



Services for older people in South Lanarkshire

June 2016

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

Services for older people in South Lanarkshire

June 2016

Report of a joint inspection

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

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

© Care Inspectorate and Healthcare Improvement Scotland 2016

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, background and the South Lanarkshire context	2
Summary of our joint inspection findings	5
Evaluations and recommendations	10
Quality indicator 1 – Key performance outcomes	12
Quality indicator 2 – Getting help at the right time	20
Quality indicator 3 – Impact on staff	31
Quality indicator 4 – Impact on the community	35
Quality indicator 5 – Delivery of key processes	39
Quality indicator 6 – Policy development and plans to support improvement in service	47
Quality indicator 7 – Management and support of staff	56
Quality indicator 8 – Management of resources	61
Quality indicator 9 – Leadership and direction	68
Quality indicator 10 – Capacity for improvement	71
Appendix 1 – Quality indicators	74

About this inspection

From September until November 2015, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services¹ for older people in South Lanarkshire. 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 South Lanarkshire Health and Social Care Partnership had made with health and social care integration.

Our joint inspection involved meeting over 100 older people and carers who cared for older people, and around 550 staff from health and social work services, the third sector and the independent sector. We studied a lot of written information about the health and social work services for older people and their carers in South Lanarkshire. We are very grateful to all of the people who spoke with us during this inspection.

The South Lanarkshire Partnership includes principally South Lanarkshire Council and NHS Lanarkshire and is referred to as ‘the Partnership’ throughout this document. In South Lanarkshire, social work services, most community health and acute hospital services were delivered by South Lanarkshire Council and NHS Lanarkshire. In addition some specialist health services were also delivered by other NHS Boards, primarily Greater Glasgow and Clyde, on behalf of the South Lanarkshire Partnership. These were agreed through service level agreements.

Background

Scottish Ministers have requested that the Care Inspectorate and Healthcare Improvement Scotland carry out joint inspections of health and social work services for older people. The Scottish Government expected 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 good outcomes² for individuals and carers.

At the time of inspection Partnerships, across Scotland, were establishing transition arrangements to the integration of health and social work services. Each Partnership was producing a joint integration plan, including arrangements for older people’s services.

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, 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.

Partnerships also had to produce a joint strategic commissioning plan. We scrutinised how prepared Partnerships were for health and social care integration. It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

The purpose of this report is to evaluate the progress that the South Lanarkshire Partnership was making towards joint working, how that progress was impacting on outcomes for older people who used services and their carers.

South Lanarkshire context

South Lanarkshire is located in central Scotland. It covers 1,772 square kilometres and is the eleventh largest geographical local authority area in Scotland. In population terms, South Lanarkshire, had an estimated 315,360 people (2014 mid-year estimate) and was the fifth largest local authority in Scotland by population. The area encompassed a diverse mix of urban and rural environments covering four main areas which had been adopted as service planning areas. These were:

- Clydesdale
- East Kilbride
- Hamilton
- Rutherglen and Cambuslang.

The major settlements lay in the north of the council area and included Hamilton and East Kilbride, and smaller towns such as Cambuslang and Rutherglen which were close to Glasgow city. Rural areas included Lanark, Strathaven, Forth and Carluke.

Of the population of South Lanarkshire, 54,899, 17% were aged under 16 years with 66% aged 16 to 65 years and 17% aged 66 over years. A total of 25,509 (8%) were aged over 75 years.

Over the 2016-2026 period the total population was projected to increase by 4,797 or 1.5%. However, the numbers aged 65 to 74 years were due to increase by 5,959 or 18% and the numbers aged 75 years and over by 9,157 or 34%.

Over the 2012 to 2037 period the number of households in South Lanarkshire was projected to increase by 10.6%. By 2037 just over a fifth of households in South Lanarkshire will be headed up by someone aged over 75 years. Over 4,000 households were projected to consist of a person aged over 90 years living alone.

The 2012 Scottish Index of Multiple Deprivation showed that 53 South Lanarkshire data zones (13.3%) were in the 15% most deprived areas of Scotland. South Lanarkshire had the fifth largest number of employment deprived people in Scotland (13.8% of the working age population) and also the fifth largest number of income deprived people (14%). Both rates were above the Scotland average.

Around 21,000 were currently employed in health and social care and the latest employment forecasts see job opportunities rising by 2025 at a rate at least three times that of the economy as a whole driven in the main by the growing and ageing population.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (Appendix 1). Our findings on the Partnership's performance against 10 quality indicators are contained in 10 separate sections of this report. The sub-headings in these sections cover the main areas we scrutinise. We 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 also look at the role of the independent sector and the third sector³ to deliver positive outcomes for older people and their unpaid carers.

The inspection teams are made up of inspectors and associate inspectors⁴ 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 partners⁵ on each of our inspections.

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/

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.

Summary of our joint inspection findings

Outcomes for older people and their carers

Positive personal outcomes were being achieved for most older people and the majority of older people we met were generally content about the care and support they received.

The Partnership's performance was at comparable levels with the Scotland average in respect of emergency admissions, multiple emergency admissions and bed days occupied by service users aged 65 years and over subject to an emergency admission. However, rates had been increasing in recent years. The balance between hospital, care home and community care provision was improving with most service users supported at home compared to the proportion supported in care homes.

This not only helped to reduce the need for admission to hospital but supported discharge from hospital as well as supporting service users to remain at home. However, there was room for improvement. For example, progress had been limited in the development of bed-based intermediate care.

There were some positive preventative approaches to providing care and support to service users. There had been substantial investment in resources for telecare and telehealthcare services. This effectively supported large numbers of older people, including those with long-term conditions.

There were also high levels of respite care provision for older people and this was valued by carers who received it. However, approval processes to enable respite to be provided for the first time were sometimes lengthy.

However, despite these positive activities, the Partnership faced significant challenges in respect of delayed discharges from hospital. The number of service users experiencing delays had been increasing and was above the Scotland average. This was due, in part, to a lack of care at home capacity and bed-based intermediate care provision. These were areas that required 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.

Getting help at the right time

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 Partnership had worked with the third sector to increase support to carers. Improvements were needed in how information about carers' needs were identified, assessed and shared, so that carers could have better access to services for themselves and those they cared for. Carers wanted better access to respite care to support them to enable their older relative to stay at home for longer.

The quality and sharing of anticipatory care planning information was improving as was the delivery of palliative care. People with dementia did not always get post-dementia diagnostic support when they needed it.

Falls prevention and management activities produced better than national average results in the levels of those admitted to hospital as a result of a fall. However, falls prevention services were not always available.

Progress was being made in making sure that older people were offered self-directed support but access and availability needed to be improved.

Impact on staff

Staff were generally well motivated and worked well together to support older people to live in the community. Some staff told us that they were working to capacity and, as a result, were unable to carry out early intervention work. Workload pressures in some frontline services were being compounded by vacancies and staff turnover. This impacted adversely on staff morale in some areas.

There was evidence of good multi-disciplinary working and a commitment to providing good standards of care to service users. Most staff were enthusiastic about what integration of health and social care services could offer to improve outcomes for service users.

The Partnership used several approaches in communicating and informing staff, some of which were more effective than others. Frontline staff reported mixed views about the effectiveness of these approaches and there were concerns about how integration might impact on jobs and services. Most staff felt well informed about integration and had attended briefing events. Senior managers recognised ongoing dialogue with staff was needed to enable staff to feel more engaged.

Most staff were supported by their line manager and had access to professional development and effective line management. However, supervision and support was affected by workload pressures and the regularity and quality was variable in different services.

Impact on the community

The Partnership demonstrated a commitment to engagement and consultation with the community and building the capacity of local communities. It had engaged with the public about strategy development and decisions about service change to better meet the health and social care needs of older people.

Managers had an awareness of the important role that local communities could, and needed to, play. There was a good range of community supports which were in place to promote healthy lifestyles, reduce isolation and support carers. The Partnership was seeking to work productively with older people, the third and independent sectors to improve engagement and increase awareness of the local community responses to delivering support. Older people and carers were complimentary about the support they received from these groups.

The Partnership was developing further its locality-based approach to designing services to meet the needs of the local population. However, the Partnership needed to do more to measure the outcomes of these community supports, and ensure shared learning. The Partnership needed to do more to keep staff updated on the positive work they were carrying out.

Getting a service and keeping safe

There was generally good availability of information about access to services. The Partnership needed to work towards improving the pathways for accessing services for example the development of a joint single point of access.

Assessment and care management was generally good. However, there were some areas for development such as the preparation of chronologies. Case allocation could lead to delays in assessment and service delivery. Decision making arrangements through the Resource Allocation Group was causing difficulties for frontline staff and delays for some older people receiving services.

The Partnership had established processes to identify and protect adults at risk of harm. There were good working relationships across agencies involved in adult protection and support activity. Work was underway, led by the chair and co-ordinator of the Adult Support and Protection Committee, to improve its performance. While staff felt confident and supported in managing risk, the preparing and recording of risk assessments and management plans needed to improve.

Older people were being involved in decisions about their care and support. However, the implementation of self-directed support for older people was in its early stages and was not as extensive as for other care groups. The options available for service users through self-directed support were limited by availability of service providers in some areas. Further development was needed in areas to support choice.

A range of advocacy services were in place. However, information on the availability of advocacy services needed to improve.

Plans and polices

The Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked the finer detail on how they would be achieved. These plans set out the case for change and how the Partnership aimed to work with stakeholders to deliver these changes to improve outcomes for service users and their carers.

The Partnership had successfully supported the development of a range of early intervention and support services for older people and their carers. The partners were beginning to develop a joint approach to the deployment of resources.

The Partnership had used a range of quality assurance, self-evaluation and improvement approaches. Performance information was produced, reported and made available for consideration to the Partnership's senior and local management as well as council elected members and NHS board members. A draft joint performance framework linked to national outcomes was being prepared. The Partnership needed to be sure that the framework contained challenging but achievable targets for service users and their carers.

Productive joint planning arrangements were in place involving older people and their carers. Stakeholders such as the third and independent sectors were engaged with involvement in formal planning structures.

The Partnership recognised local care market challenges and was beginning to address them. It had made some progress with the 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. The Partnership needed to develop its commissioning approach to further shift the balance of care towards community services to add to the progress made so far.

Management and support of staff

The Partnership was at a very early stage of developing joint workforce planning. It had placed substantial resources into workforce training and development. Both the council and NHS Lanarkshire had a range of policies and strategies to support staff. There was evidence of health and social work services staff working effectively together to deliver good outcomes for older people and their carers.

Both organisations recognised that there were recruitment issues in some staff groups. This affected the capacity and capability of some services. Different ways to address these had been explored. However, more needed to be done.

Deployment of staff remained at a largely individual agency level although almost all staff told us there were good working relationships amongst practitioners. Most staff said managers gave them good support to explore development opportunities.

A joint workforce strategy to support health and social care integration that delivered more joint training with the third and independent sectors would be beneficial to progressing integration.

Partnership working

Good groundwork was in place for health and social care integration. Separate but effective budget management approaches existed. The new senior management structure was being put in place.

The Partnership needed to maintain the standards of effective financial governance that health and social work services had previously achieved.

The Partnership was moving in a positive direction for the sharing of information between partners. Some important information was being shared at a performance level. Partners were unable to effectively share key information electronically, such as assessment documentation, between frontline services. The Partnership had made some progress with electronic information sharing between health and social work services staff. This progress needed to be consolidated and developed.

The Partnership still had to finalise their financial budgets for the Integrated Joint Board and finalise its joint commissioning plan. However, we were satisfied that the basis upon which partnership working between health and social work services in South Lanarkshire was being built would meet the expectations contained within principles of integration.

Leadership

The Partnership had a clear vision for the future integrated delivery of health and social care services. Integration planning was progressing. Joint management, governance and locality commissioning structures were being established.

Leaders needed to communicate better about plans for health and social care integration. More work was needed to make sure that all staff understood the vision and priorities. While some joint working took place across the Partnership, the management of change needed to become more effective.

Consultation and communication with staff and other stakeholders was an ongoing activity but needed some improvement.

Capacity for improvement

The Partnership delivered good outcomes for most 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 undertake further improvements to reduce 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 other areas for development.

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

Evaluations and recommendations

We assessed the South Lanarkshire Partnership against 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	Adequate	
4	Impact on the community	Good	
5	Delivery of key processes	Good	
6	Policy development and plans to support improvement in service	Adequate	
7	Management and support of staff	Good	
8	Partnership working	Adequate	
9	Leadership and direction	Adequate	

Recommendations for improvement	
1	The Partnership should continue to develop joint approaches that help deliver on the Scottish Government delayed discharge targets to make sure older people return to their own home or a homely setting in which their needs are better met.
2	The Partnership should prepare and implement a joint, coherent approach to intermediate care home beds to help prevent hospital admission and support hospital discharge, concentrating its efforts on those areas without ready access to a community hospital.
3	The Partnership should work further with services supporting carers to improve how information about carers' needs are identified, assessed and shared so carers have better access to services for themselves and those they care for.
4	The Partnership should put further measures in place to ensure that post-diagnostic support should be available to those with dementia and their carers where required.
5	The Partnership should put in place further measures that increase the choice, availability and uptake of self-directed support for older people and their carers.
6	The Partnership should improve its approaches to the allocation of referrals and assessment of cases to make sure that they are completed within agreed timescales so this assists service users to receive services in a timely manner.
7	The Partnership should ensure all relevant case records contain accurate chronologies and, where appropriate, have written risk assessment and risk management plans in place so that people's care needs are better assessed and planned for.
8	The Partnership should make sure that the future joint strategic commissioning plan gives detail on: <ul style="list-style-type: none"> • how priorities are to be taken forward and resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • full and detailed costed action plans including plans for investment and disinvestment based on identified future needs, and • expected outcomes.
9	The Partnership should refresh its consultation and engagement approach with a range of stakeholders to better communicate on: <ul style="list-style-type: none"> • its vision and objectives • service redesign • change management, and • working with the third and independent sectors.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

Positive personal outcomes were being achieved for most older people and the majority of older people we met were generally content about the care and support they received.

The Partnership's performance was at comparable levels with the Scotland average in respect of emergency admissions, multiple emergency admissions and bed days occupied by service users aged 65 years and over subject to an emergency admission. However, rates had been increasing in recent years. The balance between hospital, care home and community care provision was improving with most service users supported at home compared to the proportion supported in care homes.

This not only helped to reduce the need for admission to hospital but supported discharge from hospital as well as supporting service users to remain at home. However, there was room for improvement. For example, progress had been limited in the development of bed-based intermediate care.

There were some positive preventative approaches to providing care and support to service users. There had been substantial investment in resources for telecare and telehealthcare services. This effectively supported large numbers of older people, including those with long-term conditions. There were also high levels of respite care provision for older people and this was valued by carers who received it. However, approval processes to enable respite to be provided for the first time were sometimes lengthy.

However, despite these positive activities, the Partnership faced significant challenges in respect of delayed discharges from hospital. The number of service users experiencing delays had been increasing and was above the Scotland average. This was due, in part, to a lack of care at home capacity and bed-based intermediate care provision. These were areas that required 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.

1.1 Improvements in partnership performance in both healthcare and social care

The South Lanarkshire Partnership's key performance outcomes for older people had a number of performance measures indicating performance better than the average for Scotland as a whole. However, there were a substantial number indicating performance either in line with or poorer than the Scotland average.

