care inspectorate

Healthcare Improvement Scotland

Services for older people in Dumfries and Galloway

October 2016

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

HAPPY TO TRANSLATE

Services for older people in Dumfries and Galloway
October 2016
Report of a joint inspection

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

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

We can also provide this report:

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

Contents

About this inspection

From January to March 2016, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services[1] for older people in Dumfries and Galloway. The purpose of the joint inspection was to assess whether the health and social work services improved outcomes for older people and their carers. 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
- support older people to be independent, safe, and as healthy as possible and have a good sense of wellbeing.

Our joint inspection involved meeting over 63 older people, carers who cared for older people, and 411 staff from health and social work services, the third sector[2] and the independent sector. We are very grateful to all of the people who spoke with us during this inspection.

We read 196 older people's health records and social work services records. Older people in our sample had between two and 10 health records, all of which we scrutinised.

We also studied a number of documents submitted by the partnership about its services for older people and their carers, as well as its strategic direction for service improvement.

[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 Third Sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers (Scottish Government definition).

Dumfries and Galloway context

Dumfries and Galloway is the third largest health and local authority partnership area in Scotland. It covers 6,427 square kilometres and is situated in the south-west of Scotland. Dumfries and Galloway has a population of 149,940. The region is characterised by small settlements of 4,000 people or less, spread across a large area. There is a population density of 23 people per square kilometre compared with the average for Scotland of 68 per square kilometre and one-third of people live in settlements with fewer than 500 people.

The council area is bordered by five local authorities: East Ayrshire; South Ayrshire; South Lanarkshire; Scottish Borders; and Cumbria in England. The council area has extensive coastline along the Solway Firth and the Irish Sea.

Dumfries and Galloway is divided into four localities: Nithsdale, Annandale and Eskdale, Stewartry and Wigtownshire.

The total population of Dumfries and Galloway is expected to decline to 141,617 by 2037. This is a decrease of 6.1%, while the population of Scotland is expected to increase by approximately 0.5 million, an increase of 8.8%. The percentage of people aged 65 years or over is forecast to increase by 40% by 2037, while the number of children and working-age adults is projected to fall.

People aged 65 years or over made up 27% of the population compared with 21% average for Scotland, at the time of our inspection. According to the latest data from the Scottish Index of Multiple Deprivation, 9,532 people in Dumfries and Galloway (6% of its population) were living in one of the 15% most deprived areas in Scotland. In 2009, this figure was 4.5% of the population. The number living within one of the 5% most deprived areas in Scotland was 1,241 - 0.8% of the population of Dumfries and Galloway.

The ageing population profile in Dumfries and Galloway brings with it significant challenges. Health and social care employment remains static while significant increases in the population of people aged 75 or over bring greater demands for services throughout the area. Recruiting staff to deliver care services in some of these areas represent a challenge for the partnership.

However, this fall in the number of working age adults provides opportunities to drive new ways of delivering services within the care sector as current models of delivery, in terms of labour intensity, cannot be sustained.

We inspected the partnership at a critical time in the implementation of health and social care integration. In common with other health and social care services, the partnership was engaged in a high level of activity to finalise structures, strategies and planning. These had not concluded, nor would we have expected them to be at the stage of our inspection.

As at March 2016, the proposed total amount to be delegated to the Integration Joint Board[3] (IJB) for 2016–2017 was £298.5 million. This was made up of a £236.1 million contribution from NHS Dumfries and Galloway and the remaining £62.4 million from Dumfries and Galloway council. The identification of this budget would underpin joint commissioning planning. The partnership decided that around one-third of the IJB's budget would be delegated to managers at the four localities.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (Appendix 2). Our findings on the partnership's performance against the nine quality indicators are contained in nine separate sections of this report. The sub-headings in these sections cover the main areas we scrutinise. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for older people and their carers. The inspections also look at the role of the independent sector and the third sector to deliver positive outcomes for older people and their carers.

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

[3] Once the resources for delegated functions are allocated to the Integration Joint Board, it makes decisions on the use of the integrated finance.
[4] Experienced professionals from local authorities seconded to joint inspection teams.
[5] Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to ensure that it engages with patients, carers and members of the public.

Our inspection process

Phase 1 – Planning and information gathering

The inspection team collates and analyses information requested from the partnership and any other information sourced by the inspection team before the inspection period starts.

Phase 2 – Scoping and scrutiny

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

Phase 3 – Reporting

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

To find out more go to www.careinspectorate.com/
or
www.healthcareimprovementscotland.org/

Evaluations and recommendations

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

Quality indicator		Evaluation	Evaluation criteria
1	Key performance outcomes	**Adequate**	**Excellent** – outstanding, sector leading **Very good** – major strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important Weaknesses **Unsatisfactory** – major weaknesses
2	Getting help at the right time	**Adequate**	
3	Impact on staff	**Good**	
4	Impact on the community	**Good**	
5	Delivery of key processes	**Adequate**	
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	The Dumfries and Galloway Partnership should develop and implement a joint coherent approach to improvement that: • supports early intervention and prevention • helps prevent hospital admission • supports hospital discharge.
2	The Dumfries and Galloway Partnership should improve support to carers. Improvement should be measured within the partnership's outcome framework.
3	The Dumfries and Galloway Partnership should take action to improve the use of anticipatory care planning. These plans should be accessible to all staff in all settings so that they have appropriate access to information.
4	The Dumfries and Galloway Partnership should ensure older people and carers waiting to have their needs assessed or receive services are: • kept informed of the reasons for the delay • given indicative timescales • informed of who to contact if their needs increase in the meantime.
5	The Dumfries and Galloway Partnership should make sure that all staff are given appropriate information on key changes such as budget arrangements and workforce developments as operational action plans are developed in localities.
6	The Dumfries and Galloway Partnership should put in place a coherent strategy on the use of community and cottage hospitals and intermediate care options as a priority. This should be carried out alongside the developments for the new hospital so that plans are managed effectively.
7	The Dumfries and Galloway Partnership should ensure that the necessary controls are put in place to avoid any potential instances of conflict between its responsibilities to the NHS board and the Integration Joint Board (IJB).
8	The Dumfries and Galloway Partnership should put a plan in place to ensure the most efficient and effective use of unallocated funds. Procedures and controls should be established to ensure that all funding allocations, including those delegated to locality managers, are made in accordance with national guidance.
9	The Dumfries and Galloway Partnership should give timescales for the development and implementation of SMART locality action plans so that new models of care can be put in place. The partnership should be able to demonstrate how it will communicate plans with all staff across all agencies within the individual localities.
10	The Dumfries and Galloway Partnership should ensure that the role of the public health workforce is made explicit within its strategic plans. This should also be made explicit within its focus on early intervention and prevention approaches.

Quality indicator 1 – Key performance outcomes

Summary

In this section, we report on the real difference and benefits that health and social work services were 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 outcomes being achieved for individuals and their carers.

Performance in this indicator was **ADEQUATE**. The partnership had experienced some success in shifting the balance of care from hospital to community-based provision, enabling more people to be supported to remain living as independently as possible in their own homes. We found positive outcomes being achieved for older people in the records we read and in respect of the people we met. There was a clear focus on outcome based and person-centred approaches. The partnership had instigated pilots to test out new models of care following a personalisation ethos of service delivery. The partnership generally performed well in comparison to the rest of Scotland in relation to emergency admissions and multiple emergency admissions. The partnership also compared positively in the amount of care at home services provided. Alongside these strengths however, there was a rising trend in delayed discharges and emergency admissions to hospital. Older people and carers found that getting care at home at short notice and in more isolated areas was very difficult. There had been very limited investment in telecare and telehealthcare. There was insufficient respite provision to meet need, which was jeopardising carers' ability to continue in their role.

1.1 Improvements in partnership performance in both healthcare and social care

The partnership is one of only two partnerships in Scotland that have included acute services within its scheme of integration, reporting that this arrangement demonstrates a shared commitment to a step change in how the agencies will work together. Their aim is to use this whole-systems approach to managing resources to improve partnership performance, in turn leading to better outcomes for older people and their carers. It was too early to assess the impact of this ambitious model.

At the time of our inspection, the partnership in Dumfries and Galloway was performing better than the Scotland average in emergency admissions and multiple emergency admissions to hospital and had been for several years (Appendix 1, Figure 1). However, it was facing increasing challenges in preventing emergency admissions to hospital and in achieving timely discharges from hospital. Demand for acute medical admissions had risen on a national basis over recent decades and, in Dumfries and Galloway, those aged over 85 years constituted the fastest growing section of the admitted population. In our staff survey, less than a quarter of respondents agreed or strongly agreed that a broad range of services was available to offer alternatives to hospital provision.

Whilst the partnership had piloted and tested a number of different approaches to service delivery, there were few services or new models of care, with the exception of the Short Term Assessment and Referral Service (STARS), which was retained following a pilot to provide early supported discharge and admission avoidance. This service was an integrated approach to reablement and was delivered across the partnership. It offered a six-week programme to older people following their discharge from hospital, or support for an older person to remain in the community rather than being admitted to a hospital. Older people described finding value in the practical and supportive nature of the service in helping them return to, or maintain, independent living following illness or injury.

There had been reductions in some older people's dependency levels following an intervention from the STARS. However, a lack of care at home capacity had meant that the STARS needed to support mainstream care at home. This meant that the service continued working with older people well after their reablement period was over. This reduced the capacity for responding to new referrals for reablement. We saw evidence of this in the records we read, which showed delays for individuals in moving from short-term reablement to long-term care at home packages. There would be value in ensuring that the STARS initiative was able to focus on delivering its core service.

Once a patient is assessed as medically fit to be discharged from hospital, it is important that there are no delays in the person being discharged. This is important in terms of the person's care but also to ensure that resources are used efficiently. The partnership's performance in preventing people experiencing delays once they are assessed as medically fit to be discharged from hospital, in line with Scottish Government targets, had fluctuated, but was better than the Scotland average (Appendix 1, Figure 2). However, in common with the rest of Scotland, levels of delayed discharges were on the rise. The partnership acknowledged the negative trend and knew it had work to do to reverse this.

The most common reasons for people being delayed in hospital were because there was no care at home service immediately available, or because the individual was awaiting a care home placement. The lack of development of intermediate care services and reablement meant that the partnership was unable to support greater numbers of individuals in their own homes or more homely settings than hospital. The impact of this, along with the care at home challenges the partnership faced, meant that some older people were at risk of experiencing poor outcomes, such as not living where they wanted to, and potentially adverse effects on their wellbeing, such as a loss of independence.

The partnership was delivering care at home services to an increasing number of older people. It was performing at around the Scotland average in the levels of population aged over 65 years receiving care at home (Appendix 1, Figure 4).

Overall trends in care at home were positive. However, the lack of availability of care at home staff from any sector in some locations was a recurring theme and a source of concern for frontline staff and for carers. Some older people had to wait

for the care at home service they needed to help them achieve their desired personal outcomes. There was also insufficient care at home provision to meet needs when the older person needed or wanted the service. The partnership was at the early stages of looking at diversifying commissioned services and focusing on local community-based services.

The partnership was also at the early stages of developing intermediate care options across all localities. The high demand for beds and the challenge of managing the volume of patients and their admission and discharge meant that community and cottage hospitals could not always be used as a resource for intermediate care. The partnership could not articulate a clear strategy in how it currently used, or how it intended to use, community and cottage hospitals, in respect of intermediate care.

Frontline staff told us that community hospitals were, at times, being used to provide step-down care. However, some older people were delayed in community hospitals for lengthy periods while they waited for care at home packages. This was a significant risk in the more rural areas. It reduced the capacity in these hospitals to provide this step-down care as well as step-up care. The problem was compounded by a lack of care providers in the area, limiting the ability to provide care in the most appropriate place for the older person.

There were very limited numbers of designated intermediate beds. The Putting You First initiative had funded a pilot project which saw a small number of beds block-purchased to provide intermediate care in care homes in Annan for six weeks. However, this had been discontinued following a review. The partnership was at the early stages of considering commissioning 16 beds in a care home facility. This would offer step-up, step-down and intermediate care. We talk more about this in Quality Indicator 6.

Recommendation for improvement 1

The Dumfries and Galloway Partnership should develop and implement a joint coherent approach to improvement that:

- supports early intervention and prevention
- helps prevent hospital admission
- supports hospital discharge.

Positively, a high proportion of older people in Dumfries and Galloway were spending their last six months of life at home or in a community setting. This performance was in the top quartile of partnerships across Scotland. Also positively, long-term care home places and places supported by the local authority were lower than the Scotland averages and these numbers were continuing to reduce. The complete length of care home residents' stay (aged over 65 years) was lower than the national average (Appendix 1, Figure 4). This showed the partnership was using approaches that were purposefully and successfully shifting the balance of care towards community settings.

An area for improvement was the provision of respite support. Total overnight and daytime respite provision for older people and their carers was significantly lower

than the Scottish average (Appendix 1, Figure 6). The level of daytime respite provision was particularly low. Some carers told us how much they valued the respite care they had received. However, they also told us about difficulties they had when trying to access respite. This could intensify the pressure they were under as carers. We heard adverse comments from some carers about the availability of emergency respite which had not been available when they were in crisis. The lack of respite, particularly emergency respite, had, in some cases, led to hospital admissions for the cared for person.

There had been very limited investment to date in telecare and telehealthcare services. The partnership provided lower levels of community alarms and telecare services to older people than the Scottish average. This was the case for people aged over 65, 75 and 85 years. Funding secured through the Putting You First initiative aimed to address these shortfalls. We acknowledge the connectivity challenges for some telecare services in some geographical areas. However, the partnership was unable to demonstrate the use of a wide range of telecare and telehealthcare.

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

We were confident that the majority of staff had an appropriate focus on outcomes for older people and their carers. The records we read showed that health and social work services delivered a range of positive personal outcomes for almost all older people. Nearly two-thirds (64%) of care plans were outcome-focused.

Most older people and their carers told us that, as a result of the health and social work services they received, they felt safer, were living as well as they could be and had things to do as well as having friends and relationships.

Progress was being made in respect of implementing self-directed support[6] legislation and ensuring that older people were offered the four options[7]. However, access and availability needed to be improved. While there had been a steady increase in recent years across Scotland in the proportion of people receiving self-directed support, this was not the case in Dumfries and Galloway. Across all services, the proportion of people getting to choose how their support needs were met was lower than the Scottish average.

In the records we read, 79% of people were identified as having been offered self-directed support options. In almost all cases, the local authority was continuing to arrange and deliver the services. In the remaining 21%, none of the four self-directed support options had been offered. Some older people and their carers we met were aware of self-directed support. However, most said they found it too

[6] Self-directed support is a term that describes the ways in which individuals and families can have informed choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments.
[7] 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.

complicated and they were used to services being provided for them or on their behalf by the council. Some carers reported that they did not get enough help to complete the self-directed support forms.

