

Services for older people in Aberdeen City

September 2016

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

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About this inspection

Aberdeen City Health and Social Care Partnership

Summary of our joint inspection findings

Background

Between November 2015 and February 2016, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services¹ for older people in Aberdeen City.

The inspection took place at a time of considerable reform of health and social care services and the establishment of the Aberdeen City Health and Social Care Partnership (hereafter referred to as ‘the partnership’). At the time of our inspection, NHS Grampian and Aberdeen City Council were working hard to put in place the operational and governance arrangements needed to establish the Integration Joint Board (IJB).² These new arrangements needed to be in place by 1 April 2016.

Despite this being a time of transition, we saw some evidence that partners were on target to have a strategic plan and budgets in place as required in the legislation, and were committed to improving and integrating services across Aberdeen City. Many of the changes introduced as part of the integration agenda were at too early a stage to show impact, although they provide the building blocks to help address the areas for improvement set out within this report.

Throughout our inspection, we have taken into account the early stage of the reforms, and recognised the early progress made within Aberdeen to better integrate health and care services. We hope that this report is a useful contribution to the IJB, NHS board and council, as they continue to improve the support available for older people living in Aberdeen City.

The purpose of the joint inspection was to assess whether the health and social work services improved outcomes for older people and their carers³.

We wanted to find out if health and social work services worked together effectively to:

- make sure people receive the right care at the right time in the right setting
- deliver high quality services to older people, and
- support older people to be as independent, safe and healthy as possible and have a good sense of wellbeing.

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 Integration Joint Board is responsible for the planning of integrated arrangements and service delivery of functions delegated to the IJB from NHS Grampian and Aberdeen City Council.

³ In this report when we refer to carers this means unpaid carers

Our joint inspection involved meeting over 100 older people and their carers, and around 300 staff from health and social work services, the third and independent sectors. We read a sample of older people's health and social work services records. We also studied a number of documents provided by the partnership about the health and social work services for older people and their carers in Aberdeen City. We are grateful for the time and effort provided by the older people, their carers and staff who met with us during the inspection.

Aberdeen City context

Situated in North East Scotland, Aberdeen City covers an area of 186 square kilometres, is the third largest city and one of the most densely populated authorities in Scotland. There are a number of distinct features of the local area, each of which have impacted on the needs of the population and the services provided. These include:

- an increasing population, with the proportion of people aged under 16 rising more quickly than in many parts of Scotland
- a history of a very strong local economy, due to the oil and gas industry, which has been significantly affected by the downturn in the sector
- areas of significant deprivation across the city, and
- difficulties with the recruitment of suitable staff to deliver some health and social care services.

The population in 2015 was 230,350, an increase of 0.6% from 2014. Of this, 7.9% is aged 65–74 and 7.1% is aged over 75. Since 2000, the population in Aberdeen City has risen by 7.5% – more than the average rise of 5.1% for Scotland. The number of people aged under 16 is forecast to rise at a higher rate than the rest of Scotland over the next decade.

Aberdeen City is a city with a traditionally strong economy with unemployment and benefits dependency well below the national average. Employment has been higher than the Scottish average at 77.2% with 9% employed within caring, leisure and other services. However, the downturn in the oil and gas sector had affected this. The fall in global commodity prices, reduction in investment and reduced operating expenditure in the oil and gas industry had an effect on reducing employment and the wider supply chain. Job seekers allowance data over the year to November 2015 indicated there was an increase in people claiming job seekers allowance.

There are many prosperous areas within Aberdeen City; however, there are also areas of significant deprivation within the city. The Scottish Index of Multiple Deprivation (SIMD) report of 2012 showed that 8% of the population were living in one of the 15% most deprived areas of Scotland. Twenty-two of the 976 most deprived datazones in Scotland were in Aberdeen City this was a reduction from 28 in 2009. The most deprived datazone in Aberdeen City in the 2012 SIMD data was in the intermediate zone of Torry East, (ranked 22), and was amongst the 5% most deprived areas in Scotland.

In terms of health, 48 (4.9%) of the 976 datazones in the 15% most deprived areas were in Aberdeen, a rise from 44 in 2009. The most health-deprived area was Heathryfold and Middlefield, (ranked 61), making it amongst the 5% most deprived areas in Scotland.

Increased demand and reducing resources has led to a number of challenges for the council and NHS Grampian delivering health and care services to meet local needs. The health and care partnership in Aberdeen is responsible for significant resources. At the time of the inspection:

- the council had a budget of around £456 million for its running costs and received the eighth largest level of general government grants in Scotland
- NHS Grampian was the fourth largest health board in Scotland with a revenue budget of around £1,080 million, and
- the partnership had an indicative delegated budget for running costs of around £250 million.

An arms-length external organisation, Bon Accord Care (BAC) had been set up from which the majority services for older people were commissioned. This included care homes, care at home and day support (total spend around £34 million per year).

There had been significant change in senior management posts. The chief executives of Aberdeen City Council and NHS Grampian as well as the chief officer for the partnership had all been in post for less than two years. Whilst healthcare service managers had been in post for a number of years, the majority of the service managers from social work were in temporary posts with most new to their role.

We inspected the partnership at a critical time in the implementation of health and social care integration. The partnership was engaged in a high level of activity to finalise structures, strategies and planning that had not concluded while the inspection team was on site.

Summary

Key performance outcomes

There were several approaches taken by the partnership that resulted in significantly fewer older people being admitted to hospital on an emergency basis, compared to the Scottish average. One such approach was anticipatory care planning. Significant progress had been made in developing an anticipatory care approach and the preparation of anticipatory care plans for older people who otherwise had a high risk of emergency hospital admission.

Although there were some recent signs of improved performance, too many older people still experienced a delay in their discharge from hospital. Care at home provision, an important factor contributing to delayed discharges, was a significant challenge for the partnership. The partnership's commissioned care at home provision did not have sufficient staffing capacity to meet the growing demand from older people. Some older people and their carers struggled to cope while they waited for a care at home service.

The partnership was beginning to strengthen its approach to self-directed support for older people. It was also reviewing its approach to reablement. The partnership acknowledged that these were key areas for further improvement.

Getting help at the right time

The partnership's approach to the design and delivery of care for older people had a clear focus on maintaining their independence, good health and wellbeing. There was a strong message from the partnership that educating and supporting communities as partners in managing health and care needs was important in order to improve wellbeing and reduce the impact of ill health. There was a clear plan for supporting and encouraging healthy ageing throughout the city. Some innovative and effective initiatives included the 'wellbeing' team and the 'Silver City' project.

Once in receipt of services, older people and their carers we met were, in the main, satisfied with the quality of the support and care they received. Older people and carers greatly appreciated and praised the post diagnostic support offered following diagnosis of dementia. However, access to this service was sometimes delayed.

Carers reported that they would like easier access to respite care and day services to support them and the person they cared for. Supporting carers by offering and completing a carers' assessment and providing timely support were areas identified for improvement. However, there was clear evidence that when carers were supported in this way it had led to improved outcomes for them.

Impact on staff

Almost all the staff we met enjoyed their work and most said that they felt valued, recognised, and supported by managers and other professionals. There was good access to professional development. Staff were generally well motivated. Although approaches to improvement were underway, increased workloads, vacancies, absence and cumbersome

assessment paperwork were having a negative effect on staff morale in some services. Frontline staff were involved in improvement activity to reshape assessment materials.

A more cohesive approach to planning and delivering services was beginning to be achieved through multi-agency working. Despite some of the challenges caused by staff shortages and increased demands on time, staff remained committed to ensuring they delivered high standards of person-centred care for older people and their carers.

The partnership had a number of effective approaches to communication in order to keep staff updated. There was evidence that staff had been able to influence future service design through consultation events. Most staff had attended briefing events and said they felt well informed about integration. However, some staff reported differing views about the effectiveness of these approaches and expressed some concerns about how integration might affect jobs and services. Generally, staff expressed enthusiasm about what integration could offer to improve outcomes for older people. Senior managers recognised that continued dialogue with staff was needed to enable frontline staff feel more engaged.

Impact on the community

The partnership was strongly committed to engaging with and involving local communities in planning how to meet the health and social care needs of the older population.

A range of effective engagement opportunities was in place to support communication with local stakeholders and communities to contribute to discussions about the needs of their communities. A number of locality planning events were taking place, which aimed to increase local ownership. This approach towards collaborative working was at an early stage.

The partnership's strong commitment to promoting healthy active ageing was evident. Working with organisations across the whole care sector, opportunities to support healthy lifestyles, reduce isolation and support carers were being taken forward. These had resulted in access to a wide range of creative opportunities and activities being developed. Individuals and groups we met spoke very positively about these developments.

An excellent example of an innovative approach was the Golden Games, Aberdeen's annual festival for activity, which won the Healthier Lifestyle Award in 2015 in recognition of invaluable contribution to Scottish healthcare.

Overall, there had been significant mobilisation of community capacity to effectively support older people and their carers.

Delivery of key processes

Both health and social work services had centralised referral processes. Although this made initial contact easier, it did not always mean services were provided in an appropriate time frame. There was also a range of service specific criteria that led to multiple pathways into services. Older people and their carers found this confusing. Nearly a quarter of older people were on a waiting list for services and some service provision had been delayed in excess of six months. The partnership was actively

progressing a range of initiatives to support improved access to services including access to out of hours support. It was too early to measure the impact of these developments.

There was clear evidence that investment had been made in relation to anticipatory care planning and we found this approach was achieving better outcomes for some older people.

Many older people told us that they felt they had been involved in discussions about their assessed needs, though some said choices were limited. This was not helped by the slow implementation of self-directed support for older people.

A significant concern was in respect of adult support and protection referrals. Although initial screening was undertaken in an appropriate time frame, critical tasks such as initial enquiries and full investigations were not, in some cases. Such delays potentially left a few older people at significant risk of harm over a protracted period.

Policy development and plans to support improvement in service

A number of key strategies were in the process of being finalised. These strategies had been developed to support the effective delivery of services to older people. Most were on target to be in place for the official start date for the partnership.

The partnership's joint strategic plan had been subject to wide consultation. This plan set the high-level direction for future planning and delivery of services. To support its strategy, the partnership needed to develop a 'market facilitation' strategy. This was yet to be started.

The partnership had an agreed locality structure and was in the process of developing the supporting management arrangements. Learning from a development site in the south side of the city was being used to progress locality planning across the city but was at a very early stage. Stakeholder engagement including involving older people and their carers was being incorporated into locality planning.

The partnership's development of preventative services was limited. Current service contracts were based providing services on assessment of critical and substantial need and on a time and task allocation. This task-based approach did not support the development of prevention and earlier intervention.

Managers needed support to present and analyse data. Some performance management systems were in place although as part of the development of the IJB, these systems were not yet streamlined to inform joint performance measurement activities.

Management and support of staff

Overall, we found that staff were working effectively together to deliver good outcomes for older people and carers. However, there were significant recruitment issues for some staff groups that were affecting the capacity and capability of services to focus on prevention, earlier intervention and reablement.

Although staff universally reported positive working relationships across the organisation, deployment was still at an individual agency level. The partnership was at an early stage of developing joint workforce planning.

The majority of staff felt they had effective line management and had access to profession-specific supervision and appropriate training and development opportunities. The partnership was working to establish an organisational development plan to support health and social care integration.

Management of resources

Joint working between the finance teams within the council and NHS Grampian was effective. Development of joint financial management arrangements were on target for the start of the Health and Social Care Partnership.

Health and social work services had successfully achieved required savings targets in previous years and the partnership acknowledged the need for this to continue in the challenging financial climate. As the new integrated arrangements take shape, the partnership needs to work more closely with the third and independent sectors to deliver some of these savings through service redesign.

There was evidence of learning from initiatives supported by the change fund. Progress had been made in allocating funding from the integrated care fund to provide continuing support for change initiatives.

The partnership had begun to address the challenges of electronic information sharing between health and social work, building on earlier developments within GP practices. This work was at an early stage of development and would be a key area for the Integration Joint Board to progress.

Leadership and direction

The partnership had a clearly articulated vision for older people's services within its strategic plan although it still had to set out the actions that would ensure this plan was implemented. The partnership was engaging well with key stakeholders including local communities, staff and partner services. There had been effective engagement with staff to involve them in the planning and development of services. Senior managers acknowledged that this needed to be a continuous process to keep staff informed and engaged in the change and improvement processes. It was essential that the partnership built on and improved its collection and analysis of performance information to inform change and improvement.

The development of a locality-based model was underway but needed greater impetus through the appointment of the next tier of the management team to support implementation of the new ways of working in Aberdeen City. This included the need to improve engagement of clinical managers. Although there was effective clinical leadership, clinicians required more support to take a leadership role to be successful in delivering the partnership's ambitious change agenda.

Capacity for improvement

The partnership delivered positive outcomes for many older people. The partnership's efforts to build community capacity and enhance individual wellbeing had helped many older people lead healthier and included lives.

The partnership was building on the work it had started to reduce the number of people whose discharge from hospital was delayed. Completing carers' assessments and providing support to those carers who need it should be given greater priority.

The leadership within the partnership clearly supported staff to be engaged in informing continuous improvement in the Aberdeen area. The partnership needed to consolidate its management team to implement the new structure and ways of working to deliver its aspirations.

We considered that the partnership had set a clear agenda to drive the health and social care partnership and deliver the required improvements as it goes forward.

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
<http://www.healthcareimprovementscotland.org/>

Evaluations and recommendations

Evaluations are awarded on the basis of a balance of strengths and areas for improvement identified under each quality indicator. By balance, we do not mean a simple count of the strengths and areas for improvement. While each theme in an indicator is important, some may be of such importance to achieving good outcomes for older people and their carers that they are given more weight than others. Weaknesses may be found which impact only on a small number of individuals but be so significant, or present such risks, that we give them greater prominence. All evaluations are agreed only after a thorough consideration of the issues.

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

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

Recommendations for improvement	
1	<p>The partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to:</p> <ul style="list-style-type: none"> • deliver the Scottish Government's delayed discharge target of no delays over two week duration, and • ensure fewer older people experience delayed discharge from hospital.
2	<p>The partnership should work with carers and those services that support them to ensure that:</p> <ul style="list-style-type: none"> • carers are routinely offered a carer's assessment • carers' assessments are completed for those carers who request them • offering and completing carers' assessments is clearly documented, and revisions to future formats for carers' assessments take into account new carers legislation.
3	<p>The partnership should ensure that:</p> <ul style="list-style-type: none"> • pathways for accessing services are clear • eligibility criteria are applied consistently across services, and • waiting lists are monitored to manage the allocation of pressurised resources equitably.
4	<p>The partnership should work with the Aberdeen City adult protection committee to support improvement in adult support and protection by:</p> <ul style="list-style-type: none"> • including timescales for all partners for the completion of all stages within the adult protection processes • providing oversight of progress of action plans completed from audits, and • providing oversight and quality assurance of any action plan resulting from the commissioned review of adult support and protection.
5	<p>The partnership should take action to ensure that frontline staff are supported to complete initial inquiries, risk assessments and risk management plans timeously.</p> <p>This action should include:</p> <ul style="list-style-type: none"> • working alongside Police Scotland to develop a joined up approach for completing inquiries • streamlining its risk assessment frameworks, and • ensuring that risk assessments and risk management plans are completed and actioned.

6	<p>As part of the continued development of the new integrated arrangements, partners should develop their strategic approach to joint training and development. This should aim to:</p> <ul style="list-style-type: none"> • offer opportunities beyond mandatory training • include the third sector to enhance a shared knowledge of roles and responsibilities, and • achieve a cohesive approach to care delivery for older people.
7	<p>As part of the continued development of the new integrated arrangements, partners should put a formal plan in place that sets out the future allocation of the integrated care fund and set out clear criteria for how these projects would be evaluated.</p>
8	<p>As part of the continued development of the new integrated arrangements partners should set a clear timetable to agree and implement the structure for locality management teams.</p>

Quality indicator 1 – Key performance outcomes

Summary

In this section, we report on the impact that health and social work services are making to the lives of individuals and their carers. We focus specifically on improvements in the partnership's performance in both health and social care and the specific improvements in health and wellbeing outcome being achieved for individuals and their carers.

Performance in this indicator was **ADEQUATE**. The Aberdeen City Partnership delivered positive personal outcomes for many older people and their carers.

There were several approaches taken by the partnership that resulted in significantly fewer older people being admitted to hospital on an emergency basis compared to the Scottish average. One such approach was anticipatory care planning. Significant progress had been made in developing an anticipatory care approach and the preparation of anticipatory care plans for older people who otherwise had a high risk of emergency hospital admission.

Although there were some recent signs of improved performance, too many older people still experienced a delay in their discharge from hospital. Care at home provision, an important factor contributing to delayed discharges, was a significant challenge for the partnership. The partnership's commissioned care at home provision did not have sufficient staffing capacity to meet the growing demand from older people. Some older people and their carers struggled to cope while they waited for a care at home service.

The partnership was beginning to strengthen its approach to self-directed support for older people. It was also reviewing its approach to reablement. The partnership acknowledged that these were key areas for improvement.

