care inspectorate

Healthcare Improvement Scotland

Services for older people in Glasgow

August 2015

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

HAPPY TO TRANSLATE

Services for older people in Glasgow
August 2015
Report of a joint inspection

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

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

We can also provide this report:

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

Contents

Summary of our joint inspection findings

Background

Between October and December 2014, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services[1] for older people in Glasgow. The purpose of the joint inspection was to find out how well the services of Glasgow City Council and NHS Greater Glasgow and Clyde (referred to in this report as the Glasgow Partnership or the Partnership) delivered good personal outcomes for older people and their carers. We use Partnership to describe the health and social care partnership arrangements for the governance, planning and delivery of health and social care services within the context of the emerging Health and Social Care Partnership in Glasgow. In doing so, we recognised the stage of development the partner agencies shared at the time of the inspection. We wanted to find out if health and social work services worked together effectively to deliver high quality services to older people. This would enable them to be independent, safe, as healthy as possible and have a good sense of wellbeing. We also wanted to find out if health and social work services were well prepared for legislative changes designed to get health and social care services to work closer together. We were also mindful of the significant change and development agenda that was underway in Glasgow at the time of our inspection. In particular, we noted the evolving work to introduce new and improved arrangements for hospital discharge through the introduction of intermediate care. We were also informed about the Glasgow Partnership approach to mainstreaming initiatives funded from the change fund. At the time of our inspection the evaluation of this work was underway. We recognised the scale of the program underway and have attempted to reflect this in our narrative and assessment.

Our joint inspection involved meeting over 130 older people and unpaid carers who cared for older people, and over 380 staff from health and social work services. We read some older people's health records and social work services records. We also read policy, strategic and operational information about the health and social work services partnership and services for older people and their carers in Glasgow.

In Glasgow City, social work services and most community health services were delivered by Glasgow City Council and NHS Greater Glasgow and Clyde.

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

Outcomes for older people and their carers

Our joint inspection found that the Partnership provided a range of services to older people and unpaid carers who cared for older people. Health and social work services staff worked well together to deliver these services, In many instances, this transformed older people's lives, enabled them to remain in their own homes, kept them safe, as well as possible and maintained their wellbeing.

The Partnership had made some progress reducing the numbers of older people, whose discharge from hospital was delayed. The Partnership was also making progress reducing the numbers of older people permanently admitted to care homes. The Partnership needed to work together to reduce the numbers of older people who had an emergency admission to hospital.

What did older people and their unpaid carers think?

Many older people told us they were happy with the support they received from the Partnership. Carers told us they were generally happy with the services provided to them. They told us they felt that the services they received improved their health and wellbeing.

An extensive range of services had been developed across the Partnership to support older people to maintain their independence and feel supported in their own home.

We talked to a significant number of people who used services who told us a variety of opinions about how service was delivered by the Partnership. Some of these comments were:

"Have to work your way through the system".
"Top marks Wonderful People".
"Processing people not engaging with them".
"NHS community engagement officers do great work".
"It is not our fault that we are living longer!"
"Steady stream of different staff".
"Getting access to support could be a 'maze'.

Involving the local community

We found that the Partnership was committed to developing community capacity for supporting older people across the city. There was a good range of community supports already in place to enable older people to have healthy and fulfilling lifestyles at home or in a homely setting in their local community.

We saw a variety of pilot projects funded by the change fund and transformation monies. The Partnership had consulted with local communities about meeting the health and social care needs of older people across the city. Glasgow Council for Voluntary Services facilitated a series of engagement events for older people, carers and providers to inform and develop future service improvement plans and priorities.

Elected members and senior managers from health and social work acknowledged that they needed to do more to develop a cohesive approach to locality planning and community capacity building.

Getting a service and keeping safe

There was a good range of information available to older people referred for services, about how to access support. Waiting times for assessment and the availability of some services meant they sometimes had to wait to get the services they needed.

Financial pressures meant that sometimes older people had to wait until funding was available to access the support they needed.

There were effective processes in place to support adults at risk of harm and management of risk was improving. However, managers and staff were concerned about some delays in progressing adult protection referrals.

Plans and policies

The Partnership had a good set of joint plans, policies and procedures for older people's services. Older people themselves and carers who cared for older people had been widely involved in the preparation of plans for the services that they, the older people and their carers, depended upon.

We found that plans, such as the change fund plan[2], had been implemented by the Partnership, to improve services for older people and to improve outcomes for older people. An example of this, was the development of the reablement service, which helped older people who had had some form of crisis, such as a fall and a hospital admission, to regain their confidence, independence and ability to manage comfortably and safely at home. Implementation of service development plans was often initiated through pilot developments in different areas around Glasgow.

[2] The change fund is a Scottish Government grant to health and social work services partnerships, which aims to help the partnership develop services for older people and carers who care for older people.

Working together

Staff from health and social work services in Glasgow City had a history of good working relationships and effective joint working. The creation of the shadow integration joint board had helped to strengthen the existing good relationships and good joint working. The Partnership was well prepared for legislative changes designed to get health and social care to work closer together. One area for improvement was that communication between senior managers in the Partnership and frontline health staff and social work services staff needed to improve, to bridge the disconnect between strategic planning and staff delivering frontline services.

Leadership

Members of the health and social care partnership executive group and the shadow integration joint board gave strong leadership for the work of the health and social care partnership. The Partnership vision for integrated health and social care services was well developed and published within the commissioning strategy. The actions from the vision and aims reflected the national and local priorities. The Partnership vision for joint working was owned by Partnership senior and middle managers. However, the vision needed to be communicated effectively to frontline staff. Radical redesign of services has left some staff uncertain about the future. However, leaders were confident that they were working hard to resolve this.

Capacity for improvement

Overall, our joint inspection considered that the Partnership had good capacity for improvement. It delivered good outcomes for many older people and their carers. However, the leaders in the organisation were aware that there was much to be done, and there was further work required to improve performance, which would be challenging due to the competing pressures of strategic change and financial constraint.

Evaluations and recommendations

We assessed the Glasgow Partnership against nine quality indicators. Based on the findings of this joint inspection, we evaluated the Partnership at the following grades.

Quality indicators		
1	Key performance outcomes	Adequate
2	Getting help at the right time	Adequate
3	Impact on staff	Adequate
4	Impact on the community	Good
5	Delivery of key processes	Adequate
6	Policy development and plans to support improvement in service	Good
7	Management and support of staff	Adequate
8	Partnership working	Good
9	Leadership and direction	Good

Evaluation criteria

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

Recommendations for improvement	
1	The emerging Glasgow Health and Social Care Partnership should increase its efforts to reduce the number of older people admitted to hospital as an emergency or as a repeat emergency.
2	The Glasgow Partnership should ensure that all carers are offered a carers' assessment in line with legislation and that these are regularly reviewed, and ensure that carers linked to a carers' centre can seek a review should their needs change.
3	The Glasgow Partnership should continue to develop anticipatory care planning for older people, ensuring a more streamlined, standardised and multi-agency approach, with anticipatory care plans that are accessible across the partnership.
4	The Glasgow Partnership should make sure that older people have timely access to occupational therapist assessments to enable them to get the support they need to remain within the community.
5	The Glasgow Partnership should take immediate action to improve the engagement with frontline practitioners and their managers. They need to improve quality, consistency and frequency of communication and engagement with staff across all sectors. Thereafter the partnership should put systems in place to measure if the desired improvements are realised.
6	The new Glasgow Health and Social Care Partnership should routinely gather and report on comprehensive data on the numbers (and eligibility criteria categories) of older people waiting for an assessment or review, the length of time they have to wait, and the length of time for service deployment following completion of their assessment.
7	The Glasgow Partnership should make sure that proper chronologies are prepared and placed in the individuals' electronic or paper record.
8	The Glasgow Partnership should develop a joint workforce development strategy during the first year of integration which sets out clear joint priorities. This should identify possible staffing shortfalls and outline measures to address these as the integration of health and social care agenda progresses.
9	The Glasgow Partnership should reinforce and communicate their organisations' information sharing protocol so that there is a shared understanding among all staff about the confidential information they are permitted to share via secure email systems.
10	The Glasgow Partnership should ensure that development of a comprehensive risk register is aligned with the shadow integration joint board's function in overseeing the integrated arrangements and onward service delivery. This should be maintained when the integration joint board is established.

Background

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

The Scottish Government expects NHS boards and local authorities to integrate health and social work services from April 2015. This policy aims to ensure the provision of seamless, consistent, efficient and high-quality services, which deliver very good outcomes[3] for individuals and unpaid carers. Local partnerships have to produce a joint commissioning strategy. They are currently establishing shadow arrangements, and each partnership is producing a joint integration plan, including arrangements for older people's services. We will scrutinise partnerships' preparedness for health and social care integration.

It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

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, shown in Appendix 1. Our findings on the Glasgow Partnership's performance against the quality indicators are contained in separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector to deliver positive outcomes for service users and their carers. The inspection teams were made up of inspectors and associate inspectors from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors who were carers on each of our inspections. To find out more go to: **www.careinspectorate.com** or **www.healthcareimprovementscotland.org**

[3] The Scottish Government's overarching outcomes framework for health and care integration is centred on, improving health and wellbeing, independent living, positive experiences, improved quality of life and outcomes for individuals, unpaid carers are supported, people are safe, health inequalities are reduced and the health and care workforce are motivated and engaged and resources are used effectively.

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 inspcetion team before the inspection period starts.

Phase 2 -Scoping and scrutiny

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

Phase 3 - Reporting

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

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

Joint inspection of health and social work services for older people in Glasgow

The joint inspection of services for older people in the Glasgow Partnership took place between October and December 2014. During our inspection, we scrutinised social work services and health records for 103 older people using services in Glasgow. We analysed nationally published and local statistical data about the Partnership's provision of health and social work services for older people. We reviewed the Partnership's policy, strategic and operational documents. We spoke with people who received health and social work services and their carers. We spoke with health and social work services staff with leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We are very grateful to all of the people who talked with us as part of this inspection.

Glasgow City context

Glasgow City is the largest city in Scotland and is situated on the banks of the river Clyde in the Western part of the Scottish central belt. Glasgow has a population of 595,080, which is the largest population of the 32 Scottish local authorities, with a population density of 3,407 people per square kilometre.

The Council area is bordered by six local authorities: East Dunbartonshire, West Dunbartonshire, North Lanarkshire, South Lanarkshire, East Renfrewhsire and Renfrewshire Councils.

Glasgow is divided into three sectors: North West, North East and South and these sectors are made up of the member wards of Glasgow City Council.

People aged 65 years or over made up 16% of the population compared with 21% average for Scotland.

The age group that was projected by the Scottish census projections 2011 to increase the most in size, in Glasgow by 2037, was people aged 75 years and over. This was the same as for Scotland as a whole. Glasgow's population of people of pensionable age was due to increase by 4.56% by 2020, and increase by 31.64% by 2030 respectively. The equivalent Scotland figures were 11.46% and 37.74%. More specifically, Glasgow's 75+ years population was due to reduce by 0.42% by 2020 and increase by 18.07% by 2030 respectively. The equivalent Scotland figures were 13.99% and 51.51%.

According to the Scottish Index of Multiple Deprivation, 233,714 (39%) of the population of Glasgow were living in one of the 15% most deprived areas in Scotland. In 2009, this

figure was 42% of the population. The number living within one of the 5% most deprived areas in Scotland was 117,307 (20%) of the population of Glasgow.