The implementation of self-directed support was also limited by the lack of choice of care providers and limited capacity of third and independent sector service providers. This meant that the ability to select the self-directed support option where the person chooses the service and the service provider or option four (which is a combination of the other options) was constrained.

Quality indicator 2 – Getting help at the right time

Summary

In this section, we examine the experience and feelings of individuals and carers and 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 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 **ADEQUATE**. Positive personal outcomes were being achieved for many older people. We saw evidence that the partnership was trying to support individuals and their families by taking a more streamlined approach. There were examples of information being shared well through 'key information and emergency care' summaries which helped support better experiences and outcomes for people who need services. However, carers did not always find it easy to access support. There was a lack of signposting to services and insufficient respite, which impacted on their ability to maintain their caring role. There was not enough use of anticipatory care plans to ensure information was shared effectively in order to meet people's needs.

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

The partnership was able to demonstrate a person-centred, outcomes-focused approach to care which supported a number of older people to remain living at home or a homely setting. In over 95% of the records we read there was evidence that older people's needs and choices were taken into account. Older people told us that having the choice to remain at home was important and they valued an individual approach to planning care provision.

Older people and their carers who received care at home said they were satisfied with these services and felt efforts were made to meet individual needs. This included flexibility in the timing of care visits to suit individuals. Consistency of care at home staff and their ability to communicate proactively with GPs to ensure timely intervention and prompt response to increased care needs was also generally positive. Very good use was being made of time banking[8] to provide tailored outcomes-focused services for individuals.

GPs provided a helpful first point of contact to older people and were proactively trying to maintain people at home rather than referring them to hospital. Easier

[8] Time banking is a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants 'deposit' in a time bank, perhaps by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they themselves are in need.

access to diagnostics in the community had supported this and GPs were involved in increasing access to diagnostics as part of the development of the new hospital.

Where poor outcomes were recorded in the records we read, this was mainly due to individuals experiencing social isolation. We were aware that some public health projects were starting to address the issue of social isolation and loneliness as well as other low level needs. For example, in Dumfries, 40 projects had been funded to address isolation and loneliness. However, there was not yet a comprehensive, coordinated approach to ensure that these initiatives could be accessed by all older people across Dumfries and Galloway.

Staff were aware of the need to identify and meet the needs of carers. There was evidence that carers were appropriately and meaningfully involved in decisions about care being delivered to the cared for person. However, this was not always as a result of a robust assessment of the carer's needs. Most of the carers we spoke with had not been offered a carer's assessment. In the records we read, although just under half of the older people had a carer who provided a substantial amount of care, almost three-quarters of these carers were not offered a carer's assessment. Where carers are not being appropriately supported by a carer's assessment, it can mean increased carer stress and an inability to sustain the caring role. This could result in increased demand for services from the partnership. A primary aim of the Carers Strategy for Scotland 2010–2015[9] is that carers are supported to manage their caring responsibilities with confidence and in good health.

Some carers also told us that there was a lack of signposting from the partnership about how to get support as a carer. We described earlier the difficulties experienced by carers in accessing respite.

The partnership's Carers Strategy 2012–2017 stated that carers required "Access to information about issues and available support relating to their roles and life such as benefit information or rights". It further adds "Carers can feel excluded and powerless when information is not shared about the person they care for or about support that is available to carers themselves."

During the course of the inspection, a more robust approach to carers' assessments was introduced which included an updated referral process for carers' assessment and support plans. Support to help carers complete the assessments was being made available through the Carers' Centre. This new arrangement had been communicated to staff, however this was the first communication to staff about the new arrangements and many staff across the partnership seemed unaware of these new processes.
The partnership had developed a performance management framework designed to measure improvements against the nine national health and wellbeing outcomes[10]. This should support the partnership in measuring health and wellbeing outcomes as

[9] Caring Together: The Carers Strategy for Scotland 2010 - 2015 sets out 10 key actions to improve support to carers. The focus is on improved identification of carers, assessment, information and advice, health and well-being, carer support, participation and partnership.
[10] Lists of items that help check how local authorities NHS boards and their partners are performing in delivering on their single outcome agreements.

well as providing a base measurement for continued improvement. The need for carers' support had been identified in the framework but detail was still required as to what would be done and how this would be measured.

Recommendation for improvement 2

The Dumfries and Galloway Partnership should improve support to carers. Improvement should be measured within the partnership's outcomes framework.

2.2 Prevention, early identification and intervention at the right time

The partnership acknowledged that this was an area that required improvement, recognising that implementation of its approach to prevention and early intervention had not progressed as quickly as it could have. In the records we read, early intervention or preventative options had been considered in only just over half of cases where it would have been appropriate to do so. Nonetheless, there were examples of good practice which were benefiting some older people, although they were not available across the area.

For example, we looked at an improvement initiative in Annan and Eskdale designed to provide a preventative approach to care. Forward Looking Care Planning aimed to enable individuals to:

- live in their own home for as long as possible
- prevent or reduce the impact of crisis through early intervention
- avoid unnecessary admission to hospital
- deliver services in a responsive and efficient manner
- improve the health and wellbeing of individuals.

Older people, carers and staff we met were able to provide clear evidence of the positive impact of this approach, but at the time of our inspection, there were no plans for the approach to be implemented in other localities.

Example of good practice – Mature Driver Scheme

The Wigtownshire Mature Driver Scheme aimed to give people over the age of 70 the guidance and support they needed to keep driving safely for longer. Support sessions increased awareness of driving behaviours and highlighted any steps to increase safe driving. This was a collaborative programme between NHS Wigtownshire Health Improvement Team, Police Scotland and Dumfries and Galloway Community Learning and Development. All 40 older people who undertook the scheme confirmed that participation had helped them stay independent for longer. Participants also stated that they had an increased confidence in seeking advice from both Police Scotland and healthcare staff about driving. The plan was to roll this scheme out more widely.

Social prescribing[11] was a positive initiative that had been piloted in GP practices in Castle Douglas and Dalbeattie and received positive feedback from older people as well as GPs. Older people with long-term conditions and their carers were supported as early as possible to self-manage their conditions and access low-level support. This involved identifying referral pathways between GP practices and community resources. The evaluation showed this helped support self-management and increased feelings of wellbeing.

An important element of any prevention strategy is the prevention and management of falls. Although historically there had been some strategic overview to ensure approaches to the prevention and management of falls were in place, this was not evident at the time of our inspection. Some older people had been assessed as being at risk of falls but, from our review of case records, we could see that there was no consistent risk management strategy being applied. The partnership acknowledged the need to establish a more effective, collaborative falls prevention and management framework and ensure that this becomes embedded across systems of care.

There were positive developments in relation to services for people with dementia. These included the introduction of 'dementia passports', dementia-friendly communities, home-based memory rehabilitation and the establishment of communication clinics. Day care that focused on extra sensory stimulation had been piloted and had received positive feedback from carers. Designed for people in the late stages of dementia, this had a higher staff to older person ratio than traditional day care. This was a positive initiative with the potential to be developed and rolled out further. There was a waiting list for dementia day care services, meaning a negative impact for those older people requiring specialist support with their condition while they waited for services.

We found the partnership's strategic approach to palliative and end-of-life care to be of an acceptable level. Frontline staff told us that practitioners aimed to deliver this to meet individuals' wishes. A specialist palliative service was based in the Alexandra Unit of Dumfries and Galloway Royal Infirmary. A Macmillan nursing service was available across the partnership and Marie Curie had recently introduced a befriending service. Alzheimer Scotland had introduced an enhanced day care provision for people with dementia in the late to end-of-life stages. These are the minimum range of services we would expect to see in place in any partnership area.

Anticipatory care plans[12] (ACPs) support prevention, early identification and intervention at the right time. In this aspect, performance was disappointing. Of the records we read, only 2% were found to have an ACP where we would have

[11] A means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.

[12] These anticipate significant changes in an older person's health and social care needs and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals.

expected to see one. Key information summaries (KIS) and ACPs were completed but staff were not making the best use of these communication/information tools, which were not being shared effectively with all staff that needed them. The use of KIS was seen as improving with more being completed and to a better quality. Positive use of such information summaries was being made by accident and emergency departments. This supported better patient pathways.

A nurse had been employed in the partnership's palliative care team to support care homes to complete ACPs. For people with a diagnosis of dementia, anticipatory care planning was helpfully carried out during the post-diagnostic support period. However, awareness of, and access to, these plans was not always evident. It was also not clear how the plans were shared. Some frontline staff were aware that GPs held ACPs but did not know how to access them. We saw examples in records of anticipated future needs and wishes being recorded. However, there was no clear mechanism for ensuring that other professionals involved in that individual's care knew that these were available.

Recommendation for improvement 3

The Dumfries and Galloway Partnership should take action to improve the use of anticipatory care planning. These plans should be accessible to all staff in all settings so that they have appropriate access to information.

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

We note in the previous chapter that the majority of older people were being offered the self-directed support options.

We understood that, as well as at initial assessment, discussion about self-directed support options took place with the older person at initial assessment and at case review. However, a practice was in place which, at the time of review, placed a high number of older people already receiving services onto option three of self-directed support. There was no evidence of discussions with these individuals. Both staff and carers' groups identified a need for training in respect of self-directed support across the partnership. Funding from the Integrated Care Fund[13] had been allocated for a care at home provider to deliver training on self-directed support over 12 months across the 17 care at home providers working across Dumfries and Galloway.

[13] The Scottish Government made additional resources of £100m available to health and social care partnerships in 2015-16 to support delivery of improved outcomes from health and social care integration, to help drive the shift towards prevention and further strengthen the approach to tackling inequalities.

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**. Although there were some variations across the partnerships and across disciplines, overall we found a workforce where the majority enjoyed their work. Most staff told us they felt valued by their line managers and other professionals. They reported they had effective and supportive line managers and that there was very good communication across frontline staff. They were benefitting from regular, purposeful supervision. Despite a number of actions taken to improve communication, there was less confidence among staff in how senior officers were managing the change process.

3.1 Staff motivation and support

We reviewed a range of documentation submitted by the partnership and met with more than 250 health and social work services staff in focus groups. Three thousand, three hundred and ninety seven (3,397) health and social work staff were asked to complete our survey with 716 responding. Of the 716, 468 (65%) completed the survey in full. This was an overall response rate of 21%.

Of those who returned our questionnaire:
- 75% were employed by NHS Dumfries and Galloway
- 19% were employed by the local authority
- 5% were employed in 'other' sectors.

Responses to the survey therefore predominately reflected health staff opinion. Respondents were generally clear about their roles and responsibilities. Almost all enjoyed their work and felt valued by other practitioners when working in partnership. There was also a clear majority of positive responses about line managers. Staff said:
- they felt valued by managers
- they had effective line management, including clinical supervision
- they felt supported in situations where they faced personal risk.

Overall, our inspection activity showed that morale across the partnership was more variable than the staff survey suggested. While some staff we met in focus groups were contented, enthusiastic and upbeat about the future, a significant number repeatedly told us that they felt they were 'fire-fighting' rather than adopting a considered approach to delivering good outcomes for older people and carers.

Staff told us about factors that impacted on their ability to remain motivated. These were:

- significant changes to leadership and management
- increased workloads
- staff vacancies
- the use of short-term and rolling contracts through the period of transitional change.

The partnership had commissioned an independent consultant to carry out a detailed programme of activity focused on developing a new organisational culture. This commenced in August 2015. A well-planned timeline for this work was in place and was being adhered to. Staff had been consulted on this programme of activity.

Notwithstanding the pressures and challenges at a time of major change, staff we met were unanimously committed to working effectively to deliver a good service and good outcomes for older people.

Despite the positive responses in our staff survey about line managers, fewer than half (40%) of respondents agreed that senior managers communicated well with frontline staff about changes which affected services. Staff attending focus groups also reported that communication with senior managers in the partnership was less positive. A range of communication methods had been developed to help engage staff on the key milestones of the integration of health and social care services. These included:

- use of various social media such as Facebook, Twitter and blogs
- newsletters and bulletins
- road shows
- events and forums
- consultation with trade unions.

However, senior managers recognised that they still needed to make improvements in how effectively they communicate with staff.

The partnership was in the process of transformational change which was being driven through its draft integrated workforce plan 2016–2019[14]. To meaningfully develop its leadership capacity and to drive the required change forward, plans were in place to identify 15 leaders, across social work, healthcare and the third sector, for whom bespoke professional development plans would be created. These would focus on strengthening leadership capacity and embedding a new coaching culture within the partnership. The partnership had invested in a number of individuals who had gone on to achieve their diploma in business coaching. This was a clear indicator that the principles of this approach were being positively developed. Other leadership initiatives also appeared to have a positive impact such as the Aspire to Lead training for staff. This is a leadership programme supporting potential leaders of the future to develop skills and experience. This was initially rolled out jointly with three other NHS boards. However, the partnership had made a very purposeful decision to extend this opportunity to staff from all sectors, showing a commitment to a joint approach.

[14] Dumfries and Galloway, Health and Social Care, Draft Integrated Work Force Plan 2016–2019.

These were positive initiatives. However, it was too early in the process to assess the impact these initiatives would have on staff by helping to improve their practice and enhance their capacity to deliver positive outcomes for older people and their carers. The partnership was committed to monitoring this.

Frontline social work services staff reported that the number of referrals of older people with complex care and support needs had increased, paperwork was cumbersome and they were unable to share information with healthcare staff. However, while staff found these factors frustrating, the partnership had responded well to overcome information sharing issues. An information exchange portal for the electronic sharing of information was being developed between healthcare, social work and other key agencies such as Police Scotland. We talk more about this in Quality Indicator 8. Once established, this innovation has the potential to bring about significant benefits for team working across agencies.

Health and social work professionals had separate arrangements for individual supervision, annual performance appraisal and individual professional development. Staff reported that the supervision they received was regular, purposeful and supportive. Supervision and performance arrangements for social work services staff were subject to monthly management reports. At the time of our inspection, personal development reviews were being completed for the majority of social work staff.

At this early stage in the partnership's development, we acknowledged that healthcare and social work still had their own suite of training and development resources. Formal joint training opportunities were limited, although adult support and protection training was accessible to staff in all sectors.

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 **GOOD**. There were important strengths in a structured approach to consultation and a high level of engagement with older people and their carers. The results of this engagement could be identified clearly in plans. Communication was effective, with several forums in place for engaging with older people. The partnership had developed a practical locality-focused approach to support the design and delivery of future services. The partnership now needed to deliver on intentions to improve carers' access to support and a lack of signposting from staff, to ensure they maximise community capacity to support older people at home.