1.1 Improvements in partnership performance in both healthcare and social care

Significantly, fewer older people were admitted to hospital as an emergency than the Scotland average (Chart 1). The number of acute bed days occupied resulting from emergency admissions of older people was also less than the Scotland average, as were the number of multiple emergency admissions of older people to hospital and the resultant acute bed days. In Aberdeen City, there had been a significant downward trend in emergency admissions of older people since 2012.

Senior managers gave the following reasons for the progress in preventing older people experiencing an unscheduled acute care episode:

- cohesive work by GPs within their localities and partnership to prevent avoidable emergency admissions
- development of an anticipatory care approach to looking after older people, and
- activities such as falls prevention and pharmacy reviews for individuals at risk of emergency admission to hospital.

Making sure older people were discharged from hospital when medically fit for discharge, was still a major challenge for the partnership. Senior managers within the partnership identified that improving performance in this area remained a priority. The partnership had reduced the number of standard delays⁴. In 2014–15, the partnership had on average, 120 standard delays per month. In 2015–16, the partnership had reduced this figure to 107 standard delays. The number of people delayed in hospital continued to reduce. However, from April 2015–January 2016, the partnership still had an average of 59 delays each month, which continued to miss the two-week target (Chart 2). The main reasons for these delays included lack of care at home and care home placement availability, and assignment and completion of community care assessments (Chart 3).

In 2015–16, the partnership reduced the number of bed days lost to standard delays⁵ (Chart 4). There was a 17% average monthly reduction in bed days lost to standard delays compared to previous years. In the winter of 2015–16, the partnership achieved its target set by the Scottish Government for a percentage reduction in the number of delayed discharges, compared to the previous year. This meant that older people were spending less time in hospital overall.

The partnership had put a number of interconnected measures in place to help reduce delayed discharges for older people. These included:

- creation of the discharge hub and daily discharge meeting
- intermediate care, comprising 30 step down beds
- the Adapting for Change project, which was a demonstrator site which aimed to reduce delays in the delivery of adaptations in individual properties, and
- a discharge forum, which reviewed the data on delayed discharges.

Senior and middle managers within the partnership recognised that reducing the number of delayed discharges for older people was an area that required constant vigilance and further improvement.

4 A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place – standard delay.

5 Partnerships have worked towards discharging patients from hospital within a maximum time period, defined by the Scottish Government as follows:

2011/12 – 6 weeks

2013/14 – 4 weeks

2015/16 – 2 weeks

From April 2016 there will be a move towards measuring the number of patients delayed for less than 72 hours.

The partnership had made progress reducing the overall number of code nine⁶ delays including those involving people with dementia who lacked capacity. (Capacity means the ability of an individual to make an informed choice in any given situation). However, the number of delays and the number of bed days lost to them remained relatively high compared to the Scotland average. Senior managers identified the following challenges around code nine delays:

- limitations to the use of legislation relative to the need to gain the consent of all of the relevant parties⁷, and
- the time it took to secure welfare guardianship for individuals.

Senior managers were working with their legal advisors to seek appropriate ways to address these issues.

Recommendation for improvement 1

The partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to:

- **deliver the Scottish Government's delayed discharge target of no delays over two weeks duration, and**
- **ensure fewer older people experience delayed discharge from hospital.**

The partnership delivered marginally less care at home and intensive care at home (10 hours plus) than the Scotland average. Delivery of enough care at home to meet the needs of older people and deliver positive outcomes for them was a constant challenge for the partnership. Each week the partnership faced a shortfall of around 500 hours care at home which commissioned services could not provide to the individuals who needed the care. This had an obvious impact on older people and their unpaid carers. We met older people who had to wait for the care at home they needed to meet their personal care needs. Some carers we met had experienced undue stress when their cared for person did not get the care at home service they needed quickly enough. The partnership acknowledged that increasing the availability of care at home was an area for improvement and we saw evidence of staff working with providers to develop services.

It was positive that the Scottish Government's quarterly survey (2015) showed that the partnership in the main provided services immediately, including care at home, to individuals with critical needs.

Bon Accord Care (BAC) staff, including occupational therapists, had carried out reablement but this ceased in the spring of 2015 following review. The hospital based community rehabilitation team carried out skilful and successful rehabilitation work with older people. The partnership's review of adult and older people's services would consider how reablement would be delivered into the future. We met with some older people who confirmed the integrated support they received from health and social work services

⁶ Code nine delays include people whose discharge arrangements may be more complex due to the specific care needs of the patient (for example where there are guardianship or incapacity issues which are referred to a court of law).

⁷ Section 13 Z A of the Social Work Scotland Act 1968 enables individuals who lack capacity to be moved to an appropriate care setting.

staff when they were discharged from hospital. This helped them 'to get back on their feet' and supported them to do as much as possible for themselves, thereby maintaining their independence. We considered there was a lack of a cohesive approach to the development of reablement within the partnership.

In 2013–14, Aberdeen City had fewer older people experiencing a fall leading to an emergency admission to hospital than the Scotland average (Chart 5). However, trend information showed that this fluctuated. We met with older people who had had a falls risk assessment. This had reduced their risk of falling and contributed to their overall safety.

The partnership had a falls lead, who was developing a Falls Pathway for Aberdeen City. Staff were trained well in the use of the partnership's Falls Pathway and cascaded information about falls prevention. The partnership had also put in place a falls information zone, Falls Assist, which was a self-assessment tool as well as an osteoporosis service.

We saw a very good example of an initiative set up to enable older carers and 'cared for' people with dementia to attend a falls exercise group. Staff in this service evaluated it using 'Emotional Touchpoints'⁸, which combined patients' experiences, therapeutic outcomes and questionnaires. The aggregate results of this evaluation were very positive in terms of reducing participants' risk of falling, giving them the opportunity to socialise, and generally enhancing their wellbeing. Short-term funding was currently in place however there was uncertainty about the future resourcing for this successful project.

The partnership successfully delivered telecare to 795 people, most of whom were older people. Forty-four people with dementia had global positioning system (GPS) tracking devices to enhance their safety and continued independence. Over 2,400 people had a basic community alarm. We met with older people who said that provision of telecare helped them to keep safe and maintain their independence. BAC was able to show evidence of creative use and development of their telecare service, which operated very effectively, responding quickly and efficiently to requests for the installation of equipment. (High-priority individuals received a service within two days).

The partnership placed marginally more older people permanently in care homes than the Scotland average (Chart 6). Senior managers within the partnership considered that they did not have enough care home places for older people and they needed to stimulate the care home provider market to create more places. Lack of availability of care home places was another reason for older people experiencing delays in their discharge from hospital.

The partnership delivered less respite care for older people and their carers than the Scotland average (Aberdeen Partnership delivered 35% less total respite weeks to older people than the Scotland average). We found from speaking with carers that they had varied experience of receiving services. Some carers we met said that they had difficulty getting respite from caring for their cared for person. Other carers we met had a very positive experience of getting a short break from their caring role using a voucher scheme. We found it reassuring that equitable support to carers was included as a priority within the draft strategic plan.

⁸ Emotional Touchpoints is an evaluation tool used to capture moments or events that stand out for those involved as crucial to their experience of receiving a service.

The partnership was working to improve the use and quality of anticipatory care planning. The partnership had supported this work with a successful pilot initiative, whereby a specialist nurse prepared comprehensive anticipatory care plans for individuals who had long-term conditions.

In the main, GPs completed these plans, sometimes supported by community nursing staff. Thirty-nine per cent of the older people whose records we read had an anticipatory care plan in place. While just over half of the anticipatory care plans we analysed were simply key information summaries the remainder of these plans contained important additional information, as well as a list of individuals' medications and morbidities.

There was information about:

- individual's care choices if they were no longer able to live at home
- discussions with the carer
- whether the individual had granted power of attorney
- whether there was a 'do not attempt cardio pulmonary resuscitation protocol' in place for the individual, and
- actions to take in the event of an emergency such as the carer being unable to care for the individual.

We considered that the partnership had made reasonable progress with the development of anticipatory care plans and the associated development of an anticipatory care ethos for GPs and partnership staff. Senior managers partially attributed the significant fall in emergency admissions of older people to hospital from 2014, to effective anticipatory care planning carried out by GPs and partnership staff. The partnership said they planned to develop this further.

The average inspection grade assigned by the Care Inspectorate to the regulated services for older people, which were run by the independent sector and the third sector, was 'good'. Overall, regulated services for older people delivered good outcomes for older people and their carers. We met many older people who used regulated services. Almost all of these older people said that they greatly valued the services they received. They described some good outcomes in terms of enabling them to be independent, enhancing their wellbeing and supporting them to keep safe. We met older people who were permanent residents in care homes run by BAC. They said that the care home staff looked after them very well, and the service delivered positive outcomes for them in terms of their health and wellbeing. BAC was showing signs of improved services for older people and was beginning to drive up its average inspection grades.

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

The partnership delivered positive outcomes for almost all older people whose records we read (93%). This was in line with results for other health and social care partnerships we have inspected.

We were particularly impressed with the work of the partnership's wellbeing team.

We met with older people who participated in some of the wellbeing team's activities. They were complimentary about the team's enthusiasm. They said that they had benefitted hugely from participating in activities such as the Golden Games. We consider the work of this team further in quality indicators two and four.

The council received 30 complaints relating to adult social work services in the year April 2014 to March 2015. Thirty per cent of the complaints were upheld or partially upheld. We do not have comprehensive benchmarking data, but the fact that only 4 out of 56 complaints were upheld is low compared to other partnerships, whose complaints data we have analysed. Adult social work services performed relatively well on investigating complaints timeously.

Information available for NHS Grampian as a whole showed that in the years 2010–11 to 2014–15, the average number of complaints responded to within the 20 day target was – Scotland 65%, NHS Grampian 51%. The health village⁹ had developed the use of 'improvement trees' to effectively gather and analyse feedback from people accessing services there.

The partnership had made slow progress delivering self-directed support for older people. Senior managers readily acknowledged this was an area for improvement. Our review of older people's records showed that 86% of the individuals who should have been offered the four self-directed support options¹⁰ had not been offered them. One of the reasons for this was that a self-directed support infrastructure had not been put in place. We met with the partnership's enthusiastic self-directed support team. They were making progress creating the necessary infrastructure for the effective delivery of self-directed support to older people that included a suite of documentation, key processes for the implementation of self-directed support and robust monitoring of individual's direct payment arrangements.

The partnership provided direct payment to increasing numbers of older people at a level around the Scotland average (Chart 7). Some staff reported that individuals they worked with had found it quite easy to get direct payments and set up their scheme. They said that direct payments had worked very well for some individuals, by giving them the choice and control that they desired as well as improved personal outcomes.

⁹ The health village was an urban community hospital without inpatient beds delivering a small range of diagnostic and treatment services in partnership with Aberdeen City Council.

¹⁰ Option 1 – direct payment, Option 2 – directing the available support, Option 3 – services arranged for the person by the local authority, Option 4 a mixture of 1–3.

Quality indicator 2 – Getting help at the right time

Summary

In this section, we examine the experience and feelings of individuals and carers, how they understand and appreciate the services provided to them. We specifically look at their experience in relation to improved health, wellbeing, care and support. We also consider prevention services from the perspective of the individual and also the access to information about support options available to them, including information on self-directed support.

Older people's access to help at the right time was **GOOD**. The partnership's approach to the design and delivery of care for older people had a clear focus on maintaining their independence, good health and wellbeing. There was a strong message from the partnership that educating and supporting communities as partners in managing health and care needs was important in order to improve wellbeing and reduce the impact of ill health. There was a clear plan for supporting and encouraging healthy ageing throughout the city. Some innovative and effective initiatives being delivered by the partnership were the wellbeing team and the Silver City project.

Once in receipt of services, older people and their carers we met were, in the main, satisfied with the quality of the support and care they received. Older people and carers greatly appreciated and praised the post diagnostic support offered following diagnosis of dementia. However, access to this service was sometimes delayed.

Carers reported that they would like easier access to respite care and day services to support them and the person they cared for. Supporting carers by offering and completing a carer's assessment and providing timely support were areas identified for improvement. However, there was clear evidence that when carers were supported in this way it had led to improved outcomes for them.

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

Older people and their carers were generally appreciative of the services that they received. This was confirmed in the health and social work records we read where we saw a high proportion of assessments that had taken the older person's choices into account (95%). This was also the view of 67% of the staff who responded to our staff survey. We met with over 100 older people and their carers. Many older people and their carers we met said they were very satisfied or satisfied with the outcomes from the care they received. Other carers we met, while positive about the support they received, highlighted that they were still waiting for services to be provided following assessment.

We met older people who attended Kildrummy Day Hospital. They had confidence in the services they received and highlighted the benefits for them of attending the day centre. Exit questionnaires, reports and group meeting minutes involving older people and their carers showed older people were very enthusiastic about the day hospital and the positive outcomes it delivered for them. The day centre was available for older people with functional mental health conditions and was open five days a week. It offered treatment, therapies and activities, which were outcome focused and person-centered. Some of

these older people also attended the hospital's 'techno gym' which was supported by the wellbeing coordinators. Older people continued to benefit from exercise by attending a techno gym nearer to their home.

The partnership had a long-term conditions practitioner whose role was to support individuals to self-manage their condition and to train other staff about the management of long-term conditions. Advanced nurse practitioners also supported individuals with long-term conditions and gave advice on self-management. We met with some older people who had long-term health conditions, who said that the support they received to manage their condition, had helped them to cope and improved their wellbeing.

Older people and their carers were positive about the benefits to them from a number of groups provided by third sector organisations. These groups provided them with much needed information, support and social contact. Lack of transport however, could be a barrier to attendance at these and other health and social care support.

Forest Grove (Kings Gate) is a Voluntary Service Aberdeen initiative funded until March 2017. This funding provided resources for the development of further day support for people with dementia and their carers in other localities across the city to provide more locally based services. The centre provided carer support, day service care and flexible respite for people with a diagnosis of dementia or chronic long-term conditions. A weekend day service for people with dementia was also provided. This service was highly rated by the carers we met. Older people and staff who supported them also praised the service provided. The centre staff were highly motivated. These services provided a responsive and valued service for older people and their carers.

Occupational therapy and housing staff worked together with hospital teams as part of the Adapting for Change project. This initiative identified housing need to prevent the older person's discharge from hospital being delayed by housing requirements. Changes made to the housing allocation system ensured that people did not lose additional housing priority points¹¹ awarded while they were in hospital. Housing services provided support to help older people complete applications where necessary. Housing services were planning to develop the use of additional housing properties as 'step down' accommodation. This work included an option to use sheltered housing to test individuals' safety and build confidence in a safe environment before they returned home.

The partnership's delivery of support to unpaid carers was mixed with some carers finding it easier to access support than others. The older people's records we read showed that half of the carers we identified had not been offered carers' assessments. One third of carers who requested a carer's assessment did not receive one.

We found in 50% of the carers' assessments completed, there was evidence to confirm that the support provided as a result of the assessment had led to improved outcomes for the carer.

Voluntary Service Aberdeen had developed a promising revised and simplified carer's assessment format. This was called 'Looking after someone – who is looking after you?' The aim was to develop an approach which looked at the impact of caring on carers' lives

¹¹ Applicants for rented housing are prioritised by awarding points, based on the current housing circumstances.

rather than on the tasks they carried out. Voluntary Service Aberdeen also planned to develop telephone support, and were waiting for agreement from the partnership before implementing this approach.

A number of staff described how the practice of offering carers' assessments varied across teams. We were concerned about this variation, given carers' assessments are a gateway to respite and other support.

We met some unpaid carers who spoke very positively about the support they received from the Carers Centre, which the partnership jointly funded. This included a designated older people carer support worker and a male carer support group. The carers' worker, based at Cornhill Hospital, enabled easy access to information for individuals attending the hospital for treatment or support.

We met with staff who delivered post-diagnostic support to individuals diagnosed with dementia and to their carers. We considered that this service delivered valuable practical and emotional support to carers, as well as the cared for individual diagnosed with dementia. We met with carers who said the support they received from this service was invaluable. The support had helped them to cope with the challenge of caring for someone diagnosed with dementia.

Some carers told us that they had experienced a wait for assessment, review or services, which resulted in them taking on additional care for the person they cared for. We considered support and services to carers needed to be more consistently provided across Aberdeen City. The partnership, in reviewing its documentation, should take into account the new Carers Bill.

Recommendation for improvement 2

The partnership should work with carers and those services that support them to ensure that:

- **carers are routinely offered a carer's assessment**
- **carers' assessments are completed for those carers who request them**
- **offering and completing carers' assessments is clearly documented, and**
- **revisions to the future format for carers' assessments take into account new carers legislation.**

A variety of services were in place or were being developed to support improving outcomes for older people and their carers. These included:

- The Aberdeen Advocacy Service, a small charity with funding from a range of sources including NHS Grampian and Aberdeen City Council. A large volume of its work was linked to statutory mental health and adults with incapacity legislation, generally supporting those over 65 with mental health problems. Advocacy staff told us that one of the major challenges for their service was to be able to meet demand. There was a waiting list for the service. Advocacy staff recognised the challenges of raising awareness amongst professionals and the public about the role of advocacy services.

