care inspectorate

Healthcare Improvement Scotland

Services for older people in East Lothian

May 2016

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

HAPPY TO TRANSLATE

Services for older people in East Lothian
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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.

We can also provide this report:

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

Contents

About this inspection

In June till October 2015, The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services[1] for older people in East Lothian. The purpose of the joint inspection was to find out how well the health and social work services partnership delivered good personal outcomes for older people and their unpaid carers. We wanted to find out if health and social work services worked together effectively to deliver high quality services to older people, which enabled them to be independent, safe, as healthy as possible and have a good sense of wellbeing. We also wanted to find out what progress the East Lothian Health and Social Care Partnership had made with health and social care integration.

Our joint inspection involved meeting over 50 older people and carers who cared for older people, and around 200 staff from health and social work services, the third sector and the independent sector. We read 99 older people's health records and social work services records. Older people in our sample had between two and ten health records, all of which we scrutinised. We scrutinised around 700 health records. We also studied a lot of written information about the health and social work services partnership and services for older people and their carers in East Lothian. We are very grateful to all of the people who spoke with us during this inspection.

In East Lothian, social work services and most community health services were delivered by the health and social care partnership. Social work services for adults was called adult wellbeing, which comprised social work services for adults, (including older people) and criminal justice services.

Background

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

The Scottish Government expects NHS boards and local authorities to integrate health and social care services from April 2016. This policy aims to ensure the provision of seamless, consistent, efficient and high-quality services, which deliver very good outcomes[2] for individuals and unpaid carers. Local partnerships have to produce a joint commissioning strategy. We will scrutinise partnerships' progress with 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.

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

[2] The Scottish Government's overarching outcomes framework for health and care integration is centred on, improving health and well-being, independent living, positive experiences, improved quality of life and outcomes for individuals, 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.

East Lothian context

East Lothian has a population of 102,050 and covers 679 square kilometres, with a population density of 150 people per square kilometre. The population of East Lothian has increased by 11.3% since 2003, while overall Scotland's population has increased by 5.3%. In East Lothian, 60% of the population is of working age. This compares with a Scotland figure of 62%, while 22% of the population is over 65 (Scotland figure is 21%).

From the 2012-based population projections, the population of East Lothian is due to increase by 9% by 2022 and increase by 19% by 2032 (Note: both changes relate to the 2012 population). The equivalent Scotland figures are an increase of 4% by 2022 and an increase of 8% by 2032.

East Lothian's population of those of pensionable age is due to increase by 3% by 2022 and increase by 32% by 2032. The equivalent Scotland figures are an increase by 3% by 2022 and an increase by 20% by 2032.

The joint inspection of services for older people in the East Lothian area took place between June and November 2015. It covered the health and social work services in the area that had a role in providing services to benefit older people and their carers.

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 2). Our findings on the partnership's performance against the nine quality indicators are contained in nine separate sections of this report. The sub-headings in these sections cover the main areas we scrutinise. We used this methodology to determine how effectively health and social work services worked in partnership to deliver very good outcomes for older people and their unpaid carers. The inspections will also look at the role of the independent sector and the third sector[3] to deliver positive outcomes for older people and their unpaid carers.

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

[3] The Third Sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers (Scottish Government definition).
[4] Experienced professionals from seconded to joint inspection teams.
[5] Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to ensure that it engages with patients, carers and members of the public.

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 www.careinspectorate.com/
or
www.healthcareimprovementscotland.org/

Summary of our joint inspection findings

Outcomes for older people and their carers

Outcomes for older people and their carers were predominantly good. Almost all of the older people and carers we met, or whose records we read, confirmed this. We considered the East Lothian Service for Integrated Care of the Elderly (ELSIE) was a very promising and innovative initiative. ELSIE had had a positive impact on delayed discharges and unscheduled acute admission avoidance. These were areas that required continuous improvement, as too many older people had their discharge from hospital delayed. This could result in negative outcomes for them, such as loss of confidence and capacity for self-care, and having to remain in a setting, which was not best placed to meet their needs.

The discharge hub and the huddle were a success and a platform for effective integrated working. The care pathway to ELSIE needed to be clearly documented and disseminated.

The partnership had made a considerable investment in intermediate care (Crookston Step-Down Unit). This purpose-built, well-appointed facility was very popular with its service users. And it had reduced the number of older people whose discharge from hospital was delayed and the number of acute bed days lost to delayed discharge. The partnership recognised this unit needed to operate more efficiently by discharging service users to appropriate care when their rehabilitation was completed.

The partnership acknowledged it had significant problems with care at home capacity. This had caused negative outcomes for a number of older people, such as having to wait for the care at home service they needed. The partnership was striving to enhance its capacity to deliver care at home to older people.

We analysed anticipatory care plans for older people. The East Lothian Partnership was the first to give us access to anticipatory care plans for all of the individuals in our sample who had them. A high proportion of these plans consisted of just a list of the individuals' various medical conditions and the medicines prescribed for them. Whilst these plans did not fully comply with Scottish Government guidelines, they did comply with key aspects of the specification in the general medical services contract.

What did older people and their unpaid carers think

The partnership's approach to reshaping the design and delivery of care for older people had a clear focus on maintaining their independence, their good health, and wellbeing. The prevention of unnecessary unscheduled admission to hospital and timely hospital discharge for older people, were key priorities. Older people and carers we met were satisfied with the quality of support services they received and the desired personal outcomes these services delivered for them. The lack of capacity in care at home services meant that some older people had to wait for the deployment of care at home and, in a few instances, this led to their delayed discharge from hospital.

The partnership had commissioned a third sector organisation to increase support to carers. Carers wanted improved access to respite and day care services, to support them and the person they cared for. .

The partnership rightly acknowledged it needed to continue to improve the provision of support for older people following a diagnosis of dementia.

Impact on staff

Almost all respondents to our staff survey and staff we met enjoyed their work, and felt valued and recognised by managers and other professionals. They considered they were well supported to manage risk and had competent, effective, and supportive line management. The East Lothian Partnership had a committed and resilient workforce.
Most of the staff we met felt their service had excellent working relationships with other professionals. Frontline staff communicated well despite the challenges around electronic information sharing systems.

The majority of staff who responded to our staff survey, and those we met during our inspection, agreed they had good opportunities for training and development. Our evidence was congruent with the partnership's own staff surveys. For example, an NHS Lothian Report demonstrated how training had helped staff develop an enhanced understanding of their role. The partnership rightly acknowledged it needed to improve its change management, but had implemented a number of initiatives designed to address this.

Impact on community

The East Lothian Partnership was committed to community engagement and consultation. The partnership had successfully engaged with the public about strategy development and decisions about service change. We saw less evidence of communication of the outcome of consultation to stakeholders.

The partnership was developing the community's capacity to support its older citizens. The partnership supported a number of third sector organisations to provide invaluable support to older people and their carers. Older people and carers we met were highly complimentary about the timely and empathetic help and support they received from these bodies. The partnership effectively signposted older people and their carers to these community supports.

The partnership rightly acknowledged, as an area for improvement, its engagement with the third sector for the development of community capacity to support older people and their carers.

Getting a service and keeping safe

The East Lothian Council Contact Centre Access Team provided an effective single point of contact into the social work service for older people, their carers, and partner agencies.

Waiting times for some services for older people could be lengthy. For example, local authority occupational therapy assessments, and reviews of care and support. The partnership needed to strengthen its approach to managing waiting times and determining the impact of waiting times on older people.

A lack of care at home service capacity was a persistent challenge for the partnership. It had taken some action to address this.

The partnership was moving towards personalised approaches to assessment and care planning for older people. The implementation of self-directed support for older people was in its early stages, and was not as extensive as for other service user groups.

The partnership had established effective processes to identify and protect adults at risk of harm. The East and Midlothian Public Protection Team provided expert advice and promoted consistency of practice. A twice-weekly multi-agency meeting to screen referrals had a positive impact on sharing information as well as directing referrals to appropriate agencies when adult protection intervention was not required. We read the records for individuals at risk of harm, who were now safe and protected, as a result of highly effective collaborative work undertaken by the partnership's staff.

Plans and polices

The partnership's joint strategic plan had been subject to wide consultation and review that informed the future direction of older peoples and other services across the partnership. This plan clearly set out the case for change in East Lothian, and how the partnership aimed to work with stakeholders to deliver these changes to improve outcomes. The partnership's priority to deliver more care closer to home was clearly articulated within its plan. A revised communication and engagement strategy had led to improved engagement with key stakeholders.

The partnership's approach to strategic commissioning and the development of the strategic plan was based on a review of information from their joint strategic needs assessment and an imperative to move from a bed-based to a community-based service provision.

The partnership had successfully supported the development of a range of community-based early intervention and support services for older people and their carers. The third sector mainly delivered these services, which were user-friendly and much valued by older people and their carers.

The partnership had a cohesive range of quality assurance and improvement activities. Going forward, it needed to make sure that the health and social work service elements of the partnership carried out these activities in tandem.

There were many positive and productive examples of the partnership involving older people, their unpaid carers and other stakeholders in service planning, delivery and evaluation. However, a number of carers and other stakeholders we met did not feel consulted and included.

The partnership had made progress with the planning and execution of joint commissioning of health and social care services for older people and their carers. In common with many other partnerships in Scotland, we considered this was a critical area for continuous improvement.

Management and support of staff

The partnership had remodelled care in some areas such as medicine for the elderly, and was working constructively with care at home providers to ensure recruitment was more equitable across the sector.

Deployment of staff remained at a largely individual agency level although almost all staff we met during our inspection said there were good working relationships amongst practitioners. A clear majority of staff said managers gave them good support to explore development opportunities. The partnership should prioritise more joint training around self-directed support and dementia awareness.

There was extensive evidence of health and social work services staff working effectively together to deliver good outcomes for older people and their carers.

The partnership needed to step up its efforts to reduce staff absence with its consequential negative impact on the partnership's capacity to deliver services to older people and their carers.

Working together

The health and social care partnership had made good early progress with the instigation of a number of key financial systems for integration. East Lothian Council exercised sound financial management, in the face of the very significant challenges encountered by all local authorities in Scotland. East Lothian Council received a very positive audit report for 2014-15 from its external auditors.

In 2014-15 NHS Lothian achieved its substantial target for efficiency savings (£39.4m). At the time of our inspection, The NHS Board had a projected "worst case scenario" overspend for 2015-16 of £28m. This was a very significant concern, which had the potential to have a negative impact on the budget settlement for the East Lothian Integrated Joint Board. The NHS Board and its partners were working diligently to reduce the projected overspend. At March 2016, NHS Lothian was projected to break even for 2015-16, and this was confirmed at the board's finance and resources committee on 9, March, 2016.

The partnership had used the change fund purposefully to support shifting the balance of care for older people towards older people receiving their care, support and treatment at home and within their communities.

The partnership had made some progress with electronic information sharing between health staff and social work services staff. This progress needed to be consolidated and developed.

The health and social care partnership had a sound platform on which to develop. It needed to make swift progress creating integrated teams of health and social work services staff.

Leadership

The East Lothian health and social care partnership had a clear and compelling vision for the future integrated delivery of health and social care services to older people and their carers in East Lothian. This well-articulated vision had at its core the imperative that older people and their carers should lead healthy, safe, included, independent lives, and have a good sense of wellbeing. There were promising signs that at this early stage the partnership had good, well-informed governance and leadership from the integration joint board. Consultation and communication with its staff and the promotion of its vision was an area for continuous improvement.

The partnership was aware it needed to work harder to fully include older people and their carers in all of its planning activities. The vacancy for the head of adult wellbeing post had reduced the overall strategic leadership capacity of the partnership. The timely successful filling of this post would augment the partnership's leadership capacity to take forward its ambitious and challenging change and improvement plans.

Capacity for improvement

The East Lothian Health and Social Care Partnership delivered good outcomes for many older people. As a consequence of the partnership's efforts, many older people had enhanced wellbeing, and led healthier, included, independent, and fulfilled lives. The partnership needed to effect continuous improvement to minimise the numbers of older people who experienced poor outcomes, such as when their discharge from hospital was delayed or they had to wait for the deployment of care at home services. Support to unpaid carers and the roll-out of self-directed support to older people were areas for continuous improvement.

The partnership benefitted from strong, purposeful leadership and management. It needed to develop and enhance its leadership and management capacity to make sure that all elements of the new integrated structure profited from competent, consistent strategic and operational leadership and management.

We considered that the partnership had made good progress with health and social care integration, and it had the capacity to lead, manage and deliver required improvement.

Evaluations and recommendations

We assessed the East Lothian 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	**Adequate**	**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	**Good**	
7	Management and support of staff	**Adequate**	
8	Partnership working	**Adequate**	
9	Leadership and direction	**Good**	

Recommendations for improvement	
1	The partnership should ensure fewer older people experience delayed discharge from hospital, and that it meets the Scottish Government's target of no delays over two weeks' duration.
2	The partnership should implement integrated service redesign for the ELSIE service, so that it is staffed by both health and social work services professionals.
3	The partnership should take steps to improve anticipatory care plans. These plans should be prepared in line with Scottish Government guidance.
4	The partnership should ensure all unpaid carers are offered a carer's assessment and this offer should be clearly recorded. Carer's assessments should be completed for carers who request them.
5	The partnership should ensure that people diagnosed with dementia and their carers receive post-diagnostic support, in line with the National Dementia Strategy.
6	The partnership should make sure that older people get timely needs assessments and service provision.
7	The partnership should ensure that suitably detailed chronologies are prepared for appropriate individuals.
8	The partnership should make sure that older people receive timely reviews of their care and support.
9	The partnership should reduce staff absence, and set challenging targets for reducing the number of working days lost to staff absence.
10	The partnership should plan to mitigate the impact that potential shortfalls in the delivery of savings and cost reduction plans will have on the long-term sustainability of services to be transferred to the integration joint board.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

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The discharge hub and the huddle were a success and a platform for effective integrated working. The care pathway to ELSIE needed to be clearly documented and disseminated.

The partnership had made a considerable investment in intermediate care (Crookston Step-Down Unit). This purpose-built, well-appointed facility was very popular with its service users. And it had reduced the number of older people whose discharge from hospital was delayed and the number of acute bed days lost to delayed discharge. The partnership recognised this unit needed to operate more efficiently by discharging service users to appropriate care when their rehabilitation was completed.

The partnership acknowledged it had significant problems with care at home capacity. This had caused negative outcomes for a number of older people, such as having to wait for the care at home service they needed. The partnership was striving to enhance its capacity to deliver care at home to older people.

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1.1 Improvements in partnership performance in both healthcare and social care

The East Lothian Partnership's rate of emergency admissions for people aged 65 and over was below the Scottish average in 2014-15. The rate of emergency admissions of older people to hospital had been consistently lower in East Lothian than in Scotland for ten years (Chart 1). The multiple admissions rate and risk of readmissions for over 65s for East Lothian were also lower than the Scotland average.

The partnership acknowledged that performance in relation to delayed discharge had historically been poor and they had been working hard to improve. The partnership had put improvement measures in place so that it could achieve the Scottish Government target of no delays over two week's duration, which came into place in April 2015. From January 2015, there was a reducing trend of delayed discharges (Chart 2) and this indicated that the partnership had taken robust action to improve its performance.

The reasons for the delays had also changed over that six-month period, with a decline in individuals waiting for a community care assessment, which showed improvement in the timely assignment and preparation of assessments. The principal reasons for delay were individuals awaiting place availability in a care home and patients waiting to go home who needed care at home support (Chart 3). The reasons for the partnership's delayed discharges which did not meet the current Scottish Government target of no delays of over two weeks duration are shown in (Chart 4) The partnership closely monitored delayed discharge performance on a weekly basis through multi-agency meetings.

The partnership's challenges with delayed discharge had resulted in more acute beds lost to delays than the Scotland average. (Chart 5) shows an encouraging recent monthly fall in the number of bed days lost to delays. Code nine delayed discharges relate mainly to individuals who have dementia, and who are subject to the provisions of the Adults with Incapacity (Scotland) Act 2000. The partnership's level of code nine delays was relatively constant. From the available evidence, the partnership was managing code nine delays reasonably competently.

