



Services for older people in Scottish Borders

September 2017

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

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Report of a joint inspection

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1. About this inspection

Background

From October 2016 until February 2017, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services for older people in the Scottish Borders.

The Scottish Borders Health and Social Care Partnership includes Scottish Borders Council and NHS Borders and is referred to as ‘the partnership’ throughout this document. In the Scottish Borders, social work services, most community health and acute hospital services are delivered by the council and NHS Borders.

Scottish Borders Council has also established an Arm’s Length External Organisation (ALEO), which is called SB Cares. This organisation manages the majority of the council’s adult social care provision including care at home, residential care homes, day services, community alarm service and joint equipment store. SB Cares is a Limited Liability Partnership which is wholly owned by the council.

The purpose of the joint inspection was to find out how well the partnership delivered good personal outcomes for older people and their unpaid carers¹. 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 place
- deliver high quality services to older people
- support older people to be as independent, safe and healthy as possible and have a good sense of wellbeing.

We hope that this report is useful for the Integration Joint Board (IJB)² and the partnership as they continue to improve health and social work support available for older people living in the Scottish Borders. As with other partnerships across Scotland, many of the changes introduced as part of the integration agenda were at too early a stage to show impact, although they will provide the building blocks to help address the areas for improvement set out in this report.

Our joint inspection involved meeting 95 older people and carers who cared for older people, and almost 300 staff from health and social work services, the third sector³ and the independent sector. One thousand, one hundred and twenty-eight staff were asked to complete our staff survey with 376 responding (33%). We are very grateful to all of the people who spoke with us during this inspection. We also considered a range of documentation submitted by the partnership.

¹ In this report when we refer to carers this means unpaid carers.

² Integration Joint Boards are legally responsible for the effective delivery of a large range of health and social care services since April 2016. The memberships of the IJB is largely prescribed by the Scottish Government in terms of numbers and the organisations they represent.

³ The third sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

2. The Scottish Borders context

The Scottish Borders area is 4,732 square kilometres (1,827 square miles) located in the south east of Scotland. It has Edinburgh and the Lothians to the north, Northumberland to the south and Dumfries and Galloway to the west.

Scottish Borders is a rural local authority where 30% of the population lives in settlements of fewer than 500 people or in isolated hamlets. The largest town is Hawick which had a population of 13,888 in 2015, followed by Galashiels, with 12,528. The only other towns with a population of over 5,000 people are Peebles, Kelso and Selkirk.

Scottish Borders is the seventh most rural local authority in Scotland and the fourth most rural mainland local authority area after Highland, Argyll & Bute and Dumfries & Galloway. There are significant differences within localities as well as between them. All localities record areas of high poverty alongside areas of relative affluence with pockets of persistent deprivation, particularly in the largest towns of Hawick and Galashiels. At the time of the inspection, the partnership was about to reorganise its services based on localities and clusters.

According to the National Records of Scotland (NRS) 2015 Mid Year Population Estimates, the Scottish Borders had an estimated population of 114,030. NRS projects a 2.7% increase in population for Scottish Borders between 2014 and 2039, lower than the Scotland average. It is projected that there will be an increase of 27.9% in over 65 year olds in the population in the next 25 years, just marginally lower than the national increase.

Working age people aged 16-64 years make up 60% of the Scottish Borders population, which is already below the Scotland average. The same NRS data estimates a decrease of 7.4% in the number of working age people in the Scottish Borders in the next 25 years, in contrast to a national increase of 1.2%. This projected imbalance in the population will make caring for older people very challenging with lower proportions of younger people and working age people than are needed to support the ageing population in the traditional way.

The number and proportion of over 75s is projected to experience the highest rate of increase of all age groups. It is estimated that there will be an increase of 89.5% in the number of over 75 year olds in the next 25 years in Scottish Borders, higher than the equivalent national figure of 85.4%. More people are likely to be living longer with long-term conditions including dementia, disabilities and complex needs. The uneven age distribution is more acute in the Scottish Borders than many other areas hence the partnership's focus on developing appropriate services.

The Scottish Borders Community Planning Partnership's 2016 Strategic Assessment is aligned to 16 National Outcomes with key drivers falling into five themes:

- Economy and Income: realising our economic potential
- Education and Learning: enabling young people to be better educated and more successful in life
- Life Stages/Health and Wellbeing: tackling inequalities, supporting children and older people, improving life chances for vulnerable groups
- Community and Environment: enabling resilient, safe and attractive communities
- Continually improving and responsive public services⁴ .

Both the demographic and geographic challenges in the Scottish Borders will have implications on the costs of providing services to the council. There are an estimated 12,500 adult carers in the Scottish Borders, 18% of whom are aged 70 and over. It is expected that the numbers of carers will rise due to the increasing population, the increasing elderly population and more people living with disabilities.

⁴ 2015 NRS SAPE, the 2014- based NRS population Projections, the Joint Strategic Assessment 2016

3. How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (Appendix 1). Our findings on the partnership's performance against the nine quality indicators are detailed on page 6. 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 inspectors⁵ 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 partners⁶ on most of our inspections.

Our inspection process

Phase 1 – Planning and information gathering

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

Phase 2 – Scoping and scrutiny

The inspection team looks at a random sample of health and social work records for 100 people to assess how well the partnership delivers positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny consists 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 an inspection report. This includes evaluations against the quality indicators, any examples of good practice and any recommendations for improvement. We have reviewed the report format and have made some changes to the format from the previous inspections for this, and subsequent reports. The main changes are to ensure that the key messages from the inspection are clearly highlighted at the start of the report and to reduce the number of sections contained within the report.

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

⁵ Experienced professionals from local authorities seconded to joint inspection teams.

⁶ 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.

4. Evaluations and recommendations

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

We assessed the 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 outcomes for older people and 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 the right help at the right time	Adequate	
3	Impact on staff	Adequate	
4	Impact on the community	Good	
5	Delivery of key processes	Weak	
6	Strategic planning and plans to improve services	Weak	
7	Management and support of staff	Adequate	
8	Partnership working	Adequate	
9	Leadership and direction	Weak	

Recommendations for improvement	
1	The partnership should deliver more effective consultation and engagement with stakeholders on its vision, service redesign and key stages of its transformational change.
2	The partnership should ensure its revised governance framework provides more effective performance reporting and an increased pace of change.
3	The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.
4	The partnership should review its delivery of care at home, care home and intermediate care services to better support a shift in the balance of care towards more community based support.
5	The partnership should update its carers strategy to have a clear focus on how carers are identified and have their needs assessed and met. The partnership should monitor and review performance in this area.
6	The partnership should ensure that people with dementia receive access to a timely diagnosis.
7	The partnership should take action to provide equitable access to community alarm response services for older people.
8	The partnership should provide stronger accountability and governance of its transformational change programme. It should ensure that: <ul style="list-style-type: none"> • progress of the strategic plan priorities are measured and evaluated • service performance and financial monitoring are linked • locality planning is implemented and leads to changes at a local level • independent needs assessment activity is included in the joint strategic needs assessment • there is appropriate oversight of procurement and commissioning work • a market facilitation strategy is developed and implemented.
9	The Integration Joint Board should develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved.
10	The partnership should ensure that there are clear pathways for accessing services and that eligibility criteria are consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.
11	The partnership should work together with the critical services oversight group and adult protection committee to ensure that:

	<ul style="list-style-type: none"> • risk assessments and risk management plans are completed where required • quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve • improvement activity resulting from quality assurance processes is well governed.
12	<p>The partnership should develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.</p>
13	<p>The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and providing a skills mix that delivers high quality services.</p>

5. Key messages

The partnership had experienced significant personnel changes at a senior level. There were numerous interim posts and appointments throughout the partnership as a result. However, most stakeholders said that recent appointments were starting to make a positive impact. Whilst there was a growing sense of optimism, confidence and motivation about the partnership's ability to lead change and make the necessary improvements, real progress was at an early stage. The partnership needed to use this momentum to accelerate progress in the areas of practice we identify in this report.

Despite some positive early work in respect of health and social care integration, the partnership's vision had not been communicated effectively to all stakeholders. Restructuring had created uncertainty across some areas, particularly mental health older adult services. Many staff were anxious about what the changes would mean for them and for their services. Leaders were visible in taking forward some key developments such as community-led support⁷ and Buurtzorg⁸. However, more visible leadership and effective communication regarding the wider vision and reasons for change was needed to keep staff motivated and engaged throughout this period of transition.

We found significant weaknesses in assessment and in particular risk management of adult protection and other complex case work. Processes to identify and protect adults at risk of harm needed to improve significantly. Adult support and protection quality assurance, self-evaluation and performance frameworks all required updating. The partnership needs to work closely with the Adult Protection Committee to ensure more robust quality assurance approaches are in place.

The partnership had longstanding governance arrangements in place for the integration of health and social care but had recently reviewed them. There was a need to embed the new governance framework, improve the use of data, update or complete key strategies and commission work across the whole system more coherently. Becoming more efficient in this way will help the partnership to more effectively track progress and to meet the significant financial challenge to the long-term sustainability of the partnership.

People generally valued the services they received, which were usually of good quality. It was clear services did make a positive difference to their lives. However, many older people and carers were unable to get help unless their needs were deemed critical. It was not uncommon for older people to wait for lengthy periods before getting the support they needed, including assessment and equipment. The partnership recognised that demand for services was increasing and had taken some positive measures to address this, including participation in national pilot schemes. These initiatives were at an early stage.

⁷ Community-led support is an 18 month collaboration between the Scottish Borders and the national Development Team for inclusion (NDTi). This work focusses on planning, designing, implementing and evaluating services designed by practitioners and members of the community they served.

⁸ Buurtzorg is an approach that builds relationships with people to make informed-decisions about their own care which promotes wellbeing and independence with active involvement of family, neighbours and the wider community, where appropriate.

The partnership had invested substantial funds in developing innovative pilots in localities but it was often unclear why projects were being continued or ended. To address this the partnership intended to allocate the Integrated Care Fund (ICF)⁹ and Social Care Fund on a more strategic basis in the future. This included the executive management team taking direct responsibility for all ICF applications and more carefully linking them to strategic priorities through a transformation programme model.

Morale varied across services though most staff reported feeling valued and well supported by their immediate line managers. With a few exceptions, most had good access to learning and development opportunities and were highly committed to better joint working and the possibilities afforded by integration.

⁹ ICF funding was made available by the Scottish Government to health and social care partnerships in 2015-16. This was to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen our approach to tackling inequalities.

6. Leadership

This section considers the vision, values and culture within the partnership. It discusses how joint strategic leadership influences governance arrangements, the promotion of partnership working and its capacity to improve.

We evaluated the leadership provided by the partnership as weak. Whilst the partnership's vision was articulated in key strategic documents and shared by the executive management team, it had not been clearly communicated to all stakeholders, who, as a result did not share the same level of ownership. A new management team had formed and we were confident about their commitment to engage stakeholders in future partnership initiatives. They had taken forward work to strengthen both their governance framework and strategic and planning delivery groups. The new management team needed to ensure these revised processes supported the significant change required. Much work was still required to complete key strategies. The Integration Joint Board and the Strategic Planning Group needed to be used more effectively in the planning of services. More focus and investment was needed to achieve sustainable prevention and early intervention services. A range of initiatives developed locally was achieving positive results but a more strategic 'whole system' approach was required to ensure better outcomes were achieved for older people and their carers across the Scottish Borders.

Vision, values and culture across the partnership

At the time of our inspection the partnership was in a period of transformation. There were some key changes to senior management, including the Chief Officer leaving the partnership early in our inspection to take up a post in another area. The partnership quickly took steps to mitigate the risks associated with the loss of such a key role.

The Scottish Borders Partnership's Strategic Plan 2016¹⁰ was helpfully linked to the Community Planning Partnership's (CPP) vision including the Inequalities Action Plan¹¹. The partnership's vision was based on "*working together for the best possible wellbeing in our communities*" which were threaded through all its key strategies.

Leaders of health and social work services collectively understood the need for change in the strategic delivery of older people's services. They had identified many of the future challenges in delivering integrated services for older people. The partnership had made efforts to communicate its vision for health and social care integration to people who use health and social care services, staff and the wider public. However, this had not been communicated as effectively as it could have been as some staff and other stakeholders were uncertain about the vision and key issues impacting on them. Only 40% of those responding to our staff survey agreed

¹⁰ Scottish Borders Health and Social Care partnership, Changing Health and Social care for You, Strategic Plan 2016-19

¹¹ Reducing Inequalities in the Scottish Borders 2015-2020 Strategic Plan.

there was a clear vision for older people's services although social care staff results were proportionately more positive in this particular area. Integration Joint Board members were also unclear and did not fully understand the vision for integration.

It was not surprising then that less than half of responses in our staff survey were positive in respect of the extent to which the vision for older people's services was set out in comprehensive joint strategic plans, strategic objectives with measurable targets and timescales. Additionally, less than a third of staff agreed that their views had been taken into account when planning. As a result there was a lack ownership of the vision.

The locality plans were in draft form and senior managers acknowledged that they needed to go beyond planning to the implementation stage. While reports were being prepared for the IJB outlining proposals to make this step change, the partnership still had much work to undertake to both communicate and deliver their vision.