The ageing population profile in Glasgow brings with it significant opportunities with health and social care a growing employment sector throughout the area. The rise in population within the city comprises a high number of working age adults. The opportunity exists to further grow the care sector. The most significant increase for Glasgow is in the 85+ age group, with a 16.99% increase predicted in the period 2014 - 2020 and an even higher increase predicted between 2014 - 2030, with an increase of 33.46%. (Looking ahead to the year 2037 the data reflects a 51.67% increase in over 85s.) There are challenges too with significant areas of deprivation within the area remaining.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

The Glasgow Partnership faced considerable challenges delivering positive outcomes for the high numbers of older people who needed health and social work services. These 'Glasgow' challenges included large scale of service delivery, high levels of deprivation,and associated higher morbidity levels for older people than the rest of the Scotland population.

Overall, we found that the Partnership delivered good outcomes for many older people. Some older people experienced poor outcomes, such as those who had their discharge from hospital delayed or who had an avoidable admission to an acute hospital bed.

The Partnership was trying to make sure that older people who were medically fit for discharge from hospital were discharged promptly. The Partnership had made progress reducing the number of older people who experienced an unnecessarily protracted stay in an acute hospital bed. It needed to sustain its efforts to meet the Scottish Government's delayed discharge target, and more importantly reduce the negative impact on the older people whose discharge from hospital was delayed. The Partnership had recently made good progress implementing the Scottish Government's discharge within 72 hours initiative.

The Partnership had below average performance on emergency admissions of older people to hospital. It needed to continue its efforts to reduce the number of older people who experienced an unnecessary unscheduled admission to hospital.

The Partnership provided proportionally more home care and intensive home care to older people than the Scotland average. In March 2014, over 5,000 Glasgow older people received a home care service. In general, home care services were provided promptly and delivered positive outcomes for large numbers of older people.

The Partnership delivered significantly less respite for older people and their carers than it had in previous years. Carers we met said that this had a negative impact on them.

The Partnership's extensive reablement initiative delivered very good outcomes for older people. The service users we met were highly satisfied with the reablement

service they received and their associated outcomes, whereby they were supported to live independently at home. The Partnership's performance data on reablement highlighted the scale and success of this joint service reform program.

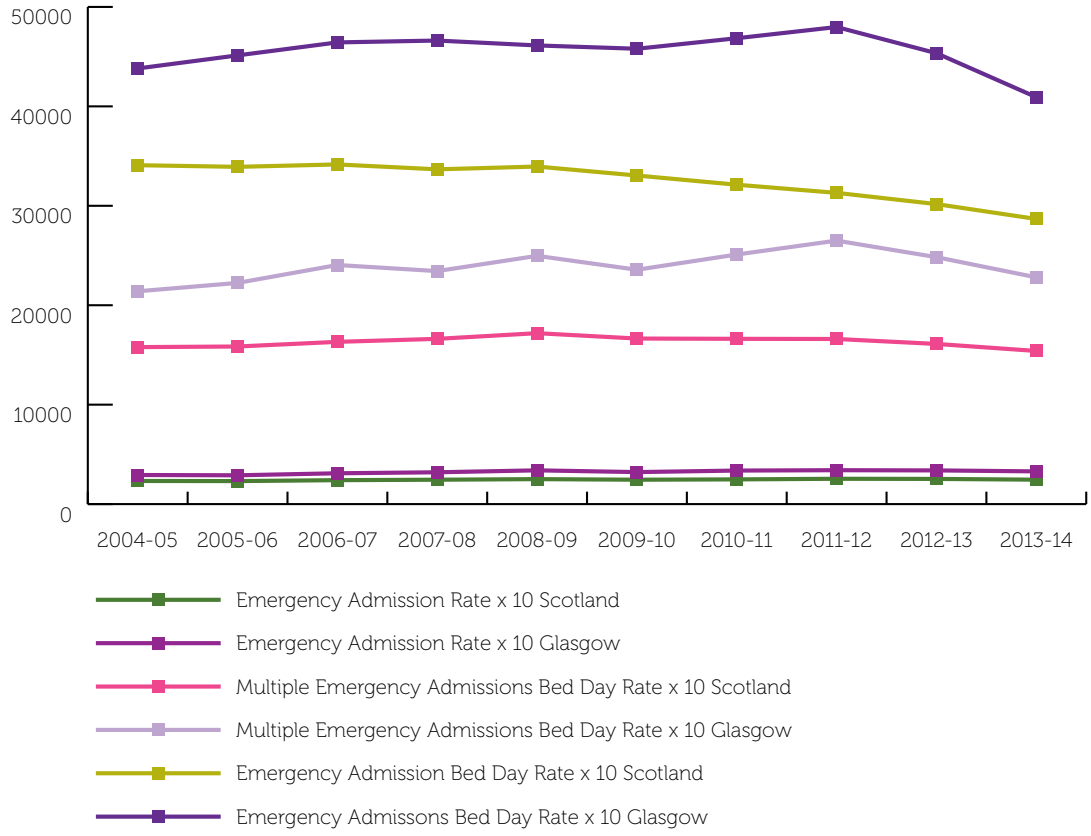
The Partnership had made modest progress providing direct payments to older people.

1.1 Improvements in partnership performance in both health and social care

Emergency admission to hospital

An emergency admission is 'when admission is unpredictable and at short notice because of clinical need'.

Chart 1: Glasgow, emergency admissions and multiple emergency admissions of older people, rates per 100k population



Source: Information Services Division

Chart 1 shows the Partnership's performance on emergency and multiple emergency admissions of older people to hospital. The Partnership's performance was significantly

below the Scotland average. The chart shows a small, three-year downward trend in both of these indicators. This may be the result of the Partnership's efforts to drive improvement in this area. One such effort was the recent initiative at Glasgow Royal infirmary to carry out investigations, diagnosis and treatment of older people at a specialist receiving frail elderly assessment unit, without the need for older people to be admitted to a ward.

One of the reasons for the Partnership's below average performance on emergency admissions is that there are five large general hospitals in Glasgow which have accident and emergency facilities. This increases the likelihood of older people being admitted to an acute ward. Another factor identified by the Partnership staff we spoke with, was that frail older people referred to accident and emergency departments tended to be admitted to hospital for investigations. Glasgow's high deprivation levels and health inequalities were other reasons for high numbers of emergency admissions of older people to hospital.

Health and social work services staff we spoke with said that the work of the falls service on falls prevention and falls management helped to prevent older people having an emergency admission to hospital. The care home falls prevention change fund project had delivered 90 falls awareness sessions to over 500 staff. Other services which had an impact on reducing the number of emergency admissions of older people to hospital included the following.

- The pharmacy service reviewing patients with multiple medications and carrying out medicines reconciliation for patients. There is evidence that a significant proportion of emergency admissions of older people to hospital are related to medicines.

- Step-up beds, used to reduce hospital admissions of older people by treating them within a care home. The Partnership strives to minimise patient stay in the step up service to a maximum of 7 days. Across Glasgow, six step-up beds are located in a single care home.

The closure of part of the Victoria Infirmary, Glasgow, and the opening of the new South Glasgow University Hospital in June 2015 will reduce the number of available acute hospital beds in Glasgow by 300 beds. Planning by the Partnership shows a significant shift to preventative and anticipatory care in the future. It is likely that this will reduce the number of emergency and multiple emergency admissions of older people to hospital as more people will be supported to remain in the community.

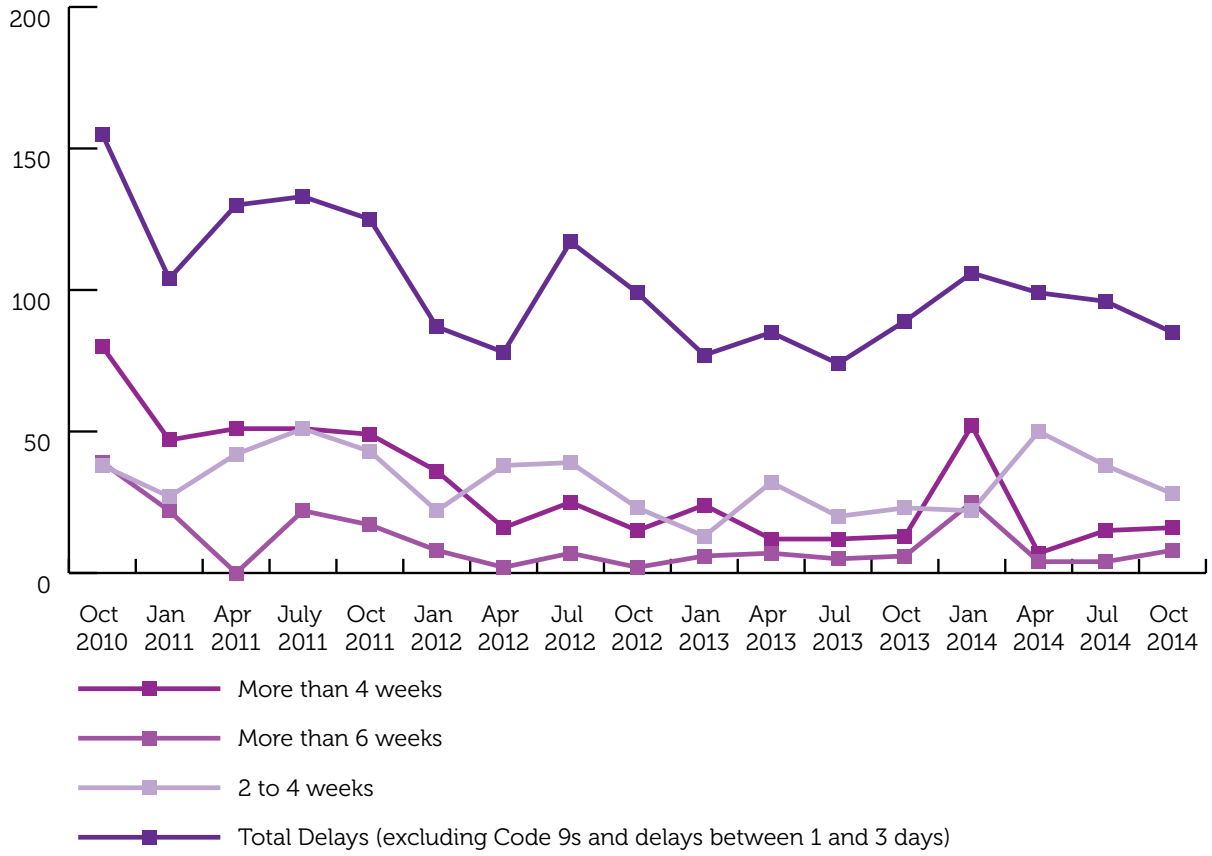
Recommendation for improvement 1

The emerging Glasgow Health and Social Care Partnership should increase its efforts to reduce the number of older people admitted to hospital as an emergency or as a repeat emergency.

Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. The Scottish Government's target is that there should be no delayed discharges over four weeks' duration, From April 2015, the target will reduce to two weeks.

Chart 2: Glasgow, delayed discharges by length of delay



Source: Information Services Division

Chart 2 shows comprehensive data for standard delayed discharges in Glasgow City, including a number of relatively positive factors.

- There is a broad downward trend in overall delayed discharges of older people from hospital.