4.1 Public confidence in community services and community engagement

The importance that the partnership placed on community engagement and increasing community resilience was evident in service design, policy and strategy development. Involving the public in policy and service development, co-production and community resilience building were themes that ran throughout the partnership's strategic plan for older people 2012–2022 and the Nithsdale, Stewartry, Wigtownshire, and Annandale and Eskdale locality plans.

The partnership had carried out extensive public consultation during the development of its strategic plan. The communication and engagement plan for Dumfries and Galloway's strategic plan for health and social care April 2015–March 2016 underpinned its approach to consultation. A variety of engagement methods had been used, including conversation cafes, road shows, one-to-one conversations and existing consultation forums. There was evidence of the impact of the partnership's approach in the level of stakeholder engagement achieved. The impact of consultation was evident in the redraft of the strategic plan.

The partnership built on the success of the strategic plan consultation when it engaged with the public and stakeholders in the development of the locality plans. Public health had a significant role in carrying out the consultation and the uptake was high across the region. The partnership's strategic and locality plans clearly showed the influence of feedback received in developing the final plans. Older people we met told us that this was noticed and appreciated.

The partnership showed a strong commitment to promoting awareness of health and social care integration. It had developed a health and social care integration

involvement, communication and engagement action plan. This SMART[15] action plan monitored progress in communicating with the general public as well as stakeholders. Again, a variety of methods was used, from good news stories in the press, to impact assessments with stakeholders. The partnership had also clearly identified the strategic groups linked to each activity on the action plan and was monitoring progress.

The partnership's commitment to effectively engaging with communities was underpinned by several forums. These sought feedback on strategy and policy development as well as providing relevant information about service changes. They included the following.

- The Building Healthy Communities partnership forum was made up of volunteers who represented local agencies, organisations or community groups. The partnership provided information to the forum, which took decisions at locality level and provided feedback to the partnership on service developments and strategy. Members of the forum told us that participation in the group was a rewarding experience and that they benefitted from positive relationships with the partnership.

- The public reference group was made up of members from the third sector, the NHS, the local authority and members of the public. The group provided an opportunity for information sharing, as well as consultation and feedback.

Example of good practice – Older people's consultative group

The older people's consultative group was made up of professional and lay members, but was predominantly lay members. Each represented an organisation from across the region with an interest in older people. A formula determined membership, which made sure the group was representative of the constituencies of each organisation.

The group had a significant role in consultation on strategy and service development. Its role was to ascertain, coordinate and reflect the views of older people in Dumfries and Galloway. The group provided feedback to the partnership on service and strategy developments after consulting with their constituencies. This ensured it was representative of a wide population of older people. Examples of consultation included the care at home service review and the new build of the district general hospital. We observed and heard of strong relationships between the statutory agencies and the group. The group also sought information from the partnership about concerns affecting members of their organisations. This included the use of single rooms in the new hospital, and concerns about social isolation.

The partnership showed a commitment to improved engagement with carers. The carers' reference group had representation from across the region. Local authority and NHS representatives co-chaired. The facilitators provided the carers with comprehensive information to aid understanding of relevant legislative

[15] SMART Objectives are Specific, Measurable, Achievable, Relevant and Time-bound

developments. The group reviewed carer representation on various strategic groups to ensure that carers' views could be heard and appropriately influence plans, policy and developments. We heard from carers that this role had developed and that the representatives felt their contributions were valued and respected in locality and regional strategic groups. A key aspect of the group was consultation on service design and delivery for carers. The inclusion of carers in testing and providing feedback on the new carers' support plan was a positive approach. The carers in the group confirmed difficulties in accessing carers support and a lack of signposting from frontline staff. However, the group was a positive initiative to engage carers in improving future access and service provision.

The partnership demonstrated its strong commitment to building community capacity by using funding from the Putting You First initiative and the Integrated Care Fund to develop a number of projects that complemented existing community groups. The projects articulated the needs of older people, provided support for those who were self-managing long-term conditions, supported the statutory agencies and enhanced community capacity. Examples included the following projects.

- The Food Train provided individualised support for older people. This included a befriending approach, as well as support and encouragement to participate in group activities facilitated by the Food Train. The project had been providing support to older people for over 10 years and had expanded over recent years to over 350 volunteers in the region.

- Building Healthy Communities provided support for people with long-term conditions. Based on an enabling model, the Building Healthy Communities projects across the region aimed to tackle health inequalities at a local level. We visited the Nithsdale project which facilitated skills development, reduced social isolation and provided training opportunities for older people. The project was very positively perceived by those who attended. Many had developed the skills required to run Tai Chi groups on a voluntary basis for other older people with long-term conditions. People who attended the service told us that it had improved their physical and mental health and built their confidence and resilience.

Example of good practice - Community link workers, Annandale and Eskdale

An extensive consultation was carried out in Annandale and Eskdale that involved community agents consulting with over 850 local people by going door to door, visiting local services and approaching people in the community known to be vulnerable. Over 800 people were consulted, of whom more than 200 identified the need to develop a service that would signpost to local services, provide early intervention and prevention and reduce social isolation. In response, a community link worker role was developed, four of whom are in post in Annandale and Eskdale. Using a co-production[16] approach, they have supported more than 200 older people.

[16] Co-production describes a relationship between professionals, service provider and service user that draws on the knowledge, ability and resources of all to develop solutions to issues and to develop and deliver services.

Anticipatory care planning, signposting and regular support have enabled the project participants to achieve their personal goals. Community resilience[17] has been a key aspect of the community link worker's role. They also have a key role in facilitating continuous community engagement. The development and ongoing support of community projects has facilitated community resilience.

Older people told us about the positive impact these projects had on their lives. Some of the most successful projects were being continued from mainstream budgets following the end of Putting You First funding.

[17] Community resilience is about communities using local resources and knowledge to help themselves.

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 **ADEQUATE**. There were strengths in the way in which the partnership adopted approaches that fully involved individuals in their assessment and care planning. Multidisciplinary meetings were increasingly providing an effective means of joint working to support older people. Overall, services responded quickly to assess individual need. However, risk assessments and management practices needed to be strengthened to more consistently ensure the safety of vulnerable individuals. The exception was in adult support and protection where encouraging progress had been made in strengthening the approach to protecting individuals from harm, albeit from a low base. We had concern about the partnership's ability to ensure consistent provision of some services, such as care at home and respite. In situations where services were not readily available, there was little evidence to demonstrate how this was communicated to individuals and their carers or how the impact was recorded.

5.1 Access to support

A range of information was in place in various formats to inform the public about health and social care services for older people and carers. However, this information had not been developed as part of an overarching joint public information strategy. The partnership acknowledged the need to jointly review the quality and effectiveness of the information it provided.

A number of processes and pathways had been developed for accessing support. This had been done predominantly on a single-agency or service-specific basis. Recent examples included a pathway to manage post-surgery recovery and a protocol for accessing the crisis assessment and treatment mental health service out of hours. In a few areas, a more integrated approach had been adopted. For example, an integrated pathway had been developed for accessing some specialist reablement and dementia care and support at home using the STARS and the Care and Support Services integrated care pathway.

We heard mixed views from older people, carers and staff about how effectively the arrangements for accessing services and supports worked from their perspective. GPs provided an important access point for many older people. The partnership told us it was keen to see an increase in the extent to which GP practices referred patients directly to third sector organisations. GPs we met were keen to do this and recognised the key role that third sector and community organisations could play in supporting older people. However, they were also mindful of the significant

pressures on GP capacity and the challenges this posed for their key role in coordinating access to services.

Ease and speed of access to some community-based services was variable, both across different services and geographically. Access to advocacy and physiotherapy services was described as good. However, there were waiting lists for occupational therapy, some day care services, memory clinics and Alzheimer Scotland dementia link worker services. Some local initiatives had been taken to manage and reduce waiting lists. These included setting up occupational therapy clinics in Castle Douglas and the establishment of a foot care service in the Stewartry area. These initiatives had reduced waiting lists and times for these services.

Most older people we met said that making contact with the new social work contact centre was problematic. They described difficulty in getting through to the right person on the first time of calling. Additionally, some staff felt it took away good local communication and also felt that contact had become less efficient. Once contact had been made, older people reported that social work staff carried out assessments with minimal delay. However, as previously noted in this report, significant waiting periods could often be experienced before a service could be provided.

The social work service was reviewing its emergency out-of-hours provision. At the time of our inspection, the call response and initial screening continued to be purchased from the Glasgow and Partners Emergency Social Work Service. Older people and staff we met said that it could be very difficult to get through to this service. This contract is due to expire in 2018. Alternatives were being considered with a view to developing a more responsive, locally-based service.

We asked about access to services in our staff survey. A quarter of respondents agreed or strongly agreed that joint teams responded within agreed organisational timescales. A third disagreed or strongly disagreed. There was the same level of agreement, that there was fair geographical coverage of services to support older people. From the records we read, disappointingly, in 13% of cases, we found that individuals experienced a significant delay in their service being provided following their assessment.

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

The partnership's own audit activity noted that, while the assessment process was carried out on a single-agency or single-discipline basis, assessments themselves had multi-agency input and were shared. Furthermore, protocols had been developed to support effective information sharing among the key partners. Unfortunately, our review of records did not corroborate this. In just over half of cases (55%) the assessment had been informed by contributions from a range of other professionals, where we would expect to see such contributions. Slightly more (59%) showed evidence that healthcare, social work and other staff were sharing information and recording this in the file.

Positively, the partnership was taking steps to enhance information sharing to improve the delivery of services for older people and the outcomes achieved. Within the acute hospital, work was underway to develop more person-centred documentation to support the patient's pathway in hospital and appropriate discharge planning. A multi-agency group was working to develop a consistent set of documentation, which would be used across the partnership including care at home services, care homes and third sector providers.

In order to develop a personalised approach, the partnership had used the Talking Points[18] approach and had developed a forward-looking care planning tool as detailed in Quality Indicator 2. Most staff we met demonstrated a helpful focus on personal outcomes for older people and this was reflected in our review of records. We found that 94% of the files contained an assessment of the older person's needs and in 89%, the older person's choices had been taken into account.

However, there was still some way to go before a comprehensive outcomes-based assessment framework was in place. Given the variable quality of the assessments we read (we evaluated 49% as being very good or good, 45% as adequate and 6% as weak) and the fact that staff felt current paperwork was cumbersome, we suggest that training and support for staff would be beneficial, alongside the development of the assessment framework.

Good practice would locate the discharge planning process closer to where older people presented to emergency care services. The partnership was piloting a new frailty model to provide assessment and outreach treatment from the accident and emergency department at Dumfries and Galloway Royal Infirmary with the aim of preventing admissions into hospital. This was done by a team that included a physiotherapist, occupational therapist and social worker. The partnership had also recently introduced coordinators in the hospital to improve patient flow, which senior managers felt was proving effective. The introduction of electronic systems had also helped to speed up the referral of patients to social work services and allied health professionals, such as occupational therapy and physiotherapy. It had also helped to speed up the discharge process.

The joint, co-located discharge team at Dumfries and Galloway Royal Infirmary told us that they were able to secure safe discharge for 80% of the older people referred to them from the accident and emergency department, who were considered to have the potential for discharge within 72 hours. However, this was dependent on the accident and emergency department involving them at an early stage and within the national four hours HEAT target for accident and emergency departments. Having sufficient staffing available was also a factor. For example, the team told us that while physiotherapist input was available every day of the week, occupational therapy input at weekends was more limited.

For older people in hospital, effective multi-agency discharge planning is crucial to achieving positive personal outcomes and in avoiding delayed discharges. There was still work to be done to ensure that systems were sufficiently robust and

[18] Talking Points Approach: An organisational approach that puts people using services and unpaid carers at the centre of the support they receive

consistent across the region. Multidisciplinary team meetings made a positive contribution to effective discharge planning from the community hospitals, but these meetings were less commonplace in Dumfries and Galloway Royal Infirmary. Daily 'huddles' had been introduced at the acute hospital, which provided a mechanism for discussing and progressing discharges from the hospital. Delayed discharge multidisciplinary meetings were also taking place every week.

During our review of records, we looked at care planning. Almost all files contained a care plan, with over half having been completed within the previous six months. Most plans also set out the desired personal outcomes for the older person. Less positively, only 55% had a comprehensive plan and 57% were not SMART, making it difficult to monitor progress in implementing plans or to measure the impact on people.

In addition to the use of national eligibility criteria to help prioritise demand, the social work service had adopted an approach that meant 'open cases' would not be carried on an active caseload after the initial assessment and service provision had been completed. The aim was to avoid confusion about which staff member or agency had the lead care management role. Instead, the names of older people in this situation were held in a 'virtual box'. The risk of such a system is that the circumstances of these older people may be reviewed only if information comes to light that their circumstances had deteriorated. Without a robust reviewing system in place, the increasing needs of some older people could be missed.

To address outstanding reviews, a pilot project had started in the Dumfries area with a social worker seconded for a year to carry out reviews of the needs of this group of older people. At the time of our inspection, reviews had been completed for 17% of the older people subject to the virtual box arrangement. To further increase the focus on reviews and staff capacity in this area, the service planned to extend the timescale before it responded to some referrals by introducing a period of 'referral holidays'. We were concerned that there could be an impact on individuals who were waiting following referral and a risk those delays could simply be moved from one part of the system to another. It also reinforced our findings of the need for the partnership to communicate with older people about difficulties in not being able to readily provide the service, following assessment.

Recommendation for improvement 4

The Dumfries and Galloway Partnership should ensure older people and carers waiting to have their needs assessed or receive services are:

- kept informed of the reasons for the delay
- given indicative timescales
- informed of who to contact if their needs increase in the meantime.

We met a number of older people whose medication had not been reviewed for some considerable time. Some community-based staff we met said this was a particular problem for older people living in their own homes. However, more positively, as part of the Optimise Project (covering nine GP practices in the

Nithsdale locality), pharmacists were carrying out medication reviews of patients living in their own homes or in care homes.

Example of good practice – Optimise Project

The Optimise Project was jointly funded by health and social care services. Pharmacists were carrying out medication reviews of both patients in care homes and those living in their own homes in the Nithsdale locality. Medicine reviews were carried out for patients identified as high risk, for example, aged over 75, on more than 10 medicines, or on high-risk medicines. Care workers, carers and other healthcare professionals were able to refer the patient to the relevant pharmacist. To date, 131 patients had been assessed, with cost savings of £12,626 based on the reviews so far. However, this did not take into account the possibility of reduced adverse effects, hospital admissions and improving the ability of someone to manage their medication at home. The driver for this project was the growing demand on costly compliance devices and the lack of capacity within community pharmacy to keep delivering these without any assurance checks taking place. Stockpiling issues for patients was also improving.