Recommendation for improvement 1

The partnership should deliver more effective consultation and engagement with stakeholders on its vision, service redesign and key stages of its transformational change

Partnership working

The partnership recognised the importance of prevention and early intervention and acknowledged it had been slow in the development of such services. Some senior managers were relatively new in post as a result of staff moving on or retiring. There were early indications that partners were starting to work more effectively together to shape services, such as introducing a performance reporting framework, a revised governance framework and locality planning process. The interim chief officer, alongside the IJB members and executive management team, was forging closer working relationships and further developing a shared vision. Good progress had recently been made to the realignment of management team structures. Providing this progress is sustained, these should allow the partnership to move forward effectively in an integrated way.

Additional work was needed to more meaningfully use the Strategic Planning Group and IJB. These were key partners to the parent bodies (health and social work) and both groups expressed views about a lack of progress. However, these groups felt that early challenges, which we describe later in this report, were being overcome and that they were now in a better position to drive the integrated work forward more coherently than in the past.

The majority of staff in both health and social work services had positive and constructive professional relationships with each other. Most staff said that joint working was supported and encouraged by managers. In addition, 66% of staff told us that there were positive working relationships between staff at all levels, indicating

the partnership were succeeding in promoting a joint working culture across services.

Governance

Both the IJB and executive management team acknowledged that there had been too much focus on getting health and social care governance and accountability structures in place. This had been at the cost of progressing other key strategic planning activity. This was reflected in the significant number of strategic documents that needed to be refreshed, which we highlight throughout this report.

A number of governance models had been put in place during integration. The partnership presented its most recent arrangements to the IJB during our inspection. This model looked robust and had the potential to address the frustration that many stakeholders told us during the inspection when they described the previous challenges of getting strategies approved and the length of time it took. However, it was too early for us to assess the impact this new approach was having on delivering the partnership's key business objectives.

Integration Joint Board members acknowledged that they need to further develop their understanding of integrated services. Briefings and training opportunities had supported board members and they were confident that future members would also be supported to take up their roles.

As discussed later in this report, IJB members estimated that they were about one year behind where they wanted to be. However, they had expressed renewed confidence in themselves, the interim chief officer and extended management team. The leaders of the partnership were unanimously optimistic about developing and achieving their strategic plans. Whilst we welcomed this, much of the positivity was focussed on certain individuals or posts within the partnership. We acknowledge that we could see green shoots of a more collective and sustainable approach which will be required to continue driving change forward in the future.

Both social work services and NHS Borders had clinical and care governance arrangements that were measuring delivery against indicators, targets and improvement plans. The partnership brought together elements from previously established quality assurance models rather than following a single framework. Integration Joint Board performance reporting arrangements required to be further developed. The partnership was confident this would be strengthened through the new governance arrangements. At IJB meetings, the emphasis had been on financial monitoring with no links to service performance. The recently developed performance framework reporting to the IJB provided the partnership with an opportunity to address this.

Recommendation for improvement 2

The partnership should ensure its revised governance framework provides more effective performance reporting and an increased pace of change.

7. Outcomes and experiences

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

Improvements in partnership performance in both healthcare and social care

The partnership's performance in ensuring positive experiences and improving outcomes for older people was adequate. We reviewed performance based on a review against key national outcomes or proxy outcome performance indicators. The rates for emergency admissions and multiple emergency admissions were broadly in line with the national average. However, bed days occupied by delayed discharges and, more significantly, the rate of bed use following emergency admissions of older people in the Scottish Borders were better than the Scotland average. While these were positive indicators, a few older people had their discharge from hospital delayed because of a lack of appropriate support for them returning home, or because of a lack of care home placements. A few older people experienced poorly planned discharges, some outside normal service hours, where there was a lack of communication between key agencies. Sometimes this contributed to poor outcomes for individuals, including, on occasion readmission to hospital. The partnership had developed some new and positive initiatives such as ward huddles and weekly discharge meetings, the result of which was that delayed discharges from hospital were being more consistently addressed. Carers often found it difficult to access support such as respite to help them continue in their caring role. Overall, older people and carers experienced long waits for assessment and intervention. However, when they did get services, these were generally valued and they made a positive impact on the person's life.

Admissions to, and discharge from, hospital

The partnership's rate of emergency admissions and multiple emergency admissions to hospital for older people had been stable and performing at comparable levels to the Scotland average for several years. More positively, bed days occupied due to delayed discharges was below the Scotland average and the rate of emergency admission bed day use in hospital by older people was amongst the lowest in Scotland. Whilst these indicated that the partnership was discharging people from hospital promptly, some older people told us that their hospital admission and discharge was not a positive experience. For example, some older people, carers and staff told us about poorly planned and co-ordinated discharges late at night or at weekends. This led to a lack of appropriate services upon discharge or in some occasions older people needing to be readmitted to hospital again a few days later.

The Scottish Government's 2015/16 Health and Care Experience Survey¹² of the Scottish Borders indicated that:

- older people in hospital needed to be more involved in decisions about leaving hospital
- older people in hospital were not always clear about who to contact if they had any questions after leaving hospital
- older people in hospital were not always clear about the danger signs to watch for when they left hospital.

Overall, the partnership was meeting and exceeding some key Scottish Government performance indicators such as emergency and multiple emergency admissions, bed days occupied by delayed discharges. Nonetheless, the partnership recognised from this survey that further work was needed to continue improving the personal outcomes for people admitted and discharged from hospital care. The partnership had commissioned an external consultant to support them to continue to improve experiences for older people being admitted and discharged from the hospital, from and back into their community.

As mentioned earlier in this report, the partnership was performing well in respect of bed days lost to delayed discharges but like elsewhere in Scotland was not consistently meeting targets set in respect of delayed discharges. The most common reasons for delayed discharges included lack of care at home provision and a lack of residential and nursing care placements, particularly where people were expressing preferences. In response, the partnership was promoting the 'choice protocol' and had initiated a range of measures, joint daily reviews, ward huddles on key inpatient wards, weekly multi-agency operational meetings and a tracker system designed to mentor people at risk of becoming delayed discharges. The NHS Borders Winter Plan 2016/17 stated they would continue to use surge beds¹³ in both the Borders General Hospital and the Knoll Community Hospital to help relieve pressure on hospital beds. Whilst these were interesting joint initiatives, there was no evidence yet of sustained positive impact.

In September 2016, NHS Information Services Division data showed that code nine¹⁴ specific delayed discharges, which are typically the most complex cases to discharge from hospital, made up 23% of the total number of delays in the Scottish Borders. This was in line with the national average, indicating that hospital discharges for this population were being adequately achieved.

¹² Health and Care Experience Survey 2015/16. Results for Scottish Borders Health and Social Care Partnership.

¹³ Winter plans are submitted to the Scottish Government each year to ensure that health and social care services provide safe and effective care for people using services. They ensure effective levels of capacity and funding are in place to meet additional challenges that are faced at winter time including beds in hospital being made available for this purpose – "surge beds".

¹⁴ Code nine delayed discharges are mainly due to patients who lack capacity and require powers from a court to move them from an acute bed to a care home. Code nine delays can be due to the need to secure a specialist health resource for a patient.

The partnership was positively revising key policies in relation to legislation that protects people who are not able to make decisions about their own care. Mental health officers, who play a critical role in respect of the above, were undertaking positive awareness raising work at the Borders General Hospital and were working collaboratively with inpatient colleagues.

A number of different joint teams had been established to speed up hospital discharge and provide an improved link between acute and community services. These included the Rapid Assessment and Discharge Team, Short-Term Assessment and Reablement Team and Older People Liaison Team. However, a lack of understanding among staff about each other's roles and respective pathways between services led to an overall lack of co-ordinated planning and support for hospital discharges. These teams had the potential to facilitate hospital discharges but clarity about roles and pathways needed to be clearly established.

There was a range of community services available to support older people at home that could help to avoid a hospital admission or support timely discharge. However, the partnership acknowledged more work was required to build on services, focussing on intermediate care, reablement, hospital at home and other preventative and early intervention services.

Recommendation for improvement 3

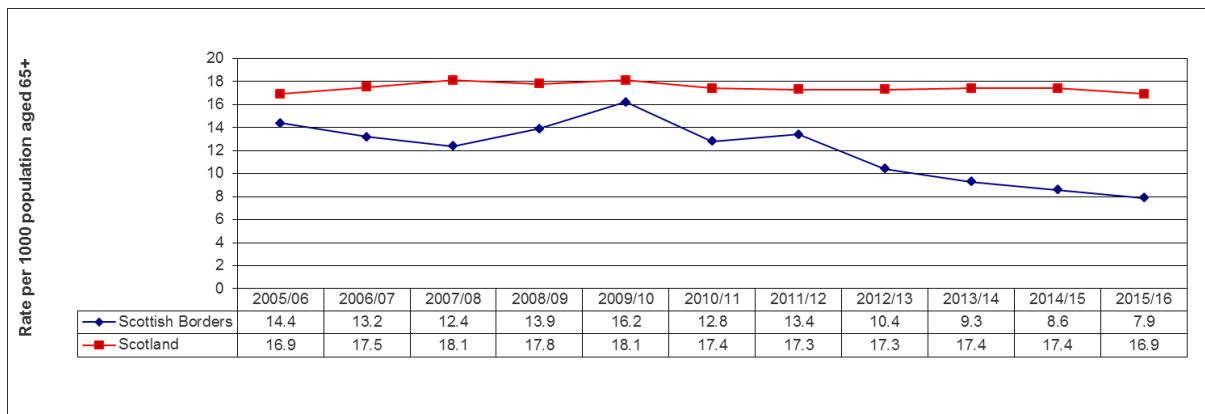
The partnership should further develop and implement its joint approach to early intervention and prevention services so that it continues to improve the range of services working together that support older people to remain at home and help avoid hospital admission.

Care at home

Providing sufficient and flexible care at home provision is essential in achieving a shift in the balance of care from hospital and care home settings, and to ensuring that older people remain in their own homes, safely and for as long as possible. Nationally there has been a downward trend in the numbers of older people aged over 65 years receiving care at home. This is partly because of challenges of recruitment and retention of staff to care at home services, but also because care at home is increasingly targeted towards supporting people with more complex needs. This means that a smaller number of people are getting more hours of support to meet their needs.

Within Scottish Borders, provision of intensive care at home (people aged 65 and over, receiving 10+ hrs of home care) was below the Scotland average and continuing to decrease (Figure 1 below). A few older people were not accessing the intensive levels of services they needed. More work was needed to ensure care was in fact being targeted at those with the most complex needs.

Figure 1; the number of people receiving intensive home care (10+ hours per week) between 2006/06 and 2015/16 in the Scottish Borders and Scotland as a rate per 1,000 65+ population.



Source: Scottish Government Social Care Survey

The partnership had recently awarded a contract for a new care at home service aimed at increasing capacity, quality and choice. The partnership recognised care at home recruitment was a challenge in parts of the Scottish Borders. The introduction of the £8.45 Scottish living wage had been a helpful factor in increasing the number of providers available. SB Cares was the largest provider and the partnership recognised the need to further stimulate and develop the market to increase choice and enhance care at home availability.

Sometimes older people experienced a lack of consistency of care, with a high number of different paid carers supporting them. Scrutiny by the Care Inspectorate shows that the number of carers attending to support an individual could be as many as 24 in a three month period although it was clear that recipients of care were treated with dignity regardless of who provided the care. In common with other rural partnerships, the lack of care at home capacity was a major theme throughout our inspection, particularly in Tweeddale and Berwickshire. This had a negative impact directly on the experience and outcomes for older people and their carers.

There were more people in Scottish Borders in receipt of self-directed support direct payments than the Scotland average. In 2016, 270 people in Scottish Borders received direct payments, a 23% increase from 2015. (There were also more individuals waiting to be reviewed before being put on the list which would enhance this performance further.) Scotland overall saw an increase of 17%. Of those 270 people, 150 (56%) were aged 65 years or over, also significantly higher than the national figure of 38%. The total value of the self-directed support (direct payments) in the Scottish Borders was £2m over half received by older people.

Self-directed support was offered to older people in 70 of the 84 applicable health and social work records we read. We could see that assessment tools were in use to promote this approach. Some older people we met used self-directed support flexibly to remain in their own homes when other care provision options were not available. The partnership had commissioned Encompass, a local user led organisation that supported people to manage their direct payments. They were

undertaking an important supporting role and had supported 467 people of whom 117 were older people.

Overall, we found that the partnership was fully committed to resourcing and continuing to implement this person-centred approach across its older people's services.

Care homes

Over the last decade the number of residents in care homes for older people in the Scottish Borders had reduced by 16%. This was higher than the national decrease of 9%. The partnership had decommissioned beds and was appropriately investing in some alternative models of care, particularly housing with care across the Scottish Borders. To date there was one development in the Peebles locality with plans for at least four more developments, one in each of the localities. While we recognised that this represented progress, the decommissioning and commissioning strategies were not fully aligned with gaps still evident in the provision of care home beds for older people with complex care needs and or specialist dementia care needs.

Information, support and choice of care homes providing specialist dementia care was limited. A number of care homes registered to take people with nursing needs were seeking registration amendments from the Care Inspectorate to allow for more enhanced models of care because of difficulties recruiting qualified nurses. To address this, the partnership was working with providers of care home services to review the needs of existing residents and reassess the level of nursing care needed. It was too early to assess the impact of this work.

Some consultants told us that as a result of the diminishing care home nursing provision, hospital admissions from care homes had risen. An existing specialist psychiatric liaison nursing team had been in place for seven years to support the care home sector and had been valued by the care home sector. The partnership was considering how to build on this service.