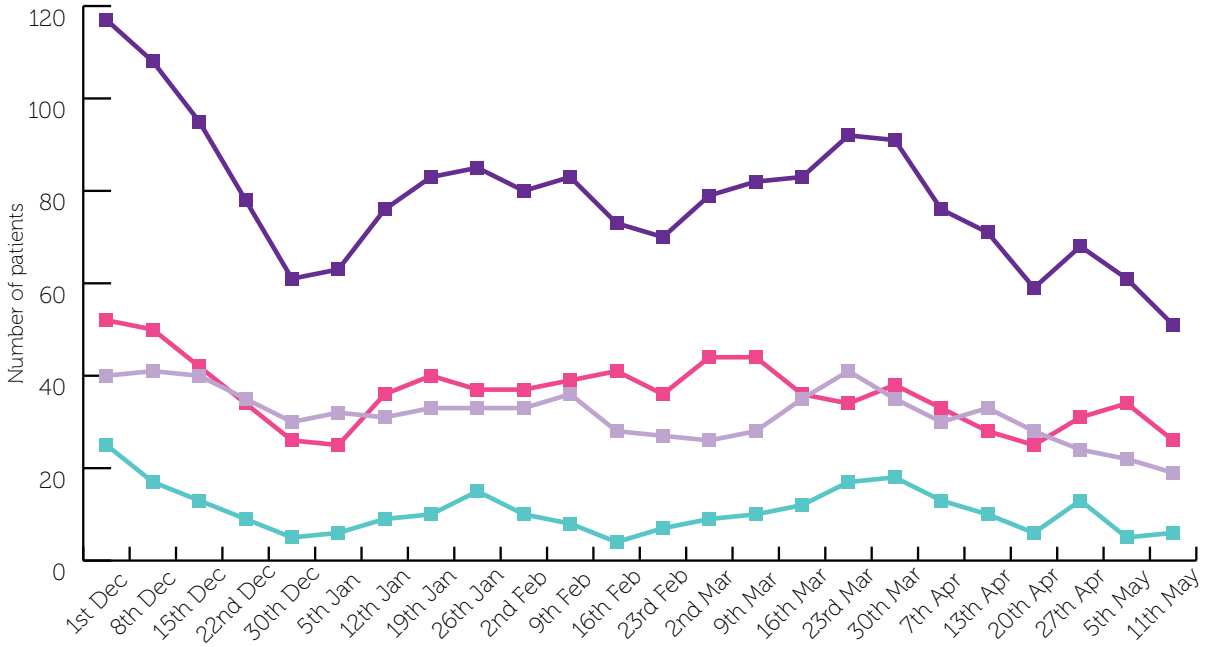
- Delayed discharges of over four weeks' duration show a general downward trend from 2010, apart from a sharp increase in January 2014. Staff told us that this was due, in part, to a halt on admissions to some care homes in parts of the city. Chart 3 below shows that lack of availability of care home places was one reason for the January 2014 increase. The other reason was delays in the assignment or completion of community care assessments.

- The number of delayed discharges of over six weeks' duration have generally been consistent (apart from a less pronounced January 2014 increase).

Chart 2 also shows that the Partnership only met the Scottish Government's delayed discharge target once, in April 2011. At that time, the delayed discharge target was no delays over six weeks' duration. The Partnership has never met the current Scottish Government's target of no delayed discharges over four weeks' duration. The Partnership has the largest number of older people in Scotland. This means that, at any one time, large numbers of older people across Glasgow need a social care package to allow them to be discharged from hospital. This makes it difficult for the Partnership to fully meet the Scottish Government target of no delays over four weeks.

The Partnership was working with the Scottish Government's joint improvement team to make sure that as many older people as possible, who were evaluated as ready for discharge from hospital, were discharged within 72 hours. There is evidence that the longer an older person spends in hospital when they do not need to be there, the harder it becomes to discharge them home. Chart 3 (latest local data) shows the Partnership's good progress ensuring that older people who were fit for discharge were discharged within 72 hours, with a 56% reduction in the number of patients who were not discharged within 72 hours.

Chart 3: Number of patients breaching 72 hr discharge excluding MH, AWI and <65 split by sector. From 1 December 2014 to 11 May 2015

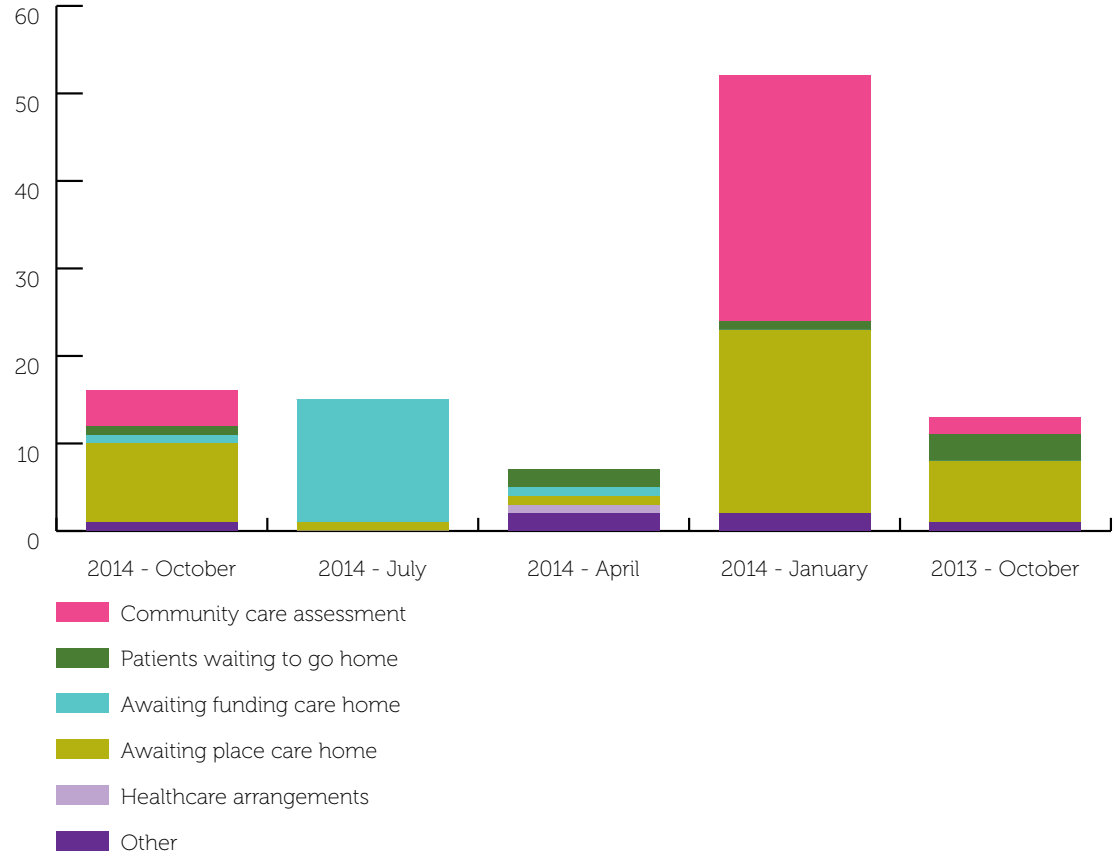


Total patients	117	108	95	78	61	63	76	83	85	80	83	73	70	79	82	83	92	91	76	71	59	68	61	51
South Sector	40	41	40	35	30	32	31	33	33	33	36	28	27	26	28	35	41	35	30	33	28	24	22	19
West Sector	52	50	42	34	26	25	36	40	37	37	39	41	36	44	44	36	34	38	33	28	25	31	34	26
East Sector	25	17	13	9	5	6	9	10	15	10	8	4	7	9	10	12	17	18	13	10	6	13	5	6

Source: Glasgow Partnership Edison Report

We were told about the Partnership's use of step-down beds. These enabled older people to be discharged from an acute hospital bed before either returning home (the ideal scenario), or being placed in a care home. Some staff we spoke with expressed concern that too many older people placed in a step-down bed ended up in a care home or back in hospital, rather than back in their own home. Ten percent of older people placed in step-down beds returned home (the partnership's target was 30% returning home). Of the 90% who did not return home, most were placed in a care home and some went back into hospital. Step-down beds were only available in some parts of the city, for example the North East.

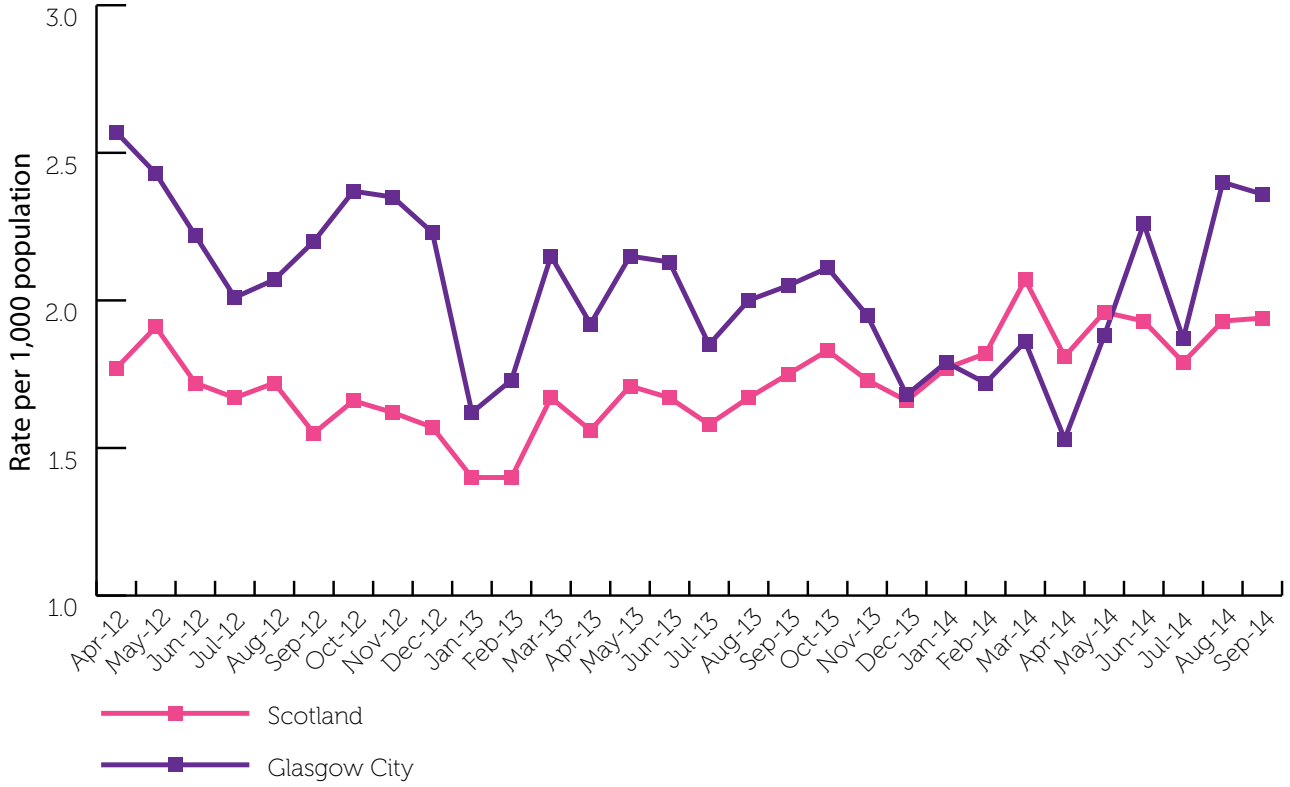
Chart 4: Glasgow, reasons for delayed discharges of over four weeks' duration



Source: Information Services Division

Chart 4 shows the reasons for the Partnership not reaching the Scottish Government's no delays over four weeks target from April 2013 to October 2014. The most common reason for this target not being met was the non-availability of care home places. Either no places were available or there were insufficient funds to pay for the care home places needed. We attended a meeting of a resource allocation group which, amongst other things, handled the admission of older people to care homes. It was clear that, due to financial constraints, there was a restriction on the number of older people that could be admitted to care home in any one month. Some older people who needed a care home place had to be managed at home with the provision of community support services. Another factor, was that some older people occupying an acute hospital bed could not be admitted to the care home of their choice. The Partnership had robust protocols designed to make sure there were no undue delays due to older people and their families waiting for the care home of their choice.

