirit existed, we did not see evidence to show that the Partnership had a well-developed strategic approach to community capacity building. This was listed as one of the key priorities of the Partnership's Joint Commissioning Strategy for services for older people (2013–2023). This included some high level long-term objectives and areas for development during the first three years of the strategy. Examples included increasing the capacity of the Third Sector interface to respond to the needs of older people and progressing the development of social enterprise in the Western Isles. However, the strategy lacked detail of the actions needed to achieve the developments and we saw limited evidence of progress having been made by the time of our inspection. This work needed to be accelerated.

The Partnership has considered the issue of localities in relation to the development of its strategic plan and a preference had been expressed for four localities. This was still to be considered by the Integration Joint Board ahead of a formal process of consultation as required by the legislation. A pilot group had been established in the Uists that included representation from key professionals, the Patient Participation Groups and the Community Council Associations. Health profiles, local social care

statistics and needs assessments were in the process of being collated. The Partnership advised that it had continued its ongoing engagement and involvement with the existing locality planning groups whilst the new arrangements were being decided.

The Western Isles Community Care Forum (WICCF) provided a vehicle through which the Partnership could disseminate information to the voluntary and independent care sector. We noted that representatives from the community care forum served on committees and groups, representing people who used services and their carers. This included the Older People's Partnership[13], local planning groups, the adult protection committee and the community health and social care partnership. The Partnership also worked with Western Isles Carers and Users of Services Network (WICUSN). This included providing information and briefings in relation to SDS.

Tagsa Uibhist[14] was a service which provided a range of predominantly free services for residents in the Uists and Barra. This included respite care, overnight support, mental health and wellbeing outreach support, and other home-based support. The residential respite provision was developed following a stakeholder survey. The company was a registered charity and received grant funding from the Comhairle as well as from the Scottish Government and others. It also received independent donations from the public and held fundraising events. It charged for some of its services such as its domestic cleaning and handyman service.

Examples of good practice: Tagsa Uibhist

Tagsa Uibhist is a voluntary organisation based in Balivanich on the Isle of Benbecula. Since its foundation in December 1999, Tagsa Uibhist have provided support for carers, people living with dementia, and vulnerable people living in their own homes throughout Uist. This included care at home support and respite care. It was well regarded in its localities and had an important place in the local social landscape. The relative geographic isolation of the area, combined with the limited availability of alternative provision made the contribution made by the organisation to the welfare and wellbeing of older people particularly important.

Some third sector staff told us they did not feel included in the integration process. They said there had been limited involvement of the third sector in the development of the Western Isles Partnership. The Integration of Health and Social Care in the Western Isles consultation report summary stated that 'a common view was that services could be improved by better communication and joint working to meet people's needs in a flexible and more efficient manner.' It also stated that 'in each session, frustrations were expressed at the limited degree of consultation that had taken place to date, with an accompanying request that local groups be engaged in the development of strategic plans.'

[13] Older People's Partnership: This was part of an initiative by the Community Planning Partnership to engage with and seek the views of older people.
[14] http://www.tagsa-uibhist.com/

In response to our staff survey, 49% of staff said that they agreed or strongly agreed that there was strong positive engagement between the partners and local community and voluntary groups, while 17% disagreed or strongly disagreed and 33% said that they did not know. A high proportion of don't know responses to this question has been a common response in other inspections to date.

Recommendation for improvement 4

The Western Isles Partnership should review and make explicit how it can further develop arrangements for third sector and local community involvement in strategic planning. The Partnership should also explore opportunities to promote inclusion of a wider range of people within the older person's network (co-production activity).

The Partnership provided us with the outline business case for the St Brendan's project which aimed to provide a new health and social care hub on the site of an existing hospital and care home on Barra. The business case showed that there had been community meetings and involvement in the development of the planned model of care. A communication plan for the project also included community engagement.

Results from our staff survey indicated a lack of knowledge and communication among staff about strategic approaches and policies for community engagement and capacity building. For example:

- less than half (41%) of staff said they agreed or strongly agreed that their service recognised and consulted diverse local communities about levels, range, quality and effectiveness of services, whilst 49% of staff indicated that they did not know
- 35% of staff agreed or strongly agreed there were clear joint strategies to promote and expand community involvement and communicate change, whilst 20% disagreed or strongly disagreed and 45% indicated that they did not know.

Commonly, staff told us they were not aware of community capacity building or locality planning taking place in their area. Staff had a good understanding of the large and significant role that local communities and community groups played in supporting older people. However, there was much less awareness of the important role which the Partnership services and staff could play in supporting co-production and helping build community capacity. Some staff thought that this should be communicated through the Joint Planning Group (a key joint group of senior managers), but were not sure that this was happening.

The carers' strategy group told us about its work in community involvement and with community groups looking at the health inequalities of carers. The Partnership was involved in the Well North project. This involved a mobile bus visiting remote and rural areas to target and address the health concerns of those between the ages of 40–69 years and with a specific focus on cardiovascular issues. The Partnership was working with the third sector and with the University of Stirling to evaluate the quality and effectiveness of the various carer support services and projects such as Crossroads and the Good Night's Sleep project.

The Partnership's health and wellbeing group was linking in with mental health services in relation to their community care bundle. The group was working with local staff and people in Harris as, with public health support, the community was actively involved in a number of community development initiatives. This included a community buyout facilitated by the third sector. The health promotion service was also working with community groups to celebrate and promote the benefits of engaging with the Gaelic culture.

We heard frequent comments about the important contribution made by community and third sector groups. They were described as delivering valuable services to older people in the Western Isles. Some community groups and third sector representatives said there was potential for growth in the number and variety of areas where joint working by the Partnership with the third sector and local communities could be developed. A number of staff and managers we met acknowledged this.

We saw that there was an appetite from the local communities and third sector groups for them to be more involved in the integration process and to be part of developing co-productive partnerships. The Partnership should explore this further.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

Most older people and carers were clear about how to access services. They relied heavily on local knowledge and word of mouth rather than on the Partnership's public information which was of variable quality. The Faire Careline service provided an effective call service and was supported by local staff acting as responders in the more rural areas. Access to services was generally good with the exception of some services, such as care at home and care homes where there were significant resourcing issues. The Partnership needed to ensure that where older people had to wait for services, they were kept informed in the meantime.

Findings from our file reading about the quality of assessments were generally positive with older people having good quality needs assessments in place. Most older people also had care plans in place, although keeping these subject to review was a challenge with a significant backlog in reviews for older people in Lewis and Harris. Improvement was required in the number of carer assessments being completed. Not all staff appeared to understand the potential added value for carers in having their own needs considered and addressed.

There had been some strengthening in the governance arrangements surrounding adult support and protection and the work of the adult protection committee. However awareness-raising on adult protection, the collection and use of management information and self-evaluation activity all required further attention as a matter or priority. There were good arrangements in place to manage risks for older people associated with adverse weather conditions in the Western Isles and its dispersed geography.

The findings from our file reading exercise about involving older people in their care and support were generally positive with the exception of independent advocacy being offered (where appropriate) where the results were disappointing.

5.1 Access to support

We found that access to support across the Western Isles was generally good. Written information about some services was available in Comhairle offices and in GP practices. However, information about access to wider services was patchy. There was a significant reliance on information being passed on by 'word of mouth' according to some carers we spoke with. This was more prevalent in more remote and rural parts of the islands.

Both the NHS Western Isles and Comhairle websites offered key basic information and some signposting to services. For example, care at home services were described in some detail and interested parties were advised to contact their local social work office. On both websites, some pages were under development. On the NHS Western Isles website, the out-of-hours services page was incomplete. However, older people we spoke with were generally clear that they could access services through their GP in the first instance. They were less able to identify how they might contact social work services directly for the first time.

Faire Careline Service was the 24/7 call centre for all Comhairle services. All community alarms and telecare went through the service. The operators had flowcharts to follow and were trained to 'triage' calls. They were clear they did not make any managerial decisions. Social work enquiries were transferred to a duty social worker during office hours. Faire staff had access to CareFirst[15]. This informed their decision making and was generally reported by the team as working well.

The manager of Faire told us that, out of hours, they had good access to social work services through duty manager arrangements. We were told the Partnership had improved access to out-of-hours services such as the redesigned mobile overnight support service. This had increased the number of older people they could support. Out-of-hours services had also been extended to include community unscheduled care nursing staff with enhanced assessment skills.

Access to mental health officers was reasonably good. Managers told us there was ongoing training to increase staff numbers. Staff from Faire told us they did not have difficulties accessing mental health officers through the duty manager out of hours.

Staff from Faire told us they were limited in the level of emergency response they could provide due to geographical constraints. There was one staff responder in Stornoway, another in West Lewis and a third responder for Lewis. There were no responders in Harris and further south. A rota of community nurses and community psychiatric nurses was in place. They were called out if named responders were unable to attend. While this worked to a degree, there was a pressure on frontline staff to manage this. The Partnership should consider a more sustainable arrangement for emergency responses.

The majority of social work-related calls were about managing care at home staff absences and finding alternative staff to cover. The manager of the service reported this issue occurred very regularly and was staff intensive. The Comhairle had taken a positive step towards addressing this. In April 2015, arrangements changed with all calls relating to care at home services now being directed to the on-call home care co-ordinator. This new process operated six days each week in Lewis and Harris. The manager had indicated a significant improvement in working practice, such as a reduction in care at home staff sickness and other absences. However, this was only based on anecdotal feedback. It was not clear how the time-limited trial of the new arrangements was being evaluated.

[15] CareFirst is an electronic social care case management system for adult and children's services.

The Faire team felt that their system could be more joined up with the NHS 24 system, as there was little follow up of cases and sharing of information. We considered that information sharing arrangements would be strengthened if a more formal link was established between Faire and NHS 24.

The Partnership operated a series of duty cover arrangements during office hours to manage referrals. This included care management and health professionals, such as physiotherapy and occupational therapy. We heard from carers, older people and staff that these arrangements were adequate, in that there were few delays in making contact with a professional. However, they also told us there were some delays in services then being provided in some areas, particularly when further away from the main centre (Stornoway).

The referral process for social care provision was subject to written eligibility criteria. This was banded depending on the indicative level of needs of the older person concerned. The four bands were consistent with the national eligibility criteria: critical, substantial, moderate and low.

The demand for services in Lewis and Harris was significantly higher than in the Uists and Barra. This reflected the differences in population and demographics. From the data provided by the Partnership, we could see that there were delays in dealing with some referrals and, in particular, completing assessments.

The response and management of referrals between health and social work services was mixed. We spoke with staff in remote and rural areas with well-established informal professional networks in place. They were generally able to access services within reasonable timescales. However, other frontline healthcare staff expressed frustration in accessing social work services. They told us there were waiting lists both from referral to social work assessment and from assessment to service provision.

In particular, this related to accessing a care home placement, respite and care at home services. Staff told us this significantly affected older people in Lewis and Harris. Some staff said that older people in these areas who wanted to be cared for at home were at risk of hospital admission due to the lack of community supports. Some staff also said that the care at home service was in crisis and was not able to respond to the needs of older people on the islands. We spoke with a number of older people, carers and frontline staff who told us there could be long waiting periods for receiving care at home services. Changes to care at home packages, especially requests for an increased level of service, could involve lengthy waits.

Managers confirmed that given the capacity pressures facing care at home and care home placements, they had systems in place to prioritise referrals and to monitor and manage waiting lists. For example, weekly ‘criteria panels’ were held by the social work service to review and prioritise service requests and to agree provision where possible. In addition, the care at home service had the authority to change a care package by up to 3.5 hours.

Care home provision in the Uists and Barra appeared to be well managed with beds normally available. However, the position in Lewis and Harris was very different and

at the time of our inspection, we were told that approximately 29 older people were delayed in hospital waiting for a care home placement

Recommendation for improvement 5

The Western Isles Partnership should make arrangements to ensure that older people whose discharge is delayed receive services in hospital that maintain or improve their independence in line with their personal outcomes.

We found that many older people contacted services at a late stage, having been supported by their family and other social networks. Frontline staff told us that, as a consequence, when older people were first referred their needs could be significant. They told us there were insufficient preventative approaches and resources to meet the needs of older people to avoid or delay the need for more intensive supports.

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

The Partnership's position statement stated that the current social work assessment and care planning arrangements were outcome-focused but the associated documentation was outdated. As a result, it was in the process of developing new documentation and care management tools which would reflect an outcome-focused approach. It would also reflect the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013.

The self-directed support team was working on an assessment format detailing what information should go into CareFirst. The Comhairle was using the care at home service request form as a starting point. However, it acknowledged that improvements were needed to make it outcome-focused.

The team was also considering other assessment tools. It had reviewed tools from a number of other councils to see if they could potentially be adapted to reflect local circumstances. Staff we spoke with were familiar with of Talking Points[16]. The Partnership had received support from the Scottish Government's Joint Improvement Team[17] in implementing this approach.