The Care Inspectorate inspects registered social care services delivered by local authorities, the third and independent sectors. It evaluates the quality of care and support, the environment, staffing, and management and leadership. Registered services include care homes, housing support services and other support services for older people, such as care at home and day care services. At the time of inspection, regulated services were generally performing well across sectors and provision types and achieving positive grades. The care homes inspected were run by SB Cares, third and independent sector providers. Most were receiving good grades in the quality of care and support, the environment, staffing and management and leadership. Most third sector care at home services were achieving good or better grades across all four indicators.

Recommendation for improvement 4

The partnership should review its delivery of care at home, care home and intermediate care services to better support a shift in the balance of care towards more community based support.

Improvements in outcomes for individuals and carers in health, wellbeing, and quality of life

Older people's circumstances and personal outcomes had improved as a result of the services they received in almost all of the 100 health and social care files we read (93%). Usually this was about the older person living where they wanted (77%). The majority of files we read also indicated that the older person was helped to stay as well as they could (73%) and to feel safe (68%).

While there was evidence of good outcomes in almost all the files we read, just over a quarter of older people in our sample had also experienced one or more poor personal outcomes. The less positive areas we identified were similar to the areas of positive findings. For example, of these older people over half were not feeling as safe as they could (46%), not living where they wanted (31%) and some were not staying as well as they could (38%). This highlights a disparity amongst some older people's experiences of services which the partnership needs to address.

Overall, services worked hard to ensure mostly positive outcomes for older people. In cases where older people had experienced improved outcomes, just over half (56%) could be attributed to partnership working. While good progress was being made in this area, closer joint working could bring about further positive outcomes.

8. Providing the right help at the right time

In this section we consider whether older people and their carers had access to a full range of information. We also consider the partnership's approaches to early intervention and prevention. This includes its approach to reablement, intermediate care and support for self-management.

We evaluated how well the partnership provided the right help at the right time to older people as adequate. Although it was not always easy to get information about sources of help, the majority of older people knew where and who to contact for support. Once older people got access to services their experiences were mostly positive. Demand for care at home services outstripped supply, which had a significant knock-on effect in other parts of the system of care and support. There were a few positive initiatives and examples of innovation, such as the Transferring Care after Treatment Service and Cheviot Community Health Service but they only benefited some people in certain parts of the Scottish Borders. Although it was clear that the partnership understood the need to support carers' wellbeing, carers assessments were not being routinely completed. The provision of support, including respite care to help carers maintain their caring role, was not sufficient. The partnership had made some progress in the completion of anticipatory care plans but more work was needed. Services concerned with early intervention, telecare, long-term conditions, dementia, falls and reablement all had good examples of local activity being undertaken but lacked coherent strategies that linked them together.

Access to information

Although there were exceptions, the majority of older people and carers knew where to find information and who to contact if they wanted to access health and social work services. The websites of the Scottish Borders Council and NHS Borders as well as local community facilities also played an important role in providing public information about services. Older people and carers identified GP practices as being their primary source for accessing health services.

The council previously had a social work telephone contact service which dealt with approximately 150 enquiries a week for adult social work services leading to difficulties in allocating appropriately qualified officers to relevant calls. In order to better cover the workload and address queries, the decision was made to integrate the separate function into Customer Services and gradually remove qualified social worker and occupational therapist staff who were then deployed to local offices duties. However customer service staff retained immediate access to social work duty workers who could be contacted at any time for advice and assistance. The customer services department was under review in order to continue to revise and improve its processes which was prudent as we heard frustration from some staff about about how enquiries were addressed under this arrangement. Staff continued to handle enquiries in accordance with the processes and protocols agreed with social work staff meantime.

Experience of individuals and carers

In 2016, an NHS national inpatient experience survey¹⁵ took place which covered NHS Borders hospitals, in which 60% of respondents were older people. While responses were broadly positive and in some cases better than the Scotland average, some NHS Borders results were not as positive. This included views about nurse staffing levels and joint working around hospital discharge.

A separate national health and care experience survey¹⁶ was sent to 12,160 people registered to GP practices in Scottish Borders asking about experiences of GP practices, out-of-hours care and social care services. Two thousand nine hundred and seventy returned the feedback questionnaires of whom 48% were aged 65 or older. In almost all questions respondents were more positive when compared to the national average, in particular the extent to which people felt they had a say in how their help, care or support was provided and how safe people felt. These positive opinions about services were also reflected in the majority of views expressed by older people we met during the inspection.

Carers

Support to carers was promoted and delivered by a range of organisations, including Borders Voluntary Care Voice, Macmillan Cancer Care and the Borders Carer Centre. While carers and agencies representing them told us of their active involvement in consultation events, they were less sure about how their input helped to develop services. There were signs the partnership had some good foundations in place for effectively engaging with carers but more work needed to be done to demonstrate to carers how their views were actually influencing decisions.

The views of carers about access and overall care provided by GPs were positive. Carers told us that their own health needs were being addressed promptly and this was mostly attributed to information held at GP practices and GPs offering appointments at a time to suit them. Border Carers Centre also provided advice and support for carers and was valued by carers we met.

The partnership's Joint Carers' Strategy (2014-17)¹⁷ was being reviewed. The revised draft plan set out the priorities to support those who provided unpaid care and was supported by a range of services. The partnership was also appropriately targeting the issue of carer ill-health in the new Health Inequalities Plan and clearly linked this to their long-term conditions activity.

Less positively, our case file reading showed that less than half of identified carers had been offered an assessment or had been offered advocacy when they needed it.

¹⁵ The Inpatient Experience Survey is a postal survey with the aim of establishing the experience of a sample of adults who had a recent overnight hospital stay.

¹⁶ NHS Inpatient Experience Survey 2016. Results for NHS Borders.

¹⁷ Caring Together in the Scottish Borders, Joint Carers Strategy 2011-2015

Recommendation for improvement 5

The partnership should update its carers strategy to have a clear focus on how carers are identified and have their needs assessed and met. The partnership should monitor and review performance in this area.

The partnership's respite provision for older people and their carers was significantly below the Scotland average although we recognise that measuring like for like nationally is very challenging. This was particularly true for day time provision although respite trend information showed this gap was closing. The partnership did not have a clear understanding of how it recorded its respite provision and partners were not confident about the accuracy of the data they collected in respect of this provision.

Staff and carers were generally positive about the benefits of respite. However some described examples where older people were admitted to residential respite only for this to quickly break down, leading to hospital admission.

More positively viewed was the dementia daycare provision across the Scottish Borders which provided a number of therapeutic interventions. A review of this service was planned, the findings of which will be critical given the lack of specialist dementia care home beds and the pressure on the mental health older adult team's to deliver dementia support.

Prevention, early intervention and the intervention at the right time

The partnership's strategic plan focussed on promoting the shift in balance towards community support services. Services including reablement and pharmacy were in the process of being further developed through the Integrated Care Fund and the community-led support and Buurtzorg approaches were being positively designed. However, while services were developing, it was clear that the partnership had still not developed the range of accessible preventative and early intervention services required. There were strategic gaps around falls management, reablement, anticipatory care plans, telecare/telehealth and dementia services.

The partnership recognised that prevention and early intervention were areas for improvement and had commissioned an external consultant to undertake an independent evaluation of the delayed discharge processes including home to home pathways. This work was focussed on achieving better outcomes for older people. Early feedback from the consultant included several recommendations around the future role of community hospitals, care home services and care at home provision. A final report was due for submission to the partnership shortly after the inspection.

Prescription for Excellence in Pharmaceutical Care¹⁸ was driving a strategic review of the community pharmacy model including new ways of working in the Scottish Borders. The pharmacy service had made some encouraging progress to ensure it

¹⁸ Prescription for Excellence; A Vision and Action Plan for the Right Pharmaceutical Care Through Integrated Partnerships and Innovation. The Scottish Government.

developed safe medicines administration. For example, a medicine review service was available in 26 of the 28 community pharmacies across the Scottish Borders. Older people were invited to visit their local pharmacy to discuss and review their medication. This was positively received by some of the individuals we spoke to who said it was a valuable resource that provided support and reassurance to help them to self manage their medication. All GP practices had a link pharmacist who provided prescribing support as well as assisting GPs to identify and prioritise medicine reviews for targeted clinical groups of individuals on specific medication. An enhanced community pharmacy service had commenced in some care homes to provide advice and guidance on the safe storage, management and administration of medicines for residents. Although these were all promising initiatives, the partnership needed to develop a standardised approach to medicines management to ensure that older people who needed assistance with medication, received consistent support from staff. Pharmacists were supporting the finalisation of a Scottish Borders-wide medicines management policy.

Anticipatory care planning and end of life care

Anticipatory care plans (ACPs)¹⁹ support prevention, early identification and intervention at the right time. The partnership told us that GPs had used eKIS²⁰ to record the anticipatory care needs for approximately 5000 people. (We found that the partnership had made some good early progress in developing anticipatory care planning initiatives but this had not been consolidated.) A number of ACP initiatives had been taken, for example, in 2014 Change Fund monies had been used in one GP practice with evidence of positive outcomes including early supported hospital discharge. More recently a one year Scottish Government funded post to promote innovative GP practice had been introduced, linked to the frailty team and focussed on developing ACPs in Galashiels for older people with complex needs. Borders Emergency Care Service was also undertaking some realistic medicine²¹ work in Galashiels which was designed to put the older person receiving healthcare at the centre of decisions affecting them.

The partnership had an enhanced contract with GPs to develop ACPs in care homes but this work was at an early stage and only covered one care home at the time of inspection. The work was designed to complement the changes from nursing to enhanced care home provision. While the benefits for the partnership developing such approaches with GPs and care homes was clear, approaches to identify the impact of these changes in respect of outcomes for older people needed to be improved. The Diabetes Specialist Service also used ACPs in circumstances where there was a risk that symptom development could lead to an older person's readmission to hospital. These were stored in the out-of-hours service to ensure easy access if required.

¹⁹ An anticipatory care plan is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision-making.

²⁰ eKIS information is information held on GP practice electronic medical records and then made available to other healthcare professionals when this is appropriate to provide ongoing care.

²¹ Realistic medicine puts the person receiving health and care at the centre of decision-making and creates a personalised approach to their care.

ACPs were generally considered to be a role for district nurses working with older people receiving end of life care. There was no standardised documentation or clear mechanism for ensuring that other professionals involved in caring for individuals could access ACPs and the lack of pharmacy input remained an important issue to address. We saw only a small number of ACPs as part of our review of health and social care records and the quality varied widely. Those we did see could have been valuable tools for older people and their carers to set out their wishes and preferences if their health deteriorates or their circumstances change in other significant ways. Although in its infancy, the partnership had set up a multi-agency working group to support and improve the development of anticipatory care planning for older people. Links with the national improvement team in the iHUB²² were established and work was underway to upgrade electronic systems to enhance access and sharing of this important information.

The partnership had reviewed its strategic approach to palliative and end of life care. A comprehensive strategy outlining future service developments was in place to achieve more equitable access to palliative care services and address the low percentage of older people spending their last six months at home. The Margaret Kerr Unit is a resource based at the Borders General Hospital for people with highly specialised palliative care needs living in the Scottish Borders. It hosted a specialist cancer pharmacist who was working to develop support for palliative care patients, including a community pharmacist's network of shared expertise.

Example of good practice – Transferring Care After Treatment (TCAT)

The partnership had a close working relationship with the South East Scotland Cancer Network (SCAN) and had introduced the Transfer of Care After Treatment (TCAT) project which was piloted in four GP practices in Tweeddale. This was a multi-agency approach that demonstrated clear partnership working between health, council and third sector partners. It worked with individuals, including older people, post treatment and helped them to regain their confidence to self-manage their own care. The initial evaluation of this project produced some positive outcomes for those who engaged with the service. The service operates a reablement approach by providing a tailored one-to-one support plan based on what is important to their recovery, build up their emotional and physical strength and re-engage with friends and activities within their local communities. The Canadian Occupational Performance Measure (COPM) was used by OTs to set and measure individual outcomes as set by the individual. Most that we saw showed a good level of improvement and personal satisfaction.

The Fit Borders project was linked to a GP practice for people with a diagnosis of cancer to improve health and wellbeing through increased activity and encouragement for people to move more. Its reablement principles were similar to the transforming care after treatment programme. A Peebles GP was looking at encouraging movement and independence after treatment for cancer. This project

²² The Improvement Hub has been created to support those who are delivering integrated health and social care across Scotland including health and social care partnerships, third sector organisations, the independent care sector and housing organisations. The Improvement Hub also provides national improvement support for NHS boards.

and transforming care after treatment were being aligned to ensure shared learning.

Staff we met were committed to delivering person-centred and compassionate care and support for older people with palliative care needs. However, the limited capacity within district nursing teams, care at home and the Marie Curie service impacted on the extent to which staff were able to deliver this support when and where it was needed. Even some older people deemed as 'critical' under the council's eligibility criteria found it difficult to get the support at a time when it was most needed. Overnight care for people with end of life care needs was particularly problematic for those wishing to die at home.

Telecare/telehealth

There was no clear strategy and vision for telecare and telehealth services. The absence of a technology champion in the partnership seemed to have slowed progress. There had been a recent appointment to lead on aspects of this work but it was in the early stages of development. Bordercare provided a responder service but access was dependant on older people having their own nominated person who could respond in a crisis. There was a gap in service provision for people who did not have anyone to nominate. As a result we found that some older people were at risk of not being responded to appropriately. This is an issue we discuss in more detail later in this section under falls prevention and management.