Chart 5: Glasgow City, bed days lost to code nine delays



Source: Information Services Division

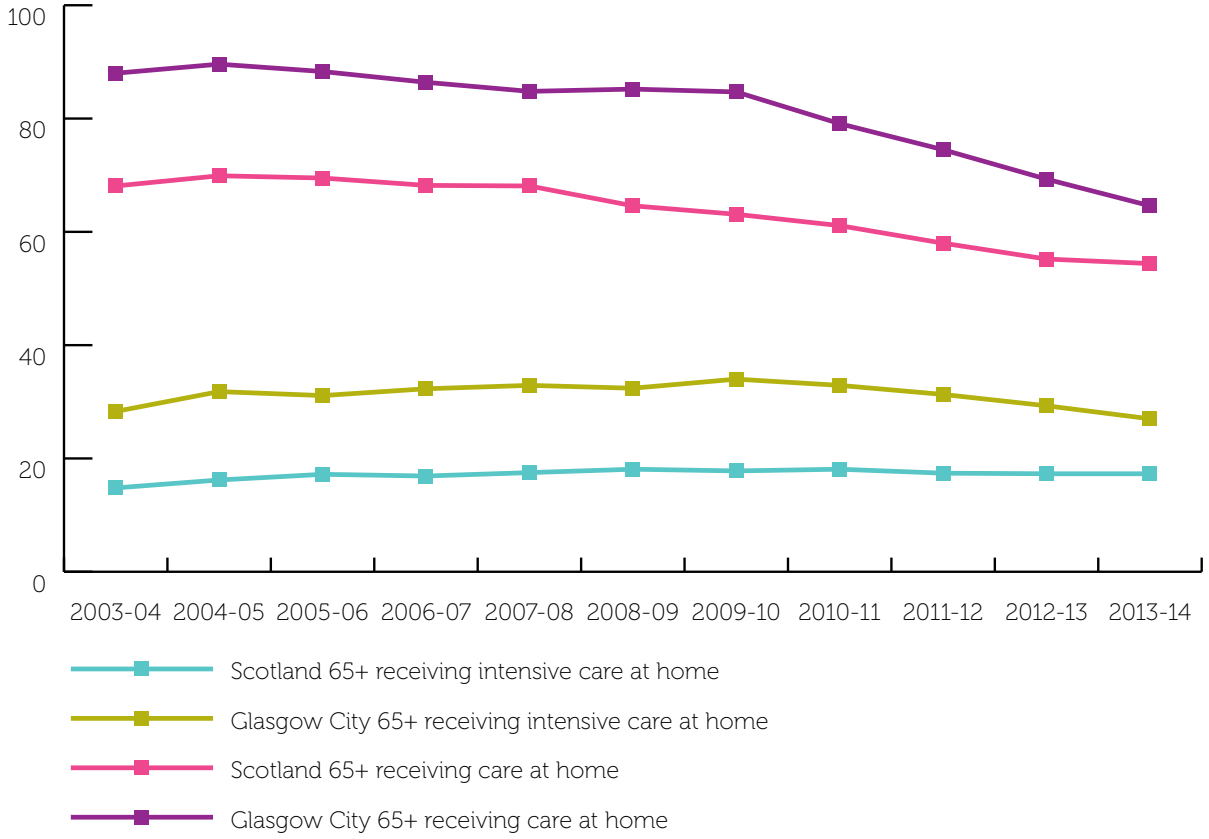
Chart 5 shows the Partnership's variable performance (against the Scotland average) on bed days lost to code nine[4] delayed discharges. The Partnership had made reasonable use of Section 13ZA of the Social Work (Scotland) Act 1968. This allows (under certain circumstances) individuals who lack capacity to be moved from an acute hospital bed to a care home, without using court powers to ensure the move is legitimate. The Partnership had set up a successful power of attorney campaign. This aimed to encourage individuals, while they have capacity, to grant power of attorney to their desired proxy. This meant that older people occupying an acute hospital bed who lacked capacity could be moved to a care home with the approval of their attorney. This had helped the Partnership to manage code nine delays.

Provision of care at home services

Care at home is care and support for people in their own home to help them with personal and other essential tasks of daily living.

[4] Patients whose discharge is delayed for reasons linked to the Adults with Incapacity (Scotland) Act 2000 and for reasons related to the availability of specialist healthcare facilities

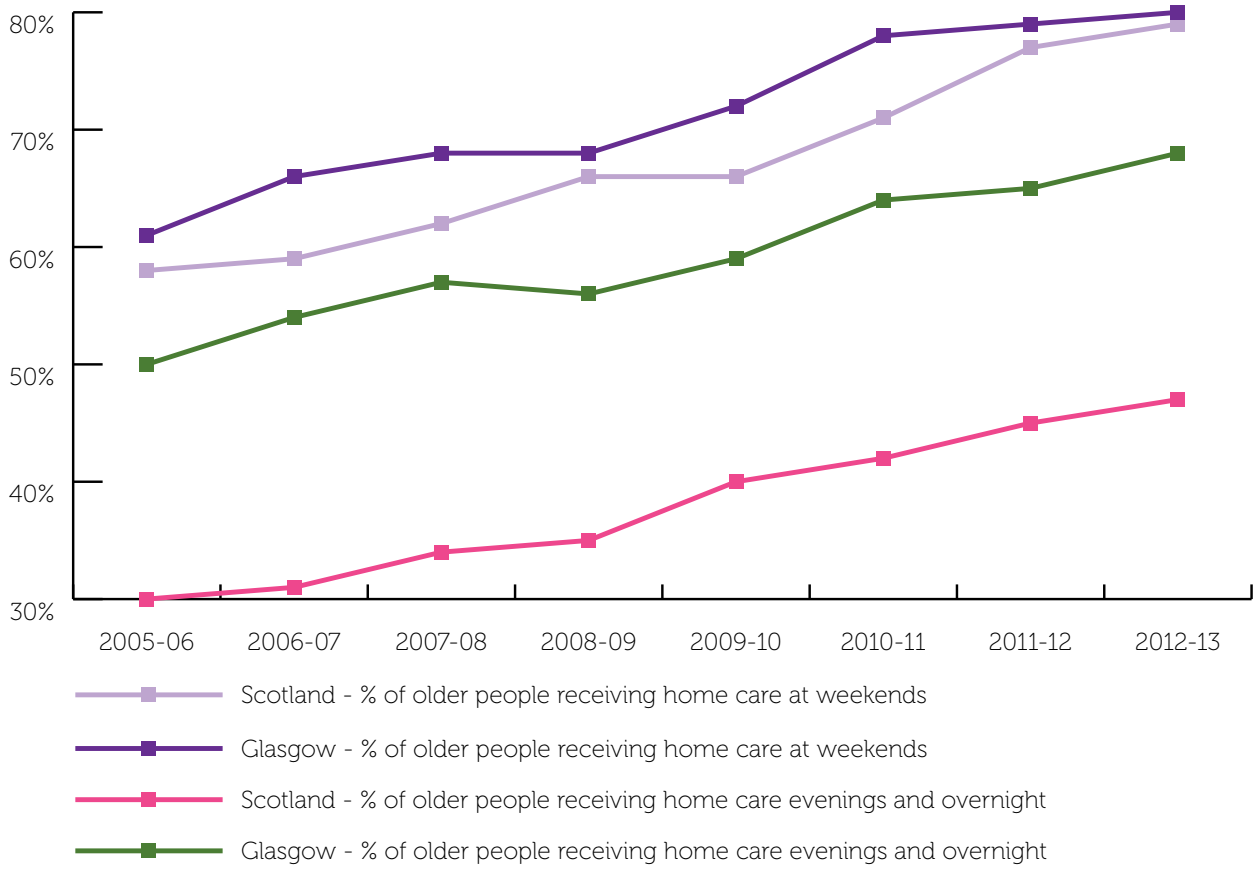
Chart 6: Glasgow, provision of home care and intensive care at home to older people per 1,000 population 65+



Source: Scottish Government

Chart 6 shows the Partnership's performance on delivery of care at home services to older people. Proportionally, more Glasgow older people received care at home and intensive care at home services than older people in the rest of Scotland. These services were provided promptly and delivered positive personal outcomes for a high proportion of recipients (5,337 older people in March 2014). From 2009–2010, there had been a downward trend in the provision of care at home and intensive care at home services in Glasgow. This was probably due to the success of the Partnership's extensive reablement initiative. This aimed to support older people to be able to self-care and live independently at home, and reduce their dependency on the continued use of care at home staff to support them.

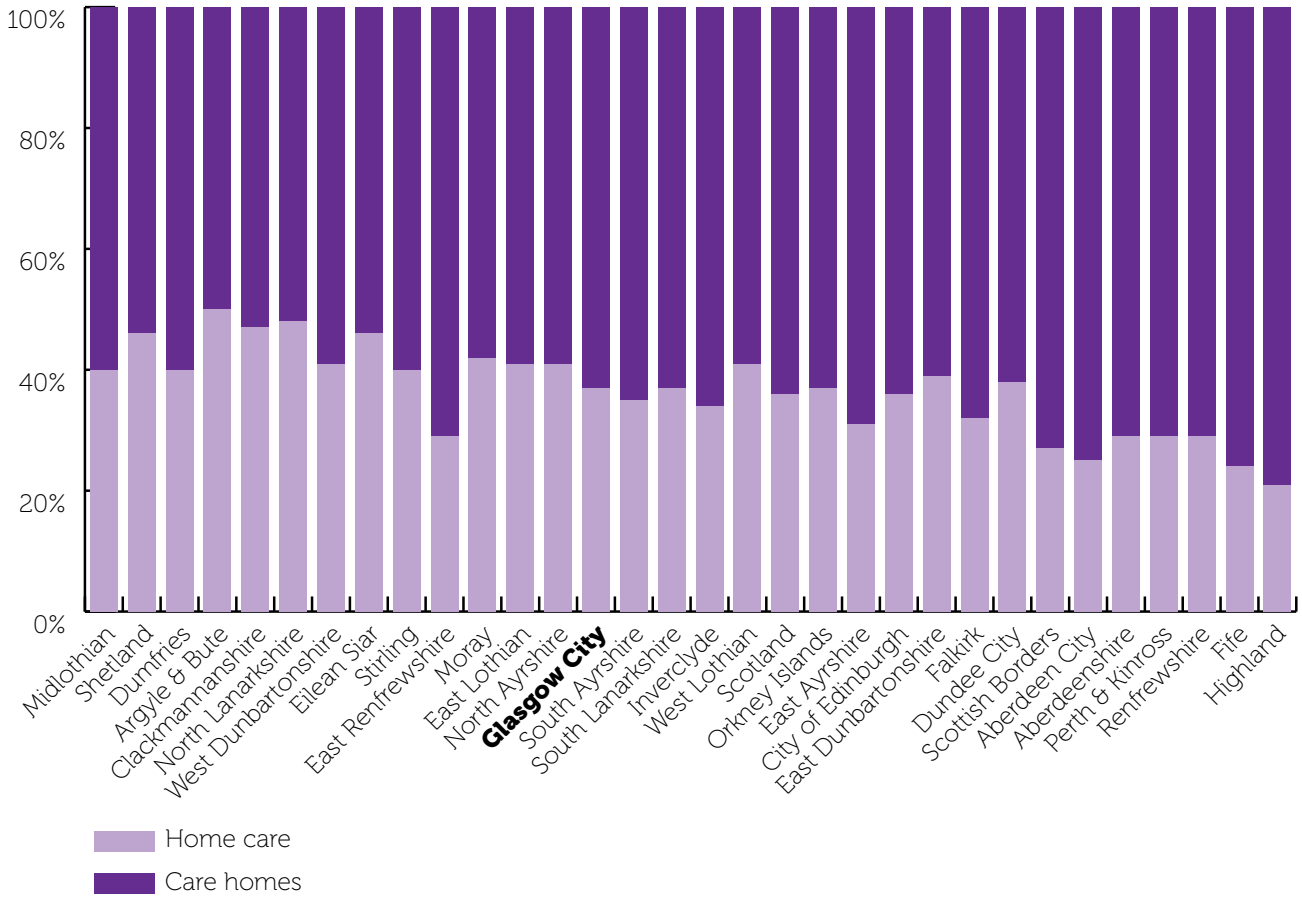
Chart 7: Glasgow number 65+ care clients receiving care at home evenings/ overnight and weekends as percentage of clients



Source: Scottish Government

Chart 7 shows that the Partnership delivered evening, overnight and weekend care at home support to older people at levels above the Scotland average. This meant that many older people received care at home support when they needed it.