Social work services had recently introduced weekly criteria panels. These looked in detail at how budgets were managed and were described by the Partnership as having an outcomes-based focus. The panel took account of the needs of the individual older person and the pressure on any family members and carers. It operated to the eligibility criteria, including substantial or critical levels where the package required more than 37.5 hours each week. The Comhairle had indicated this level of support was not sustainable by care at home services, particularly for older people except in the short term. This level of support for complex needs had to

[16] Guide developed by the Joint Improvement Team to support the continued implementation of the Talking Points: Personal Outcomes Approach.
[17] Joint Improvement Team: A strategic improvement partnership between the Scottish Government, NHS Scotland, Convention of Scottish Local Authorities (COSLA) and the third, independent and housing Sectors.

be approved by the Health and Social Care Committee. An agreement was then in place that older people would be put on the waiting list for residential care. It was too early to assess how well these panels were functioning.

Staff were used to assessments being based around available resources and where most of this activity was social care related. This was reflected in the health and social work services records we read. Almost all of the assessments we evaluated were located in the social work records. However, in 74% of these, we saw that information from other professionals such as nurses and allied health professionals had contributed to the assessment.

Our main findings from our review of health and social work services records on assessment practice were positive in that:

- almost all cases (92%) had a needs assessment on file
- in the majority of all cases, the purpose of assessments and reports was clearly stated (89%), and
- almost all assessments took into account individual's needs (98%) and individual's choices (96%).

We also assessed 80% of the assessments as 'good' or 'very good', and a further 20% were rated as 'adequate'.

Staff said that the inability to share information electronically was a significant and ongoing frustration. We found evidence of assessment documentation held within each agency that was not necessarily shared either electronically or in paper format across key workers. Frontline staff agreed that this reflected their experience and practice.

In contrast, we spoke with a range of frontline staff who were very clear that they had regular contact and dialogue with their colleagues. We saw and heard about many instances where staff worked well together in sharing information. There were numerous examples of well-established multidisciplinary meetings where health and social work services staff met regularly. These included clinical team meetings in remote and rural areas. These were usually held at the GP practice and discussion focused on clinical issues with new or existing patients. Referrals were made to social work services from these meetings where appropriate.

Service managers from the Partnership attended a weekly delayed discharge meeting. They discussed the discharge planning for delayed patients and for older people who had recently been admitted to hospital. Reports from this group were sent to the Health and Social Care Committee. The group also agreed the allocation of care home beds from hospital and reviewed community waiting lists.

The findings from our review of health and social work services records about care planning were generally mixed. Most cases had a care plan on file (91%) and, in all cases, the care plan addressed identified needs either partially or completely. In 75% of cases, the care plan set out the individuals' desired outcomes. However, most of the care plans were aligned to traditional services such as day care and other

mainstream resources. Therefore, we saw limited evidence of outcomes-based care plans. In terms of quality, we also saw that, less positively, 91% of the care plans were not SMART[18]. We found 94% did not have clear timescales and almost two-thirds were not measureable.

Many of the staff we spoke with said there were delays in older people receiving assessments and services. Our review of health and social work services records in this area showed no delays in the older person being assessed for key services (86%) or in receiving key services following assessment (78%). However, in 34% of cases where there had been a delay, the older person had not been given the reasons for the delay. The Partnership could improve its performance through more effective communication with those older people who had experienced a delay in receiving services.

We spoke with a range of staff about community nurses taking on care management responsibility in the Uists where cases usually had more of a clinical focus. There was a general consensus that this worked extremely well and enabled closer relationships to develop between the older person and staff. Staff told us that the cases they managed were appropriate to their skill sets and, when appropriate, the case would be transferred to social work services. These staff felt strongly that this model should be rolled out across the Western Isles.

From our review of health and social work services records, we were encouraged to see that, in almost all files we read (90%), the older person had been supported to self-manage their condition. In the majority of cases, the support was provided by more than one service. We saw that when the older person was being offered support, this was discussed with them. In almost all the files, there was evidence that the service actively sought to take into account, where appropriate, the older person's views at the assessment, care plan and review stage.

From our staff survey, we found that 74% of staff agreed or strongly agreed that services worked well together to support people's capacity for self-care and self-management.

As part of our review of health and social work services records, we looked at the extent to which the delivery of care and support met the needs of the older people concerned. Positively, we evaluated that this was completely or mostly the case in 83% of the files, and partly the case in a further 13% of files.

Frontline social work services staff told us that, in the Lewis and Harris area, they were not carrying out any annual reviews of care home residents. This was confirmed by senior managers who also indicated routine reviews on CareFirst were also behind. They were looking at ways to improve this and had identified staff members to start carrying out the regular reviews. They were confident that more complex reviews were up-to-date and had arrangements in place to manage and prioritise reviews. Staff from both health and social work services confirmed that older people with more complex needs were more routinely reviewed, usually on a multi-agency basis.

[18] SMART: Specific, measurable, achievable, realistic, timebound.

In the Uists and Barra, we were told that reviews were held on a three to six-monthly basis with good representation, including community nursing and GPs. However, some older people, carers, families and frontline staff told us that all of the key people, including the older person and family members, were not always involved in the review process, particularly clinical reviews. Reviews were often single agency and changes were not always communicated between health and social work services staff and relevant agencies.

It would strengthen the Partnership's care management arrangements if attendance at reviews, including clinical reviews by professionals and other appropriate parties was improved. This would allow a more holistic focus on outcomes for older people's health and wellbeing if all agencies were kept up-to-date with respective care and support arrangements. Positively, we noted that the social work service was taking steps to address the annual review backlog.

We found improvements were needed in relation to carers needs. From our review of health and social work services records, of the 60 applicable files, 32 (52%) of the carers had not been offered a carer assessment. Of the nine files where the carers were offered and had accepted a carer assessment, only five assessments had been completed. Some staff we met did not appear to understand the importance of carer assessments and the potential benefits which could result for carers in having their own needs considered. Frontline staff told us that not all carer assessments would be routinely shared among services. As a result, evidence of carer assessments would not always be present in individual files.

The community care forum carried out carer assessments and delivered training to carers. The forum staff who carried out the assessments were unsure what happened to them after they had completed them. They did not know if they were shared with, and were accessible to, social work services staff. An added difficulty was that different assessment forms were used in different areas. Staff acknowledged, and GPs confirmed, that the carers' database had not captured a significant number of unpaid carers.

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

The Partnership had inter-agency procedures for adult support and protection. These were well laid out and clear for readers. The procedures were designed to ensure consistent intervention and practice across the agencies. The documents stated these were regularly reviewed and updated. We saw evidence that this was the case. The current procedures were dated April 2014.

From our staff survey, we noted that 78% of staff agreed or strongly agreed there was clear guidance and processes in place to support staff in assessing risk. Also, the majority (62%) of staff said risk assessment tools were available to them. This was confirmed when we spoke with frontline staff. They told us the risk assessment tools they used were usually unique to their agency or department, or were specialist.

At the time of our inspection, the Comhairle had been leading and co-ordinating and was concluding a large scale enquiry in respect of adult support and protection concerns for a number of older people in a care home. No formal action required to be taken to protect the older people concerned and we saw that the enquiry had been well managed and sensitively handled by the Comhairle.

Results from our review of health and social work services records for risk assessments were mixed. We looked at files where adult protection-type risks (current or potential issues regarding adult protection or protection of the public), and non-protection types risks such as a frail older person at risk of falling and sustaining an injury or the risk to an adult with dementia of experiencing harm, had been identified.

Only four of the 101 records we read as part of our inspection contained issues relating to protection type risk. We were very surprised at this relatively small figure which was considerably less than in other inspections to date. Only one of the four records contained a risk assessment. The quality of social work recording of these four records was generally poor, particularly within the CareFirst system. Relevant documentation was not fully completed or was not on file. Such a small sample of files including protection type risks made it very difficult to draw conclusions about professional practice in this area.

We considered it was possible that the Partnership was not as sighted as it should be on the potential level of risk of harm to older people in the Western Isles. We noted, for example, that whilst the number of adult support and protection referrals had increased from 29 to125 from 2010/11 to 2012/13, the number of case conferences held had only increased from one in 2010/10 to two in 2011/12 and in 2012/13. The Partnership said that it had an effective tripartite (social work, police and health) weekly screening arrangement which considered the need for any action in response to all referrals. We concluded that the Partnership should ensure that its audit activity should include a focus on its response to adult support and protection referrals.

More broadly in respect of non-protection type risk, we found that:

- 82% of the relevant files (79) contained a risk assessment
- we rated 57% of these risk assessments as good or very good, 34% as adequate and 9% as weak
- 68% of the relevant files contained a risk management plan, the majority of which were up-to-date.

One of the key issues identified as contributing to the poorer findings was that risk assessment and risk management activity was carried out on a single agency basis. As such, while specialist health risk assessments were generally good, using appropriate templates and formats, they were often not shared with other services involved with the older people concerned. Independent sector care providers told us that risk assessments they received were usually contained within the single sharable assessment template. They expressed some concerns about their quality and said that some were out of date.

In March 2013, the Care Inspectorate had produced a report on the effectiveness of adult protection arrangements in the Western Isles. This identified the need for improvement in the use of management information and in the undertaking of self-evaluation activity. We noted that these continued to be identified as area requiring attention and improvement in the adult protection committee's biennial report 2012–14. In particular:

- File audit activity by the Partnership had been limited. This was highlighted in the latest report (2012–2014) for the adult protection committee and, more recently, by its lead officer. Only three out of the six planned file audits had been completed. It was not evident how these audit findings were being used to support improvement. The Partnership had indicated there were plans to improve this, but no clear timescale or programme of work was in place to achieve this.

Recommendation for improvement 6

The Western Isles Partnership, through its involvement in the Public Protection Chief Officers group and the adult protection committee, should ensure that action is taken to improve data collection, its use for improvement purposes and the quality of CareFirst recording. It should also ensure that a clear programme of self-evaluation is undertaken. This should include an audit of the effectiveness of its screening arrangements for adult support and protection referrals.

- The adult protection committee had an independent chair, based on a two-year rotation. The committee had a strong multi-agency membership. It was encouraging that NHS Western Isles had taken a more prominent membership role than previously. The committee held 12 meetings during 2012–2014. One joint meeting had also been held involving the adult protection committee and the child protection committee. These two committees had agreed a meeting schedule in which at least two meetings each year were to be held on the same date. This would enable the committees either to meet jointly or to have an element of overlap between them.
- We saw that the adult protection committee had recognised the need for engagement and involvement of older people service users and carers. However, we saw no evidence of arrangements, either through questionnaires or other means, to gather feedback from people who had been involved in the adult support and protection process. The committee had also identified the importance of self-directed support in enabling older people to make choices about how they were supported. It was also mindful of how older people were to be kept safe from harm and how unregulated service providers should be 'screened' in the future. An invitation was to be extended to the self-directed support lead to discuss these issues. Given the relatively high number of existing self-directed support arrangements in place, the Partnership needed to ensure that it had procedures in place to address the adult protection implications arising from the availability of self-directed support.
- The Partnership's responsibilities for supporting vulnerable people were linked to the work of the care for people group. This was a sub-group of the Western Isles

emergency planning co-ordinating group. Due to the geographic location of the islands, significant resources were needed to ensure the safety of the wider population, in particular older people and vulnerable individuals. For example, the emergency planning co-ordinating group led on the co-ordination of a number of multi-agency initiatives to ensure appropriate support had been provided to vulnerable people during a sustained period of bad weather.

A severe weather contingency plan was in place for adults and older people in care settings in the community. The Outer Hebrides Community Safety Partnership's Get Ready for Winter awareness-raising programme targeted vulnerable people within the community. A booklet was produced which had been endorsed by the World Health Organisation. Similarly, for health-based services, a winter plan identified risks and addressed business continuity.

5.4 Involvement of individuals and carers in directing their own support

In its position statement, the Partnership stated that carer involvement and feedback was strengthened through its open and constructive dialogue with Western Isles Carers and Users Support Network.

The Comhairle had led on the information sharing process in relation to self-directed support. It had worked closely with the community care forum to share information about self-directed support to ensure that all stakeholders were fully briefed. The community care forum had developed a directory of services which practitioners used to signpost older people who fell below the substantial and critical thresholds of the eligibility criteria. We saw that there had been a significant increase in the uptake of self-directed support from the previous year.

From our review of health and social work services records, we saw that staff were involving older people in directing their care and support. The findings were positive in that:

- in almost all files, there was evidence that the service actively sought and took into account the individual's views at the assessment stage (95%)
- in 97% of cases, there was evidence that the service actively sought and took into account the individual's views at the care plan stage. This figure was 86% at the review stage
- in 95% of cases, there was support for the individual to contribute to the care plan.