- The Silver City project set up in conjunction with the Northfield and Mastrick medical practice, based in an area of high deprivation in the city. The project provided a well-coordinated approach to improve the support, care and opportunities offered to older people in the city. The project aimed to look at how integrated care would work in one GP practice and drew together current practice to form a model, which could be replicated across the city. This promoted more integrated care of older people within their communities.
- The wellness group comprised a representative from public health, a capacity building officer, wellbeing coordinator, development officer, nurse practitioner and third sector representation. The group facilitated sessions with older adults about how they would like to be helped to access social activities. These sessions were called Big Blether and were reported by older people and staff as being very successful.

2.2 Prevention, early identification and intervention at the right time

The wellbeing team promoted and supported early intervention. The partnership had taken positive action to promote the concept of 'wellbeing'. Older people, their carers and staff all spoke very positively about the beneficial effect of these services. The council and NHS board jointly funded the wellbeing team who offered advice and coordination on an Aberdeen City-wide basis. This team had recently begun to provide support to those living with dementia by providing access to physical activities across Aberdeen City.

This highly committed team carried out a range of excellent work with older people, which enhanced their wellbeing, improved their health and fitness, offered them opportunities for socialisation, and afforded them recognition and inclusion in their communities. The innovative work of this team included:

- the Golden Games, an extensive highly cost effective programme of activities for older people of all ages and abilities (the oldest participant was 102)
- a successful support group for men whose wives or partners had died
- purposeful practical support for older people about to be discharged from hospital
- the development of the techno gym exercise programme for older people
- work with older people with functional mental health problems, and
- support for local community groups to take forward enterprises initially developed by the wellbeing team.

There was a range of other services in place to support older people with long-term conditions such as Parkinson's specialist nurses, stroke rehabilitation and cardiac rehabilitation. Older people we met said they valued these services.

Sixty per cent of older people whose records we read, had a long-term condition and most were supported to self-manage this. This support came from a range of professionals including care service providers; social workers; allied health professionals; community or district nursing service; pharmacists and independent or third sector providers. Our staff

survey confirmed that 66% of staff who responded agreed or strongly agreed that the service worked well together to support people's capacity to self-care and manage their conditions.

Community nurses worked closely with care agencies to provide end-of-life care in older people's own homes. The NHS managed the Macmillan service that mainly provided training and development to staff and carers. Marie Curie staff continued to provide support to older people and their families but like other services, because of recruitment difficulties, could not always respond quickly to people needing support. Sometimes older people returned home with only support from their family and without a full assessment of their needs. Community nurses were providing additional care and support which could have been provided more appropriately by a care at home service.

In response to an increase in the level of unscheduled work at the weekends including palliative care and discharges from hospital, community nurses were concerned that they would not always be able to offer support to older people. The partnership was reviewing how the service was structured.

The falls carers group was a good example of a well attended initiative, which enabled older carers and cared for persons with dementia to attend a falls exercise group.

Staff reported that people with dementia were seen earlier than in the past, because the speed of diagnosis had improved. Some staff thought this was because there had been a lot of publicity which had raised awareness and people saw their GPs earlier. The consultants from old age psychiatry confirmed that there had been an improvement in early diagnosis of dementia.

Older people, carers and staff said that dementia diagnosis was usually through the older people's mental health team (OPMHT) following referral from their GP. For most of the older people we spoke to, diagnosis was timely and made with minimal delay. The Community Psychiatric Team or Nurse (CPN) provided Post Diagnostic Support (PDS) when clinical input was needed. Older people and their carers at the dementia cafe we attended told us that the PDS link workers commissioned from Alzheimer Scotland were very helpful. Their support made a difference in helping older people and carers to cope with their situation. There was however, a waiting list for this service and this meant that there was a delay for some older people and their carers accessing support when they needed it.

Staff said that they were doing well in meeting the needs of older people with dementia. The PDS link workers had improved the service and aimed to minimise delays to appropriate support. They completed a specialist assessment with the individual and their carer. This helped develop personalised support based on the individual's wishes which they shared with other professionals to ensure the tailored support was continuous.

Each GP practice had a link pharmacist. The time that older people had to wait for Multi-compartment Compliance Aids (MCAs) to manage their medication was variable. Community pharmacies completed risk assessments to prioritise medication management approaches and had capacity issues in terms of management of MCA provision. Some older people experienced long waits for these (one of over six months). This is a national issue and not unique to Aberdeen.

The partnership had used change fund resources to review medication management and acknowledged that supporting people to manage their medication was an area they were continuing to work to improve.

In the main, older people and carers gave positive feedback about the services they received in their own home, once they were in place. However, older people, their carers and staff all agreed that it was difficult to increase care packages if this was required. Often, this meant that the carer was responsible for continuing to care for the older person while there was a gap in care provision. Due to the lack of staffing capacity, the ability of older people to choose the time or provider for their care package was severely restricted.

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

There was a range of information available to older people to help them access services and support. Leaflets, newsletters and advice access points were available in the health village and libraries, as well as social work and health premises and on the internet. Third sector organisations such as Voluntary Service Aberdeen and Alzheimer Scotland had centres where information and support were available.

Several older people and carers we met were very positive about the impact of attending Alzheimer Scotland 'Seize the day' information sessions that had helped them learn about dementia and develop coping mechanisms. This project was funded by the Scottish Government.

Most older people and their carers said that they had not been offered the choice of any of the four self-directed support options¹². Where there was evidence that self-directed support was offered, we found the level of information given to older people was poor. They had received little information other than their care manager sending information leaflets in the post.

Generally, staff in the NHS we met did not feel confident that they had enough information or training about self-directed support to be able to discuss these person-centered approaches with older people. Social work staff had a better understanding of the options available but workload pressures sometimes prevented them from developing conversations with older people and their carers about self-directed support options. Staff said that sometimes older people and their carers were fearful of the additional responsibility of direct payment.

The self-directed support team acknowledged that they had not made as much progress as they would have hoped in developing self-directed support options with older people and their carers. The self-directed support project manager being seconded to manage the joint inspection had also impacted on implementation. The self-directed support team was well placed to make further progress and was actively improving their systems and documentation to improve information and ease of access to self-directed support to the different options.

¹² Option 1 – direct payment, Option 2 – directing the available support, Option 3 – services arranged for the person by the local authority, Option 4 a mixture of 1–3.

Quality indicator 3 – Impact on staff

Summary

In this section, we consider what employees think and feel about working in the partnership. We consider how motivated staff are, their feelings about their support and management, how effective they feel teamwork is and their understanding of and support to organisational priorities.

Impact on staff was **GOOD**. Almost all the staff we met enjoyed their work and most said that they felt valued, recognised and supported by managers and other professionals. There was good access to professional development. Staff were generally well motivated. Although approaches to improvement were underway, increased workloads, vacancies, absence and cumbersome assessment paperwork were having a negative affect on staff morale in some services.

A more cohesive approach to planning and delivering services was beginning to be achieved through multi-agency working. Despite some of the challenges caused by staff shortages and increased demands on time, staff remained committed to ensuring they delivered high standards of person-centred care for older people and their carers.

The partnership had a number of effective approaches to communication in order to keep staff updated. There was evidence that staff had been able to influence future service design through consultation events. Most staff had attended briefing events and said they felt well informed about integration. However, some staff reported differing views about the effectiveness of these approaches and expressed some concerns about how integration might affect jobs and services. Generally, staff expressed enthusiasm about what integration could offer to improve outcomes for older people. Senior managers recognised that continued dialogue with staff was needed to enable frontline staff to feel more engaged.

3.1 Staff motivation and support

We looked at a range of evidence including documents submitted by the partnership, results from recent staff surveys in health and social work and a staff survey we conducted as part of the joint inspection. We met with over 300 staff. This included face-to-face meetings with managers and focus groups with staff from health, social work and other care settings. We asked 1,423 staff to complete our survey with 318 responding. This was a 22% response rate.

Of those who returned our survey:

- 55% were employed by NHS Grampian
- 44% employed by the local authority, and
- 1% employed in 'other' sectors (for example GPs).

Staff said they had a clear understanding of their roles and responsibilities within the partnership. Overall, they were committed to delivering and improving care, support and treatment for older people and their carers.

Our survey showed that almost all staff enjoyed their work (90%) and most felt valued by other practitioners when working in partnership (81%). Key findings from our survey confirmed a clear majority of positive responses about line managers where staff said:

- they felt valued by managers (75%)
- they agreed their workloads were well managed to enable them to deliver effective outcomes to meet individual needs (64%), and
- they felt supported in situations where they faced personal risk (82%).

Staff morale was generally good. However, in a few settings, staff were less positive. Some staff said they were working to full capacity and felt they were 'fire fighting'. Consequently, they often struggled to adopt a planned approach to delivering good outcomes for older people. Staff attributed this to increased workloads, high volumes of paperwork, staff shortages and difficulties accessing support services to help older people remain at home.

Aberdeen City Council and NHS Grampian's most recent surveys also indicated low staff morale in some areas. Some staff said demands on their time had meant that they did not feel involved in or understood the impact of the integration process on the work they did. Although senior managers had set out a range of opportunities for staff engagement, the pressures already outlined in relation to workload meant that some staff did not feel able to engage in consultation events.

Innovative and inclusive engagement events set up by the partnership's organisational development staff had involved around 1,400 staff from across the public, independent and third sectors. Senior managers prioritised attending these events to engage with staff to discuss and shape the plans for integration and provide assurance about the way forward. Generally, most of the people we spoke to across staff groups were enthusiastic about integration.

The partnership's action plan for improvement supported managers by offering training in management and leadership. Senior leaders were more visible to frontline staff than previously. The chief officer shadowed teams to learn more about their work and kept the partnership informed about the changes and improvements necessary to improve staff morale, enhance communication and reduce workload pressures. Most health and social work staff welcomed these developments, which actively demonstrated the partnership's joint communication and engagement plan.

In our staff survey, the majority of respondents (64%) agreed that senior managers communicated well with frontline staff. The partnership had developed a range of communication methods to help engage staff on the key developments of health and social care integration. This included:

- a dedicated website for the health and social care partnership
- a partnership newsletter
- integration events
- videos of events, and
- consultation with trade unions.

Although the partnership had made promising developments to engage the workforce, senior managers recognised they needed to continue to improve communication of change to staff. They acknowledged that strengthening workforce engagement was the key to implementing positive change and the overall success of the partnership.

There was a long history of positive informal joint working between health and social work staff at an operational level in Aberdeen City. Some staff said this worked particularly well when they were co-located in the same building. Our staff survey results showed positively that 69% of respondents agreed or strongly agreed their service had excellent working relationships with other professionals and 85% agreed or strongly agreed that managers supported and encouraged joint working. Our review of older people's health and social work records endorsed these findings. Almost all (91%) of the files evidenced multi-agency working.

We saw some positive joint working arrangements that had begun to deliver a more cohesive approach to ensure older people received the most appropriate care and support when they needed it most. The discharge hub, older people's acute liaison team, GP clusters and the community health and care village were positive examples of joint working initiatives under development.

Staff had reservations about whether there was sufficient capacity within their teams to cope with future demand for services. In common with other areas in Scotland, only 28% of respondents to our staff survey felt they had sufficient capacity within their team to carry out preventative work.

Frontline staff said the number of referrals for older people with complex care and support needs had increased. We heard about increasing pressures on social work services staff. This sometimes had an impact on the approval process for older people with complex care needs and resulted in a delay in delivering services for older people. The partnership had reviewed its assessment documentation, and streamlined the social work referral process in response to feedback from staff at engagement events and on-site visits from senior leaders. Although at an early stage of development, we considered these were promising developments to maintain and improve staff morale.

At times of crisis, services generally worked well together to provide appropriate care and support for vulnerable older people who were at risk of harm. For example, staff across all sectors worked with the community to keep people safe during the extensive flooding in the area in January 2016. We saw good examples of this when we reviewed the health and social work records of older people. Our staff survey results showed that most (81%) respondents agreed or strongly agreed their service worked well with other agencies to keep people safe and protect those at risk of harm. This was confirmed when we met with older people and their carers, although some of the results from the records we read detracted from this positive picture.

Eighty per cent of respondents said they had access to effective line management including profession-specific supervision. This was particularly so for social work staff. We discuss this in more detail in quality indicator seven. Our staff survey results showed that most staff had good access to training and development. Providing joint training opportunities was an area for development that the partnership was beginning to address.

Quality indicator 4 – Impact on the community

Summary

In this section, we consider the approaches to promote positive engagement with the community and approaches to building community capacity. We look for evidence that the characteristics of local communities are understood and that there is clear evidence of community participation.

Impact on the community was **VERY GOOD**. The partnership was strongly committed to engaging with and involving local communities in planning how to meet the health and social care needs of the older population.

A range of effective engagement opportunities was in place to support communication with local stakeholders and communities for them to contribute to discussions about the needs of their communities. A number of locality planning events were taking place, which aimed to increase local ownership. This approach towards collaborative working was at an early stage.

The partnership's strong commitment to promoting healthy active ageing was evident. Working with organisations across the whole care sector, opportunities to support healthy active lifestyles, reduce isolation and support carers were being taken forward. These had resulted in access to a wide range of creative opportunities and activities being developed. Individuals and groups we met spoke very positively about these developments.

An excellent example of an innovative approach was the Golden Games, Aberdeen's annual festival for activity, which won the Healthier Lifestyle Award in 2015 in recognition of invaluable contribution to Scottish healthcare.

Overall, there had been significant mobilisation of community capacity to effectively support older people and their carers.

4.1 Public confidence in community services and community engagement

The partnership was committed to engaging with and involving the community. There was clear evidence that the public and a range of other stakeholders had the opportunity to learn about what integration would mean in Aberdeen City and for them.

The communication and engagement strategy effectively informed and involved the citizens of Aberdeen City in the changes to health and social care services. As well as using meetings and events, an online survey encouraged further comment from the public.

The partnership consulted a wide range of groups including:

- NHS Grampian public forum
- Civic Forum

- Sheltered Housing Network, and
- community councils.

Responses from these activities informed the finalised strategic plan.

The partnership was committed to engaging with the public using Aberdeen Cityvoice, which was a citizens panel for Aberdeen City. The citizens of Aberdeen let organisations know what they thought about services in the city by this means. A panel of Aberdeen residents regularly contributed their views on a wide range of issues. The panel had over 900 citizens. Responses relating to older people over 65 informed developments that the partnership needed to address and included:

- continued work with people living in local communities
- listening and responding to the voices of local people, and
- developing sustainable wellbeing opportunities.

The monitoring arrangements that the partnership had put in place ensured that citizens had opportunities to be kept informed, involved and participated in the development of plans. The partnership communications included press releases, the partnership newsletter, and the development of a website and regular use of social media. The newsletter, Partnership Matters, provided meaningful updates to staff and the public. There were links to the progress of integration and service development news such as community meals, podiatry and community nursing. The partnership effectively set out its plans for the future of health and social care in Aberdeen City and the contribution that stakeholders could make.

The Health and Social Care Partnership website was very informative. This aimed to provide staff and members of the public with news about the developing partnership arrangements.

The partnership intended to develop services within four natural localities across Aberdeen and build community resilience based on an asset planning approach to increase local ownership to drive change. The partnership anticipated this would support people to better access local non-medical help and services such as care at home, social activities, local groups, money advice and carer support, and promote collaborative working.

A number of locality planning events were taking place and actively engaging with staff and citizens. In one locality, we observed a workshop focused on raising the awareness of enablement and provided an overview of progress with the development of integrated localities. This event was well attended by partners from health, social work, third and independent sectors. A participant at an event echoed the views we heard expressed across the partnership, 'feels different, feels better'.

The partnership had recently appointed an integrated localities programme manager who had begun to engage with people to better understand the needs of the local community. The manager's primary aim was to support the development of local initiatives which

would assist older people to remain in their own communities. A member of staff told us that the capacity-building model was 'helping to shift what had previously been a very service orientated model'.

Some staff groups highlighted that the involvement of the third and independent sector in strategic planning needed to be strengthened, although we found that these sectors along with housing services were engaged in planning. This work was being further strengthened with effective support from the integrated localities programme manager.

Care management teams in each of the four localities were linked to GP practices. The partnership planned to further develop integrated teams to ensure better joined up working. There was a strong commitment to ensuring a more equitable service across the city. To develop the vision for partnership working further, Nurture Development¹³ had been commissioned to support the redesign of services and engage collaboratively with members of the public in the development of their communities and in particular, the establishment of locality based services.

The partnership had worked hard to promote healthy, active ageing in Aberdeen by working with statutory organisations and the third sector alongside students from local education establishments. We visited community projects aimed at preventative interventions and met many older people and their carers who told us how they had benefited significantly from community supports and activities. The wellbeing team was committed to the prevention of ill health and encouraged older people to take part in activities, which reduced loneliness and isolation by creating community support groups for them.