There was room for improvement in delivery of services that helped the prevention of emergency admissions. The Partnership was performing at adequately comparable levels with the Scotland average in emergency admissions, multiple emergency admissions and bed days occupied by service users aged 65 years and over subject to an emergency admission. However, rates had been increasing in recent years. Our staff survey found that less than half of respondents agreed that there was a broad range of services available to offer alternatives to hospital provision.

Performance in relation to delayed discharges had historically been poorer compared to Scotland average levels. Overall the Partnership's performance on preventing delayed discharges against the Scottish Government targets was consistently below Scotland average levels, as was the associated bed days occupied by delayed discharges. The Partnership acknowledged that this was an area for improvement. The most common reason for delayed discharge was due to delays in the allocation and completion of community care assessments. Another common reason was service users waiting to go home but were unable to do so. This was mainly due to no care at home service being immediately available or that they were waiting for a care home placement.

Bed days lost to code nine⁶ delays were below Scotland average levels. Some of the health and social work services staff we met told us that a few individuals, who lacked capacity, experienced delays. This was due to powers (in line with the Adult with Incapacity (Scotland) Act 2000) being obtained from a court to move them from an acute hospital bed to a care home.

The Partnership had a number of initiatives to address delayed discharges. One such initiative was integrated 'discharge hubs' at Hairmyres and Wishaw Hospitals. Most of the comments we heard about the hubs were positive. Successes had included better sharing of information about older people's needs, greater clarity and consistency of discharge planning processes which led to greater confidence in older people being discharged with appropriate care packages. The 'hubs' had helped to improve the joint working relationships between hospital wards (and especially the care of the elderly wards) and the social work service.

Staff recognised the need to have similar approaches with accident and emergency services and receiving wards. This was clear from the comments we received from some hospital based staff who said they considered some relatively straightforward discharges were better achieved without reference to the 'discharge hubs'. They told us of a few cases where suitable care packages had not been put in place following discharge and this had led to a readmission which had caused the service user and their carer's distress. We concluded that the Partnership needed to further develop its services to improve its performance in relation to delayed discharges.

⁶ Code nine delayed discharges are mainly due to patients who lack capacity and require powers from a court to move them from an acute bed to a care home. Code nine delays can be due to the need to secure a specialist health resource for a patient.

Recommendation for improvement 1

The Partnership should continue to develop joint approaches that help deliver on the Scottish Government delayed discharge targets to make sure older people return to their own home or a homely setting in which their needs are better met.

In 2014 a national inpatient experience survey⁷ took place which covered Lanarkshire hospitals. Of the respondents, 38% were older people. The responses were mostly positive. However, some Lanarkshire results were not as positive as the Scotland average figures. This included the questions about service users' views on the arrangements surrounding their discharge from hospital. A separate national health and care experience survey⁸ showed that responses in most areas (for example care, support and help with everyday living) were, generally, positive and in line with Scotland averages.

Unavailability of care at home staff (from any sector) in some locations was a theme throughout our inspection. Some older people had to wait too long for the care at home staff they required to meet their needs and deliver their desired personal outcomes. There was sometimes insufficient care at home provision to meet the needs of people at the time when the service user needed or wanted the service. Health and social work services staff and carers of service users reported this to be the case. Where the service user needed two staff to provide their personal care some individuals had their care delivered by more than one service provider. This made it difficult for teams to maintain continuity of care and promote personal choice.

Overall the Partnership delivered care at home services to an increasing number of older people. It was performing above the Scotland average in areas such as:

- percentage of care at home service users receiving a service during the evening or overnight, and
- percentage of care at home service users receiving community alarm/telecare.

The Partnership was performing at around the Scotland average in the:

- percentage of care at home service users receiving a service during weekend
- levels of population over 65 years receiving care at home
- levels of population over 65 years receiving intensive care at home (more than ten hours per week), and
- percentage of care at home service users who were over 65 years.

The Partnership was performing less well, compared to the Scotland average, in the total number of care at home hours per population over 65 years.

⁷ 2014 NHS Lanarkshire Hospital Inpatient Experience Survey

⁸ 2013/14 NHS Scotland Health and Care Experience Survey

Most of the Health and Social Work service staff we met told us there was, in the main, an adequate level of care at home provision for most service users, however, care at home provision was service led, based on time allocation, rather than person centred. Care at home provision is best on a co-produced assessment based on individual needs. The Partnership recognised this was an area for improvement. Frontline staff and managers told us that in some instances where care at home services were unavailable the Partnership had been creative and provided assistance by having NHS nursing staff directly providing care. Whilst this was effective and showed the Partnership's commitment to enabling high quality care in a range of settings, the Partnership needed to evaluate the long-term appropriateness of this approach.

The Partnership had developed a range of services to support older people at home, avoid unnecessary hospital admission and support hospital discharge planning. These included 'Supporting Your Independence'. This was the Partnership's approach to reablement which focused on goal setting with older people over a period of up to six weeks. The Partnership reported that this resulted in a 30% average reduction in care at home hours between the start and end of the reablement period as service users gained skills and confidence to live more independently. Around 85% of service users referred to the care at home service, due to their needs profile, would go through the reablement process.

'Supporting Your Independence' provided an effective means of early intervention. Care at home staff confirmed that they had received training to follow a reablement approach. However, some said doing so could be a challenge given the time pressures they were working under and that it was often quicker to do things for service users rather than to support them to do things for themselves.

In each locality area 'Integrated Community Support Teams' provided inter-agency support for frail older people requiring co-ordinated support and care in their own homes. This led to improved outcomes for older people by preventing hospital admissions, allowing quicker access to care with an integrated approach. We received numerous positive comments about the teams during our inspection from service users, their carers and a range of staff. Carers liked the responsiveness of the teams. The teams had been strengthened further by the addition of evening and night time community nursing and care at home staff. Feedback suggested that the service could be improved by the teams having an occupational therapy equipment budget to prevent the need for a further onward referral to other services.

Example of good practice - Integrated Community Support Teams

These teams operated 24 hours a day, seven days a week, offering inter-agency support for frail older people. They consisted of community nurses, occupational therapists and physiotherapists, and the provision of out of hours care at home support. Team structures varied across locations. Out of hours services were co-located with care at home team members. The teams played a pivotal role in preventing hospital admission and enabling hospital discharge.

Hospital at Home was a multi-disciplinary acute care team, made up of NHS Lanarkshire consultants, advanced assessment nurses, allied health professionals and community psychiatric nurses. Established in the East Kilbride locality in April 2015 it was to be rolled out across all four localities in due course. Specially trained medical professionals provided immediate treatment and involved service users and carers in assessments and care plans.

As an alternative to hospital, the team delivered specialist, co-ordinated and comprehensive assessment and care to frailer older adults in their own homes. The team linked with care at home services and the Integrated Community Support Team. The model had been developed and tested in North Lanarkshire. Although relatively new in a South Lanarkshire context it had shown early signs of effectiveness. However, it was too early to conclude how positive its detailed impact had been.

Despite these initiatives, the Partnership still faced significant challenges in preventing unscheduled admissions to hospital and in achieving timely discharges from hospital. The lack of availability of permanent care home places, care at home capacity and intermediate care beds (step up and step down) were key factors. Frontline staff and managers confirmed this.

The development of four intermediate care beds had been piloted in an independent sector care home in East Kilbride. The number of referrals to the service had been low and the service was discontinued. It was unclear why the pilot had been unsuccessful as a full evaluation had not been completed. A further development of eight intermediate beds had commenced at a council care home in Stonehouse in the Hamilton locality. The Partnership also used beds in community hospitals as a step up and step down facility to enable older people to receive support in preparation for returning home.

However, there was a lack of a clear, coherent, jointly agreed and fully developed strategy for how intermediate care beds should be developed to meet demand in each of the four localities. Preventing unscheduled admissions to hospital and achieving timely discharges from hospital were areas for improvement. Health and social work services managers acknowledged this.

Recommendation for improvement 2

The Partnership should prepare and implement a joint coherent approach to intermediate care home beds to help prevent hospital admission and support hospital discharge, concentrating its efforts on those areas without ready access to a community hospital.

Overall there were higher than national averages of care home places, those supported long-term in care homes and the complete length of care home residents' stay, (aged over 65 years), on entry. This showed the Partnership needed to further shift the balance of care towards community settings.

There had been care quality issues in a few care home services. Resulting moratoriums on admissions to these services had impacted on capacity and subsequent delays in discharge from hospital due to the reduction in bed availability.

The Partnership had taken a proactive approach to improve quality of care in care home settings. Local enhanced GP services for all care homes for older people meant more proactive engagement in areas such as medication reviews and anticipatory care planning. A protocols group had been set up to make sure that care approaches were applied consistently across all care homes. Allied health care professionals promoted the maximisation of independence of individual care home residents. Care home liaison nursing services were viewed very positively by service providers particularly when they delivered clinical assistance, education and training. Link social workers visited care home services and helped to monitor the quality of services.

Positively, the Partnership's respite provision for older people and their carers was above the Scotland average. This was true for total, overnight and daytime respite provision. Some carers we met told us how much they valued the respite care they had received. Respite worked best when a programme of planned respite was already in place. However, some carers reported difficulties they had when seeking to access respite for the first time. They described the process as being complex and taking some time. This could intensify the pressure they were under as carers.

We heard variable comments from some carers about the availability of emergency respite. Most staff commented that it was usually available when required. However, some older people and carers told us that respite had not been available to them when they were in crisis. Some carers who cared for people with dementia, told us it was difficult to obtain respite and that this had a negative impact on their capacity to continue in their caring role. Obtaining respite beds for older people with dementia could be problematic. Whereas a number of beds were specifically available for these service users in the council's own care homes, beds were only available on a spot purchase contracted basis in the independent sector and supply was not always guaranteed.

The Care Inspectorate inspects regulated social care services delivered by local authorities, the voluntary and independent sectors. These services included care homes, housing support services and other support services for older people, for example care at home and day care services. For each service, the Care Inspectorate awards performance grades on criteria such as the quality of care and support, environment, staff and management and leadership. At the time of inspection regulated services were generally performing well across sectors and provision types.

Overall local authority care homes were performing at evaluations of good or better grades in areas such as quality of care and support, environment, staffing and management and leadership. Most council care at home and day care services were performing at good or better levels. Directly provided housing support services had evaluations of mostly good or better grades.

On average, third sector care homes were receiving good grades in the quality of care and support, environment and adequate or better for staffing and management and leadership. Third sector care at home services had adequate grades across all four areas inspected. Day care services were performing at good or better levels. Housing support services had good grades.

Independent sector care homes had a wide range of grades in areas such as quality of care, environment, staffing and management and leadership with the average at adequate. With some exceptions, many independent sector care at home and day care services were performing at good or better levels. Independent sector housing support services had mostly good grades.

It would help the Partnership's performance if it continued to monitor the level of care home provision along with the provision of care at home services (for example, in relation to delayed discharges). Statistical evidence showed that the Partnership was comparable to the national average 'balance of care' with most service users supported at home compared to the proportion supported in care homes. This was improving with a growing proportion of older people being supported at home. The Partnership needed to continue its work with providers and regulatory agencies to improve grades particularly in some independent sector care homes. In the main, with some exceptions, regulated care services delivered good outcomes for service users and their carers.

We found that the Partnership had invested significantly and well in telecare and telehealthcare. The Partnership provided higher levels of community alarms to older people than the Scotland average. One example of a telehealth development was the text messaging 'Florence' initiative. This helped monitor the condition of service users who had suffered from heart failure or chronic obstructive pulmonary disease. From our review of health and social work services records, there was evidence that telecare, including community alarms, had effectively supported many vulnerable older people to live independently and safely in their own homes. Future priorities involved home health monitoring and extending the uptake of telecare supported by more video conferencing and digital infrastructure.

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

During the inspection most service users and their carers told us that, as a result of the health and social work services they received, that they felt safer, were living as well as they could, had good wellbeing and things to do, as well as having friends and relationships.

Health and social work services delivered a range of positive personal outcomes for almost all of the individuals who were part of our case record sample. From our analysis of service users' social work and health records we concluded that 96% of individuals achieved one or more positive personal outcomes.

For 88% of cases there had been improvements in their circumstances which one would have reasonably expected to see. The most common positive outcomes achieved were staying as well as you can (80%), living where you want (77%) and feeling safe (75%). In 54% of cases the improvements were mainly a result of partnership working.

However, it should be noted that 30% had also experienced one or more poor personal outcomes. The most common poor outcomes were not seeing people (32%), not living where you want (25%) and not feeling safe (22%). In 16% of cases the lack of improvement was mainly as a result of poor partnership working.

We were encouraged to find that 73% of care plans we read were outcome focused. The results of our survey of health and social work services staff showed positive results in respect of outcomes. For example:

- 74% agreed that their service works well with other agencies to keep people safe and to protect people from risk of harm
- 74% agreed that their service does everything possible to keep older people at home and in their local communities
- 74% agreed that their service does everything to ensure that older people receive the health care they need when they need it most
- 72% agreed that their service does everything possible to make sure people are supported to live as independently as possible
- 71% agreed that services work well together to ensure that they are successful in helping older people lead as independent a life as possible; and
- 71% agreed that their service works well with its partners in supporting older people and any legally appointed person to be actively involved in the planning of their care.

However, there were less slightly positive responses where:

- 59% agreed that services worked well together to prevent avoidable hospital admissions, and
- 57% agreed that their workload was managed to enable them to deliver effective outcomes to meet individuals' needs.

Overall, we saw a range of services that helped deliver good personal outcomes in areas such as care at home, reablement, respite and telecare. However, to help deliver good personal outcomes there was room for improvement in particular areas such as prevention of admission to hospital, delayed discharges, intermediate bed-based care, and care at home.

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 Partnership had worked with the third sector to increase support to carers. Improvements were needed in how information about carers' needs were identified, assessed and shared, so that carers could have better access to services for themselves and those they cared for. Carers wanted better access to respite care to support them to enable their older relative to stay at home for longer.

The quality and sharing of anticipatory care planning information was improving as was the delivery of palliative care. People with dementia did not always get post-dementia diagnostic support when they needed it.

Falls prevention and management activities produced better than national average results in the levels of those admitted to hospital as a result of a fall. However, falls prevention services were not always available.

Progress was being made in making sure that older people were offered self-directed support but access and availability needed to be improved.

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

We found good outcomes were generally delivered for service users where staff worked together as part of multi-disciplinary teams and as multi-agency partners. A good range of options was available for older people to help support improved health and wellbeing. A number of self-management groups were in place.

Individuals using telecare and telehealthcare prompts told us how effective this was to help them manage their conditions. Some service users were able to access support from community groups organised to support self-management of long-term conditions. We saw examples of older people being supported to remain in their own homes with appropriate and responsive levels of care and support in place including support to manage long-term conditions.

As part of Reshaping Care for Older People agenda⁹ the Partnership had introduced 'Supporting Your Independence' which encouraged joint working. This supported the service user to achieve better self-care and self-management and the Integrated Community Support Teams to improve interventions at the right time.

The Partnership had clear processes and protocols in place for admission, transfer and discharge of service users from acute and community hospitals. In the main these processes worked well for service users. However, a lack of available care at home staff in some locations meant that some people had to stay longer in hospital than needed.

Older people and their carers told us about good services delivered by care at home and community nursing staff. However, we found that communication between care providers when more than one service provider was delivering care and support was challenging.

Occupational and physiotherapy services were reduced in capacity due to recruitment issues and vacancies resulting in limited service in the community hospitals. Occupational therapy staff told us there were waiting lists for occupational therapy assessments in some areas. We found that, generally, service users and their carers did not usually wait for long for the delivery of equipment. However, the Partnership could improve communication on waiting times when there was a delay.