Chart 8: 2014 balance of care between older people living at home with intensive home care and older people living permanently in care homes



Source: Scottish Government

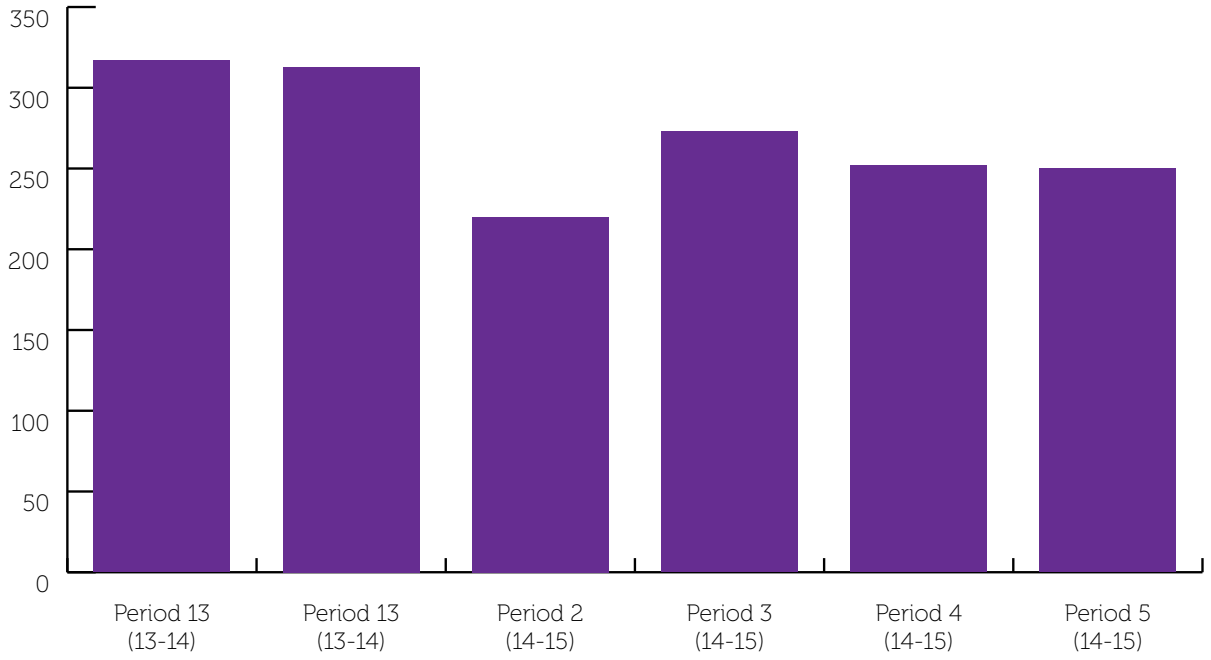
Chart 8 shows the Scottish Government's measure of balance of care for older people. This is the ratio of percentage of older people who reside permanently in care homes over the percentage of older people who receive intensive care at home services (more than 10 hours). The Partnership's higher than average placement of older people permanently in care homes was offset by its higher than average provision of intensive care at home services.

Reablement

Reablement is the delivery of intensive and specialist care at home support, often delivered alongside intermediate care services such as physiotherapy, occupational therapy and rehabilitation. This is normally delivered for a prescribed period of up to six weeks and it aims to help people regain confidence, and focuses on skills for daily living. It can enable people to live more independently and reduce their need for ongoing services and supports.

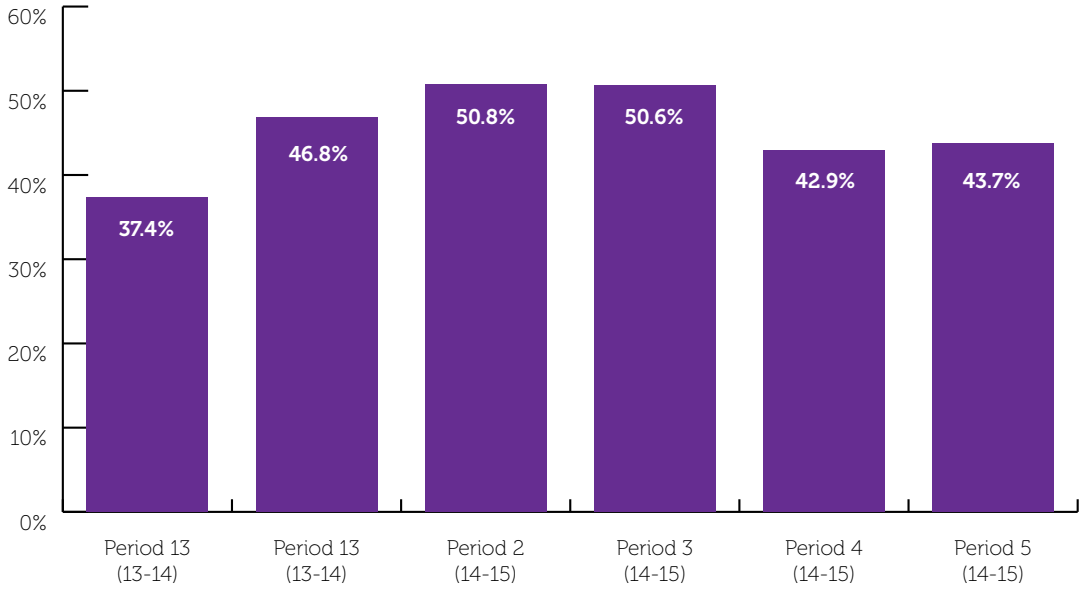
The Partnership had invested a considerable amount of effort and resource into delivering timely, effective reablement for large numbers of older people. All older people who were in hospital and were referred for social care support on discharge were automatically referred to the Partnership's reablement teams. Older people received a timely and potentially extensive short-term package of social care and other supports such as occupational therapy or physiotherapy to enable them to go home. We met with a number of older people who had benefitted from reablement. They all praised the quality of the service they received, the positive outcomes that the service delivered for them, and the caring, committed and competent staff who gave them the support they needed. "I don't know what I would have done without the caring staff who supported me" was a genuinely and consistently expressed view from older people we met during our inspection who had received reablement support.

Chart 9: Glasgow, number of referrals to reablement



Source: Social work services performance reporting

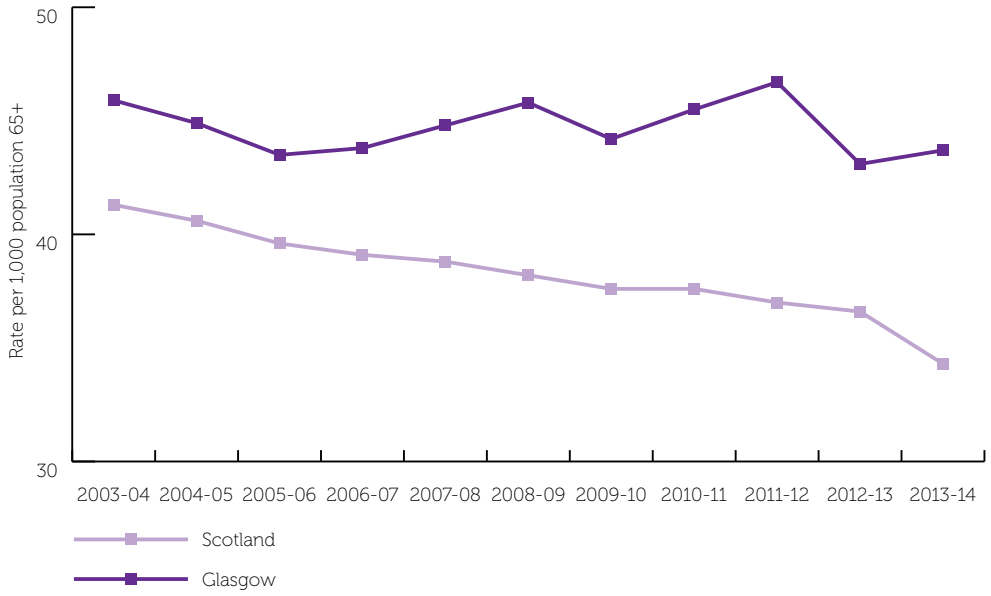
Chart 10: Glasgow, aggregate percentage reduction in care hours following reablement



Source: Social work services performance reporting

Charts 9 and 10 show the Partnership's performance on delivering high numbers of reablement episodes and reducing the number of post-reablement care hours needed by some older people who had received reablement support.

Chart 11: Permanent residents 65+ of care homes supported by Glasgow City Council rate per 1,000 population 65+



Source: Information Services Division

Care homes

Chart 11 shows that the Partnership placed higher numbers of older people in care homes compared to the Scotland average. Reasons for this given by health and social work services senior managers included the long-term impact of deprivation and the associated poor morbidity of the Glasgow population. We considered that room for improvement was needed. The Partnership should reduce its dependency on in-house and purchased permanent care home places for older people and support more of them to live independently at home, while respecting their choice.