Just Checking was an important telecare development managed through the council's social work service to help monitor an individual's movement within their own home. Resulting data was not being used as much as it could have been to inform assessment and care planning and there was no clear policy on this initiative's use. The Just Checking deployment relied largely on individual practitioners' judgement rather than being used as a standard tool for gathering important information across service areas, thus diminishing its potential impact.

There were also developments in health using initiatives called wardview and hospital view. These were both designed to extend information sharing across acute and community sectors and manage capacity in hospitals more efficiently. However, despite sound beginnings they did not effectively tie in to discharge planning or support a more joined up approach to care planning.

The partnership's ehealth strategy was described by staff as aspirational but not yet delivering on the ground. In addition pharmacy had no involvement with telecare or telehealth initiatives. A joint workstream was developing eHealth across the partnership but the membership of the group was not consistent and a proposed strategy had yet to be approved by the executive management team.

Self-management and the management of long-term conditions

There had been some good examples of work around long-term conditions but approaches were not as widely available or coherently developed as they could be.

The Long-Term Conditions Shared Management Project was established following a local needs assessment in 2013 and was designed to run over two years in Galashiels and Coldstream. It was led by the Public Health section of the Health and Social Care Partnership in collaboration with the Red Cross, district nurses and community pharmacy services. The project was based on the House of Care²³ model and was designed to empower older people to self manage their condition using individualised care plans. It involved two GP practices in the areas working in partnership with the Red Cross. The project had been formally evaluated and evidenced a 21% improvement in wellbeing for service users and 31% reduction in the need for contact in GP practices. But while positive feedback from GPs and good outcomes were evident from this project, there was no additional funding available to expand the approach across the partnership, meaning wider benefits to the community had not been achieved.

A pilot had been started for people diagnosed with Type 2 diabetes where they met with a psychologist regularly for six months. The focus of this collaborative intervention was on healthy eating education and subsidised exercise programmes but it was too early to measure the impact of this initiative. There was evidence the partnership had focused a lot of work on diabetes. Population profiling relating to Type 2 diabetes had been undertaken and work was ongoing to segment this into age groups.

Partners were confident that progress was being made to use public health expertise to tackle inequalities in the Borders. While there was no specific long-term conditions strategy, the draft locality plans were appropriately drawing on health inequality data and related project work. These provided a vehicle to design and deliver work on long-term conditions more cohesively.

Dementia support

Support for older people with dementia across Scottish Borders was inconsistent. Some hospital staff considered there to be clear pathways for the initial diagnosis of dementia and through care internally in the hospital and on to community services but this was not a view shared by all older people, their carers and community staff.

Dementia diagnosis was usually through the mental health older adult teams. Most assessments and diagnosis took place in the person's own home. While this was viewed positively by some older people and carers we met, the partnership lacked sufficient community-based clinics for people who were not being visited at home by their consultant. This would ensure greater equity of access across Scottish Borders. The partnership had identified both the diagnosis and the provision of post-diagnostic support as areas for improvement.

²³ The House of Care Model supports management of long-term conditions in a very different way. It recognises that we have to shift away from a way from the 'medical model' of illness towards a model of care which takes into account the expertise and resources of the people LTC's and their communities to provide an holistic approach to their lives and help them achieve the best outcomes possible.

Although the partnership was not yet meeting the Scottish Government's HEAT target²⁴, 91% of those diagnosed with dementia were receiving post-diagnostic support when they should have. The partnership had taken further steps to improve performance. For example, there was a joint review of the GP dementia diagnosis database and a pilot with the Selkirk GP practice which positively increased the number of diagnoses on the GP database by approximately 20%. More practices had been identified for inclusion. A short-term working group had been established to improve delivery of post-diagnostic support. This group was particularly important as Alzheimer Scotland's role in providing post-diagnostic support had stopped due to reductions in funding and mental health older adult team staff did not have the capacity to meet this gap in early intervention work. There was evidence that the partnership had invested in training and development opportunities for its staff.

Dementia day services provided various groups to meet the needs of people at different stages of dementia. We visited a centre which ran groups on lifestyle matters, golf and cognitive stimulation therapy. Feedback from those taking part and their relatives was very positive. All the groups and activities were designed to maintain the skills and interests of those accessing the service.

Some community initiatives were in place and were delivering positive experiences for older people diagnosed with dementia and for their carers. These included dementia cafés across eight villages which were advertised in local directories. However, diminishing support from the partnership, including Alzheimer Scotland's input, was threatening the future of these groups and the café in Peebles had already ended. There were support groups at the carers centre and the Borders Dementia Working Group made up of older people with dementia who provided both a supporting and consultation role to older people and carers as well as the partnership in respect of strategic developments. While they were content being involved, they reported frustration about the lack of progress around local and national dementia strategies.

Dementia support was one of the partnership's top three priorities. However, a lack of focus was reflected to us by older people, carers and staff as they awaited a refreshed national dementia strategy. A 2015 tender for a unique model of dementia care to include 27 care home beds in three settings with NHS nursing input had not progressed due to a lack of market take up. Alternative models were being explored using the Integrated Care Fund for initial support.

Recommendation for improvement 6

The partnership should ensure that people with dementia receive access to a timely diagnosis.

²⁴ The Scottish Government HEAT target is 'People newly diagnosed with dementia will have a minimum of one year post diagnostic support.'

Falls prevention and management

Falls can be a significant factor in older people being admitted to hospital. Preventing falls wherever possible is critical to improving outcomes for older people. We found inconsistent approaches to falls prevention and management. The partnership acknowledged this was an area for improvement and that the focus around falls prevention pathways had been on acute inpatient settings. The partnership was re-evaluating its falls strategy in an exercise led by the Director of Nursing. It had also undertaken a benchmarking exercise against the national falls framework. Although we saw evidence that there had been a recent effort to re-invigorate work around falls management and prevention, more work needed done to strengthen partnership working.

We heard some positive feedback from older people who had accessed falls programmes within day and community hospitals and Borders General Hospital. Positive examples of the work being done to strengthen the partnership's inpatient falls pathways included the Rapid Assessment and Discharge Team work and that being undertaken by the frailty group to provide a one stop shop for interventions within the Borders General Hospital.

GPs were confident that there were effective falls pathways between the primary and acute healthcare settings. Both GP and district nurses could make direct referrals to the Accident and Emergency Unit or the Acute Assessment Clinic. This was helping early identification of underlying medical reasons attributing to the fall as well as access to physiotherapist and occupational therapists.

While the above pathways were developing in the acute sector, falls work in the community was not as encouraging despite some examples of positive joint working. There were joint pathways between social work and health services where older people assessed by social work as at risk of falls would be referred to the day hospitals. However, it was clear from our review of health and social care records that information about plans to manage and reduce the risk of falls was not routinely shared with either the older people, their carers or staff in other services. Additionally, falls risk assessments completed by district nurses were being kept in the older person's own home and different falls assessments were used in different areas. This negated the potential benefits of established pathways.

The partnership's out-of-hours services highlighted concerns about falls in the community and said there was a lack of clarity about how falls should be responded to. Staff gave a few examples of older people being left on the floor of their house, with distressed relatives, for lengthy periods before support arrived. There were limited sharing of risk assessments, a lack of management plans and few response services linked to telecare to reduce risk. The partnership was working with SB Cares to develop a proposal for a responder service due to be submitted in the next financial year. In the meantime the partnership was dependent on the availability of family and friends to act as key holders with no dedicated mobile response team to respond. We considered that this could lead to older people waiting a long time for help after falling.

Recommendation for improvement 7

The partnership should take action to provide equitable access to community alarm response services for older people.

Reablement and intermediate care

Although there was not a coherent reablement approach, there was a number of established or developing initiatives. The short-term assessment and rehabilitation team was an established team based at Borders General Hospital. However, it had been subject to a significant level of change including a change of team leader and new referral processes. The current team consisted of social workers and nurse care managers but there was uncertainty among staff we talked to about how referral pathways were working or how the nurse care manager posts were being used. The team had also lost two physiotherapy posts funded by the council, having a negative impact on its ability to undertake joint rehabilitation work.

The NHS Borders Rapid Assessment and Discharge Team is led by allied health professionals and based at Borders General Hospital. It was providing an assessment service for older people presenting at hospital who did not require a medical intervention and followed up patients in the community who avoided the need for hospital admission. While these teams had provided supported discharge using a reablement approach, there was no dedicated care at home reablement service. Both teams described difficulties accessing community services for patients being discharged, thus restricting the benefit they offered to older people using the service.

Despite both these services being based at Borders General Hospital, neither service was clear about the other's role nor how they were being deployed. To further compound this lack of clarity, some hospital based staff were unaware of any community based reablement services available to support older people on discharge. This highlighted a lack of awareness from staff around recent key developments such as the intermediate care facilities at Waverley care home.

The Reablement Review Service was a new council initiative that reviewed older people leaving hospital and provided reablement-focused visits within 48 hours of discharge. This service was using reablement support plans and had pathways in to the hospital-based short-term assessment reablement team, locality teams and care provider services to make best use of resources. While this had the potential to be an effective service it was too early to measure its impact.

Intermediate care arrangements had only just been implemented. The partnership had had a commitment to intermediate care for some time and had invested in the refurbishment and design for a number of care homes to provide this service, including Grove House in Kelso. However, although the model was successful it was difficult to source the required trained staff. Intermediate care been reinvigorated with this commitment to 'step up, step down' care. Since November 2016, Waverley Court had provided 11 step down beds with referrals discussed at the weekly social work and health meetings. The service aimed to accommodate

older people for up to six weeks with support from dedicated allied health professional staff from the Borders General Hospital. At the time of our inspection, admission to the facility was restricted to step down provision for older people but there were plans to develop similar resources in the Kelso and Eyemouth communities. The eligibility criteria for the intermediate care service was agreed but as it was a relatively new service there was a requirement to communicate this more widely. While both the reablement review service and the Waverley care home intermediate care service were positive developments, it was too early to tell whether or not they would deliver the scale of change required to address the need for intermediate care provision.

Evaluations from the Transforming Care After Treatment and Red Cross Reablement Buddies services showed positive outcomes for those who had engaged with the services. Each had provided personalised reablement plans with clear measures set out at the beginning of involvement but remained as projects and had yet to be implemented more widely across Scottish Borders.

The partnership had a range of strategies and plans for almost all specific services. Many were either draft or in the process of being reviewed and it was unclear how the different strategies were co-ordinated. Staff spoke of strategies being developed in isolation. We say more about this in section eight. The partnership had recently implemented a new governance structure aimed at streamlining planning and commissioning processes but it was too early to judge whether it was having a positive impact.

9. Strategic planning and plans to improve services

In this section, we report on the contribution that strategic planning made to the lives of older people and their carers. We focus on the partnership's strategic plans, needs analysis, strategic commissioning, consultation and involvement. In addition, we look at the management of resources, finance, asset management and information systems.

We evaluated the partnership's approach and delivery of strategic planning as weak. Despite some good locality mapping that had been produced by the Community Planning Partnership, the health and social care partnership had yet to finalise and approve its joint strategic needs assessment to fully underpin its joint strategic plan. It had set out an overall direction for the future planning and delivery of services for older people but the implementation plans lacked detail, including how targets would be achieved, performance outcomes identified and progress measured. The development of prevention and early intervention now needed to be taken forward apace. Quality assurance, self-evaluation and performance frameworks were hosted under refreshed governance arrangements and needed time to embed. Joint planning arrangements involved older people, their carers and key stakeholders, including the third and independent sectors. The partnership demonstrated co-designed 'you said, we did' approaches throughout. Despite aspects of positive work some stakeholders were disengaged and others remained unsure about how their involvement contributed to either the vision or service planning and delivery. The partnership's market facilitation and commissioning approaches and procedures required significant improvement. Effective budget management was evident but financial risks to the long-term sustainability of the partnership remained which needed to be closely monitored and controlled.

Strategic plans

The partnership's Strategic Plan 2016 linked closely to the Community Planning Partnership's vision and set out the joint commitment to delivering a set of local objectives. The vision had nine local strategic objectives and was clearly linked to the Community Planning Partnership's Health Inequalities Action Plan. Both the strategy and the plan talked clearly about trying to improve outcomes for older people. However, while these documents were rich in terms of data, they lacked detail in terms of how successful implementation would be measured and evaluated. Within the three year strategic plan, the partnership had rolling annual plans. These were described as iterative and appeared to offer the opportunity for the partnership to flexibly respond to the demands upon it. For 2016-17, the annual plan had two priorities, one relating to supporting people to live at home and one relating to staff morale and wellbeing. The performance indicators for supporting people to live at home²⁵ were part of the partnership's ongoing suite of performance measures but the partnership had no plans to measure the indicator in relation to its staff. The

²⁵ The National Health and Wellbeing Outcomes Framework. Scottish Government.

partnership had not finalised its plan for 2017-18 and anticipated it being implemented in June 2017.

Overseeing all of the partnership's strategic planning activity were the Integration Joint Board (IJB)²⁶ and Strategic Planning Group²⁷. Both had initially struggled to meet their intended aims, with the IJB confirming it felt about one year behind where it needed to be and only at the starting point in key areas such as performance reporting and scrutiny arrangements. The Strategic Planning Group had not been functioning effectively. There were regular low levels of attendance at Strategic Planning Group meetings that meant they were often not quorate, negatively impacting on their ability to make decisions and progress agenda items. However, whilst these had been significant weaknesses previously, attendees of both forums were much more optimistic about participation and progress at the time of inspection. Signs of improvement included revised terms of references and membership of key groups, increased attendance at meetings and a widely reported much improved joint working culture.