Support to carers was promoted by both the South Lanarkshire Carers Network (the strategic voice of carers) and the Carers Trust Lanarkshire Carers (information and direct support to carers). The Carers Network told us of their involvement in strategic planning events and the development of services. Network members told us they felt actively involved in the planning of future services for carers. Lanarkshire Carers Centre took referrals from a wide number of sources to help co-ordinate assistance for carers.

The South Lanarkshire Carers' Strategy (2012-17) set out the priorities to support those who provided unpaid care. A range of services offered support to carers. These reflected the main priorities of the local carers' strategy which was being updated. Good examples included NHS carer support team, dedicated carer welfare rights officers, carer's support workers and an enhanced GPs service for carers.

Delays in accessing carer assessments were common. Carers told us they found it frustrating as they could not access some services without the assessment. They had difficulties in getting a response from social work when they asked for an assessment. Senior managers told us a new model of carer assessment, a carer enablement plan with a resource allocation feature, was being developed with input from carers. This was due to be implemented in spring 2016.

⁹ Scottish Government Reshaping Care for Older People: A Programme for Change 2011–2021

Carer assessments were carried out by council social work services. Staff and carers told us that the sharing of carer information and access to services depended upon individual social worker's awareness. Information between council social work, Lanarkshire Carers Centre and the NHS carer support team was not always shared and co-ordinated. On occasions this did not lead to service delivery. There were gaps in how carers obtained information. Some carers were not always made aware of the options available to them for their own support and support for the individual they cared for.

Example of good practice - NHS Carer Support Team

The NHS Carer Support Team had a co-ordinator in each main acute hospital as well as assistants including some who worked specifically with people with mental health problems or dementia. In hospital, the team received referrals from acute and community health services. The team was involved in referrals to other services, hospital multi-disciplinary teams, discharge planning, sign posting to services and follow up calls to carers. In the community the team had links with GPs (for example the GP carers' registers had 6,500 carers), signposting and providing lifting and handling training for Lanarkshire Carers Centre.

From our review of case records just over half (53%) had a carer who provided a substantial amount of support. Of these we found that carer assessments were not offered in 66% of cases. Of those carers who did receive an offer of a carer's assessment, more than half declined. Where the offer of an assessment had been accepted, a completed assessment was evident in half of cases. Staff and managers generally acknowledged the need for increased awareness of, and focus on, the added value for carers in having their own needs assessed.

Recommendation for improvement 3

The Partnership should work further with the services supporting carers to improve how information about carers' needs are identified, assessed and shared so that carers have better access to services for themselves and those they care for.

Our staff survey found that 73% of the respondents agreed that the views of carers were taken into account when planning and providing services to individuals. Over two-thirds (69%) of respondents agreed that their service worked well with partners to make sure that older people and their carers were provided with full information about any support, care or treatments they required. Carers told us that they had access to carers support groups for carers of people with dementia, for example 'stress and de-stress groups'. Carers told us that they had good support from day service staff and where they had access to specialist support this had been helpful. However, carers had concerns about continuity of care at home staff as some carers had experienced frequent changes in staffing which were confusing to older people with dementia.

Some carers told us that respite care had become difficult to arrange and plan, with some reporting that respite was only available in emergency situations. The impact of these delays meant that carers could not commit to holiday arrangements with any certainty. These delays increased carers' stress.

A few carers we met felt that the services that they had been offered had been inadequate or had been offered at the wrong time. Care at home services were not always available when the service user wanted them. One of the reasons this had happened was due to difficulties with the recruitment of care at home workers and staff rotas.

Some carers reported that they had not been offered training. From our case record reading we found that half of carers had not been given relevant information or advice on equipment or adaptations. Only one in 10 had attended training organised by health or social work services.

Example of good practice: 'Respitivity'

Lanarkshire Carers Centre had introduced a 'Respitivity' project where carers could have a short break away from caring. The scheme offered free or discounted breaks within the local hospitality sector. Carers could access this following registration as a carer through their local GP practice or social work service. This had increased options for carers to access a break even for short periods and showed good use of local community resources.

2.2 Prevention, early identification and intervention at the right time

We found that the Partnership had made good progress with providing help and support to older people with long-term conditions. The Partnership's initiatives for the management of long-term conditions delivered good outcomes to older people. These enabled older people to have more control and choice by planning for their preferred support and care intervention should there be a deterioration in their condition.

Staff described a wide range of initiatives such as 'Weigh to Go' and 'Healthy Valleys' to support local communities in ill-health prevention activities. However 47% of respondents to our staff survey agreed that older people were able to access a range of preventative and enabling services to suit their needs when they needed them.

From our staff survey 72% of staff felt that services worked well together to support people's capacity for self-care and self-management. Additionally, 63% of staff agreed that services worked together to enable people with long-term conditions and those with dementia to remain active. Most staff had a good understanding and knowledge of activities available for older people to manage their condition and how they could access these activities.

Service users told us that they found self-management support enabled them to remain well at home. Many of the service users we spoke with in self-management groups were positive about how they had been signposted, when they were diagnosed, to a helpful activity by staff. From our review of health and social work services records, we were encouraged to see that in almost all the records we read (95%) the older person had been supported to self-manage their condition. In the majority of cases, the support was provided by more than one service.

'Living It Up' was an online self-management hub, which empowered people to improve their health and wellbeing. It was useful for those with long term health conditions. The Partnership had been proactive in making sure that the local section content was relevant and up to date on the website. The website provided a good range of information about groups and activities that would enable individuals to participate in meaningful activity, help reduce isolation and improve wellbeing.

A few unscheduled admissions of older people to hospital were related to medicines management. We learned about positive work carried out by local pharmacy services. These included participating in reviews of medicine management, polypharmacy reviews¹⁰ and contributing to resource allocation assessments. Staff reported that this had worked well.

A pilot project, aimed at expanding the administration of medicine at home with enhanced training, was underway. This project was to fully include the independent sector. This involved the participation of pharmacy services, social workers, community nurses and care at home services.

There was also dedicated support for care homes from pharmacists. This included consultation and training on tools, guidance and processes for medicines management. These had led to less polypharmacy and associated risks, reduced costs and improved service user care. There had been positive feedback from care homes about this.

Some NHS staff told us that the medication reconciliation and management process on admission and discharge did not always work well. They cited instances where older people were being discharged from hospital without their medication which placed an immediate pressure on the carers and the local GP practice to rectify this quickly.

The Partnership was implementing its own dementia action plan based on Scotland's National Dementia Strategy 2013-2016. The Partnership had set up a dementia strategy planning group. The role of carers and the independent sector needed to be more incorporated into the work of this group to help make sure that all stakeholders' views were represented.

We noted from statistical evidence that the Partnership performed at about the Scotland average in diagnosis of dementia. We were informed that the vast majority of service user diagnosis of dementia was by a consultant and not GPs.

¹⁰ Polypharmacy – the use of multiple medications

Consultants were content for GPs to diagnose but this rarely happened. GPs told us that access to mental health officers and their response to statutory requirements was generally good. Staff told us that the waiting time for an older person with dementia to see a consultant was typically eight to 12 weeks. It would strengthen the Partnership's performance if access to a diagnosis was more widely available. This could reduce waiting times.

There were inconsistencies in local delivery. Community mental health teams offered support following diagnosis. Staff had concerns that there were not enough resources to deliver services to meet increased demand. These concerns included service users waiting long periods of time to access post diagnosis support. In many cases support was stopped a year after diagnosis. This was reflected in our staff survey where:

- 46% of respondents agreed that their service did all it could to make sure that older people receive a timely diagnosis of dementia, and
- 37% of respondents agreed that older people were able to timely access post diagnostic support.

Staff raised concerns with us that the Partnership used an overly strict interpretation of the Scottish Government's national Heat Target¹¹ by limiting post-diagnostic support to a one year period only. We heard from staff and service users that waiting lists had increased and that additional support to community groups such as the 'dementia café' and 'call back' services had been reduced as resources were otherwise reprioritised.

Recommendation for improvement 4

The Partnership should put further measures in place to ensure that post-diagnostic support should be available to those with dementia and their carers where required.

Improvement action plans were underway in acute settings to help deliver better care for people with dementia. For example, 'getting to know me' documentation was used by both the council and NHS Lanarkshire. This tool was an excellent way of sharing information when an older person was admitted to hospital. However, consultants were concerned that some older people with mental health problems were placed in care of the elderly wards in Udston Hospital when they should be in specialist old age psychiatric wards. Udston Hospital did not have the same level of comprehensive care for dementia compared with Hairmyres Hospital. This was causing staff concern. The Partnership's preference was to concentrate provision for South Lanarkshire of old age psychiatric beds on one site. However, this was not planned in the immediate future.

¹¹ Scottish Government target - To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker, including the building of a person-centred support plan.

As a general approach the Partnership were trying to encourage a move away from medication only focussed responses to dementia through 'Promoting Excellence'¹². They had seen some progress with this and we noted that care homes and day services were less likely to request medication responses as a result.

Alzheimer Scotland delivered dementia training and this was well embedded throughout the Partnership in various care settings. Day services had been developed that provided for people with dementia and their carers told us that these services were of a high quality. High demand outstripped local supply for residential and nursing care dementia beds. We met with some carers of people with dementia. They told us that they did not always feel supported by staff when trying to support their relative at home. They had experienced difficulties obtaining information accessing services, particularly respite services.

The Partnership had made good progress in the preparation and sharing of anticipatory care plans. Over 17,000 plan summaries had been created across North and South Lanarkshire with service users provided with a paper copy to keep at home. GPs, community and Macmillan nurses, were increasing the number of anticipatory care plans they completed. The quality and the detail contained within plans were variable.

Some health staff we spoke with (such as community nurses) said that these plans had directly prevented a number of older people from being admitted to hospital. This positive approach could be improved if more information from the plans was more routinely shared. Plans were mostly single agency (health) plans, with limited contributions from social work services. Many social work staff perceived that these plans were primarily a health tool. To try to address this, the Partnership had a focus on anticipatory care planning 'champions' training to cascade information and practice to a wider range of staff. This included care home, care at home, mental health and community psychiatric staff. Engagement with advocacy services to help prepare anticipatory care plans was also underway.

Some service users living in care homes told us that they had their anticipatory care plan prepared by care home staff familiar to them and then shared with their GP and the Scottish Ambulance Service. Some staff told us that plans were mostly completed for people who have palliative care needs. There had been a drive to expand take up with service users with long-term conditions. There had been positive public campaigns on anticipatory care take up and carers' organisations had started to hold anticipatory care planning clinics.

GPs were positive about anticipatory care planning and having individual GP practices allocated to each care home helped. Plans were available to hospital services through 'key information summaries'. However, these could not be shared readily electronically with social care and other services. This issue also applied to sharing information with the Scottish Ambulance Service. For example, care homes used paper versions. GPs had an electronic version and therefore there could be delays updating these plans. Managers told us that systems needed to be improved for sharing plans.

¹² Promoting Excellence – A Skills and Knowledge Framework for Dementia – Scottish Government (2011)

Progress was being made in delivering palliative care for older people. A palliative care strategy aimed to provide services to service users in their own homes or their care home where necessary. Around 90% of people spent their last six months of life at home or in a community setting. Although performance was improving it was still below the Scotland average. Support to people at the end of their life was prioritised well by all services.

The Partnership was operating a 'generalist model' where mainstream nursing was supported by specialist Macmillan nurses hosted by NHS Lanarkshire. Seven day community nursing support was available. These staff worked purposefully with Macmillan nurses and Marie Curie to help deliver co-ordinated care. Staff told us that where palliative care needs had been identified, health and social care services worked well in supporting the service user and carer with a range of services. This included overnight services, to allow people to die at home. NHS Lanarkshire had prioritised palliative care specialist cover at weekends and palliative care hospital discharge management.

Although services were prioritised for palliative care, we heard from staff and carers that a few service users with palliative care needs had to wait for care services. This was due to the lack of available care at home staff to support them at home. Community nursing services would assist by providing required care until care at home was available. The aim being that this would be for a maximum of one week. We found a willingness and commitment by staff to support palliative care arrangements from all staff. However, a few staff reported equipment delays for palliative care cases (for example for hoists). However, we were told that the 'Resource Allocation Group' prioritised palliative care cases.

The Partnership could commission from specialist hospice palliative care beds in Airdrie and Denny. Three community hospitals in South Lanarkshire also offered step up and step down care, rehabilitation and admitted GP palliative care referrals. Over 20 local pharmacies specialised in palliative care allowing medication to be accessed when required. Palliative care 'champions' were in place in each care home. Marie Curie nursing was available on a commissioned basis. However, staff told us that access to this service was sometimes constrained due to resource constraints. Weekly multi-disciplinary 'gold standard' palliative care meetings were held with Macmillan nurses, GPs and community nursing. These were viewed positively by staff. GPs aligned with care homes helped with medication and palliative anticipatory care plans. A protocols group helped to make sure there was consistency in the support and pathways for anticipatory care planning.

A 'hub' model provided a multi-disciplinary support approach to hospital discharge. Discharge hubs had been formed to quicken hospital discharge and provide an improved link between acute settings and social work services. Multi-disciplinary team meetings in hospitals used a 'huddle' format to discuss and progress discharges from hospital. This provided a good platform to promote quicker discharge. Staff told us that they generally worked well together. However, there could be tensions on timescales and resources. Staff were keen to develop this approach with hospital accident and emergency services to help deliver earlier interventions for service users. The discharge hubs also helped to prioritise palliative care for rapid discharge.

The realignment of NHS Greater Glasgow and Clyde and NHS Lanarkshire boundaries and the corresponding transfer of services were in transition. Social work staff felt they had lost good working relationships with NHS Greater Glasgow and Clyde Health staff and this had led to delays in discharging service users in some cases. Staff told us of the added frustration when Glasgow hospitals would sometimes discharge service users without communicating with health care services in South Lanarkshire.

There were examples of a lack of co-ordinated planning and support for hospital discharge. In a few cases, older people experienced problems when being discharged from hospitals in the NHS Greater Glasgow and Clyde area.

In these instances care home and care at home staff told us that they had received little notice of when the older person was to be discharged. This meant that some older people were moved from a hospital in the NHS Greater Glasgow and Clyde area with limited discharge planning information. In these occasions the outcomes for the older people involved were poor with packages of support unable to be planned in advance. Senior managers had recognised this issue and placed a social worker link officer in Glasgow hospitals to try and improve discharge planning.

Hospital staff could refer to the Integrated Community Support Teams to access nursing and care support to support discharge during the week and at weekends. This provided better support for out of hours discharges. Having access to 24 hours a day, seven days a week nursing as part of Integrated Community Support Teams helped to reduce delays in accessing support when leaving hospital. Some frustration was expressed by care home and care at home staff as well as carers about communication processes. For example, staff sometimes did not always get timely discharge letters and good assessment information from the hospitals. Both Integrated Community Support Teams and 'Hospital at Home' did not always provide feedback or provide relevant information. Telephone calls from locality teams to the Integrated Community Support Teams and 'Hospital at Home' were not always returned leading to delays in accessing assessment information and onward referral to services. The way assessment information was shared between care settings could be improved.

Falls can be a significant factor in older people being admitted to hospital. We saw a good focus on falls prevention and management, including a 'falls bundle' of services and the introduction of a falls 'hub'. If older people attended accident and emergency services as a result of a fall we were told nursing staff focussed on ways to assess and help the older person with their mobility, rather than to admit them to hospital. Senior managers anticipated that the range of falls prevention work being undertaken would lead to a reduction in the rising number of falls. We found variable responses on falls prevention and management referrals and take-up from our case record reading exercise and from our meetings with older people and their carers. We noted that the rate of falls of older people was slightly below the national average, as it had been over a number of proceeding years.