Our staff survey indicated that 75% of staff agreed or strongly agreed that services communicated well with older people who use services.

Independent advocacy

One way in which older people can be supported in having their views and wishes taken account of is through independent advocacy services.

Advocacy Western Isles was commissioned by both NHS Western Isles and the Comhairle. It was the only provider of independent advocacy services on the islands. The service had to provide performance reports to both agencies in separate

formats. Representatives from Advocacy Western Isles said that this created duplication of work and a burden on time.

During our review of health and social work services records, we found disappointing results about advocacy. The involvement of independent support or advocacy was considered appropriate for 14 of the older people whose records we read. However, only five of these older people were offered advocacy support and for only two of these was there evidence that advocacy had been provided. Frontline staff and service providers told us that advocacy services would try to make best use of their time, for example by holding sessions in day services where they could be available to a large number of older people.

We looked at the Partnership's websites and were able to navigate to Advocacy Western Isles. We noted there was minimal information about advocacy services for carers. The site was last updated in 2009.

It would strengthen the independent support provided to older people if the Partnership utilised advocacy services management information and streamlined reporting arrangements to make service improvements.

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

Summary

Evaluation – Weak

The Partnership had a Joint Commissioning Strategy. Whilst this provided a useful direction of travel it needed to be converted into a detailed plan as a matter of priority. There was awareness across the Western Isles Partnership of the need to move forward with planning and implementing service changes. This was required so that the NHS Western Isles and the Comhairle could more effectively respond as a Partnership to the presenting levels of need and the demographic pressures of an ageing population.

We concluded that the development and implementation of early intervention and support services had been limited, a view echoed by many staff in our staff survey.

Some operational restructuring and strategic planning was taking place. This included significant and important work around care at home, reablement, intermediate care and a review of residential care. However, much of this work was at an early stage or was some way off fruition. The Partnership acknowledged considerable work was required to take this forward now that some of the foundations for change were being put in place.

Some stakeholder engagement had been taking place, but this was limited. The Partnership needed to develop its approach to its involvement of, and engagement with, all stakeholders. Staff at practitioner level felt distanced from the integration agenda.

The Partnership acknowledged it needed to further develop its approaches to quality assurance and self-evaluation and some work was already under way.

There was a pressing need to ensure that priority was given to the development of the joint strategic commissioning plan, and the related financial and resource mapping in consultation with all stakeholders.

6.1 Operational and strategic planning arrangements

At the time of our inspection, work was being carried out by the Partnership to progress and resubmit its draft integration scheme to the Scottish Government for approval. The Partnership received confirmation of its approval in June 2015.

A number of key groups were responsible for taking forward the strategic workstreams for integration. This included a clinical and care governance group

which reported to the joint planning group. In turn, this group reported into the Health and Social Care Committee. Decisions about resources were made by separate NHS Western Isles and Comhairle policy and resource committees. Finance colleagues were included within this reporting structure. Senior managers acknowledged that this reporting structure needed to be strengthened to enable more efficient and joined-up decision making and to support the scheme of integration.

While work was ongoing to develop operational and strategic planning arrangements, we found these were progressing slowly. Some strategic work had been halted, for example work on both the dementia strategy and carers' strategy. This was partly due to changes that had taken place in key senior posts. Similarly, some of the key strategic documents necessary to inform service planning and development needed to be updated and finalised. This included the housing strategy and the Joint Commissioning Strategy for services for older people.

The Single Outcome Agreement provided an overview of the challenges for the Partnership, what partners hoped to achieve and how they would measure success. However, there was no reference within the Single Outcome Agreement to the Joint Commissioning Strategy for services for older people.

The Partnership produced its joint commissioning strategy for services for older people in 2013. It set out the national and local policy context and statistics about current service provision, projected demand as a result of demographic factors as well as the projected increase in the number of people living with long-term chronic conditions and the decline in the number of people of working age. However, there was no risk analysis and the strategy was still to be developed into a joint strategic commissioning plan with an integrated resource framework. We were advised that there was ongoing work to update this and we were provided with an action plan summary dated July 2015. This detailed the outcomes to be delivered, some information about the progress to date in taking these forward and an overall summary for each outcome which included some statements of intent.

The Partnership acknowledged that the draft dementia strategy (an NHS Western Isles document in draft since 2008) had been put on hold. As a result, the provision of post-diagnostic support to older people and their families, and the inclusion of the dementia strategy into the Joint Commissioning Strategy for services for older people, had been limited. We saw that, partly as a consequence of this, there had been little progress in the development of services for people with dementia. Senior managers suggested that development of the dementia strategy would be part of the remit of the managed clinical network. Discussions were ongoing to develop a nurse consultant post in line with a similar model working in Orkney.

Recommendation for improvement 7

The Western Isles Partnership should take steps to ensure that the draft Joint Commissioning Strategy for services for older people is finalised. A SMART joint strategic commissioning plan should also be developed in consultation with all stakeholders to deliver a range of services to help support older people to remain at home successfully. The plan should include detailed costs based on identified future needs.

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

It was clear from our review of health and social work services records, and from the results of our staff survey, that there was a strong support for supporting older people to continue to stay in their own homes for as long as possible, while minimising risk. For example, our observation of multi-disciplinary meetings found that health and social work services were working hard within the limitations of available resources to enable and support hospital discharge.

In line with Scottish Government policy, there was an explicit remit to shift the balance of care towards care at home services by reducing the number of beds in care homes and by increasing the number of people receiving intensive care at home services. Part of this strategy was to offer self-directed support, where the service user could purchase and manage their support package. However, it was clear from our review of health and social work services records, and in discussions with frontline staff, that the option of self-directed support was not always viable given the lack of availability of carers. We were advised that external funding bids had been prepared by the Partnership to address gaps in provision with specific reference to brokerage services and training projects.

The demand for care at home services outstripped the capacity to deliver a responsive service. This was more challenging in more remote and rural parts of the islands. This was compounded by the demographic changes in the Western Isles, resulting in an increasing older population and fewer people of working age. The Partnership was keenly aware of the pressure to meet demand and the impact on older people and their carers. While the national trend across Scotland has been for local authority care at home provision to decrease with the private and voluntary sectors providing larger packages of care, the opposite had been the case in the Western Isles which had consistently maintained all of its in-house provision. Senior managers advised that it was current policy to maintain care at home provision in-house and that there was little appetite to commission externally provided care at home services.

A major piece of work was being carried out to review and revise the care at home services provided by the Comhairle. We found that the approach to this exercise had been very thorough, with the Comhairle having researched what was in place in other Partnership areas and whether it would be appropriate for the Western Isles.

The main aims of the review of the care at home service were identified as:

- to ensure flexibility in the deployment of the workforce
- to respond more effectively to assessed need
- to enable more equitable access to support at home across the Western Isles, and
- to move from a time-based to a care-focused model, adopting an area caseload approach and more local administrative and line management support.

The review process had included a number of key milestones for change. These involved the redeployment and employment of administrative staff, consultation with staff on changes to supervisory posts and the re-contracting of front line staff with all new job descriptions including a reablement role. As a result of this significant change programme, a new structure was beginning to be put in place for the care at home service. We concluded it was vital that the redesign of the care at home service was driven forward as a matter of priority in order to meet the required level of demand for this key service.

In terms of other areas of service development we found the following:

Polypharmacy project. As referred to in Chapter 2, a pilot project had been carried out involving the pharmacist based in the Western Isles Hospital and in primary care pharmacies. Four GP practices situated in North Uist, Benbecula and Stornoway were involved in the project. The pilot had been funded by the Scottish Government. It included the review of medication with patients over the phone or by video conferencing. While there had been some challenges for patients in accepting this approach, the evaluation of the project found some reduction in the amount of medications prescribed. Work was also under way to assess the use of psychotropic medication. A proposal was under way to introduce virtual ward rounds in The Uists and Barra Hospital, Benbecula, using new technology.

Telehealthcare and telecare. The Partnership was considering how to take forward a proposed approach where all managed clinical networks would work together to monitor those older people who had more than two long-term chronic conditions. One element of this was the use of telehealthcare in remote and rural areas to monitor older people with long-term conditions. Additional funding of £80,000 had been made available to increase the capacity of the community alarm service and to develop telecare. Tracking systems had been identified as a potential service gap, although it was recognised that the broadband connection to the area was a limiting factor. Consideration was being given to combining the community equipment service with the telecare service. The action plan summary reported that work was being undertaken to examine options to support service users with dementia living in remote areas and for whom it was proving challenging to provide safe and sustainable care at home. It was also the Partnership's intention to increase the use of telecare on an annual basis until all adults aged over 75 who had been assessed as benefitting from telecare received it.

Reablement. A reablement service had been piloted via a dedicated occupational therapy team, although it was recognised that this had been a limited resource. It

had not yet been developed as part of support at home and the Partnership said that the development of reablement and intermediate care services would be included in the strategic plan.

Overnight care. The availability of care at home staff for overnight support was limited. There was no provision on the Uists or Barra and some other remote and rural areas. The service had been reduced following a review in 2013. This indicated that a number of the service users at that time no longer needed the service. We heard mixed views from staff about the ability to deliver end-of-life care at home services. Variations in different geographical areas were linked to the availability of staff. However, managers told us that GP referrals for care at home services were being accepted out of hours and at weekends for the provision of end-of-life care.

Community unscheduled care nurses. This project was based on Lewis and Harris. As indicated in Chapter 2, this service had been a significant success with an evaluation reporting a reduction in overnight admission to hospital (during the pilot period) and a recorded reduction in the number of calls to the physician on-call. The rationale for this improved position was that having GPs on-call meant that they were able to provide cover at a senior physician level. Also the GPs often knew the patients and their local community, and with support from the community unscheduled care nurses and the mobile overnight support service were able to help keep older people at home.

Overall, we concluded that the development and implementation of early intervention and support services had been limited. This was also reflected in our staff survey. Whilst 46% of staff disagreed or strongly disagreed that older people were able to access a range of preventative and enabling services to suit their needs when they needed them, only 31% of staff agreed or strongly agreed. This level of agreement was significantly less than in other inspections to date.

6.3 Quality assurance, self-evaluation and improvement

Documentation provided by the Partnership showed a commitment to self-evaluation and improving practice. This included the chief social work officer's interagency action plan and monitoring report dated April 2015. A number of planned actions were being taken forward against which there was a progress update detailed in the action plan. These included support to staff through training and supervision. A draft case file audit policy outlined the approach to be taken to case file auditing across social and community services. This aimed to ensure that case file auditing formed part of the performance management framework. We were provided with data by the Comhairle which showed that case file auditing had been taking place weekly since mid-May 2015.

The NHS Western Isles annual review of October 2014 reported positive results, with 96% of respondents stating they were satisfied with their overall care and treatment. In its position statement, the partnership advised that as part of the review, the dedication and commitment of local NHS staff had been commended and the board had performed well against a number of national targets.

Within NHS Western Isles, it was acknowledged that the evaluation and quality assurance process to deal with applications for funding was variable. This was dealt with by a number of different committees and individuals. The process was viewed mainly as a conversation looking at the application for the next year of funding. NHS senior managers acknowledged and agreed that the processes for evaluation and quality assurance needed to improve.

This was echoed by third sector providers who felt that the Partnership's reporting mechanisms for performance linked to the allocation of Change Fund monies had been excessive. However, they felt there was minimal feedback provided once performance reports had been submitted. The Partnership acknowledged that annual contracts for funding third sector services did not promote stability in the sector or encourage innovation and development. Managers indicated that there were no dedicated performance staff working within health. The Comhairle was using a data analysis system which had been short-term funded using Change Fund monies. It was recognised that, historically, there had not been the skills in-house to produce collaborative reports on performance data. This had improved using the data analysis system.

The Partnership had implemented a set of Change Fund monitoring measures which also included some analysis. Two examples of this were in the areas of emergency admissions to hospital and falls. Annual data showed that emergency admissions within the over 75 age group were below the national average, with the falls rate reported as above the national average. We also noted that performance data was being collated on the community equipment service. This showed a reduction in the time taken to deliver/uplift equipment.

A joint performance and monitoring group was in the process of mapping the current Comhairle and NHS strategic outcome measures to the proposed outcome measures from the Integration Joint Board. The Partnership acknowledged that this was challenging in the absence of a joint strategic commissioning plan. The proposed outcome measures were to be reviewed once the joint strategic commissioning plan was finalised. Work had begun to align health and social care datasets to enable a better level of oversight.

Overall, it was clear some systems were in place to support and report on quality assurance, self-evaluation and improvement. The Partnership recognised that these needed to change and adapt to enable and improve joint reporting.

6.4 Involving individuals who use services, carers and other stakeholders

We saw a number of examples where older people and other stakeholders had been involved in service planning and development activities.