In order to ensure the sustainability of these activities, the team worked in partnership with statutory and third sector organisations both in the community and within hospitals in Aberdeen. The work of the wellbeing team complemented the range of very good work that the partnership had done with the third sector in respect of developing community supports for older people. Overall, there was a great deal of third sector activity supporting older people and their carers. We visited groups run by enthusiastic volunteers who worked hard to support individuals, such as:

- Alzheimer's support group for people with dementia
- Way Ahead Group for former carers, and
- Living Well Café for those with memory loss.

The wellbeing team had also established links with Aberdeen Football Club Communities Trust (AFCCT) that supported the development of innovative and positive initiatives aimed at improving wellbeing and healthy activity for older people. The AFCCT, Sport Aberdeen and Aberdeen Sports Village worked in partnership to effectively promote active ageing and the AFCCT hosted one of the techno gym facilities. These gyms were available in a variety of locations across the city. The AFCCT also provided a wide range of other meaningful activities such as football reminiscence sessions, walks, ball games and

¹³ Organisation that promotes Asset-Based Community Development (ABCD), a movement that considers local assets as the primary building blocks of sustainable community development.

walking football in a full weekly programme. The AFCCT also offered a limited number of free season tickets for over 65s to enable them to attend home games.

Sport Aberdeen offered positive opportunities for older people to take part in a series of chair exercises, individual fitness MOTs and provided advice about falls prevention. Attendees told us that they found the project enjoyable and helpful although they sometimes found it difficult to attend when transport was not provided.

We visited the Big Blether project, which aimed to reduce social isolation. It is recognised that loneliness can cause people to 'over medicalise' their condition and contact GPs inappropriately. The Big Blether targeted socially isolated people who were invited for a cup of tea and to learn about local group activities. This promoted effective contact and engagement of older people.

The Golden Games was Aberdeen's annual festival for activity for people over 65. It had taken place for the past five years and featured more than 30 different activities in venues across the city. These games had given older people the opportunity to engage in physical activity as well as provide them with a chance to meet other older people, thus reducing social isolation. This was an excellent example of partnership working.

Active Ageing Aberdeen provided a range of physical activity opportunities for older people. They worked closely with the partnership to respond to the health needs of citizens in Aberdeen. The number of older people engaged in activities in their community was increasing. In their annual report for 2015, Active Ageing Aberdeen reported an increase of 78% for those participating in their programme and an increase by 48% of the number of sessions offered, thus widening the range of events available.

Third sector staff and volunteers provided a helpful range of support for older people and their carers. Alzheimer Scotland, for example, had a resource centre in the town centre, which hosted a range of supportive activities and information sharing. We joined older people at a dementia café in the town centre, which was well attended by people with dementia and their carers. They enjoyed the social interaction the café provided and the opportunity to talk to others in similar circumstances.

The Living Well project was an effective befriending service for older people in north Aberdeen. In partnership with Aberdeen City Council and Alzheimer Scotland it also provided help and support to older people with memory loss, dementia and their families and carers.

Overall, there had been significant mobilisation of community capacity to effectively support older people and their carers. One older person who had a diagnosis of dementia told us 'there is always something on somewhere' and another said 'there are activities for all tastes'.

Example of good practice – Wellbeing team

A member of the wellbeing team was invited into Woodend Hospital to provide advice on how to maintain the physical and emotional health of potentially long-term patients with the aim of preventing deterioration of patients' conditions and possibility of readmission to acute care.

For example, a member of the team offered an older person a number of options such as befriending, delivery of home books, and referral to allied health professionals. We considered that this was genuinely innovative and creative work.

This approach was a positive example that presented further opportunities to develop hospital links with the wider community and third sector.

Quality indicator 5 – Delivery of key processes

Summary

In this section, we look at approaches taken by the partnership to ensure ease of access to support and services. We consider the effectiveness of assessment, support planning and review. We assess the extent to which shared approaches are protecting individuals who are at risk of harm. We also consider how well individuals are involved in directing their own support.

Delivery of key processes was **WEAK**. Both health and social work services had centralised referral processes. Although this made initial contact easier, it did not always mean services were provided in an appropriate time frame. There was also a range of service specific criteria, which led to multiple pathways into services. Older people and their carers found this confusing. Nearly a quarter of older people were on a waiting list for services and some service provision had been delayed in excess of six months. The partnership was actively progressing a range of initiatives to support improved access to services including access to out of hours support. It was too early to measure the impact of these developments.

There was clear evidence that investment had been made in relation to anticipatory care planning and we found this approach was achieving better outcomes for some older people.

Many older people told us that they felt they had been involved in discussions about their assessed needs, though some said choices were limited. This was not helped by the fact that the implementation of self-directed support had been very slow in relation to support for older people.

A significant concern was in respect of adult support and protection referrals. Although initial screening was undertaken in an appropriate time frame, critical tasks such as initial enquiries and full investigations were not, in some cases. Such delays potentially left a few older people at significant risk of harm over a protracted period.

5.1 Access to support

There was a helpful range of public information available through the partners' websites as well as attractive informative leaflets.

Both health and social work had centralised referral processes. Although this made it more straight forward for older people and their carers to make their initial first contact, it did not always support ease of access to services.

The partnership had a range of service specific criteria, which resulted in multiple pathways for accessing social work services. Older people and carers we met found these pathways complex to understand. For example, we met some older people who had places at more than one day service, whilst others had none and were on a waiting list for a place.

People who had critical and substantial need were prioritised for services. Those older people who did not meet the criteria were signposted to alternative sources for advice and support. Social work service staff used agreed criteria when assessing need although they acknowledged that some older people who met the criteria still had to wait to get services they needed. We found delays were due to a number of reasons:

- increasing level of demand
- lack of care at home staff across the sectors
- variable range of services available to older people depending on their location, and
- lack of equity of allocation of scarce resources.

The health village had valuable and effective information points such as the healthpoint and carerspoint¹⁴. Older people and their carers we met spoke positively about the health village and how visiting this resource had helped them to access information and services.

The partnership had completed an effective redesign of out-of-hours services. The development of community link coordinator posts were proving effective in helping to prevent admission to hospital. Staff confirmed that the link coordinators had made a positive difference to the way health and social workers worked together to make sure individuals were being well supported. Whilst there were efficient systems in place to support older people getting an initial response and assessment promptly, older people, their carers and staff we met expressed frustration at the potential delays in getting resources after completion of the assessment.

Waiting lists for a range of services was a significant issue for the partnership and for the older people who had to wait. While the health and social work records we read indicated 7% of older people had experienced unreasonable delay in being assessed for key services or support, a further 23% of older people were on a waiting list for services with delays for some exceeding six months. Older people had to wait for a range of services, which included care at home, care home provision, very sheltered housing and day care.

All staff we spoke to acknowledged the challenges of getting services to older people timeously. Whilst the partnership had begun to gather information on unmet need for care at home services, staff were unclear how this information was used to inform service priority and development. Whilst the partnership was working hard to address these issues, we were concerned that they did not have an efficient system in place to monitor how many older people were actually waiting for services across Aberdeen. Collection of this data would help the partnership to manage waiting lists and waiting times and inform future commissioning of services.

¹⁴ The carerspoint was a joint venture, which provided an excellent range of information and advice in an accessible venue.

Recommendation for improvement 3

The partnership should ensure that:

- pathways for accessing services are clear
- eligibility criteria are applied consistently across services, and
- waiting lists are monitored and reviewed to manage the allocation of pressurised resources equitably.

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

Aberdeen City Council used the Single Shared Assessment (SSA) to assess older people's needs for social care and support services. Staff said they found the SSA cumbersome to use. They did not routinely share the assessment with, nor was it used by, partners to inform assessments. Senior managers were aware of the limitations of the SSA and the views of staff about it. Managers had piloted a streamlined version of the SSA with staff in one of the localities with the intention of rolling this out across services. Managers had yet to set a timescale for this. Health and social work staff were beginning to work together to develop a more outcome focused approach to assessment.

It was evident that the partnership had made investment and was committed to introducing anticipatory care plans for older people to support assessment and care planning. Our findings confirmed these were beginning to support improved outcomes for some older people.

We looked at the quality and content of assessments and care planning.

From our review of older people's records, we found:

- 89% of records contained an assessment with 1% evaluated as excellent, 15% very good, 41% good, 35% adequate and 7% weak with none evaluated as unsatisfactory
- 69% of records confirmed that a range of professionals had contributed
- 98% of assessments took account of the individual's needs
- 66% of records had evidence of consent being sought to share information, and
- in 76%, evidence of partners sharing information and recording this in their records.

These findings showed that partners were working well together and with older people. It was also positive to find evidence of line managers' scrutiny in 57% of records we reviewed.

Fifty-nine per cent of older people whose records we read had a comprehensive care and support plan in place. Thirty per cent had a care plan that was less comprehensive with 11% having no care and support plan. We found a range of different care plans being used and new versions were being tested that aimed to streamline these.

All staff we met told us about the significant shortage of, and difficulties they experienced trying to obtain some services for older people. This was consistent with findings from our staff survey where only 26% of staff who responded agreed or strongly agreed that a broad range of services was available to offer alternatives to hospital admission. Fifty-five per cent disagreed or strongly disagreed.

The partnership had established a number of positive initiatives involving a stronger multidisciplinary approach in order to address the challenges in delivering services to older people.

- Fortnightly multidisciplinary team meetings were introduced into one GP practice to provide an effective forum to discuss the care of older people with complex needs. This supported improved joint working and found shared solutions to support older people.
- To help facilitate timely discharge from hospital, the partnership had created a multi-agency discharge hub that included a discharge coordinator and care manager. This allowed social work and health staff to triage older people more effectively and support discharge. The hub was a promising development.
- ‘Care of elderly’ consultants introduced comprehensive geriatric assessments for older people referred to accident and emergency, which helped improve older people’s experiences and treatment.
- To provide effective support to non-specialist wards and to inform effective discharge processes, the older people acute liaison (OPAL) team based within the discharge hub also held productive daily meetings.

To address the delays of those older people needing residential care or with more complex support needs, the partnership had successfully increased the availability of interim and intermediate care placements by commissioning 30 beds from the independent care sector.

Community nurses worked hard to ensure that older people received the equipment they needed and a nurse specialist was available to provide training and support to staff. The telecare service based within BAC had been successful and responsive in providing equipment promptly with no waiting lists. However, the partnership recognised that a joint equipment service would improve efficiency of access.

Although progress had been slow, a redesign proposal for joint provision was now in draft form and was moving forward as part of the strategic plan.

Staff from across the partnership, expressed concern that some older people were discharged from hospital without any care at home service in place to meet their personal care needs. Hospital staff had not referred these older people to social work for assessment to allow service provision to be in place at the point of discharge. Social work services had to deploy emergency care at home provision to look after these older people in order to meet their critical personal care needs such as for food, water and getting to the toilet. Whilst the discharge hub was helping to reduce the number of older people being discharged from hospital without appropriate care being in place, nevertheless,

staff confirmed this unacceptable practice still occurred. The partnership should work to reduce these occurrences. They acknowledged that they needed to encourage staff to report on failed discharges and to collate data more accurately to help them improve their understanding of the extent of this problem better.

Most older people in hospital with high priority needs had good access to rehabilitation on discharge from hospital. This was not so good for those with lower priority needs. The community rehabilitation team based in hospital provided effective support to older people before and after discharge. Some staff across the partnership spoke positively of the enablement team previously in place. However, the loss of this team in June 2015 had contributed to a reduction in available resources to support older people to return home with an intensive time limited support package.

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

The independent convenor of Aberdeen City Adult Support and Protection Committee also chaired Aberdeenshire and Moray Adult Support and Protection Committees. This chairing arrangement for Adult Support and Protection Committees across Grampian was effective in providing consistency between partners. The three committees shared Grampian wide interagency policies and procedures for the support of adults at risk of harm. The partnerships had structured governance arrangements in place for adult support and protection. The Aberdeen City Adult Support and Protection Committee enhanced its membership with strong representation across the sectors and included representation from the GP clinical lead.

Each partner had its own additional local guidance. In Aberdeen City whilst the guidance was clear, it did not set out timescales for the completion of critical tasks such as initial inquiries and full investigations.

Council officers and Adult Protection Unit staff told us that screening at the point of adult protection referral was generally dealt with timeously. Aggregated data gathered by the Adult Protection Unit and our review of records confirmed this.

However, lack of clear timescales had led to drift in the completion of initial inquiries and lack of clarity as to when investigations needed to be progressed to case conference. We also found council officers were not always supported by their partners with delays from police completing enquiries or by health staff completing capacity assessments promptly. These delays potentially left a few older people at significant risk over a protracted period.

Council officers believed that part of the reason they were taking longer to complete initial inquiries was due to their practice of completing more detailed assessments than required at this early stage. We concurred with this view and found from older people's records we read, that assessing staff carried out more detailed investigations at the initial inquiry stage than we have seen in some other partnerships in Scotland.

An NHS Grampian risk assessment tool supported risk assessment, and although not specifically designed for adult protection, it covered most risks and was used by the majority of staff. However, managers recognised that risk thresholds were not clear within documentation and were working to improve this. From our staff survey results, 75% of

staff agreed or strongly agreed that there was clear guidance and processes in place to support all staff in assessing and managing risk. Sixty-two per cent agreed or strongly agreed that there were a range of risk assessment tools that they could use.

Aberdeen Adult Protection Unit staff produced a suite of data to inform the performance monitoring aspect to the Aberdeen City Adult Support and Protection Committee. These reports were informative in keeping the committee abreast of trends as well as developments in training and development. For example, in order to encourage older people's involvement and participation in the adult support and protection process, the unit offered full training to advocacy services operating in Aberdeen. Advocacy staff told us they felt confident in their role in supporting adults at risk of harm. The Adult Protection Unit coordinator set the operational priorities for the unit and offered advice to council officers when required. Staff we met valued this source of support. However, staff vacancies and temporary staffing within the Adult Protection Unit for a period of 18 months had led to gaps in the support being available.

We were concerned that previous monitoring and quality assurance of adult support and protection work had not continued following self-assessment activity and adult protection case file audits in 2012 and 2014. These audits highlighted a range of areas of good practice as well as areas for development. However, the findings from the audits were not always supported by specific, measurable, achievable, realistic and time-bound (SMART) action plans to take forward learning, and as result improvements were slow to progress.

Managers accepted that adherence to the previously established file review process, which was in place had become much less routine and robust. This was due to management changes within social work services.

The older people whose records we read showed mixed findings in relation to risk assessment and risk management¹⁵. Only 5% of records we reviewed contained a chronology of key events whilst a further 29% did not have a chronology where there should have been one. Managers had introduced training for staff to improve the use and content of chronologies.

We were concerned that in a few of the records of older people we read (4 out of 14), we found lengthy delays (up to six months or more) in the completion of initial adult support and protection inquiries. This in turn had led to delays in making important decisions as to whether to proceed to a full investigation. Other reasons for delays identified from our review of older people's records included:

- lack of capacity within the adult teams to carry out adult support and protection initial inquiries and investigations timeously
- delays in capacity assessments being completed by NHS staff
- slow decision making by partners such as Police Scotland, and
- lack of discussion and joint decision making in some cases creating significant delays for some individuals.

¹⁵ A chronology can give an early indication of emerging patterns of concern and risk. These can be used to inform any risk assessment.

Council officers also highlighted the impact of different priorities applied to Adult Support and Protection by partner agencies when carrying out investigations. These delays meant that a few older people were left at significant risk for unacceptable periods.

Managers accepted the very serious concerns we raised about adult support and protection following our reading of older people's records and said they were committed to re-establishing regular audits of adult protection records to quality assure practice. They had taken decisive action to review the care and support of adults at risk of harm in Aberdeen City and had commissioned an external review of all adult protection cases.

Recommendation for improvement 4

The partnership should work with the Aberdeen City adult protection committee to support improvement in adult support and protection by:

- **including timescales for all partners for the completion of all stages within the adult protection processes**
- **providing oversight of progress of action plans completed from audits, and**
- **providing oversight and quality assurance of any action plan resulting from the commissioned review of adult support and protection.**

The partnership fully acknowledged that it needed to review and revise the effectiveness of its governance and oversight systems for adult support and protection. It had recently put in place a process to review and improve its monitoring systems and delivery of adult support and protection.

Staff were undertaking risk assessments reasonably frequently and were keeping risk management plans up to date. They regularly reviewed these plans. Although only a proportion of adults at risk of harm may need a protection plan, we were reassured to find these were in place for just over half of the records of older people that we read.

In the majority of cases, where applicable, there was evidence that the views of partners from different agencies had informed the protection risk assessment (71%).

Forty-two per cent of protection risk assessments were rated as very good or good, 36% rated as adequate and 21% of cases were rated as weak or unsatisfactory.

We found for records that had non-protection type risk issues, such as a frail older person at risk of falling, 80% of cases had a non-protection risk assessment on file.