Where older people had fallen there had generally been a focus on preventing further falls, often involving the provision of equipment or adaptations. However, not all the assessments of frail older people whose records we read, included an assessment of the risk of falls and where appropriate, a plan to manage that risk. Some older people we met who had had a number of falls were not registered on the falls register also.

2.3 Access to information about support options including self directed support

Both the council's and NHS Lanarkshire's websites had information with links to help individuals consider their options and information on how to access services. This included eligibility criteria, and what to expect from the service. Written information was available in council offices, libraries and in primary and acute care locations. However, some older people and their carers that we met did not always know where to find information about services and supports that may be available for them in their locality. Some carers told us they had limited information on self-directed support and felt frustrated at the delay in getting the right information. We met several carers who had very differing experiences of how information about support was shared with them or what could be available to them. This occurred even with carers from the same locality.

Whereas there had been a steady increase in recent years across Scotland in the proportion of people in receipt of self-directed support, there had been a small decrease in South Lanarkshire. Across all services the proportion of people needing social work support to choose how their support needs were met was lower than the Scotland average. The Partnership delivered less direct payments to older people than the Scotland average. Of those individuals who chose direct payments (option one) less than one in four were older people.

The roll out of self-directed support was limited by the lack of care provider choice and limited third and independent sector service provider capacity. This meant that the ability to select option two (individual chooses the service and the service provider) or option four (a combination of the other options) was constrained. In our staff survey 49% of respondents agreed that their service worked well with partners to promote the implementation of self-directed support.

Social work staff acknowledged there was not a significant uptake of self-directed support within older people's services. Some older people and carers we met had some awareness of self-directed support. However, most of them said it was too complicated and they were used to services being provided for them or on their behalf by the council (option three). Staff and managers acknowledged that take-up for older people had been limited and that supporting processes could be streamlined. Our review of case records showed that one third of individuals were offered any of the four self-directed support options. The discussions had taken place with them at either the assessment stage or review stage. Existing service users were offered self-directed support at review meetings.

For the individuals who were offered the self-directed support options the local authority was arranging the services in almost all of the cases. For the two-thirds of individuals who should have been offered the self-directed support options, there was no evidence in their case records that the options were offered. These findings matched our findings from our discussions with older people, their carers and staff.

The council had developed a web page and trained staff to offer self-directed support advice at the assessment or review stages. 'Take Control' offered a brokerage service to help people access self-directed support. Carers' forums, service users' networks and 'Take Control' acted as sounding boards to provide feedback on self-directed support to help identify improvements.

Recommendation for improvement 5

The Partnership should put in place further measures that increase the choice, availability and uptake of self-directed support for older people and their carers.

Quality indicator 3 – Impact on staff

Summary

Evaluation – Adequate

Staff were generally well motivated and worked well together to support older people to live in the community. Some staff told us that they were working to capacity and, as a result, were unable to carry out early intervention work. Workload pressures in some frontline services were being compounded by vacancies and staff turnover. This impacted adversely on staff morale in some areas.

There was evidence of good multi-disciplinary working and a commitment to providing good standards of care to service users. Most staff were enthusiastic about what integration of health and social care services could offer to improve outcomes for service users.

The Partnership used several approaches in communicating and informing staff, some of which were more effective than others. Frontline staff reported mixed views about the effectiveness of these approaches and there were concerns about how integration might impact on jobs and services. Most staff felt well informed about integration and had attended briefing events. Senior managers recognised ongoing dialogue with staff was needed to enable staff to feel more engaged.

Most staff were supported by their line manager and had access to professional development and effective line management. However, supervision and support was affected by workload pressures and the regularity and quality was variable in different services.

3.1 Staff motivation and support

We considered a range of evidence, including documentation submitted by the Partnership (for example training plans), results from recent health and social work staff surveys and a staff survey we conducted as part of the inspection. We met with approximately 550 health and social work services staff. This included face-to-face meetings with managers and staff groups in health and social work and other care settings. Over 6,000 health and social work staff were asked to complete our survey with 1,266 responding. This was a 21% response rate. Of those who returned our questionnaire:

- 62% of the respondents were employed by NHS Lanarkshire
- 37% were employed by the local authority, and
- The remaining 1% were employed in 'other' sectors (for example GPs).

Most staff were clear about their roles and responsibilities. On the whole they were enthusiastic and committed to delivering and improving the care, support and treatment for older people and their carers. Responses to our survey showed that staff:

- enjoyed their work (88%), and
- felt valued by their managers (68%).

The most recent NHS Lanarkshire staff survey showed some similar findings in that:

- 92% of NHS staff indicated they were 'happy to go the extra mile at work when required', and
- 81% still intended to be working with NHS Lanarkshire in a year's time.

There were limited differences in the responses between NHS and local authority staff to our survey. However, a slightly higher proportion of local authority staff were more positive in areas such as performance outcomes, the impact on older people and their carers, policy development and partnership working.

Overall staff morale was generally good. Motivation to provide care, treatment and support to older people was evident in interviews with staff, but there were some factors which staff told us impacted on morale. In some settings morale was uneven and some staff felt they were 'fire-fighting' rather than adopting a planned approach to meet the needs and desired outcomes of older people and their carers. We were told this was largely due to sickness/absence levels, unfilled vacant posts, increased workloads, high volumes of paperwork, uncertainty about the assessment processes and a perception of losing professional autonomy. Despite these pressures, staff told us they had continued to work hard to ensure they delivered a good service for older people.

In some areas low morale was more of a matter for social work staff. We noted that there were differences of opinion between some professions. This highlighted that there were less positive views on service delivery for some staff groups (such as social workers, consultants and occupational therapists). The council's most recent social work staff survey indicated morale as an issue with nearly two-thirds of respondents commenting adversely on it. Managers we met were aware that there was work to be done on this.

The Partnership had developed a range of partly effective communication methods to help engage staff on the key developments of health and social care integration. These included websites, newsletters, road shows and events. However, some staff groups told us they did not feel engaged or have enough information about integration. They were uncertain about how integration would develop and what it might mean for them and the impact of this on service delivery and service users.

Senior managers were keen to maintain ongoing communication with staff. They acknowledged that strengthening workforce engagement was key to implementing positive change and the overall success of the Partnership's move towards integration.

Frontline staff and integrated teams worked well together. For example, the Integrated Care and Support Team and Hospital at Home teams told us how staff supported each other. Senior managers commented that these projects had improved morale as staff saw improved outcomes for service users.

There was a history of informal joint working between health and social work staff at an operational level in South Lanarkshire. Most staff said they felt valued by their colleagues, partner agencies and line managers. They welcomed the prospect of integration and saw this as the formalisation of a joint working approach that already existed in some parts of health and social work services. Our staff survey results showed that 72% of respondents agreed they had excellent working relationships with other professionals.

We learned of good examples of front line staff working in an integrated way and developing relationships across health and social work services to provide care and support for service users. Most staff said that they had a clear understanding of their role and the roles of others in their teams. Our survey results also showed that staff felt that they worked well with other agencies to provide care for service users in that:

- 78% felt well supported in situations where they may face personal risk; and
- 77% felt valued by other practitioners and partners when working as part of a multi-disciplinary or joint team.

Staff had reservations about whether there was sufficient capacity within their teams to cope with future demand. For example, 39% of staff felt they had sufficient capacity within their team to carry out preventative work. Front line staff told us the number of referrals of older people with complex care and support needs had increased. We heard about the increasing pressures on staff. This could sometimes impact on the assessment approval process for services and result in a delay in delivering services for older people.

At times of crisis, services generally worked well together to provide an appropriate level of care and support for vulnerable older people who were at risk. We saw examples of this when we reviewed the health and social work records of older people. This was generally confirmed by those service users and their carers.

For social work staff, there was an expectation that supervision for staff should be in place. We noted that, positively, 72% of case records we read recorded decisions and discussions from supervision and 60% of cases had been read by line managers. Frontline staff told us they felt supported by immediate line managers but had limited contact with senior management.

Health and social work services had arrangements in place for supervision, annual performance appraisal and individual professional development. Staff reported that they were able to gain access to appropriate training, development and supervision in their respective professions. This was reflected by the council having achieved 'Investors in People' status and the NHS 'knowledge and skills framework'.

Supervision and performance review was reported to be variable. Some staff had access to regular support and reviews. However, others told us that they had waited more than 12 months for supervision. Team leaders told us that work demand pressures affected the regularity and quality of supervision they could offer. Our discussions with organisational development staff confirmed that supervision on an individual basis was not always achieved.

Most staff told us that they felt supported by their line manager or team leader. This was also the case for managers. Senior strategic managers were seen as being more remote from frontline staff. In our staff survey 76% of respondents agreed they had access to effective line management, including regular professional specific supervision. This was particularly so for local authority staff. However, some social work staff told us that some supportive practitioner forums had ceased and that this had been a loss to promoting improved practice.

Most staff were supported by their line manager and had access to professional development and effective line management. However, supervision and support was affected by workload pressures and the regularity and quality was variable in different services.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

The Partnership demonstrated a commitment to engagement and consultation with the community and building the capacity of local communities. It had engaged with the public about strategy development and decisions about service change to better meet the health and social care needs of older people.

Managers had an awareness of the important role that local communities could, and needed to, play. There was a good range of community supports which were in place to promote healthy lifestyles, reduce isolation and support carers. The Partnership was seeking to work productively with older people, the third and independent sectors to improve engagement and increase awareness of the local community responses to delivering support. Older people and carers were complimentary about the support they received from these groups.

The Partnership was developing further its locality-based approach to designing services to meet the needs of the local population. However, the Partnership needed to do more to measure the outcomes of these community supports, and ensure shared learning. The Partnership needed to do more to keep staff updated on the positive work they were carrying out.

4.1 Public confidence in community services and community engagement

There was evidence that the public and a range of stakeholders were given the opportunity to learn about what integration would mean for South Lanarkshire, and to contribute and to have their say. Senior managers and Integration Joint Board members placed importance on building the capacity of local communities and that engaging them in service changes and developments was a priority. Positively, involving the public in policy and service development was also a theme in the Partnership's draft Joint Strategic Commissioning Plan and partner agencies were consulted on the Partnership's health and social care integration scheme.

We noted the variety of effective engagement methods used included websites, newsletters, leaflets, seminars, events and videos. We noted examples of how the Partnership had used individual personal stories about how South Lanarkshire's approach to Reshaping Care for Older People was benefiting individuals and their carers.

A review of 'Out of Hours' health service provision had been conducted in order to meet the needs and increasing demands of the local population. The service moved to a two site model in July 2015. Public consultation took place in early 2015 to gather the views of all interested parties in how the service could be improved.

This review led to a potentially controversial reduction in the number of delivery locations. As part of the consultation the public and other stakeholders were reassured about the future accessibility, availability and quality of services. Feedback on the revised delivery approach service users was reported to be favourable as were the service's performance outcomes.

We learned of examples where older people and carers and their representatives had participated in engagement activities and events. These included the South Lanarkshire Carers Network who were key partners with the Partnership. They were represented on the main strategic planning groups and helped provide a voice for carers and opportunities to raise their profile and promote their interests.

'Seniors Together', a group of older people, commissioned by the council, consulted with older people about changes to service provision. It provided opportunities for older people to comment by encouraging them to get involved in regular task group meetings and assemblies. It was represented on strategic planning bodies. They had also contributed to the development of active ageing projects and helped other projects with funding applications. It also focussed on providing information and advice to older people on topics such as palliative care, power of attorney and anticipatory care planning.

Voluntary Action South Lanarkshire was the third sector interface. Its remit had grown in recent years. It offered a range of services designed to support the voluntary services and the wider community, reducing pressure on statutory services and preventative work. There was a commitment by the Partnership to the role of the third sector, and to advance this work Voluntary Action South Lanarkshire was asked to lead and co-ordinate resources made available to the role of the sector. The organisation acted as a forum for the third sector. One of its main aims was to build community capacity with the Partnership. Voluntary Action South Lanarkshire was commissioned by the Partnership to lead and co-ordinate significant investment to strengthen support and services for older people and their carers. Positively there were more than 600 organisations involved in assisting older people across South Lanarkshire.

Example of good practice: LOCATOR

Voluntary Action South Lanarkshire had developed a resource directory called 'LOCATOR'. This was produced following a detailed mapping exercise of voluntary sector organisations providing support and services for older people. Launched in 2013 and available online the directory proved popular with Partnership staff who used it in their daily work to signpost potential service users. It had over half a million hits. The tool also contributed to locality profiling exercises.

We asked about community involvement in our staff survey. Results showed that:

- 48% of respondents agreed that their service recognised and consulted diverse local communities about levels, range, quality and effectiveness of services
- 47% of respondents agreed that there were clear joint strategies to promote and expand community involvement and communicate change, and

- 46% of respondents agreed that there was a strong positive engagement between the partners and local community and voluntary groups.

Approximately 10% disagreed with these statements and around 40% indicated that they did not know. From our focus groups with frontline health and social work services staff, we also found that there was a limited awareness that health and social work services had an important role to play in developing community capacity. The Partnership could better promote the importance of engagement and involvement with local communities and other provider sectors with their staff. Senior managers and frontline staff told us that a locality-based approach to capacity building was in its early stages.

The impact of community consultation was not always routinely, fully and effectively shared with communities. The Partnership could better ensure stakeholder feedback is always used as a tool to drive improvement, and that the results of community consultation are always available and shared in detail.

We met health improvement staff who set out how different initiatives delivered between health and leisure and sport partners were making a difference to peoples' lives by promoting health and preventing illness. Joint working between these partners was well established. Initiatives in local communities included:

- A pilot research project called Acceptability of Community Cycling Exercise for Stroke Survivors (ACCESS) delivered tailored cycling sessions for stroke survivors in local leisure centres. Participants completed wellbeing questionnaires and physical tests, as well as eight weeks of cycling sessions increasing the cycling by duration, frequency and intensity. The project measured the fitness levels of stroke survivors and provided them with training programmes on how they could make the most of their local leisure facilities
- 'Weigh to Go' combined learning about diet and behaviour change with physical activity. A fifteen week programme, led by a specialist dietician, trained local leisure staff on programme delivery. The combination of providing nutrition information and levelled exercise sessions proved to be effective helping participants achieve a healthy weight and maintain it. More than 250 older people had taken part with ongoing monitoring
- 'Healthy Valleys' walking groups were a part of a physical activity programme for adults and older people. The programme increased participants' activity levels, improved and sustained good health. It also created an opportunity for people to be more involved in their community and increase social networks. Walks were led by trained volunteers
- 'Re-Connect', was aimed at people aged over 50 years living on their own in the Clydesdale, Cambuslang and Rutherglen localities locality who experienced loneliness and isolation making it difficult for them to live independently. Volunteers visited service users' homes and identified suitable and accessible local groups and activities that met individuals' interests and needs. They helped link individuals with these services, to meet friends and enjoy life more. All who participated reported that the service had a positive impact on their lives and 90% reported reduced feelings of isolation.

We saw that managers had an awareness of the important role that local communities could, and needed to, play. We learned about a good range of community supports which were in place to promote healthy lifestyles, reduce isolation and support carers.

To reinforce this progress the Partnership could develop an overarching joint community capacity and co-production strategy. This should show how local services were to be supported, with a measurable action plan that clearly set out the role of community support interventions in delivering the overarching joint strategic commissioning plan.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Good

There was generally good availability of information about access to services. The Partnership needed to work towards improving the pathways for accessing services for example the development of a joint single point of access.