The partnership was quite clear what improvements needed to be made to support a reduction in delayed discharges. A delayed discharge task force group met fortnightly to drive improvement on reducing delayed discharges. We considered this was having a positive impact on reducing delays. We met some older people whose discharge from hospital was delayed. Those waiting to go home, pending the deployment of a care package, expressed frustration at the delay.

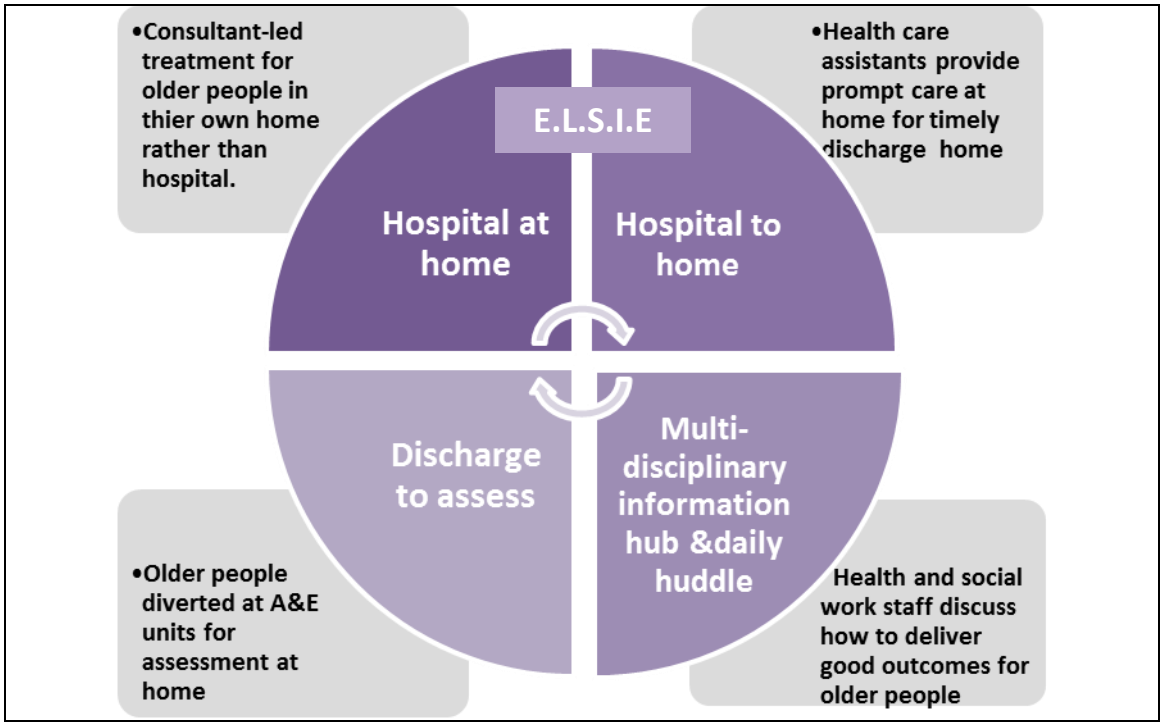

Figure 1

The East Lothian Service for Integrated Care of the Elderly (ELSIE see fig 1) provided the services of hospital at home, hospital to home, emergency care at home, and the daily information sharing and decision making huddle. We considered ELSIE was a very promising development, which provided a more efficient way of delivering services to older people, contributed to fewer avoidable admissions to acute hospital beds, reduced delayed discharges, and introduced streamlined pathways for service users.

The hospital at home service had allowed some older people to receive consultant-led treatment at home (e.g. intravenous antibiotic therapy). We met some older people who said they had benefitted considerably from this efficient and effective service. We read the records for some older people who had been treated and cared for successfully at home, thereby preventing an unscheduled acute hospital admission and the possibility of a delayed discharge.

The shortfall in care at home provision had resulted in around 500 hours of care at home required to meet demand. Adult wellbeing's emergency care service was looking after some older people who should have had a mainstream care at home service. This diminished this service's capacity to do what it was meant to do.

We considered the consultant-led discharge hub and the huddle was a purposeful development, with the right health and social work staff around the table at the right time. This initiative had played a considerable part in reducing delayed discharges. We attended the huddle, and there was evidence that admissions to acute hospitals were decreasing, and more people were supported by hospital at home.

Table 1 shows the ELSIE service's promising early achievements.

Early performance results for the ELSIE service (October 2015)			
Acute unscheduled admissions prevented by hospital at home service	No of individuals who used hospital to home service. This expedited their discharge from hospital	User satisfaction rate for hospital at home service	Individuals benefitting from discharge to assess service
128	**192**	**97.6%**	**Around 5 per week**

Table 1

The partnership had developed a step-down service at the Crookston Unit. This had facilitated timely discharges of older people from acute hospital beds, supported improved delayed discharge performance, and provided rehabilitation to individuals in a more homely setting than a hospital ward. Occupational therapist and physiotherapist support were available at Crookston, and this service had reduced dependency for some people and increased their capacity for self-care. We discuss Crookston service user's experience in chapter two.

Recommendation for improvement 1

The partnership should ensure fewer older people experience delayed discharge from hospital, and that it meets the Scottish Government's target of no delays over two weeks' duration.

The local authority duty, response, and rehabilitation team (DRRT) dealt very effectively with crisis intervention, the prevention of hospital or care home admissions, hospital discharges, rehabilitation, and duty work. This was managed through a single point of contact, which provided a more efficient triage of referrals, and helped to ensure that individuals were referred to the most appropriate health or social care service. In 2014, the DRRT carried out seven hundred and thirteen assessments. We met with older people and their carers who said that they found the service they received from the DRRT team was timely, efficient, and effective. In 2015, in the period up till June of that year, 107 older people had a reablement episode delivered by the DRRT. The individuals achieved 76% of the reablement goals staff set for them.

The partnership rightly acknowledged that the ELSIE and DRRT services needed to be integrated, to avoid older people having to undergo multiple assessments and prevent duplication of work. This would be an early piece of focused work for the new integrated management team.

Recommendation for improvement 2

The partnership should implement integrated service redesign for the ELSIE service, so that it is staffed by both health and social work services professionals.

The partnership had made service developments to provide longer term care at home support to service users who had completed a period of reablement but still required some support. Both reablement and long-term support were provided by the local authority care at home service. There had been delays with the provision of longer-term support due to care at home capacity issues. This had in turn affected the partnership's ability to provide a coherent approach to reablement. The partnership planned a further enhancement of the reablement service and this would be done alongside efforts to expand care at home capacity.

We met a number of staff who were unclear about when older people should be referred to the suite of services under the ELSIE umbrella and when to refer to the DRRT. Preparation of a clear care pathway for the ELSIE and DRRT services would greatly assist staff.

The delivery of sufficient care at home to meet the needs of older people was a pervasive issue for the partnership. The number of older people receiving a care at home service in East Lothian in 2014-15 was above the Scotland average, as it was for the previous nine years (Chart 9).

In 2014-15 in East Lothian, over 400 older people received intensive care at home (10+ hours per week) (Chart 6). For ten years, the partnership had delivered more intensive care at home to older people than the Scotland average. These figures evidenced that East Lothian maintained an effective balance of care, which was above the Scotland average (Chart 7) with a relatively high number of individuals living independently in their own home in accordance with their choice, as opposed to a care home.

Adult wellbeing's new emergency care service delivered timely and high-quality care at home to older people. Older people and their carers, whom we met, attested to the first-rate service they received from the emergency care service.

In 2013-14, the partnership – positively – placed fewer older people permanently in care homes than the Scotland average (Chart 8). This had been the trend for the previous six years. From 2003 to 2014, there was a 16% reduction in the numbers of East Lothian permanent care home residents compared to a 4% reduction for Scotland as a whole.

The Care Inspectorate assigned poor inspection grades to a few care homes. Resulting moratoriums on these services had impacted on capacity and subsequent delays in discharge from hospital due to the reduction in care home places. The partnership had taken a sound, proactive, preventative approach to drive up quality in care homes, with the institution of a care home team. This approach effectively supported improvement.

We analysed the use of anticipatory care plans for older people, mainly completed by GPs. We obtained the following key data.

- Forty-one per cent of the individuals in our sample had an anticipatory care plan, 59% did not have one (this does not imply they should have had an anticipatory care plan).

- Eighty-three per cent of the anticipatory care plans were no more than key information summaries; that is, a list of the patients' medications and their morbidities.

- Seventeen per cent of the anticipatory care plans had a little more information about the patient such as, "would like needs managed in a care home rather than hospital".

- Anticipatory care plans did not fully comply with Scottish Government guidelines, although they did meet key aspects of the specification in the general medical services contract[6]. The missing elements were:
  - involvement of the patient and their carers
  - clear delineation of the patients' wishes and preferences
  - contributions from other health professionals who looked after the patient
  - contributions from social work and social care staff
  - evidence that the anticipatory care plan could be accessed by all staff who might need to see it
  - clear guidance on what do in an emergency, such as an unpaid carer unable to continue to care for the patient.

The partnership acknowledged the information in the anticipatory care plans was brief and incomplete. They did provide critical information that could be used to support individuals at a time of crisis.

Frontline health and social care staff had limited knowledge of anticipatory care plans. Community nurses, who worked with individuals with end-of-life care needs, said that they prepared detailed anticipatory care plans. These were focused on a discussion with the individual and their carers about their wishes for their end-of-life care. These anticipatory care plans represented a very small percentage of the total number of anticipatory care plans in East Lothian. Anticipatory care planning also took place in some care homes.

Recommendation for improvement 3

The partnership should take steps to improve anticipatory care plans. These plans should be prepared in line with the Scottish Government guidance.

The partnership provided community alarms and telecare systems to older people at a level around the Scotland average. Telecare services provided a range of

[6] This contract specifies the work that GPs should carry out

equipment to keep older people safe from harm and enable them to summon assistance in an emergency. We heard how some older people with dementia were supported to maintain their independence with the aid of technology such as door sensors and global positioning system (GPS) tracking equipment to minimise risks to their safety and wellbeing.

We looked at falls prevention and falls management. The partnership did not have a dedicated falls team; however health and social care staff undertook this work as part of their existing duties. The DRRT previously had a falls coordinator, funded by the change fund, who was heavily involved in falls prevention, but the staff member left. When the change fund grant ceased in 2014-15 the partnership reviewed this post and decided it should not be continued. The withdrawal of physiotherapists from the DRRT (in spring 2015) was viewed by frontline staff as a missed opportunity to further develop falls prevention work and the team has noticed a decline in the number of staff trained by them to undertake multifactorial assessments. The health physiotherapist and occupational therapist were hospital based, but they had started to undertake some falls prevention work in the community. The first pilot of a falls prevention programme had just been completed. The partnership should evaluate the pilot programme to determine the best approach to falls prevention and falls management.

Regulated services for older people operating in East Lothian, average of inspection grades assigned by the Care Inspectorate at January 2016 (source Care Inspectorate data store)				
Grade 1 – unsatisfactory, 2-weak, 3-adequate, 4-good, 5-very good, 6-excellent				
Provider	**Quality of Care and Support**	**Quality of Environment**	**Quality of Staffing**	**Quality of Management and leadership**
East Lothian Council	4.5	4.3	4.5	4.2
Independent sector	4.1	4.0	4.1	4.0
Third sector	5	4.8	5	4.9
Some key points – No regulated services for older people run by East Lothian Council, the independent sector or the third sector were graded weak or unsatisfactory. Third sector services achieved an average grade of very good for quality of care and support and quality of staffing.				

Table 2

Table 2 shows the average inspection grades assigned by the Care Inspectorate to regulated services for older people operating in East Lothian, which were run by East Lothian Council, the independent sector, and the third sector. Overall, all of these regulated services for older people delivered good outcomes for older people and their carers. We met many older people who used regulated services. Almost all of these older people said that they greatly valued the regulated services they received. And they delivered some good outcomes for them in terms of enabling them to be independent, enhancing their wellbeing and supporting them to keep safe. Some older people and their carers said that some regulated services they received

delivered poor personal outcomes for them. For example, care at home services, which were not available at the specific times the individuals wanted.

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

We spoke with a number of individuals and their carers, most stated that they were happy with the care and support they received, their needs were met, and the partnership delivered positive outcomes for them. This was entirely congruent with the results of the partnership's patient satisfaction surveys. From our reading of case records, we found the partnership had delivered positive, desired personal outcomes for almost all individuals in the sample.

There was room for improvement in the partnership's support to carers. Whilst there had been an increase in carers assessments completed, reported in the adult wellbeing performance scorecard, there was a need for a more coherent strategic approach to supporting carers.

There had been a reduction in respite to unpaid carers. This had had a detrimental effect on carers and their capacity to continue in their caring role. The partnership acknowledged that further work was required in relation to respite care and the development of a joint respite strategy was a key objective. In 2013-14, the partnership provided around half of the Scotland average of respite weeks for older people and their carers.

We saw the evaluation of the short breaks bureau, which was a change fund initiative. The Carers of East Lothian provided the short breaks service. Older people and their carers who were supported by the short breaks service expressed satisfaction with the service. There were some good examples of flexible respite for carers, such as support workers supporting the cared for person in their own home to give the carer a break.

We analysed adult wellbeing's performance on complaints handling. In 2013-14, adult wellbeing received 16 stage one complaints (complaints dealt with directly at point of service) and 32 stage two complaints (complaints requiring a formal investigation and response to the complainant). Of the stage two complaints, 58% were not upheld and 42% were either partially upheld or upheld. It was creditable that adult wellbeing services received more compliments (60 in 2013-14) than complaints. Adult wellbeing managers recognised that they needed to resolve a higher proportion of complaints made by service users and carers, directly at service level, i.e. at first instance. Complaints, which went beyond service level, were mostly about the quantity, quality, and availability of care packages.

In 2014-2015, the East Lothian Community Health Partnership (CHP) received ten complaints and nine complaints for the year 2015-16 up till November 2015. The complaints related to cancer services, primary care services, health and social care partnership, general surgery, general medicine, facilities, allied health professionals and community nursing. The CHP could not break down the data to complaints about older peoples services. From the available data, there were relatively few

complaints to the CHP. The CHP did not submit any information about the outcomes of complaints. There were no complaints referred to the Ombudsman.

In 2014, 160 individuals in East Lothian received self-directed support (direct payments) which was a 1% decrease from 2013 (11% increase for Scotland). Of these, 80 individuals were older people. The partnership provided direct payments to more individuals than the Scotland average.

Adult wellbeing was at the early stages of working with staff to ensure that they understood self-directed support and new outcomes-focused documentation had been introduced to support the assessment for self-directed support. Work should continue to ensure that self-directed support is offered to older people in accordance with the legislation, with self-directed support offered at reviews as well as at initial assessment.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Adequate

The partnership's approach to reshaping the design and delivery of care for older people had a clear focus on maintaining their independence, their good health, and wellbeing. The prevention of unnecessary unscheduled admission to hospital and timely hospital discharge for older people, were key priorities. Older people and carers we met were satisfied with the quality of support services they received and the desired personal outcomes these services delivered for them. The lack of capacity in care at home services meant that some older people had to wait for the deployment of care at home, and in a few instances, this led to their delayed discharge from hospital.

The partnership had commissioned a third sector organisation to increase support to carers. Carers wanted improved access to respite and day care services, to support them and the person they cared for.

The partnership rightly acknowledged it needed to continue to improve the provision of support for older people following a diagnosis of dementia.

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

A high proportion of the health and social work service records we read showed that assessments took into account older peoples' choices (84%). We met with older people and their carers who were very satisfied with their care at home provision. They said it met their needs and delivered their desired outcomes. Community nursing staff and allied health professionals provided specialist support and treatment to help older people to keep as well as possible and live independently at home. Our findings were consistent with the positive results the partnership obtained from its various user satisfaction surveys.

We met older people who had had been in the Crookston Step-Down Unit, and they were very complimentary about the care they received and the quality of the very well appointed, modern setting. The service had allowed individuals to remain in the East Lothian area, so they were closer to their family and community. Although most older people in the unit only waited two or three days for care at home on discharge, a few waited several months for a care package. This could have an adverse effect on older people's recovery and ability to return home. The partnership acknowledged that the unit could run more efficiently if care at home capacity was improved, but recognised that some longer stays were inevitable due to capacity related issues and the need to pursue guardianship for some individuals.