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

Discussions took place between the Care Inspectorate and the chief officers' group about adult support and protection arrangements following an inspection of services for children and young people in Dumfries and Galloway conducted in 2014. Work subsequently undertaken by the Care Inspectorate's designated link inspector working alongside local staff identified the need for governance arrangements for adult support and protection to be significantly strengthened. In advance of the inspection, the partnership judged that it had made some progress in developing its approach to public protection, including adult support and protection, but that further work was required to embed this. This view was consistent with our inspection findings. We concluded that partnership had strengthened governance arrangements for adult support and protection.

- Membership of the adult support and protection committee now had a stronger multi-agency and partnership focus. A new independent chair had been appointed in August 2015, along with a new lead officer. Relevant subgroups had been established to focus on performance management and quality and improvement. We attended a meeting of the committee and saw that it was well attended with appropriate representation and a clear agenda. We were able to confirm from previous minutes that these meeting were regularly well attended and progress on several issues was being made.

- An adult support and protection services executive group, comprised of senior managers from the key partner agencies, had been established and met on a weekly basis. This group had developed the proposals for a multi-agency screening hub (MASH) where information could be shared and decisions made on a multi-agency basis on how to deal with all new adult support and protection

referrals. This was due to start during summer 2016. The group had also taken forward arrangements to introduce initial referral discussions based on the established process used for child protection concerns.

The partnership had developed a shared initial referral discussion process for child protection concerns, which ensured effective communication and decision-making across agencies. This system had not been expanded to include adult support and protection activity, which could have proved useful whilst MASH was being developed.

NHS Dumfries and Galloway had strengthened its partnership contribution to adult support and protection. It had appointed a nurse consultant for public protection and was in the process of appointing two adult support and protection nurse advisors. It had also introduced a new electronic adult support and protection referral form for healthcare staff. We noted there had been an increase in the number of such referrals. This was a positive development given concerns at a national level about the low proportion of adult support and protection referrals that come from healthcare staff.

Across the partnership, some important tasks had been identified to further strengthen adult support and protection arrangements. These included reviewing the existing action and improvement plans into a single plan and introducing a new risk protection matrix. It also included developing more specific and task-focused adult support and protection guidance to maximise support to staff. We welcome these plans, in particular because there is a clear need for development in this aspect. Nearly one in five staff survey respondents felt they did not have guidance and processes to support them in assessing and managing risk. One in four disagreed or strongly disagreed that there was a range of risk assessment tools available for them to use.

During our review of records, we looked at risk assessment and risk management practice. Fourteen of the 100 records we read related to protection type risk (current or potential issues about adult support or protection, or protection of the public). Given this relatively small number, some caution needs to be exercised in drawing conclusions from the data. However, findings were mainly positive in that:

- 79% of files contained a risk assessment
- 91% of the assessments had been informed by the views of multi-agency partners
- we assessed the quality of 72% of the assessments as very good or good, (18% were adequate and 9%, weak)
- 64% of the relevant files had a risk management plan and 89% of these were up to date.

Less positively, in 43% of relevant files, not all protection type concerns had been dealt with satisfactorily. This was either due to an inadequate response to initial concerns raised or poor recording.

A larger proportion of the records we read related to non-protection type risk (for example, a frail older person at risk of falling). Generally, our findings were less

positive for these records than for those records with protection type risk identified. For example:

- a smaller proportion of files (58%) contained a risk assessment
- fewer (67%) of the assessments had been informed by the views of multi-agency partners
- we assessed the quality of a smaller proportion of assessments (40%) as 'very good' or 'good'
- fewer (43%) of the relevant files contained a risk management plan.

As stated earlier, there was an absence of risk management strategies in relation to falls prevention and management.

Chronologies can give an early indication of emerging patterns of concern and risk. Of the records we reviewed, only four out of 58 records contained a chronology where we would have expected to see one. The very small number of chronologies we saw had been completed in response to protection type concerns and these were of an acceptable standard.

From our review of health and social work service records, and the follow up activity we carried out with some families and staff, we identified concerns that applications for guardianship were being taken forward through adult and support and protection procedures. This now included the requirement for the older person's circumstances to be considered at an adult support and protection case conference. It had been introduced with the intention of ensuring that any adult support and protection related concerns of older people who may lack capacity were fully considered alongside the need to pursue a guardianship application. While accepting that the change had been well intentioned, the consequences of this approach caused us some concern, for the following reasons.

- The requirement for all older people to be dealt with through adult support and protection processes, where guardianship was being considered, meant that families felt they were subject of some type of formal investigation, even where there were no specific adult support and protection concerns.

- It led to some protracted timescales and delays in taking forward guardianship applications due to the volume of adult support and protection case conferences required and the limited availability of adult support and protection conference chairs.

- The demand for adult support and protection case conferences and the limited availability of adult support and protection conference chairs had resulted in conferences being chaired by colleagues from children's services, who may not have had the experience and knowledge required.

Senior managers confirmed the arrangement was under review with the anticipated outcome that guardianship and adult support and protection processes would be separate processes. The exception would be for those older people where there were specific adult support and protection cases. Two adult support and protection

conference chairs were now dedicated solely to adult support and protection, thereby building up their experience and knowledge.

5.4 Involvement of individuals and carers in directing their own support

In the position statement submitted, the partnership outlined the broad approach it was taking towards involving older people and carers in directing their own support as part of its engagement with all older people and carers. It described this as a "supported self-assessment approach" designed to "encourage good conversations" between staff and older people and carers.

In the records we read, we saw evidence that almost all of the older people had their views sought and taken into account as part of the completion of their assessment and care plans. There was also evidence that the majority of older people receiving services received feedback at each key stage of their involvement with them. In our staff survey, 56% of respondents agreed or strongly agreed that services communicated well with older people who used services.

We read case studies that showed how the partnership had worked with independent sector care at home providers to help equip their staff to work with older people in providing a more personalised care at home service. The case studies indicated that, through this approach, they had been able to amend the time and manner in which they provided support to allow older people to do the things they really wanted to do.

The partnership commissioned independent advocacy services Dumfries and Galloway Advocacy Service and User and Care Involvement (UCI) to provide one-to-one and group advocacy for older people. As part of our review of records, we looked at the provision of independent advocacy support. In nine out of 23 relevant files we read, independent advocacy support had been offered, and for five of the older people concerned, the advocacy had helped them articulate their views. Advocacy was generally available when sought, though some managers felt that advocacy for older people tended to be underused and was mainly done as part of guardianship considerations. The relevant documentation had recently been revised to encourage health and social work staff to consider referrals for advocacy support in a broader range of circumstances.

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**. There were good links between the locality leads and the Integration Joint Board (IJB). There was a well-established joint quality and commissioning team and clear consideration was being given to how this team would support locality planning and locality service provision. Support of self-care and self-management of long-term conditions was a focus area for the partnership with evidence of some effective approaches. However, locality planning was slow in translating into operational actions. Further work was required in outcomes based commissioning.

6.1 Operational and strategic planning arrangements

The community planning partnership's single outcome agreement 2016 identifies the priorities for public service reform and the pace of service integration. The health and social care partnership had framed its operational and strategic planning arrangements within priority three of the single outcome agreement: We will care for older and vulnerable people.

The core strategies identified by the partnership were the:

- Dumfries and Galloway single outcome agreement 2014–2017
- Dumfries and Galloway draft joint strategic plan for older people 2012–2022
- Dumfries and Galloway carers strategy 2012–2017.

A three-year joint strategic commissioning plan was being developed and taken forward by the strategic planning subgroup of the community planning health and social care partnership. An additional group focused on the planning and delivery of services for carers.

The draft joint strategic plan for older people 2012–2022 was circulated widely for consultation. It contained overviews of health and social work needs analysis and the strategic direction and identified strategic priorities as determined by the Putting You First initiative. It also signposted implementation plans associated with individual workstreams within Putting You First and some financial information. Some workstreams such as low-level guided health walks had been successfully introduced in towns across the region to increase levels of physical activity. Other workstreams were still developing such as the Dumfries and Galloway time banking

network providing voluntary care and support to older people. The plan signalled areas for future disinvestment and investment including hospital sites.

Having been drafted, a consultation exercise for the strategic plan 2016-2019 was completed in December 2015. The plan identified 10 key themes for older people and outlined the overarching strategic priorities which were to be taken forward by the IJB when it was inaugurated in April 2016. The plan gave a clear view of the direction of travel, but lacked some of the finer details on how the priorities would be achieved. The plan was not always fully costed nor delivery timescales identified.

The IJB members had clear expectations in respect of regular reports on progress on delivering locality action plans. The development of these operational plans was linked to strategic plans by operational managers who were members of the managers' group. This group was critical in taking forward improvements through its role in monitoring implementation of the strategic plans and making key decisions on changes to support operations. The adult support and protection committee also had a role in monitoring the policy, procedures and implementation of adult support and protection arrangements across Dumfries and Galloway.

Operational action plans for each of the partnership's four localities had been developed through consultation with key stakeholders. Positively, public health had a significant role in consultation for the locality plans. The partnership was aware that locality planning was progressing at differing rates. This was coupled with differing priorities between localities. Staff spoke positively about locality planning but said it was taking a long time and was slow to move forward to action plans.

The partnership's expectation of the strategic planning group was to measure national and local performance. This group had 45 identified representatives from key stakeholder groups. Two representatives were IJB members. The group was expected to have a reviewing and planning role. There were opportunities under discussion for the locality development groups to make links with this group through their representatives.

Some important procedures were not up to date and some procedures now overlapped as a result of introducing changes in processes. An example was where guardianship procedures had been incorporated into adult support and protection procedures with no benefit to older people. This meant greater demands made on operational staff and managers to satisfy the procedural requirements such as case conferences. These demands impacted on the time and focus required in adult support and protection referrals for individuals at risk of harm or in need of protection.

The development of operational monitoring systems was at an early stage. A data dashboard was being used to give managers day-to-day information on operational activity. This system had only been in operation for six months and was limited in the depth of information.

Management information from GPs was not routinely shared and attempts had been made to gather information from other primary care statistical sources with limited success. As a result, little information was gathered directly on GP services.

Working to an outcome-focused model of assessment and support is a fairly new change in ethos. Staff were not always clear how outcomes were achieved and measured. Most data gathering was quantitative rather than qualitative. Further plans to develop outcome-based measures were described to us but were at too early a stage to evaluate their effectiveness.

Staff told us that the integration process was discussed across frontline services and to some extent they felt well informed. However, they thought that the plans lacked detail. They were unclear on how change would be implemented on 1 April 2016 and did not know how joint budgets were to be introduced. Our staff survey found that only a quarter of respondents agreed or strongly agreed that the views of staff were taken into account fully when planning services at a strategic level. Some staff thought user involvement was variable outwith the locality planning process and the impact of user involvement in influencing service development was not always evident. Operational and strategic planning arrangements were in the early stages of implementation and measurement of progress against plans was limited.

Recommendation for improvement 5

The Dumfries and Galloway Partnership should make sure that all staff are given appropriate information on key changes such as budget arrangements and workforce developments as operational action plans are developed in localities.

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

Positively, the partnership was taking steps to strengthen its early intervention and support services, as described elsewhere in this report. The aim was to reduce the number of older people being admitted to hospital and the number of people waiting for placement in the community whilst in hospital. This was based on a whole-systems approach to include acute care. The intention was to enhance the experience of individuals through better coordination of services and improved information sharing. Some work had already been implemented in multidisciplinary information sharing, for example, the regular 'huddle' meetings used by hospital staff to discuss individual cases to ensure people were discharged as soon as possible.

The partnership was developing support for self-care and self-management for people with long-term conditions as one of the priority focus areas in the draft joint strategic plan for older people.

Recommendation for improvement 6

The Dumfries and Galloway Partnership should put in place a coherent strategy on

the use of community and cottage hospitals and intermediate care options as a priority. This should be carried out alongside the developments for the new hospital so that plans are managed effectively.

Through the Change Fund and the Integrated Care Fund, the partnership had taken a joint approach to the deployment of resources to support improved outcomes for older people. This funding had been used to test different models of care. As stated in Quality Indicator 1, a step-up and step-down care pilot project in Annan aimed to enhance options available to provide appropriate care closer to home, through all care homes in the Annan area and Annan Hospital. However, the pilot project concluded that whilst using care homes to provide step-up care provision was of benefit, the viability of an expansion of this model largely depended on spare capacity in the local care home market. Further plans had been identified to use beds in the Allanbank facility, an ex NHS-contracted care home, to develop a step-up option. Alongside this, capacity in the care home market was being explored. However, despite these locally progressed plans, we were concerned that a number of key actions were still required in order for this option to be fully realised.

The partnership perceived the main risk to successfully implementing an early intervention and prevention strategy was financial in nature, combined with increasing demands for adult health and social care. To mitigate this, the intention behind the IJB bringing together all health and social work resources was to achieve a radical shift in service design that would support early intervention and prevention. The Integrated Care Fund was to be used by the IJB to help develop the future shape of how health and social work services would be designed and delivered and, specifically, to pilot future innovation projects.

The partnership recognised that telecare and telehealthcare services were key areas of development to help build community capacity. There was now a drive to increase access to telecare with Putting You First short-term funding to be used for additional staffing. However, given the limited investment to date, the partnership had some way to go to establish a full range of telecare and telehealthcare services to help monitor and improve older people's ability to live independently. From our review of records, there was evidence that telecare, such as community alarms, had effectively supported some vulnerable older people to live independently and safely in their own homes. However, as noted earlier in this report, the potential of telecare and telehealthcare had not been fully realised and its expansion could benefit a wide range of older people.

Key stakeholders told us there was a good understanding of the historic role and remit of the third sector and private service providers among senior and frontline staff. However, barriers to partnership working were evident. Key stakeholders stated that managers did not fully understand or value the now changing and collaborative contribution that third sector and private service providers could make.

Dumfries and Galloway's population of older people includes a significant proportion living in rural areas. We heard from staff and older people about many challenges that the distances between communities and services could present to older people, which contributed to many older people becoming isolated. Some older people and

carers criticised the lack of available community transport provision, although local initiatives did exist, for example, a patient travel scheme and use of volunteer drivers. IJB members had identified addressing isolation in communities as a strategic priority. They had communicated this effectively to frontline staff and older people who told us about many Putting You First initiatives aimed at addressing social isolation, including volunteering and creating support networks.

6.3 Quality assurance, self-evaluation, and improvement

There was a robust structure in place in relation to performance reporting in terms of clinical and care governance as well as management governance. This supported the role of the NHS board's healthcare governance committee and the council's social work committee's in leading the governance of the partnership's performance.