Assessment and care management was generally good. However, there were some areas for development such as the preparation of chronologies. Case allocation could lead to delays in assessment and service delivery. Decision making arrangements through the Resource Allocation Group was causing difficulties for frontline staff and delays for some older people receiving services.

The Partnership had established processes to identify and protect adults at risk of harm. There were good working relationships across agencies involved in adult protection and support activity. Work was underway, led by the chair and co-ordinator of the Adult Support and Protection Committee, to improve its performance. While staff felt confident and supported in managing risk, the preparing and recording of risk assessments and management plans needed to improve.

Older people were being involved in decisions about their care and support. However, the implementation of self-directed support for older people was in its early stages and was not as extensive as for other care groups. The options available for service users through self-directed support were limited by availability of service providers in some areas. Further development was needed in areas to support choice.

A range of advocacy services were in place. However, information on the availability of advocacy services needed to improve.

5.1 Access to support

We found that the Partnership had developed clear routes of access to services. We saw a range of information leaflets and newsletters available in settings such as social work offices. Positively, there were direct telephone links to other key services, such as housing repairs and environment services. Service information was also available in GP Practices.

Access to social work services, whether through self-referrals, partner agency referral or the council's website, was to social work reception services teams available in locality offices. These were the first point of contact. As part of an ongoing improvement agenda, these services were under review to ensure that the correct resources were available at each locality.

Access to NHS primary and secondary services were through a variety of routes such as GP practices, community health and accident and emergency services respectively. There was no joint single point of contact arrangement in place between health and social work services. Both the NHS Lanarkshire and council websites were well laid out and provided useful signposting to services. There were clear directions about what was available and how to make contact about services. Most, though not all, older people and carers we spoke to said they would know where to go if they needed to find out about services.

The Partnership had a set of eligibility criteria for accessing services. A set of priorities was in place to allow for the appropriate targeting of services across both health and social work services. Criteria banding depended on the level of needs. The four bands were consistent with the national eligibility criteria. These were critical, substantial, moderate and low. Priority was given to older people who had critical or substantial needs. Individuals whose risks were assessed as moderate or low were directed to appropriate third sector organisations. Our staff survey reported that 39% of respondents stated that there were joint eligibility criteria for services which were consistently applied. Under half (44%) said they did not know.

Various social work staff told us that cases were routinely allocated in the knowledge that the social worker was at capacity and would not be able to undertake the assessment within targeted timescales. Frontline social workers told us that some cases could remain untouched for several weeks. Most frontline staff told us they were dealing mainly with the most urgent cases and were not able to focus on preventative work through early intervention. This meant that older people were being assessed at a later stage with more complex needs.

Referrals between health and social work services were generally good. We spoke with some frontline health and social work staff who had established professional networks. However, other frontline healthcare staff expressed frustration in accessing social work services. They told us there were waiting lists both from referral to assessment and from assessment to service provision. They said it was difficult getting a response from telephone calls to social workers, whilst acknowledging the heavy caseloads social workers were managing. A range of frontline staff expressed frustration at the duplication of occupational therapy services in different teams. Long waiting times were reported by occupational therapists in some localities. The Partnership's delivery of occupational therapy services would be strengthened if there were clearer procedures and referral routes in place.

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

The Partnership was carrying out work to refine and improve the assessment and care management processes. We saw some evidence of outcome focused assessment and care planning arrangements in individual records during our case record reading. However, ongoing changes to the assessment and care planning documentation to support self-directed support were causing some delays in decision making. As such some older people were not receiving services in a timely manner.

Assessments and care package approval were appraised at twice a week 'Resource Allocation Groups' and 'Performance Resource Allocation Groups'. The quality assurance part of this process was adding time to the decision-making process. Senior managers advised that assessment quality was improving and that the process was becoming more streamlined. Most frontline health and social work staff told us this process had introduced delays in older people receiving services. Senior social work managers acknowledged some delays but advised the position was improving. Conversely, some social workers felt they were working to unrealistic timescales for completing assessments particularly in relation to hospital discharge. However, emergency and palliative care packages were given immediate priority.

The majority of staff said that the 'Performance Resource Allocation Groups' raised issues of professional integrity and autonomy. Staff in different localities and professions told us that they felt very frustrated when service users were waiting for services because of the assessment appraisal approach.

When we viewed the Partnership's data for 2014/2015, we saw delays in dealing with some referrals and completing social work assessments. Overall the Partnership performed less well than the Scotland average for the time from referral to completion of assessment. This was particularly the case with prospective service users waiting longer than six weeks (42% of cases). The Partnership also performed less well compared to the Scotland average for the time taken from assessment to the delivery of services. This was particularly the case with prospective service users waiting longer than six weeks (12% of cases). It would strengthen the Partnership's ability to reduce waiting times for service delivery if it routinely collected waiting time information.

Our review of health and social work services records showed delays in service users being assessed for services in 15% of cases and in receiving services following assessment (15%). In 67% of cases, the older person had not been given the reasons for the delay. The Partnership could improve its communication with those older people waiting for services.

Recommendation for improvement 6

The Partnership should improve its approaches to the allocation of referrals and assessment of cases to make sure that they are completed within agreed timescales so that this assists service users to receive services in a timely manner.

Individuals' case records demonstrated a generally positive picture of assessment and care management. From the records we read, 91% of people had a needs assessment completed. In 67% of those assessments, it was clear that a range of professionals had contributed to the assessment. Early intervention and prevention options had been considered in 73% of cases.

We evaluated 80% of the assessments we read as good or better. For 4% we evaluated them as weak. The remainder were adequate. Less than half of the relevant records we read (45%) contained a chronology. A quarter of those chronologies we read were not of an acceptable standard.

Positively, almost all assessments (98%) we read had taken account of the individual's needs and almost all had taken account of the individual's choices (96%). Staff generally obtained agreement to share information across agencies (89%) with 68% having clear evidence that health, social work and other services had shared relevant information. From our staff survey:

- 73% of respondents agreed that individual care plans identified health and social care needs and the role of relevant staff
- 66% of respondents agreed that care plans were regularly reviewed, signed and implemented
- 54% of respondents agree that key professionals worked together to inform a single, user friendly assessment, and
- 43% of respondents agreed that joint teams responded within agreed organisational timescales.

From our review of health and social work case records we found that:

- in almost all cases there was evidence that the service actively sought and took into account the individual's views at assessment (99%), care plan (93%), and review stage (94%)
- less than half of all cases had a comprehensive care and support plan (49%); for 44% the care and support plan was not comprehensive and 7% had no plan
- 39% of the care and support plans were not SMART¹³, and
- in most cases (90%) the health and social care support was subject to regular review.

¹³ SMART: Specific, measurable, achievable, realistic, time bound

Recommendation for improvement 7

The Partnership should ensure that all relevant case records contain accurate chronologies and, where appropriate, have written risk assessment and risk management plans in place so that people's care needs are better assessed and planned for.

Most of the care plans were aligned to services such as day care and care at home with 73% setting out the service user's desired outcomes. As part of our review of case records, we looked at the extent to which the delivery of care and support met the needs of the older people concerned. Positively, we evaluated that this was completely (33%) or mostly (59%) the case in the records we reviewed.

Staff from both health and social work services confirmed that service users with more complex needs were more routinely reviewed usually on a multi-agency basis. However, a few frontline social work staff told us they were behind with annual reviews. Reviews were sometimes single agency and changes were not always communicated between health and social work services staff and relevant agencies. It could strengthen the Partnership's care management arrangements if attendance at reviews, including clinical reviews by professionals and other appropriate parties was improved. This would improve outcomes for older people's health and wellbeing if all agencies were kept up to date with respective care and support arrangements.

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

Well structured governance arrangements were in place for adult support and protection. A Chief Officer's Group was in operation, met regularly and was well attended. This group provided strategic leadership for the Partnership particularly in relation to risk assessment. Members of the Adult Support and Protection Committee told us they had good communication with the Chief Officer's Group. The adult support and protection committee had a strong multi-agency membership and had recently appointed a new independent chair.

The council's adult support and protection guidance and procedures were revised in 2013 and scheduled for review in July 2015. The review was not complete at the time of inspection. The procedures were designed to support social work staff by providing information about adult harm, relevant agencies' responsibilities and procedures for responding to allegations of harm. A quick guide set out the process from raising a concern to closure. Whilst NHS Lanarkshire was involved in the guidance review, it would strengthen the Partnership's approach to adult support and protection if there were joint guidance and procedures across the Partnership.

NHS Lanarkshire's corporate risk register identified adult support and protection as a 'medium' acceptable risk level. It would strengthen the Partnership's position in relation to the safety of older people if NHS Lanarkshire identified and completed the work necessary to achieve a 'low' risk level.

As well as the guidance and procedure review, a number of key areas were being looked at by the adult support and protection committee. This included the policy of two council officers making initial visits as this was impacting significantly on social workers' caseloads. The committee was considering a move from locality office point of referral to a 'hub' model. A Lanarkshire wide regular newsletter was produced, highlighting adult support and protection, child protection, tackling gender based violence and management of high risk offender activities. It contained articles on national policy changes and local initiatives. The content showed good interagency working across Lanarkshire.

From our staff survey, we noted that 79% of staff agreed clear guidance and processes were in place to support staff in assessing risk and that 70% of staff said risk assessment tools were available to them. This was confirmed when we spoke with frontline staff. They told us the risk assessment tools they used were usually unique to their agency or department or were specialist to their profession. Not all risk assessments were shared routinely.

However, senior Partnership managers acknowledged risk assessments were generally completed on a single agency basis. These managers also indicated they were at the early stages of a risk enablement approach that supported self-directed support.

During our review of health and social work services records, we looked at risk assessment and risk management practice. Twelve of the 105 records we read related to protection type risk (current or potential issues regarding adult support and protection or protection of the public). We found that operational practice was not always consistent with best practice. For example, in the files with adult protection type risks identified, we found that:

- 67% had a risk assessment on file
- the timing of the most recent risk assessment was in keeping with the needs of the individual (100%)
- multi-agency partners' views had informed the protection risk assessment (88%)
- 75% of risk assessments were rated as good or better with 13% rated as 'adequate' and 12% rated as 'weak'
- 50% had an up-to-date risk management/protection plan and in all cases these were up-to-date
- 66% of risk management plans were rated as 'good' or better, while the other third were rated as 'adequate'. No plans were rated as 'weak' or 'unsatisfactory', and
- 25% had not dealt with risks adequately.

Whilst some caution needs to be exercised with these findings, given the small sample size of adult protection type cases, areas for improvement included risk assessment and planning. A range of social work staff and managers told us that staff were completing risk assessments where these were needed. However, we found from our case record reading these were not always formally recorded in the service user's case record. In the case records with adult non-protection type risks identified (such as a frail older person at risk of falling and sustaining an injury) our case record findings indicated that for those cases (94 of the 105) where non-protection type risks existed:

- 86% had a risk assessment on file
- the timing of the most recent risk assessment was in keeping with the needs of the individual (90%)
- multi-agency partners' views had informed the protection risk assessment (54%)
- 64% of risk assessments were rated good or better
- over half had a risk management plan (59%) with 87% of plans up-to-date
- 60% of the risk management plans were rated as 'good' or better, while a third were rated as 'adequate', 8% were rated as 'weak' or 'unsatisfactory', and
- 75% of cases had all risk concerns dealt with adequately.

Areas for improvement included risk assessment and planning.

5.4 Involvement of individuals and carers in directing their own support

Self-directed support lead officers told us that since April 2014 all assessments were intended to be co-produced, based on graded statements in relation to service user risks, needs and capacities. A 'pre-self-directed support' assessment tool was in use for those cases that were not stable and ongoing. This was used mainly for care at home and occupational therapy services. The council had taken positive steps and were working with 'Take Control' to engage with individuals to explain self-directed support options. We were aware there was work still to be done to deliver supporting electronic information systems.

Frontline social workers acknowledged there was not a significant uptake of self-directed support in older people's services. The option for the local authority to arrange support was the one most often recorded. The range of service providers was limited in some areas. This could be particularly challenging in rural communities.

We were also encouraged to learn that self-directed support options for people leaving hospital were now being offered. There had been a small number of self-directed support packages which led to avoiding admission to a care home. Despite some recent success, we concluded the challenge remained for the Partnership to make self-directed support fully meaningful to older people and their carers.

The Partnership had a number of arrangements in place with advocacy providers such as 'People First' and 'Speak Out' for people with a learning disability. 'The Advocacy Project' catered for older people including matters such as adult support and protection. South Lanarkshire Carers Network and Lanarkshire Carers Centre were the main contributors of Advocacy support for carers.

Referrals for independent advocacy services were mostly linked to statutory mental health and adults with incapacity legislation. Good referral links were made with some staff within health and social work. The Advocacy Project's service level agreement with the Partnership had recently been subject to financial pressures. It was anticipated that this would adversely affect the overall volume of service that could be offered.

Advocacy was offered routinely by The Advocacy Project's in adult support and protection matters. However, it acknowledged that there may have been a few cases where this does not happen. There had been limited referrals for self-directed support. During our review of health and social work services records, we found disappointing results about advocacy services. The involvement of independent support or advocacy was considered appropriate for 24 of the 105 records. There was evidence that advocacy services had been provided in five of the cases.

We were able to navigate to advocacy services from signposting from the council's website. However, there was no information on NHS Lanarkshire's site or on the health and social care website. We also noted very limited information about advocacy services for carers and this needed to improve.

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

Summary

Evaluation – Adequate

The Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked the finer detail on how they would be achieved. These plans set out the case for change and how the Partnership aimed to work with stakeholders to deliver these changes to improve outcomes for service users and their carers. The Partnership had successfully supported the development of a range of early intervention and support services for older people and their carers. The partners were beginning to develop a joint approach to the deployment of resources.

The Partnership had used a range of quality assurance, self-evaluation and improvement approaches. Performance information was produced, reported and made available for consideration to the Partnership's senior and local management as well as council elected members and NHS board members. A draft joint performance framework linked to national outcomes was being prepared. The Partnership needed to be sure that the framework contained challenging but achievable targets for service users and their carers.

Productive joint planning arrangements were in place involving older people and their carers. Stakeholders such as the third and independent sectors were engaged with involvement in formal planning structures.

The Partnership recognised local care market challenges and was beginning to address them. It had made some progress with the 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. The Partnership needed to develop its commissioning approach to further shift the balance of care towards community services to add to the progress made so far.

6.1 Operational and strategic planning arrangements

The community planning partnership had set out its shared vision for South Lanarkshire in its single outcome agreement 2013–23. This identified the outcomes the partners aimed to achieve and how they would measure their success. It included commitments related to the Scottish Government's national priorities on older people. The Partnership had produced a joint commissioning strategy for older people's services in 2013 and a consultation draft joint strategic commissioning plan in late 2015 with the aim of publishing a final plan by April 2016.

The 2013 strategy had focussed on hospital discharge, integrated community support teams, day opportunities, community capacity and engagement and business planning. In addition there was a dedicated carers' strategy which was being updated.

The Partnership had carried out locality needs assessments as part of the preparation of the consultation draft joint strategic commissioning plan. This work was to be further developed to create locality profiles which in turn would inform locality commissioning.

The consultation draft joint strategic commissioning plan was a high level statement of intent. It lacked a detailed implementation plan for investment and disinvestment. It contained overviews of locality health and social work needs analysis, the strategic direction and identified strategic priorities. A strategic commissioning group was taking forward the preparation of the joint strategic commissioning plan. However, this work was at an early stage. Additional groups focused on the planning and delivery of services for care groups such as carers and people with dementia etc.