- Planning for the St Brendan's Hub resource had included the recent engagement of the Dementia Services Development Centre at the University of Stirling. There had been a remit to work with all stakeholders in managing and consulting on this project.

- A significant level of consultation with staff and service users had taken place as part of the redesign of the care at home services. Feedback from this consultation had been reported to the Health and Social Care Committee.

- The Western Isles community care forum had been given the lead in developing a database of carers. This was to be modelled on the system in place in Perth & Kinross.

From the information we received from the Partnership, we noted that there had been some dialogue with the association of community councils in North Uist and Benbecula about health and social care provision during 2014. We also saw there had been some discussion about locality planning, and patient and public involvement, at a patient participation group forum. However, it was unclear how frequently these discussions were taking place or what the impact of these was on planning processes and decision making. Most of the above engagement activities also appeared to have been carried out on an issue by issue basis. We were not provided with any documentation which showed that the Partnership had, or was in the process of, developing a more systematic and comprehensive approach to stakeholder engagement.

From our focus groups, it was clear that relatively few frontline staff had been fully involved in, or had much awareness of, locality and strategic commissioning. They were also unclear about how older people themselves had been involved in the planning process. This was reflected in our staff survey.

- Whilst 22% of staff agreed or strongly agreed that the views of older people who use services and their carers were fully taken into account when planning services at a strategic level, a total of 67% of staff either disagreed or indicated they did not know.

- Similarly, whilst 24% of staff agreed or strongly agreed that the views of staff were taken into account when planning services at a strategic level, a total of 76% of staff either disagreed or indicated they did not know.

The level of agreement with these statements was at the lower end of findings from other inspections to date.

When we spoke with frontline staff, we noted there was a degree of confusion about some of the service development plans. This was particularly evident in respect of the future use of the beds at the Bethesda care home. Some staff understood that these beds were to be used as step-down from hospital, while social work managers were confident that these beds would be used for respite only and not as part of a reablement programme.

It was clear there was a difference in perception about the degree of engagement with frontline staff in strategic planning between those working at practitioner level and managers. Staff told us they would advise their line manager in team meetings of any issues or concerns about gaps in service provision. While they were confident their concerns would be passed on, they were not aware of any feedback or

outcomes. Frontline staff in both health and social care services told us they did not feel that they were actively involved in discussions about strategic planning.

However, staff working at management level told us there had been a number of meetings set up to keep staff updated on changes. Information had also been disseminated in emails and in other forums. Managers indicated they were keen for staff to be involved in creating the joint strategic commissioning plan.

The Partnership's position statement indicated that it would be developing approaches to co-production of services and the agreement of the joint strategic commissioning plan for the Western Isles. However, it was clear that a more joint approach was needed. For example, representatives of third sector providers indicated to us they did not feel like real partners in the planning processes. They were keen to be much more involved and engaged in discussions about the longer-term strategic plans for service development.

Recommendation for improvement 8

The Western Isles Partnership should develop a comprehensive and strategic approach to how it involves all relevant stakeholders in its strategic planning activity.

6.5 Commissioning arrangements

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

The Scottish Government required health and social care partnerships to produce joint strategic commissioning strategies for older people's services by April 2014. In 2014, additional Scottish Government guidance advised that these plans were to be developed to include detailed financial planning as well as extending to all adult groups. These plans would be called joint strategic commissioning plans.

We found there was a lack of detail in the Partnership's Joint Commissioning Strategy for services for older people (2013–2023) about how services would be developed or redesigned. It was also unclear what actions would be taken to develop commissioning skills and competencies within the workforce to carry out the redesign of services. The Partnership acknowledged that there had been limited progress made in joint strategic commissioning activity. Some projects were very much at an early stage and had uncertain timescales for completion. Much of this development work was concerned with replacing existing services rather than developing new service capacity or innovations. Senior managers said that the resources to support the strategy were being mapped through the integrated resource framework. However, there was a lack of detail on how this was progressing. The planning activity for service development was as follows:

Long-term care home provision
A number of hospital beds had been re-provisioned for alternative use in the Western Isles Hospital over a number of years. However, a plan to build community capacity to replace these had not been produced or put in place. When the hospital opened in 1992, there were 212 beds. This had reduced to less than 100 beds by 2015. The Comhairle told us that this reduction had not been accompanied by any resource transfer to support the development of alternative community-based supports and services.

It was clear that the Partnership was facing considerable pressure with respect to older people being delayed in hospital, with the majority of older people being recorded as waiting on a care home placement. The Partnership acknowledged there was insufficient supply to meet demand.

A multi-agency residential review group had been set up to assess the current care home provision and develop options for future models of care and support. This group included a number of stakeholders, including the Comhairle, the NHS and the Hebridean Housing Partnership. Part of its remit was to consider the long-term future of two of the six care homes operated by the Comhairle. These were no longer seen as being fit for purpose, in particular for people living with dementia. The group was also looking at the long-term viability of three small 'care units'. These were struggling to meet the increasing needs and frailty of their existing residents.

The work of the review group was still at an early stage. It included mapping of resources, researching service redesign in other areas and planning for future need. This mapping work had started to link into the broader housing strategy group to inform and shape future specialist housing provision. It was recorded within the Joint Commissioning Strategy action plan summary of July 2015 that the health and social care committee had considered a report in June on the future of residential care for older people. This included a presentation of housing with care support model operating in Shetland. £45,000 had been allocated to develop an asset plan in respect of the accommodation needs of older people living on Lewis, the island affected most by delays in discharging older people from hospital.

Respite provision
The Partnership had approved the provision of 12 additional care home beds to be used for respite care. Nine of these were to be located in the Bethesda care home, Stornoway (owned and operated by the third sector), with another three in two alternative sites in Harris and Uist. Once these beds became fully operational, it was planned that those beds currently used for respite across the Comhairle care homes would be re-provisioned as long-stay beds.

The Partnership expected this would have a positive impact on the number of older people delayed in hospital awaiting a care home place, especially in Lewis where the problem was most pronounced. The commissioning of these beds had been completed by the Comhairle and a three-year block contract was in place for all of the beds. This was at a higher rate than that set by the national care home contract. It was clear that the capital investment to create the new respite beds was being made by the third sector and through local fundraising.

Housing
The Partnership faced a number of particular challenges in terms of housing provision. For example, 80% of housing was owner occupied and 40% of these properties were owned by older people. There had been an historical reliance on Scottish Government grants by owner occupiers to upgrade properties. This was now a significant issue as grants had been cut and eligibility criteria changed. There was an awareness of the need to upgrade accommodation to support older people to stay in their own home for as long as possible and to reduce the amount of fuel poverty. The Partnership informed that 80% of pensioner households were in fuel poverty. The crofting grant had been cut by the Scottish Government, and there was a concern that this would lead to the deterioration in the condition of housing.

The Comhairle told us about discussions it had recently held with the Hebridean Housing Partnership about the possibility of using vacant tenancies to support older people to be discharged from hospital whilst awaiting adaptations or other supports. These discussions were very much at an early stage. The Hebridean Housing Partnership told us that it would consider this approach, although it had to be mindful of its need to maintain high levels of occupancy for financial purposes.

Although these issues were being taken forward through the housing strategy, the Partnership recognised there was a need for greater collaboration and engagement between housing, health and social care colleagues in strategic planning discussions and decision making.

St Brendan's Hub
NHS Western Isles' Clinical Strategy Paper (2009) proposed the development of 'hubs' within certain locations across the Western Isles. This would refocus and resource community services and hospitals. This included St Brendan's and The Uists and Barra Hospital (situated on one site). The hospitals' site also included a ten-bedded care home operated by the Comhairle. A capital replacement programme and outline business plan had been developed to re-provision St Brendan's as an integrated health care facility. This would include five acute beds and ten flats (eight permanent tenancies and two for flexible use). The flats would be operated as 'extra sheltered housing' by the Comhairle. However, we found there was a lack of detail on what this might mean in respect of a service specification. The proposals also included accommodation for dental services, visiting clinical teams and office space. The intention was to relocate the existing GP practice, ambulance service and community teams.

The project plan was described by senior managers as being 'at a crossroads'. A funding shortfall had yet to be resolved, and consultation with the respective staff groups employed by the NHS and the Comhairle, as well as the wider community, had yet to begin. It was clear that this was an ambitious project, but it remained at the early stages of development. However, a commitment had recently been made to move forward with staff and community engagement. Positively, there were five members of the public on the project board.

Day care provision
A project board had been set up to review day care provision which was provided by a range of third sector organisations as part of service level agreements with the

Comhairle. This was to include consideration of issues such as transport and the day care model to be followed. This would include the times of day the service would operate and whether it would be buildings based. At the time of our inspection, this review was ongoing.

During our inspection, staff and managers acknowledged there were some challenges surrounding strategic planning activity and service development. For example, senior managers in the Comhairle said they had faced major challenges in developing independent sector service provision in the islands. The small size of the Western Isles meant that most managers carried both operational and strategic responsibilities. As described earlier, we saw a number of examples where strategic planning and development activity had been delayed or had stalled. Workforce availability and development was not only a problem now, but could also become more of a problem in the future. A 61% increase was anticipated in the population aged over 75 years between 2015 and 2022. This was likely to further stretch the availability of working age people who choose to work in the health and social care sectors.

The joint strategic commissioning plan should be progressed to include both health and social care developments, the resources available and the role of the third and private sectors in developing capacity in service provision. Decisions about investment and disinvestment need to form part of the overall approach to resource mapping, budget planning and service development.

Contracting

The Partnership said that Change Fund monies had been used to improve self-evaluation and that the service specifications for care at home, housing and other service areas been a product of this work. A post had been established whose remit was to monitor contracts. Social work reviews, Care Inspectorate reports of regulated services, complaints and spot visits by the commissioning team were tools used to evaluate quality.

In its position statement, the Partnership said that improvements had been required in its procurement processes and that this work was ongoing. For example, we noted that while some spot purchase arrangements were in place for care at home services, there were no contractual agreements or review processes to monitor and quality assure these. To address this, the Comhairle had begun the process of collating data on the extent of current spot purchased provision. This was with a view to moving to block contract arrangements. The Partnership acknowledged there had been a history of spot purchasing care at home services on demand to fill service gaps and that these arrangements had not been contractually managed.

We concluded that joint strategic commissioning was not developed in the Western Isles but there was a clear commitment to take this forward within the constraints set by the challenges of island living and demographic changes. As yet, there was no evidence to indicate to what extent the current planning and redesign activity taking place would stimulate a mixed economy of care provision or whether it would be sufficient to respond to the needs and aspirations of older people.

Quality indicator 7 – Management and support of staff

Summary

Evaluation – Adequate

The Western Isles Partnership was clear about the value of having a motivated and well informed workforce. It had worked hard to ensure that staff were given professional support and opportunities.

Both NHS Western Isles and the Comhairle had clear approaches to address the long-term issues of recruiting and retaining staff. This was a particular issue that they experienced along with other remote and rural partnerships, and they were part of an international group working to address this. The Partnership was also looking at internal measures. These included strengthening links with further and higher education facilities to develop career pathways and to provide continuing professional development opportunities for staff. We did not see much evidence of NHS Western Isles and the Comhairle, until recently, sharing the learning from the actions which they had taken on a single agency basis to address recruitment and retention challenges. Most staff worked in single agency teams.

There were very few co-located or joint teams, although this did not prevent front line staff from working closely and flexibly together. The Occupational Therapy Team was a joint team and operated as an effective and fully integrated team and service. Some broad joint principles had been agreed for the workforce as part of a workstream for health and social care integration. This was at an early stage and further work was required to develop this.

Managers were supportive of staff and recognised the pressures they faced in carrying out their work. Staff recognised this and felt valued. Where appropriate training and support was not available locally in the Western Isles, the Partnership was supportive of this being accessed from the Scottish mainland.

7.1 Recruitment and retention

The recruitment of staff in the Western Isles had been a long-standing issue for both NHS Western Isles and the Comhairle. There were ongoing plans to address this at a number of levels and the Partnership saw recruitment and retention of staff as a key strategic priority.

NHS Western Isles, in conjunction with a number of European countries and NHS Highland, had invested in the Recruit and Retain project. This was designed to identify and pilot test ‘solutions’ to the continuing challenges of recruiting and retaining health professionals in remote and rural areas. The project included partners from Scotland, Sweden, Greenland, Iceland, Ireland, Norway and Canada. The key approach was to attract staff by selling the lifestyle of the area as well as

just the post itself. A further funding application had been made as part of Recruit and Retain 2, to continue taking forward the recommendations of the project and to build a business model which would help the retention of medical staff in areas like the Western Isles in the longer term. As well as working with its international partners, this also involved NHS Western Isles taking a lead role of behalf of a Scottish Consortium involving NHS colleagues from Orkney, Shetland and the Highlands.