Partnership performance officers noted a specific intention was to provide effective support to the IJB to support their understanding of the importance of performance management as some board members had little experience in this area. To that end, members of the IJB attended a workshop covering performance management arrangements in March 2016.

In addition to needing more quantitative data, the partnership identified an increased need for qualitative information to support the outcomes targets. One of the workstreams which sat below the shadow IJB was the performance management workstream. This workstream had used the community planning partnership's single outcome agreement as a template capturing the national outcomes framework and this meant that outcomes target data was important to inform progress and future service development. The partnership had separate performance reporting frameworks for each agency. The local authority reported through business plans and cost centres with key performance indicators and key projects captured on the reporting system. Health and social care reporting arrangements were made through locality performance reports. Work was being done to make sure that performance reports could be generated for IJB to ensure that the partnership's performance against the locality plans could be measured at each board meeting held quarterly.

Local area committees had strengths in local knowledge and a link to the community. They were to have a role in the monitoring and scrutiny of the IJB's effectiveness in their areas. Several staff and other stakeholders reported a tension between the board, being responsible for delivering services, and local area committees, which scrutinise progress.

Staff responsible for the key performance indicators updated the local authority risk register. The IJB and the council's social work committee considered risk with the clinical care and governance group every six months. NHS Dumfries and Galloway had a separate risk committee. A shared understanding of, and attitude to, risk at corporate and political level had yet to be developed. Work in this area was planned for autumn 2016 with the IJB.

The local authority sought early resolution of complaints. Complaints informed learning logs and examples were given where staff training was introduced following complaints in key areas such as domestic abuse awareness. The NHS board's complaints handling system presented complaints data to Dumfries and Galloway NHS board, with data being shared with the council's social work committee.

The partnership joint quality and commissioning team's contract management programme used a risk-based approach and procurement procedures. This included contract monitoring, contract compliance and service review. Quality assurance measures were in place for externally commissioned services as part of contractual compliance procedures. Monthly meetings were held between the heads of community services and the joint quality and commissioning team to liaise and monitor arrangements. This was a robust practice to keep track of progress in services commissioned from the third sector. It was regrettable that forums providing opportunities for regular contact with providers had not been held recently.

6.4 Involving individuals who use services, carers and other stakeholders

We observed a locality development meeting attended by staff across the partnership, the third sector and independent sector partners. It was clear from discussions that more input was needed from older people and carers in this particular locality. However, the locality development group had drawn up plans to seek older people's and carers' opinions and was clearly motivated in taking these forward.

Community engagement by the strategic planning group on the draft joint strategic plan for older people was good, with over 2,000 individuals consulted. Results of the consultation were widely shared and the IJB received regular updates from the strategic planning group on the progress made following the consultation work. The IJB was keen to build on the strengths of communication within the partnership. It planned to schedule regular meetings across the county to engage with the localities and the public.

The partnership was working to develop customer satisfaction surveys. However, there were no joint surveys at the time of inspection. Feedback forms were not used routinely for performance reporting in care at home services or care homes (two key areas of customer contact). The absence of any joint surveys implied some complacency in robustly measuring performance, although the locality development groups showed evidence of inclusion of user groups. There was also evidence elsewhere of engagement through stakeholder forums. Staff told us they were aware they needed to do more surveys in the future to address this shortfall.

6.5 Commissioning arrangements

Joint strategic commissioning involves all the partners jointly assessing and forecasting needs, agreeing desired outcomes, and deciding how services should be designed to maximise outcomes. The Scottish Government expected health and

social care partnerships to produce joint commissioning strategies for older people's services during 2013. Strategies were expected to focus on delivering improved outcomes for older people and carers through better aligning investment with what the evidence shows are the needs of older people in local communities. In 2014, additional Scottish Government guidance advised that these strategies were to be developed further to include detailed financial planning as well as extending to all adult groups. The partnership produced the health and social care strategic plan 2016-2019 which encompassed the expectations of the Scottish Government.

We observed the shadow IJB demonstrating governance in commissioning services and clarifying its responsibility for staff. The board reached agreement and demonstrated that it was functioning at a joint decision-making level when considering future service development and joint use of resources on behalf of older people.

The partnership recognised when and where there were weaknesses in local market supply in areas such as care homes and care at home services. A care at home framework had been established to try to continually improve quality and reliability of service delivery. However, this had been only partially successful. A strategic partnership with care at home providers, Scottish Care and the in-house service providers were working to agree future care at home priorities such as use of common paperwork, shared training and the potential to rationalise payment rates. The partnership was addressing recent policy changes such as the introduction of the national living wage. This was causing anxiety for external service providers who felt that the current financial constraints would require them to absorb further costs.

A need for improved dialogue between the commissioning team and some providers was evident. Providers told us they felt decisions taken by the partnership were forced upon the third and independent sector. An example was the introduction of real-time monitoring. This system had been introduced in other parts of the country but there was a local perception that no consideration had been given to the barriers for its implementation, such as IT issues.

We were told that housing services and registered social landlords did not feel part of the joint planning process. There had been difficulties in developing initiatives such as step-up and step-down care facilities. As a result, developments were not coordinated well enough to make sure that appropriate housing was available to older people in the right location at the right time. A more comprehensive housing contribution statement to the draft joint strategic plan for older people should address specific areas. This should support better coordination and increase the likelihood of concerns from housing and registered social landlords being addressed.

The approach taken to develop locality plans had fostered a helpful focus on, and commitment to, community development and capacity building. The partnership was still to decide what changes they would make to the current centralised planning structures.

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 team work and training.

Management and support of staff was **ADEQUATE**. The impact of high levels of staff absence and the lack of success in recruiting to key posts was having a notable impact on the partnership's ability in continued service delivery. Nonetheless, the partnership was working constructively to develop approaches to recruitment which were hoped would deliver more equitable results across the sector. Strategies were also being employed to reduce higher than average levels of sickness absence. Managers supported staff to make use of training and development opportunities. Clarity was needed about ongoing funding to important dementia training developments to ensure they were sustainable. There was strong evidence of health and social work staff working effectively together to deliver services and improve outcomes for older people and carers.

7.1 Recruitment and retention

As discussed in Quality Indicator 3, the partnership had appointed an independent organisational consultant to look at a three-year cultural change programme. While this provided some sound beginnings, it was too early to assess its impact in delivering a better health and social care integrated working environment.

Understandably, joint health and social work workforce planning was at an early stage. The partnership had established a joint organisational development workstream group which provided an annual progress report to the IJB. The group had worked purposefully to oversee and implement the new integrated management structure. It had also produced a high-level draft integrated workforce plan which included a participation and engagement strategy. This group was linked to other relevant workstreams such as clinical care and governance. It also clearly linked to workforce outcomes stipulated in the health and social care strategic plan 2016-2019. Recruitment had been made to most posts within the new senior management structure. Overall, the partnership had made relatively good progress with the development and implementation of its integrated structure.

There was a longstanding challenge in recruitment and retention in areas such as acute and diagnostic medical staff, GPs (in- and out-of-hours services), allied health professionals and the council's social care services. At the time of the inspection there were 12 consultant vacancies across NHS Dumfries and Galloway, with consultant geriatricians particularly underrepresented. This had been identified as sufficiently serious to warrant recording as a high risk on the NHS board's risk register.

The partnership was responding to these challenges, but was at the early stages of considering new models of care which had the potential to offset recruitment difficulties. For example, the introduction of advanced nurse practitioners in medicine for the elderly and GP practices was being considered, albeit this was viewed as a longer-term approach to address recruitment issues. Discussions were ongoing about the line management structures of this new development. A number of other collaborations were being undertaken to improve the staffing situation, such as joint work undertaken locally with neighbouring NHS boards and the consideration of hybrid medical posts across different disciplines. The medical director was personally carrying out interviews with all the GP registrars completing their training, to try to retain as many registrars as possible. Posts were being made more attractive, flexible and with added opportunities for development.

The pharmacy leads also acknowledged recruitment issues and were taking action to address them. Prescription for Excellence in Pharmaceutical Care[19] was driving a strategic review of the community pharmacy model, including various pilot proposals for new ways of working. In terms of social services, social worker posts were typically filled, though staff said it could take a long time to appoint to vacancies. This was putting more pressure on frontline services.

The heads of human resources from health and the local authority outlined a range of additional joint recruitment initiatives undertaken. This included jointly advertised medical and teaching posts that might have been attractive to families seeking to move to Dumfries and Galloway as a lifestyle choice.

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

The absentee rate in social work adult services in October 2015 was 6%, with care at home services proving to be a particular area for concern. The local government benchmarking framework highlights an upward trend in staff absence in Dumfries and Galloway since 2010–2011. NHS Dumfries and Galloway had an absentee rate of 5.06% (2014–2015). This was also above target and on an upward trend. However, both the NHS board and the council had detailed strategies to reduce absence levels. For example, health services had focused particular support on those staff with the greatest number of recurring absences. Social work services had refocused its priorities by introducing monthly management reporting. 'Challenge panels' had been introduced where the nature and type of absences would be carefully considered and actions taken to improve trends in the worst affected areas.

[19] Prescription for Excellence 2013 complements the Scottish Government's 2020 Vision Route Map and Quality Strategy Ambitions. It plays to the strengths of pharmacists as experts in the therapeutic use of medicines and their potential contribution and integration into health and social care teams.

7.2 Deployment, joint working and team work

We found evidence of small-scale examples of successful joint working to:

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

Frontline staff, as well as NHS and social work services managers, reported good working relationships with colleagues across the services. This was evidenced in our staff survey. They said that an increased focus on outcomes was evolving as a result. GPs told us that they generally had very good links with social work services, which they perceived to be competent and responsive.

As yet, there were few examples where joint teams were co-located. Early multi-agency pathfinder pilots of the health and social care hubs still had some aspects of shared accommodation in place. Human resource and organisational development senior managers were strongly committed to health and social care integration but not necessarily to creating joint teams. The strategic vision of senior management was to embed the culture of an 'integrated space' rather than integrated teams.

The partnership had taken the decision to move all mental health officer posts out of community teams and into a centralised team. The remit of this large team (16 full-time and three part-time mental health officers) was to focus exclusively on statutory mental health duties. This decision had increased the workload for those in community teams who were required to manage the generic case work for which mental health officers had been responsible previously. It had also left significant gaps in terms of the particular knowledge, skills and expertise they shared with community teams in day-to-day operational case work. The partnership was committed to using its mental health officers to meet the continued challenges of increased statutory mental health work. However, the approach lacked an appreciation of the unintended consequences and appeared disproportionate to the challenges it faced when compared to similarly sized partnerships nationally.

7.3 Training, development and support

We reported in Quality Indicator 3 on staff satisfaction with the frequency and quality of supervision and clinical supervision (where appropriate) provided by their line managers.

A majority (64%) of staff survey respondents agreed or strongly agreed that they had good opportunities for training and professional development. Through the survey and from staff focus groups, it was clear that meaningful training and professional development opportunities were provided for staff. There was a shared view that single agency training opportunities were good. A variety of training was available to make sure staff maintained their skills, knowledge and accountability in their

respective professions. Some staff felt there were not enough shared events across the partnership. They said it was a challenge to find capacity in their schedules to attend all the training they wanted to and felt the focus was on mandatory topics, which did not allow them to explore new interests. Joint staff training was available in specific areas such as adult support and protection. The Short Term Assessment and Referral Service (STARS) had worked in partnership with Dumfries and Galloway College and the Care Training Consortium to jointly develop an accredited Scottish Vocational Qualification (SVQ) award in reablement that workers in that team had undertaken. The plan was to make this available to the wider workforce.

Despite self-directed support training being provided to all social work staff, a fair proportion of staff we met were still not clear on how they should offer self-directed support options to older people and their carers. In particular, healthcare staff felt they needed to learn more about self-directed support. Additional training was planned for a wider audience, which would include NHS and third and independent sector partners.

There was a well-considered approach to training and development about dementia that formed an effective foundation as the partnership moved forward on the dementia agenda. Dementia training and awareness activity was overseen by the dementia strategy group, using a dementia standards assurance framework. To date, training and development to Dumfries and Galloway Royal Infirmary and Galloway Community Hospital has been delivered by the Interventions for Dementia, Education and Support (IDEAS Team)[20]. The team delivered education, training and support for a range of staff on a number of levels in line with the Promoting Excellence Framework. This included assessment, management and interventions for support around complex stress and distress symptoms in dementia.

Through the Putting You First programme, community mental health teams, occupational therapists and Alzheimer Scotland had successfully delivered a post-diagnostic self-management course called 'Living well with dementia'.

These were helpful initiatives, which have now been funded on a permanent basis.

Independent care at home services, care home and day care providers reported an improvement in access to staff training. Providers valued the opportunities and had linked into activities including self-directed support training, tendering and dementia through the IDEAS team. A planned joint induction programme for all care at home staff was under development.

The adult support and protection learning and development post had been vacant for approximately one year, leaving a significant gap in support for staff in this critical area of practice.

[20] An interdisciplinary team who use a bio-psychosocial approach to stress and distress in dementia. The team includes professionals from nursing, social work, speech and language, psychology and occupational therapy.

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.

Management of resources was evaluated as **ADEQUATE**. Budget management arrangements in both organisations were effective. Helpful and appropriate links between senior finance officers were in place, which was of particular importance given that all acute hospital services are to be included in the planned scheme of integration. Several joint projects were in process, to develop an infrastructure to underpin shared IT facilities and were progressing well. Importantly, joint capital planning required further development in order to support the partnership to make best use of its collective assets when planning and delivering future service provision. Police Scotland was recognised as an important partner and involved in joint working at operational and strategic level with the council and NHS. Housing services, although integral to the council, did not feel itself to be part of the planning process despite a lack of appropriate housing being recognised as a major barrier to allowing older people to remain in their own home.

8.1 Management of resources

Current joint financial management

Including acute medical services in the scheme of integration aimed to maximise opportunities for whole-scale integration between health and social care and reduce barriers to a whole-systems approach to finance. In common with many areas of Scotland, the partnership had decided not to combine budgets in the first year of integration. The proposed total amount to be delegated to the IJB for 2016/17 was £298.5 million[21], made up of £236.1 million contribution from the NHS board and £62.4 million from the council. Given the imbalance in funding, it is important that all key decisions are based on a consensus among partners. Strong links between senior officers within both organisations had helped ensure that a consensus approach was adopted.

The budget had been produced on a high-level basis but now needed to be further developed to contain sufficient detail to underpin joint commissioning planning. Completion of this budget should provide the IJB with sufficient opportunity to understand the final budget that would be transferred to the new body corporate arrangements.

The partnership decided that around one-third of the IJB's budget would be delegated to managers at the four localities. Finance officers had been engaging with locality managers to aid their understanding of the delegated budget.