Table 1: Performance of regulated services for older people run by Glasgow City Council

Glasgow - performance of regulated services run by the Council (at January 2015, source: Care Inspectorate data)

Grade 1 Unsatisfactory	Grade 2 Weak	Grade 3 Adequate	Grade 4 Good	Grade 5 Very good	Grade 5 Excellent

Care homes (percentage of services achieving grades1-6)

Care and support						Environment						Staffing						Management and leadership					
1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
0	8	38	38	15	0	0	0	31	54	15	0	0	0	31	46	23	0	0	31	15	38	15	0
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

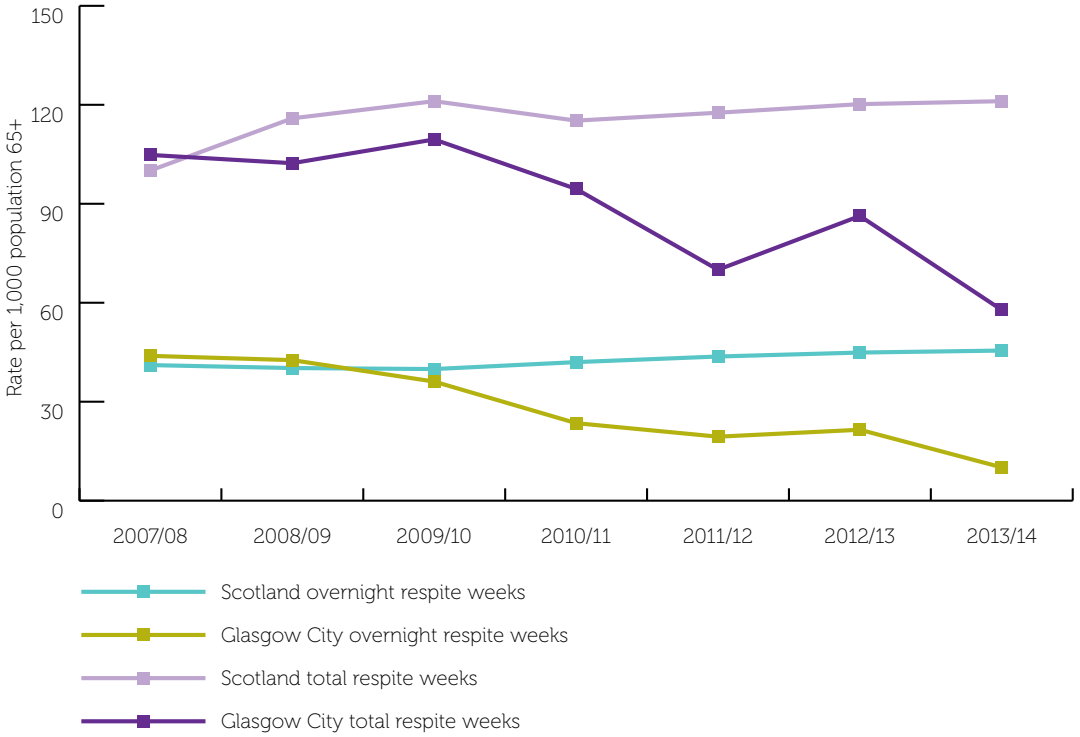
Support services for older people, not care at home (percentage of services achieving grades 1-6)

Care and support						Environment						Staffing						Management and leadership					
1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
0	0	10	29	57	5	0	0	5	33	57	5	0	0	0	48	48	5	0	0	14	52	33	0
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

Table one shows a summary of the grades the Care Inspectorate assigned to regulated services for older people run by Glasgow City Council. While these services delivered good outcomes for many older people, the aggregate of inspection grades indicates performance of the Council's regulated services for older people was an area for improvement.

Respite care for older people and their carers

Chart 12: Glasgow, total respite weeks for 65+ and overnight respite weeks by 65+



Source: Scottish Government

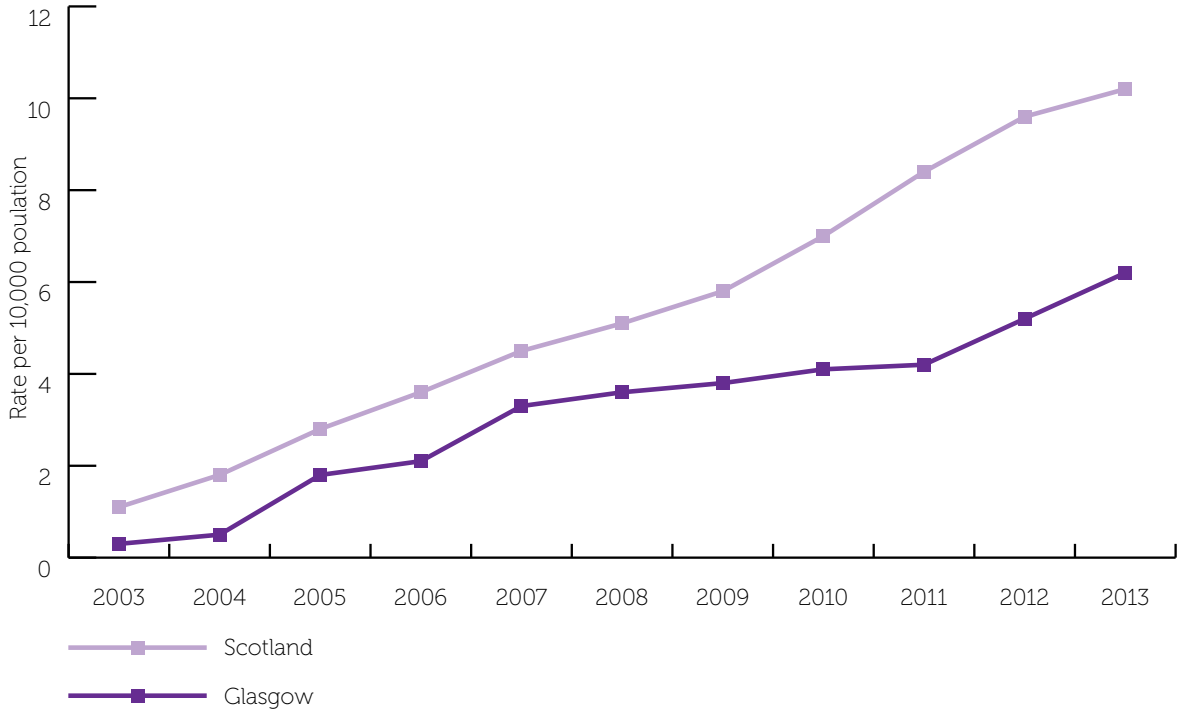
Chart 12 shows a significant downward trend in the Partnership's respite provision for older people and their carers. In recent years, the Partnership delivered respite for older people and their carers at a level significantly below the Scotland average. We met with a group of carers who cared for frail older people and older people with dementia. They all told us about the difficulties getting respite, the reduction in the Partnership's respite provision, and the negative impact this had on them as carers and the older people they cared for, as they felt increased stress and pressure as a result. Carers told us that the Partnership had capped respite at a maximum of 14 days each year and managers confirmed that this was the norm.

Self-directed support

Self-directed support means the ways in which individuals and families can have choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. Since April 2014, councils have a statutory duty to offer the four self-directed options[5] to older people and other adults who need social care services.

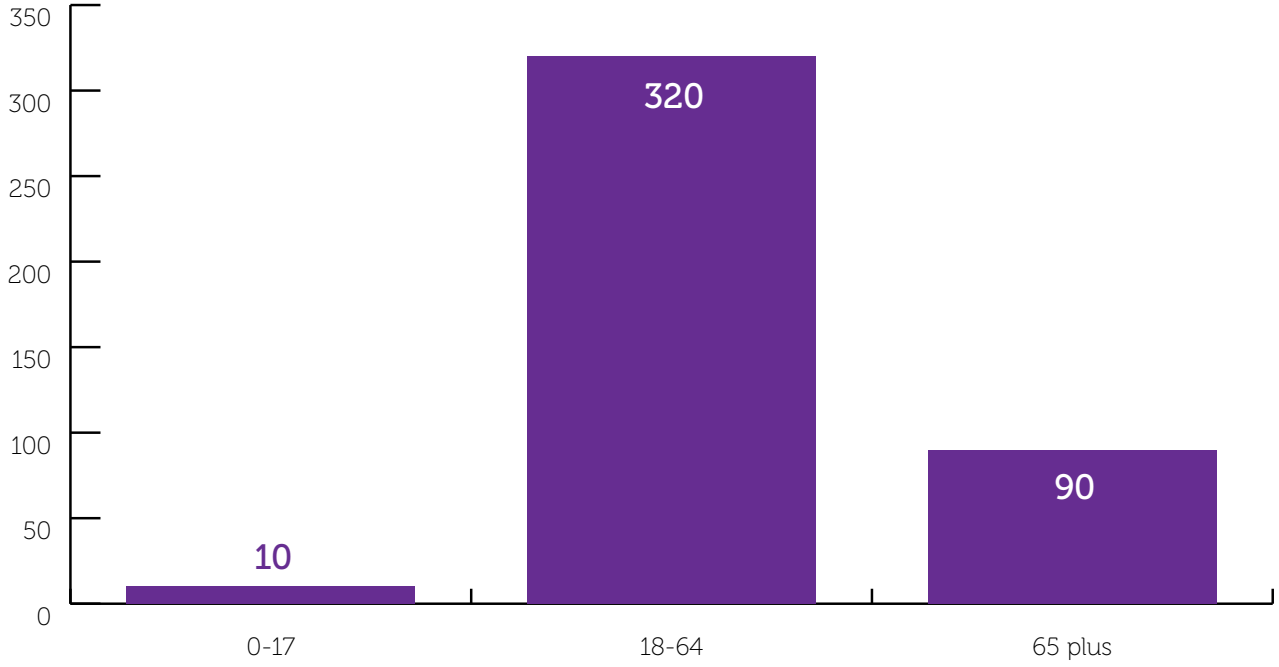
[5] 1 direct payment, 2 individual choses services and service providers, 3 local authority arranges services, 4 mixture of 1 to 3.

Chart 13: Glasgow, service users in receipt of direct payments



Source: Scottish Government

Chart 14: Glasgow 2013, provision of direct payments by age group



Source: Scottish Government

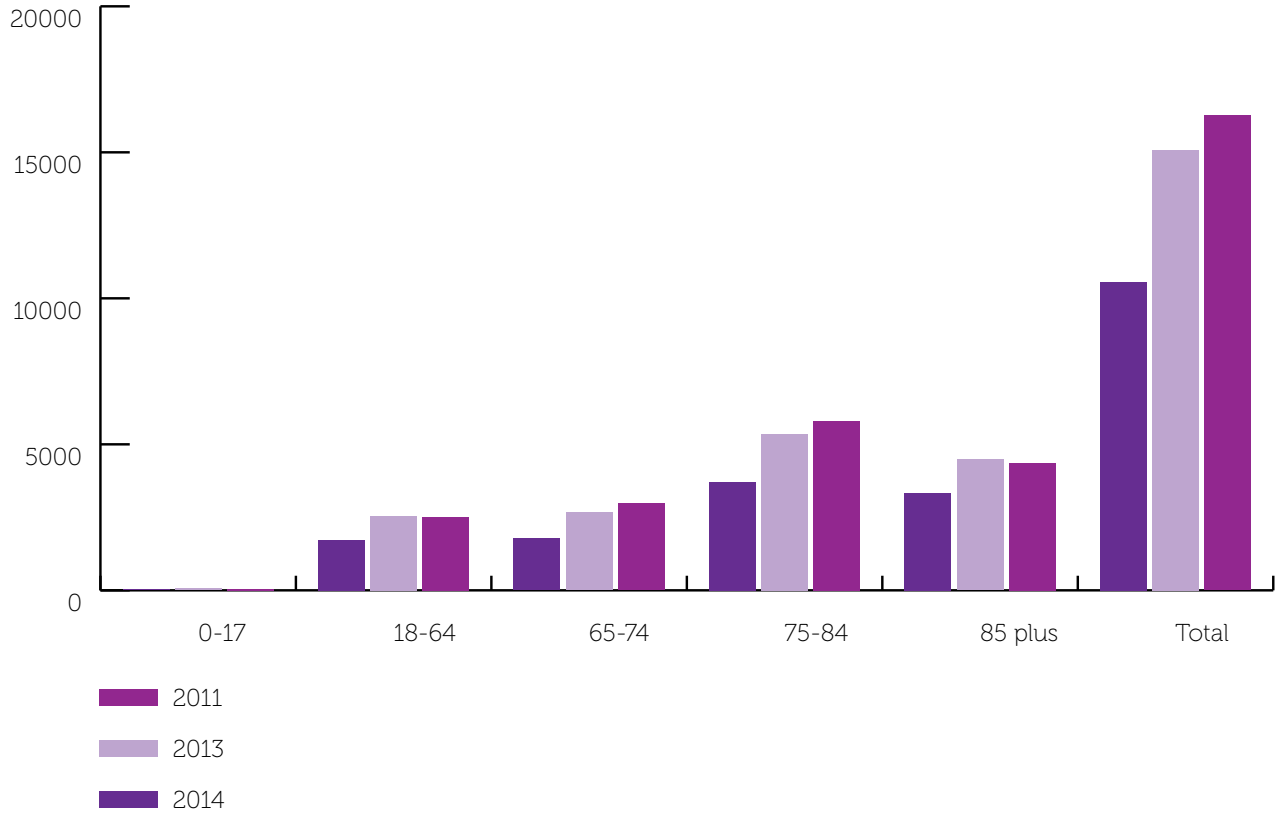
Charts 13 and 14 show the Partnership's progress with the overall delivery of direct payments and the delivery of direct payments to older people. See Quality Indicator 5.4 for discussion of the issues pertaining to the Partnership's delivery of self-directed support to older people.