NHS Western Isles made considerable use of locum cover particularly for some medical staff in hospitals, including consultants. This incurred a considerable expenditure. During our inspection, the need to employ a locum consultant for a period of one week in June 2015, at a cost of £19,000, attracted much local and national media attention. The Partnership advised that it had innovative work underway to reduce locum costs including a new model of locum use which was cost effective. It had been asked to present this work at a national forum in December 2015.

GP vacancies had impacted on NHS Western Isles' ability to deliver good quality care. This was an issue of concern to both the Partnership and the local community. A short life working group had been set up to consider options to address medical provision. Senior managers thought that effective solutions to these difficulties, if they could be found, would have cost benefits.

The Comhairle also faced recruitment and retention challenges. Managers told us that posts were often difficult to fill and some posts had been advertised three times without much response. Recruitment hot spots included care staff, posts at service manager level and at times social worker posts. As with the NHS, this also required them to use locum cover and to employ temporary staff from specialist employment agencies. Senior managers were concerned about their ability to maintain a quality service when they needed to use a number of staff who were contracted for shorter periods of time to cover vacancies. The workforce also had an older age profile and the Comhairle was aware of the need to focus on effective workforce planning. Recruiting care at home staff, especially in some of the more remote and rural areas, was a constant challenge. One action taken to deal with the rurality issues was by providing additional supports such as 'pool' cars to increase the transport and mobility options for staff working in these areas.

We saw little evidence that until recently NHS Western Isles and the Comhairle had sought to share learning from the individual actions they had taken to try and address the recruitment and retention challenges they both faced.

From our staff survey and discussions with staff at focus groups, it was clear that staff across both organisations generally felt well supported and able to access appropriate training. However, some staff told us that opportunities for promotion within the Western Isles could be limited. The small size of the Western Isles meant that the service structures were relatively flat. This meant that they could not offer the level of promoted posts which were available in larger authorities or organisations. However, senior managers were supportive of staff widening their experience and recognised the need to offer staff a range of specialist skills to compensate for this. This was of benefit to the Partnership, but also acted as an

incentive to help retain staff. Training was offered to support this. Personal development plans for staff included training on mainland Scotland. These initiatives included links to senior practitioners and consultants in Inverness and Glasgow to ensure that staff had opportunities to benefit from a good range of experience and knowledge.

The Partnership had used the Change Fund to look at career pathways. This included a project which focused on developing skills to help people to become part of a health and social care workforce. One workstream had completed with two others under way and one due to begin in autumn 2015.

The Partnership's focus had been to engage young people in their final years at school in considering care as a future career. Initially, young people recruited through this route had been placed to work in residential care homes. They were encouraged to link with the University of the Highlands and Islands to undertake qualifications in care. This project was established to enable the Partnership to examine options for developing qualifications to prepare the community-based workforce for a career in care. The project was also responsible for developing career paths to strengthen the viability and attractiveness of a career in care for young people leaving school as well as adults looking at career options.

The Project completed key areas of work, working largely with Education and Children's Services, Skills Development Scotland, and further education providers to develop options for a skilled workforce for the future, based on national recommendations for services. The project also worked with colleagues at a national level in Scottish Social Services Council, NHS Education Scotland, Skills Development Scotland, Scottish Qualification Framework, Joint Improvement Team and Colleges of Scotland Network. Senior managers told us this had been successful and there had been a retention rate of 80% of the young people involved.

NHS Western Isles engaged with local schools to raise awareness of nursing and allied health professional careers among young people.

The Comhairle was developing a more flexible contract which would apply to all residential and care at home staff. This would allow more flexible staff support to be provided to older people across a range of settings within the community. Managers also saw this as a means of addressing some of the recruitment issues to the care at home services. One aspect of the redesign of the care at home services was to introduce contractual arrangements which were both more family friendly and flexible and more conducive for service delivery and continuity. Some staff we spoke with felt that more could have been done to help recruit to the care at home services by changing and improving terms and conditions at an earlier stage.

Both the Comhairle and NHS Western Isles were continuing to work to their individual workforce plans. Previous workforce plans, whilst acknowledging the need for a partnership approach to some issues, had still largely addressed these on a single agency basis. Both existing workforce plans were due to be refreshed. Some initial scoping work in moving forward towards health and social integration had been carried out. However, only limited progress had been made in the absence of a broader and agreed joint strategy for integration.

To support recruitment and retention of health and social work services staff, staff and managers acknowledged the pressing need to provide adequate and appropriate housing provision to accommodate the workforce needed to deliver services.

7.2 Deployment, joint working and teamwork

The majority of staff in the Western Isles were deployed in single agency teams and services. A significant exception was the occupational therapy service where staff were both co-located and had a jointly appointed and accountable manager. Both the health and Comhairle occupational therapy staff carried out the same roles and responsibilities making this a truly integrated team. This level of integration was unusual, if not unique.

Example of good practice – Occupational therapy service

The occupational therapy team was a good example of a fully integrated team and service. As well as having a single manager, NHS and Comhairle staff in the team undertook integrated roles with both staff groups providing rehabilitation and a reablement approach for older people and also being involved in the provision of aids and adaptations. This approach had improved continuity for older people and reduced the need for duplication of information. We heard and saw several examples of where this service had improved outcomes for older people.

Staff who responded to our survey and those we met said they enjoyed good working relationships with other staff locally. We found that staff worked hard to ensure there was good communication with their colleagues in support of good outcomes for older people. In our survey:

- 76% of staff agreed or strongly agreed that joint working was supported and encouraged by managers, and
- 75% of staff agreed or strongly agreed that they had positive working relationships with colleagues in other agencies.

Staff, including those in the out-of-hours nursing service and the care at home services, worked well together to cover care tasks along with carers. In some areas, and most notably the Southern Isles, both health and social work services staff attended GP practice meetings. This helped to ensure that all aspects of the treatment and care package were being managed effectively. It also helped to ensure that staff could intervene early when concerns arose about an older person in the local community. There was good joint working on the prevention and follow-up of falls. Occupational therapy staff provided good support to carers. Staff also worked flexibly to support and care for older people with end-of-life care within their own homes.

As reported in Chapter 2, as part of the Erisort project, the Partnership had plans to introduce a virtual ward. Although this development was still in its early stages, we

found that staff from a range of backgrounds were enthusiastic about the prospect of being able to work together in a way which could make a positive impact on the lives of the older people they were caring for.

Staff had developed flexible ways of working with carers to support older people at home. There were areas where the recruitment of care at home staff was continuing to be very challenging. As a result, staff worked with family members and carers to provide them with relevant support training (for example in the use of equipment) and often worked alongside them.

Frontline managers and staff indicated they had good access to support and to clinical and professional supervision. In our survey, 77% of staff agreed or strongly agreed they were well supported in situations where they might face personal risk.

7.3 Training development and support

Staff were supported with training and development opportunities, and there were links to the systems for continuing professional development. Nursing staff were linked into the NHS knowledge and skills framework system which offered both appraisal and opportunities to continue to develop professionally and to develop wider skills. Online training was seen by NHS Western Isles staff as one way of allowing them to access training and education. They were able to access this from their own homes. A recent review of community nursing had included a number of recommendations aimed at enhancing the staff group's professional skills to enable them to deliver an enhanced service.

Training had been provided for medical staff to ensure that they developed and retained the necessary skills which were required within the Western Isles. This included them been linked into consultants and training in Glasgow and Inverness. It also included opportunities to work for periods out with the Western Isles to retain and develop skills.

Comhairle social work staff were also supported to access training on the Scottish mainland where this was required.

Partnership staff spoke positively about training for self-directed support and telecare, as well as support for training in dementia for key staff. Staff were supported to undertake qualifications with the University of the Highlands and Islands. Over 100 staff had achieved SVQ level 2. A continuing rolling programme was in place to help care staff achieve this and to move onto SVQ level 3. NHS staff had provided training to care home staff on infection control, oral hygiene and end-of-life care, all of which had been well received.

In our staff survey, 86% of staff agreed or strongly agreed they had access to effective line management through clinical and/or professional supervision. This finding was significantly above findings in other inspections to date.

Some staff with specialist knowledge and skills, for example mental health officers and some medical staff working in the more remote and rural areas, said the relative rarity with which they were required to exercise their specialist knowledge and skills

could leave them feeling de-skilled. Efforts were made to support these staff by linking them with colleagues in other areas of the Western Isles.

Joint training was focused on a few specific areas of practice, for example, adult support and protection where a range of public awareness training had taken place during 2014 and 2015. It also included training input for staff based at A&E at Western Isles Hospital. Some staff told us that joint training could be arranged on an ad hoc basis making it difficult for them to find time to attend. They said there was little or no protected time for training. Managers had made attempts to overcome this, but indicated that some sessions which had been arranged, such as 'lunch and learn' events had been poorly attended. The Partnership should consider ways to further develop and promote joint training.

Recommendation for improvement 9

As part of health and social care integration the Western Isles Partnership should develop an integrated training strategy. In doing so, it should consider ways to jointly develop and provide access to a range of training and education for staff which can be accessed easily and provided in a range of formats. This should be informed by staff views and through a training needs analysis.

Quality indicator 8 – Partnership working

Summary

Evaluation – Adequate

There were a number of significant financial challenges and pressures on the provision of more integrated services, particularly in relation to providing services on a sustainable financial footing and remaining within budgets.

A combined budget for services which would become integrated was still to be agreed. A chief finance officer for the Partnership had yet to be appointed. Planning was underway for the use of the Integration Fund, including funding for additional care home beds.

In common with other partnerships, the Western Isles Partnership faced challenges from having separate IT systems. However, it had taken some actions to address this, including expanding the number of staff from each organisation with access to each other's systems. It was also considering a joint tendering exercise for a client/patient recording system. It was keen to look at initiatives, such as the use of digital pens to improve efficiency and communication for community nursing staff.

Historically, there had been difficulties in partnership working at the highest level between NHS Western Isles and the Comhairle. Senior managers said this was no longer the case and we saw some limited evidence to support this. Staff and third sector organisations retained some scepticism about this.

The length of time it had taken before agreement was reached on the model for health and social care integration and then with the subsequent appointment of a Chief Officer meant considerable detailed preparatory work was going to have to be completed in a relatively short timescale.

8.1 Management of resources

Current joint financial management
The Directors of Finance for both organisations met on a monthly basis and submitted joint quarterly reports on health and social work service spend to the Health and Social Care Committee. The total combined 2014/15 budget for the Community Health and Social Care Partnership was £46.7 million. There was an overall year end overspend of £0.7 million (1.6%) for these services.

Historically there has been no alignment of budget setting and reporting arrangements. At the time of our inspection, a combined forward looking budget for 2015/16 was not available. The Comhairle's 2015/16 integrated services budget was £18 million representing a 0.2% reduction compared to 2014/15. As at March 2015 the Health Board estimated that a budget of £25.2 million would be within the scope of the Integration Joint Board (IJB). However, this figure was still to be finalised. This

represented a £3.4 million (12.0%) reduction from 2014/15 budget for these health related services. This set the estimated combined budget at £43.2 million representing a total reduction of £3.5 million (7.5%) against the 2014/15 Community Health and Social Care Partnership joint budget. It was not clear how this estimated budget reduction would be achieved.

Financial Performance of Western Isles Council
In April 2015 the Comhairle reviewed its long-term funding requirements. This identified a growing funding gap of between £7.2 million and 10.6 million between 2016/17 to 2017/18. This gap was projected to be £4.1 million in 2016/17, the first full year of operation for the IJB. The Comhairle had decided to utilise reserves to address part of this gap. However, this still required significant savings to be achieved year on year across the council's services.

Per the 2014/15 unaudited accounts, the Comhairle had made a surplus against the provision of services of £2.7 million and held reserves of £76.8 million of which £22 million were classed as being usable There were no plans to assign any of these reserves to the new IJB .

The 2014/15 budget for the social and community services that were to be integrated into the new IJB was £18.1 million. There was an overall year end overspend of £1million (5.5%) for these services. The main areas that contributed to this overspend were home care (£0.4 million (8.8%) overspend), adult and support services (£0.2 million (8.1%) overspend) and assessment and care management (£0.1 million (10.2%) overspend). The main pressures on these areas included the growth in number and complexity of service users, additional staffing costs (including increased agency costs), the impact of SDS and the travel costs associated with working in remote areas.

The Comhairle's overall saving target for 2015/16 was set at £2 million, of which Social and Community Services were required to contribute £0.9 million. £0.6 million of this was expected to come from re-allocating change fund monies (£0.2 million), increasing income from care homes (£0.2 million), sickness/absence management (£0.1 million) and the introduction of community meals (£0.1 million).