The IJB had a lead role in terms of the governance and assurance of service delivery and quality. Both social work and NHS Borders had established clinical and care governance arrangements that were scrutinising delivery against set indicators, targets and were linked to improvement plans. The partnership brought together elements from established quality assurance models. The IJB performance reporting framework was still to be developed as the emphasis had been solely on financial monitoring with no links to service performance. There was no evidence that the impact savings were having on service provision was routinely monitored. Recently, the partnership submitted its first performance framework to the IJB, providing the partnership with an opportunity to address performance reporting and improvement gaps.

The partnership had access to the Integrated Care Fund (ICF) to develop innovative and transformative models of care. The partnership acknowledged that governance around the use of ICF monies had previously been overly complex. It had reviewed the decision-making process to enable funds to be allocated more easily. The partnership had not yet allocated all the funds available. Some ICF monies had been directed by the IJB to NHS Borders to assist with hospital discharge pathways and surge beds. The executive management team had recently assumed responsibility for the ICF budget. The aim was to ensure that this money is being used to initiate transformational projects that delivered positive outcomes which could then be scaled up in a sustainable manner.

The partnership was at an early stage of locality planning, commissioning and operational service delivery. Plans for each of the five localities in the borders had been developed by locality co-ordinators in collaboration with community stakeholders but they were still at the draft stage and there were no identified budgets or delegated financial governance arrangements in place for the areas.

²⁶ The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities to work together to deliver quality and sustainable services. The IJB is responsible for planning of integrated services.

²⁷ The role of the SPG is to support the IJB in the cyclical development, finalising and reviewing the delivery of the Commissioning Plan against local and national outcomes.

This was making the transition from planning to implementation challenging for key people involved in this work.

While the planning arrangements of the partnership demonstrated a commitment to improving outcomes for older people, actual plans and strategies needed to be completed in some case and significantly more robust in others. All need to have clear indicators about what would constitute success and defined timescales for success.

The local authority had contract and procurement procedures in place. The recent care at home contract was a significant procurement exercise. These and other contracts were routinely monitored against key performance indicators by the contracts monitoring team. Monitoring information was routinely collated and reported through the council's governance arrangements. Where performance concerns about commissioned services existed, the partnership had a range of options to support improvement.

Needs analysis

The partnership's strategic needs assessment²⁸ dated 2015 had been prepared in co-operation with a wide range of stakeholders. It was rich in detail and had quantitative data but key sections were missing and it was still in draft form. Sections such as supported and sheltered housing were incomplete but there had been very good work undertaken to shape locality mapping by the Community Planning Partnership. This work shaped strategic needs assessments of the five localities in a great deal of detail. Where such work is completed, the strategic needs assessment should be updated to reflect it. The document should reflect that the IJB has provided the appropriate oversight and accountability in terms of aligning the strategic plan with the locality plans.

The Strategic Plan was informed by a number of service specific strategies as well as by commissioning plans. Some of the specific strategies addressed mental health, learning disabilities and the needs of older people. However, many were under review. This made it difficult to have accurate and up-to-date data about unmet need in each locality to inform prioritisation, strategic planning and decision-making.

The partnership had recently developed a draft Berwickshire locality plan for consultation. This was well informed by needs analysis data and gave a detailed breakdown of the demographics of the locality population including Accident and Emergency attendances; emergency admissions to hospital; the rate of older people subject to falls; the number of people with long-term conditions and the number of people on both the diabetes and dementia registers. It also provided detail on neighbourhood and community information, namely rates of road and home safety incidents, rates of fires in homes and areas where people do not feel safe. Although this was at an early stage this was a good example that showed how the partnership was developing approaches to support improvement.

²⁸ The Scottish Borders Health and Social Care Partnership; Draft Joint Strategic Needs Assessment

Strategic commissioning

Joint strategic commissioning means all the parties to the partnership jointly assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working together to put these in place. They should do this in partnership with the community.

The partnership had worked to streamline its commissioning processes, reducing the number of people involved and speeding up the decision-making process while ensuring that the management team continued to have oversight. The partnership acknowledged there were particular issues of demography and rurality that led to commissioning difficulties. This was especially the case for care at home provision which relied heavily on SB Cares. Although it was a relatively new organisation, early signs were that it was successfully meeting the partnership's expectations. This included its requirement to act as provider of last resort. It had successfully been involved when two other independent care at home providers had failed to deliver the services required of them by the partnership.

SB Cares had an established suite of key performance indicators as part of its contractual arrangement. These included regular contracts meetings, a set of key performance indicators and the monitoring of complaints and gradings awarded to services by the Care Inspectorate. Overall there was effective monitoring of both financial and key performance indicators at regular intervals through the year. However, the partnership had not formally evaluated this service, neither did it have a market facilitation or similar plan²⁹ in place. Nevertheless, it was able to demonstrate approaches to try and address gaps in the care at home market, though this was at an early stage. Developing and implementing a plan was important to the partnership in terms of articulating the future shape of the market. Bi-monthly reports considered by the IJB highlighted financial pressures on the market such as an overspend in residential care; an increase in care at home costs (including increasing hourly rates influenced by both the recent care at home tender and introduction of SB Cares) and challenges meeting the growing demand on services. Having a plan in place would better support the effective management of a range of sustainable resources.

The partnership had identified a need for increased capacity in care homes providing nursing support and specialist dementia care. The partnership had engaged in discussions with providers about commissioning additional capacity dating back to 2015 for additional dementia care in the Scottish Borders. This commissioning went to tender but there was no take up from the private sector. During our inspection providers expressed concerns about nursing care, specifically the pressures of recruiting and retaining agency nurses. This had led to care homes working with the partnership and the Care Inspectorate to vary their registration status.

²⁹ The partnership must ensure that any person in its area wishing to access services in the market has access to a variety of providers to choose from, a variety of high quality services to choose from and has sufficient information from which to choose.

The partnership had also identified a gap in provision around intermediate care. The transitional care facility at Waverley care home was intended to provide a resource that would help address this but the impact of the service was yet to be established, given it had only very recently become operational.

There had been a significant delay in securing a successful tender for mental health services but the partnership was considering alternative options for dementia services. At the time of inspection, this process had not been concluded and the partnership expected to have new arrangements in place some 14 months later than originally intended. The partnership acknowledged that the uncertainty caused by delays was detrimental for people using services.

As discussed earlier in this report, a potentially valuable initiative had just been agreed by the IJB to develop a joint transformation programme. There had previously been separate plans for the council and NHS Borders. The council had a well-developed corporate approach to managing transformational change. The council had managed its business well within the allocated budget for the last three years. It was proposed that this model of resource management be applied across the IJB financial planning and delivery processes. The partnership had a sound understanding of the challenges it faced in terms of commissioning and in response had plans to employ a project manager later in 2017 at a senior level to monitor and progress work more coherently.

Recommendation for improvement 8

The partnership should provide stronger accountability and governance of its transformational change programme. It should ensure that:

- progress of the strategic plan priorities are measured and evaluated
- service performance and financial monitoring are linked
- locality planning is implemented and leads to changes at a local level
- independent needs assessment activity is included in the joint strategic needs assessment
- there is appropriate oversight of procurement and commissioning work
- a market facilitation strategy is developed and implemented.

Consultation and involvement

Across services we found staff were committed to the continued involvement of the public and finding better ways of demonstrating how their input helped to develop service delivery.

Stakeholder engagement was a strong feature in the development of the strategic plan. Other initiatives such as community-led support, Buurtzorg, See Hear and Transferring Care After Treatment services were all able to demonstrate very clear and meaningful involvement of stakeholders. The partnership supported the Senior Citizens' Forum which acted as a network body for various groups and services across Scottish Borders, allowing the views and opinions of older people to be fed into the planning structures of the partnership. The funding for supporting the forum

was time bound although there was a realistic intention that the forum would become self-sustaining.

We found evidence that SB Cares was able to actively contribute to the planning of services but this was not the case for other providers. While providers spoke of good relationships with partnership staff, they did not feel there were enough opportunities to inform and contribute to planning decisions. This was despite the partnership hosting regular provider forums and the active promotion of 'you said, we did' consultations on their websites. Care home providers also said they had not been involved in locality plans. There was evidence that information was disseminated by Scottish Care³⁰. So despite some proactive measures undertaken by the partnership to inform its stakeholders, it was clear that there was an appetite for greater direct involvement from local providers. More clarity was needed about the role and purpose of provider forums given the opportunity they obviously presented and the mixed views we heard about them. The partnership acknowledged that engaging with GPs in consultations had been particularly challenging. This was despite intervention from both the council and NHS Borders chief executives who personally visited them to discuss their vision. Senior managers and IJB members felt engagement was improving with new GP representatives now attending key strategic meetings.

Management of resources

The IJB's interim chief finance officer was appointed in March 2016 to oversee the transition of services to the IJB. There was evidence that joint working between health and social work senior finance officers was taking place through the IJB network of finance leads. This network included the directors of finance from both partnership organisations as well as the IJB chief finance officer. Financial performance and financial governance matters were also discussed at the executive management team meetings held on a fortnightly basis.

Similar to other IJBs, the initial 2016/17 Scottish Borders IJB budget was arrived at following each partner's separate budget setting processes. As a result, the joint budget did not fully reflect the priorities set out in the strategic plan. We were informed the partnership had aspirations to more closely align the strategic plan priorities with the budget in subsequent years, although work on this had yet to be started. In order to achieve this, the IJB board planned to revisit the strategic plan throughout 2017/18.

The partnership carried out a due diligence process on the initial IJB budget which allowed the partnership to gain assurance over the initial budget allocation. Both the council and health board had a sound understanding of the financial pressures affecting their organisations.

The partnership had not yet allocated or delegated budget responsibility on a locality basis. We were told this was because of the difficulties combining budget information from each partner's financial ledger to establish baseline budgets. The council was preparing to change its financial ledger and we were informed that IJB

³⁰ Scottish Care is a national organisation that represents the views of the largest group of independent sector health and social care providers across Scotland.

financial information reporting considerations were being built in to this. To allow the effective and efficient management of resources on a locality basis, it was essential that this budget information is compiled at as early an opportunity as possible. Once the locality managers are appointed, they will need this information to allow a comprehensive understanding of the budget being allocated.

The IJB had a coherent risk management strategy but did not maintain a risk register. Risk management was recorded through an Internal Audit Annual Plan. Individual workstreams and projects had their own risk register or risk management plans.

Finance

The delegated IJB budget was £139.150m with £18.128m relating to an acute services set-aside. As at October 2016 (reported in December 2016), the projected outturn was £144.760m representing a £5.610m overspend within the delegated budget, £5.232m (93.3%) of which related to NHS delegated services. The projected overspend was largely as a result of pressures with GP prescribing, agency staff costs and not meeting the planned efficiency savings. An NHS Borders 2016/17 recovery plan was put in place to address the financial pressures experienced across the health board. The plan was looking to achieve £14m of savings with £5.232m relating to delegated functions. Members of the IJB were not actively involved in the process of creating the recovery plan although they were kept informed of the actions that related to the delegated services.

Some of the Integrated Care Fund (ICF) money still had to be allocated at the time of the inspection (£0.600m against a total of £2.13m). The executive management team, who had taken direct control of ICF, were no longer accepting any new bids for ICF allocations, halting the potential allocation of funding for new or proposed projects. In addition to the under-allocation of ICF, there had been slippages in a large proportion of projects and it was planned that part of the unutilised funds would be used to contribute to overspends within the IJB savings plans. The partnership recognised the unsustainable position of using non-recurring funding to cover savings shortfalls. A more financially sustainable approach is required going forward that does not rely on non-recurring funding.

Budget monitoring reports presented to the IJB were comprehensive and gave a clear picture of the financial performance of health and social care services against each budget heading. However, concerns were raised over the limited opportunities that IJB members had to influence the financial recovery activities arising from projected year end overspends. The lack of IJB member involvement in budget setting and management processes undermines their strategic role in planning and commissioning integrated services. There is a risk that opportunities to develop new ways of service delivery may be missed without adopting a more joined up approach and without allowing an alignment of funding to Strategic Plan priorities. Also, under the terms of the Integration Scheme the IJB requires its own recovery plan approved by the board. The partnership needed to ensure this was undertaken.

Recommendation for improvement 9

The Integration Joint Board should develop and implement a detailed financial recovery plan to ensure savings proposals across NHS Borders and council services are achieved.

Asset management

The NHS capital planning group had historically been routed through well established community planning partnership structures. The interim chief finance officer assured us that he was sighted on any joint plans arising because he also sat on the relevant health and council capital related committees. His role to date had been more in NHS Borders activity with a recent business case being approved for a £3m spend on upgrading primary care premises.

With the Scottish Government's approval, NHS Borders had been allowed to allocate some of their capital budget to revenue activity (£2.1m) because they had not spent all of it. NHS Borders felt they had been open and transparent with the IJB including contingency and capital project slippage money reallocated to budget pressures following Scottish Government consultation. The interim chief finance officer recognised that there was room for more improvement in this area of joint work.

The partnership was actively looking at how buildings could be used and shared more efficiently including a review of transport. The focus of this work centred on mental health, learning disability, physical disability and older people daycare services. The partnership was at an early stage of a benchmarking exercise that considered models developed by other partnerships.