Telehealthcare and telecare

Telehealthcare assists the self-management of patients' conditions and may include video-conferencing, older people's remote consultations with health professionals or environmental monitoring devices installed in older people's homes.

Telecare is equipment and services that support people's safety and independence in their own home. Examples include community alarms,smoke sensors and movement sensors.

Chart 15: Glasgow, community alarm and telecare provision trend by year and age group



Source: Scottish Government

Chart 15 shows a significant downward trend in the provision of community alarms and telecare services to older people (and other client groups) from 2011 to 2014. Staff told us that they thought increases in charging for these services was the cause of the reduction.

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

Outcomes are the changes in individuals' lives that are a result of the services they receive. Outcome-focused assessments and care plans emphasise the desired positive changes the individual wants and the provision of services that are designed to achieve these changes.

Chart 16: File reading results on the range of positive outcomes delivered by health and social work services for individuals

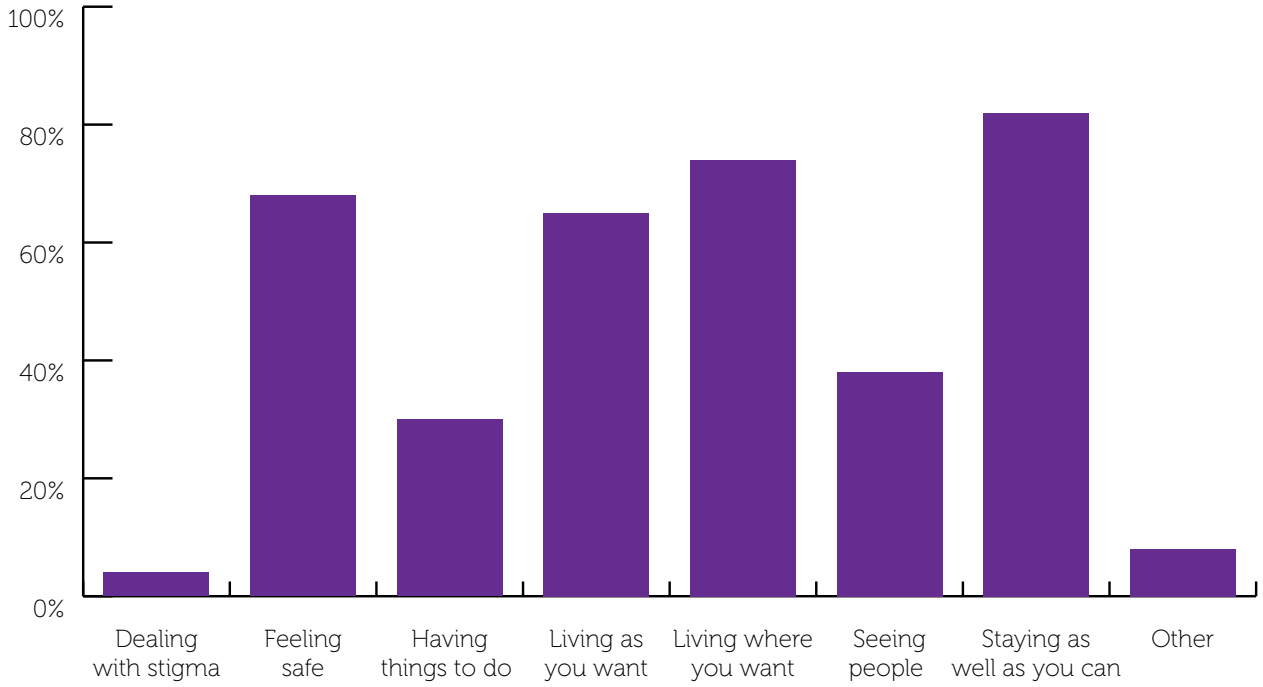


Chart 17: Results of Glasgow joint inspection staff survey on outcomes for older people

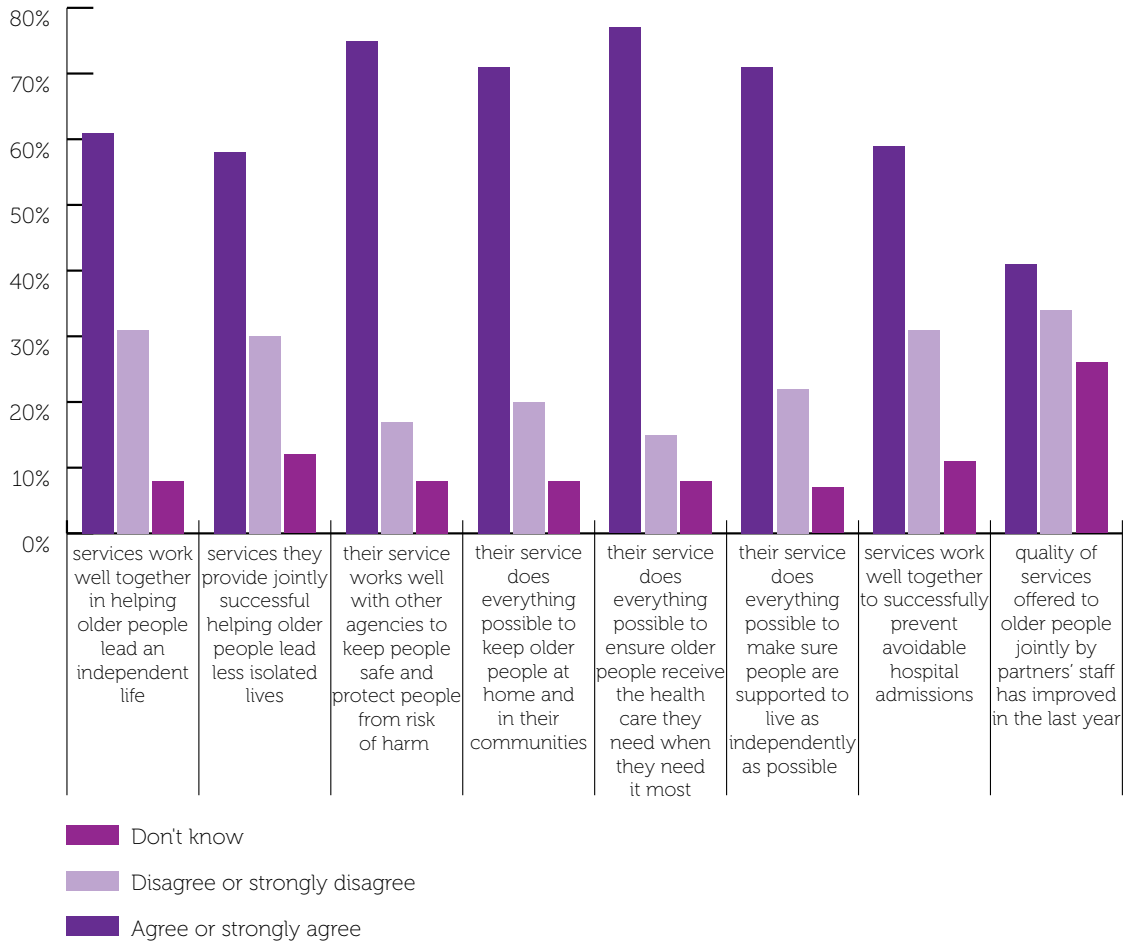


Chart 16 shows the positive results on outcomes for older people from the health and social work services records we read. The Partnership delivered positive personal outcomes for 93% of these older people.

We met with a large number of older people who told us that the health and social work services they received kept them safe, enabled them to live independently at home, kept them as well as possible and enhanced their wellbeing.

Staff responses on delivery of outcomes for older people were relatively positive (chart 17).

Outcome-focused care plans

For over half (58%) of the older people whose records we read, their primary care plan was not outcomes-focused, as they did not set out the individuals' desired personal outcomes. The Partnership needed to improve in this area.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Adequate

Older people and their carers were generally happy with the services provided to them by the Glasgow Partnership. They felt these services improved their health and wellbeing.

Good progress had been made in the development of the carers' pathway. The Partnership was working hard to make sure it identified and supported carers at the right time, with 6,220 new carers identified through the pathway from 2012-2015.

An extensive range of services had been developed across the Partnership to support older people to maintain their independence and feel supported in their own home. However, the majority of these initiatives were pilot projects, were time-limited and were not accessible to all older people due to where they lived. Therefore, the Partnership should consider how it will achieve sustainability for these initiatives and ensure equity of access to these services.

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

An outcome-focused approach

From the health and social work services records we read, we saw evidence of good personal outcomes and positive changes for older people after intervention by health and social work services.

We saw positive personal outcomes being achieved for many older people. (Chart 16.)

Amongst other funding streams, the Glasgow Partnership received transformation funds from the Scottish Government. Using these funds, the Glasgow Partnership, the third sector and the independent sector had developed many initiatives and pilots across different localities. These were focused on improving outcomes for older people by reducing social isolation, increasing physical and mental activity and managing long-term conditions. The following are some examples of what we found.

- The Visibility project was an early intervention project which targeted people aged 55 years and over who had experienced deterioration in their sight but had not yet registered blind or partially sighted. This project offered emotional support, advice and practical support to help people come to terms with their condition and make the most of the sight that they still had. The Glasgow sensory impairment social work team worked closely with this project. They provided aids and adaptations to encourage independence to enable individuals to remain at home.

- The Art of Wellbeing project was an arts-based project based in the North West of the city. It provided arts and social activities for older people, with the aim of reducing social isolation and promoting movement and activity.

Older people who attended some of the activities associated with these initiatives told us that they contributed very positively to better outcomes for them. They helped to reduce social isolation, increase their activity levels and empower them to have more controlover their condition. The majority of these initiatives were were time-limited pilot projects.

Improving care and support for older people

The Partnership piloted an initiative at Glasgow Royal Infirmary where older people bypassed the accident and emergency department and were assessed in a frail elderly unit. This was a medical assessment unit and older people could then have access to appropriate staff from older people's medicine services. Staff told us that this unit has resulted in fewer admissions of older people to Glasgow Royal Infirmary. Following an evaluation of this unit, the Partnership planned to extend this initiative to other acute hospitals in Glasgow including the new Southern General Hospital when it was opened.