Longer term savings target proposals were to be considered by members in September 2015. Additional consultation on the require savings was planned between the council and NHS board. It was anticipated that significant savings would be required to be achieved year on year across the council's services.

Financial performance of NHS Western Isles
In the Health Board's 2015/16 Local Delivery Plan the board set out how they would deliver transformational change. In order to achieve a break even position for 2015/16 to 2017/18, the plan identified the need for total efficiency savings of £7.2 million. A savings target of £2.6 million was set for 2016/17 and it was expected that a savings target of 3% would be set for the services being included within the IJB. With the integration of services with the Comhairle, the board was likely to have reduced flexibility to achieve future savings across the organisation.

The board was required to meet various financial targets set by the Scottish Government, including remaining within its revenue budget and achieved a break even position. For 2014/15 this was achieved. The savings target of £2.1 million had also been achieved.

This 2014/15 year end position included a £0.2 million underspend from the services expected to be included within the new IJB. While overall there was an underspend within these services, there were a number of areas of overspend. These included out of hours (£0.1 million (12.4%) of £1.0 million budget) and mental health nursing (£0.1 million (6.8%) of £1.8 million budget).

Financial Outlook
Due to the financial pressures of the existing economic environment for public sector bodies most councils and NHS boards had been experiencing challenges in delivering their services. The demand for older people services in the Western Isles would increase with the demographic shift to an aging population. As a result, the longer-term financial plans of both the council and the board remained at risk of not being affordable.

We concluded that this presented a significant challenge for the future. To ensure that older people receive the services required in the future, it was important that budget overspends were resolved. Affordable financial plans are essential for ensuring that the IJB is placed in a sustainable financial position going forward.

Partnership
The council and health board set up a Joint Planning Group to help support engagement between the council and health board on leadership, strategic direction and management relation related issues. One of the key objectives of the Joint Planning Group was to ensure the best use of resources and it was given the responsibility for preparing the three year strategic plan. The group involved both directors of finances when required and was accountable to the Health and Social Care Committee.

As at June 2015, a chief financial officer had yet to be appointed. The postholder would be responsible for developing the financial regulations and ensuring that appropriate systems and processes were in place to effectively manage resources. It was important that an appointment was made timeously to this position to allow sufficient time an integrated budget to be set and supporting financial regulations to be put in place within the required timescales.

Change Fund
From 2011/12 the Scottish Government had provided funding to Partnerships to assist the move to more community-based care through the Change Fund. The government expected the Change Fund to be used as ‘bridging finance’ to enable the redesign of services and facilitate achievement of national policy. It was also expected that the use of the fund should influence decisions on the nature of Partnership spending with a significant shift to anticipatory and preventative approaches in order to achieve and sustain better outcomes for adult care including older people.

By 31 March 2015, the Western Isles Partnership had received £2.5 million in funding. The funding contributed to a number of work streams. These included: reablement; modernising community nursing; mental health modernisation; future of caring at home career pathway; community equipment; and patient held records. The spend against this fund was monitored by the Health and Social Care Committee. However, this had last been monitored at committee level in April 2014. The Change Fund ended in April 2015 and all change fund projects were either mainstreamed or discontinued. Continued funding was provided for dementia link nurse, community equipment store and some third sector transport.

The Scottish Government had provided additional resources to Partnerships to support investment in integrated services in the form of an Integrated Care Fund. This fund was not restricted to older people, but extended to include support for all adults with long-term conditions.

For 2015/16, £0.6 million was available to the Western Isles Partnership. Agreement had been reached to use this funding for an additional 12 care home respite beds to alleviate the pressures arising from delayed discharge. We concluded that it was important that a plan was produced as a matter of priority setting out how these funds would be used for each of the three years and also that this was jointly monitored on a regular basis.

Recommendation for improvement 10

The Western Isles Partnership should jointly produce and monitor a forward looking combined budget for the services that will become integrated to ensure that the financial monitoring arrangements are bedded in preparation for the IJB going live. A plan should also be produced for how the Integrated Care Fund will be used for each of the three years of the funds life and this should be jointly monitored on a regular basis.

8.2 Information systems

Sharing data across health and social care systems is a challenge. We found this to be the case in the Western Isles. There were issues with access to information technology in some of the more remote and rural areas. For example, healthcare staff had to print out written notes and pass them to social work colleagues who then inputted the information onto the CareFirst system.

In our staff survey, 32% of staff agreed or strongly agreed that information systems supported frontline staff to communicate effectively with partners, and 47% disagreed or strongly disagreed with this statement. Many staff spoke of the difficulties they faced resulting from the incompatibility of electronic systems. These included information having to be repeated numerous times and the danger of important information not being shared. They also said there could be considerable duplication of work.

The Partnership had taken a number of actions to facilitate joint working. It had adopted the Scottish Accord for the Sharing of Personal Information (SASPI)[19] and had developed and agreed an information sharing protocol. This defined the information which could be shared between the Comhairle and NHS Western Isles. Managers told us they were taking forward plans to jointly tender for an integrated information technology system. This was, in part, based the 'AYRshare' model[20] which had been developed jointly by NHS Ayrshire & Arran with its three local authority partners.

Some action had already been taken as part of the CareFirst action plan to extend access to parts of the system to more NHS staff. During our focus groups, staff told us that further moves in this direction would be a positive step in managing shared data. They said the use of an integrated information technology system would enable single shared assessments to be more 'live' documents, and should release more time to care. GPs told us their systems were accessible to community nursing staff. Treatment notes could be left by a GP visiting an older person at home and viewed by the nurses.

Telecare and video consultations can have a valuable part to play in remote and rural locations. However, as indicated in Chapter 2, sometimes this was undermined by technical problems in the more remote and rural areas.

Community nursing staff and care at home staff had shared communication notes. These were available to be read and added to by any professional delivering care to an older person in their home. Relatives and carers could also contribute to these notes as well as the older person individual receiving care. The use of Call Confirm Live, a system to manage the work schedules and deployment of care at home staff, was having a significant impact in ensuring the most effective use of that large workforce.

Community nursing staff were using a digital pen system. This enabled them to immediately write up their notes and then have this information downloaded to their office base. The use of digital pens was noted to have released more time for care and was being rolled out to other staff groups. The only downside to this approach was that the legibility of the notes was still dependent on the quality of the handwriting.

The joint performance and monitoring group had been involved in a number of data cleansing and inputting exercises. This had included CareFirst care at home data with further work planned on telecare, residential and day care services. The absence of an information system for community nursing was making aligning information about older people receiving care at home services challenging.

[19] SASPI: a two-tier data sharing framework based on the well-established national Welsh model. The SASPI offers a mechanism for Scottish agencies to transition from multiple and diverse regional agreements to a single consistent, clear and accessible national framework.
[20] http://www.nhsaaa.net/media/186042/280313ayrshare.pdf

8.3 Partnership arrangements

Compliance with integration delivery principles[21]
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.

An integration scheme was agreed between NHS Western Isles and the Comhairle and submitted to the Scottish Government in March 2015. Feedback was received from the Scottish Government covering a number of technical points and a revised integration scheme was submitted to the Cabinet Secretary and approved in June 2015. Parliamentary approval was expected to be given by the end of July 2015. We say more about this in Chapter 9. However, the relative lateness in this process was, in part, of a consequence of a lack of agreement between NHS Western Isles and the Comhairle on an integration model. In December 2013 NHS Western Isles confirmed a 'lead agency' model as its favoured model (with NHS Western Isles as the lead agency) while the Comhairle wanted to opt for a 'body corporate' model22. We read documentation provided by the Comhairle which showed that it had considered the possible integration models and its rationale for choosing the body corporate model. Agreement on the body corporate model was not reached until August 2014.

An appointment had been made to the post of chief officer with the postholder taking up post in July 2015. Much of the work to take forward and conclude the planning and development for integration had been deferred until the chief officer was in post. Senior managers confirmed and acknowledged that the Partnership had considerable work to conclude and this needed to be progressed quickly now that the chief officer had been appointed.

Some structures had been or were being put in place to support partnership working. Key among these was the shadow Integration Joint Board (IJB) which was to have its initial meeting in autumn 2015. Agreement had been reached that NHS Western Isles and the Comhairle would each have four voting members on the board. Other members of the board would include the chief officer, the chief social work officer, the chief finance officer and a registered medical practitioner. At its initial meeting, the shadow IJB would consider how other key stakeholders such as third sector bodies, service users and carers would be involved.

In its position statement, the Partnership stated that the appointment of the most senior elected members and NHS board members to the Integration Joint Board was

[21] 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.
[22] Body Corporate: The delegation of functions and resources by NHS boards and local authorities to a body corporate. This would be managed by an integration joint board with an appointed chief officer who would be jointly accountable to both chief executives.

a reflection of the Partnership's commitment to the integration agenda. This would positively impact on 'cultural change' through both partner organisations. As the Integration Joint Board had not yet met, we were unable to assess its operational effectiveness and its impact.

The Joint Planning Group (JPG) had been set up to provide a mechanism to support engagement between the Comhairle and NHS Western Isles on leadership, strategic direction and management. It reported to the Health and Social Care Committee. The group met every two weeks and was co-chaired by the Partnership's chief executives. The work of the group was being taken forward through four workstreams, namely; corporate governance; clinical and care governance; workforce; and performance management.

We read the terms of reference for the workstreams, attended one meeting of the Joint Planning Group and one session of the joint performance and management group. This was in the process of aligning and agreeing outcome measurement arrangements for health and social care integration where we were provided with documentation on the work dome to map national and local indicators. However, we were provided with little other documentation to show how these workstreams were progressing. The workstreams on workforce and clinical and care governance, in particular, still appeared to be at an early stage.

We saw more evidence of joint approaches and partnership working around some specific service development initiatives. These included:

- the residential care home review
- the Erisort ward
- the 12 new care home beds
- the St Brendan's Hub, and
- Scottish mainland placements.

These other areas of work were being taken forward on a day-to-day basis by the various heads of service and service managers. We could see that staff at these levels were working closely together to improve services and to try and overcome some of the significant challenges facing the Partnership.

We found there was a greater history of joint working between the two organisation's finance teams than the human resources teams. In planning for integration, the human resources teams had only recently held a preparatory meeting to share some thoughts on culture, values and leadership.

We met with the Hebridean Housing Partnership and the Comhairle's housing services. In 2006, the Comhairle's housing stock was transferred to the Hebridean Housing Partnership in 2006. However, the Comhairle retained responsibility in terms of planning. Both services said that, historically, the Partnership had not really involved and engaged them in its future planning for services for older people. While we saw that the Joint Commissioning Strategy for services for older people included recognition of the key role of housing in supporting older people, it did not include a housing statement. Both services said the invitation from the Partnership to be involved in the Joint Commissioning Strategy had been received too late to allow the inclusion of a housing statement.

Third sector staff told us they had not felt properly or fully included in broader service planning activity or in the integration process. They said they had difficulty managing future planning or capacity building when funding was provided on an annual basis. We were told that they did not feel they were consulted on decisions made which involved posts, such as the decision to discontinue the funding for the dementia link nurses posts which they had supported. They said that on the ground health and social care staff worked very well together, but this seemed less the case 'the higher up the chain you went'. They did not consider there was a joint strategic approach to integration. A number of third sector representatives we met said that they did not think the Partnership valued them as real and equal partners. They hoped was that with the new appointment of the chief officer this would improve.

Based on our discussions with senior managers, elected members and board members, we concluded that the Partnership was more confident in the strength of its working relationships with third sector partners than was reflected to us when we met with third sector representatives ourselves. We concluded that the Partnership needed to invest strongly in its relationship with third sector partners and with local communities in order to relieve some of the pressures on statutory agencies and to make the most of opportunities for co-production.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Weak

The Partnership had a clear high level vision for older people which was consistent with the reshaping care for older people agenda. However this was not supported by a detailed plan on how this vision would be taken forward and implemented. This was highlighted in our staff survey which reflected a lack of awareness amongst staff about the service development agenda. The Partnership needed to move quickly to develop its detailed plans for older people as part of its strategic plan for integration.

Historically there had been difficulties in aspects of partnership working between NHS Western Isles and the Comhairle. We could see that these had meant that the organisations had not worked together effectively to develop a range of community services to support older people. They were now facing the consequences of this in high numbers of delayed discharges.

Senior managers, elected members and board members said these difficulties were now in the past. Most staff, third sector partners and other stakeholders we met were sceptical about this.

Initially the NHS and the Comhairle had favoured different models for health and social care integration. They had only agreed on the body corporate model relatively late in the day and this had impacted on the timescale for appointing a chief officer. We also saw this was reflected in the four main workstreams in preparation for health and social care integration which would require a considerable amount of work to be concluded in a short timescale.

Both organisations made good efforts to communicate with staff using newsletters and other means. Staff were generally positive about their line managers and middle managers, but they questioned the visibility of the most senior managers. This was particularly true of staff in the Southern Isles.