The partnership was undertaking improvement activity to strengthen falls prevention and management. This included the following.

- A joint equipment store enabled older people to receive aids and equipment promptly to minimise falls risks. Generally this worked well and older people said their equipment was delivered promptly.

- Hospital-based occupational and physiotherapists had completed the first pilot of a falls programme for those at risk of falling. This included health checks, referral to the telecare service and strength and balance exercises. However, community based social work occupational therapists had no direct access to this initiative.

- The council's emergency care team delivered a twenty four hour rapid response service to older people following a fall at home, and a robust system was in place to alert the DRRT when there was a falls risk. We met with older people and their carers who had benefitted from this service. They spoke very highly about the prompt, attentive care and support that they received and the quality of the care.

Notwithstanding this, we found that local authority resources were stretched and there was a waiting list for occupational therapy assessments. The partnership lacked a cohesive approach between health and social work services to streamline falls prevention and management for older people at risk of falling.

Third sector organisations and volunteers provided a good range of support for older people. Local churches and community centres accommodated and supported some of the volunteer led activities. This encouraged people to stay active, improved health and wellbeing and reduced isolation. Activities included tea dances; keep fit, woodwork, and art classes. There was also a well-established befriending service, which was valued by older people and their carers. Older people we met, told us about the significant personal benefits they gained from attending these activities. These benefits included enhanced:

- health
- wellbeing
- opportunity for social contact
- opportunity to get out and about
- opportunity to try new things
- inclusion within their communities
- opportunity to give help and support to others.

Many carers we met spoke positively about the support they received and the quality of care delivered to the people they cared for. Some carers said they felt under pressure from the demands of their role and the limited options available for them to have a break. Access to respite and day care was important to carers but this was not always available near to where they lived. We spoke to individuals who told us they had not had a proper break from their caring role for some time.

The partnership offering carer assessments and completing them when requested was an area for improvement. Some carers recalled completing a carer's self-assessment, but they were unsure how this information was used to support them in their role. The partnership commissioned Carers of East Lothian, a third sector

organisation, to develop support for carers. It had proactively supported a number of carers to obtain information and advice, and short respite breaks. They also assisted carers with power of attorney applications and provided information and support about benefits. Table 3 summarises information about the work of Carers of East Lothian supporting carers. We heard about some recent positive work by GPs and Carers of East Lothian to consolidate a single register of carers across East Lothian. Senior health and social work managers rightly acknowledged they needed to develop a more coherent strategic approach to meeting the needs of carers.

Carer supports delivered by Carers of East Lothian (commissioned by the health and social care partnership)				
Number of carers identified in 2015	Additional welfare benefits secured for carers in 2014- 15	Number of carers supported to obtain short breaks	% of carers rating Carers of East Lothian services as very good or good	Payment from the partnership to Carers of East Lothian in 2014-15
410 (cumulative no from 2007 **1937**)	**£1,034,370** additional money **£504,960** annualised benefits	**69**	**99%**	**£374,878**

Table 3

Positive survey responses from carers supported by Carers of East Lothian included:

"Support has made me less stressed, more relaxed. So good to know help is readily available and I am not alone"

"I attend monthly support group, feel better talking to others, not so isolated"

We met with carers who had contacted Carers of East Lothian, when they were under considerable pressure. They were very fulsome in their praise for the quality of the timely help and support they received.

Recommendation for improvement 4

The partnership should ensure all unpaid carers are offered a carer's assessment and this offer should be clearly recorded. Carers' assessments should be completed for carers who request them.

2.2 Prevention, early identification and intervention at the right time

It was positive that 88% of the older people, whose records we read, were well supported to self-manage their health condition. This included signposting to other support available in the community. This was consistent with our staff survey, where 77% of staff felt that services worked well together to support people's capacity for self-management. This was despite that fact that the partnership had no long-term conditions strategy to plan services for self-help and management. Managers agreed this was a priority for development.

Community nurses provided the majority of the support to people who had long-term conditions, with appropriate input and education from other key health professionals. It was progressive that the hospital at home service had successfully treated a number of older people with long-term conditions at home, thereby preventing their admission to hospital.

East Lothian's 'Ageing Well' project, a partnership initiative between East Lothian Council and NHS Lothian, aimed to promote good health in later life. The website provided people with an impressive range of up-to-date information about groups, events, and local activities for adults over fifty. This included specific activities to support people with long-term conditions. We met some older people who told us how these services had helped to substantially improve their health and wellbeing. Third sector services featured prominently supporting older people with long-term conditions.

A good example of a partnership initiative to support people with long-term conditions was Active Choices in East Lothian. Older people, who attended, told us of the significant benefit they had gained from participating in the exercise programme. Benefits they reported included:

- enhanced wellbeing
- improved health and fitness
- improved mental health
- improved socialisation and inclusion
- enhanced ability to take control (manage) of their long-term condition.

Example of good practice: Active Choices in East Lothian

Active Choices in East Lothian was a highly cost effective joint project that supported adults with long-term conditions to become more active in the community. This initiative provided an exercise based referral programme to support people to improve confidence and motivation to lead healthy and fulfilling lifestyles to self-manage their long-term condition. Participants in the programme reported that they had experienced very significant benefits to their health and wellbeing.

When we spoke to carers of older people who had dementia, they told us that the person they cared for had their dementia diagnosed at a relatively early stage. We met with a number of older people with dementia and their carers who said that they had received timely, sustained, and valuable post-diagnostic support from the

community psychiatric nursing service. Some carers said that in their experience post-diagnostic dementia support was limited or absent.

The partnership acknowledged there was a gap in data about the number of people who had a dementia diagnosis across East Lothian. It had also been slow to introduce post-diagnostic support. On the positive side, an Alzheimer's Scotland support worker was recently appointed to progress this work. Post-diagnostic support had commenced for 133 individuals and their carers.

Senior medical staff raised concerns about the future sustainability of memory clinics to screen patients for dementia. They were looking at ways to empower GPs to diagnose their own patients, to improve efficiency, and resolve capacity issues in old age psychiatry services. There were no integrated mental health teams. During our file reading, staff focus groups and our interviews with people with dementia and their carers, we found compelling evidence of joint working to achieve positive outcomes for older people with dementia. The older people's mental health team had recently set up a memory skills group in Musselburgh. This enhanced the range of services available for people with dementia.

Recommendation for improvement 5

The partnership should ensure that people diagnosed with dementia and their carers receive post-diagnostic support, in line with the National Dementia Strategy.

Third sector partners provided locally based dementia services and initiatives for older people and carers. This included reminiscence and activity based groups, a dementia cafe, and the development of dementia friendly communities. We received very positive feedback from people who attended these services. We heard about an innovative psychology led initiative to support and educate care home staff about how to reduce psychological stress for older people with dementia.

Access to palliative care in the community was underpinned by the national action plan (Living and Dying Well) and NHS Lothian's Palliative Care strategy (2010-15). There was a managed clinical network to compassionately look after people with a life-limiting illness. In 2013-14, the East Lothian CHP ranked 12 out of 32 local authority areas for the percentage of individuals' last six months of life spent at home or in a community setting (91.8% for East Lothian, Scotland average 90.8).

The majority of palliative and end-of-life care was led by GPs and care was delivered by community nursing services. This included an out-of-hours and seven-day fast-track service. Specialist input for individuals at end-of-life stage was provided in partnership with MacMillan and Marie Curie nurses. These nurses provided compassionate, skilled, and knowledgeable care to older people who were approaching the end of their life. Older people and their carers who received these services valued them greatly. Frontline health staff perceived that palliative care support was better for cancer patients than for patients with non-malignant conditions.

The partnership had recognised the important role of care homes in delivering palliative and end-of-life care. The partnership established a joint care home team to support and educate staff to care for older people approaching end-of-life. The care home team effectively trained staff in anticipatory care planning to help ensure older people could die in the home, rather than being admitted to hospital.

As with many other partnerships, there was significant pressure on the occupational therapy (OT) service waiting list and there was a steady increase in those waiting to be assessed. The partnership had tried several improvement initiatives:

- the creation of new geographical patches for OTs
- the use of agency staff
- devolvement of non-complex assessment to other staff groups
- undertaking in-house waiting list initiatives
- the constructive use of overtime.

In spite of these initiatives, there was still a significant waiting list for occupational therapist assessments.

Pharmacists had a crucial role in admission and discharge planning for older people. This included medicines review and reconciliation. They undertook invaluable polypharmacy reviews for older people over 75, who were prescribed multiple medications. This reduced the risk of hospital admission. Pharmacy technicians had established good relationships with GPs and had begun to purposefully support a number of surgeries with safe medicines management for their patients. We considered the partnership had made good progress recognising and cultivating the vital contribution of pharmacy to the health, wellbeing, and safety of older people.

At a strategic level, key pharmacy representatives were working in partnership with health, social work and the independent sector to develop a consistent approach to medicines management for care at home services. The plan was to develop a policy and training for care at home staff to move away from the 'prompting' only service currently delivered. This pleasing development would help to deliver a more holistic approach to medicines management and deliver better outcomes for older people.

We met with some older people who had benefitted from the involvement of an advocate who helped them articulate their views and made sure health and social work services took account of their views.

The Edinburgh Advocacy and Representation Service (EARS) annual report to funders (2014-15), noted a low number of referrals for advocacy for older people in East Lothian. There were also low numbers of advocacy referrals for older people resident in care homes. In 2015-16, EARS received 97 referrals in respect of older people in East Lothian – seven of these were about adult support and protection. The partnership needed to make sure that all older people who needed advocacy were referred to advocacy services. The partnership was organising an input by advocacy to the adult wellbeing teams, to raise awareness of advocacy and drive up the number of referrals.

There was a lot of constructive work being done by GPs, particularly around risk prevention and early intervention, to ensure the sustainability of practices across

East Lothian. Practices completed risk profile questionnaires to identify risk factors early. As a result of this work, practice support to care homes was rationalised, to make sure that each practice took a fair share of the work.

Another simple and effective initiative within GP practices was the introduction of electronic clinical mailboxes. These mailboxes were introduced in each practice to aid better communication between GPs, other health professionals and social work services staff.

We were impressed with the use of third sector services supporting individuals to attend appointments at GP practices. Some practices had a systematic programme of regular monitoring visits to vulnerable older people. This enabled GPs and primary care to monitor individuals' health to identify problems early and support them to keep as well as possible.

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

The partnership adopted an 'equivalency model' to allocate resources for the development of self-directed support. This meant that individuals with eligible needs were entitled to a personal budget equivalent to the cost of arranging traditional services to meet these needs. Since 1 April 2014, the partnership had completed 130 self-directed support assessments, but only 16 were for older people. Our file reading analysis showed that 70% of older people had not been offered the four self-directed support options where this would have been appropriate.

There was a range of websites to help people access services and support. Leaflets and newsletters were distributed in libraries, health centres, and road shows to promote services such as telecare. This activity aimed to inform people about the services available and how to access them. Some of the older people and carers we met said they found out about services from the internet and leaflets.

Quality indicator 3 – Impact on staff

Summary

Evaluation – Good

Almost all respondents to our staff survey and staff we met enjoyed their work, and felt valued and recognised by managers and other professionals. They considered they were well supported to manage risk and had competent, effective, and supportive line management. The East Lothian Partnership had a committed and resilient workforce.

Most of staff we met, felt their service had excellent working relationships with other professionals. Frontline staff communicated well despite the challenges around electronic information sharing systems.

The majority of staff who responded to our staff survey, and those we met during our inspection, agreed they had good opportunities for training and development. Our evidence was congruent with the partnership's own staff surveys. For example, an NHS Lothian Report demonstrated how training had helped staff develop an enhanced understanding of their role. The partnership rightly acknowledged it needed to improve its change management, but had implemented a number of initiatives designed to address this.

3.1 Staff motivation and support

We considered a range of documentation submitted by the partnership and met with approximately 228 health and social work services staff in focus groups. Nine hundred and forty one health and social work staff were asked to complete our survey with 348 responding. This was a 37% response rate, which was higher than the average for other joint inspections we have undertaken. Of those, 284 (82%) finished completing the survey. Of those who returned our questionnaire:

- 55% were employed by the local authority
- 44% were employed by NHS Lothian
- 1% were employed in 'other' sectors.

We found that staff were generally clear about the roles they undertook within the partnership. Despite typically heavy workloads, staff we met were enthusiastic and committed to delivering and improving the care, support, and treatment for older people and their carers. Key responses to our survey showed that almost all staff enjoyed their work and felt valued by other practitioners when working in partnership. In addition, there was a clear majority of positive responses about line managers, where staff said:

- they felt valued by managers
- workloads were well-managed
- they had effective line management, including clinical supervision
- they felt supported in situations where they faced personal risk.

Staff morale in the partnership was predominantly very good. Staff we met in focus groups were contented, enthusiastic, and upbeat about the future. However, some individuals felt they were 'fire-fighting' rather than adopting a considered approach to delivering good outcomes for older people and carers.

Staff we met said factors which decreased their motivation were significant changes to leadership and management, increased workloads and a high volume of paperwork. The local authority chief executive acknowledged that this had been a challenging time for staff, but that senior managers were sensitive to the responses received from their staff engagement survey. They were responding accordingly in their council improvement plan 2015 -16 and service specific action plans. Despite these pressures, staff we met were unanimously committed to working hard to deliver a good service and good outcomes for older people.

In our staff survey, we found that a small majority of respondents (53%) agreed that senior managers communicated well with frontline staff about changes, which affected services. The partnership had developed a range of communication methods to help engage staff on the key developments of the integration of health and social care. These included:

- a dedicated website
- newsletters and bulletins
- road shows
- events and forums
- appropriate consultation with trade unions.

Social work services had effectively executed transformational change through their Work Force Development Strategy 2011-15[7]. It fostered a coaching culture. The partnership worked cohesively to establish practice development programmes around a personal outcomes partnership framework and appreciative enquiry approaches. The partnership collaborated purposefully with external stakeholders such as the Joint Improvement Team, Alliance and Thistle Foundations, NHS Education for Scotland and the Scottish Social Services Council. Staff we met said that these programmes had helped to improve their practice and enhanced their capacity to deliver positive outcomes for older people and their carers.

While the foregoing were all positive developments, senior managers recognised they needed to do more to improve communication about change to staff. They acknowledged that strengthening workforce engagement was pivotal to implementing positive change and the overall success of the organisation.

There was a long history of effective operational joint working between health and social work staff in East Lothian. Our staff survey found positively that 76% of respondents agreed or strongly agreed their service had excellent working relationships with other professionals and 79% of respondents agreed or strongly agreed that they felt valued by other practitioners and partners when working as part of a multi-disciplinary or joint team. Almost all staff we met said they welcomed

[7] East Lothian Council, Work Force development Strategy, Adult Social Care, A Strategic Vision for 2011-16

further health and social care integration, and perceived this as a catalyst to consolidate and improve joint working.

When we met with staff, it was evident they were genuinely committed to providing and delivering services to support older people to lead purposeful and fulfilling lives, increase opportunities for independence and keep people safe from risk of harm. Our staff survey findings endorsed this view from frontline practitioners.

Less than half (44%) of the health and social work staff responding to our survey had reservations about sufficient capacity to cope with demand, although this is consistent with our joint inspection findings nationally. Frontline social work services staff said the number of referrals of older people with complex care and support needs had increased and paperwork was cumbersome and not sharable with health staff. The partnership had introduced an information exchange portal for the electronic sharing of information between health and the DRRT. Staff felt this had offered limited benefits to date. This innovation had the potential to bring about significant benefits for teamwork.

As we would expect at this point in the partnership's development, health and social work partners had separate arrangements for individual supervision, annual performance appraisal, and individual professional development. Staff said the supervision they received was regular, purposeful, and supportive.

The NHS Scotland staff survey, East Lothian Report, showed the following.

- There was an overall increase in practitioners undertaking the knowledge skills framework. Almost half of the staff said it had helped them to do their job better.
- Eighty-eight per cent of staff who had had an appraisal said they had agreed a personal development plan or equivalent.
- Seventy-nine per cent of staff who had a personal development plan said they had received, or expected to receive, the training that was identified in that plan.