As a result of concerns we raised following the review of records, the partnership took immediate and positive action. This included re-establishing the adult support and protection operational management group to better quality assure practice.

Recommendation for improvement 5

The partnership should take action to ensure that frontline staff are supported to complete initial inquiries, risk assessments and risk managements plans timeously.

This action should include:

- **working alongside Police Scotland to set clear timescales for completing inquiries**
- **streamlining its risk assessment frameworks, and**
- **ensuring that risk assessments and risk management plans are completed and actioned.**

5.4 Involvement of individuals and carers in directing their own support

Many of the older people we met told us they felt involved in discussions about their support needs. However, some older people said that some of their choices were limited. Our review of older people's records found a very good level of engagement with older people. For example:

- in 95% of cases an individual's choices had been taken into account in the assessment
- 96% of individuals were involved in their assessment
- 90% were involved in their care plan and review, and
- in 71% of records there was evidence that the individual had control over the kind of support they received.

Older people and their carers said they greatly valued support provided and enjoyed services such as the singing group and techno gym facilities. They considered that the partnership sought their views to inform evaluation of these and other services.

Senior managers acknowledged that implementation of self-directed support had been slower for older people. Clear procedures and documentation were now in place. There was also a range of informative guidance and documentation to support staff and care providers in implementing self-directed support.

Recent positive action had been taken to appoint a new project manager for self-directed support. We found a thoughtful research-based approach to developing Option 2 of the four available self-directed support options.

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

Summary

In this section, we look at organisational and strategic management across the partnership. We consider how well strategies and plans reflect the partnership's vision. We look at operational and strategic planning arrangements, development of early intervention, quality assurance, self-evaluation and improvement. We also consider how the partnership involves individuals who use services, their carers and other stakeholders.

Policy development and plans to support improvement in service was **ADEQUATE**.

A number of key strategies were in the process of being finalised. These strategies had been developed to support the effective delivery of services to older people. Most were on target to be in place for the official start date for the partnership.

The partnership's joint strategic plan had been subject to wide consultation. This plan set the high-level direction for future planning and delivery of services. To support its strategy, the partnership needed to develop a 'market facilitation' strategy. This was yet to be started.

The partnership had an agreed locality structure and was in the process of developing the supporting management arrangements. Learning from a development site in the south side of the city was being used to progress locality planning across the city but was at a very early stage. Stakeholder engagement including involving older people and their carers was being incorporated into locality planning.

The partnership's development of preventative services was limited. Current service contracts were based on assessment of critical and substantial need and on a time and task allocation. This task-based approach did not support the development of prevention and earlier intervention.

Managers needed support to present and analyse data. Some performance management systems were in place although they still had to be streamlined to inform joint performance measurement activities.

6.1 Operational and strategic planning arrangements

The partnership had produced a number of strategic papers setting out its aspirations and intentions for the delivery of health and social care in Aberdeen City, how it aimed to achieve these and how it would measure success. Managers acknowledged there were challenges in respect of the operational delivery of services for older people, in particular the recruitment and retention of health and social care staff. Nonetheless there had been progress made in setting a high-level strategy for the integration of health and social care in Aberdeen. The strategic documents were not yet specific on how the partnership would achieve the aspirations outlined. The inspection took place during a time of significant change and the partnership was in the process of developing an implementation plan that identified joint performance measures including financial targets and the delivery of personal outcomes.

The single outcome agreement (2013–16) outlined the Community Planning Partnership's aspirations as:

- older people in Aberdeen have increased independence
- more older people in Aberdeen are benefitting from 'active ageing', and
- carers are effectively supported.

The Aberdeen City Council five-year business plan usefully set out their vision and key priorities. The chief executive of Aberdeen City Council was working constructively with community planning partners to connect the various strategic plans for the totality of the Aberdeen City population. The community planning partnership's single outcome agreement would aim for more integrated plans for NHS Grampian, Aberdeen City Council and the IJB as well as include other public bodies like the fire service and police. Audit Scotland expected Aberdeen City Council to develop a refreshed single outcome agreement, which the council aimed to have completed by the summer of 2016.

The joint commissioning strategy for older people 2013–23, 'Ageing with Opportunity' was the key shared document, which fully outlined the partnership's commissioning intentions and the collective vision for service delivery. This would be replaced by the IJB strategic plan from April 2016. The partnership had worked purposefully together to produce the Aberdeen City joint strategic needs assessment (2015). This detailed the demographic pressures and more importantly identified the priority areas for longer-term planning.

The partnership's draft Strategic Plan (2016–19) was an overarching statement of intent outlining its vision and values. This included a stated recognition of the need to work differently and support community self-management in response to demographic pressures and the Reshaping Care agenda. Their aspiration was to commission outcome focused services and involve service users and their carers in the commissioning processes. Positively, the investment intentions were linked to the nine national health and wellbeing outcomes, and included the increased use of telehealth and telecare and a review of bed-based services. The partnership was about to publish its revised strategic plan on 1 April 2016 following the conclusion of a widespread and effective formal public consultation process.

The housing contribution statement was updated in March 2016. This comprehensive strategic document linked well to the council's five-year business plan and the joint commissioning strategy. A statement of intent, it set out how housing services would be involved in maintaining older people at home for longer and reflected the intentions of the local housing strategy.

The partnership had made progress in developing the four identified localities within the city. They had appointed an integration and locality development manager with responsibility for developing communities. Their locality planning approach started as a development site in the south of the city. The intention was to develop this across the partnership. This work was being supported and shared with staff and the public using videos of activities – showing what was working well and what they were changing. The partnership was making steady progress with their strategic planning arrangements.

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

In line with Scottish Government policy, Aberdeen's Health and Social Care Partnership strategic objective was to optimise the independence of people at home. The partnership acknowledged that there were areas where they needed sustained improvement. One of these areas was the continued development of anticipatory and preventative approaches that were responsive to the changing demography within the city. It was evident they had made good progress in respect of earlier intervention, examples of which are described in detail in quality indicators one, two and four. Further work was needed by the partnership to develop more anticipatory and preventative resources. The chief officer for the IJB recognised that the partnership had not continued some of the change fund¹⁶ projects set up to test and reshape care to deliver on improved outcomes. The chief officer worked well with the management team to develop proposals for sustained change and improvement based on the business case model for the use of the integrated care fund. The partnership's management team anticipated that these would deliver the intended measures and outcomes.

Like other areas of Scotland, a significant volume of accommodation of more than one storey brought a number of challenges in respect of supporting people to remain independent within their own homes when they become less mobile. Aberdeen City Council had invested significant funds in improving housing. This included investment in telecare and upgrading to its sheltered housing stock. This helped to provide more flexible support packages using electronic assistive technology systems. Unlike the national trend, which had shown a small decrease, the number of people in receipt of a community alarm/telecare service in Aberdeen had increased by 48% in 2013–14.

In order to develop a more equitable approach, partners from the city's housing services, Registered Social Landlords, the NHS and BAC occupational therapy services were involved in the Adapting for Change demonstration project. The Joint Improvement Team¹⁷ supported this work, which had been set up to test new approaches in relation to the provision of the Aberdeen City adaptation services. This work was beginning to streamline pathways, deliver in faster time scales and promote the use of technology to meet the needs of older people and their carers more effectively. One example of a new initiative was a scheme whereby tenants living in sheltered housing could order meals using a touch screen, saving them time and effort in placing meal orders.

Aberdeen City Council recognised it had been slow to progress some of the actions arising from its housing review. This was as a direct result of having insufficient vacant tenancies and an inability to recruit the number of care staff needed to develop the models of accommodation, care and support. A programme of transition from sheltered to very sheltered housing began in 2013. Managers intended to present a further report to the council in May 2016 with proposals on how they would escalate this work to support more people with complex needs in the community.

¹⁶ A £230 million Older People's Change Fund was made available to Health and Social Care Partnerships from the 2011–12 financial year. A further £70 million was made available for the 2014–15 financial year. NHS Boards and their local authority partners submitted change plans, detailing how they proposed to spend this funding.

¹⁷ The Joint Improvement Team – strategic improvement partnership between the Scottish Government, NHSScotland, COSLA (Convention of Scottish Local Authorities) and the third, independent and housing sectors that provided a range of practical improvement support

6.3 Quality assurance, self-evaluation, and improvement

The partnership was working towards development of fit for purpose systems to measure and report on quality assurance, self-evaluation and improvement. Whilst there was evidence of managers regularly reviewing performance data, there were some challenges for the partnership including:

- current performance information systems that were not sufficiently joined up
- limited staff capacity within the NHS and the council to present and analyse data, and
- gaps in information from the NHS, for example there was no information on how long it took to provide a piece of equipment to an older person.

We found this position reflected in our staff survey where half of those who responded did not know whether there was a coherent strategy in place to gather and use data to improve outcomes.

Service managers recognised gathering and analysing performance information would continue to be an issue, particularly when the move to localities would increase the number and range of reports needing to be produced. The council was working with the Good Governance Institute to set out the chief social work officer's role in terms of quality assurance of standards of professional practice.

However, the partnership was beginning to make progress towards more efficient performance reporting and to bring together NHS and council data to improve joint understanding of performance. This included a joint performance work stream and discussions were ongoing in respect of how to improve information systems. Aberdeen City Council had a council wide corporate risk register. The IJB had completed some work looking at risk appetite, risk management and what a risk register would look like. Positive preparatory work with the Good Governance Institute had taken place to develop and put in place clear quality assurance frameworks to help inform the work of the partnership. The chief executives of NHS Grampian and Aberdeen City Council and the chief officer of the IJB were meeting monthly to review joint performance management against a high-level matrix.

Examples of activities measured by the partnership included:

- delayed discharge
- capacity of current resources to meet need and projected demand. This data was especially critical for those staff involved in commissioning activity
- staff vacancies
- national outcomes, and
- strategic planning.

The partnership had not yet streamlined all of its performance measurement activities.

The partners were mapping information against the national indicators. This aimed to support a gap analysis exercise and look at information for localities. Although it was possible for the partnership to capture data on how they had been involved in meeting outcomes, it was not yet possible to bring this information together, for example, using information about the number of people being supported in their wish to die at home to help inform the future shape of services and support.

Aberdeen City Council had four arms-length external organisations including the adult social care and training services provided by BAC and BAC Learning and Development. There was some evidence that these contractual arrangements were not sufficiently flexible or responsive to the needs of the partnership.

Systems were in place to monitor the performance of BAC and Learning and Development. An Audit Scotland report, *Audit of Best Value and Community Planning* (July 2015) stated that the council needed to progress its plans to put in place systematic monitoring of its arms-length external organisations. In response to this, the governance hub met more frequently than the previous twice yearly meetings. BAC provided performance information against a set of key performance indicators. The data provided covered a large number of performance areas including the number of referrals and the use of care home placements. The partnership was beginning to analyse this information to help inform their decisions about what kind of services they needed now and in the future.

Methods used to report on performance included quarterly reports submitted to elected members. Cluster, operation and management groups in the NHS were receiving regular performance data to help influence service delivery. Social work managers met regularly with colleagues in finance to look at quality issues such as invoicing. The partnership had devolved spend to care managers. Their team leaders monitored this and the monthly commitment reports produced on expenditure to identify any budget pressures that helped inform local planning for services.

Senior social work managers had only recently started to receive weekly reports on unmet need and to collate this information. They were yet to identify targets linked to this but it was a promising start. Managers recognised they needed to ensure the information recorded was accurate so they could interrogate the information to identify, for example, the level of unmet need linked to people delayed in hospital waiting for a community support service. In respect of contract compliance of purchased services, the system in use duplicated some of the regulatory inspections carried out by the Care Inspectorate. Service providers indicated they did not find this helpful.

6.4 Involving individuals who use services, carers and other stakeholders

There were some good examples of involving and consulting with stakeholders. The partnership had a constructive approach to engagement. Their communication and engagement plan comprehensively detailed a programme of engagement activities and progress in implementing them. It helpfully included feedback from consultation sessions, including concerns highlighted by staff and other stakeholders that they addressed in future sessions. There was less evidence of how the partnership was using feedback to inform future strategic priorities. The partnership acknowledged that there was room for improvement in respect of user and carer participation at a locality level.

It was evident that there were some mixed views from providers on the usefulness of the provider's forum meetings, in part due to their views on the variations between current contractual arrangements. The care at home provider's forum met every two months. Providers valued the meeting as being a good conduit for sharing information, although they found the heavy focus on the management of delayed discharge left less opportunity to discuss other sector wide issues. Voluntary Services Aberdeen indicated that they were trying to get a mental health forum started to improve engagement from people with mental health issues to inform the future shape of services.

There was a joint multidisciplinary older adult psychiatry group chaired by social work. This group discussed both strategy and funding. One of the positive outcomes from this forum had been the provision of flexible respite for older people.

Staff workshops on integration had taken place. These clearly set out the vision and future priorities for the partnership. A two-day workshop in September 2015 engaged staff in developing their understanding of asset-based community development. The partnership had been taking forward this work with Nurture Development to engage with citizens and communities. Some third sector provider organisations told us they attended workshops to contribute to and comment on the strategic plan.

Whilst staff were aware of the high-level national outcomes, there was less awareness of what the impact might be on local service delivery. Though some staff were uncertain about how locality working would develop, they felt they already worked in an integrated way to support older people and carers. It was evident that staff continued to be committed to working together to build better relationships and develop the localities.

Housing issued an informative newsletter called News Bite. The sheltered housing network enabled good engagement and regular consultation with tenants.

6.5 Commissioning arrangements

The Scottish Government expected Integration Authorities to produce a strategic plan for all its delegated functions by April 2016 and their impact monitored by scrutiny bodies from April 2017.

The partnership recognised there were challenges in respect of the available capacity in community support services. Demand for services was outstripping supply. Whilst there was a comprehensive analysis of current and future need, the partnership had not yet created a clear plan for developing a range of service provision. The current approach was to source social care services externally with no in-house provision for older people.

The partnership in Aberdeen City acknowledged that current commissioning processes and contractual arrangements were not developing the market appropriately to respond to levels of demand. For example, some care was purchased on a block purchase basis and some care providers were only paying staff for the time they were directly providing care. This approach limited purchasing options for those older people who may wish to self-direct their support. The difference in rates charged by providers and the rate paid by the council as well as less flexibility in how time could be spent was adversely affecting the level of service individuals could afford.

The number of long stay residents living in care homes in the city had consistently remained higher than the Scottish average. However, managers described the care home market as 'fragile', with some care homes having recently decided to cancel their registrations resulting in a reduction in the number of places available. Aberdeen City Council was awaiting the outcome of the national negotiations in respect of the national care home contract and the Local Government financial settlement. This meant that care home providers had no information about the fee rates for 2016–17. In addition, providers were concerned about a lack of clarity about the implementation of the Scottish Living Wage. This was a concern nationally.

It was evident there was limited availability of specialist care home resources for older people with a diagnosis of dementia. There were delays in discharge from hospital for some older people with specific care and support needs linked to their dementia. In addition, bed-based respite within care homes which provided nursing care was all spot purchased so this was difficult to plan, reduced choice and affected continuity of care. Managers were beginning to get a clearer understanding of the factors that influenced delays in discharge from hospital and using this to work with care providers to support change.

The partnership's preparations for locality commissioning needed to be progressed. Commissioning staff advised that they were looking at how they will commission on a locality basis. However, they acknowledged that this was not well progressed as the locality structure was in development. This had limited their ability to consult with people living within those localities. In common with other areas in Scotland, the partnership had extended current contractual arrangements with providers to allow time for the development of the commissioning plan.

There had been a lot of work carried out to progress and implement the infrastructure for the integration of health and social care. Nevertheless, although there was a joint commissioning strategy in place, the joint commissioning plan and market facilitation strategy to support it was not yet in place.

Quality indicator 7 – Management and support of staff

Summary

In this section we look at how well staff are supported, managed and trained to undertake their roles in a changing culture. We consider joint workforce planning and deployment. Focus areas include recruitment and retention and deployment, joint working and teamwork and training.

Management and support of staff was **ADEQUATE**. Overall, we found that staff were working effectively together to deliver good outcomes for older people and carers. However, there were significant recruitment issues for some staff groups which was affecting the capacity and capability of services to focus on prevention, earlier intervention and reablement.

Although staff universally reported positive working relationships across the organisation, deployment was still at an individual agency level. The partnership was at an early stage of developing joint workforce planning.

The majority of staff felt they had effective line management and had access to profession-specific supervision and appropriate training and development opportunities. The partnership was working to establish an organisational development plan to support health and social care integration.

7.1 Recruitment and retention

Policies, procedures and strategies for safer recruitment and the management and support of staff were robust and fit for purpose.

Joint health and social work service workforce planning was at an early stage but an organisational development plan was under development by the partnership. In order to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, the senior management team had a focus on designing new models for integrated leadership in four discrete localities across the partnership. Their intention was to develop integrated management teams in each locality. In their position statement, the partnership recognised integration as an improvement opportunity and not simply a structural change.