The Partnership was working on a number of important service development and redesign initiatives, but for most of these it would still be a significant amount of time before the potential benefits would be experienced by older people and their carers.

9.1 Vision, values and culture across the Partnership

The overarching vision for the Western Isles Partnership was expressed in the Single Outcome Agreement (SOA) 2013–2023. This said that: ‘Our vision for the Outer Hebrides is a prosperous, well-educated and healthy community enjoying a

good quality of life and fully realising the benefits of our natural environment and cultural traditions.'

The SOA included a good level of information about older people. It reflected the Partnership's awareness of having to meet the needs of older people in a complex and challenging geographic environment. In addition the Western Isles was projected to have the highest elderly percentage (34%) of older people in Scotland by 2037. As well as highlighting the needs of the growing elderly population, the SOA also positively highlighted the valuable contribution that older people make to their local communities. One of the local priorities contained within the SOA was to ensure that 'Older people positively contribute to our economy and communities, and access appropriate and quality services to enable them to retain their independence.'

The Partnership's vision for integration was 'to improve the wellbeing of people in the Western Isles and to work together to better support those who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time.'

The Partnership said it was also committed to continuing to work to promote independent living to develop further the provision of preventative and anticipatory approaches.

From our staff survey and from our focus group activity it was clear that staff and managers from across the Partnership had a shared view of this higher level vision and a commitment to working hard to provide good outcomes from older people. We also saw some evidence of this from the elected members and board members we met and when we attended the Health and Social Care Committee.

However, what was much less evident was a more detailed understanding of how these higher level aims aspirations and objectives were to be delivered. This was reflected in our staff survey where we found that:

- 35% of respondents agreed or strongly agreed that there was a clear vision for older people's services with a shared understanding of the priorities. 32% disagreed or strongly disagreed and 33% indicated that they didn't know

- 25% of respondents agreed or strongly agreed that there are effective Partnerships which focus on delivering key policies and plans for older people and include relevant stakeholders. 14% disagreed or strongly disagreed and 61% indicated that they didn't know.

For both of these survey questions, the results were significantly below (at more than 10 percentage points) other inspections to date.

We considered it likely that these findings were also a reflection of where the Partnership was in terms of its more detailed strategic plan. For example some important strategies such as a dementia strategy and the carers' strategy were either still to be completed or out of date. A Joint Commissioning Strategy for 2013–2023 had been completed. Whilst this contained a clear and positive general direction of travel in terms of reshaping care for older people towards more community-based

care and support, it lacked detail of how this was to be achieved. Also whilst some service development and redesign initiatives were being taken forward, these were being progressed on an individual basis, rather than part as a well-developed Joint Commissioning Plan.

It had also taken the Partnership some considerable time to decide on its model (a Body Corporate model) for health and social care integration. The Partnership also did not appoint a chief officer for the new Partnership until June 2015. Both these factors meant that the Partnership had only made limited progress in completing its detailed strategic plan for health and social care integration.

Recommendation 11

The Western Isles Partnership should ensure that its strategic plan for health and social integration provides detailed and measurable actions of how its higher level visions and objectives for older people will be delivered.

We commented in the Chapter 8 on what had been in some respects a troubled history of Partnership working at the most senior strategic level between the Comhairle and the Western Isles NHS. However, the most senior managers, elected members and board members told us that this was now a thing of the past. They said that whilst there could still be differences of opinion and disagreements, actual working relationships were now generally positive. We saw some confirmation of this at the Health and Social Care Committee and the Joint Planning Group where members of these groups indicated to us that joint working was becoming more embedded in the move towards integration. A number of staff and less senior managers we met expressed reservations about how well elected members, board members and senior managers were working together in collaboration. We concluded that members and senior managers had more to do to convince staff and other stakeholders of their commitment to Partnership working and integration.

We had numerous opportunities to meet with mixed groups of staff from front line to heads of service level and saw that they were used to working together and were comfortable in doing so. In our staff survey, we asked a number of questions which related to joint working and culture and the findings of these were positive and compared favourably to findings from other inspections to date. For example:

- 79% of respondents agreed or strongly agreed that they feel valued by their managers. 30% disagreed or strongly disagreed with this statement

- 75% of respondents agreed or strongly agreed that there are positive working relationships between practitioners at all levels. 17% disagreed/strongly disagreed

- 60% of respondents agreed or strongly agree that high standards of professionalism are promoted and supported by all professional leaders, elected members and board members. 10% disagreed or strongly disagreed with this statement.

9.2 Leadership of strategy and direction

The Community Health and Social Care Partnership (CHaSCP) had been the key partnership in health and social care. It was established in June 2007 and had a scheme of establishment which was a well written and substantial document which detailed the scope and implications of closer partnership working. However, a report published by Audit Scotland[23] in June 2011 contained some criticism of the Partnership – considering it not to have developed a clear role, and to have made insufficient progress in facilitating better joined-up health and social care services.

The Care Inspectorate's most recent report[24] of Comhairle nan Eilean Siar's social work services was published in February 2012 and included a focus on Partnership working. It found that the CHaSCP was some distance away from providing a fully functional health and social care management structure. It said that managers had agreed that the potential of the CHaSCP had yet to be realised.

During our inspection, we heard numerous references to these difficulties in partnership working, although there was little sense of what had caused them other than reference to the problems as having been at the most senior strategic level and to personality clashes. There was a general acknowledgement that a lack of positive partnership working in the past had been a key factor in the lack of development in the Western Isles of the range of sustainable community-based services required to successfully reshape care for older people. It was not the remit of our inspection to revisit this historical context. What we noted was that senior managers in the Partnership expressed a greater degree of confidence in the present state of joint working relationships than most of the staff groups we met.

We saw that some more integrated structural arrangements had been put in place. The two main developments were some changes to the remit of the Health and Social Care Committee and the establishment of the Joint Planning Group.

The membership of the Health and Social Care Committee had been reviewed and it now consisted of elected members from the Comhairle, non-executive and executive members and officers of the NHS Western Isles and Third Sector partners. The Committee had provided the forum for Partnership discussions on the implementation of the Public Bodied (Scotland) Act 2013 and for working through the various governance issues to submit the Integration Scheme to the Scottish Government. As well as attending a scheduled meeting on the committee, we also read the minutes of previous meetings. These indicated that historically the majority of reports presented to the committee came from the Comhairle. However, from more recent reports we could see that a good level of information was provided to committee members on the progress of key service developments. Health and social care integration, joint finance reports and performance management reporting were being dealt with as standing items. At the meeting we attended, we saw a joint sense of ownership and responsibility for addressing the key operational, financial and strategic challenges facing the Partnership. A number of Comhairle and NHS staff

[23] Review of Community Health Partnerships, June 2011. www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf

[24] Comhairle nan Eilean Siar Scrutiny Report. Publication code: OPS-0212-118, February 2012

told us that the committee was now a much more co-operative and joint venture than it had been in the past.

Prior to April 2014, the Health and Social Care Committee had been supported by a Joint Liaison Planning Group which had been established as a key joint forum for health and social care planning. In April 2014, the Health and Social Care Committee approved a revised terms of reference resulting in the establishment of The Joint Planning Group (JPG) which had a strengthened role and remit as a Partnership and joint venture in preparing for health and social care integration. Since then the JPG had met fortnightly and was co-chaired by the chief executives from the Comhairle and NHS Western Isles. It included the following key objectives.

- To encapsulate the principles of integration to achieve better outcomes for people who use services and for their carers.
- To ensure best use of resources with decisions on their deployment which are transparent and in response to shared priorities such as national outcomes, targets and guarantees.
- To provide a strategic planning mechanism for integration and joint working arrangements.
- To form a management structure, that produces an implementation plan in line with the Public Bodies (Joint Working) (Scotland) Bill.
- To develop performance management in line with the national outcomes for integration. Benchmark, review and learn as an ongoing process to constantly improve quality.

The JPG also had delegated responsibility to coordinate the implementation of the Integration Scheme through four workstreams, namely: Corporate Governance; Clinical and Care Governance; Workforce and Performance Management.

We were satisfied that the revised arrangements for the Health and Social Care Committee should provide a solid basis from which the Partnership's higher level vision and objectives could be taken forward. However, we were provided with little information which could confirm the actual effectiveness of the JPG and we had reservations about whether the Partnership had sufficient capacity to invest in strategic and service development. A number of key developments and initiatives had stalled or been subject to delays.

Previous inspection reports had highlighted the challenges faced by the Partnership in developing policies and plans due to its size. Unlike many larger Partnership areas, it had few staff with a specific remit for policy development. This meant that managers had to try and carry out this work alongside their day-to-day operational responsibilities. This remained a challenge, but some senior managers we met expressed optimism that the move into the new health and social care Partnership would allow more staff capacity to be invested in policy planning and development activity. A positive illustration of this, albeit on a relatively small scale, was the decision by the Partnership to continue the Change Fund investment in a data analyst post.

The Partnership had left it relatively late in agreeing its integration model, appointing its Chief Officer and submitting its integration scheme for approval. The Partnership

said this meant that they had been able to learn from the experiences of other Partnerships. However, whilst this may well have been the case, we concluded that the Partnership had not helped itself by leaving these matters so late, and especially the first two. It meant that the Partnership had only been able to proceed so far with some important strategic planning and leadership activity, including the completion of its strategic plan for integration.

The position statement provided by the Partnership included some brief descriptions about the proposals for Integration Joint Board and the roles of the Health and Social Care Committee and the Joint Planning Group. However, that aside the statement said very little about how the strategic direction was actually being led and the supporting documentation was very limited. As stated in Chapter 6, work was still required to convert the Joint Commissioning Strategy into an effective commissioning plan. The staff and managers involved were working hard to address this, but we could see from a July 2015 progress report that whilst this detailed the outcomes to be delivered and some information about the progress to date in taking these forward, the focus was much more on statements of intent and action still required than on actions which had been successfully delivered.

The Comhairle together with Orkney and Shetland Islands councils was taking forward the Our Islands Our Future campaign. This campaign sought to engage positively with both the Scottish and United Kingdom Governments to ensure that the needs of the three Scottish island areas were adequately taken in to account, acknowledged and recognised going forward. The overarching objective of the campaign was to secure the best possible outcome for the three islands through lobbying activity.

We read documentation provided by the Partnership about the campaign and could see that the various priority areas identified, such as energy and fuel poverty and digital connectivity, were relevant to older people as well as the population as a whole. However, there were few specific references to the needs of older people on the documentation which we saw. It was anticipated that the Scottish Government would come forward with an Islands Bill at some point in 2016 or soon after.

A number of staff and third sector representatives we met said an area like the Western isles should be ripe for effective partnership working. However, they said that rather than focusing on potential there was a tendency within the Partnership to concentrate on potential problems and barriers.

9.3 Leadership of people across the Partnership

Frontline health and social staff care we met at focus groups spoke positively about the support and leadership from first line managers. In the main this view was replicated up through the structures up to and including to head of service or equivalent level. Staff were more circumspect about leadership beyond this point. It was not that we heard critical comments about individual senior managers it was more that staff considered that there was a lack of visibility of the most senior managers. Staff seemed uncertain about how at the senior strategic level operational and strategic priorities were being established. This uncertainty was partly in respect of what was happening within NHS Western Isles and the Comhairle, but more

strongly about what collective senior leadership activity was taking place. As with other matters this sense of disconnection was more evident the further away staff were from Stornoway.

We could see that Both NHS Western Isles and the Comhairle had given consideration and attention to communication with staff both on an ongoing basis, but also specifically on health and social care integration. Team meetings, team briefings and cascaded e-mails were all used. The Comhairle had a staff newsletter. *E-Cengal*. NHS Western Isles had a well-established newsletter called *Slainte*. This had been nominated for a number of awards and won the Professional Publisher's Association's Scottish internal magazine of the year award in 2013. The Chief Executive of the NHS held open staff meetings in different locations across the Western Isles. The agenda for these meetings included integration. The Comhairle had arranged for Social Work Scotland[25] to provide staff with an opportunity to discuss the implications of integration on social work practice.

Providing good communication to staff with the right amount of information and in appropriate ways is a challenge for Partnerships. Most staff we met acknowledged that the Partnership put efforts in to communicating with them. However, we heard some mixed views about the quality and effectiveness of this communication. Some staff said the communication felt about right, others that there was too much communication and others that there was not enough. Front line staff in particular tended to say that they had received little information about health and social care integration. Front line social work staff we met in talking about resourcing challenges they faced in providing care packages said they would like the Comhairle to be more upfront about these challenges in its communication with the media.

Recommendation for improvement 12

The Western Isles Partnership, as it moves into the new integrated partnership, should review how it communicates with its staff and with the wider community.