We considered these results were very positive.

Social work services' coherent work force development strategy constructively set out how personal development plans were linked to both the corporate competency and continuous learning frameworks. The adult wellbeing, essential learning and development policy was also impressive, with its service-wide training matrix for staff.

At this early stage in the partnership's development, health and social work had their own suite of training and development resources. Joint training opportunities were limited. Adult support and protection training was accessible to health and the third sector. We considered the joint human resources and organisational development plan was a very positive development.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Adequate

The East Lothian Partnership was committed to community engagement and consultation. The partnership had successfully engaged with the public about strategy development and decisions about service change. We saw less evidence of communication of the outcome of consultation to stakeholders.

The partnership was developing the community's capacity to support its older citizens. The partnership supported a number of third sector organisations to provide invaluable support to older people and their carers. Older people and carers we met were highly complimentary about the timely and empathetic help and support they received from these bodies. The partnership effectively signposted older people and their carers to these community supports.

The partnership rightly acknowledged as an area for improvement, its engagement with the third sector for the development of community capacity to support older people and their carers.

The need to involve the public in policy and service development was evident in the East Lothian Older People's Strategy and draft Joint Strategic Plan 2015-2025. The partnership had engaged with people using a variety of approaches. There was evidence throughout the strategy that the outcome of the consultation had positively influenced the strategy's development. Engagement methods included local area forums, the public partnership forum and established community groups, including Community Councils and Friends of Edington Hospital. Furthermore, it was evident in the strategy that consultation had influenced service redesign for hospital closures and the redevelopment of council care homes.

Consultation on the first draft of the Joint Strategic Plan 2015-2025 was completed early in 2015. Some third sector groups we met felt they had not been consulted about the strategic plan.

The partnership showed a commitment to engagement with staff, and had undertaken a series of road shows. It had held an excellent Big Conversation event, at which third sector and independent bodies were well represented. A second draft of the consultation was expected to appear on the consultation hub in spring 2015,

The partnership had commendably adopted a 'people's voice' approach to community planning. Based on national standards, the approach provided a highly effective framework for engaging with communities. People's voice had practical tools to inform and evaluate community engagement.

The health care and social care partnership recently established area locality partnerships. There were six locality forums which had representatives from the

third sector and the independent sectors. As they become embedded, they would become the primary mechanism for community engagement. There was evidence that the partnership regularly sought feedback from older people about the health and social care services they had received. In the citizens panel survey the council recognised the importance of feeding back to participants about the impact of their contribution. They had introduced a 'You Said, We Did' sheet in response to each survey, to allow participants to see the impact of survey completion. The partnership conducted regular surveys of older people about their experiences of using health and social care services. There was limited evidence of robust improvement plans as a response.

The East Lothian Council internet based consultation hub was regularly and effectively used to seek public opinion. The hub was an innovative initiative to reach a wide audience. The hub could be improved by providing the public with feedback on the outcome of consultation. For example, 113 people engaged in consultation about the introduction of a beach wheelchair project. However, they received no feedback on the outcome of the consultation.

There were effective forums at which members of the public influenced service delivery.

- There was an increasing number of patient engagement patient partnership groups (PPGs) in GP practices. The groups have already made a tangible positive impact on service delivery for older people. They initiated an increased number of local clinics, which made it easier for older people to get the treatment and care they needed.

- The Brunston Court Tenants Committee influenced improvements such as improved carpeting and lighting, new kitchens in sheltered housing, and better social activities for residents.

We asked about community involvement in our staff survey.

- Fifty-three per cent of respondents agreed or strongly agreed that there was a strong positive engagement between the partners and local community and voluntary groups. Thirteen per cent disagreed or strongly disagreed and 34% didn't know.

- Fifty per cent of respondents agreed or strongly that there were clear joint strategies to promote and expand community involvement and communicate change. Sixteen per cent disagreed or strongly disagreed and 34% didn't know.

From our focus groups with health and social work services frontline staff, we found they had limited awareness of community capacity building and the role that health and social work services had in its development.

We visited a locally-established support group for carers who cared for people with dementia. This dementia resource had a small library of books, and leaflets to signpost people to sources of support. Volunteers ran the support group. The

individuals attending the group said they benefitted from the empathy, support and socialisation the group offered.

We visited community projects aimed at preventative interventions. These were well attended.

- The Sporting Memories Group provided socialisation and stimulation for older gentlemen from the local community. A variety of sports and hobbies was the theme for reminiscence, lively discussion, and activities. Group members said, "They liked coming along to the group and they very much valued the range of positive experiences that the group gave them". They said, "Most of the guest speakers were fantastic, and even if they weren't they very much appreciated them coming along to speak to them".

- The Macmerry Men's Shed, based on the Australian Men's shed concept, was established using money from the change fund. The workshop provided a social environment for older men who engaged in woodwork, metal work and fly-tying. Individuals who attended said they very much enjoyed these activities and they benefitted greatly for opportunities to socialise and try new and familiar activities.

The partnership developed community capacity for early and preventative interventions using the integrated care fund. These included the development of a community hub to promote the role of the smaller community groups, which could provide specialist support to older people and their carers. A project based on the Alliance Model in Glasgow placed staff from the third sector in some GP surgeries to offer social prescribing and signposting to community resources. The partnership needed to improve publicity to potential beneficiaries, to ensure the optimum benefit of such projects. There was excellent involvement from GPs for this initiative.

Older people we met said lack of suitable transport could be a significant barrier to accessing health, social work, and social care services. The partnership responded constructively by supporting the inception of a much-valued community health transport project.

Example of good practice – community health transport project

An innovative use of change fund money was the introduction of the Community Health Transport Project. Royal Voluntary Service volunteers provided transport to take people to their GP surgery. The target group was people over 75, who had long-term conditions, were frail, and required regular monitoring of their health to prevent deterioration. The project's success led to the volunteers' duties expanding. They provided support to older people to do their shopping, collect prescriptions from chemists and provide companionship to prevent loneliness and social isolation.

Partnership managers acknowledged building community capacity to support older people was an area for improvement. Third sector representatives we met agreed. The partnership was making some progress on engaging with the third sector on reshaping care of older people and community capacity building. Around one third of

the integrated care fund money was to be allotted to the third sector for the development of services and support for older people and their carers, which would deliver very good outcomes for them. Thereby, considerably more older people and their carers would have their health, wellbeing, independence, and safety enhanced by the work of the third sector.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

The East Lothian Council Contact Centre Access Team provided an effective single point of contact into the social work service for older people, their carers, and partner agencies.

Waiting times for some services for older people could be lengthy. For example, local authority occupational therapy assessments, and reviews of care and support. The partnership needed to strengthen its approach to managing waiting times and determining the impact of waiting times on older people.

A lack of care at home service capacity was a persistent challenge for the partnership. It had taken some action to address this.

The partnership was moving towards personalised approaches to assessment and care planning for older people. The implementation of self-directed support for older people was in its early stages, and was not as extensive as for other service user groups.

The partnership had established effective processes to identify and protect adults at risk of harm. The East and Midlothian Public Protection Team provided expert advice and promoted consistency of practice. A twice-weekly multi-agency meeting to screen referrals had a positive impact on sharing information as well as directing referrals to appropriate agencies when adult protection intervention was not required. We read the records for individuals at risk of harm, who were now safe and protected, as a result of highly effective collaborative work undertaken by the partnership's staff.

5.1 Access to support

A good range of public information was available through East Lothian Council, NHS Lothian and GP practice websites. Some older people and carers told us that the partnership was poor at communicating with older people to promote services and advise older people of how to access support. We heard that older people often relied on word of mouth or support from peers to access services.

The partnership had eligibility criteria for accessing health and social work services. The council's eligibility criteria prioritised people who had critical or substantial needs. Staff said that individuals, whose risks were assessed as low, were signposted to third sector organisations. Older people and carers told us that communication about eligibility criteria for specific health services could be confusing.

Social work referrals were received and screened by East Lothian Council Contact Centre Access Team. Referrals were then passed to the duty response and rehabilitation team (DRRT) and the adult wellbeing social work team. Managers in the adult wellbeing team – rightly – asserted that this positive service redesign quickly directed referrals to the right place.

Waiting lists for services were an issue for the partnership and the individuals who had to wait. The health and social work records that we read indicated that 20% of older people were on some waiting list for services and 60% of these individuals had waited for over six months. For 75% of the individuals who were on a waiting list it was not recorded they were given reasons for the delay. Staff said there were substantial waiting lists for some services, including local authority occupational therapy assessments and care reviews. Staff expressed concern that waiting times prohibited early intervention and preventative work, which resulted in older people requiring a higher level of support from health and social work services. Social work services managers told us waiting lists were reviewed periodically however, we found little evidence of a systematic approach to managing waiting lists. At the time of our inspection there were:

- 292 individuals waiting for an occupational therapy assessment
- around 300 individuals waiting for a community care assessment.

Managers indicated that less than 10% of those waiting had been evaluated as in urgent need of an assessment, and they gave assurance that people needing urgent help were always responded to quickly. This assertion was supported by the Scottish Government's quarterly social care survey data, which showed that adult wellbeing assessed individuals with critical needs immediately, with no wait for the provision of services following assessment.

Recommendation for improvement 6

The partnership should make sure that older people get timely needs assessments and service provision.

Some older people and carers told us that care at home services were not flexible enough, there was lack of choice of service providers, and that there were issues with consistency of carers delivering support.

The partnership was making positive attempts to maximise the available care at home resources, through regular meetings with providers to ascertain capacity and deploy services efficiently across East Lothian. It was too early to tell if this was effective. We also heard about plans to expand council care at home service provision in an attempt to increase capacity.

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

The partnership was moving towards personalised approaches to assessment and care planning in respect of older people, but this was in the early stages.

Assessment and care planning documentation to support this had recently been introduced. It focused on individual outcomes for older people and gave staff tools to offer self-directed support options to older people and their carers.

We analysed assessments in both the health and social work services records we read. The assessments in health records mainly related to individuals' health conditions. Our findings on assessments were generally positive in that:

- 88% of records contained an assessment
- a range of professionals had contributed to the assessment in two-thirds of cases
- 95% of assessments took account of the individual's needs
- we evaluated 60% of the assessments as very good or good quality and none were unsatisfactory.

From the social work services records we read, we saw evidence of line managers' scrutiny of records in only 35% of the records we reviewed. In three quarters of the older people's records we read, there was some evidence that health, social work and other services shared information to help inform the care and support needs of these individuals. We found that staff shared information regularly but did not specifically collaborate for assessment preparation. From our analysis of health and social work records, we found:

- almost a quarter of individuals had a comprehensive care and support plan
- 63% of individuals had a care plan, which was less than comprehensive
- 13% of individuals did not have a care and support plan.

A chronology should be prepared for people who have complex circumstances, are subject to significant risks or where professional judgement determined a chronology was necessary. Of the 23% of individuals whom we considered should have had a chronology, only 22% had a chronology (under half of the chronologies were of an acceptable standard).

Recommendation for improvement 7

The partnership should ensure that suitably detailed chronologies are prepared for appropriate individuals.

Our review of health and social work records found that 67% of individuals' health and social care support was subject to regular review. Evidence from our inspection fieldwork was more mixed. There was a significant waiting list for reviewing the care and support for older people. Adult wellbeing had a team of three reviewing officers, whose main role was to undertake reviews of older people receiving services. Staff absence and the involvement of reviewing officers in large-scale adult support and protection inquiries had diminished the team's capacity to undertake reviews and clear the backlog.

Managers recognised that efficient robust review processes were required. They cited lack of capacity as the reason for delays in reviews. The partnership

acknowledged the need to review all large care packages to make sure service users received the appropriate level of care to meet their current needs.

Recommendation for improvement 8

The partnership should make sure that older people receive timely reviews of their care and support.

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

The partnership had put well-structured governance arrangements in place for adult support and protection. The East and Midlothian Public Protection Committee (EMPPC) was established in mid-2014 and incorporated the duties of the previous adult protection committee and the child protection committee. A public protection performance framework was implemented in 2015. It was too early to determine the effectiveness of the framework. An adult support and protection improvement plan was in place in 2015, and progress was reported to the EMPCC.

Service users and carers were not directly represented on the EMPCC. The partnership systematically elicited the views of people who had been involved with adult support and protection processes, through the completion of a post-involvement questionnaire.

The East and Midlothian Public Protection Team was also established in 2014 and it has staff from the police, social work services and health. It supported operational staff across partner agencies, and provided expert advice and promoted consistency of practice. Staff and managers said that, whilst it was early days, their experience of the joint public protection team was very positive.

The partnership had clear, comprehensive, and up-to-date multi-agency adult support and protection policy and procedures in place. These were dated June 2015 and were bedding in with staff. Health and social work staff said there was effective joint working in relation to adult protection inquiries and investigations. Social work staff advised that, where it was safe to do so, adult protection investigations and interviews were normally undertaken by one social worker acting in their capacity as council officer. This was due to lack social worker availability. We considered it would be safer practice if two members of staff were always deployed to adult protection investigations.

The partnership had piloted a twice-weekly referral-screening meeting, which involved health, police, and social work. This forum had a positive impact on sharing information and screening referrals that did not meet the criteria for adult support and protection involvement.

Our findings about risk assessment and risk management practice from the health and social work records we read were reasonably positive, with the quality of risk assessments being the main area for improvement. For example, for the individuals

with adult protection type risks extant, (current or potential issues regarding adult protection or protection of the public), we found that:

- 79% of individuals with protection-type risk identified had a risk assessment
- We rated 54% of risk assessments as good or very good, with 46% rated as adequate or less
- 82% of the protection-type risk assessments had evidence of multi-agency input
- In 91% of the applicable records, the timing of the risk assessment was in keeping with the needs of the older person
- 78% of protection type risk management plans were rated as good or very good, with 22% adequate or less.

We saw some good examples of detailed and comprehensive adult protection type risk assessments and risk management plans which demonstrated the involvement of individuals, their families (where appropriate), and adult protection partners. Our analysis of records of some individuals who were subject to the adult protection procedure, showed that staff from different agencies had carried out well-planned, cohesive work to make sure the individuals were safe and protected.

We also considered the management of non-protection type risks such as the risk to an older person at risk of falling and suffering an injury or the risk to an adult with dementia at risk of wandering and experiencing harm.

- Seventy-six per cent of individuals with non-protection type risk identified had a risk assessment.

- Fifty-six per cent of the non-protection type risk assessments had evidence of multiagency input.

- The timing of 75% of the non-protection type risk assessments was in keeping with the needs of the older person.

- Seventy-five per cent of the non-protection type case records had a non-protection risk management plan in place.

We found some good examples of non-protection type risk assessments and management plans, although just under half of the risk assessments (47%) and risk management plans (44%) were of good or very good quality.

Example of good practice: multi-agency police adult concern form screening group

There was an adult support and protection multi-agency screening meeting (held twice weekly). Police Scotland, social work, and health were represented at this meeting. This group considered every adult concern report and the appropriate response. This group was initiated in response to the impact on adult wellbeing services of increasing numbers of adult concern reports sent by the police, and the need for a more coordinated approach. This group only passed on referrals to the DRRT that required further investigation. The work of this group had streamlined and improved the investigation of adult protection concerns. This made an important contribution to the safety and wellbeing of adults at risk of harm.

5.4 Involvement of individuals and carers in directing their own support

We found positive results about the extent to which the partnership involved older people in discussions and decisions about their care, treatment and supports. The health and social work services records we read showed that almost all people were involved in their assessment (94%), support plan (83%) and review (87%). Many of the older people we met told us they felt involved in discussions about their support needs and how these would be met. However, some older people told us that some of their choices were limited, including choice of care provider and the time that they received support.

Staff were positive about how they engaged with carers; 77% of respondents in our staff survey said that the views of carers were fully taken into account when planning and providing services to older people. Our file reading indicated scope for improvement in supporting carers. We found that two thirds of carers had not been offered a carer's assessment where this would have been appropriate. Of the cases where the carers were offered and had accepted a carer's assessment, only 50% of carer's assessments had been completed. Senior local authority managers recognised that the partnership needed to improve support to carers, particularly in completing carers' assessments and offering personalised support to them. Positively, we heard of pro-active work between GP practices and Carers of East Lothian to identify hidden carers and offer them support.