A capital works programme was underway at Waverley care home to create en suite facilities in all of the bedrooms in line with registration requirements. Work had already been completed on 12 rooms. When the work is completed this will provide a further six transitional care places which the partnership had initially earmarked for use as step up beds to positively develop its capacity to provide an alternative to hospital admission. An application to vary the registration of this provision being prepared at the time of the inspection, with refurbishment work progressing, monitored by the Care Inspectorate.

Information systems and technology

The partnership is part of the general pan-Lothian data sharing partnership. Leading up to health and social care integration, the joint information governance group and IT workstream stopped progress for a period of time resulting in work stalling. The partnership had appointed a new chair for this IJB workstream in January 2017 and work was progressing once again. As a result of the delay the partnership had an agreed data sharing vision but not a formal strategy.

The partnership's aim was that staff at all levels should have access to individuals health and social work records to support better outcomes for older people and their carers. The partnership, like others nationally, were finding the development of

integrated data sharing arrangements challenging and were a long way from achieving their aims in full. Even in well established integrated services such as learning disability and mental health services, difficulties existed due to imposed security controls.

Although there was no overarching joint strategy, the council was about to implement a move from ITC systems Frameworki to Mosaic while the health board was developing Trakcare and EMIS. The partnership was exploring and testing ways of sharing information across these new systems. Mosaic arrangements had already been put in place for the council's duty team and wider contact centre staff. The implementation of this system was being led by the Mosaic Delivery Project which had consulted widely across the partnership. The new system was regarded as being more flexible to the needs of the partnership and more effective at putting controls and measures in place so that staff see only records of the particular individuals with whom they are working.

At the time of the inspection, few frontline staff and managers had confidence that information systems were supporting them to communicate effectively. The accuracy of information was variable depending on how managers were using the systems. There was no evidence that assessment documentation held by each agency was shared either electronically or in paper format between relevant staff. Staff were frustrated by clumsy electronic systems and the consequent risk of working with only a partial picture of the older person's needs. This included the rapid assessment and discharge and short-term assessment and reablement teams who were supporting hospital discharges. Health staff expressed frustration at the lack of electronic information sharing capacity within their organisation. This was the case for staff working out-of-hours who relied largely on local knowledge and contacts to ensure that the needs for older people were met. In areas including palliative care there had been some recent early developments to improve information sharing but other services such as GP services and district nursing still held the health and social work records in separate systems or in paper files in patients' homes.

Both healthcare and social work systems were able to generate performance reports which allowed managers to monitor work processes and, more recently, some limited information on outcomes achieved. Managers said that they reviewed these on a regular basis and they supported managerial actions they needed to take or highlighted issues which need to be raised with senior managers. These reports were shared appropriately with the IJB, the NHS board and the council's senior management and elected members.

10. The provision of care, support, treatment and protection

In this section, we report on the contribution that key operational processes could make to underpin the delivery of care, support, treatment and protection for older people and their carers. We look at access to support and services, the assessment of older peoples' needs and wishes and the care planning which could deliver on those needs. In addition, we look at the shared approaches to protecting individuals who were at risk of harm and the involvement of individuals and carers in directing their own support.

We evaluated the partnership's performance in this area as weak. There was a need for significant improvement in how staff assessed and managed risk and in the partnership's quality assurance in this area. Although the partnership had audited files in advance of the inspection, the issues of protecting older people from harm had not been fully identified. The support and protection of adults deemed at risk of harm required considerable improvement. Despite clear guidance from the partnership, there was evidence that it was not being adhered to by staff. There was variability in the services available in different parts of Scottish Borders. Like other rural areas, public transport for older people without a car was limited making it difficult to access some services, despite recent efforts by the partnership to subsidise transport. There was limited services to prevent hospital admission and to support timely hospital discharge planning. The partnership was taking positive action to improve, but it would be some time before these would achieve benefits in alleviating pressure in key service areas. This was reflected in the significant number of older people who had to wait to have their needs assessed or to receive some services, such as care at home. The approach to assessment, care planning and review all showed an outcome focused approach. Staff involved older people in decisions about their care and treatment. However, there was a need for improvement in arrangements for reviewing the circumstances of older people living at home and in the number of carers who were offered and provided with a carer assessment.

Access to support and services

Although there were some exceptions, the majority of older people and carers knew where to find information and who to contact if they wanted to access health and social work services. Both the partners' websites contained information about the services available. Nevertheless, in our staff survey only 21% of respondents agreed there was a fair geographical coverage of services to support older people. During the inspection we heard numerous comments from older people, carers and staff about significant variability in the services available across Scottish Borders.

The council had commissioned the National Development Team for Inclusion³¹ to support implementation of community-led support. This was an ambitious project

³¹ The National Development Team for Inclusion (NDTi) is a not for profit organisation working to enable people at risk of exclusion, due to age or disability, to live the life they choose. We inspire and

that aimed to move the partnership away from service led solutions to growing community based resources. After extensive consultation, there were plans to open two new community 'front doors' where it was hoped the public could be supported at the first point of contact. Additionally, the partnership was a national test site for Buurtzorg which promoted self-managing teams to find practical solutions for older people. This model has proved to be effective from both a financial and outcomes based perspective, when implemented in other areas of Europe. While there was evidence of strong commitment to develop this model it was yet to be implemented.

Like many other rural partnerships across Scotland, many older people, carers and staff told us about the limited public transport available and how this could cause difficulties in accessing support and services. In order to alleviate this, the Community Planning Partnership had taken the positive step of commissioning a transport hub using integrated care fund monies and supported by the Scottish Borders Transport Service. This provided subsidised transport to assist people to attend medical appointments. It also sought to link medical appointments to available public transport. The hub could also be accessed to provide transport to assist older people attend important social events.

In line with other partnerships nationally, the council operated eligibility criteria for access to its social work services. However, pressure on services was such that the council was only able to provide services timeously, or in some instances at all, to older people deemed as being in 'critical need'. We heard of older people deemed to have "substantial" needs having to wait considerable amounts of time for an assessment and/or for a service. Some staff alluded to taking a broad interpretation of "critical" as the only way of ensuring a service was provided, thus falsely distorting referral and resource allocation processes.

The care at home and equipment and adaptations services were both under considerable pressure. Information provided by the partnership showed that in December 2016 there were 321 older people on waiting lists for assessment. There was an average waiting time of nine weeks for older people in the top priority and 15 weeks for those in the second priority. Both social work and occupational therapy services were outwith the top priority waiting time target (six weeks) but within the priority two waiting time target (18 weeks). Staff told us that closer to 400 people were on occupational therapy waiting lists, more than the official number of 321. Access to occupational therapy services was not helped by the fact that both health and social work were operating different eligibility criteria for equipment. The partnership had much work to do in this area to ensure quicker access to assessment, equipment and adaptations.

Frontline staff were finding it difficult dealing with the volume of work and the waiting lists. This was highlighted in our staff survey where fewer than half agreed that joint teams responded within agreed timescales. The partnership did have a number of systems in place to keep older people informed about timescales for receiving services. However, there were some gaps in information being shared with other professionals about waiting times. This could cause complications for other services

support policymakers, services and communities to make change happen - change that leads to better lives.

in co-ordinating service delivery. Some GPs expressed frustration at occasionally not knowing if or when a care at home service for an older person would be provided, causing uncertainty for them in deciding whether or not to admit an older person to hospital.

Recommendation for improvement 10

The partnership should ensure that there are clear pathways for accessing services and that eligibility criteria are consistently applied. It should communicate these pathways and criteria clearly to all stakeholders. The partnership should also ensure effective management of any waiting lists and that waiting times for services and support are minimised.

Assessment of needs and wishes

Individuals' case records showed that staff had tools to help them complete outcome-focussed assessments for older people. Assessments remained largely single agency, although the partnership had identified integrating assessments as an area for improvement. Most staff expressed satisfaction with the tools, although some social work staff said completing the assessment template on Frameworki could be laborious and cumbersome. However, they agreed that the assessment framework included a helpful focus on personal outcomes and on recording choices on the self-directed support options. The partnership had developed a shorter functional assessment for use in some less complex cases, although we did not see much evidence of its use during the inspection.

The findings about assessment from our review of health and social work records were positive and broadly in line with other inspections to date. For example:

- ninety-two percent of files had an assessment and all but one of these took account of the older person's needs
- we evaluated 95% of the assessments as at least of adequate standard (59% being good or very good)
- of the 84 applicable records, 70 contained evidence that self-directed support options had been discussed and showed which option had been taken by the individual.

The predominantly single agency approach to assessment was reflected in the findings of the case file reading. In over a third of the assessments, we did not see evidence of information from a range of professionals contributing to the assessment. Staff said that much of the information they sought from other professionals was obtained over the phone. They added that it was rare for completed assessments to be shared with professionals in other agencies.

Fifty six of the older people whose records we read were supported by an unpaid carer, but carers assessments had been offered in just 41% of cases. The partnership submitted data for 2012-16 which suggested a higher proportion of carers being offered an assessment (generally averaging between 45-55% of carers). However, this did not show how many of the carers had accepted the offer and received a carer assessment. The council had an arrangement in place for the

carers centre to complete carer assessments on its behalf. We heard mixed views about whether information about carers' needs was shared with those staff working directly with them.

Care planning

Almost all of the files had a care plan, of which most were comprehensive. The majority of the plans set out desired outcomes for the older person and most addressed their needs. However, less than half of the plans were SMART (specific, measurable, achievable, relevant and time bound) with plans not being time bound or measurable being the main deficits. A lot of work remains to be done in this area to ensure the partnership has accurate ways of measuring improvements in personal outcomes following interventions from services.

In the majority of the records interventions met the older person's needs and, where applicable, supported discharge from hospital. We saw some positive examples of health and social work staff working well together to deliver effective care, support and treatment. These included joint working out-of-hours between Accident and Emergency staff, the out-of-hours community nursing staff and the social work out-of-hours emergency duty team. These services shared a sound understanding of each other's roles and said that knowing exactly who to contact and thinking imaginatively were important factors in achieving effective joint working relationships. Other positive examples included the following.

- The specialist paramedic project where GPs in Hawick and Kelso worked closely with paramedics to support them to provide timely triage and initial assessment to people at home. Paramedics were able to access EMIS notes and pharmacy support whilst undertaking this preventative role.
- The involvement of the Red Cross Buddies service in multidisciplinary discharge planning meetings at Borders General Hospital to provide practical and emotional support to older people being discharged home.
- The Fire and Rescue Service in Kelso which, in response to referrals from the local GPs, assessed for trip hazards in older people's homes when undertaking fire safety checks.

However, these examples of good multidisciplinary working were only in place in one or two parts of Scottish Borders. The partnership needed to ensure that initiatives and developments which had been positively evaluated were rolled out across the whole of Scottish Borders area, albeit services should meet local need. Future tests of change should be driven by locality plans and reflect the diversity of the rural partnership area.

The types of positive examples described above were outweighed by the number and scale of areas where the partnership faced significant difficulties in providing the right care and support at the right time, including care at home provision. This could be a problem anywhere but was most acute in the outer parts of Scottish Borders, leading to some delayed discharges from hospital. The circumstances of some older people at home deteriorated while they waited for care at home, resulting in

increased stress for their carers. The lack of mainstream reablement services meant that services were rarely able to support older people to resume a sufficient level of independence to free up care at home resources. As indicated earlier, there were problems in providing aids, equipment and adaptations on a preventative basis to those deemed as not being in 'critical' need and instances of unsatisfactory and unhelpful hospital discharge planning.

The partnership was about to pilot a service matching unit in Hawick for care at home provision. (Service matching units provide a more efficient and effective way of tracking capacity and identifying available services). It was hoped that the unit would provide a better overview and deployment of care at home provision as well as free up time for care managers. Similar units have been shown to work effectively in other partnership areas.

We found a mixed picture in terms of how well the partnership reviewed the needs of older people and the effectiveness of the support and services they received. The social work service had a dedicated review team who undertook reviews of older people in care homes and for people resident outwith the area. However, the team had high case loads and described real challenges. These included the loss of administrative support; involvement in other duties; newly introduced paperwork and addressing the gaps in information for older people in care, all of which had reduced their capacity significantly. Despite these pressures, the majority of older people's health and social care support in care homes was subject to regular review.

Reviews were carried out far less rigorously for older people living at home with care and support. Here there was evidence of significant delays. Although there was a specific review team for older people at home, staffing difficulties had significantly reduced creating capacity and made it hard to meet need.

Shared approach to protecting individuals who are at risk of harm

Scottish Borders Adult Protection Local Procedures 2016 provided clear and appropriate guidance for staff. This was reflected in our staff survey where most of respondents agreed there were clear guidance and processes in place to support them in assessing and managing risk. However, there was a lower level of agreement that there were a good range of risk assessment tools available for staff to use. Our review of records produced a number of poor results in respect of risk assessment and management. In particular, for files which included adult protection type risks we found that:

- of the 21 applicable records, only eight (38%) contained a risk assessment
- only five of the eight risk assessments had been informed by the views of multi-agency partners
- in almost half, (10 of the 21 applicable records) we concluded that not all concerns regarding protection type risk had been dealt with adequately.