In our staff survey, 56% of respondents agreed or strongly agreed that senior managers communicate well with front line staff whilst 38% disagreed or strongly disagreed. The levels of agreement were higher amongst health staff who responded.

The work to develop a joint commissioning plan was a key focus of the Partnership's strategic agenda. The action plan to take this forward included the need for a communication strategy to increase awareness of what was planned and being done. This was not yet in place. Senior managers acknowledged the need for this to be done quickly. We agreed that this was a priority given the vacuum which staff perceived around senior leadership.

The Chief Social Work Officer (CSWO) had a responsibility for the provision of leadership to promote professional social work practice. This important role was

[25] Social Work Scotland: A membership organisation which represents social workers and other professionals who lead and support social work across all sectors.

undertaken by the Director of Community Services. Comments made by staff and managers indicated that he was seen as being approachable and supportive in this role. However, as part of revised management structure arrangements, he moved to a senior management position within the Education and Children's Services Department in June 2015 and he was due to retire in March 2016. The Comhairle aimed to have a new CSWO in place prior to this to facilitate a smooth transition. In the meantime some additional training had been provided to some existing managers with a professional social worker qualification so that they could provide cover for this role when the CSWO was on leave. The Partnership and in particular the Comhairle needed to give careful consideration to how the new CSWO was best placed to effectively fulfil this role in respect of professional social work leadership and practice within the new Health and Social Care Partnership.

NHS Western Isles had recently reviewed and re-organised its clinical governance system. There was now a Board Healthcare Governance Committee and within the organisational structure the single operating division oversaw the clinical governance activities. These were delegated to a clinical governance committee (operational across acute, primary care and mental health) and a learning review group. Part of the learning review group's function was to gather information and identify thematic learning. The NHS Western Isles used the Care Aims framework for clinical decision making based on identified duty of care and risk. Care Aims training had been facilitated by the Speech and Language Therapy Department (SALT) and training had also been offered to all AHP staff, learning support staff and community nursing staff. The aim was to support clinicians to examine the impact of their interventions and to reflect on the outcomes.

In our staff survey, 60% of respondents agreed or strongly agreed that high standards of professionalism are supported by professional leaders, elected members and board members. Only 10% disagreed or disagreed strongly. The levels of agreement were broadly in line with other inspections to date, whereas the levels of disagreement were significantly less which was encouraging.

9.4 Leadership of change and improvement

As indicated in Chapter 6, staff, managers, elected members and board members expressed a strong commitment to improving services and outcomes for older people. The roles of self-evaluation and performance management in achieving this were recognised. Audit Scotland's follow-up report in May 2014 of its audit of best value and community planning found that the Comhairle has consolidated earlier progress in developing performance management, reporting and self-evaluation. The Care Inspectorate's performance inspection of the Comhairle's social work services in 2012 had more mixed findings in respect of self-evaluation within Social and Community Services. In the position statement, the partnership was able to point towards some positive performance and improvements as part of its 2014 annual review with the Scottish Government. Whilst some of the highlighted performance was not exclusive to older people, they would have featured heavily in the improved performance in areas such as stroke and cancer care.

We saw that a number of service and strategic improvement initiatives had either been completed were in train or were being planned. The review of the Mobile

Overnight Support Service, the extension of the Out of Hours Service to include Community Unscheduled Care Nursing Staff and the introduction of the community meals service were all examples of improvements which had been made. These were all important and positive, but of a relatively small scale.

In contrast, the redesign of the care at home service whilst still under way and being implemented on a staged basis was on a much larger scale. We were impressed with the careful planning and the strategic approach which was being taken to the redesign which had the potential to have a significant impact in addressing some of the key challenges being faced by the Partnership, particularly the timeous discharge of older people from hospital.

A number of other key developments, such as the St Brendan's Hub, the Erisort Intermediate Care Initiative and the Residential Care Review which had either already been or were now the subject of considerable planning activity were all still some way of being able to achieve their desired outcomes.

Overall we saw that the Partnership through its Joint Commissioning Strategy (JCS) and as part of the Single Outcome Agreement had a fairly strong and clear vision for older people. However, whilst these provided a positive and useful overarching vision and framework for older people, they lacked a detailed implementation plan. This needed to be done as a priority both as part of moving the JCS into a Joint Commissioning Plan and as part of the completion of the strategic plan for health and social care integration.

In the absence of such detailed plans, it meant that the Partnership's overall approach to its improvement activity for older people remained rather reactive and piece meal in nature. It also meant that the overall vision was less clear to some staff and that there were some significant differences between the positive vision and reality of the actual service provision on the ground. It was also reflected in our staff survey where staff views about how well change was managed and the extent of overall service improvement were mixed with staff fairly evenly split in their views. For instance:

- 43% of respondents agreed or strongly agreed that changes which affect services were managed well, whilst 38% disagreed or strongly disagreed with this statement
- 24% agreed or strongly agreed that the quality of services offered to older people had improved over the last year whilst 31% disagreed or strongly disagreed.

The lack of a positive and effective approach to partnership working in the past meant that the Partnership faced a number of outstanding and significant challenges. In short it had not taken the planned and structured action needed to develop the range of alternative community-based services to allow it to effectively shift the balance of care on a sustainable basis. Whilst the number of hospital beds had reduced, alternative community provision had not been developed. Staff and managers we met were investing considerable hope that the newly appointed chief officer would be able help lead and steer the Partnership through its difficulties. We heard comments from staff that the reality of health and social integration had necessitated a greater willingness for NHS Western Isles and the Comhairle to work

more closely together than has been the case in the past. Senior managers spoke about some tangible improvements in joint working at the most senior level. We concluded this would need to be continued if the improvements hoped for were to be implemented and embedded into long term planning and resource allocation. This was not only dependent on the success of health and social care integration; it also required the Partnership to deliver on the real engagement with and participation of the third sector and local communities.

Quality indicator 10 – Capacity for improvement

Summary

The Partnership faced some very significant challenges which could have an adverse impact on the outcomes for and experience of older people and their carers. The fact that our inspection found some important weaknesses in outcomes for older people, in self-evaluation for improvement and in leadership raises concerns about the Partnership's capacity for improvement.

Whilst some service redesign work had been completed, the majority of the major service improvement and redesign activity was still very much work in progress and for a number of these developments it would be some time before the expected benefits would be in place for older people.

The Partnership had a clear high level vision of what it wanted to offer and achieve for older people. However, it had work to do to complete a detailed plan on how to deliver this. Frontline staff considered themselves to well-supported by their more immediate managers. Senior managers worked hard to communicate with staff; however many staff we met questioned their visibility.

There had been some historical difficulties around partnership working between NHS Western Isles and the Comhairle at the most senior level. In addition the Partnership had left it relatively late before agreeing on its model for integration. It had considerable work to do in order to complete its strategic plan for integration.

The Partnership demonstrated a generally good level of awareness of the challenges it faced. It was aware of the need for it to make a success of health and social integration. Some optimism was expressed that the appointment of the chief officer would help increase the chances of this happening. We concluded that it would also require the chief officer to be supported by the efforts of all key stakeholders.

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

National performance data suggested the Western Isles Partnership's performance was above the national average in a number of areas. These included the low level of emergency admissions to hospital, the amount of care at home provided, and the proportion of older people cared for at home rather than in care homes.

However, this data did not reflect some very serious areas of service pressures which were adversely impacting on outcomes for older people. These included a significant proportion of older people who were subject to delayed discharges from

hospital and older people having to wait, sometimes for significant lengths of time, to receive care at home support or to access a place in a care home. For some older people, the length of their delayed discharge from hospital meant that the opportunity for a successful return home was lost.

Self-directed support was being discussed with older people and the take up of this was increasing. However, a number of families and staff told us that self-directed support was not a real choice, but was an alternative to an older person having to wait for an uncertain length of time for a Comhairle care at home service.

In comparison with other Partnerships, there had been very limited development of reablement and intermediate care services. This meant very few older people had been able to benefit from these. Whilst, the Partnership had some plans and was taking some service development actions to improve outcomes for older people, it was going to be some time before older people and their carers would be able to benefit from most of these.

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

The Partnership had a Joint Commissioning Strategy. This provided a useful direction of travel, but needed to be converted into a detailed plan. This was required so that the NHS and the Comhairle could more effectively respond as a partnership to the presenting levels of need and the demographic pressures of an ageing population. The Partnership was aware of the need to move forward with planning and implementing service changes. A reflection of this was a joint agreement to commission additional care home beds as a means of both increasing care home capacity and of reducing delayed discharges from hospital.

Some operational restructuring and strategic planning was taking place. This included significant and important work around care at home, reablement, intermediate care, a review of residential care and the St Brendan's Hub development. Some of this work was at an early stage or was some way off fruition. These areas of work were being taken forward on a day-to-day basis by the various heads of service and service managers. We could see that staff at these levels were working closely together to improve services and to try and overcome some of the significant challenges facing the Partnership.

The Partnership acknowledged it needed to further develop its approaches to quality assurance and self-evaluation and some work was already under way to address this.

Effective leadership and management

The Partnership had a clear high level vision for older people which was consistent with the reshaping care for older people agenda. However, this was not supported by a detailed plan on how the vision would be taken forward and implemented. The Partnership needed to move quickly to develop its detailed plans for older people as part of its strategic plan.

Historically there had been difficulties in aspects of partnership working between NHS Western Isles and the Comhairle. We could see that these had meant that the organisations had not worked together effectively to develop a range of community services to support older people. They were now facing the consequences of this in high numbers of delayed discharges.

Senior managers, elected members and board members said these difficulties were now in the past. Most staff, third sector partners and other stakeholders we met expressed some scepticism about this.

Both organisations made good efforts to communicate with staff using newsletters and other means. Staff were generally positive about their line managers and middle managers, but they questioned the visibility of the most senior managers. This was particularly true of staff in the Southern Isles.

Preparedness for health and social care integration

An integration scheme had been agreed between NHS Western Isles and the Comhairle and submitted to the Scottish Government in March 2015 with Parliamentary approval expected to be given by the end of July 2015. The relative lateness in this process was, in part, a consequence of a lack of agreement between NHS Western Isles and the Comhairle on its integration model.

An appointment had been made to the post of chief officer with the postholder taking up post in July 2015. Much of the work to take forward and conclude the planning and development for integration had been deferred until the chief officer was in post. Senior managers confirmed and acknowledged that the Partnership had considerable work to conclude and this needed to be progressed quickly.

Some structures had been or were being put in place to support partnership working and integration. The shadow Integration Joint Board (IJB) was to have its initial meeting in autumn 2015. Agreement had been reached that NHS Western Isles and the Comhairle would each have four voting members on the board. The Health and Social Care Committee had been in place as a joint committee for a number of years, although comments that we heard and agendas which we saw indicated the majority of its business had been generated by the Comhairle. We saw some indications that this had started to change with the approach of health and social care integration.

The Joint Planning Group (JPG) was set up to provide a mechanism to support engagement between the Comhairle and NHS Western Isles on leadership, strategic direction and management. It reported to the Health and Social Care Committee. The group met every two weeks and was co-chaired by the Partnership's Chief Executives. It provided an important forum where senior managers could come together to discuss and take forward the service development agenda. The work of the group was also being taken forward through four workstreams for integration, at least some of which were still at an early stage.

Some stakeholder engagement had been taking place, but this was limited. The Partnership needed to develop its approach to its involvement of, and engagement

with, all stakeholders. Third sector staff told us they had not felt properly or fully included in broader service planning activity or in the integration process. A number of third sector representatives we met said that they did not think the Partnership valued them as real and equal partners. Partnership staff at practitioner level felt distanced from the integration agenda.

Many staff, managers and third sector representatives we met expressed both hope and some optimism that the appointment of the chief officer would help lead to improvements in a whole number of areas, including the successful implementation of health and social care integration. We concluded that for this improvement to be achieved and sustained, the chief officer would require the support of staff and managers at all levels and also of elected members and board members.

What happens next?

The Care Inspectorate and Healthcare Improvement Scotland will ask the Western Isles Partnership to publish an action plan detailing how it intends to make the necessary improvements identified as a result of this joint inspection.

Based on the findings of this inspection, we would want to revisit the partnership within one year of the publication of the report. This will be so the Care Inspectorate and Healthcare Improvement Scotland can assess and report on progress being made in meeting the areas for significant improvement set out in this report.

March 2016

Appendix 1

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<tr><th>What key outcomes have we achieved?</th><th>How well do we jointly meet the needs of our stakeholders through person-centred approaches?</th><th>How good is our joint delivery of services?</th><th>How good is our management of whole systems in partnership?</th><th>How good is our leadership?</th></tr>
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2.2 Prevention, early identification and intervention at the right time

2.3 Access to information about support options including self directed support</td><td rowspan="5">5.1 Access to support

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9.3 Leadership of people across the Partnership

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