The partnership had draft policies for self-directed support. The partnership had recently developed comprehensive outcome-focused assessment and support-planning documentation, which was linked to its delivery of self-directed support. The partnership recognised that further work was needed to embed all of its self-directed support processes within staff's practice.

We did meet with some older people who received direct payments. They said that direct payments afforded them enhanced flexibility, choice, and control, with consequential improved outcomes.

The implementation of self-directed support for older adults was not as well developed as other service user groups. An internal audit of self-directed support in March 2015 found that appropriate older people had not had the four self-directed support options discussed with them. Our file reading strongly confirmed the internal audit's findings. Social work staff, older people and carers we met also confirmed this. The partnership was beginning to address this and implementation of self-directed support for older people had commenced. The local authority had recently integrated its adult and older adult social work teams and managers were hopeful that this would help share learning and improve the approach to self-directed support.

Some staff, older people and carers told us that service providers and support options were limited. We heard that social work strategic planning had worked with service providers to improve and develop a range of support options for people. The partnership had developed a simple contract with third sector providers to enable them to provide services not covered by other framework agreements. This aimed to make purchasing easier.

From our analysis of health and social work services records, we saw that where advocacy was provided this had helped the older person to articulate their views and ensure services took account of their views. We concluded that there was scope to improve staff awareness on the role of advocacy. We noted low numbers of referrals to Edinburgh Advocacy and Representation Service (EARS) in 2014-15. There was improvement in the number of referrals for advocacy for people involved in adult support and protection processes in the first half of 2015-16.

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

Summary

Evaluation – Good

The partnership's joint strategic plan had been subject to wide consultation and review that informed the future direction of older peoples and other services across the partnership. This plan clearly set out the case for change in East Lothian, and how the partnership aimed to work with stakeholders to deliver these changes to improve outcomes. The partnership's priority to deliver more care closer to home was clearly articulated within its plan. A revised communication and engagement strategy had led to improved engagement with key stakeholders.

The partnership's approach to strategic commissioning and the development of the strategic plan was based on a review of information from their joint strategic needs assessment and an imperative to move from a bed-based to a community-based service provision.

The partnership had successfully supported the development of a range of community-based early intervention and support services for older people and their carers. The third sector mainly delivered these services, which were user-friendly and much valued by older people and their carers.

The partnership had a cohesive range of quality assurance and improvement activities. It needed to make sure that the health and social work service elements of the partnership carried out these activities in tandem, going forward.

There were many positive and productive examples of the partnership involving older people, their unpaid carers and other stakeholders in service planning, delivery and evaluation. However, a number of carers and other stakeholders we met did not feel consulted and included

The partnership had made progress with the planning and execution of joint commissioning of health and social care services for older people and their carers. In common with many other partnerships in Scotland, we considered this was a critical area for continuous improvement.

6.1 Operational and strategic planning arrangements

The partnership had a well-developed draft joint strategic plan for health and social care that had been subject to comprehensive, productive consultation with key stakeholders. These included staff, people who used services, carers, and providers in the third and independent sectors. The partnership's revised second consultation draft had constructively set out the key changes necessary to shape future service delivery. This plan included a clear, shared vision and meaningful proposals for

testing and implementing changes to service provision. The older people's planning group had recently met after a lengthy gap, and was effectively re-engaging with partners to support more purposeful care group planning.

The partnership's systematic focus on improving outcomes for older people was beginning to show positive results. There were early indications that increasing numbers of older people were supported to remain at home. The partnership had reduced the number of in-patient beds and the number of older people living in care homes. It was also engaged in a significant reshaping of care at home services to deliver care at home as quickly as possible. The partnership identified delivering more care closer to people's homes as an immediate priority.

The partnership's revised strategic plan and supporting action plan addressed how changes and development of services would be progressed. The plan needed to be more SMART[8] to help the partnership measure and review its impact. The timescales were very broad and did not include key milestones for review, although performance measures were identified.

Operational and strategic planning arrangements were well linked into East Lothian and Lothian wide strategies. The joint strategic plan articulated well how these plans linked together to deliver a coherent range of services. The partnership's initial consultation on the joint strategic plan, alongside a review of existing plans, had identified a number of areas where there were planning gaps. These included dementia, primary care, carers, transitions, respite, and reablement. These domains were considered within the revised strategic plan, with specific improvement actions identified.

The partnership had a strong emphasis on supporting older people to live as independently as possible. However, the success of this approach was compromised by a lack of available staff to deliver sufficient care at home services across East Lothian. The partnership had implemented a number of initiatives to build the workforce capacity including work with schools and colleges to promote care careers.

The partnership acknowledged that its strategic planning needed to address how to increase care at home provision and develop reablement to meet the partnership's aspirations to support more older people in the community. East Lothian provided a higher level of care at home hours and intensive care at home support than many other areas in Scotland, but this was insufficient. The partnership, supported by the Joint Improvement Team, was working constructively to improve their relationship with the independent and third sector providers to increase capacity to deliver care at home.

The partnership was making continued progress in reducing the level of avoidable unscheduled care in acute hospitals. However, when an individual was admitted to hospital they could stay longer than necessary because they were awaiting a care at home service. We considered the partnership was giving the necessary priority to performance improvement on delayed discharge.

[8] specific, measurable, achievable, realistic, time bound.

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

The partnership promoted early intervention for older people. There were many examples of the partnership delivering highly effective early intervention and support services, which we discuss in other sections of this report.

The partnership had invested over £0.5m to support increased capacity in the care at home sector to prepare for additional winter pressures. The additional monies were to be spent on purchasing care from care at home providers, with a proportion allocated to the council-run care at home service.

ELSIE was developed to enable a quicker and more flexible response to individuals to be discharged from hospital or at risk of admission to hospital. This had helped to mitigate some of the impact of the lack of care at home capacity. The partnership successfully supported care homes to continue to care for older people with increasing complex health needs. The new health care home team worked cohesively alongside social work staff to support care homes to maintain older people in the home and prevent admissions to hospital.

Managers recognised that there was some overlap between teams delivering reablement and preventative services, and work was commencing that would rationalise their roles. Developments to support older people to remain in the community included enhanced roles for community nursing staff who worked alongside ELSIE staff, to provide effective rehabilitation for older people.

The partnership's use of telecare as part of an early-intervention approach was relatively well developed. The telecare strategy still had to be agreed before implementation, and the vacant telecare lead post needed to be filled.

The partnership's strategic plan had identified that services for people with dementia and their carers was an area for improvement. We found that there was good engagement with the third sector to create dementia friendly communities. We met carers who cared for individuals with dementia. They gave compelling examples for how the dementia friendly community had made a difference. For example, staff in shops were patient, understanding, and empathetic when they served a customer who had dementia. We heard from some carers about their difficulties in accessing suitable day care for individuals whose behaviours could challenge services. We considered there was a need to develop specific day care for people with dementia.

6.3 Quality assurance, self-evaluation, and improvement

The partnership was working constructively with NHS Information Services Division to develop better information about the range of health needs in different localities. This would assist with planning, prevention and early intervention measures. The partnership used Scottish Patients at Risk of Readmission and Admission (SPARRA) effectively to identify people at risk of admission to hospital and inform planning for health and social care. The partnership was actively working on fulfilling the information requirements for integration. They were working productively with Information Services Division to develop an integration dataset.

Workshops with staff and surveys of people who used services helped to identify improvement actions. The council used How good is our council? as their self-evaluation approach and this was underpinned by a range of performance reports produced by both health and social work. The partnership had made early progress with the use of the public sector improvement framework as its self-evaluation tool. The partnership used this effectively to evaluate the outcomes it delivered for older people.

The Sporting Memories Group was working productively with individuals, some of whom had a diagnosis of dementia. This group had carried out an evaluation and could evidence impressive positive outcomes for attenders. This group, and others we visited, evidenced the partnership and the third sector's development of effective early-intervention resources for older people and their carers.

The public protection committee had identified a range of cogent improvement actions to expand support to adults at risk of harm. The partnership systematically used the findings from national reports and investigations to inform practice development. As a result, adults at risk of harm were safer and better protected. Some of the committee's audit activity had a single agency rather than multi-agency approach, although this was being developed. They had created an 'evaluation calendar' that set out a coherent programme for audit and quality assurance activities.

We found that the integration joint board members were actively engaged in monitoring performance and the need for improvement in key areas, such as the capacity to deliver care at home. Information on the delivery of mental health officer services was reported to strategy planning and delivery groups. As a result, the partnership had recently recruited additional mental health officers to provide improved monitoring of guardianships.

The partnership reviewed complaints as part of the contract monitoring process, and the chief social work officer's report incorporated complaints information. In the main, there was a robust, well-organised response to complaints.

The change fund programme board evaluated change fund projects. This provided an effective platform for reviewing if services delivered good outcomes for individuals. This process productively supported a range of service improvements including:

- providing additional assessment staff for the DRRT team to support hospital discharge
- enhanced befriending services
- the Royal Voluntary Service transport scheme had been expanded, and it supported more people to attend GP and hospital appointments.

The partnership's performance information on the implementation of self-directed support identified areas of improvement. Their latest performance results were beginning to show an increased level of support being provided as self-directed support. Self-directed support leads were developing a range of tools to measure outcomes for service users.

We met a number of staff who felt engaged in contributing to service review that informed improved practice and service development. We also met some staff who did not feel engaged or able to contribute to how services were being developed. We found that managers were communicating well with staff through newsletters and briefings to improve staff awareness of the change process. Managers recognised that communication with staff was an area for continuous improvement.

6.4 Involving individuals who use services, carers and other stakeholders

The partnership's strategic plan identified carers as playing a crucial role in the delivery of health and social care. The partnership planned to update its carers strategy after it completed its strategic plan and submitted this to Scottish Ministers. We considered the partnership needed to give greater priority to operational support for carers and engagement with carers.

The partnership had carried out some positive work to proactively identify carers and support them. The carers short breaks bureau supported carers to access and plan respite support when they needed it.

The partnership was working to improve its communication and engagement strategy, which would inform future consultations on developments. They had produced regular newsletters that aimed to keep communities across the area meaningfully informed on actions following consultations.

Service providers were effectively engaged in the development of services. Local authority and registered social landlords were well engaged with health and social care developments, and were informing the partnership's draft strategic plan. The contribution of housing services to delivering good outcomes for older people was well embedded. A representative from housing services was a member of the integration joint board.

Housing services was working well to improve the use of their housing stock – working with tenants to downsize to housing more suitable to their needs. A dedicated occupational therapist within housing services helped older people secure home improvement grants. This made sure older people's housing needs were met by upgrading their home environment.

6.5 Commissioning arrangements

Joint strategic commissioning within the partnership was informed by a comprehensive joint strategic needs assessment. This identified the needs of the different localities and informed the strategic plan. The 2013 joint older peoples commissioning framework was the basis for commissioning practice, and services were procured through a central team.

The arrangements for commissioning of health and social work services after April 2016 must be put in place as a priority and progress made on securing the range of services required to meet the future demands, in particular for older people. The links between the commissioning plan and the medium term financial plan were insufficiently clear.

Productive discussions were underway with care at home providers to try to rationalise packages of care across localities. The Earthlight collaborative allocations pilot aimed to improve capacity in the system and outcomes for service users. This was aimed at reducing the number of providers operating in each area and making the best use of care staff by reducing the amount of travelling and as a result increase the amount of time for direct care delivery. This work had resulted in a productive exchange of ideas; for example, linking male service users with male care workers.

Some elements of commissioning needed to be clearer, for example medication management by care at home providers. This was set out in a council policy, and there was a council-run training programme. There was an inconsistent approach by providers on which medications they would administer. Staff training to support medication management needed to be developed and delivered. The partnership's pharmacy leads were productively engaged in developing a clearer policy for medication administration. This would not be in place for some time.

There was a robust process in place to monitor the quality of commissioned services that was based on feedback from staff and reviews of people using these services. A joint forum that involved service managers from health and social work services and the Care Inspectorate, shared information about the delivery of care services and identified improvement actions. This had included support from the care home liaison team and an occupational therapist, to support improvement work in care homes. The partnership evidenced a clear commitment to improving procurement through the procurement improvement panel.

The partnership did not always give providers clear information about funding decisions. Providers complained about lack of transparency on funding decisions that left them unclear why the council rejected some funding bids. This was an area for improvement.

Work with some care providers had helped to grow the market to deliver care and support to individuals with an individual budget. However, some assessed needs for lower levels of care and support meant that it was not viable for providers to deliver a service (for example, a provider had a set hourly rate of £14.50 per hour and four 15-minute visits would only attract a budget of £12.00). East Lothian Council paid one of the lowest rates for care at home in Scotland. We considered the partnership needed to engage with care at home providers to address these issues.

Quality indicator 7 - Management and support of staff

Summary

Evaluation – Adequate

The partnership had remodelled care in some areas such as medicine for the elderly, and was working constructively with care at home providers to ensure recruitment was more equitable across the sector.

Deployment of staff remained at a largely individual agency level although almost all staff we met during our inspection said there were good working relationships amongst practitioners. A clear majority of staff said managers gave them good support to explore development opportunities. The partnership should prioritise more joint training around self-directed support and dementia awareness.

There was extensive evidence of health and social work services staff working effectively together to deliver good outcomes for older people and their carers.

The partnership needed to step up its efforts to reduce staff absence with its consequential negative impact on the partnership's capacity to deliver services to older people and their carers.

7.1 Recruitment and retention

Joint health and social work workforce planning was at an understandably early stage. The partnership had constructively established joint human resource and workforce development groups. The groups were working purposefully to an agreed timescale for introducing the new integrated structural arrangements, and they were appropriately linked to the clinical and care governance work stream. Many of the senior posts within the new senior management structure had been filled successfully. The partnership was working towards having their service managers in post by March 2016. There were individuals in these positions on a temporary basis. Overall, the partnership had made relatively good progress with the development of its integrated structure and the filling of management posts within the new structure.

The partnership's workforce planning group had constructively involved an independent organisational consultant to consider different approaches to support recruitment and retention, service mapping, training and conditions of service.

In our interviews and focus groups with a range of frontline staff and managers, we learned about the ongoing challenge of recruitment and retention in areas such as GPs and care at home services. The partnership was developing improved new models of care in medicine for the elderly services and GP practices, with the institution of nurse practitioners. Social worker posts were typically filled quickly. There were 20 pharmacists working across East Lothian, with medicines advice and

support available round the clock. There was a pharmacy champion in each area, who effectively cascaded and promoted new initiatives.

There was a high turnover of staff in care at home services in particular. Both the local authority, third and independent sector providers all reported difficulties with recruitment, and this was more challenging in remote areas. The partnership was working with care at home providers to address recruitment challenges.

We met with the heads of human resources from health and social work. They outlined a range of coherent joint recruitment initiatives undertaken. Recruitment campaigns and collaboration with universities had taken place to try to attract people to work in the area. The partnership had purposefully considered an additional range of approaches to make health and social work jobs more attractive career options. There were positive developments underway, such as care at home providers working collaboratively with strategic planning staff on:

- locality based service level and framework agreements
- development of a co-production approach between the partnership and provider (supported by the Joint Improvement Team)
- developing 'grow your own' schemes including modern apprenticeships
- joint work with the economic development services about how to attract a new generation of potential employees in to the area
- diminishing the use of zero hour contracts within the council.

Adult wellbeing submitted staff absence data. The average absentee rate in adult wellbeing between April and October 2015 was 7.97%. Despite this being an improvement on the previous year, it was above the council average and above their target. NHS Lothian had an absentee rate 6.0%, (2014-15), which was improving, but also above target. Both social work services and health had detailed strategies in place to reduce absence levels.

Recommendation for improvement 9

The partnership should reduce staff absence, and set challenging targets for reducing the number of working days lost to staff absence.

Laudably, East Lothian Council had attained 'Healthy Working Lives' gold standard status and NHS Lothian had attained silver status.

7.2 Deployment, joint working and team work

We found many positive examples of successful joint working. There was evidence of joint working to:

- prevent avoidable hospital admissions
- make sure older people fit for hospital discharge were discharged timeously
- protect adults at risk of harm
- support older people to live independently
- enhance older people's wellbeing and inclusion within their communities

- support older people to do as much as possible for themselves.