These plans gave a clear view of the direction of travel, but lacked some of the finer details on how they would be achieved. This limited their use as delivery management and accountability tools. They were not always fully costed in detail and delivery timescales were not always clearly identified.

Planning for the future delivery of services took place on a care group basis. The Partnership was following national policy frameworks with local costed action plans for carers, dementia and telecare services. The Partnership needed to refresh and articulate its formal strategic priorities for these areas in the context of health and social care integration timescales involving service users, carers and other relevant stakeholders in their development and implementation.

NHS Lanarkshire was preparing a local healthcare strategy. This work was supported by a range of service development workstreams on topics such as cancer services, mental health, learning disability, property assets, unscheduled care and palliative care. It was essential that the NHS Lanarkshire local healthcare strategy and the final joint strategic commissioning plan's priorities were concurrent and had strong links with NHS Lanarkshire's local delivery plan.

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

Across health and social work services, initiatives were developed that helped to support older people to remain independently at home. This included the promotion of reablement, care at home and telecare. The tiered eligibility model for accessing services formed the basis of the approach to early intervention and prevention. This aimed to provide an incremental delivery of care and support.

Through the Change and Integrated Care Funds, the Partnership had taken a joint approach to the deployment of resources to support improved outcomes for older people. Learning from Change and Integrated Care Funds had led to positive service redesign in areas such as reablement and care at home.

The Partnership's Change and Integrated Care Funds expenditure had been successfully geared towards preventative and anticipatory care and proactive care and support at home.

The Partnership was at a relatively early stage of developing step up (for example, avoiding unnecessary hospital admissions) and step down services (for example, to support early supported discharge) capacity. There were high levels of respite care provision for older people and this was valued by most carers who received it. However, access approval processes could be lengthy for some individuals.

6.3 Quality assurance, self-evaluation, and improvement

The Partnership demonstrated that it had made progress in developing performance management frameworks. The range of information produced was reported and made available to the Partnership's senior management as well as council elected members and NHS Board members. Performance information based on national and local indicators formed the basis of the approach.

Progress was being made against the Partnership's own targets, in areas such as reablement and carer's support. Targets were not being met in areas such as emergency hospital admission bed days, delayed discharges and absenteeism. The indicators tended to focus mostly on input/output measures rather than qualitative measures. Performance was reviewed mostly separately through a series of scrutiny groups such as the NHS Lanarkshire Board's Planning, Performance and Review Committee and the council's Social Work Resources Committee. The council had a range of performance information through its 'Improve' performance management system. A draft joint performance framework linked to national outcomes was being prepared. This would help the Partnership to identify areas where performance was improving or required improvement. Joint performance measures would be based on national and local indicators. It was intended that the joint performance framework would focus, in due course, on personal outcomes as well as input/output indicators at a locality level.

The Partnership had carried out a series of self-evaluation exercises on topics such as the enhanced GP service to care homes, the Integrated Community Support Team, day care and primary care out of hours provision. A 'contribution analysis' approach had been applied to learn from Change Fund projects. Evidence included case studies, questionnaires and 'service user stories'. These had helped to identify future areas for improvement.

The council had contract supplier management and procurement procedures. These included contract monitoring and contract compliance. Commissioning officers advised us that externally commissioned services had quality assurance measures in place as part of contractual compliance procedures. Meetings were planned with all service providers every three months and providers found them constructive.

Council operated care homes had their own quality assurance processes. There was an annual two day external peer audit of the care homes. Council contracts staff reviewed regulatory reports and quarterly information from care home providers. Independent sector care at home providers were required to submit quarterly monitoring reports. Providers indicated that they felt the council was generally supportive in these circumstances.

Directly provided care at home services were monitored, for example on activity levels and complaints. Each locality had an improvement plan. Manual records were held and electronic or 'dial in' recording was not available. Reviews took place every six months and included practice observation. Local managers reviewed regulatory reports and submitted improvement action plans to the Care Inspectorate. Performance reports with areas of significant concern were escalated to relevant council committees as required.

Feedback was sought from service users in annual questionnaires in different care settings directly provided by the council. Social work operational staff indicated that they would like to have access to internal performance data, in particular the results of the corporate annual survey of service users by the council. NHS staff received feedback from questionnaires which were placed in service users' homes for completion.

We were advised by senior managers that file review in social work services was primarily undertaken as part of supervision and appraisal arrangements. A small scale file audit had taken place for adult support and protection cases. However, this approach needed to be expanded to other care areas to help improve and assure practice. From the case records we read, we saw evidence of first line management scrutiny in 78% of records. Different processes existed in health services. Health professionals had a different model of supervision, appraisal and auditing of care provision.

Results from our staff survey showed that informing and receiving feedback on performance required some improvement as:

- 79% agreed that their service regularly evaluated its work and took appropriate action for improvement
- 71% agreed that the service had measures in place to ensure the quality of the services they deliver
- 69% agreed that their service had measures in place to ensure they monitor the impact of care and support, and
- 47% agreed that the quality of services offered to older people jointly by partner's staff had improved in the previous year.

Satisfaction levels with social work services were below the Scotland average¹⁴. NHS Scotland carried out surveys of service user experiences.¹⁵ In South Lanarkshire the most recent surveys showed levels of satisfaction were comparable with Scotland averages.

¹⁴ Improvement Service Benchmarking Network

¹⁵ Scottish Inpatient Patient and Health Care Experience Surveys

During our inspection we noted recommendations made following a recent Older People's Acute Hospital inspection at Hairmyers Hospital carried out by Healthcare Improvement Scotland¹⁶.

NHS Lanarkshire Board's Planning, Performance and Review Committee scrutinised the improvement action plans and monitored the overall improvement process. Items were referred to NHS Lanarkshire Board's Audit Committee as required. This helped to monitor improvement plans.

The Partnership had separate but very detailed strategic risk management registers. These identified possible risks and mitigating actions. The Partnership also has a risk register for integration.

NHS Lanarkshire undertook care quality monitoring of NHS Lanarkshire block contracted continuing care beds. It reported its clinical governance performance. It had a quality assurance and improvement strategy with an annual report on progress.

Senior staff involved in performance management activity in health and social care services told us that they have developed quality indicators. These were useful in providing a meaningful baseline from which to report improvements. They were clear that this would be an evolutionary process as the work of the Integration Joint Board developed. They were confident that the process was sufficiently developed to be able to provide performance data across the Partnership area as well as for localities.

Joint performance development was ahead of joint strategic planning processes. Some work was needed to develop and measure the outcomes being delivered for service users by the third and independent sector. It was vital that evaluation of the investments made in pilot projects was fully carried out to help inform future service redesign. Health and social work services managers and staff recognised that they needed to do more to evidence the positive personal outcomes and impacts of some of the supports delivered to service users and their carers.

6.4 Involving individuals who use services, carers and other stakeholders

Both NHS Lanarkshire and the council had policies for engaging with people who were using their services as well as with other stakeholders including staff and external providers. Most staff told us that they were encouraged to participate in seminars to share information about the progress of integration. Other methods such as websites, newsletters, topic interest groups and locality briefings were also used.

Collectively, frontline staff were very much of the view that they had been working collaboratively for some time and discussions about strategy were considered as being at a high level with staff unclear how this might impact on future working arrangements.

¹⁶ Unannounced Inspection Report – Care for Older People in Acute Hospitals – Hairmyers Hospital NHS Lanarkshire - October 2015

From our meetings with frontline staff it was clear they had a good knowledge and understanding of areas of provision where there were significant challenges in respect of choice, availability and specialism. They were keen to feed this back to senior managers to help inform decision making but were not confident in taking this forward. Staff also indicated they were keen to have more involvement in planning for service changes. This was evidenced in our staff survey where:

- 56% agreed the vision for older people's services was set out in comprehensive joint strategic plans, strategic objectives with measurable targets and timescales
- 51% agreed views of older people and their carers who use services were taken into account fully when planning services at a strategic level
- 46% agreed that priorities set at Partnership, team and unit levels reflected jointly agreed plans, and
- 41% agreed views of staff were taken into account fully when planning services at a strategic level.

Overall, independent and third sector providers were generally content about the level of support they were provided with by the Partnership to improve their performance.

Senior Partnership managers and independent sector representatives told us that consultation, engagement and involvement with providers was ongoing. For example, strategic planning groups included independent sector representatives. Regular care home and care at home provider liaison forums were held. However, some providers told us that engagement with them could be improved. This was particularly the case on operational matters such as assessment, care planning, allocation of cases and service redesign. GPs told us that they wished to be more involved in integration planning. Discussions had taken place with partners about how to build and implement a personal outcomes approach to commissioning. However, it was not clear when this would be fully translated into how services were being delivered.

Our discussions with operational staff, third sector organisations and independent sector providers suggested that there was work still to do to make sure that engagement was fully meaningful that influenced decision making about service developments.

The Partnership had a track record of including service users and carers in planning processes. At a strategic level, the views of older people were well represented. Examples of this included service user and carer groups within residential and day care settings as well as the older people's assembly facilitated by Seniors Together. It was clear that there was dialogue with stakeholders and a commitment to ensuring that it would continue. Service users and carers' groups were party to many, though not all, relevant strategic planning forums. The Partnership could further improve service user and carer engagement in service redesign.

Council housing staff were encouraged to participate in joint planning at strategic and operational levels and they welcomed this. The council's local housing strategy had identified as a major theme 'meeting particular needs'. This included older people.

Close working was underway in areas such as 'housing with care', delayed discharges and adaptations. For example, Change Fund investment in amenity housing had been delivered.

Council housing senior managers told us that they were keen to be more innovative, replicating positive approaches in some other partnership areas. This included developing sheltered housing as community hubs and using housing with support for step up and step down services. Registered social landlords had a generally positive working relationship with the council and wished to be more involved in discussions with the Partnership on the future of housing and support for older people. They wanted greater clarity on what was to be commissioned and to have greater recognition of their potential role and contribution.

6.5 Commissioning arrangements

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

The Scottish Government expected health and social care partnerships to produce joint strategic commissioning plans for all adult care groups by April 2016. These aimed to provide jointly assessed and forecasted needs, detailed financial planning, desired outcomes, and plan the nature, range and quality of future services. This plan should focus upon delivering improved outcomes for users and carers through better aligning investment with what the evidence shows about the needs of service users in local communities.

The Partnership recognised challenges in local supply and capacity of some care markets. Supply and quality was an issue in the care home sector. The council had a long term commitment to its directly provided care home services. It provided around 16% of the market. It intended to replace some of its older stock. A proportion of the Integrated Care Fund was allocated to boosting the supply of care home places.

The Partnership needed to develop a cross sector long term approach to address the need for care homes including nursing provision and respite care which responded to high levels of residents living in care homes with dementia. It could include assessing overall capacity including direct provision, improving quality and reducing the length of a resident's stay.

A number of bed places within independent sector care homes were block purchased by NHS Lanarkshire for older people with complex mental health needs and for those who may require palliative care. These older people may have previously been resident in North or South Lanarkshire and have been assessed as needing continuing NHS care. The contract (in place since 1993) was extended every year on a rolling basis. There was limited evidence to suggest that the Partnership had considered alternatives to this type of provision which could offer a more person-centred approach and increased choice.

The council was working to modernise care at home services. Improvements in 'brokerage' (streamlining referral sources) had taken place. A planned piloting of the full implementation of the Partnership's medication policy with the independent sector had yet to commence. A care at home framework had been established to try to improve the quality and reliability of service delivery. However, this had been only partially successful.

The council had a very high share of the care at home market. The care at home framework identified directly provided services as the preferred provider in the first instance. If there was no in-house capacity the council offered business to one of four preferred framework providers in each locality. If these providers were unable to take up the package then a non-preferred provider, often at a greater cost, would be selected. Commissioned hours were often referred back to the council from the independent sector as they did not have the capacity to provide the service.

This framework has been in place since 2013. Contracts currently in place were due to end in March 2016. The council was in discussion with providers to extend this arrangement for a further 12 months. In the intervening period a council led review was planned.

A number of lower unit value 'legacy contracts' with the independent sector were also in place. Care packages referred to independent sector providers, whether they were part of the framework or not, were in effect on a spot purchase basis. Therefore longer term and sustainable business development became challenging for these providers under the framework. These factors had an adverse impact on the service. We were aware of examples where there were delays for some people in accessing care at home service or in receiving an increased package in response to changes in assessed need. The Partnership needed to take a wider whole system cross sector approach to its commissioning of care at home services as part of its review. This should include national living wage considerations. This applied to other care sectors too.

The council had the vast majority of the day centre market share. It was acknowledged that there were significant challenges regarding capacity. There was more than 30% under occupancy. Some services had responded by having evening and weekend opening and catering for those with additional needs principally dementia.

Weekend day service opening had been a long established arrangement across eight day service settings. Following a review of demand the service changed to provide day care in four locality based day services at weekends in June 2015. At the time of the inspection only one evening care service ran in Rutherglen which ceased in October 2015.

The Partnership recognised that they were mainly providing a 'centre-based' model of day care. This service delivery model should be reassessed to enable a greater choice of more flexible options for service users and their carers. There needed to be a greater focus on offering individual day opportunities.

We noted that the limited availability of a range of community individual support services and demand on existing capacity resulted in a lack of choice, limited purchasing options for those service users who wished to choose to self-direct their support.

The Partnership's preparations for locality commissioning were underway. Some Integration Joint Board members would take the lead for a locality planning group and each locality lead had been provided with a locality profile of needs and available resources. Locality planning leads were being appointed. The joint management structure was being implemented from early 2016. Senior managers and staff were working with partners to progress locality commissioning structures. As locality plans developed, the Partnership needed to set out a quality assurance framework for localities and detail how they would consistently measure local performance in addition to that already carried out.

Progress had been made in supporting the care at home and care home markets. However, future commissioning developments would need to stimulate the market, for example, by considering more care at home and self-directed support options, more cross sector co-ordinated delivery and co-ordinated training with the third and independent sectors.

To date, joint strategic commissioning activity had primarily focused on older people's and cross-boundary hosted services. The work of the strategic commissioning group was at a very early stage. The group's work was made more complex in the areas of hosted services. The Partnership needed to develop its commissioning approach to further shift the balance of care.

To further articulate its strategic intentions, and in line with Scottish Government guidance, the partnership should produce a 'SMART' joint strategic commissioning plan by April 2016. The Partnership consulted on its draft joint strategic commissioning plan in late 2015.

Recommendation for improvement 8

The Partnership should make sure that the future joint strategic commissioning plan gives detail on:

- how priorities are to be taken forward and resourced
- how joint organisational development planning to support this is to be taken forward
- how consultation, engagement and involvement are to be maintained
- full and detailed costed action plans including plans for investment and disinvestment based on identified future needs, and
- expected outcomes.

Quality indicator 7 - Management and support of staff

Summary

Evaluation – Good

The Partnership was at a very early stage of developing joint workforce planning. It had placed substantial resources into workforce training and development. Both the council and NHS Lanarkshire had a range of policies and strategies to support staff. There was evidence of health and social work services staff working effectively together to deliver good outcomes for older people and their carers.

Both organisations recognised that there were recruitment issues in some staff groups. This affected the capacity and capability of some services. Different ways to address these had been explored. However, more needed to be done.

Deployment of staff remained at a largely individual agency level although almost all staff told us there were good working relationships amongst practitioners. Most staff said managers gave them good support to explore development opportunities.

A joint workforce strategy to support health and social care integration that delivered more joint training with the third and independent sectors would be beneficial to progressing integration.