We also looked at records where more general types of risks had been identified, such as a frail older person at risk of falling and sustaining an injury, or the risk to an adult with dementia of experiencing harm. Our findings in this area were more mixed in that:

- of the 81 applicable records, 64 (79%) files contained a risk assessment

- of the files with a risk assessment, 61% had been informed by the views of multi-agency partners
- in 27% of cases, we concluded that not all concerns regarding non-protection type risk had been dealt with adequately.

We raised these findings with the partnership at the time they became evident. While an audit of files had been undertaken by managers recently, this quality assurance work had not picked up many of the issues which we subsequently raised.

The Adult Support and Protection committee had the necessary structures in place to fulfil its responsibilities. As well as the main committee, it had three sub-committees in place, namely an interagency operational group, an audit subgroup and a learning and development subgroup. As elsewhere in Scotland, the committee reported to an overarching group for public protection, the critical services oversight group. However, despite these structures, the findings from our review of health and social work records called into question the strength of the committee's quality assurance processes.

A specialist adult protection unit had been in place for some time. Frontline and other staff felt it provided helpful advice about adult protection issues, for example responding to questions about the three point test³². The unit had two staff who also chaired case conferences. One of the staff was also the main trainer for adult protection training but when they were absent the unit lacked sufficient capacity to deliver the anticipated training to the partnership. The unit was also subject to review at the time of our inspection.

Case chronologies are important as they can give an early indication of emerging patterns of concern and risk. This means they can play an important role in helping staff to assess risk. As we have seen in other partnerships, we found room for improvement in staff understanding and completion of chronologies. Fewer than half of older people's records which should have contained a chronology had one (38 out of 75). Of those records that did contain a chronology, less than half were of an acceptable standard. In many cases, they were merely a list of meetings and staff activities rather than key life events that impacted on the individual. The partnership strengthened its policy in December 2016 so that all new case records must include a chronology, with the case recording tool in Frameworki amended to support this practice. Training had also been rolled out to staff. We expect these measures will drive improvement in this area.

³² The main aim of the Adult Support and Protection (Scotland) Act 2007 is to keep adult's safe and protect them from harm.

The Act defines an adult at risk as people aged 16 years or over who:

- are unable to safeguard their own well-being, property, rights or other interests; and
- are at risk of harm; and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected

This is commonly known as the three point test.

Recommendation for improvement 11

The partnership should work together with the critical services oversight group and adult protection committee to ensure that:

- risk assessments and risk management plans are completed where required
- quality assurance processes to ensure that responses for adults who may be at risk and need of support and protection improve
- improvement activity resulting from quality assurance processes is well governed.

The care home review team also had an important role to play in dealing with any adult support and protection concerns. This was viewed as being an effective response both by the care review team themselves and by other relevant staff.

Involvement of individuals and carers in directing their own support

We found positive evidence that older people and their carers were listened to and supported by staff to make choices about their care and support. Many older people told us they felt involved in discussions about their support needs. Almost all of assessments we read took account of the person's choices and, in the majority of records, the time when support was to be provided had been discussed with the people involved. Questions in our staff survey about the involvement of older people at the assessment, care planning and review stages all had positive responses of over 85%. However, some older people said that some of their choices about support options were limited due to the limited number of care at home providers.

Example of good practice – Encompass

We met with Encompass which had originally been commissioned by the council to support people with direct payments, but more recently had become a user led charitable organisation. It provided a range of services including information and advice to people interested in self-directed support, the recruitment of paid carers and personal assistants, third party banking and a payroll service. At the time of our inspection Encompass was supporting a total of 467 people of whom 117 were older people. We met a number of these older people and their carers and they spoke very positively about the support and service they received from Encompass. A carer told us that "Encompass have been brilliant. A real help in terms of sorting this out for me".

Advocacy

We found a very mixed picture in respect of independent advocacy for those older people whose records we read. Although six older people had been offered advocacy, we identified a further 19 who would benefit from being offered it, but had not been. More positively, for the majority of older people who received advocacy support, there was evidence that that it had helped them articulate their views. We

also identified a small number of carers (five) where advocacy support would have been appropriate, but only one of these had been offered it.

The main provider of advocacy services was the Borders Independent Advocacy Service. This service had responded to 23 new referrals from older people during the period July-September 2016. There had been an increase in requests from people wanting support to make a complaint about services and/or charging arrangements, particularly around self-directed support. Although an independent advocacy plan had been prepared collaboratively by the Scottish Borders Council, NHS Borders and Borders Voluntary Care Voice, progress on this strategic document had been slow. The action plan lacked detail and it remained in draft form.

Of the case records we read, 30 older people had difficulties making independent decisions about aspects of their everyday life. The majority of these had made arrangements and granted the power of attorney prior to losing capacity. This may indicate that some staff were engaging in some positive anticipatory and forward planning discussions with older people and their families. A review of the care of older people in the Borders General Hospital in 2016³³ concluded that NHS Borders needed to improve its processes and procedures for patients who lacked the ability to make decisions for themselves. As mentioned earlier in this report, council mental health officers were working alongside their NHS colleagues to improve awareness of legislative requirements in the hospital settings. The partnership still had work to do to protect vulnerable older people who lacked the ability to make decisions for themselves both in community and hospital settings.

³³ Review of the Care of Older people, Borders General Hospital, NHS Borders by Healthcare Improvement Scotland, August 2016.

11. Impact on staff and on the community

In this section, we report on the impact that health and social work services were having on staff and the community. We focus on the experiences of staff, staff motivation and support, recruitment and retention, deployment, joint working and teamwork as well as training, development and support. We also look at the experiences of staff and of communities, including how the community was being engaged by the partnership in the planning and delivery of services.

We evaluated the partnership's management and support of staff as adequate. Staff were generally well motivated and felt supported by frontline managers and other colleagues across the partnership. Morale was low in some services as staff struggled with the impact of vacancies and service redesign. Throughout the partnership, staff needed managers to communicate more effectively during periods of change. An integrated approach to workforce planning was at an early stage. Recruitment and retention, particularly in some service and geographic areas, was an ongoing challenge although positive measures had been introduced to improve staffing levels. Reliance on bank and agency staff was beginning to decrease as measures to fill vacant posts were being implemented. Overall, there was a lack of integrated teams and deployment of staff across the partnership remained mainly within their parent agencies. Despite this, the majority of staff were positive about joint working and were willing to 'go the extra mile'. Staff were largely positive about their access to training but more needed to be done to develop joint training and learning opportunities. In recognition of the capacity pressures on frontline staff, the partnership had implemented a range of supportive return to work policies and initiatives that were keeping sickness absence to appropriate levels.

Staff motivation and support

We considered a range of documentation submitted by the partnership and met with more than 300 health and social work services staff. One thousand, one hundred and twenty-eight staff were asked to complete our staff survey with 376 responding. Three hundred and twenty two (86%) were health staff which reflected the employer distribution, mainly as a result of the partnership's introduction of SB Cares and the transfer of social care services into this new organisation. Many of those NHS staff completing the survey were inpatient staff who may not have been as well cited on the integration agenda as their community colleagues, meaning the findings were not as positive as they might have been. Of the 376 who responded, 251 respondents (67%) completed the survey in full. There were some differences in the responses between NHS and local authority staff to our survey questions with health responses being less positive overall. A large majority of respondents enjoyed their work, felt valued by other practitioners. They responded positively about frontline managers, indicating that they felt valued, had effective line management (including profession specific clinical supervision) and felt supported in situations where they faced personal risk.

Morale and staff satisfaction were best in the learning disability service which was a long-standing integrated and co-located service where there was a clear understanding of roles and better multidisciplinary communication. However, a significant number of staff from other services whom we met during the course of the inspection told us their morale was low. This was particularly the case in the mental health older adult teams. NHS Borders had commissioned an external organisation to review the use of current resources and improve efficiency through the use and development of management systems in these two service areas. This exercise considered the core tasks of the services involved. There were issues with the planning tool used by them which impacted on staff experiences of the process. For example, staff felt that it increased bureaucracy as they were entering activity data twice and felt that scrutiny of their work had increased. Factors impacting on areas of low morale more widely across the partnership included pressure of workload impacting on staff ability to complete work to the standard that they desired; vacancies; difficulties accessing support services to help older people remain at home; a sense of constant change and lack of consolidation; and a lack of communication by senior managers.

Staff reported positive joint working relationships across services but had reservations about whether or not there was sufficient capacity within teams to cope with both current and future demands for services. There was limited opportunity to undertake preventive work and a planned approach to delivering good outcomes. However, despite the challenges and pressures at a time of major change, staff we met were committed to working effectively together to deliver a good service and good outcomes for older people.

In terms of leadership and change, fewer than half of respondents agreed that senior managers communicated well with frontline staff or felt that changes which affected services were managed well. The partnership had used a range of approaches to help engage and communicate with staff about the integration of health and social care services. These included newsletters and bulletins, road shows, events and forums and consultation with trade unions. Despite these measures, the strength of staff views indicated that there was still a need to focus and improve communication with staff and amongst stakeholders. The joint staff forum was a conduit for staff to pass issues and comments to the IJB with representatives, one from health and the other from the council. Activity had recently increased in terms of informing staff and with IJB support, the forum was well placed to play a more positive and clearly defined role in communication between staff and senior managers in the partnership.

NHS Borders staff had the opportunity to participate in the NHS Scotland annual staff survey³⁴. Results from the 2015 NHS staff survey, although not exclusively targeted at older people's services, identified variable and similar results to the one conducted as part of this inspection. NHS Borders had also rolled out iMatter³⁵ across some NHS services with full implementation in progress and this was viewed positively in giving staff a voice. The council had made no progress in obtaining staff

³⁴ The 2015 NHS Scotland Staff Survey. Scottish Borders Results.

³⁵ iMatter is an NHS staff experience continuous improvement tool designed with staff in health to help improve individuals, team and Health Boards understand and improve staff experiences.

views, for example using annual questionnaires. This limited the ability of staff to effectively participate in service improvement and development strategies.

Recommendation for improvement 12

The partnership should develop and implement a tool to seek health and social care staff feedback at all levels. The partnership should be able to demonstrate how it uses this feedback to understand and improve staff experiences and also its services.

Social work and health professionals had appropriate but separate arrangements for individual supervision, annual performance appraisal and individual professional development. NHS Borders acknowledged that there were issues with staff having the time and capacity to meaningfully complete professional development reviews and staff commented that, as a result, both the frequency and quality was variable. At the time of our inspection, human resources management information systems within the council were unable to monitor levels of staff supervision and appraisal. This was a significant gap in its performance management abilities. The council planned to introduce a new management information system called Business World in April 2017 and was confident this system would provide better quality information to managers, and in turn, better support to staff.

Recruitment and retention

The partnership had a number of senior management vacancies at the time of the inspection. NHS senior management vacancies were primarily the result of people retiring or moving on to promoted posts elsewhere. Recruitment to joint posts within the partnership was underpinned by a joint appointment recruitment procedure. Joint posts were in place at service manager level and above and at team leader level in learning disability services. Although restricted to individual service areas thus far, there was a plan to review the joint recruitment process with a view to apply it more widely.

The partnership had identified that a number of GPs intended to retire over the next five to 10 years. The NHS Borders workforce plan had appropriately identified succession planning for GPs as a priority. The partnership had begun to look at incentivising trainee GP posts to make them more attractive to a younger workforce in the future. A medical recruitment strategy was in place to improve the success rate for recruitment to consultant and other medical vacancies. This approach had achieved some positive success ensuring that the vacancy rate for consultants in Scottish Borders had remained in line with the national average.

In our meetings with staff and managers, we heard about the ongoing challenge of recruitment and retention across health and social care services. These included areas such as allied health professionals, Band 5 nurses, social care services and residential establishments. We also heard that there were particular challenges recruiting to social work assistant team leader posts as they were paid at the same rate as qualified social workers. The council also experienced challenges recruiting to some social work posts as professional social worker rates of pay were subject to

national variation. This led to some recruits being lost to higher paying local authorities. Attempts were being made to address this in relation to hard to recruit posts through offering supplements, however it was too early to measure the effectiveness of this approach.

While managers told us that the use of agency staff was reducing, both organisations continued to rely on them. Some previously frozen posts had recently been released for recruitment in order to fill posts permanently and reduce the need for agency staff. Both NHS Borders and the council had reviewed their recruitment processes and had targets for completing recruitment within a 12 week period, reporting through clinical and care governance processes. Both organisations had processes in place to monitor and manage vacancies. The partnership was proactive in identifying staffing shortfalls and had implemented a wide range of approaches to make working in health and/or social work a more attractive career option in Scottish Borders. Approaches included working with Skills Development Scotland and further education colleges, converting temporary allied health professional contracts to permanent status and a focus on 'grow your own' activity.

Recruitment and retention was a significant challenge for the partnership's third and independent sectors. With support from the council, SB Cares had used the services of a recruitment consultant with expertise in care at home services and had changed its approach to recruitment with some success. Nonetheless, recruitment difficulties remained in areas such as Hawick and Peebles and there remained significant future challenges ahead for the partnership around service availability and sustainability in this area of recruitment.

Deployment, joint working and teamwork

Although the deployment of staff was still largely at an individual agency level, the partnership placed significant emphasis on joint working and developing positive working relationships. From our review of case records we saw evidence of multi-agency working in the majority of applicable cases and similarly that services had worked together to provide care at times of crisis. Furthermore, frontline staff and managers reported positive working relationships with colleagues across services. These themes were also evidenced in our staff survey and by staff we met during the inspection who felt there was strong working relationships with other professionals.