Frontline staff as well as NHS and social work services managers we met reported good working relationships with colleagues across the services and this was evidenced in our staff survey. They said that an increased focus on outcomes was evolving as a result. GPs told us that they generally had very good links with social work services and primary care services, which they perceived to be competent and responsive. A few GPs considered that there was room for improvement in this area.

As we have found in other joint inspections of older peoples services, dieticians and speech and language therapists were low in numbers and worked across Lothian. This inhibited their capacity to be involved in the rehabilitation of older people. Additionally, occupational therapists across health and social work said they felt that referral and intervention pathways were not as clear as they could be, and that there were areas of duplication in assessments. The partnership was responding to this and there were a number of purposeful initiatives including:

- integrated working with housing
- introduction of activity of daily living
- smart assist self-assessment tool
- Inception of joint OT clinics.

There were, as yet, few examples where joint teams were co-located in the same building, although one positive example was the early diagnostic dementia support worker based in the community mental health service. Human resource and organisational development senior managers we met were strongly committed to creating joint teams.

7.3 Training development and support

A majority (78%) of staff survey respondents agreed or strongly agreed that they had good opportunities for training and professional development. This was consistent with both partners' own staff survey results. This was strong evidence of the extensive and meaningful training and professional development afforded to staff.

There was a good variety of training available to ensure staff maintained their skills, knowledge, and accountability in their respective professions. Formal joint staff training was limited to topics such adult support and protection. There was a cohesive joint social work and health occupational therapy training programme designed by NHS Lothian. This was linked to a competency framework and trained band 3 and 4 nursing assistants to acquire additional skills and competencies.

Commendably, 85% of staff responding to our staff survey agreed or strongly agreed they received good supervision and clinical supervision (where appropriate) from line managers. The findings from our file reading strongly supported this assertion. We considered this was compelling evidence of systematic, cogent supervision and clinical supervision practice across the partnership.

Despite self-directed support training having been rolled out to all social work staff, a fair proportion of staff we met were not clear on how they should offer self-directed

support options to older people and their carers. An internal audit in 2015, found very limited implementation of self-directed support for older people. NHS Lothian staff had yet to be involved in any self-directed support training. However, more training was planned for a wider audience, and that this was to include NHS and third sector partners.

Senior managers in health told us that they had yet to appoint a lead officer to take forward the National Dementia Strategy. They said that there were many examples of bespoke dementia training in East Lothian, but that it lacked strategic oversight and therefore coherence across the partnership. These effective training initiatives included:

- community mental health team training
- psychology-led programmes
- care home team training
- training for carer groups
- impressive dementia friendly communities work.

Independent care at home, care home and day care providers reported an improvement in access to staff training. The providers were grateful for the opportunities, but said that there were difficulties releasing staff to attend. They, understandably, prioritised staff obtaining Scottish Vocational Qualification to meet Scottish Social Services Commission requirements.

The adult support and protection learning and development post had been vacant for approximately a year. Timely filling of this post would enhance the partnership's capacity in this critical domain.

Quality indicator 8 – Management of resources

Summary

Evaluation – Adequate

The health and social care partnership had made good early progress with the instigation of a number of key financial systems for integration. East Lothian Council exercised sound financial management, in the face of the very significant challenges encountered by all local authorities in Scotland. East Lothian Council received a positive audit report for 2014-15 from its external auditors.

In 2014-15 NHS Lothian achieved its substantial target for efficiency savings (£39.4m). At the time of our inspection, the NHS Board had a projected "worst case scenario" overspend for 2015-16 of £28m. This was a very significant concern, which had the potential to have a negative impact on the budget settlement for the East Lothian Integrated Joint Board. The NHS Board and its partners were working diligently to reduce the projected overspend. At March 2016, NHS Lothian was projected to break even for 2015-16, and this was confirmed at the board's finance and resources committee on 9 March 2016.

The partnership had used the change fund purposefully to support shifting the balance of care for older people towards older people receiving their care, support and treatment at home and within their communities.

The partnership had made some progress with electronic information sharing between health staff and social work services staff. This progress needed to be consolidated and developed.

The health and social care partnership had a sound platform on which to develop. It needed to make swift progress creating integrated teams of health and social work services staff.

Current joint financial management

As with many areas of Scotland, the East Lothian Partnership had decided not to pool budgets in the inaugural year of integration. Financial management responsibilities remained with NHS Lothian and the council separately until integration commencement in April 2016.

The combined indicative 2015-16 budget was set at £125.4 million and presented to the integration joint board in April 2015. Service saving requirements were built into this and the achievement of these savings plans presented a challenge and risk to service delivery. A number of costs were not included in the indicative budget, including corporate functions, strategic reserves held by NHS Lothian and facilities and property costs. The partnership was performing a due diligence exercise with the aim to examine these costs and the budgets set by each partner. Although an indicative budget was presented to the integration joint board in April 2015, no

budget monitoring information has subsequently been presented at the board meetings.

The partnership had made good progress in mapping cost centre information between the NHS Board and the council. This allowed an improved understanding of the underlying costs associated with the services transferring to the integration joint board. The partnership had also made progress in establishing draft interim financial instructions. Additional work was required to identify the integration joint board's apportionment of NHS services, which operated across Lothian, and NHS services that were hosted in the other Lothian integration joint board areas. The aim was to identify those assets that would be available to the integration joint board to fulfil their objectives in their strategic plan.

The partnership and its external managers decided efficiently to establish a shared integration joint board chief finance officer post with the Midlothian Integration Joint Board, and this position was filled on a seconded basis. Senior managers were confident that sufficient attention would be given to each area.

Financial performance of East Lothian Council

In previous years, the council relied on the use of reserves to bridge budget gaps. Plans were currently underway to move the council towards achieving a sustainable budget position by 2016-17.

In 2014-15, the council recorded a small surplus of £6.3 million. This was mainly achieved through a combination of service underspends, gains from the sale of fixed assets and an accounting adjustment to their bad debt provision. A number of these items contributing to the budget underspend were one-off non-recurring savings that cannot be achieved in future years. We concluded that the identification and achievement of recurring savings was key to achieving a sustainable budget.

Commensurate with its three-year financial strategy (2015-18), the council was planning their future budgets on the assumption that government funding would remain static. With government funding comprising around 80% of their funding, inflationary cost pressures and the increasing demand for the council's services, the council has been under financial strain. The council's plan to mitigate these pressures had involved seeking efficiency savings through their 'change programme' and constraining cost growth.

The council's adult wellbeing budget in 2014-15 was £47.2 million with a final outturn of £47.6 million. A year end overspend of £0.9 million was projected part way through 2014-15, which prompted the creation of a recovery plan. This improved the year-end position to arrive at an overspend of £0.4 million (0.8%). This overspend arose from external care packages cost pressures, in particular, in relation to elderly provision and learning disability packages. In conjunction with this, there was an under-achievement of projected savings in year 2014-15. For 2015-16, the council reassessed and revised the 2014-15 savings requirements and made the decision not to carry forward all of these targets. Also, in recognition of the significant financial pressures that adult wellbeing was experiencing, an additional £0.7 million

was allocated for 2015-16. As at the first quarter of 2015-16, the adult wellbeing budget was underspent by £0.4 million.

At the year-end of 2014-15, the council had useable reserves of £24.7 million. The overall surplus achieved in 2014-15 allowed the council to contribute towards this reserves balance. At the time of the inspection, it was not anticipated that any of these reserves would be assigned to the integration joint board.

Financial performance of East Lothian Community Health Partnership (CHP)

The NHS 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 and a small surplus of £0.2 million was recorded. Within this, the East Lothian CHP budget was overspent by £1.5 million. Prescribing costs was an area of significant budgetary pressure for the CHP with an overspend of £1.0 million (5.8%). An overspend of £0.5 million was also recorded relating to core services.

As at the end of July 2015, NHS Lothian reported an overall overspend of £6.9 million with a projected year end overspend of £28.0m. The East Lothian CHP area was overspent by £0.5 million for this period. The main budgetary pressures related to GP prescribing and nursing and medical supplies.

The anticipated overall NHS Lothian overspend presented a significant challenge to the board's plans to achieve their financial targets and its long-term financial sustainability. In response to these challenges, the Chief Executive met with other board chief executives and the Scottish Government's Director General Health and Social Care to discuss how the financial position was to be improved. At March 2016, NHS Lothian was projected to break even for 2015-16, and this was confirmed at the board's finance and resources committee on 9 March 2016.

Overall, the NHS board achieved its 2014-15 efficiency savings target of £39.4 million. Only £21.9 million (55.6%) of this was delivered through recurring savings with the shortfall of £17.5 million being met from non-recurrent savings. The board needed to achieve savings on a recurring basis in order to ensure long-term financial sustainability. Within the overall 2014-15 savings target, East Lothian CHP had a recurring savings target of £1.6 million. At the year-end, there was a £0.4 million (22.5%) shortfall against this target. Delays in the redesigning of bed capacity models arising from delayed discharge issues was cited as a contributing factor for the underachievement of these savings.

The overall shortfall in 2014-15 recurring savings was carried forward into 2015-16 to give an efficiency savings target of £49.3m. East Lothian CHP area was expected to contribute £1.2m towards this target. The realisation of these savings was considered essential to the achievement of the board's statutory targets and long term financial sustainability of services.

Recommendation for improvement 10

The partnership should plan to mitigate the impact that potential shortfalls in the delivery of savings and cost reduction plans will have on the long-term sustainability of services to be transferred to the integration joint board.

Change fund, delayed discharge fund, integrated care fund

The council and NHS Lothian had worked with the third and independent sectors to develop new models of care as part of the Reshaping Care for Older People programme. This work was continuing with the integrated care fund (ICF), although ICF was not restricted to older people, but extended to include support for all adults with long-term conditions.

Since 2011-12, the Scottish Government had provided funding to the partnership through the change fund. This was 'bridging finance' to enable the redesign of services towards prevention, early intervention, anticipatory care and rehabilitation. By March 2015, the partnership had received £5.4 million in funding.

Over the four years, the partnership divided the change fund across the following areas:

- preventative and anticipatory care (25%)
- proactive care and support at home (25%)
- effective support at times of transition (27%)
- hospital and care homes (8%)
- enablers (15%).

The partnership reviewed these projects regularly and the programme board considered investment and disinvestment options based on an outcomes approach. This resulted in a number of projects being decommissioned over the life of the fund. At the end of 2014-15, all change fund projects were either mainstreamed or disinvested. The council decided to carry forward a number of projects to the value of £0.3 million and continued funding through the integrated care fund.

In March 2015, the Scottish Government approved East Lothian's ICF submission and agreed an allocation of £1.8 million annually over the three-year life of the fund. In addition to the continuation of a number of change fund projects, other areas of spend were identified in the partnership's joint strategic needs assessment. The areas the partnership would concentrate this funding on were prevention and early intervention, care closer to home, and workforce development. The integration joint board would have responsibility for decision making and monitoring of the ICF. As at March 2015, the partnership had assigned 82% (£1.4 million) of the 2015-16 allocation. At the time of our inspection, all of the 2015-16 ICF allocation had still to be finalised. We concluded that it was important that a plan was finalised setting out how these funds would be used to ensure best value usage of the available funding.

There was a risk identified relating to the on-going funding of ICF projects when the life of the fund has concluded. This arose from the difficulty in transferring any resulting resource savings from acute services to community-based services. The partnership recognised this challenge and has considered it as part of their risk management strategy for the integration joint board.

8.2 Information systems

The partnership recognised the need to develop a joint IT strategy and effectively share information at both an individual practitioner and strategic levels. Plans which allowed local authority staff to read only access to the health TRAK system were delayed. The introduction of honorary contracts to resolve the outstanding issues was imminent. Frontline health and social work staff told us they viewed this as a positive move towards enhanced communication and information sharing, and reduced duplication of work. We agreed.

Managers said health staff access to the social work Frameworki IT system was not possible due to logistical constraints. The partnership was working constructively with the Frameworki developer to resolve this.

Adult wellbeing services were using the inter-agency information exchange (IIE). This positive, but limited, development allowed local authority staff to receive requests for service from health colleagues. Frontline staff said that they welcomed this development.

Despite limitations with shared access to IT systems, and the constraints with IIE, 53% of respondents in our staff survey agree that information systems supported frontline staff to communicate effectively with partners. Staff maintained effective contact using email, formal and informal meetings to support joint working. The daily huddles hosted by ELSIE were a catalyst for coherent information sharing within the partnership.

It was positive that in 80% of the records we read, there was evidence that information from partners informed the development of care plans. This showed that there was good communication between frontline staff, when working together for the benefit older people and the delivery of positive outcomes for them.

Earthlight was an innovative IT system used by the care brokers[9]. When a new care package was approved on Frameworki it automatically populated Earthlight. This provided a visual image of which care at home providers were working in each street in each town. Thus it enabled the care brokers to send the request for the care package to the provider who was already working in the local area The system had the potential to streamline and rationalise the delivery and deployment of care at home.

Police Scotland operated a new vulnerable adult database. This was being piloted to evaluate its efficacy. All adult concern reports and referrals were entered into the

[9] Care brokers are adult wellbeing staff who procure care at home from providers

database, which could be fully accessed by health and social work services. This was a very promising, positive joint approach to improving information sharing.

The East Lothian Partnership had invested change fund money, along with support from the NHS Information Services Division, into improved data collection and analysis on cost activity and outcomes.

8.3 Partnership working

The East Lothian Partnership had adopted the body corporate model for the integration of health and social care. Scottish Ministers had approved the partnership's integration scheme. The partnership had consulted on the first draft of the strategic plan 2015-2025. This plan incorporated the East Lothian Council and NHS Lothian corporate plan, which facilitated the transition into the health and social care partnership, whilst jointly reflecting the priorities of the respective organisations.

The partnership's integration scheme, which was approved by Scottish Ministers, included the following within the health and social care partnership:

- primary care health services
- social work services for adults (adult wellbeing)
- criminal justice services.

Membership of the integration joint board had been confirmed, with appropriate representation from stakeholders including public, third and independent sector and senior clinical representatives.

There were integration working groups, which covered the whole of Lothian (the four Lothian Health and Social Care Partnerships). There were groups on leadership, chief officers, and finance officers. These groups had been working diligently and productively to create a consistent approach across the Lothian councils for integration schemes, strategic plans, and standing financial instructions.

The partnership had successfully established the community planning partnership, area partnerships and the resilient people partnership, which supported the integration joint board to improve health and social care outcomes for older people.

The partnership had creditably spent a significant amount of time and resources communicating effectively with staff groups about partnership working and integration. The majority of staff we met during the inspection confirmed this. In our staff survey, 81% of staff agreed or strongly agreed that joint working was supported and encouraged by managers. Only 8% disagreed or strongly disagreed.

Quality indicator 9 – Leadership and direction

Summary

Evaluation – Good

The East Lothian health and social care partnership had a clear and compelling vision for the future integrated delivery of health and social care services to older people and their carers in East Lothian. This well-articulated vision had at its core the imperative that older people and their carers should lead healthy, safe, included, independent lives, and have a good sense of wellbeing. There were promising signs that at this early stage the partnership had good, well-informed governance and leadership from the integration joint board. Consultation and communication with its staff and the promotion of its vision was an area for continuous improvement.

The partnership was aware it needed to work harder to fully include older people and their carers in all of its planning activities. The vacancy for the head of adult wellbeing post had reduced the overall strategic leadership capacity of the partnership. The timely successful filling of this post would augment the partnership's leadership capacity to take forward its ambitious and challenging change and improvement plans.

9.1 Vision, values and culture

The partnership had a suite of documentation setting out its vision for the future health and wellbeing for the people of East Lothian. Key quotes are as follows:

"We will work in partnership to build an East Lothian where everyone has the opportunity to lead a fulfilling life and which contributes to a fair and sustainable future". (Partnership's statement of intent.)