Nevertheless, the lack of a clear management structure, even at this early stage of development of the health and social care partnership, was a source of frustration for many staff at different levels. Some staff we spoke to perceived this as a lack of progress towards integration. The partnership was working to consolidate its plans and share them with staff to minimise the impact of this significant change on the workforce.

The partnership had purposefully begun to look at a more joint and strategic approach to recruitment. A joint human resource and workforce planning group had utilised an NHS methodology tool to develop a combined workforce profile. A first draft of the document was with senior managers for comment and approval. We considered this a positive approach to help define the future needs, skills mix and staffing resources of the workforce and fundamental to work already underway to construct an integrated workforce plan.

The heads of human resources from health and social work outlined a range of innovative recruitment initiatives that were underway to try to make health and social care more attractive as a career. Recruitment campaigns, career fairs and collaboration with colleges and universities had taken place. The partnership had positively considered an additional suite of incentives to attract people to the area. These included generous relocation packages, affordable housing options and 'grow your own' schemes including modern apprenticeships. Senior leaders and managers recognised that recruitment and retention was a significant constraining issue for the partnership.

The development of the wellbeing team had attracted a new group of staff to work in the community with older people. Their work with the Robert Gordon University had attracted a number of sports science students to work in placements with older people and consider a career in this area of service. This energetic team encouraged and inspired older people to participate in a range of activities that improved their health and wellbeing.

Almost all of the staff we met said they were clear about their roles, remits and responsibilities. The joint workforce planning and development group had provided the partnership with valuable input to support the development of recruitment protocols, role profiles and job descriptions for future integrated joint posts.

Frontline staff and managers attested to the ongoing challenges of recruitment and retention. This was particularly evident in professions such as social work, community nursing, allied health, general practice and care at home services (third and independent sectors). Senior managers told us that some of the reasons for this included:

- national shortages of GPs, community nurses and physiotherapists
- ageing workforce
- impact of the oil and gas industries
- higher cost of living, and
- lack of affordable housing.

There was significant turnover of staff at all levels in the partnership, exacerbated by the temporary nature of posts at service manager level and pending implementation of the new structural arrangements. Frontline staff faced daily pressures to source services and resources for older people. The partnership had approved three fixed term additional senior care manager posts to help alleviate pressure on workload within social work teams and help manage the significant changes planned for services. However, recruitment to these posts had been unsuccessful.

Both the third and independent sector care at home providers reported difficulties with increased turnover of staff and recruitment. Managers said this was more challenging in some localities that were not easily accessible for staff.

Frontline social work staff told us that some older people were on a waiting list to receive a care at home service and sometimes community nurses had to bridge the gap until services became available. Senior managers recognised they needed to do more to

improve availability of care at home support for older people. The partnership had engaged in meaningful conversations with providers to consider options such as 'zoning' areas to enhance recruitment and improve continuity of care for older people.

The partnership was developing improved new models of care in the acute hospital, and in primary care services. Liaison teams were set up to assess older people in Accident and Emergency and specialist nurses were supporting GPs to develop a 'hospital at home' initiative. We found that health staff needed more training to support discharge planning and anticipated that this would be planned jointly between health and social work partners. The modernisation of community nursing services nationally would influence a focus on prevention, anticipating care needs and supporting older people to manage their own conditions. Pharmacy champions provided peer support for community pharmacists across Aberdeen City and significant investment had taken place to upskill community pharmacists as independent prescribers.

Health and social work partners submitted absence data. Social work adult services had an absentee rate of 5.27%. These absence levels were improving but were still slightly above the council average. The Aberdeen City health services had an absentee rate of 7.67% (4.60% long-term), which was above the NHS Scotland average for sickness absence. Both health and social work services had comprehensive strategies in place to reduce absence levels and deliver on absence targets. Managers regularly monitored and reported on performance.

There was recognition within the delayed discharge performance reports that the barriers to improvement included recruitment and retention of staff and the need to develop step down services in the community. Actions identified included development of social work capacity and recruitment to a delayed discharge coordinator post. Some other measures the council was putting in place included plans to allocate empty houses and build new housing for key workers. These initiatives were at an early stage of development.

7.2 Deployment, joint working and team work

Resource allocation and deployment of staff were still largely at an individual organisation level. From our review of older people's health and social work services records, we saw positive aspects of joint working. The majority (82%) showed that services had worked together, for example, to provide care and support for older people at times of crisis.

Some staff said they had previously worked in co-located teams but this had ceased some time ago. As a result, they felt some of the good communication and working relationships that had developed were lost. There were only a few examples of teams based in the same building. Staff we met who were co-located said this had improved communication, enhanced information sharing and reduced duplication of work.

Overall, we found that frontline staff and NHS and social work services managers had good working relationships with colleagues across services. We met with GPs who told us about the good links they had with specialist consultants for old age medicine and psychiatry as well as social work care managers. Most were optimistic about the value of the cluster-based models under development and viewed this as a positive approach to enable older people to access care and treatment from a range of professionals at home where appropriate.

The multi-agency discharge hub, although in its infancy, was a promising initiative that evidenced effective joint working aimed at delivering person-centred care for older people in preparation for hospital discharge. The Alzheimer Scotland dementia link workers supported community mental health teams to deliver valuable post diagnostic support for older people recently diagnosed with dementia. Specialist consultants valued their input at ward meetings in the community psychiatric hospital. They said this had helped improve communication and delivered consistent care for older people with dementia.

7.3 Training development and support

In our staff survey a clear majority of staff agreed they had access to good opportunities for training and professional development.

Health and social work services each had their own suite of training and development resources. Staff training was, in the main, delivered separately by each organisation. In addition, Aberdeen City Council commissioned elements of training from an external organisation, BAC. Senior managers confirmed that this service was no longer delivering the level of specialist training they now wanted for the wider social work staff group. Senior managers within social work assured us they were taking steps to address this.

Staff accessed training and development in a variety of ways including online, classroom and distance learning. Some staff reported challenges attending training because of workload pressures and shift patterns. In our focus groups with frontline social work staff, we identified gaps in specialist dementia training for a few staff and some slippage in adult support and protection refresher training.

The Adult Protection Unit had designed and delivered a comprehensive range of adult support and protection training for health, social work and third sector staff. This included bespoke training courses for third sector groups. Health staff in the hospital accident and emergency department had specialist training in adult support and protection. Overall, it was positive that most of the staff we met said they had completed training in adult support and protection. Managers acknowledged that they needed to ensure that this training was supported by continued practice support and supervision to increase the impact on staff practice. The partnership had put in place a requirement that all staff undertook refresher training.

The partnership's approach to the development of more strategic joint training was at an early stage. Senior managers acknowledged this as a priority area for improvement. There were a few positive examples of joint training delivered such as in palliative and end of life care for older people with dementia and community capacity building.

The majority of social work staff told us they felt supported by managers and had access to formal opportunities for continuing professional development and regular profession-specific supervision. Throughout the partnership, there was an expectation that one-to-one supervision for staff should be in place. However, frontline health staff told us this was often difficult to achieve in some health areas due to workload demands and dispersed staffing arrangements. As a result, less formal arrangements had evolved to compensate which was less robust for supporting health staff.

Both organisations had systems in place to monitor and appraise staff performance, identify training and support development needs. Positively some staff we met had been supported to access academic courses to enhance their professional qualifications in health and social work. We spoke to some individuals who had successfully achieved mental health officer and advanced nurse practitioner accreditation. This reinforced the partnership's commitment to a 'grow your own' approach as part of the strategic transformation work.

Recommendation for improvement 6

As part of the continued development of the new integrated arrangements, partners should develop their strategic approach to joint training and development. This should aim to:

- **offer opportunities beyond mandatory training**
- **include the third sector to enhance a shared knowledge of roles and responsibilities, and**
- **achieve a cohesive approach to care delivery for older people.**

Quality indicator 8 – Management of resources

Summary

In this section, we look at how the partnership manages its finances and other resources. We focus on the general management of resources, information systems and partnership arrangements.

Overall, partnership working was **ADEQUATE**. Joint working between the finance teams within the council and NHS Grampian was effective. Development of joint financial management arrangements were on target for the start of the Health and Social Care Partnership.

Health and social work services had successfully achieved required savings targets in previous years and the partnership acknowledged the need for this to continue in the challenging financial climate. As the new integrated arrangements take shape, the partnership needs to work more closely with the third and independent sectors to deliver some of these savings through service redesign.

There was evidence of learning from initiatives supported by the change fund. Progress had been made in allocating funding from the integrated care fund to provide continuing support further change initiatives.

The partnership had begun to address the challenges of electronic information sharing between health and social work, building on earlier developments within GP practices. This work was at an early stage of development and would be a key area for the Integration Joint Board to progress.

8.1 Management of resources

Current joint financial management

At the time of the inspection, a joint indicative budget to accompany the strategic plan had still to be finalised with the proposed total amount to be delegated to the IJB being £251.7 million. Governance arrangements were in place that covered the IJB's devolved responsibility for these budgets. Of this amount, £46.7 million related to amounts set aside for hospital services. The IJB planned to finalise and approve the budget by the end of March 2016.¹⁸

The partnership had worked well together to align its budget setting processes and to prepare indicative financial reports for the shadow IJB that informed members about the financial position of the services to be delegated.

The partnership had established an appropriate leadership group including the directors of finance from both partners. Part of the group's remit involved examining financial considerations for the IJB and it was developing joint standing financial instructions to govern its financial transactions. They were on target to conclude this work in time for the IJB becoming fully operational in April 2016.

¹⁸ This had been put in place after the completion of the inspection.

The health board's director of finance was appointed as the chief finance officer on an interim basis. We concluded that although there was good joint working, it was important that the IJB put in place necessary controls in the interim period while recruiting a permanent chief finance officer. The Scottish Government's Integrated Resource Advisory Group recommended that the chief officer should consult with partners on making the best use of existing capital resources and developing capital programmes. This process was at a very early stage and an area that requires development in the future.

Financial performance of Aberdeen City Council

Overall, the council recorded a small surplus of £3.1 million in 2014–15 against its service budget. Within the adult social care budget there was a year-end underspend of £0.5m, which represented 0.4% of the £124.3 million budget. This underspend was mainly achieved through savings that resulted from ongoing recruitment difficulties to some posts. As described earlier, the partnership had a number of initiatives to encourage staff to move to work in Aberdeen.

As at October 2015, there was a total underspend of £0.5 million (0.4%) within the adults social care budget. This was largely relating to the underdelivery of home care, unfilled staff vacancies and the higher than anticipated recovery of income from the integrated care fund, client contributions and housing benefit. The council projected a break-even position within this budget for year-end 2015–16. We acknowledged the challenges faced by the council in recruiting and retaining staff within social work services, which is discussed further in quality indicator seven.

The council projected a savings requirement of £52.6 million between 2014-15 and 2019–20 in order to maintain a balanced budget. Since the announcement of the 2016–17 settlement, the council was expected to receive a net reduction in funding of £7.9 million. The council's plan to mitigate these pressures had identified £5.9 million of potential savings requiring a council decision to consider in 2016–17, £0.7 million of which were to be delivered from the IJB budget. The delivery of these savings would require joint working with partners in the independent sector to achieve efficiency savings through service redesign. The overall impact these savings were expected to have on the revised five-year projection was unclear. However, the partnership expected the financial position to become more challenging going forward.

In 2013, the council transferred its remaining in-house older peoples social care services to an arms-length organisation, BAC Ltd. As part of the business plan creating BAC, the council had anticipated that savings of around £3.0 million would be generated over the five-year period to 2018. Although BAC had yet to deliver the anticipated savings, in 2015–16 contracting costs had been reduced delivering £0.7 million of recurring savings. In addition to this BAC had achieved a positive saving through reduced use of agency staff, which they had halved through the creation of an internal pool of staff. The council had recently introduced an improved approach to monitoring the financial governance and performance of BAC at the council's arms-length external organisations governance quarterly hub meetings.

NHS Grampian was required to meet various financial targets set by the Scottish Government, including remaining within its revenue budget and achieving a break-even position. For 2014–15, it achieved these targets and a net surplus of £0.1

million was recorded. This was achieved through a combination of significant overspend and underspends. There were overspends from within the acute pay bill, agency locum and agency nurse costs and GP prescribing. These were offset by a large underspend in centrally held earmarked reserves in part related to one-off allocations of funding from Scottish Government and also challenges in staff recruitment. The total 2014–15 surplus was then brought forward with the expectation of being utilised in full against financial pressures in 2015–16.

As at October 2015, NHS Grampian reported an overall year to date overspend of £4.5 million. This was £0.5 million more than had been agreed with Scottish Government, per the Local Delivery Plan. The most significant budget pressures related to the prescribing budget, both within primary and acute care and the use of agency staff to cover vacancies across all staff groups. The board was taking action to address these areas.

Within the Aberdeen City shadow IJB area, as at July 2015, the most recent breakdown available, health related services were forecast to overspend by £0.8 million by the year-end. It cited the high costs of GP prescribing and usage of medical locum coverage as the reasons for these projected overspends. NHS Grampian had set up a prescribing group to explore ways to reduce prescribing costs that included encouraging GPs to prescribe more cost effective generic drugs where possible. The impact of these actions had still to be reviewed as part of budget monitoring.

In 2014–15, overall, NHS Grampian achieved efficiency savings of £23.2 million with £5.8 million (25%) coming from non-recurring sources. NHS Grampian had agreed a savings target of £24.9 million by the end of 2015–16. However, as with the previous year, an element of this was to be achieved through non-recurring sources. The partnership acknowledged that the identification and achievement of recurring savings was essential to ensure long-term sustainability of services and were working hard towards achieving this.

Change fund and integrated care fund

The council and NHS Grampian had worked constructively with partners in the third and independent sector to help develop new models of care as part of their approach to joint commissioning of support for older people. Their review of Change Fund projects would inform how they developed further using the integrated care fund.

Since 2011–12, the Scottish Government had provided funding to the former Aberdeen City Community Health Partnership (CHP) and Aberdeen City Council through the Change Fund. This funding was to enable the redesign of services towards prevention, early intervention, anticipatory care and rehabilitation. By March 2015, they had received £11.8 million in funding from the Change Fund. The partnership evaluated initiatives funded through the Change Fund to inform their approach to redesigning services. 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 Scottish Government approved the Aberdeen City Partnership integrated care fund submission and agreed an allocation of £3.8 million annually on a recurring basis. The partnership set up an Integration and Transformation Programme Board with part of their remit being to plan and allocate this funding. The partnership planned to use these resources for an innovation pot, capital expenditure, community models to support frailty,

enablement and anticipatory care approaches and developments within local clinical and care leadership. At the time of the inspection, the partnership had allocated £1.0 million of this funding across a number of projects.

Recommendation for improvement 7

As part of the continued development of the new integrated arrangements, partners should put a formal plan in place that sets out the future allocation of the integrated care fund and set out clear criteria for how these projects would be evaluated.

In addition to these strategic funds, the partnership will be allocated recurring funding of £9.5 million from the social care fund starting in 2016–17. The partnership planned to split this funding equally between supporting existing and additional financial pressures.

8.2 Information systems

The partnership recognised that it needed to develop its IT systems. It had detailed protocols to support staff in sharing of information with colleagues in other agencies. They had developed Carefirst to support multi-agency views for primary care staff. Some of the systems were still paper based. Both managers and staff recognised that this inability of systems to share information easily was a barrier to good communication. This was common across Scotland. Staff and managers worked to ensure that this did not affect the care delivered to older people and achieving positive outcomes. For example, the acute and primary care information-sharing portal in health services worked well, supporting staff to access and share information electronically. They recognised the additional barriers currently in place and the need to improve the development of these systems.

The partnership also appointed external consultants with a brief to review the current systems and generate options for the partnership to consider. The consultants had a clear plan to achieve this within set timescales. Positively, this would allow the Aberdeen partners to agree a future approach with short and longer-term goals for improvement. Partners were realistic that an incremental approach would be required to drive improvement while recognising financial and organisational challenges may restrict their ambition.

The chief officer acknowledged that protocols in place to ensure the secure sharing of information needed reviewed. Staff told us some of the processes to ensure personal information was secure had added additional steps to the transfer of information by email. Many staff in the council did not have secure email with which to receive information easily, about people they were working with directly. Likewise, some colleagues in health had differing access to key information. The partnership was working to improve electronic information sharing and access further.

Single Shared Assessments (SSA) were held on the social work system and included information from colleagues in health. Health and other specialist staff could contribute to the SSA. These were often paper rather than electronic systems. Health electronic systems were not part of a single cohesive system and some work was being undertaken by partners to try to rationalise some of these and to make access more consistent for a range of staff. Staff that were co-located, whilst not able to access each other's systems, found sharing office premises had improved communication.

Healthcare and social work systems had the ability to generate performance information and generate reports for the Scottish Government. Managers within the partnership were able to see performance data and senior managers were able to access high-level reports regularly. Managers told us that there had been an improvement in sharing information and that this was now more effectively informing planning. We saw limited evidence of this.