[21] As at March 2016

There were strong links between each of the partner's finance teams. A long-established joint senior finance officers' group met on a regular basis. A joint finance resource workstream shared information on a range of financial matters, including budget setting. The council and NHS board had been working together to prepare indicative financial reports to the shadow IJB. This was in order to inform members of the financial position of the services to be delegated. This process had also included aligning budget-setting processes although, in common with other partnerships across Scotland, this had been challenging due to different account codes, summary reporting levels and budget presentation. At the time of our inspection, a draft joint adult services monitoring report had been produced but had still to be developed and formalised before it could be submitted to the IJB. Helpfully, the chief operating officer and the partnership's chief finance officer had hosted a number of workshops with the IJB covering a range of governance and financial matters.

In November 2015, the partnership decided that the NHS board's director of finance would take up the role of its chief finance officer. The Scottish Government's integrated resources advisory group advises against this post being filled by either partner's director of finance, except where local circumstances dictate. The partnership considered that the local knowledge of this officer, alongside both partners' respect and trust in the officer's authority, made this the right solution for them, nonetheless.

Recommendation for improvement 7

The Dumfries and Galloway Partnership should ensure that the necessary controls are put in place to avoid any potential instances of conflict between its responsibilities to the NHS board and the IJB.

Financial performance of Dumfries and Galloway Council

Overall, the council recorded a small overspend of £0.2 million in 2014/15 against its service budget of £328.6 million. The social work budget had a small year-end underspend of £0.02 million. Within this, there was an underspend in older people's services of £1.0 million (4.0% of budget) arising from greater than anticipated income. This underspend was partially offset by overspends of £0.4 million in budgets for services for both children and families and learning disability services.

As at October 2016, the council reported a total forecast overspend against budget of £0.5 million within the services being delegated to the new IJB. Older people's services were expected to overspend by £0.2 million. This was largely as a result of an increase in the number of care at home (17%) and residential and nursing (3%) placements and increased costs through the national care home contract. An overspend of £0.3 million was also projected in the budget for learning disability services. At the time of our inspection, officers told us that the overspend position in delegated services had increased to £0.7 million. This overspend was expected to be offset by underspends within non-delegated services to give an overall social work balanced budget at the year end. With the transfer of services over to the IJB

in April 2016, the services to be delegated would be expected to remain within budget.

In line with the 2014/15 published annual accounts, the council identified a funding gap of £32.3 million between 2015/16 and 2017/18. Since the announcement of the 2016/17 settlement from the Scottish Government, the council was due to receive a reduction of £13.2 million. This reduction was mid-range of the council's estimations in its further development of the financial strategy report. The impact that this had on the council's 2016/17 savings requirement was to increase it from £12.5 million to £21.1 million. This presented a significant challenge to the council.

The council's overall savings target for 2015/16 was £8.3 million. Social work's share was £1.9 million to be delivered across a range of schemes. This included:

- £0.2 million of care at home savings
- £0.9 million from a review of care packages
- £0.5 million of general efficiencies
- £0.3 million from kinship care savings.

Identification and achievement of recurring savings was essential to ensure long-term sustainability of services. At the time of our inspection, the review of care packages savings target was anticipated to be exceeded. However, the £0.2 million care at home target was anticipated to be undelivered. This was due to delays in rolling out a real-time monitoring system. The general efficiency savings target was also expected not to be achieved. This had resulted in total projected underachievement of savings within social work of £0.5 million, 26.3% of the required target.

Financial performance of NHS Dumfries and Galloway

NHS Dumfries and Galloway was required to meet various financial targets set by the Scottish Government. This included remaining within its revenue budget and achieving a break-even position. For 2014/15, a small underspend of £2.0 million was recorded against its core revenue resource limit. This had been agreed with the Scottish Government.

As at December 2015, NHS Dumfries and Galloway reported an overall year-to-date overspend of £0.5 million. The most significant year-to-date overspend related to the primary care prescribing budget. This had been an overspend of £1.5 million with a forecast year-end overspend of £2.2 million. A year-to-date overspend of £0.1 million was also recorded against the acute and diagnostics directorate which was to be included in the IJB budget. This overspend related to the use of medical locums to cover staff vacancies. Officers told us that they anticipated an overall breakeven position by the end of the year. However, this would to be achieved through non-recurring funding. The achievement of expenditure remaining within budget on a recurring basis was important to the long-term sustainability of service.

The NHS board achieved efficiency savings of £7.8 million in 2014/15. These were achieved through £7.1 million (91.0%) of recurring savings with the remaining £0.7

million (9.0%) coming from non-recurring sources. A savings target of £8.0 million was agreed for 2015/16. As at December 2015, it was reported that £6.4 million of this target had been identified. The shortfall of £1.5 million, combined with the recurring savings still to be identified for the next year, had increased the recurring savings gap for 2016/17 to £2.7 million. During the inspection, finance officers told us that, for 2016/17, a process was under way to focus on the savings that would have the least impact on service users and staff using the Making Difficult Decisions framework[22]. The total savings requirement for 2016/17 was expected to be £13 million, including the £2.7 million from 2015/16. As with the council, the identification and achievement of recurring savings was essential to ensure long-term sustainability of services.

Asset management and capital investment

To date, there had been collaboration on some small-scale capital projects. Joint meetings between the council and NHS board capital planning groups had recently been held to look at sharing capital plans. The chief officer of the IJB feeds into capital planning of health and social care services and this had been included in the integration scheme. There had also been discussions with locality managers about access to capital resources. Joint capital planning was identified as an area that required further development by the partnership.

Strategic funds

Since 2011/12, the Scottish Government had provided funding to the partnership through the Change Fund. This was bridging finance to enable the redesign of services towards prevention, early intervention, anticipatory care and rehabilitation. By March 2015, the partnership had received £10.9 million in funding, which was governed by its Putting You First initiative. The Putting You First programme board was responsible for allocating funds to various projects and initiatives. Initiatives funded through the Change Fund were evaluated to inform the partnership's approach to redesigning services, including investment and disinvestment options. This resulted in a number of projects being decommissioned over the life of the fund. We received confirmation from finance officers that, at the end of 2014/15, all Change Fund projects in the partnership were either mainstreamed or disinvested.

The Scottish Government approved the Dumfries and Galloway Integrated Care Fund submission and agreed an allocation of £3.0 million annually on a recurring basis. The partnership was drawing up guidance governing the allocation of this funding. This would be based on the national Integrated Care Fund guidance, the nine national health and wellbeing outcomes for integration and lessons learned from the previous Putting You First strategy. A plan on how the Integrated Care Fund monies would be used had yet to be fully developed and formalised. The partnership told us that they wished to postpone investment decisions until the joint

[22] Work was undertaken on a national basis which resulted in the March 2010 report Making Difficult Decisions in NHS Boards in Scotland. This was used to develop a process, with guidance, for making difficult decisions in NHS Dumfries and Galloway.

strategic plan for older people and locality plans had been finalised. In conjunction with fund allocation decisions being made centrally through the health and social care integration executive group, the partnership had taken the decision to delegate £1.0 million of the total fund to locality managers. At the time of our inspection, only £1.1 million of the £3.0 million funding had been allocated and had been used mainly to support infrastructural change, programme management and IT infrastructure.

Recommendation for improvement 8

The Dumfries and Galloway Partnership should put a plan put in place to ensure the most efficient and effective use of unallocated funds. Procedures and controls should be established to ensure that all funding allocations, including those delegated to locality managers, are made in accordance with national guidance.

In addition to these strategic funds, the partnership was informed that it would be allocated £7.6 million from the Social Care Fund starting in 2016/17. This funding would be received on a recurring basis and would be split equally between supporting existing and additional financial pressures.

8.2 Information systems

Across Scotland, the development of integrated data sharing arrangements is proving to be a challenge. The partnership did not have a joint IT strategy, but was carrying out several joint projects to develop an infrastructure to underpin shared IT facilities. This would facilitate effective sharing of information at both individual practitioner and strategic levels in the future.

Staff expressed frustration at the loss of the previous IT system which allowed shared access to information across the local authority and healthcare services. Staff told us that the Short Term Assessment and Referral Service (STARS) had access to health records and read-only access to the social work Frameworki IT system. In our staff survey, less than a third of respondents agreed that information systems support frontline staff to communicate effectively with partners. Frontline staff expressed frustration that IT systems that cannot communicate with each other resulted in duplication of assessment. This resulted in older people having to tell their story several times. Staff maintained effective contact using email and alternative formal and informal networks such as meetings and regular contact to support joint working.

The forthcoming introduction of the clinical portal will be a valuable tool for enhanced communication.

Example of good practice - Clinical portal

The development of a clinical portal to enable multi-agency access to shared information was a positive innovation. Eight of the 22 systems for health records had already been included in the portal. Plans were in place to add the remainder and

Frameworki before extending to education and third sector partners. Initial feedback from clinicians was positive. The partnership had clearly established timescales for completion of the initial phases of the portal development and implementation. The clinical portal was being designed to enable practitioners across the partnership to access relevant information and reduce duplication of assessment.

The partnership recognised the difficulties of communicating across agencies. An agreement had been reached that the LYNC system used by healthcare staff would be rolled out to include local authority staff. Safety issues were being resolved before rolling this system out. This was scheduled for completion before the new hospital opened in 2017. This was a positive innovation to build on existing practice to enhance multi-agency communication.

The partnership was also carrying out a joint project to develop a community of interest network. This cable network was designed to link local authority sites with the old and new sites of Dumfries and Galloway Royal Infirmary. This joint project would produce significant bandwidth opportunities, reduce future costs and provide backup and disaster recovery facilities. At the time of the inspection, the project was out to tender. A clear deadline of completion had been set before the opening of the new hospital.

The introduction of ePens in a number of areas had successfully enabled staff to complete clinical notes in patients' homes. Information was then transmitted back to the clinical portal. Community nursing staff told us that this had been a positive innovation and enabled them to spend more time delivering clinical care. The project was rolling out to community nursing staff across the region and to allied health professionals.

8.3 Partnership working

The first meeting of the shadow IJB took place in November 2015. As previously stated, the partnership had included acute medical services in its scheme of integration. Membership of the IJB was being finalised with the appointment of stakeholders such as a carer representative. The board was reviewing and agreeing its governance arrangements and the scheme of delegation. The clinical care and governance committee and an audit committee had been established as the two committees to which the IJB would delegate authority. The clinical care and governance committee had identified its membership and terms of reference to fulfil its role in providing accountability to the IJB. Locality managers had been appointed.

The partnership had spent a significant amount of time and resources communicating with staff groups about partnership working and integration. Despite this, we heard concern from frontline staff about confusion about future partnership arrangements. These included understanding what an 'integration space' was and a lack of clarity about the future governance arrangements for mental health services. Only just over a third of the respondents to our staff survey agreed there were effective partnerships which focused on delivering key policies and plans for older

people and included relevant stakeholders. We talk more about the partnership's communication of the strategic vision in Quality Indicator 9.

There was uncertainty about funding for posts which had been initiated using Putting You First and Integrated Care Fund monies. This included posts which were contracted only until the end of March 2016. The uncertainty about the sustainability of these posts was impacting negatively on staff morale and the future planning of services.

Positive relationships and collaborative working between the council elected members and the NHS board members were noted in the development of the new hospital. Senior staff acknowledged that the IJB had yet to take any difficult decisions, which is usually the acid test for partnership working.

Police Scotland was recognised by both the NHS and the council as an important partner. Funding had been made available for three years to increase the ability of the crisis assessment and treatment team. The team would work jointly with Police Scotland to protect and support people, including older people, who were highly distressed and at risk of admission to either the District General Hospital or Psychiatric Acute Hospital. An important aim of the project was to work closely with Police Scotland colleagues to offer advice and support to frontline officers and to reduce the need to transport people to the accident and emergency department for psychiatric assessment. It was too early to evaluate the impact of this.
Effective partnership working was also evident at a strategic level. Police Scotland was represented on the community planning executive group and the chief officers' group. However, frontline staff reported a lack of feedback from these groups.

Housing services was also a partner at a strategic level, with representation on some key groups. The partnership had a locality manager with responsibility for leading on housing matters. However, housing representatives did not feel themselves to be part of the joint planning process. Difficulties with housing provision were echoed by members of the IJB who identified the lack of suitable housing in the region as a barrier to supporting older people staying at home in later life. One initiative which had been undertaken in the partnership was the common housing register, which monitored the number and needs of people waiting for sheltered accommodation to support identification and development of suitable housing. Despite this, we heard of concerns that this register was not consistently populated with accurate information and that referrals were made at crisis point rather than through early identification.

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 better outcomes for individuals.

Leadership and direction was **ADEQUATE**. A shared strategic vision for services was evident across the senior management team. We could see the emergence of effective joint leadership based on a well-established history of joint and collaborative working. Senior managers had made efforts to communicate the strategic vision to the workforce. Despite this, some Integration Joint Board members (IJB) and frontline staff were not able to fully articulate the strategic vision although it was clear that staff were very committed to the delivery of high quality integrated services and to improving outcomes for older people and carers. Senior managers recognised that strategic plans had not yet been translated into SMART locality plans which were urgently needed to help staff articulate the vision and understand the role they play in achieving it. There was some frustration at the slow pace of progress in moving tests of change into new models of care. In addition, further work was required to identify all IJB members as required by legislative guidance. There was a helpful initiative to support GPs to understand and support their readiness for integration, though this was, as yet, restricted to just one primary care area. More work was required to ensure that GPs and primary care clinical leaders had clarity about their role in implementing locality plans.

9.1 Vision, values and culture

The partnership's senior management team had a shared strategic vision and shared aims for older people's services. This led to a high degree of commitment and enthusiasm demonstrated by senior staff and a stated drive to deliver the best possible outcomes for individuals. While the same commitment and enthusiasm was shared by the IJB, it was less clear on the strategic vision.

The shared strategic vision across the senior management team underpinned initial integrated service planning and was the foundation for how services would be developed and delivered on a locality basis. In their day-to-day activities, staff groups across the agencies showed a high level of commitment to delivering good integrated services. However, they could not clearly articulate the strategic vision, values and aims of the partnership. There was not an understanding of how the senior management's higher level aims and objectives were to be delivered. This was reflected in our staff survey where only 38% of respondents agreed or strongly agreed that there was a clear vision for older people's services with a shared understanding of the priorities. Thirty-one per cent disagreed or strongly disagreed and 32% indicated that they did not know.