"We believe that through innovative thinking, intelligent planning and by putting the views of our service users at the heart of all that we do, we can achieve our vision of Best Health, Best Care, Best Value for our communities across East Lothian. We will make sure that strong and effective partnerships are established between East Lothian Council and NHS Lothian, colleagues in the third and independent sectors and with other key partner agencies, so that we plan and commission services in a way that puts people at the heart of decision-making". (Draft strategic plan)

The partnership had made considerable efforts to communicate its vision for health and social care integration to people who use health and social care services and the wider public in East Lothian. The partnership's vision and stated values included a strong commitment to the promotion of equality and inclusion. Equality and inclusion were core themes, which were embedded in policies and procedures and staff working practices across the partnership.

We attended the well-planned and well-run Big Conversation event, which happened at the time of our inspection. The purpose of the event was further consultation on the partnership's strategic plan, and to give a wide range of stakeholders the opportunity to contribute to the partnership's plans to develop and reshape health,

social work and social care services in East Lothian. Stakeholders had the opportunity to proffer their ideas about how the partnership would meet the challenges of delivering health and social care services to an East Lothian population, which contained increasing numbers of older people with complex health and social care needs. Delivery of health and social care services would be likely to face an increasingly challenging financial climate. All of the 150 participants at the event recognised the following.

- Community supports needed to be mobilised, supported, and developed to sustain older people and other adults to remain as fit and healthy as possible, live independently at home or in a homely setting and have a good sense of wellbeing.

- Strategic and operational joint working amongst staff from the health and social care partnership, third sector and independent sector staff was a key area that required an unrelenting drive towards continuous improvement.

Members of the integration joint board had attended training and development events run by the Scottish Government. Integration joint board members said these events were beneficial as they gave them the opportunity to critique their own work and see what other health and social care partnerships across Scotland were doing.

Older people, carers, and representatives of third sector groups said that planning groups for older people and for carers who cared for older people had not met for a considerable time. This was despite the fact that the East Lothian health and social care partnership was planning the biggest change to the structure and delivery of health and social care services for some considerable time. Senior managers within the partnership acknowledged that service user and carers must be inextricably linked to the partnership's strategic and operational planning processes.

Almost all of the partnership's staff we met were optimistic and enthusiastic about health and social care integration. There was a profound hope that integration would solve hitherto intractable problems, such as information sharing between health and social work services staff and duplication of effort by health and social work services. Our staff survey revealed that:

- 60% of respondents agreed or strongly agreed that there was a clear vision for older people's services, with a shared understanding of the priorities; 18% disagreed or strongly disagreed and 21% indicated that they didn't know.

9.2 Leadership of strategy

The East Lothian Partnership was one of the first partnerships in Scotland to establish a shadow integration joint board. The shadow integration joint board operated effectively for a year, and this made sure that, once constituted, the integration joint board operated cohesively and purposefully. From the meeting of the integration joint board, which we attended, and other meetings, it was clear there were good relationships between board members, and they were all highly committed to delivering the objectives of the integration joint board and implementing health and social care integration. East Lothian Council elected members and NHS Lothian board members had forged a good working relationship.

The partnership had decided that social work services for children would not be included within the current integration scheme. However, the partnership planned to include social work services for children within the health and social care partnership around a year after its commencement. Social work services for children was included in the overall structure of the health and social care partnership under the management of the head of children's wellbeing. The partnership recognised that it would need to prepare an amended scheme of integration and submit this for the approval of Scottish Ministers. Integration joint board members and senior managers within the partnership acknowledged the volume of change management activity and organisational development work it needed to do to drive forward the implementation of health and social care. We considered – specifically for the East Lothian Partnership – the decision not to include social work services for children within the health and social care partnership at this stage was prudent. This created a more manageable and deliverable change agenda for the first stage of the partnership's development.

GPs, consultants and other doctors exercised effective clinical leadership for the work of the health and social care partnership. The lead GP was also the clinical director for the partnership and a member of the integration joint board. There was another GP representative on the integration joint board, whose specific remit was to represent the views of GPs. Sustained clinical leadership is a necessary condition for effective integration of health and social care. The partnership needed to drive continuous improvement in this and other areas, and support clinicians to take a leadership role for the delivery of the partnership's ambitious change agenda.

9.3 Leadership of people

The partnership's senior management team, whom we met, exercised vigorous, visible and competent leadership to deliver the partnership's objectives, and to the partnership's well-motivated staff. Adult wellbeing had not had a head of service for six months, although an acting head of adult wellbeing had been appointed. This leadership issue had had an adverse effect on the service in the run up to health and social care integration. Senior managers acknowledged this. At the time of our inspection, the partnership was in the process of re-advertising the head of adult services and chief social work officer post. We considered that timely filling of this post was critical for the partnership's drive to create an integrated health and social care service and deliver positive outcomes for older people and their carers in East Lothian.

The partnership had an extensive programme of leadership seminars and other events for its managers and other staff. Some of these had independent facilitation. Staff we met who had attended these seminars said that they had been beneficial. Staff expressed the following views about leadership in our staff survey.

- Sixty per cent of respondents agreed or strongly agreed that high standards of professionalism were promoted and supported by all professional leaders, elected members and board members. Thirteen per cent disagreed or strongly disagreed and 27% didn't know.

- Sixty-eight per cent of respondents agreed or strongly agreed that there were positive working relationships between practitioners at all levels. Nineteen per cent disagreed or strongly disagreed and 13% didn't know.

- Eighty-one per cent of respondents agreed or strongly agreed that joint working was supported and encouraged by managers. Eight per cent disagreed or strongly disagreed and 10% didn't know.

- Fifty-four per cent of respondents agreed or strongly agreed that senior managers communicated well with frontline staff. Thirty-nine per cent disagreed or strongly disagreed and 7% didn't know.

9.4 Leadership of change

The partnership had made relatively good progress creating an integrated structure for the health and social care partnership. There would be recruitment to a number of middle manager posts within the integrated structure. The results of our staff survey were 45% of respondents agreed or strongly agreed that changes, which affected services, were managed well, 42% disagreed or strongly disagreed and 13% didn't know. The result of the partnership's own survey was that 57% of respondents thought that the partnership managed change well. In staff surveys, staff tend to be highly circumspect about how change is managed within their organisations.

Senior managers within the partnership had demonstrated their ability to lead change initiatives and drive performance improvement. Examples of this were the partnership's successful efforts to reduce the number of older people whose discharge from hospital was delayed and the related creation of the coherent ELSIE service. ELSIE effectively tackled the issues of avoidable unscheduled acute care for older people and delayed discharge. There was a wide recognition amongst all of the partnership staff we met that the ELSIE service needed to be much more integrated, with health and social work services staff working in one integrated ELSIE team. An integrated, well-balanced ELSIE service would prevent older people having avoidable admissions to acute care and make sure that older people did not experience delays in their timely, well-planned, and well-executed discharge from hospital.

East Lothian Council social work services had undertaken a number of self-evaluation exercises. Adult wellbeing had participated in self-evaluation as one of a number of services within East Lothian Council. The council used the How Good is Our Council self-evaluation model. The health element of the partnership was not as far advanced with self-evaluation. However, on a positive note, the East Lothian health and social work services partners had carried out some cohesive self-evaluation work on services for older people in May 2015 (they used the Public Services Improvement Framework).

Quality indicator 10 – Capacity for improvement

Summary

The East Lothian Health and Social Care Partnership delivered good outcomes for many older people. As a consequence of the partnership's efforts, many older people had enhanced wellbeing, and led healthier, included, independent, and fulfilled lives. The partnership needed to effect continuous improvement to minimise the numbers of older people who experienced poor outcomes, such as when their discharge from hospital was delayed or they had to wait for the deployment of care at home services. Support to unpaid carers and the roll out of self-directed support to older people were areas for continuous improvement.

The partnership benefitted from strong, purposeful leadership and management. It needed to develop and enhance its leadership and management capacity to make sure that all elements of the new integrated structure profited from competent, consistent strategic and operational leadership and management.

We considered that the partnership had made good progress with health and social care integration, and it had the capacity to lead, manage and deliver required improvement.

Improvements to outcomes

The East Lothian Partnership delivered many older people's desired positive outcomes in terms of:

- safety
- treatment and support to be as healthy as possible
- independent living
- enhanced wellbeing
- leading a fulfilling and gratifying life
- socialisation, inclusion and recognition
- the opportunity to make a valued contribution within their communities.

The partnership was redesigning health and social work services to older people to deliver improved outcomes for them. The early performance results for the ELSIE service (prevention of avoidable emergency hospital admission and supported discharge service) were promising. We considered this was a good example of a whole-systems approach to preventing avoidable unscheduled acute care for older people and ensuring older people were discharged from hospital timeously, safely and effectively. This was work in progress, and the partnership needed to make swift headway to develop the ELSIE service as an integrated service that included staff from the council's adult wellbeing service.

Some older people and their carers, who were waiting for the deployment of care at home services, experienced poor outcomes while they were waiting. The

partnership needed to intensify its efforts to address the pervasive problem of availability of care at home services for older people. We recognised the considerable challenges for the partnership in this domain.

We found that the partnership had not extended its implementation of the self-directed support legislation to older people. The partnership acknowledged this was an area for improvement.

Effective leadership and management

The integration joint board and the corporate management team from NHS Lothian and East Lothian Council provided highly effective and informed corporate governance for the health and social care partnership. Members of the integration joint board exercised cohesive, constructive leadership for the partnership. The council and NHS Lothian's corporate managers were strongly committed to developing health and social care partnership as a body, which continuously improved its delivery of outcomes for older people.

The partnership's chief officer and the senior management team had already demonstrated, at an early stage of the partnership's development, their capacity, for vigorous, visible, accessible and successful leadership and management.

We considered that the council's adult wellbeing service, and consequently the health and social care partnership, had to an extent been detrimentally affected by the unfilled vacancy for the head of service post. The partnership was working positively to fill the head of adult wellbeing post timeously.

Our findings from meeting around 180 of the partnership's staff were that the staff were pledged to the delivery of excellent outcomes for older people and their carers, and enthusiastic about the possibilities for health and social care integration. In general, staff conveyed positive views about leadership and management at all levels within the partnership. Staff thought communication and effective, inclusive change management were areas for improvement.

Effective approaches to quality improvement

We considered the health and social care partnership had progressed self-evaluation constructively with its work to evaluate outcomes for older people. The partnership needed to progressively build on this progress. The partnership had demonstrated that it could utilise the extensive performance measurement information on delayed discharge for older people, to underpin service redesign and deliver timely hospital discharge for older people. We considered that it was critical that the partnership sustained and enhanced recent improvements in this area.

The partnership had worked effectively with the Scottish Government's Joint Improvement Team for the creation of its integration scheme and its strategic plan. And improving commissioning and procurement, particularly for care at home services for older people.

Health and social care integration

Overall, the East Lothian Health and Social Care Partnership had made good progress with:

- establishing an effective and well-balanced governance framework
- creating a committed and competent senior leadership and management team
- an integrated health and social care structure
- extensive service redesign to deliver improved outcomes for older people and their carers.

Although it was early days, we considered that the partnership was taking forward health and social care integration in accordance with the service user and carer focused integration principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

What happens next?

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

May 2016

Appendix 1 – Statistical charts

NB click on the R link to return to your place in the main text.

Emergency admissions of older people to hospital *(source Information Services Division)*

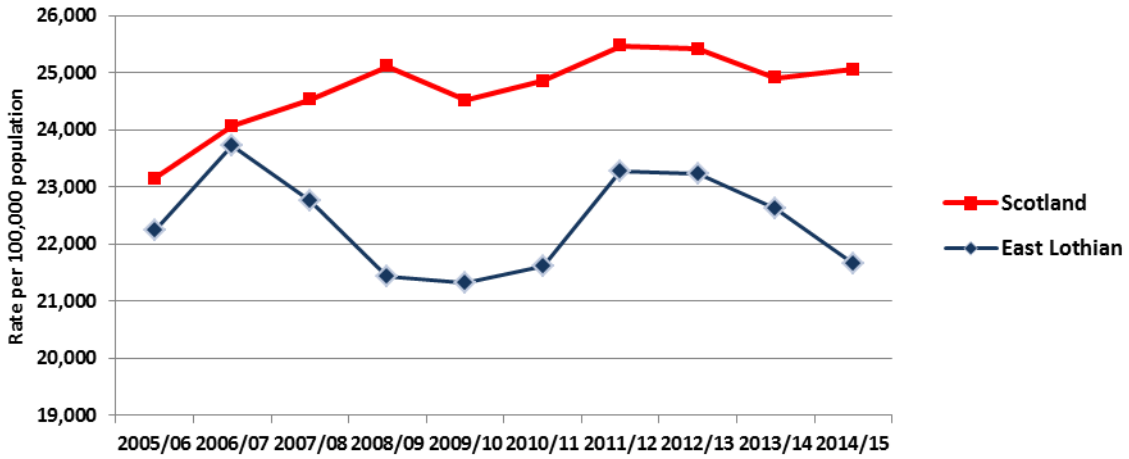

Chart 1 R1

East Lothian, standard delayed discharges *(source Information Services Division)*