The partnership had not yet developed a complete suite of joint performance information but had been able to report on key areas. The partnership was well placed to make further progress. Partners reviewed some information including information on people whose discharge from hospital was delayed, and this informed actions to address particular issues or current concerns. This was beginning to help the partnership target resources to reduce delays.

8.3 Partnership working

The partnership had adopted the Body Corporate model for the integration of health and social care. The partnership had consulted widely on the draft of the strategic plan 2016–19. This plan incorporated the Aberdeen City and NHS Grampian corporate plans and jointly reflected the priorities of the respective organisations. There was a clear emphasis on developing locality based services included in the plan. The partnership was in the process of setting up planning groups in the four localities in order to develop support based on community priorities. The final plan would reflect the key priorities of the Aberdeen City single outcome agreement, which was due to be finalised at the time of the inspection.

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

- primary care health services
- some secondary care services provided in the community including mental health services and palliative care, and
- social work services for adults.

The partnership will also host the geriatric and rehabilitation hospital-based services although these would continue to be managed by NHS Grampian.

The shadow IJB had been operational since January 2015. In April 2016, the partnership was formally established. There was service user and carer representation on the IJB. The strategic planning group membership included third and independent sector representation as well as officers from Aberdeen City Council and NHS Grampian.

The partnership's chief operating officer placed a strong emphasis on the governance and quality assurance responsibilities of the IJB. Its work with the Good Governance Institute had brought independence to the process of developing the board and their roles. The draft 'maturity matrix' set out clear indicators for progress by the IJB, in terms of their support to the development and improvement of quality and care governance within service areas. The three Grampian health and social care partnerships were working well

together to ensure their integration schemes, strategic plans and financial arrangements were broadly consistent.

Although there was a strong history of partnership working, a joined up approach to managing resources was still developing.

Cluster management groups were effective in bringing health and social work together to improve links between primary care and hospital based services as well as individual needs. This was helping find joined up solutions to the care of older people in their communities.

Example of good practice – The Health and Care Village

The Health and Care Village in the city was a good example of joint working in the partnership. The project was described as a pivotal point for older people to access preventative advice and interventions. There were health and carer advice points, a techno gym with support for users and access to allied health professional services within the one venue. Older people and their carers spoke positively about how the Health Village had helped them access information and services.

Quality indicator 9 – Leadership and direction

Summary

In this section, we consider the quality of leadership in the partnership. We look at how corporate leadership drives the vision and culture, and communicates this to its workforce and wider stakeholders. We consider how effectively the leadership of cultural change and improvements are driven by practice and secure better outcomes for individuals.

Leadership and direction was **ADEQUATE**. The partnership had a clearly articulated vision for older people's services within its strategic plan although it still had to set out the actions that would ensure this plan was implemented. The partnership was engaging well with key stakeholders including local communities, staff and partner services. There had been effective engagement with staff to involve them in the planning and development of services. Senior managers acknowledged that this needed to be a continuous process to keep staff informed and engaged in the change and improvement processes. The partnership required to improve its collection and analysis of performance information to inform change and improvement.

The development of a locality-based model was underway but needed greater impetus through the appointment of the next tier of the management team to support implementation of the new ways of working in Aberdeen City. This included the need to improve engagement of clinical managers. Although there was effective clinical leadership, clinicians required more support to take a leadership role to be successful in delivering the partnership's ambitious change agenda.

9.1 Vision, values and culture

The chief officers in NHS Grampian and Aberdeen City Council as well as the chief officer for the partnership were all relatively new in post but were working together to shape services based on the views of the totality of the Aberdeen population. The community planning partnership was refreshing its vision for Aberdeen. It planned to produce a new single outcome agreement by the summer 2016 that set out the strategic vision and informed the work of all key partners.

The health and social care partnership had set out its vision for the future health and wellbeing of their communities. They outlined their vision as being 'A caring partnership working together with our city communities to enable people to achieve fulfilling, healthier lives'.

The partnership had a clearly articulated view of how they would lead change and development in Aberdeen City. Positive attempts had been made by the chief officer and the management team to build on the areas of strength in joint working, starting from a strong base of partnership within the GP cluster arrangements. Some clinicians we met were very clear about their clinical leadership within their particular services. However, they were less clear about how they would contribute to a more joined up system in the future.

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, staff and the wider public in Aberdeen. It did this through both large-scale community events and more bespoke consultations. The partnership's vision and stated values included a strong commitment to the promotion of responsibility and choice for individuals, which were beginning to be embedded in policies and procedures and staff working practices across the partnership. This vision reflected the collective ownership of all key partners.

Stakeholders had the opportunity to give their ideas about how the partnership could deliver health and social care services in Aberdeen. The city was facing the prospect of an increased number of older people with complex health and social care needs at a time of financial challenge and uncertainty and the partnership was positively engaging with key stakeholders to help inform these hard decisions.

Many of the partnership's staff we met were optimistic and enthusiastic about health and social care integration. Managers had clearly articulated the vision to staff and the wider stakeholder community. A number of staff briefings and engagement events had taken place involving several hundred staff. Senior managers were clearly promoting the importance of professional leadership across the partnership with clinical leads and the chief social work officer included as members of the IJB.

Staff also had reservations about how the changes would happen and how these would affect them and their work. Many hoped that integration would solve previously intractable problems like information sharing between health and social work services staff that sometimes led to duplication of effort. The partnership knew it needed to continue to encourage ownership of its vision and help partners to see how integration would benefit the population of the city. Our staff survey showed that 47% of respondents agreed or strongly agreed that there was a clear vision for older people's services with a shared understanding of the priorities. Just over a quarter disagreed or strongly disagreed and 9% indicated that they did not know.

9.2 Leadership of strategy

The shadow IJB operated effectively for a year and this had helped smooth the transition to the IJB. There were good relationships between board members, and they were all unquestionably committed to effecting health and social care integration. Elected members and NHS board members had worked with the chief officers and been supported by the Good Governance Institute to establish good working relationships. Members of the IJB acknowledged that they needed to develop their leadership and governance skills further.

Senior managers within the partnership along with IJB members recognised they needed to drive forward the integration of health and social care. While recognising the significant changes that were needed, they had set a manageable pace and worked with staff and communities to test changed working practices before implementing those that worked best.

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 half the staff (54%) agreed with this. Bulletins and newsletters aimed to keep staff informed and engaged with developments.

GPs, consultants and other doctors exercised effective clinical leadership for the work of the health and social care partnership. The clinical director for the partnership was a member of the IJB and a GP represented the views of GPs. Some clinical leads we met were not engaged with developments within the health and social care partnership. More work was needed to support clinicians to take a leadership role for the delivery of the partnership's ambitious change agenda. One area for improvement continued to be reducing the number of older people whose discharge from hospital was delayed. A rapid improvement event and scoping exercise had enabled the establishment of the delayed discharge group that was beginning to show an improved response to reducing delays. This work was beginning to inform engagement with partners to update commissioning approaches.

9.3 Leadership of people

Senior managers were accessible, made clear attempts to engage with frontline staff and understood how staff felt about changed ways of working. In the main, we found that staff felt valued and supported by frontline managers. However, the gaps in available care provision and the constant struggle to secure services for older people and their carers could be demoralising for staff.

There were a number of temporary and acting up arrangements in place at middle manager and head of service level in adult social care. This had had an impact on staff and created gaps in continuity of service and support. There had been an adverse impact on the services in the run up to health and social care integration. Senior managers recognised that they needed to do more to support a collective responsibility for improving the quality of adult support and protection across all agencies involved in public protection. Senior managers were seeking to be more proactive to support staff and managers as they considered and implemented changes.

We recognised that the partnership was working hard to deliver some very significant reforms, however we considered that the partnership needed a greater impetus to create a more settled structure. This was critical for the partnership's drive to construct an integrated health and social care service that would deliver positive outcomes for older people and their carers in Aberdeen City.

Recommendation for improvement 8

As part of the continued development of the new integrated arrangements, partners should set a clear timetable to agree and implement the structure for locality management teams.

From our staff survey and the staff we met, 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.

9.4 Leadership of change

Senior managers within the partnership demonstrated their ability to lead change initiatives. They recognised the need to support front line managers to improve their understanding and interrogation of quality assurance information and were developing a mentoring approach. Some early examples of this data informed approach were the partnership's efforts to understand the causes and bottlenecks that created delays. This included setting up a delayed discharge group and looking at managing staff vacancies within their own and commissioned services.

Senior managers agreed that more work was needed to develop services such as hospital at home and a more streamlined intermediate care service. This would help ensure that vacant care home beds were used effectively and care staff appropriately trained to provide rehabilitation and support.

A considerable amount of data about services was being gathered. Senior managers regularly reported on high-level performance using performance dashboards. We did not find that this was always analysed by service managers to inform service quality and areas for improvement. Some managers were not clear about how to use the information to inform change and improvement. Managers did not yet get information that supported them to deliver on expectations about quality and improvement. Nor did they have time to analyse the information to inform and plan the future shape and delivery of services.

We were satisfied that senior managers were setting an achievable pace of change that aimed to bring staff and communities along with them. The organisation THRIVE¹⁹ was appointed to facilitate the redesign of services that helped create a culture to transform health and social care in Aberdeen City.

The work with THRIVE was beginning to prioritise locality planning. This work now needed to be supported by the implementation of the locality management structure that ensures sufficient capacity for putting changes in place. The partnership had made effective use of a wide range of improvement methodologies and tools. They had trained staff in lean methodology, used this effectively at rapid improvement workshops to deliver change and improved practice. This work had been supported effectively by external agencies to deliver incremental improvements.

¹⁹ THRIVE is the trading name for Taylor Haig, who work with business, charities, government, and local communities to tackle challenges and empower people to change the way they work.

Quality indicator 10 – Capacity for improvement

Summary

The Aberdeen City Health and Social Care Partnership delivered good outcomes for many older people. The partnership's efforts to build community capacity and enhance individual wellbeing had helped many older people lead healthier and included lives.

The partnership was building on the work it had started to reduce the number of people whose discharge from hospital was delayed. Completing carers' assessments and providing support to those carers who need it should be given greater priority.

The leadership within the partnership clearly supported staff to be engaged in informing continuous improvement in the Aberdeen area. The partnership needed to consolidate its management team to implement the new structure and ways of working to deliver its aspirations.

We considered that the partnership had set a clear agenda to drive the health and social care partnership and deliver the required improvements as it goes forward.

10.1 Judgement based on an evaluation of performance against quality indicators

Improvements to outcomes

We concluded that the partnership had the potential to develop further and have a positive impact on the lives of older people and their carers. It was beginning to consolidate responses to reducing the number of people whose discharge from hospital was delayed through joint working with providers in the third and independent sector as well as between health and social work.

A number of locality based and partnership wide planning groups showed a commitment to driving service change and improvement across the partnership. These groups reported on progress of the various developments and changes to processes as they were implemented.

Older people who used services and their carers were represented on the IJB and locality planning groups. A wide range of community based activities encouraged older people to maintain active links in their community. The health and social care partnership's joint strategic plan was clearly linked to the national wellbeing outcomes.

Effective leadership and management

Senior managers had an effective approach to engagement and communication that helped staff contribute to the developing partnership. A number of senior staff were working in temporary posts until the locality structure was developed and agreed. These managers were working hard in complex roles that maintained services but also worked towards new ways of working. In the main, they were rising to these challenges.

However, the continued impact of lack of staff capacity within frontline services meant that developing the workforce to deliver these new ways of working whilst maintaining

standards of practice will continue to be a considerable challenge for managers into the future.

Joint financial governance arrangements were in place and an indicative budget agreed for the first year of the health and social care partnership.

Effective approaches to quality improvement

The partnership had taken a measured approach to developing the IJB, taking time to ensure that it was clear about its role and function. The partnership was developing its understanding of the performance reporting requirements that would support the IJB to monitor how well it is delivering improved outcomes for its communities.

Work with the Good Governance Institute and the associated self-assessment work, including the maturity matrix, was helping the partnership understand and plan for future developments.

Service managers had a range of performance information made available to them. Newer and temporary managers were being supported to understand how to use the information to support continuous improvement.

The partnership needed to ensure it developed a joint performance framework and reporting mechanism that enabled it to measure and analyse performance effectively to inform future development. Its internal quality assurance was not sufficiently robust. Whilst recognising the partnership responded quickly and effectively to review practice following concerns raised about adult support and protection, our findings illustrated a lack of oversight and support to staff and adults at risk by senior managers.

Health and social care integration

We considered that the partnership was taking forward health and social care integration that built on their good foundation of joint working. The principles of service user and carer focus were clearly set out in its plans along with the focus of shaping support around communities to improve outcomes. However, we found that more work was needed by the IJB to ensure effective engagement with carers.

The health and care partnership had made good progress with establishing an effective governance framework that was clearly understood by the IJB. These were clearly set against an integrated structure focused on locality.

What happens next?

We will ask the Aberdeen City 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/>.

Based on the findings of this inspection, we would want to revisit the partnership within 12 months of the publication of this report. This will be so that the Care Inspectorate and Healthcare Improvement Scotland can be assured that the significant issues in relation to adult support and protection have been fully addressed.

September 2016

Appendix 1 – Statistical charts

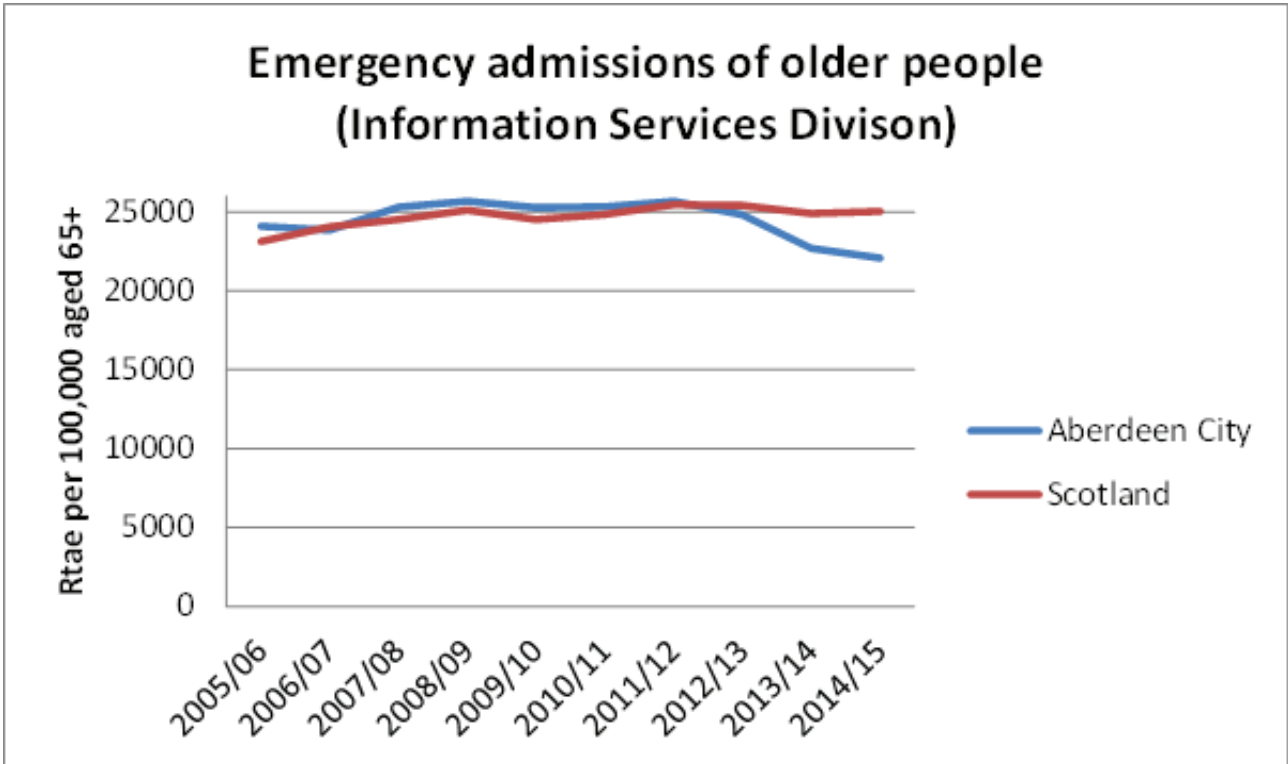


Chart 1

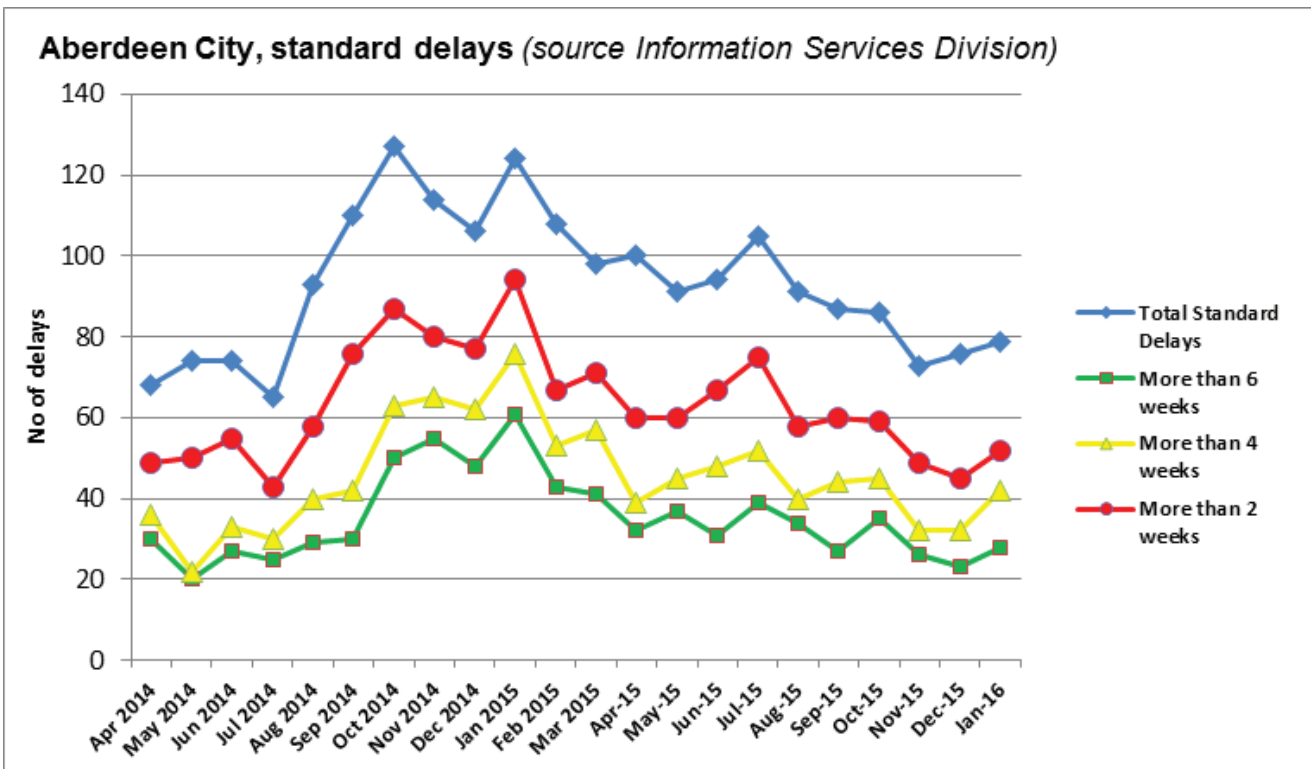


Chart 2

Aberdeen City, reasons for delays over two weeks duration (source Information Services Division)