We acknowledge the stated position of senior managers that it was appropriate to wait for the development of the localities before putting new models of care into place and thus have a better understanding of the balance of service design and provision within their area in order to meet local need. We could see that consideration and attention had been given to communication with staff on an ongoing basis. While acknowledging the volume of information, most staff felt it was still quite high level. They wished to see intentions and plans being put into action. Staff had seen a number of tests of change and pilot initiatives, but few of these had moved into new models of care. Frustration about a perceived lack of pace in moving things forward was a common theme. Our view was that some of the piloted models could have been adopted without waiting for the locality and action plans. There is substantial evidence gained from experience across the country that these models are effective in supporting admission avoidance, reducing delayed discharges and achieving better outcomes for older people. They could allow older people to get help in the most appropriate setting without unnecessary delay or unnecessary admission to hospital.

At the time of our inspection, the partnership acknowledged that the locality plans were still too strategic and individual locality action plans would have to be developed to underpin them. There had been slow progress with the implementation of the strategic plan, its transference into locality plans and the subsequent introduction of locality action plans. The absence of locality action plans added to the lack of clarity for staff.

In the absence of detailed locality action plans, the partnership's overall approach to its improvement activity for older people services was piecemeal in nature. It also meant that the overall vision was less clear to some staff and there were some significant differences between the positive vision expressed by senior management and the reality of service provision on the ground. The partnership had not yet taken all the action needed to develop the range of alternative community based services to allow it to effectively shift the balance of care on a sustainable basis.

The plans require be linked with the strategic vision and shared aims so that staff are clear about their role in delivering the vision. This should build on the positive work of the cultural diagnostic work undertaken by the partnership, and the developing culture of engaging and motivating staff across the agencies to deliver high quality services. It should also ensure that staff at all levels are encouraged to play a part in developments.

Recommendation for improvement 9

The Dumfries and Galloway Partnership should give timescales for the development and implementation of SMART locality action plans so that new models of care can be put in place. The partnership should be able to demonstrate how it will communicate plans with all staff across all agencies within the individual localities.

9.2 Leadership of strategy

The partnership was beginning to develop effective joint leadership based on a well-established history of joint and collaborative working. Strategic leaders continued to encourage productive and positive staff and team relationships. We saw this reflected in the IJB which, despite having only recently formed, showed promise of an IJB that could mature quickly. This was due to a shared history and a willingness to continue with strong partnership arrangements. Any conflicting interests between council elected members and IJB members had been managed well.

Clear lines of accountability and governance arrangements were being established. The IJB was in the final stages of agreeing the structure and membership of its strategic planning group. Representatives expressed some concern that there were insufficient non-statutory members. We were assured that priority had been given to appointing core membership as outlined in legislative guidance and the membership will be broadened to other relevant stakeholders in due course.

We were pleased to see that the local area committees would play a part in scrutinising locality plans. However, the partnership will need to ensure absolute clarity about the role and responsibility of the committees to create clarity about how this scrutiny will be undertaken.

Elected members showed an understanding of the importance of receiving and understanding performance data. They were able to demonstrate knowledge of what they needed to support their future leadership of strategy and direction.

The IJB members spoken with were clear about the reasons for the inclusion of acute services and had an understanding about the use of shared financial resources and the implications of utilising this shared resource. Strong support was being given by the chief finance officer to support the board's understanding of the finances and the impact of financial decision making.

At the time of the inspection one of the general manager posts within the senior management team structure (to support the chief officer) was vacant. The partnership saw this as a critical post in driving partnership plans forward. Therefore, the role had been taken up on a temporary basis by a senior manager from social work services. This was a helpful way of sending a clear message about joint working as well as allowing the partnership to push forward with strategic change. Nonetheless, we noted the potential negative impact on social work operations.

The engagement and involvement of primary care clinical leaders and GPs, and clarity of their role in the integration agenda, is crucial in the leadership of change. We looked at the engagement and involvement of clinical leaders in primary and secondary care and found a number of very enthusiastic staff who were able to describe their vision for the future and who looked at integration as a potentially positive process. Clinicians and GPs we met were well informed. Primary care was not yet as engaged as it could be. Clinical leads were trying to increase that engagement but were at an early stage of the process. GPs we met had a clear

vision of the process of formation of the IJB. As clinical leads for their localities, they had been involved in the formation process and had been consulted and kept informed. However, they were concerned about the lack of knowledge of future direction among staff in primary care and noted the importance of positive engagement of these staff to the success of integration. More work was required to ensure that GPs and primary care clinical leaders had clarity about their roles in implementing locality plans.

The partnership was able to demonstrate on a small scale how it had looked at supporting GP practices to plan for health and social care integration. The Supporting General Practice pilot project was in place but limited to Annandale and Eskdale. The project aimed to create a practice development plan for each GP practice that would support health and social care integration, as well as help them to develop a more person-centred care approach. This pilot meant that practices in Annandale and Eskdale would be well placed to link their practice development plans with locality plans. We considered this to be an encouraging initiative. There were no immediate plans to extend this pilot across the other localities. There was also uncertainty as to the future funding and therefore the sustainability of the Annandale and Eskdale project.

The partnership understood the importance of prevention and early intervention but acknowledged it had been slower in its development of prevention and early intervention initiatives than it would have liked. It saw this as a key focus area. We would expect to see this work strongly supported by public health, particularly in light of the Public Health Review[23]. We saw a mixed picture in this respect. The post of Director of Public Health had been vacant since the summer of 2014. The partnership purposefully had not attempted to appoint until the outcome of the review. Two individuals from the existing team had been job sharing the role on an interim basis.

At the time of inspection, the Public Health Review report had just been published. While we saw a number of small-scale public health initiatives across the partnership, we saw very little in the way of a joined-up strategic approach to the use of public health staff. Public health staff spoke about a perceived disconnect between strategic public health management, the partnership's leadership and strategic vision and the health needs and inequalities in the region.

Recommendation for improvement 10

The Dumfries and Galloway Partnership should ensure that the role of the public health workforce is made explicit within its strategic plans. This should also be made explicit within its focus on early intervention and prevention approaches.

[23] The public health review 2016 was commissioned by the Scottish Government to look at how Scotland's public health community could work better together, bring about further improvements in the nation's health and well-being and tackle health inequalities.

9.3 Leadership of people

Across the partnership, a strong drive and ambition was demonstrated by staff to continue to improve upon performance which will need to be supported by effective leadership. Planned developments showed that services were moving in a positive direction to achieve a stronger, collaborative approach. There was a particular focus on effective leadership by the locality managers.

There was evidence of strong leadership at an operational level. Senior managers were considering ways to support this further by increasing their visibility. This should also support the cultural change necessary to deliver the strategic vision of a locality model of services for older people. The development of this new culture was particularly important to ensure that disciplines were able to work in a harmonious manner, in order that professional dominance was not perceived at any level.

There were examples of good communication across the breadth of the workforce. A senior manager from social work delivered a podcast on the SharePoint system on a monthly basis. It was a positive attempt to communicate in a clear, non-jargonistic way to staff on issues of direct concern to them. A weekly blog had also been started by a senior clinician, to which a number of other staff had contributed. This contained valuable patient stories and could at times be quite hard hitting and challenging of practice. It was reported that it was generally well received across the area.

9.4 Leadership of change

We were told that the findings of the joint inspection of services for children and young people published in 2014[24] had prompted the partnership to review how it developed strong change management across all areas of its work. The partnership had established an internal inspection coordination team with staff from health and social work represented. The team had carried out pre-inspection activity in preparation for this strategic inspection of services for older people, which the partnership hoped would help in identifying areas of good practice and areas for service improvement. While the pre-inspection work no doubt surfaced valuable information for the partnership, there was little evidence that it had yet been used to direct improvements.

We found the partnership responsive to areas for development highlighted during our inspection. Several improvements were made during the inspection period, however we noted a few examples where the partnership had clearly not worked through the consequences of improvement actions. We were concerned that they should not merely seek 'quick fixes', but sustainable solutions that would do more than simply shift pressure from one part of the system to another.

Less than a third of staff who responded to our survey (28%) agreed or strongly agreed that changes that affect services are managed well. More than half

[24] Joint inspection of services for children and young people in Dumfries and Galloway, Care Inspectorate 2014

disagreed. We found that the partnership was more able to identify where it needed to improve than to demonstrate how it had used that insight to make improvements. It was also unable to identify and communicate all of its successes, or where successful initiatives could be shared and implemented. In managing change and improvement successfully, it is important that the partnership develops skills in self-evaluation which allows it to identify both areas of strengths and the need for improvement.

It was evident that, in both organisations, there were strong and competent leaders whose sense of purpose and direction was clear. However, collaboratively, there was still much work to do. We acknowledge that they are operating in a context of cultural change across the partnership, a management restructure and a time of transition. However, despite these factors, the partnership had a substantial amount of strategic development to achieve in order for partnership work to deliver and sustain better outcomes for older people.

Evidence about performance was improving with the development of information and communication technologies and outcomes-based information gathering. Further work was needed to ensure that appropriate information was being gathered to inform future service development. There was a clear willingness to engage in and rise to the challenges of the integration agenda and the service changes and improvements that were required. However, there was a concerning lack of SMART targets and planned interventions required to realise the aims operationally going forward. The resource profile was highly constrained by the recent decisions on the national living wage. Nonetheless, the senior management team had proven through the progress made following the children's inspection, that it is able to manage change to improve the planning, design, delivery and governance of service delivery.

Quality indicator 10 – Capacity for improvement

Summary

To reach a judgement on the partnership's capacity for improvement, we consider the following areas:

- improvements to outcomes and the positive impact services have on the lives of individuals and carers
- effective approaches to quality improvement and a track record of delivering improvement
- effective leadership and management
- preparedness for health and social care integration.

Improvements to outcomes

Our inspection concluded that, in general, the partnership delivered positive outcomes to older people who use services and their carers. Evidence included our analysis of nationally and locally published performance data, documentation submitted to us by the partnership, analysis of service users' social work and health records and the views expressed by people who used services, their carers and partnership staff we met.

The partnership needed to make improvements in delayed discharge, intermediate care and supporting carers.

Improvement was required in the development of early intervention and prevention approaches as well as anticipatory care planning for older people.

The difficulty with the provision of care at home services in some areas had impacted on rising delayed discharges and increased bed days lost (Appendix 1, Figure 3). It also contributed to capacity and flow issues both with the acute hospital as well as the community and cottage hospitals. We recognise that lack of care at home providers and recruitment problems were partly responsible. However, the partnership should continue to work with care at home providers and strategic planning staff to explore what providers can deliver on a locality basis.

The development of reablement, telecare and telehealthcare services could also contribute to allowing better use of limited service and staff resources.

Effective approaches to quality improvement

The partnership was able to demonstrate some well-evaluated tests of change and new models of care pilots. However, decisions about investment and disinvestment were being left until locality action plans were put in place. While we acknowledged the rationale for doing this, it had led to a perceived lack of pace in the development of services. This had also meant there has been little impact on drivers for new

models of care such as admission avoidance, delayed discharges and bed days lost to delayed discharge.

Effective leadership and management

The partnership's senior management team shared a strategic vision for older people's services. However, this now needed to be disseminated across all staff groups. We acknowledge that this has already started and the partnership's plan to focus on this on a locality basis. This should be done as soon as practical to allow staff to become familiar with the vision and also their role in delivering the vision.

Following a management restructure, leadership and management was being consolidated across both agencies. The partnership should ensure that the ongoing stability of its senior management team and delivery of operational services are maintained through any temporary change of roles.

We saw positive working relationships across the partnership, particularly with the Integration Joint Board (IJB) and its approach to taking integration forward together. This was clear from papers we read, board members we spoke with and decisions taken about integration and financial management.

The IJB demonstrated a realistic maturing understanding of its role. It recognised that sustained and focused effort would be required to meet future challenges.

Health and social care integration

The partnership had a strong history of joint working between statutory partners, the third sector and the independent sector. This will stand it in good stead as it develops its integration agenda. The partnership's ethos was developing a positive culture of consultation, engagement and involvement and was continuing to build on this to support the development of integration. We saw relationships that were mutually respectful, equitable, and characterised by enthusiasm and positive engagement.

The foundations were in place to achieve helpful integrated working. However, the pace of change needed to be accelerated in the development of the localities to ensure that integration can demonstrate continued positive outcomes for older people.

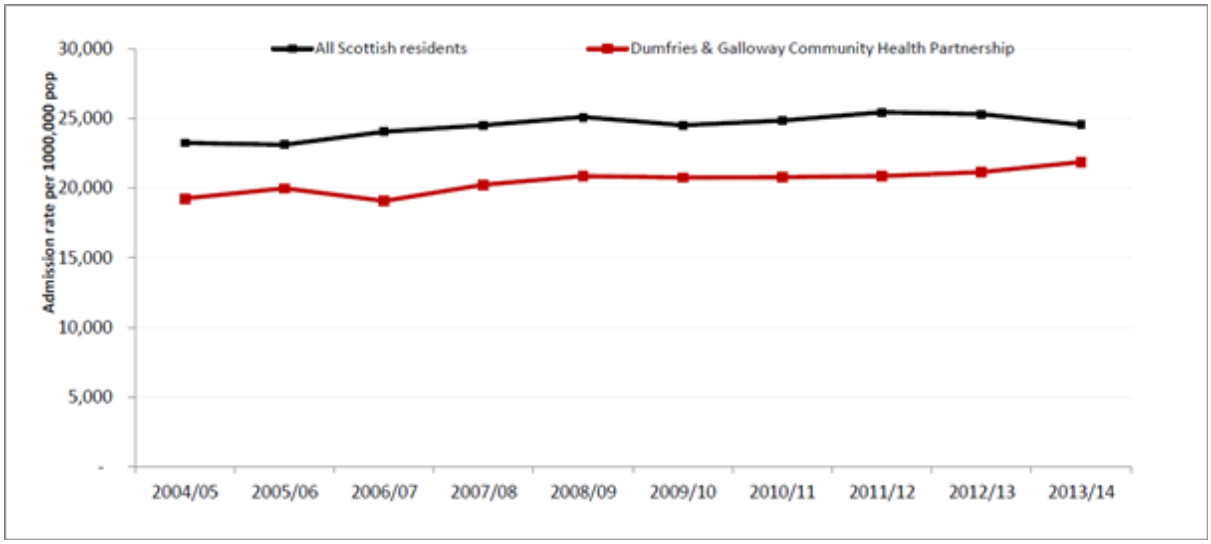
What happens next?