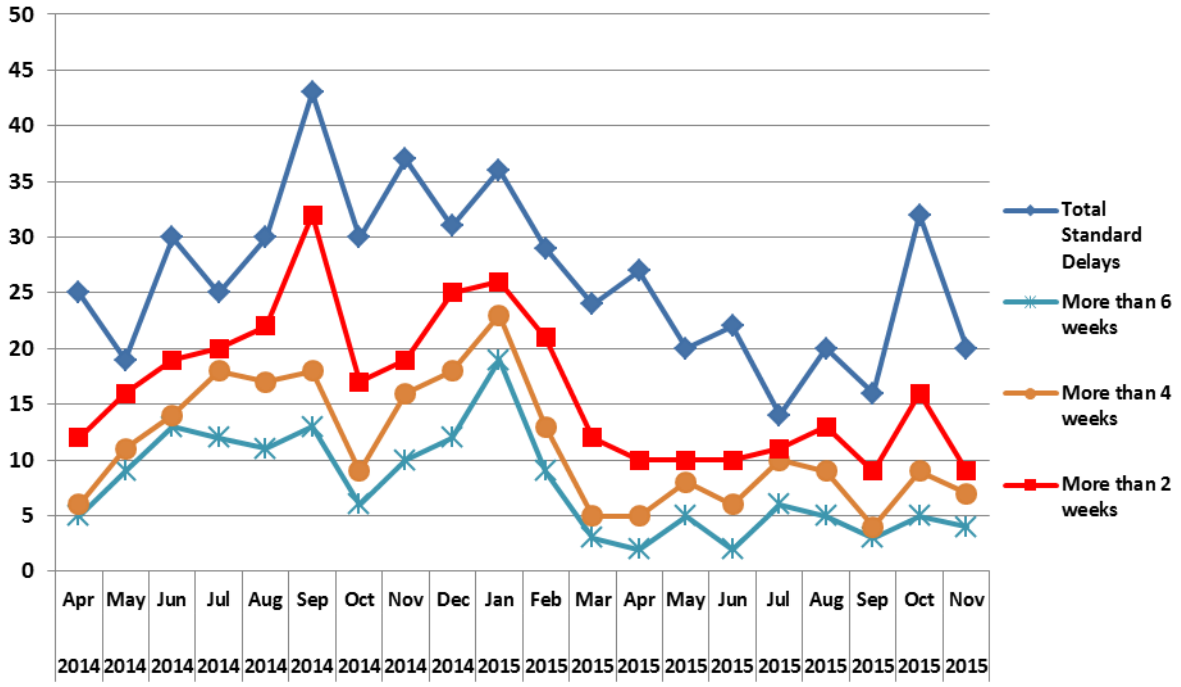

Chart 2 R2

All standard delays, reasons for delay *(source Information Services Division)*

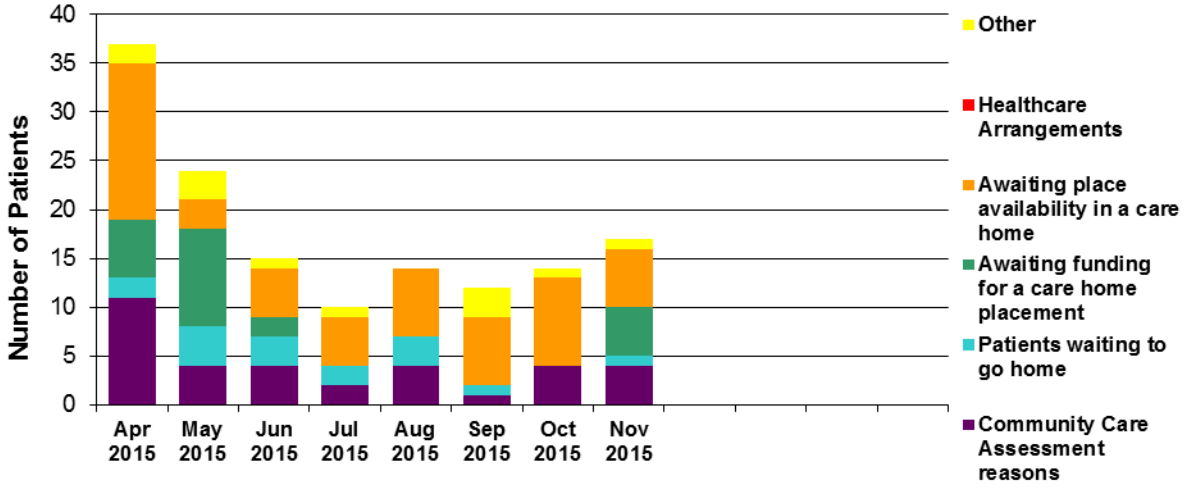

Chart 3 R3

Delays of two weeks, reasons for delay *(source Information Services Division)*

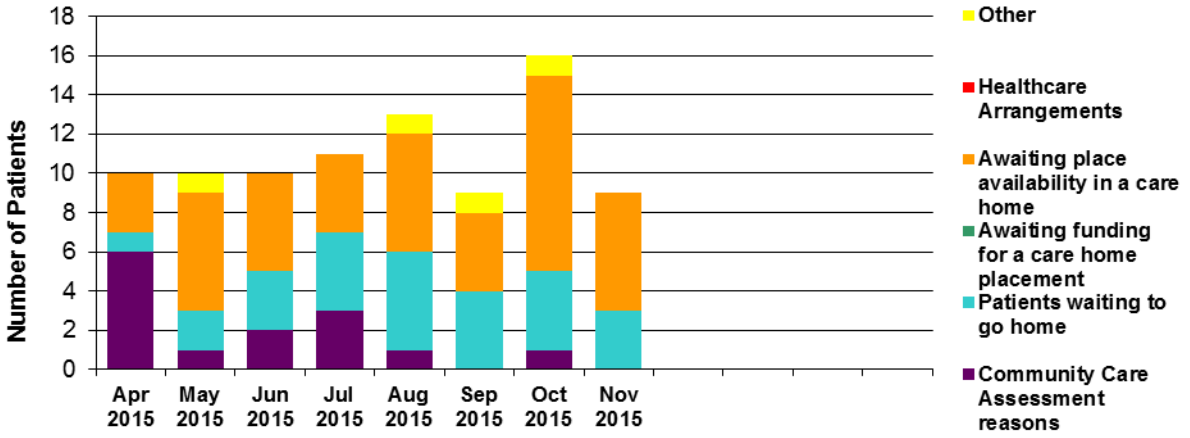

Chart 4 R4

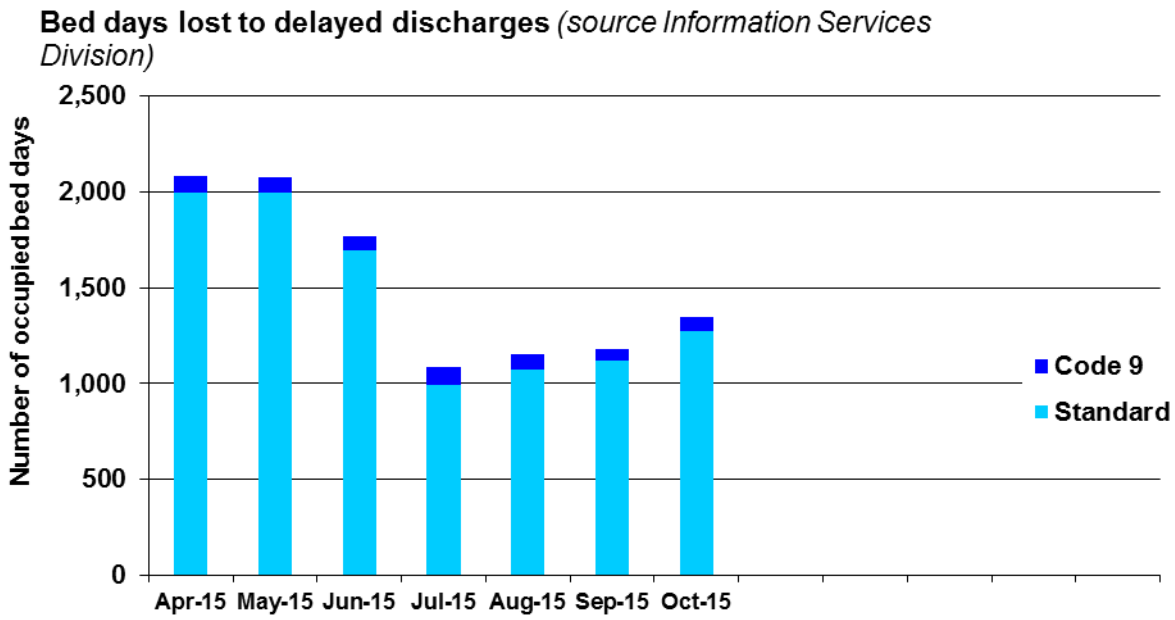

Chart 5 [R5]

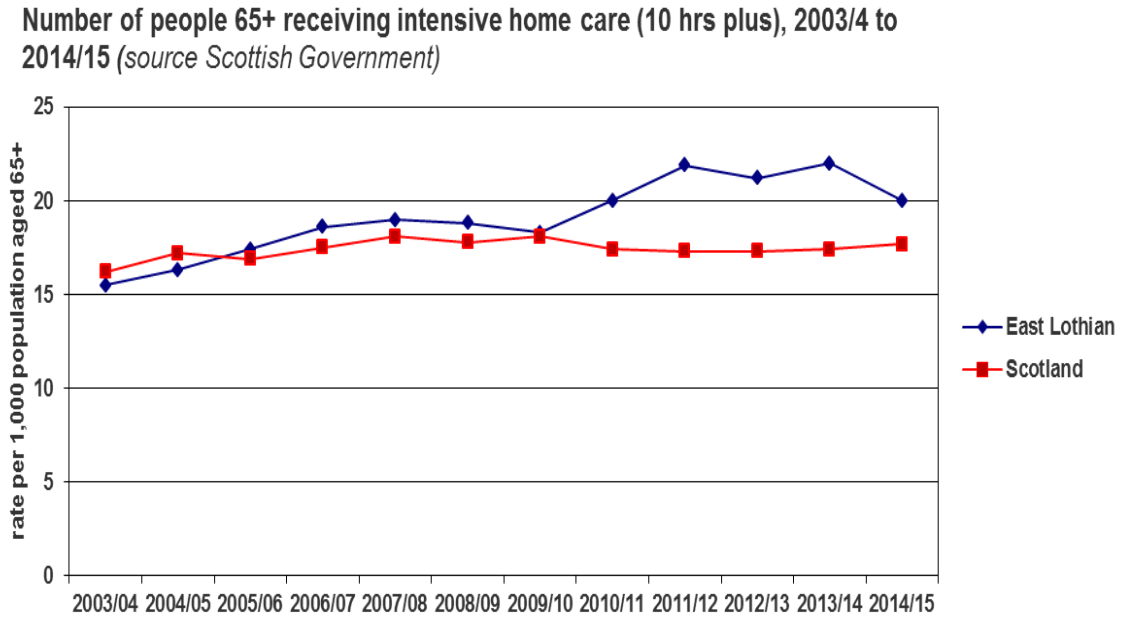

Chart 6 [R6]

2014, balance of care between older people living at home with intensive home care and older people living permanently in care homes *(source Scottish Government)*

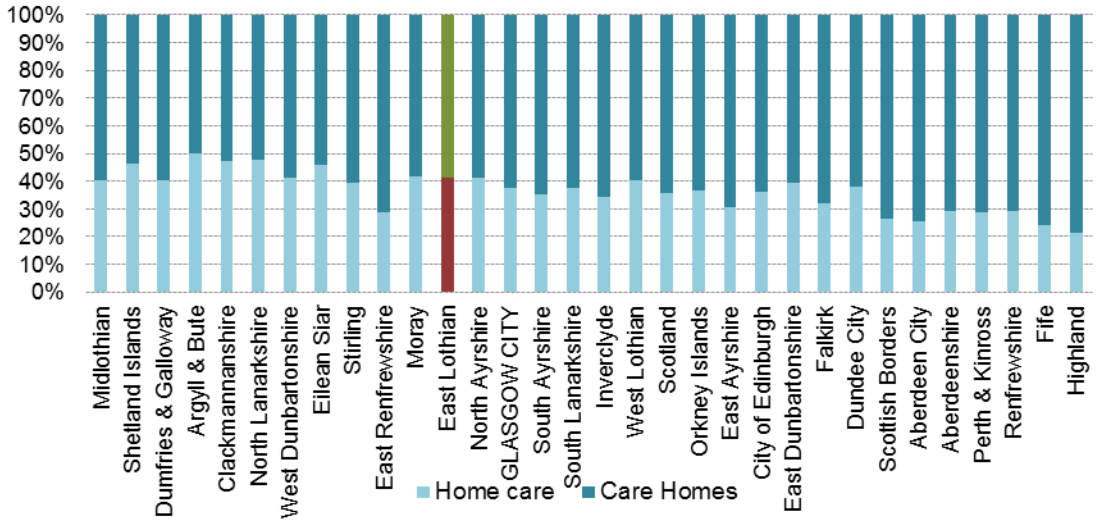

Chart 7 [R7]

Long stay care home residents aged **65+** supported by council , **2002/03 - 2014/15**
(source Scottish Government)

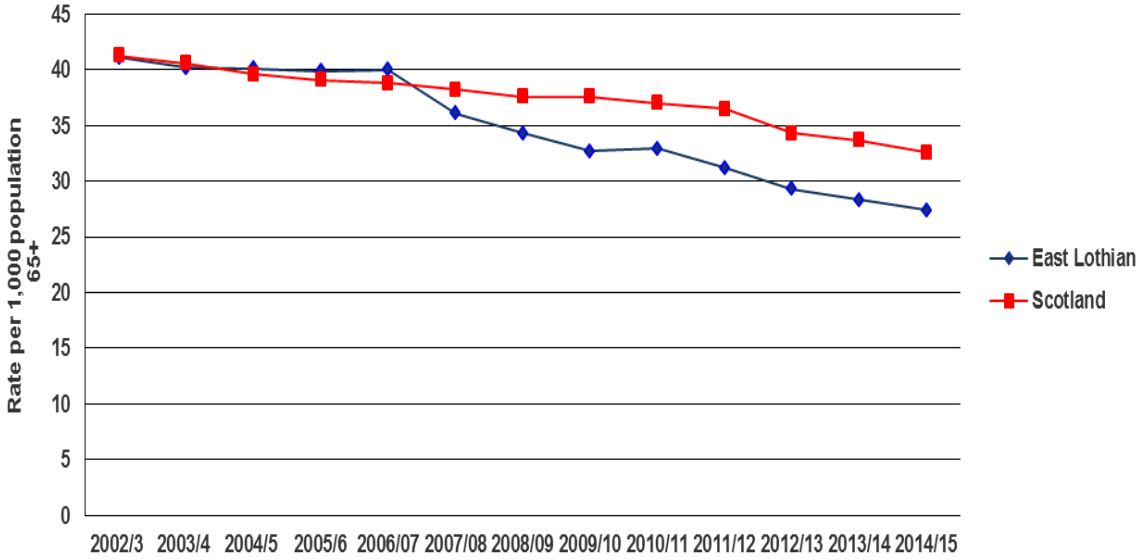

Chart 8 [R8]

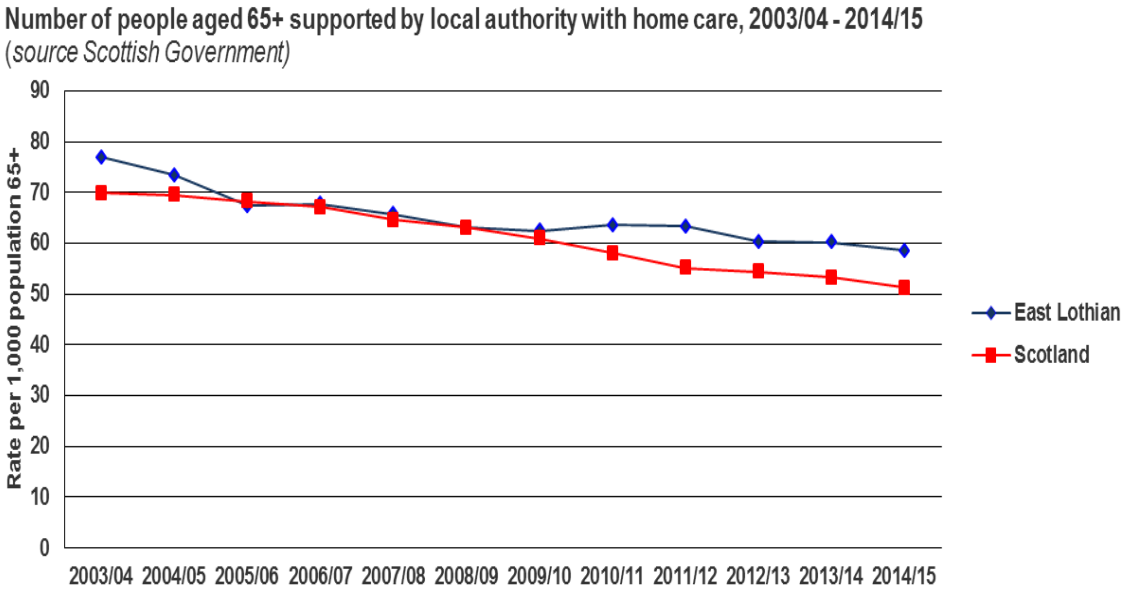
Number of people aged 65+ supported by local authority with home care, 2003/04 - 2014/15
(source Scottish Government)
Rate per 1,000 population 65+
90
80
70
60
50
40
30
20
10
0
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
East Lothian
Scotland

Chart 9 [R9]

Appendix 2 - Quality indicators

<table>
<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>
<tr><td>1. Key performance outcomes</td><td>2. Getting help at the right time</td><td>5. Delivery of key processes</td><td>6. Policy development and plans to support improvement in service</td><td>9. Leadership and direction that promotes partnership</td></tr>
<tr><td rowspan="6">1.1 Improvements in partnership performance in both healthcare and social care

1.2 Improvements in the health and well-being and outcomes for people, carers and families</td><td>2.1 Experience of individuals and carers of improved health, wellbeing, care and support

2.2 Prevention, early identification and intervention at the right time

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

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

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

5.4 Involvement of individuals and carers in directing their own support</td><td>6.1 Operational and strategic planning arrangements

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

6.3 Quality assurance, self-evaluation and improvement

6.4 Involving individuals who use services, carers and other stakeholders

6.6 Commissioning arrangements</td><td rowspan="2">9.1 Vision ,values and culture across the Partnership

9.2 Leadership of strategy and direction

9.3 Leadership of people across the Partnership

9.4 Leadership of change and improvement</td></tr>
<tr><td>3. Impact on staff</td><td>7. Management and support of staff</td></tr>
<tr><td>3.1 Staff motivation and support</td><td>7.1 Recruitment and retention

7.2 Deployment, joint working and team work

7.3 Training, development and support</td><td rowspan="3">10.1 Judgement based on an evaluation of performance against the quality indicators</td></tr>
<tr><td>4. Impact on the community</td><td>8. Partnership working</td></tr>
<tr><td>4.1 Public confidence in community services and community engagement</td><td>8.1 Management of resources

8.2 Information systems

8.3 Partnership arrangements</td></tr>
<tr><td colspan="5">What is our capacity for improvement?</td></tr>
</table>

care inspectorate

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

We can provide this publication in alternative formats and languages on request.

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