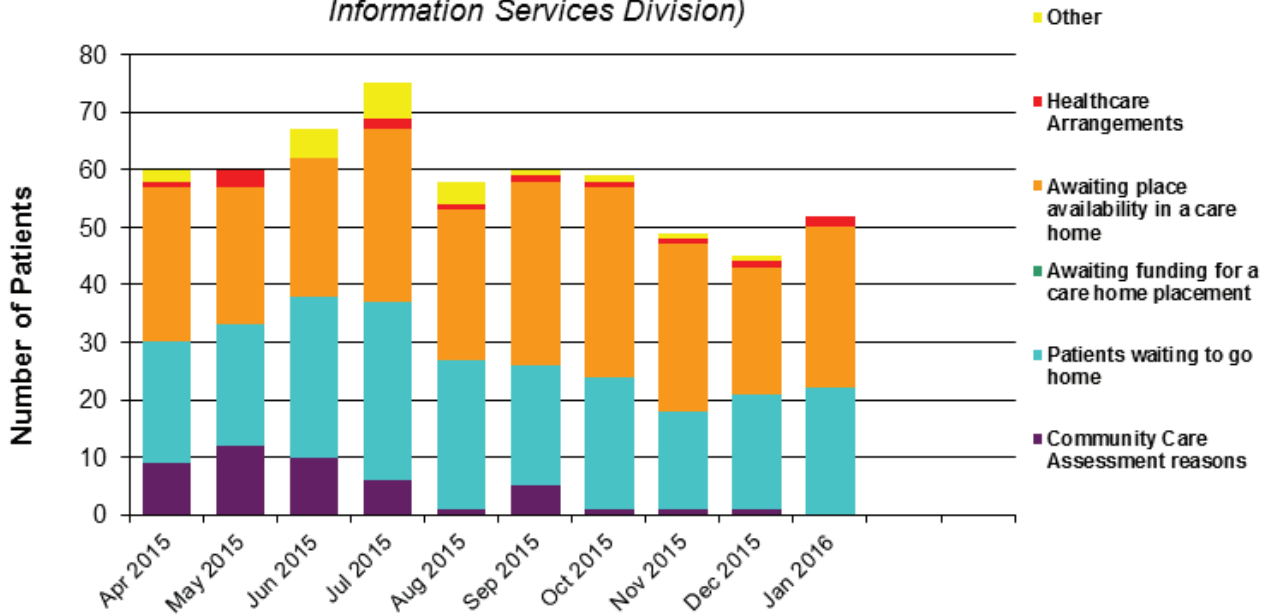


Chart 3

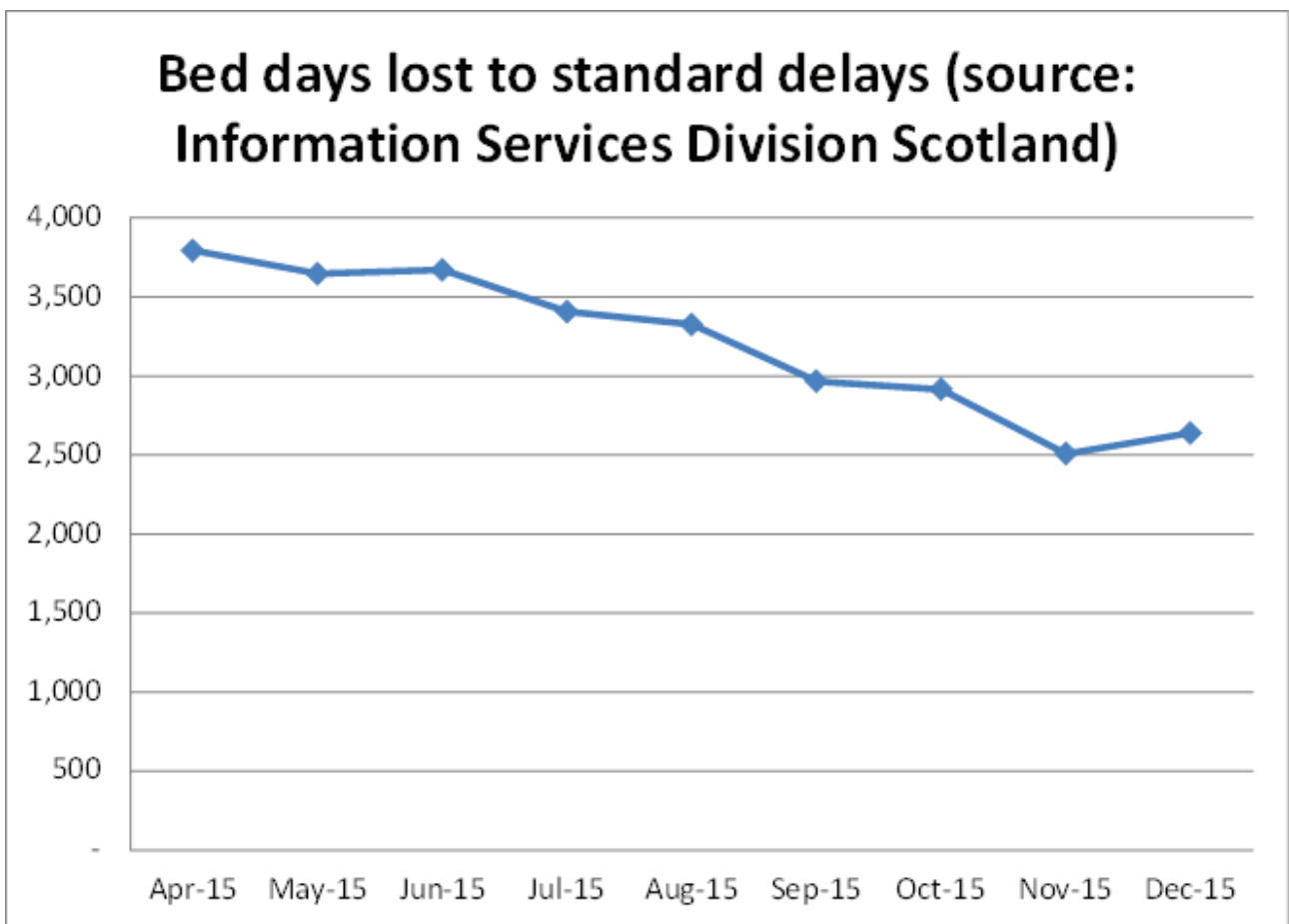


Chart 4

Emergency admissions due to older people falling (source Informaiton Services Division)

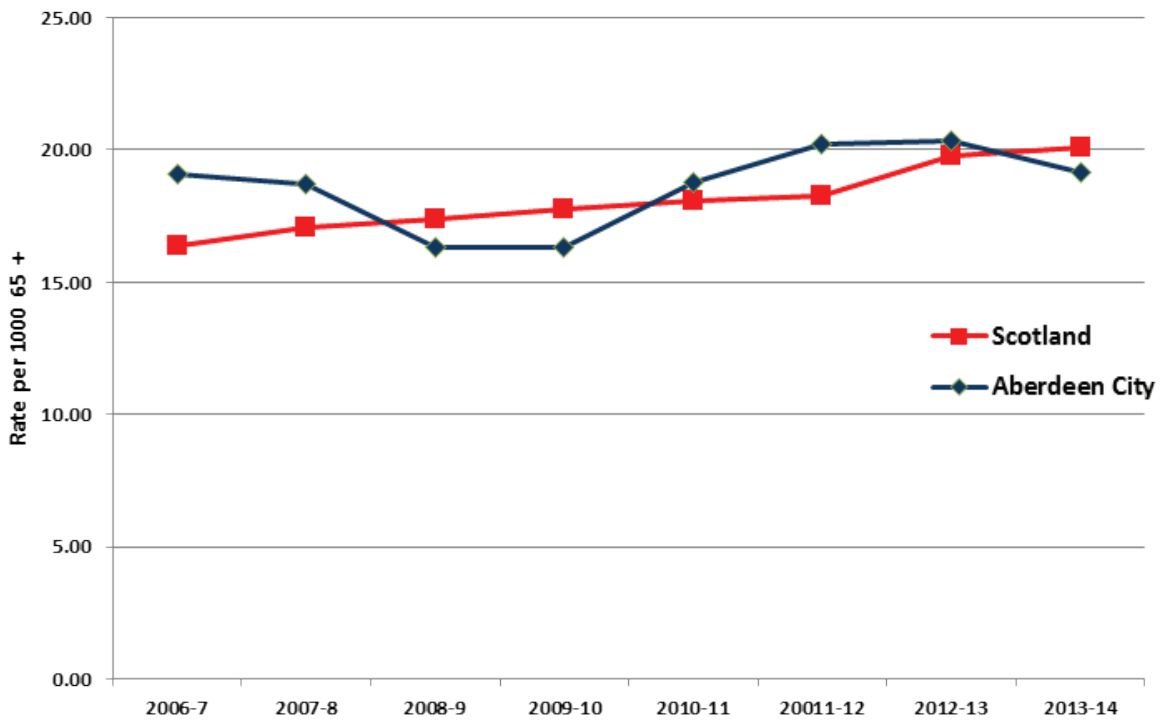


Chart 5

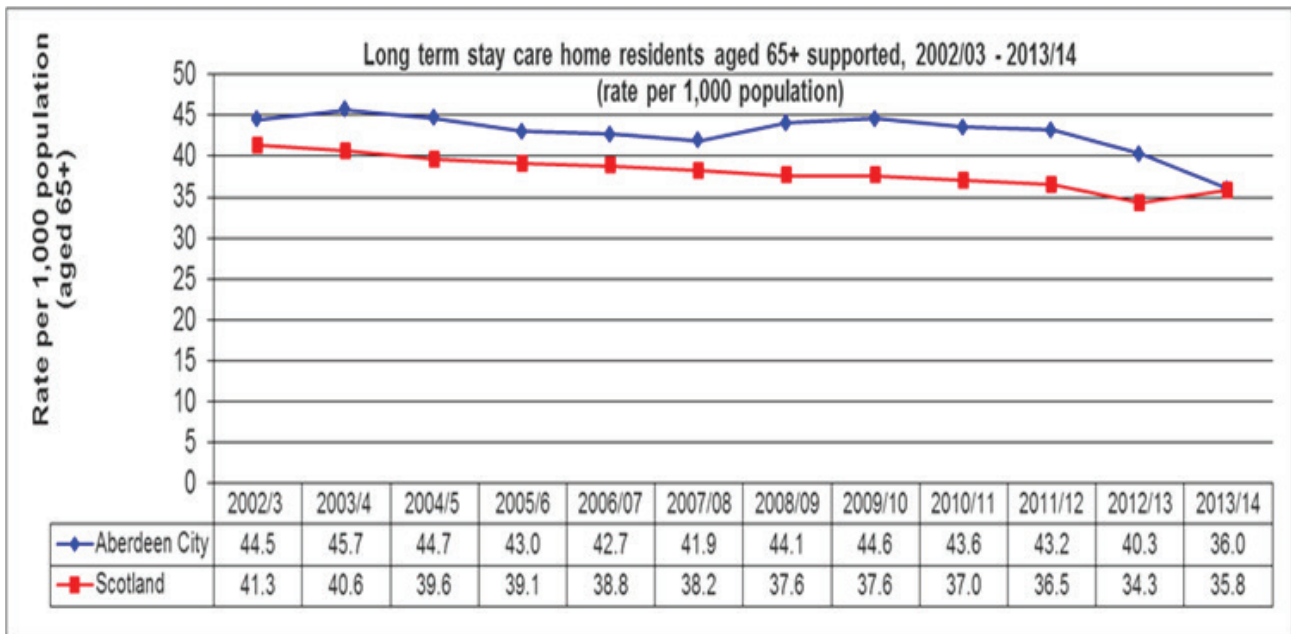


Chart 6

Number of clients per 10,000 population with direct payments packages in Aberdeen and Scotland, financial year 2014-15 (source Scottish Government)

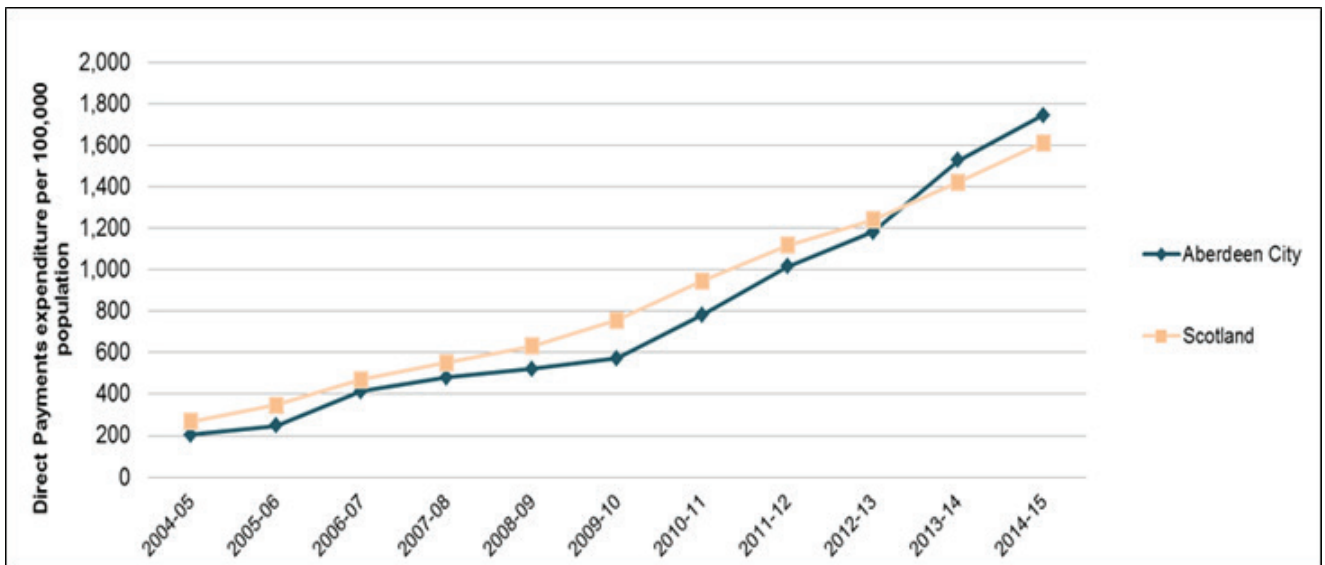


Chart 7

Appendix 2 – 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	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	5.4 Involvement of individuals and carers in directing their own support	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	



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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.