The multidisciplinary and co-located Cheviot Community Health team was a particular example held in high regard by staff we met. This service was viewed as being responsive and able to intervene in a timely manner, achieving positive outcomes for older people. Practitioners in Borders Emergency Care Service also worked well together to deliver services across Scottish Borders. While both these services had worked well to establish positive joint working arrangements the partnership had made little progress outlining its vision for integrated services for older people in localities. This was causing uncertainty among all staff groups.

Training, development and support

The Community Planning Partnership's Future Services Reform Group was leading on a joint training needs analysis at a corporate level. Mandatory training had been

mapped out and other priorities had been identified. Leadership and management development were identified amongst these. There was evidence of partnership commitment to developing leadership capacity across services through work being undertaken in collaboration with both the Scottish Social Services Council and NHS Education for Scotland.

The council had transferred responsibility for social work learning and development to the recently established social work professional development team. Social work staff were positive about this change and their views informed the action plan which aimed to progress professional leadership, training and development for social services staff. A joint learning and development strategy had not yet been developed for older people's services, although some service specific work was under development.

Most staff agreed that they had opportunities for training and professional development. We heard that the development of the advanced nurse practitioner role was being supported across the partnership, including emergency care and district nursing services. This provided opportunities for nursing staff to enhance their qualifications and experience. 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 and there was a range of health and social work forums to support professional development.

Frontline staff told us that there was too much focus on mandatory training and that it was a challenge to find time to attend all the training they wanted to. However, there was evidence of partnership investment in beneficial training such as coaching which partners were confident was helping to keep sickness absence down. There were examples of staff delivering and attending service specific training events but some staff felt the time taken travelling to training venues in large rural areas was a barrier to attending. To counter this, the partnership was increasing the range of e-learning training available for example adult support and protection, PREVENT (anti-radicalisation), information security and equality and diversity. Training on self-directed support was available for health and social work staff. But further progress was required in rolling out the self-directed support training programme and staff acknowledged that competing demands had impacted on staff attendance at training events. Joint training was available for some other specific work areas such as adult support and protection. We heard about delivery of bespoke adult support and protection training for Accident and Emergency Department staff and care homes, both of which were very positive initiatives.

GPs told us that there was strong support to sustain GP practice and that they felt generally well supported. GPs had protected time available four times per year for learning and development opportunities and this was very useful for those who took advantage of them.

A helpful range of learning and development opportunities about dementia was available. There were plans to deliver stress and distress training to dementia ward staff in January 2017, however staffing shortages required a change in the planned timescale for its delivery. The partnership had provided funding to the Borders

Voluntary Carers Voice to deliver Informed about Dementia and Skilled Practitioner in Dementia training. Positively, at the time of our inspection, 440 people had been trained at informed practitioner level and 114 at skilled practitioner level.

Recommendation for improvement 13

The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This should include a focus on sustainable recruitment and retention of staff, building sufficient capacity and providing a skills mix that delivers high quality services.

The partnership had a wide range of supports in place to reduce absence due to sickness. NHS Borders had an overall sickness absence rate of 4.7%, better than the national average. The council rate was 3.4%, also very positive. There was evidence that return to work interviews were being undertaken with targets set for reporting. The partnership had a wide range of supports in place to reduce absence due to sickness and both health and social work quarterly and annual reports reflected positive trends. Both health and the council had proactive measures in place to support staff and managers. Stress was the main cause of absence in health and social work services. NHS Borders ensured coaching for managers and staff, counselling, individual/team risk assessments and psychology services were all available. The council provided mindfulness and personal resilience courses, a counselling service and a 24 hour helpline. There were also regular meetings between managers and human resource staff to look at hotspots and assess how they could be supported to improve.

Impact on the community and community capacity

We evaluated impact on the community as good. We identified important strengths in the partnership's approach to consultation and there was a high level of engagement with older people and carers. Communication with the public was effective and several forums had developed to engage with older people. Although the partnership was at an early stage of locality planning, the role of public health was involved in the development of data to identify local need. Reducing inequalities was embedded in strategic policy and development plans and was one of the three priorities for the Community Planning Partnership. There were many innovative projects but a number had ended when their funding ran out. The partnership was committed to developing more realistic and sustainable solutions to stabilise future service provision.

Community impact

The importance the partnership placed on public engagement and community participation was evident in its service design, policy and strategy development. Empowering people to influence the planning, design and delivery of services, and building resilient communities were themes that featured in the partnership's strategic plan and the five evolving locality plans in the Scottish Borders. Community

planning partners had developed a communication and engagement framework³⁶ including a best practice toolkit to support the partnership in its engagement activities in a consistent and transparent manner.

Both the communication and stakeholders' engagement plan³⁷ and integration scheme engagement report for the strategic plan 2016-19 underpinned the partnership's approach to consultation. A variety of other engagement methods had been used to get feedback on the strategic plan. This included pop-up booths, media broadcasts, social media, community conversations, public events, existing local forums and newsletters to make sure the partnership captured the views of people across the Scottish Borders including those who lived in the most rural of communities. The impact of the partnership's approach was apparent in the level of stakeholder engagement achieved. There was also compelling evidence that feedback responses on the strategic plan had informed the final redraft using a 'you said, we did' approach which we concluded could be deployed more broadly to other consultations.

Building on the success of the consultation on its strategic plan, and in line with the principles of co-production, the partnership had undertaken extensive engagement with local people and other stakeholders to progress the development of locality plans for the commonly recognised localities in the Scottish Borders. A key driver for progressing this work was the formation of five locality working groups. These provide forums to ensure the views of local people and other key stakeholders influence the planning and future development of services. Locality co-ordinators had led on this work resulting in wide engagement with stakeholders. We found there was positivity and momentum around the benefits of a localised approach to delivering services for older people in their own communities.

The executive management team had recently reported progress on locality planning to the IJB. A clear plan was in place that detailed the priorities and timescales for finalising and approving locality plans, agreeing options for integrated teams and consulting with staff and key stakeholders. We considered that the success of this approach rests on the partnership's ability to progress from planning to implementation. Alongside this work, four GP cluster areas had been agreed. Although not aligned to the partnership's localities the partnership was confident this arrangement would not present any issues for the provision of equitable access to healthcare services. Plans were underway to formalise the cluster arrangements in preparation for the implementation of the new GP contract in April 2017.

Public health had a significant role in the development of strategic planning to address the wider health and social care needs of locality populations. Reducing inequalities was a theme that ran through many of the partnership's strategic documents and was one of three key priorities for the community planning partnership. Local needs data had begun to inform the development of locality plans to help shape priorities for improvements in health and wellbeing and prevention of ill health. Public health representatives had been deployed effectively. They were

³⁶ The Scottish Borders Community Planning Partnership, Community Engagement framework 2015-2018

³⁷ Health and Social Care Integration, Communication and Stakeholder Engagement Plan, February 2016

active members of the IJB and Community Planning Partnership group and as such were in a strong position to drive improvement in this area of work.

Borders Voluntary Care Voice is the lead organisation for the local third sector interface. One of its aims is to support and empower service users and carers to have a voice and influence on service planning and delivery. It had developed a number of successful forums including a carers planning group, a service user and carer working group and a mental health and wellbeing forum. In addition the Scottish Borders Seniors Networking Forum formed in 2016 aimed to build upon the work of Elder Voice which had a significant role in speaking up for older people living in Scottish Borders over many years. It had representation from a wide range of third sector organisations including Ability Borders, Borders Advocacy Service, Senior Citizens groups and local housing providers. The forum also acted as a voice for older people on the locality working groups.

NHS Borders had an established public involvement and community engagement structure in its own right, aiming to promote a culture of openness and transparency which encouraged public feedback and involvement. The public participation group gathered feedback from patients, carers and families about their experiences of care and treatment in the acute hospital and primary care services. The 'two minutes of your time' initiative and the patient opinion survey had influenced some positive service changes in the acute hospital. These included improved signage, additional parking and a new call system for hospital inpatients. A cohort of volunteers collected real time feedback from patients via conversations and questionnaires.

We found evidence of engagement sessions to support the partnership's plans to implement Buurtzorg and community-led support initiatives. While still in the early stages of development, the test sites had gathered positive momentum in their local communities. They had been identified as test sites because they were areas where community resilience was strong. The partnership had plans to start with community-led support before the end of May 2017, building upon these effective engagement processes.

The partnership had demonstrated its commitment to community capacity building by using the Integrated Care Fund to support the development of a number of projects which complemented existing community groups. In the previous four years a capacity building project had worked alongside the Healthy Living Network to support several hundred people to stay active through exercise. We saw evidence of positive feedback from older people who had benefited from attending exercise classes. We spoke to older people and carers who told us about the positive impact that staying active had on their health and wellbeing.

There was an established culture of volunteering and strong links existed with the third sector. The Red Cross was a key partner who delivered a flexible and responsive service to support older people to live at home. They had a large number of volunteers involved in the buddy system and had established a shopping service for a number of older people who lived alone or were socially isolated.

A six month review of a one year local area co-ordinator pilot in Hawick showed some promising developments and achieved positive outcomes for 16 older people

to help them remain connected within their local communities. Plans were underway to expand this work into the Newcastleton area.

Example of good practice – Community Capacity Building Project

In the last four years, the capacity building project has worked alongside the Healthy Living Network to support several hundred people to stay active through exercise. We saw evidence of positive feedback from older people who had benefited from attending gentle exercise classes and spoke to some older people and carers who told us about the positive impact that staying active had on their health and wellbeing. Community Capacity building teams and the Healthy Living Network worked in partnership to develop a range of projects to support older people to stay active. These included a bike project, Men's Shed, walking football, reminiscence groups, carpet bowls, lunch clubs and tea dances.

12. Capacity to improve

The Scottish Borders partnership had taken action to develop its capacity for improvement and the partnership's executive management team had a shared view of their planned direction of travel. Recent positive steps it had taken included key strategic planning and delivery groups reviewing their terms of reference and revising their memberships to support more effective and timely decision-making. We found a growing culture and strengthening of joint working at a strategic level. Integration Joint Board members and senior managers were optimistic that the level of change needed was now being taken forward at an appropriate pace. Staff and other stakeholders, including third sector organisations, also expressed some optimism about this.

The partnership was embarking on an ambitious plan to transform its approach to meeting the needs of older people. National pilots such as community-led support and Buurtzorg had the potential to radically change how the partnership delivered services across Scottish Borders in a more equitable manner. External consultants had been commissioned to facilitate and support this work. Although the work of these national pilots was still at an early stage of development, the partnership was investing significant time and resources in pursuit of its vision.

While these were promising indicators of progress, there was a risk that this positive progress might not be sustained. Most significantly was the continuing temporary composition of the senior management team with some further important changes pending, including at chief officer level. In addition, the revised governance framework had only recently been implemented. A key finding of this inspection is a lack of appropriate governance and accountability to progress developments effectively. Considerably more work and effort is required to strengthen joint financial planning, the role of the IJB and the strategic planning group. Staff have a key role to play in providing effective services. While staff in Scottish Borders were generally well motivated and prepared to go the extra mile, morale was low in some services. The partnership needed to ensure that staff motivation and commitment was sustained and in some areas, improved.

What happens next?

This inspection has concluded that there was some weak performance within the health and social work services for older people provided by the Scottish Borders partnership. This means that the outcomes and experiences of older people and their carers is at risk in certain areas. Prioritised action will be required across services to ensure that older people and their carers are protected and their needs met and their wellbeing improved. We will be discussing with the partnership how it intends to make the necessary improvements and what support will be required. We will require an action plan detailing how the partnership will take the necessary actions. The Care Inspectorate and Healthcare Improvement Scotland will monitor improvement and will return to the partnership to review progress no later than 12 months following publication of this report.

September 2017

Appendix 1- Quality indicators

What key outcomes have we achieved?	How well do we jointly meet the needs of our stakeholders through person-centred approaches?	How good is our joint delivery of services?	How good is our management of whole systems in partnership?	How good is our leadership?
1. Key performance outcomes	2. Getting help at the right time	5. Delivery of key processes	6. Policy development and plans to support improvement in service	9. Leadership and direction that promotes partnership
1.1 Improvements in partnership performance in both healthcare and social care 1.2 Improvements in the health and wellbeing and outcomes for people, carers and families	2.1 Experience of individuals and carers of improved health, wellbeing, care and support 2.2 Prevention, early identification and intervention at the right time 2.3 Access to information about support options including self-directed support	5.1 Access to support 5.2 Assessing need, planning for individuals and delivering care and support 5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks 5.4 Involvement of individuals and carers in directing their own support	6.1 Operational and strategic planning arrangements 6.2 Partnership development of a range of early intervention and support services 6.3 Quality assurance, self-evaluation and improvement 6.4 Involving individuals who use services, carers and other stakeholders 6.5 Commissioning arrangements	9.1 Vision ,values and culture across the Partnership 9.2 Leadership of strategy and direction 9.3 Leadership of people across the Partnership 9.4 Leadership of change and improvement
	3. Impact on staff		7. Management and support of staff	10. Capacity for improvement
	3.1 Staff motivation and support		7.1 Recruitment and retention 7.2 Deployment, joint working and team work 7.3 Training, development and support	10.1 Judgment based on an evaluation of performance against the quality indicators
	4. Impact on the community		8. Partnership working	
	4.1 Public confidence in community services and community engagement		8.1 Management of resources 8.2 Information systems 8.3 Partnership arrangements	
What is our capacity for improvement?				



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