7.1 Recruitment and retention

We read a range of documentation provided by South Lanarkshire Council and NHS Lanarkshire. This included policies, procedures and strategies for safer recruitment, retention and the management and support of staff. Although the documents were specific to each agency, they were robust and fit for purpose.

Joint health and social work workforce planning was at an early stage. Most job descriptions and profiles were specific to each of the partners. Most staff confirmed they were clear about their roles and responsibilities. Although recruitment processes were separate, the Partnership had begun to look at a more joint and strategic approach to recruitment. For example, the Partnership had developed a joint protocol for the recruitment of joint posts. The management of each post was clarified in the job description.

The Partnership's intention was to develop a skills mix in localities to meet the future need and demand of services for older people. To achieve its aspirations, the Partnership needed to fully identify the future staffing resources and skill mix/levels needed. Senior officers told us that the development of an integrated workforce plan was in preparation. This was to be complementary to the developing joint strategic commissioning plan and NHS Lanarkshire Healthcare Strategy.

In our interviews and focus groups with a range of front line staff and managers we learned that recruitment and retention of staff was identified as a recurring issue. This was in part a national issue. We were advised that recruitment and retention problems were significant at some locations. This was the case especially with professions such as consultant physicians, GPs, mental health officers, social workers, community psychiatric nurses, district nurses, and care at home staff (local authority and independent sectors). For example, at the time of inspection senior managers told us that NHS Lanarkshire had a vacancy rate of over 10% and that the reasons for this included:

- national shortages of staff groups such as community nurses, physiotherapists and GPs
- proximity to Glasgow with a perception that there are more opportunities in larger hospitals
- challenges of rural settings such as Clydesdale; and
- retirement of experienced staff.

Third and independent sector providers also reported difficulties with recruitment of nursing and social care posts. They also said this was more challenging in remote areas. Senior leaders and managers recognised that recruitment and retention was a significant constraining issue for the Partnership.

NHS Lanarkshire used the national workforce planning tool for reviewing nursing establishments. It had recently planned for an increased nursing capacity. Front line NHS acute services staff reported that "cohort recruitment" (recruiting staff in blocks rather than when individual vacancies arose) could lead to delays in recruitment which put pressure on staff and the service

The council was working to modernise care at home services. This included tendering for services from the voluntary and independent sector to try to expand the range of care options available. However, recruitment across all sectors remained a challenge. A recent local authority recruitment drive had brought staffing numbers to within its own identified establishment. Some independent sector staff chose to move to the local authority due to better terms and conditions. This had led to staff turnover which in turn had led to occasions where care at home services were 'handed back' to the local authority or were unavailable for service users.

In localities, where there was a lack of third or independent sector supply, the council was the 'default' provider of care at home services. On some instances community nursing service had filled the gap. This in turn had adversely affected their capacity to deliver in their own direct areas of responsibility.

There needed to be an overarching cross-sector approach to the delivery of required care at home capacity. This would need to acknowledge the forthcoming national 'living wage' legislation.

The Partnership had considered a range of approaches to make health and social work jobs more attractive career options. We were told about positive developments that were underway such as 'grow your own' schemes for mental health officer posts and offering social work degree courses. NHS Lanarkshire had made efforts to decrease the number of temporary and fixed term contracts to make posts more attractive.

Staff sickness and unplanned absence could have an impact on service delivery. Both social work and health services had strategies in place to reduce absence levels. However, the council's social work services and NHS Lanarkshire's average absentee rates were above target and higher than they could be. Absence information was reported regularly and monitored. This needed to continue to help deliver on targets.

A joint organisational development plan was in preparation. In accordance with Scottish Government guidance it would focus on the development of the Joint Integration Board, supporting strategic and locality planning and commissioning arrangements. It would also take forward workforce development to enable their active involvement in leading progress towards supporting service users. Funding from the Scottish government had been secured to take this forward.

It would strengthen the Partnership's joint organisational development plan if it could prepare and deliver a joint workforce strategy that supported sustainable recruitment and retention. It should consider the requirements of the voluntary and independent sectors so that there is sufficient capacity and suitable skills mix to deliver high quality services for older people and their carers.

7.2 Deployment, joint working and team work

We found that resource allocation and deployment of staff were still largely at an individual agency level. Staff said that they worked well with each other across health and social care services. Front line staff across health and social work services reported good working relationships with colleagues. There were examples of co-operative relationships where there were, as yet, limited formal arrangements in place. However, they did not always see themselves as working in integrated teams. They were, in effect, aligned teams although there was trust and respect for each other in their respective roles. We did not see many examples where teams shared offices or were located in the same building. Some staff said that this could inhibit good communication. Our staff survey noted that 39% of staff agreed that there were effective systems for allocation and management across the partners and teams.

We did see some good examples of joint team development in the Integrated Community Support Teams and discharge hub. Staff and senior managers were encouraged by the success of these teams. From our review of social work services and health records, we found positive aspects of joint working. In most cases, there was evidence of multi-agency working and that services worked well together, for example, to provide care at times of crisis. There was evidence that multi-agency partners' views informed individuals' assessments and risk assessments. There was evidence of multi-agency working in 87% of cases. In 68% of assessments health, social work and other services were sharing information and recording it.

7.3 Training development and support

Front line health and social work services staff we met with were positive about training opportunities. From our staff survey, we noted that over three quarters (82%) of respondents agreed that joint working was supported and encouraged by managers and that they had good opportunities for training and professional development (78%). The NHS staff survey noted that 69% of staff said that they were encouraged, trained and supported in their role to make a contribution to the highest levels of performance in service user safety.

The Partnership's move towards the development of a more strategic approach to joint training was not fully developed. Generally, health and social work services had their own suite of training and development resources. Staff told us that training was largely delivered separately within their own organisation.

We read a range of documents including training plans from health and social work staff. This included a suite of statutory, mandatory and core training. It was clear a good variety of training was available to help make sure staff maintained their skills, knowledge and accountability in their respective professions. However, much of this was single agency. Joint training opportunities were limited. Formal joint ongoing staff training was limited to topics such as adult support and protection.

Training and development were delivered in a variety of ways including online, classroom and distance learning. Staff told us that there were sometimes challenges to accessing training due to workload pressures. Some staff had undertaken some mandatory training in their own time.

A good example of training support was the education role of the NHS care home liaison nurses. The Care Home Liaison nurses spent around 50% of their time providing learning opportunities for care home staff across all sectors. In addition each care home has an affiliated community nurse who assists and supports with direct care provision as appropriate.

Local authority care home and care at home staff told us they had good access to training and development. This included moving and handling skills, dementia, reablement and the application of the Partnership's medication policy. This has been delivered on a multi-agency basis. However, there were occasions when care at home staff had not been trained in equipment use leading to poor outcomes for the service user. Independent sector staff advised us that there were limited opportunities for joint training with their local authority colleagues and this was an area that the Partnership could address. Staff in local authority residential and day care settings also said that they would like to see more locality joint training with the NHS and the independent sector.

The adult support and protection committee had rolled out a wide ranging training programme across local authority, health and independent sectors. This was a model that could be extended. Healthcare staff had appreciated this training but some suggested that there was a need for 'refresher' training.

Some staff reported that training had been delivered after self-directed support was implemented operationally. There was good training for self-directed support but staff said that the implementation was rushed and some staff felt that they had not completed enough training to manage. Health services had more of a focus on training for person-centred care and training on self-directed support was limited for health staff.

A 'train the trainers' approach has been implemented in differing care settings. This took the form of introducing 'champions' across a range of conditions. Independent sector staff told us that opportunities to be part of the 'champion' training had been limited and this was an area that the Partnership could develop.

Example of good practice: Champion cascade training

A 'train the trainers' approach was implemented across a range of health conditions and care needs topics and in differing care settings. This took the form of introducing 'champions' for topics such as dementia, carers, anticipatory care planning and palliative care.

Having undergone training 'champions' would cascade their knowledge and influence in a range of settings. This included local authority care home, care at home and day centre services as well as NHS wards and community based staff.

Practical implementation had involved dementia training provided by Alzheimer's Scotland. The 'promoting excellence' framework was used to inform the approach and there was a two year classroom training plan. More than 400 residential and day care staff and more than 30 care at home staff had been trained to 'skilled' level. More than 900 care at home staff were due to be trained by Spring 2016.

Carers' champions had been trained and were in place within hospitals. Over 200 NHS staff had been trained in carer awareness resulting in more than 6,000 carers being identified. Palliative care champions were in each care home.

Quality indicator 8 – Management of resources

Summary

Evaluation – Adequate

Good groundwork was in place for health and social care integration. Separate but effective budget management approaches existed. The new senior management structure was being put in place. The Partnership needed to maintain the standards of effective financial governance that health and social work services had previously achieved.

The Partnership was moving in a positive direction for the sharing of information between partners. Some important information was being shared at a performance level. Partners were unable to effectively share key information electronically, such as assessment documentation, between frontline services. The Partnership had made some progress with electronic information sharing between health and social work services staff. This progress needed to be consolidated and developed.

The Partnership still had to finalise their financial budgets for the Integrated Joint Board and finalise its joint commissioning plan. However, we were satisfied that the basis upon which partnership working between health and social work services in South Lanarkshire was being built would meet the expectations contained within principles of integration.

8.1 Management of Resources

Current joint financial management

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

At the time of the inspection, a joint indicative budget had still to be completed. A due diligence exercise was underway aiming to examine the costs associated with the Integration Joint Board and the budgets set by each partner. We concluded that it was essential that an indicative budget was produced timeously to underpin the joint commissioning planning and to provide the Integration Joint Board with sufficient opportunity to understand the budget that would be transferred to the new body.

The Partnership had established a joint financial governance group to examine financial considerations for the Integration Joint Board. Their remit included producing standing financial instructions to govern financial transactions of the Integration Joint Board. These still had to be finalised. A chief finance officer post was to be recruited and this part-time post would be shared with North Lanarkshire Integration Joint Board.

Financial Performance of South Lanarkshire Council

The council recorded a small surplus of £1.7 million in 2014/15. This was mainly achieved through a combination of service underspends and lower than anticipated equal pay settlements and financing costs. In 2014/15 the council's Adults and Older People Services, which formed part of the Social Work Resource budget, was underspent by £0.7 million (0.7%). The underspend related to a number of factors including care staff vacancies and lower than anticipated long term care costs. These underspends were partially offset by overspends in transport and plant costs and in payments to private contractors.

For 2015/16, the overall savings requirement was set at £18.2 million of which social work were expected to achieve £3.5 million. The main areas relating to Adult and Older People's services included reducing waking night cover for in-house care and support services (£0.4 million), reducing external supported living services costs (£0.4 million) and delaying price increase proposals and implementing self-directed support arrangements with a view to shifting current contractual arrangements with external provision of services (£1.0 million). We concluded that the council had a good record in the achievement of these efficiency savings. With the social work savings requirement increasing to £4.3 million in 2016/17 we concluded that the achievement of these identified savings was imperative to achieving a sustainable budget and maintaining service provision.

At year end of 2014/15, the council had uncommitted general reserves of £11.6 million. Although this was among the lowest in Scotland relative to the council's size, no concerns were expressed by the council's external auditors about the level of reserves held being insufficient. At the time of the inspection it was not anticipated that these reserves would be assigned to the Integration Joint Board.

In March 2015 the council increased their charges for care services. Increases were made to charges for non-residential care services as part of the Social Work Resource 2015/16 savings strategy. The council recognised the risk that these increases may impact on the service users' demand for the care services and consideration was given to this as part of their risk management arrangements. Consideration was also given to their discretion to waive charges in cases where individuals had difficulty meeting the costs of service. The council established a dedicated risk assessment team whose remit included ensuring that service users' income was maximised and the council's charging policy was consistently applied.

Financial Performance of South Lanarkshire Community Health Partnership

NHS Lanarkshire Health 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 these were achieved and a surplus of £0.4 million was recorded. This was achieved through the utilisation of £3.5 million of savings that had been permitted to be carried forward from previous years. Within this overall position, the South Lanarkshire CHP budget recorded an underspend of £0.9 million mainly as a result of underspends within community dental services and palliative care services as well as recruitment. Prescribing costs was an area of significant budgetary pressure board wide.

The financial risk associated with the prescription cost pressures is being tracked through the board's risk management arrangements. An action plan was also put in place which has involved the recruitment of pharmacy staff and technicians and was being monitored on a continual basis.

Following boundary adjustments between NHS Greater Glasgow and Clyde and NHS Lanarkshire there were delays in receiving cost growth information which made financial planning more difficult. NHS Lanarkshire and NHS Greater Glasgow had discussed the issue. This was a risk that could adversely affect the Partnership's financial planning. A service level agreement between these health boards sets out the service specification and reporting arrangements for example on service user flow across boundaries. Performance was intended to be reviewed monthly and quarterly. However, it would strengthen the Partnership's focus on cross-boundary services if the three year rolling service level agreement between NHS Greater Glasgow and Clyde and NHS Lanarkshire was updated to reflect existing provision arrangements and associated performance information.

The board achieved its 2014/15 savings target mostly through recurring savings. A savings target of £31.7 million has been agreed for 2015/16. As at September 2015, all but £3.5 million (11.0%) of this target had been identified and £15.7 million (49.5%) had been achieved which was broadly in line with plans.

The board included efficiency savings as a standing item at monthly corporate management team meetings and progress was reported to the board on a monthly basis. The achievement of these savings was important for meeting statutory targets and maintaining long term financial sustainability and the challenge of identifying and realising savings was expected to become more difficult going forward. We concluded that the board had a good record and arrangements in place for the achievement of these efficiency savings.

Asset Management and Capital Investment

For 2015/16, the social work resource capital programme budget was £0.4 million. The majority of capital expenditure related to ongoing asset maintenance and refurbishments. Per the council's Capital Programme 2014/2015 to 2016/2017, agreed in February 2014, an allocation of £0.5 million was proposed to allow initial design works to be undertaken on care home replacements in 2016/17. The replacement of the first two homes was estimated to be approximately £12.0 million with work expected to begin in 2017/18.

The majority of the council's capital programme was funded using Scottish Government grant income as well as borrowing. There was uncertainty around the levels of Scottish Government grant income available after 2015/16 and over the impact that potential rate increases could have on the cost of borrowing. Ensuring that the capital budget was not overspent was imperative for the successful completion of the council's agreed programme. The council had succeeded in keeping within their capital budget and it was encouraging that four weekly investment management meetings monitoring meetings were carried out.

In 2015/16 the health board were allocated £19.9 million from Scottish Government for capital expenditure. An additional £4.8 million was required to be found in order to fulfil their capital plan and this was anticipated to come from capital receipts. It was uncertain whether the capital receipts amount could be realised during the year and the board was in negotiations with the Scottish Government over the possibility of brokering the associated risk. At the time of the inspection the outcome of these negotiations was outstanding. Part of the boards 2015/16 capital programme included a budget of £1.4 million for the equipping of primary care health centres. As at September 2015, spend on this was in line with budget, with a forecast underspend by the year end.

A joint approach to the management of assets such as premises was needed. The Partnership needed to ensure that there was an ongoing, balanced and sustainable local demand for the services being invested in.

Change Fund and Integrated Care Fund

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 £17.2 million in funding.

Initiatives funded through the Change Fund were evaluated to inform the Partnership's approach to redesigning services, including investment/disinvestment options. 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 Partnership took the decision to carry forward a number of initiatives to the value of £4.0 million and continued funding these through the Integrated Care Fund. The largest of these initiatives included 'Supporting Your Independence' and out of hours care at home posts (£2.1 million) and the Integrated Community Support Team (£0.7 million).