We will ask the Dumfries and Galloway Partnership to produce a joint action plan detailing how it will implement each of our recommendations. The Care Inspectorate's 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/

October 2016

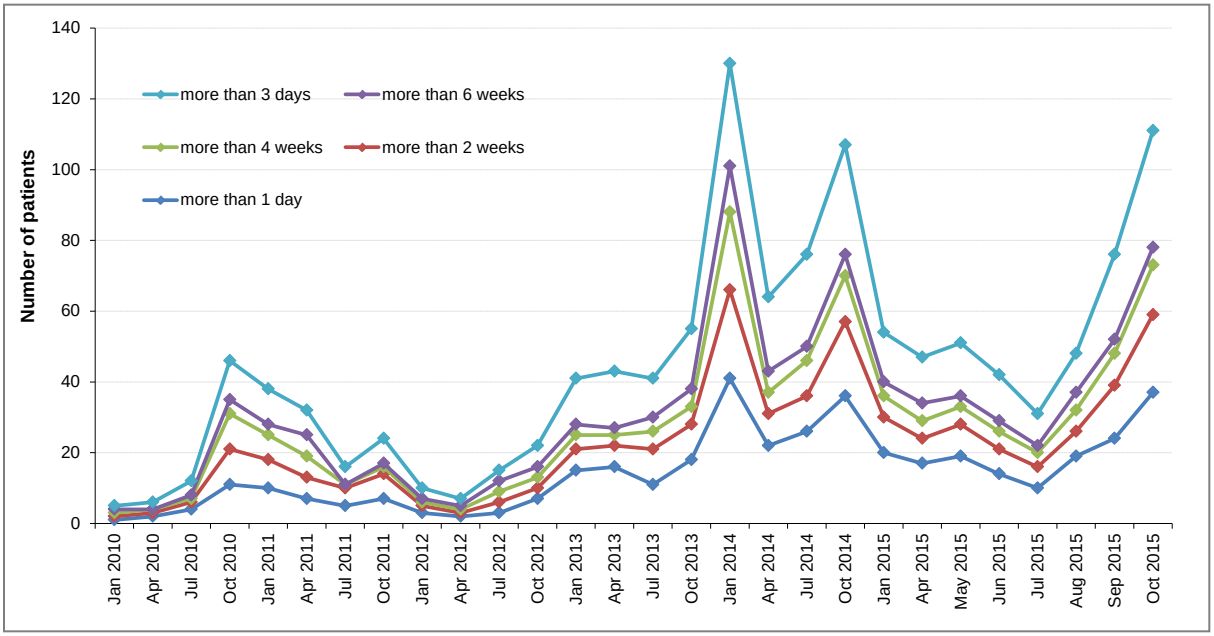
Appendix 1 – Statistical charts

Figure 1: Emergency admissions, rate per 1,000 populations aged over 65 years, 2004–2014 (Dumfries and Galloway and Scotland)



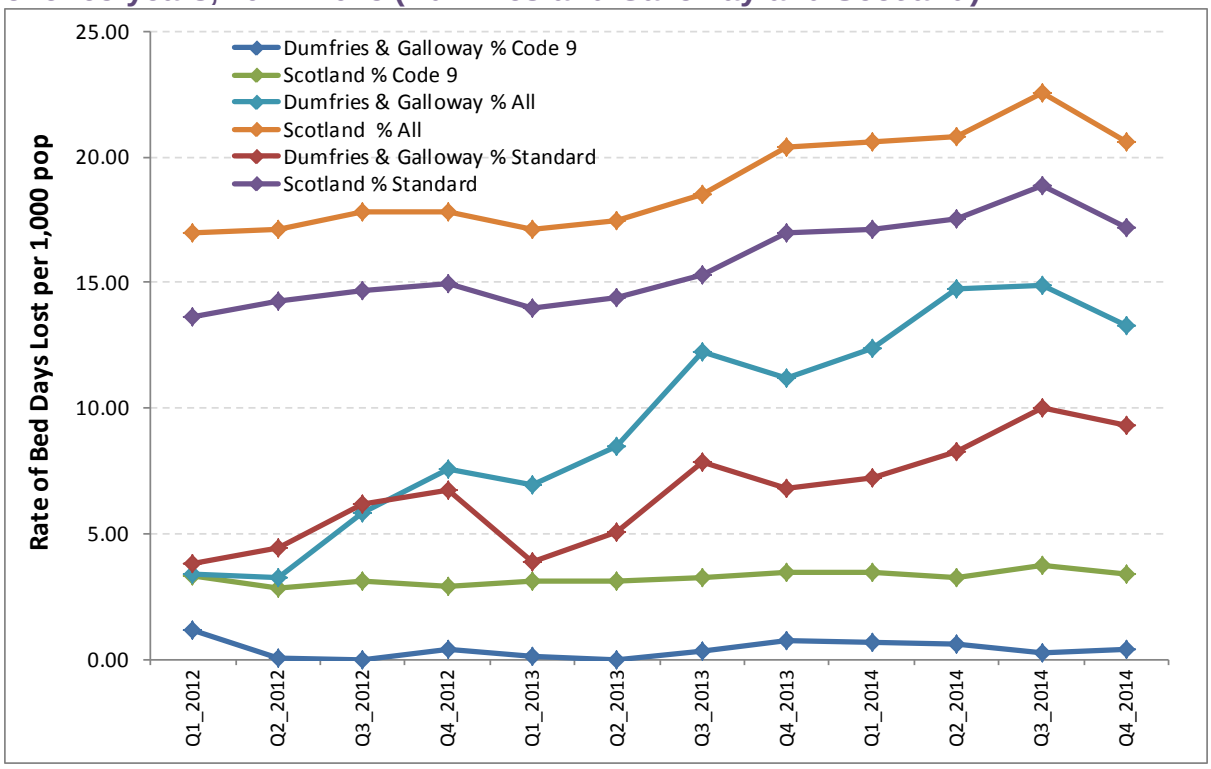
Source: Information Services Division

Figure 2: Numbers of Dumfries and Galloway delayed discharges by length of delay/performance against Scottish Government targets 2010–2015



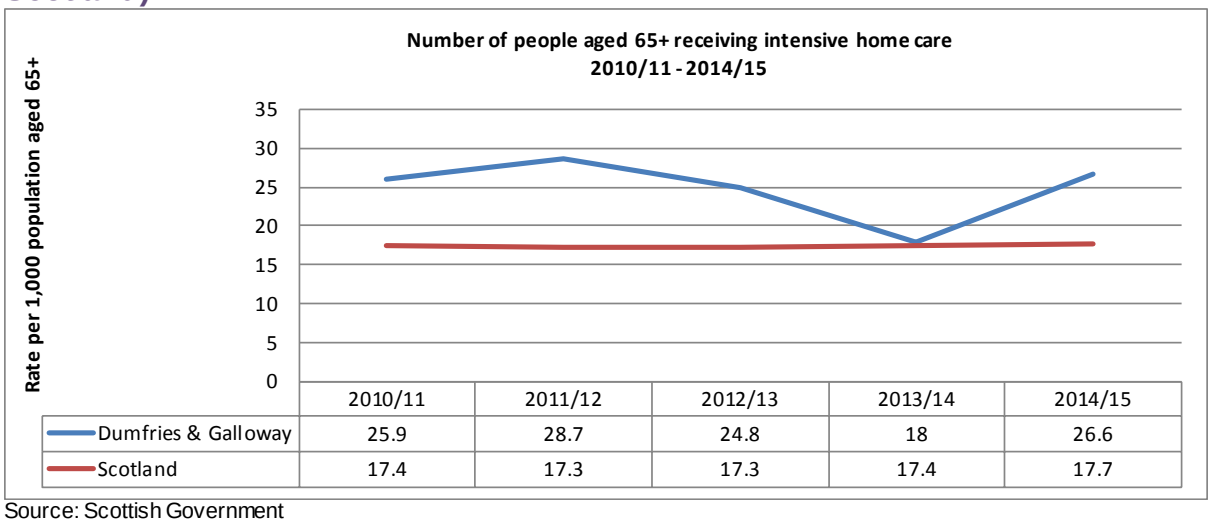
Source: Information Services Division

Figure 3: Bed days lost to delayed discharge, rate per 1,000 population aged over 65 years, 2012–2015 (Dumfries and Galloway and Scotland)



Source: Information services Division

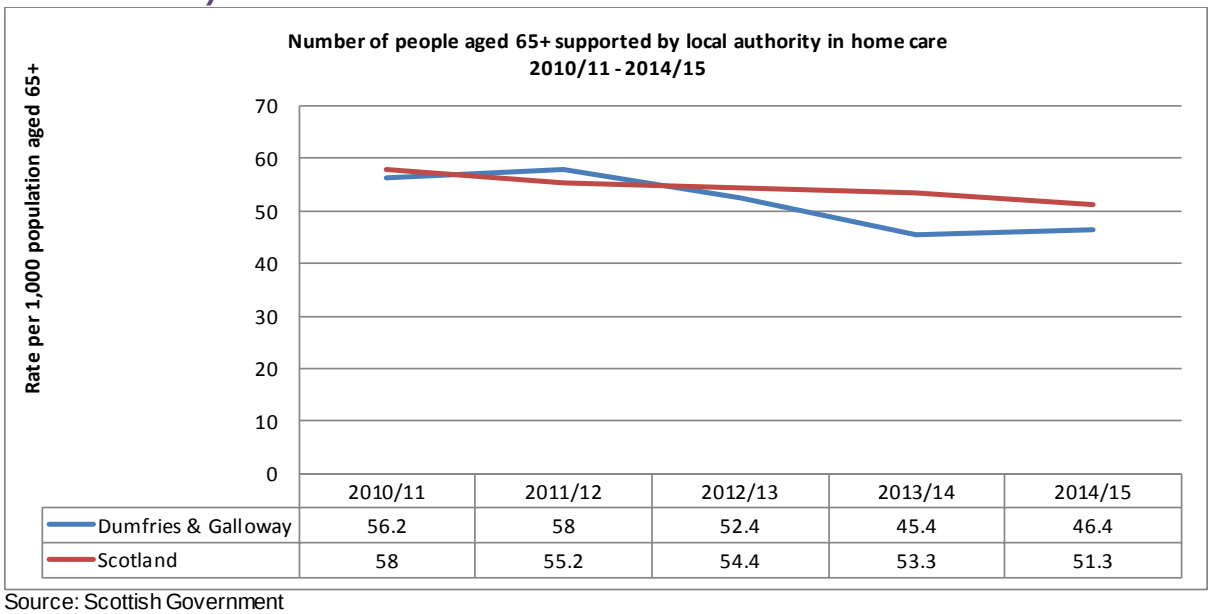
Figure 4: Number of people receiving intensive home care, rate per 1,000 population aged over 65 years, 2010–2015 (Dumfries and Galloway and Scotland)



	2010/11	2011/12	2012/13	2013/14	2014/15
Dumfries & Galloway	25.9	28.7	24.8	18	26.6
Scotland	17.4	17.3	17.3	17.4	17.7

Source: Scottish Government

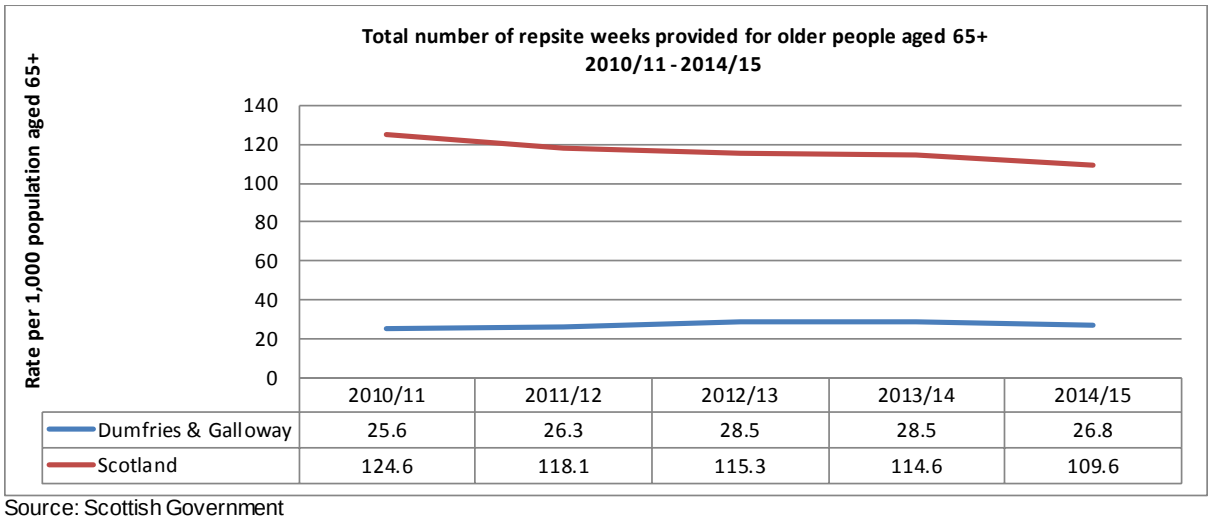
Figure 5: Permanent residents (aged over 65 years) of care homes supported by councils, (rate per 1,000 population), 2010–2015 (Dumfries and Galloway and Scotland)



	2010/11	2011/12	2012/13	2013/14	2014/15
Dumfries & Galloway	56.2	58	52.4	45.4	46.4
Scotland	58	55.2	54.4	53.3	51.3

Source: Scottish Government

Figure 6: Total number of respite weeks provided per 1,000 population aged 65+ in all 32 Scottish local authorities and Scotland in 2014/15.



	2010/11	2011/12	2012/13	2013/14	2014/15
Dumfries & Galloway	25.6	26.3	28.5	28.5	26.8
Scotland	124.6	118.1	115.3	114.6	109.6

Source: Scottish Government

Appendix 2 - Quality indicators

<table>
<tr><th>What key outcomes have we achieved?</th><th>How well do we jointly meet the needs of our stakeholders through person-centred approaches?</th><th>How good is our joint delivery of services?</th><th>How good is our management of whole systems in partnership?</th><th>How good is our leadership?</th></tr>
<tr><td>1. Key performance outcomes</td><td>2. Getting help at the right time</td><td>5. Delivery of key processes</td><td>6. Policy development and plans to support improvement in service</td><td>9. Leadership and direction that promotes partnership</td></tr>
<tr><td rowspan="6">1.1 Improvements in partnership performance in both healthcare and social care

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

2.2 Prevention, early identification and intervention at the right time

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

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

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

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

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

6.3 Quality assurance, self-evaluation and improvement

6.4 Involving individuals who use services, carers and other stakeholders

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

9.2 Leadership of strategy and direction

9.3 Leadership of people across the Partnership

9.4 Leadership of change and improvement</td></tr>
<tr><td>3. Impact on staff</td><td>7. Management and support of staff</td><td>10. Capacity for improvement</td></tr>
<tr><td>3.1 Staff motivation and support</td><td>7.1 Recruitment and retention

7.2 Deployment, joint working and team work

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

8.2 Information systems

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