The Scottish Government approved South Lanarkshire's Integrated Care Fund submission and agreed an allocation of £6.04 million annually over three years. Other areas of spend identified included developing the third and voluntary sectors, locality planning and increasing the capacity of the independent sector to engage in the agenda by the provision of a dedicated post to assist and facilitate engagement.

8.2 Information systems

Data sharing between health and social work services was a challenge throughout Scotland. The overarching Lanarkshire Data Sharing Partnership Board co-ordinated information governance. This board comprised of NHS Lanarkshire, North and South Lanarkshire councils and other key stakeholders, such as the fire and rescue service and housing colleagues. We observed that there had been no representation by Police Scotland at the board for approximately a year. We were told, however, that there had been a commitment by Police Scotland to ensure future attendance.

The board was responsible for the development and monitoring of the Lanarkshire Information Sharing Protocol, Good Practice Guidance, consent forms, public information leaflets and the information sharing protocol training programme and toolkit.

Activity from the board was taken forward by three sub groups. These were the Community Care Group, the Children's 'eCare' Group, and the Technical Group. The sub-groups had multi-agency representation, had clear direction and purpose with a focus on improving information sharing between partners.

We were told that both health and social work services electronic information systems were currently undergoing changes and review. NHS Lanarkshire was planning to change their 'MiDiS' (community health) IT system. The social work services system, 'SwiSplus' was being developed to support self-directed support and carers' enablement plans.

To support assessment and planning, the Partnership had established an approach to electronic information sharing through an 'eCare' store. This aimed to enable health and social work staff to see, share and store information in various forms in a central, secure repository. A number of systems across the partnership had the ability to send and retrieve information to the multi-agency store, for example, 'SwiSplus' (social work), 'Midis' (community health) 'Trakcare' (acute hospital) and 'Adastra' (GP out of hours services). The system enabled staff to see if a person was at risk or subject to adult support and protection activity and allowed for the sharing of information for those at risk within accident and emergency and GP out of hours service.

Frontline staff and managers told us that to date there had been limited value in the 'eCare' store. From our case record review we noted that information available in the 'eCare' store could be historical and not up to date. Therefore staff shared assessments on paper which could create delays. The 'eCare' sub-group had prioritised the work on assessments and funding had been secured to progress this work.

A few staff we spoke with said they had used the 'eCare' store. Staff expressed this as a source of frustration. We found evidence of assessment documentation held within each agency that was not necessarily shared either electronically or in paper format across key workers and where it did exist it was often out of date or incorrect. Frontline staff agreed that this reflected their experience and practice.

Frontline staff we spoke to were clear that they had regular contact and dialogue with their colleagues. We saw and heard about many instances where staff worked well together in sharing information. We asked staff their views on information systems and from the staff survey we saw that 45% of respondents agreed that information systems support frontline staff to communicate effectively with partners.

The Partnership had invested in developing e-learning programmes for all staff in relation to informing, guiding and supporting them on information sharing with partners, this included advice and direction on sharing information electronically, in writing, verbally, at meetings and by phone.

The Partnership in conjunction with North Lanarkshire Partnership had developed an electronic joint performance reporting dashboard. This had the ability to track progress against the significant key performance indicators. This had brought about a number of benefits in supporting performance improvement including sharing knowledge and expertise across both Partnerships.

An electronic dashboard tool was regularly updated with data. Work was ongoing to develop and progress this to a full health and social care performance management system to support future work about health and social care integration. This was to meet the reporting requirements of the Integration Joint Board. We saw that single agency systems were in place to collate and gather relevant data to report on performance. This data underpinned the joint performance dashboard.

Overall, there was a commitment to share information and a willingness to find solutions to enable effective sharing of electronic information. However, reporting and assessment systems remained single agency. The direction the Partnership had taken to address this was to further develop their electronic systems. Progress had been limited. It was clear that further work was needed to widen the use of these systems to enable sharing of all relevant information between staff and to further support strategic planning.

8.3 Partnership working

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) Scotland Act 2014 to review and evaluate if the planning, organisation or co-ordination of social services, services provided under the health service and services provided by an independent healthcare service is complying with integration delivery principles¹⁷.

NHS Lanarkshire and the council agreed to establish a health and social care partnership based on a 'body corporate' model. This was the delegation of functions and resources by NHS boards and local authorities to a body corporate. This would be managed by an Integration Joint Board with the appointed chief officer mandated by the board to lead this process. A new operational management structure had been agreed to take account of the wider adult health and social care agenda. Implementation was at early stage.

While there had been some progress in the appointment to joint posts services continued to work separately within agency boundaries rather than in integration. The chief officer was in post and the locality planning leads had now been identified for the four locality areas. The Partnership viewed that they would have a key role in planning how services were delivered in local areas and would also ensure close linkage between the Integration Joint Board and the health and social care management team.

¹⁷ Section 31 of the Public Bodies (Joint Working) Scotland Act 2014 states in summary: high quality integrated, effective, efficient, and preventative services should improve service users' wellbeing, take account of their particular needs and characteristics, where they live (locality), their rights and dignity, keep them safe, involve them and engage with their communities.

Previously the Health and Care Partnership was the main strategic planning group, which linked directly into the Community Planning Partnership. The Partnership planned for the Integration Joint Board to assume this role with the Joint Strategic Commissioning Plan replacing the Partnership Improvement Plan as the main plan which cross-referred to the Community Planning Partnership. The Partnership had communicated with staff groups about partnership working and integration.

A communication officer had been appointed working between the North and South Lanarkshire Partnerships to lead on raising awareness of integration.

The Partnership's health and social care integration scheme had been approved by the Scottish Government in September 2015. The Integrated Joint Board had its first formal meeting, as a legally established entity in October 2015. The Board had its core membership of eight voting members and non-voting members. This included appropriate representation of relevant stakeholders.

Although the Partnership still had to finalise their financial budgets for the Integration Joint Board and complete their Joint Strategic Commissioning Plan, we were satisfied that the basis upon which partnership working between health and social work services in South Lanarkshire was being built would meet the expectations contained within the integration principles as required by the Public Bodies (Joint Working) Scotland Act 2014.

Quality indicator 9 – Leadership and direction

Summary

Evaluation – Adequate

The Partnership had a clear vision for the future integrated delivery of health and social care services. Integration planning was progressing. Joint management, governance and locality commissioning structures were being established.

Leaders needed to communicate better about plans for health and social care integration. More work was needed to make sure that all staff understood the vision and priorities. While some joint working took place across the Partnership, the management of change needed to become more effective.

Consultation and communication with staff and other stakeholders was an ongoing activity but needed some improvement.

9.1 Vision, values and culture

The Partnership had a shared vision for services for older people. This was set out in a range of strategic plans. It was clear that leaders of health and social work services collectively understood the need for a change in the strategic delivery of older people's services and had identified many of the future challenges in delivering joined-up services for older people. They had an agreed model for integration and were building working relationships throughout the Partnership. Overall, we found that staff working across the Partnership had a shared sense of values and commitment to their work.

The Partnership's health and social care 'Integration Scheme' had been approved by the Scottish Government. An Integration Joint Board with suitable representation was established. Its key aim was to provide joint direction and recommendations to its parent organisations.

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. However, it was not always effectively delivered to frontline staff across the Partnership. This was leading to uncertainty among some staff. The Partnership needed to take additional steps to promote greater ownership of its vision and the practicalities of integration. For example, from our staff survey, 59% said that there was a clear vision for older people's services with a shared understanding of the priorities. We asked staff if the vision for older people's services was set out in comprehensive joint strategic plans, alongside strategic objectives with measurable targets and timescales. Just over a half agreed with the statement.

9.2 Leadership of strategy

We found that the Partnership had a clear vision on delivering change. However, the practical delivery of the changes in a 'whole systems' way would remain a challenge. Strategic delivery priorities across the both agencies would need to be concurrent.

We attended meetings with Integration Joint Board members and the leader of the council, NHS Lanarkshire board and council committees. There was evidence of positive working relationship between NHS board and council elected members with agreement about the way forward on integration. Integration Joint Board members had forged good working relationships and were highly committed to taking forward the work of the board and the delivery of health and social care integration.

They demonstrated a range of experience and expertise that would be invaluable in overseeing integration governance. From the focus group we carried out with Integration Joint Board members it was clear that they felt that members and officers were working effectively together.

Integration Joint Board members acknowledged that they needed to further develop their skills, understanding and expertise in integrated services, particularly understanding those services and their funding of which they were not familiar. Briefings, development sessions and 'away days' had supported board members. A training needs analysis had been prepared but had not yet not fully progressed. A senior management leadership programme was in preparation.

Both NHS Lanarkshire and the council had separate corporate risk registers. Risks were identified scored with mitigating actions. The Integration Joint Board had agreed a risk management strategy. A strategic risk register was in place and was being monitored. This was at early stage of implementation.

9.3 Leadership of people

Feedback from our staff survey showed that more work was needed to make sure there were clearer joint strategies to communicate change to staff. We asked staff whether their views were fully taken into account when services were being strategically planned. Less than half of respondents agreed that they had.

Most staff we met with told us they had been involved in a number of consultation exercises for a variety of initiatives including integration. Some commented that the profile and visibility to staff of leaders could be improved. Strategic leadership and the role of senior managers and Integration Joint Board members in supporting employees to deliver effective outcomes could be improved. This was reflected in the results from our staff survey which showed that:

- 53% agreed their views were fully taken into account when services were planned or provided (36% disagreed), and
- 54% agreed that senior managers communicated well with frontline staff (39% disagreed).

Integration Joint Board members were aware of the need to concentrate efforts on engaging and involving staff. The Partnership needed to further develop its health and social care integration communication and engagement plan. The Partnership was in the process of preparing good practice consultation and involvement packs.

From our staff survey and the staff we met with during our inspection, it was clear that the majority of staff in both health and social work services had good professional relationships with each other. In our staff survey, most staff said that joint working was supported and encouraged by managers. In addition 63% of staff told us that there were positive working relationships between practitioners at all levels. This reflected a strong commitment to the operational management of the workforce.

Recommendation for improvement 9

The Partnership should refresh its consultation and engagement approach with a range of stakeholders to better communicate on:

- its vision and objectives
- service redesign
- change management, and
- working with the third and independent sectors.

9.4 Leadership of change and improvement

There was a history of good joint working but the change agenda was a challenging one. We had some concerns about the effectiveness of change management. From our staff survey, less than half agreed that the quality of services offered to older people jointly by partner's staff had improved in the previous year. Less than half (46%) of staff agreed that changes which affected services were managed well (40% disagreed). This was in keeping with both Partnership agencies own staff surveys. However, 68% of respondents agreed that high standards of professionalism were promoted and supported by all professional leaders, council elected members and NHS board members.

A number of self-evaluation exercises had taken place and had influenced service redesign. However, this needed to be more widespread. Integration Joint Board members and senior managers acknowledged the challenge of change management activity and organisational development work needed to drive forward integration.

There was a clear view of the direction of travel. However, plans were lacking detail, for example, in decisions about investment and disinvestment. A challenge for the partners would be to ensure consistency of joint working and standards throughout the partner organisations and each of the localities. Clear and consistent senior leadership would be needed to forge stronger links between activity, investment and disinvestment decisions that led positive outcomes.

Quality indicator 10 – Capacity for improvement

Summary

We do not award an evaluation grade for this quality indicator. From our evaluations against each quality indicator one to nine we look at how confident we are that the Partnership had the capacity for improvement.

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

From evidence gathered in our inspection, we concluded that the Partnership delivered, in the main, good outcomes for service users and their carers. We found that the Partnership was committed to providing the right support at the right time delivered by the right people. However, we found areas where further improvement was required.

This was evidenced from our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership and results from our review of health and social work services case records. This was complemented by the views expressed by service users, carers, council elected members and NHS board members as well as the Partnership staff we met with. The Partnership had a number of developments to support older people's independence by reducing social isolation and increasing activity, and helping older people to stay in their own home. The Partnership was improving its balance of care performance with older people being supported to remain at home.

Older people and their carers were generally content with the services provided for them and told us that these contributed to their better health and wellbeing. There needed to be a more robust approach to service coordination for carers. This would help to continue to improve the support initiatives and services already in place for them. We saw a range of services that helped deliver good personal outcomes for service users and their carers in areas such as:

- reablement
- respite
- joint multi-disciplinary and multi-agency working
- telecare
- care at home
- assessment and care planning, and
- community infrastructure.

However, there was room for improvement in areas such as:

- prevention of admission to hospital
- delayed discharges
- care at home
- bed-based intermediate care
- access to respite
- post dementia diagnostic support
- risk assessment, planning and recording
- timescales between referral and service delivery
- self-directed support
- joint strategic commissioning
- workforce planning (including staff recruitment and retention), and
- information technology systems.

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

The Partnership was progressing with its plans on integration and monitoring how well they were delivering. The Partnership had well established performance frameworks. A wide range of performance information was produced, reported and made available to senior and local management, as well as council elected members and NHS board members. Performance was reviewed through a series of scrutiny groups such as the NHS Lanarkshire's Planning, Performance and Review and Audit Committees and the council's Social Work Resources Committee.

This complemented work undertaken by NHS Lanarkshire's Quality Assurance and Improvement Committee and Area Clinical Forums. The Partnership had progressed self-evaluation activities. It had worked co-operatively with the Scottish Government on commissioning and delayed discharges.

The Partnership had demonstrated that it could produce and analyse extensive performance information to underpin service redesign. A draft joint performance framework linked to national outcomes was being produced. Commissioning was still largely separate. A consultation draft joint strategic commissioning plan was in place. The council and NHS Lanarkshire were identifying financial resources with a joint financial framework under development.

The Partnership actively promoted service redesign in keeping with the principles of Reshaping Care for Older People. However, we found that the 'whole systems' approach to change management, planning for future commissioning could have been strengthened. The Partnership's view of joint working and in particular with the independent sector was more positive than was reflected by the independent sector itself. However, with this exception, the Partnership demonstrated a good level of self-awareness of the key challenges it needed to address. We noted positively that the Scottish Government's Joint Improvement Team had supported the Partnership with future commissioning priorities.

Effective leadership and management

Generally, with regard to integration, there was positive leadership and positive working relationships at senior levels between officials. Leaders, including council elected members and NHS board members, needed to build on the enthusiasm of frontline staff to promote the merits of integration.

Senior managers told us that council elected members and NHS board members engaged with health and social work staff and were involved in addressing relevant health and social care integration.

Frontline staff were committed to the delivery of excellent personal outcomes for older people and their carers and enthusiastic about the possibilities for health and social care integration. In general, staff conveyed mixed comments about senior leadership and management. Staff thought communication and effective, inclusive change management were areas for improvement.

Preparedness for health and social care integration

NHS Lanarkshire and South Lanarkshire Council had a good history of joint working with each other. Leaders understood the future challenges in delivering joined-up services for older people. Constructive plans were in preparation to develop more integrated health and social work services. This would mean that older people and their carers would have more positive experiences and better personal outcomes. We concluded that we were satisfied that the basis upon which partnership working between health and social work services in South Lanarkshire was being built would meet the expectations contained within the integration principles as required by the Public Bodies (Joint Working) Scotland Act 2014.

What happens next?

We will ask the South Lanarkshire 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/>

June 2016

Appendix 1 - Quality indicators

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



To find out more about our inspections go to www.careinspectorate.com and www.healthcareimprovementscotland.org

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.



Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB
Phone: 0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP
Phone: 0141 225 6999

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.