A six-bedded step-up care service was located in a care home in the North East of the city. This service aimed to prevent hospital admission by providing short-term care and support to older people for up to 15 working days. The service was led and managed by health rehabilitation services with dedicated social work services input. Referrals made to the step-up care service came from a variety of sources such as the GP, the NHS rehabilitation service, the consultant in older peoples medicine, day hospital, or social work services. Staff from the service told us that they also regularly received referrals from the frail elderly assessment unit. They told us that the two services worked well together to prevent admissions to the hospital.

The Partnership planned to roll out step-up care as part of the overall expansion of intermediate care.

Supporting carers

Older people and their carers told us they were generally happy with the services provided to them. They told us they felt that the services they received improved their health and wellbeing. From our scrutiny of health and social work services records, we saw that where carers had a carers assessment, the subsequent support provided had led to improved outcomes for almost all of the carers.

Most staff agreed that the views of carers were fully taken into account when planning, and supporting older people. Carers also have a legal right to have their own needs assessed if they so wish. From our review of health and social work services records, we found a large proportion of carers (67%) should have been offered a carers assessment. However, there was no evidence that this had been done. The Glasgow Partnership should make sure that all of the offers of a carers assessment are properly recorded.

In Glasgow City, access to services and support for carers was provided through a one-stop shop approach known as the carers' pathway. This gave carers from all care groups access to a range of services and support. This included income maximisation, where staff helped older people to access welfare benefits, emotional support, short breaks, advocacy, training, information and advice, and peer support. The Partnership felt that its current support to carers was good, as did a number of carers' groups that we spoke with. There was a strong emphasis on ensuring social work services and health professionals, including primary and acute care staff, routinely identified carers early at the point of a cared for person's diagnosis or initial contact with services. They should then be signposted towards the carers' pathway.

Carers and staff were extremely positive about the Partnership's approach to providing help and support for newly identified carers with the introduction of the carers pathway. However, carers and carers groups said that, although there had been an increase in new carers assessments and identifying carers at an earlier stage, support provided to existing carers was not always reviewed. They were concerned that existing carers were not signposted for help and support from services. Carers previously supported should be linked to a carer centre where they can return at any time should their needs change.

Recommendation for improvement 2

The Glasgow Partnership should ensure that all carers are offered a carers' assessment in line with legislation and that these are regularly reviewed, and ensure that carers linked to a carers' centre can seek a review should their needs change.

The Partnership had developed emergency plans for carers. The emergency plan detailed the steps that should be taken in the event of an unexpected crisis to make sure the cared for person was safe and well. This social work services initiative, funded through the change fund, employed two emergency planning workers to support carers to complete emergency plans. Once completed, these were stored electronically on social work services systems and could be accessed out of hours. This support had reduced anxiety and increased confidence for carers, and made them feel more secure and supported in their role.

Glasgow City Council had introduced a carers' privilege card. This provided a range of discounts, including Glasgow Life gym membership, cinema entry, parking, a range of other services and access to council staff benefits. Over 7,000 carers' privilege cards had been distributed to carers across the city.

Using change fund monies, the Partnership had provided an alternative to residential-based respite for older people with low level care needs through the development of the 'Good Morning Service'. This offered a call service to older people when carers were taking short-term breaks. Volunteers were linked to older people and called them to make sure they were well and ask if they needed any help or support. This gave carers peace of mind that someone was available nearby when they were away.

In Quality Indicator 1, we reported that Glasgow was significantly below the Scotland average respite provision for Scotland. Carers and staff we met told us about concerns they about access to respite including:

- increased stress and uncertainty due to a reduced level of respite
- a cap on the level of respite they could receive
- difficulties in securing planned respite, even when dates were notified well in advance.

Carers told us that being able to get some respite from their caring role was very important. Older people, carers and staff told us that respite care across the Partnership had been reduced. Carers, who had previously been able to access six to eight weeks of respite care, found that they could no longer get this. Two weeks now was the average amount of respite that could be accessed. We were told by staff and carers that respite places could no longer be booked in advance. Concern was also expressed about the time it took to confirm respite places and dates. This reduction in access and the new arrangements for booking respite had caused anxiety and increased stress for carers.

Carers whose respite had been reduced told us that sleep deprivation was one of the most significant causes of pressure on carers and respite provision was invaluable in helping them manage and cope with the stress of caring.

The increase in the range of services charged for, had led to some older people choosing fewer services. This then increased the strain for some carers. Some carers had felt it necessary to reduce the number of days of service that they and the person they cared for received.

2.2 Prevention, early identification and intervention at the right time

Supporting people with long-term conditions

An increasing number of people are living with long-term conditions, such as diabetes and asthma.

We found that the Partnership had made good progress with providing help and support to older people with long-term conditions. A number of active ageing classes within communities and classes for people with long-term medical conditions had been set up. These classes supported participants to exercise at a level appropriate for their functional ability and this helped participants carry out daily activities more easily. All reablement service users were offered access to these services on completion of reablement.

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

The Partnership's many initiatives around management of long-term conditions and building community capacity delivered good outcomes to older people. These enabled older people to have more control and choice by planning for their preferred support and care intervention should there be a deterioration in their condition or a carers crisis. However, the Partnership recognised that further development of anticipatory care plans was needed.

Telecare

Telecare is an alarm system with a 24-hour call handling and response service. The service is mainly used as an emergency contact service by people who live alone but can also support people who have serious mobility and/or medical problems. A variety of telecare devices are available which make sure that people are safe in their own homes. The most common devices are a pendant alarm, an alarm unit and a smoke detector. The community alarm telecare service was operated by Cordia, who provided the service

on behalf of Glasgow City Council. Older people and their carers told us they were generally happy with the telecare service provided by Cordia. They also told us it was a valuable and reassuring support.

However, staff told us that, since the introduction of the charging policy for telecare services, many older people had cancelled telecare due to the financial cost (see chart 15 in Quality Indicator 1). Cordia's annual report (2012-2014) stated that there had been a 30% increase in people cancelling their community alarms and telecare service due to the charging policy. Cordia stated that the most vulnerable service users retained their telecare service.

Implementing Scotland's National Dementia Strategy 2013-2016[6]

The Partnership was making progress in implementing Scotland's National Dementia Strategy 2013-2016. It was achieving its targets for diagnosing people with dementia and offering them post-diagnostic support. Post diagnostic support services were in place across the Partnership. Older people, carers and staff spoke positively about post-diagnostic support. However, in some areas we found that some older people with a diagnosis of dementia were having difficulty accessing day care services. This was due to waiting times for social work assessments and waits for specialist dementia day care services. We read records that showed there were some older people waiting for assessment where critical or substantial needs had been identified. Health and social work services staff told us that waiting times had impacted on carers as older people had excessive waits to be assessed and allocated day care services. This resulted in increased pressure and stress for the carer. Staff made use of interim solutions such as short breaks to support older people and their carers. The Partnership should monitor waiting times for day care and their impact.

Access to psychological therapies for older people

Health improvement, efficiency, access to services and treatment (HEAT) targets are an internal NHS performance management system that supports national outcomes. NHS boards are accountable to the Scottish Government for achieving HEAT targets.

We saw that the Partnership was meeting the Scottish Government's HEAT 18-week target for referral to treatment for psychological therapies. A number of initiatives had started, funded by the change fund, aimed at improving access to psychology and psychological therapies for older people. These included:

- a full-time permanent older people's psychologist based in the community
- a temporary assistant psychologist appointed to look at stress and distress training

[6] Scotland's national dementia strategy; Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers, Scottish Government June 2011

with plans to deliver this training to staff in wards for those with dementia across Glasgow
- training for staff in the structured psychosocial interventions in teams (SPIRIT) initiative) which trains mental health staff in the use of cognitive behavioural therapy
- access to cognitive stimulation therapy for older people with mental health conditions.

The Partnership told us that the source of funding for these initiatives and posts was time limited as they were funded by the change fund. The partnership told us that funding would continue through the intermediate change fund during 2015 and 2016.

Anticipatory care planning

An anticipatory care plan anticipates significant changes in an older person (or their care needs) and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals.

Anticipatory care planning is more commonly applied to support those living with a long-term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well.

We found variations in how anticipatory care planning was being developed and accessed across the Partnership. During our review of health and social work services records, we did not see many anticipatory care plans. Through discussion with community health staff and GPs, it was clear that anticipatory care plans were being completed. Staff groups we spoke with expressed positive experiences of anticipatory care plans, with district nursing seeing this as a pivotal part of care provision.

However, access to this information was restricted to certain staff groups as anticipatory care plans were held on the GP electronic system alongside key information summaries. These summaries allowed healthcare professionals to record and share important information about people with complex care needs or long-term conditions.

Staff told us that this restriction in accessing an older person's anticipatory care plan was detrimental to effective joint working and the delivery of the best possible outcomes for the older person. ACPs were at an early stage of development at time of inspection. Different models of anticipatory care were funded through the change fund and these had been evaluated.

From speaking with staff, older people and carers, it was clear that staff from social work services had limited involvement in anticipatory care planning. The Partnership

recognised that further development of anticipatory care plans was needed. The Partnership had made plans to develop a more streamlined and multi-agency approach to anticipatory care planning across the city. A one-year anticipatory project had been planned using Integrated Care Fund monies.[7] This project was planned to commence in 2015. While a city-wide approach had been agreed, senior managers told us that a final decision on the anticipatory care model had yet to be agreed.

Recommendation for improvement 3

The Glasgow Partnership should continue to develop anticipatory care planning for older people, ensuring a more streamlined, standardised and multi-agency approach, with anticipatory care plans that are accessible across the partnership.

Palliative and end-of-life care

We saw that good progress was being made in delivering palliative care for older people across Glasgow. Palliative care services were flexible and responsive. NHS Greater Glasgow and Clyde had developed a palliative care website. This useful website provided information on palliative care for patients and carers. This included links to resources, local services and the latest news on palliative and end-of-life care developments. The website also had a section for health professionals with the most up-to-date access on resources available for their patients, as well as opportunities for their own learning and development. Staff told us that where palliative care needs had been identified, health and social care services worked well in supporting the patient and carer with a range of services, including overnight services, to allow people to die at home.

NHS Greater Glasgow and Clyde, in partnership with Marie Curie and other local providers, had set up a fast-track discharge service in the north of Glasgow. This was in line with the end-of-life care objectives in the Scottish Government's palliative care plan.[8] This supported patients with palliative care needs and their families with in the patients' own home by providing a service which met both their health and social care needs. This service was seen as extremely successful and, following evaluation, plans were under way to extend this service across the city. However, until this evaluation was completed, it was not clear when this service would be extended.

District nurses visited hospital wards before patients were discharged from hospital. Hospital staff also spent time with district nurses in the community. This helped to

[7] The Integrated Care Fund is a new source of specific Scottish Government funding for adult social care replacing previous change fund monies and is intended for long term care across all adult care groups.

[8] Scotland's palliative care plan Living and Dying Well: Building on Progress. Scottish Government, January 2011.

facilitate better understanding and share learning and experience of supporting older people at the end of their life.

Intervention at the right time

Across Glasgow, hospital staff and rehabilitation staff were able to directly order care at home services without going through social work services. Care at home services could be ordered up till 10.00pm. This enabled older people to be discharged home from hospital when medically fit, with care at home services capable of being in place within four hours of discharge. The rapid access to care at home helped to free up beds in acute wards more quickly. Cordia, the largest care at home provider in Scotland, provided a range of care at home services on behalf of Glasgow City Council. Older people, carers and staff all spoke favourably of this city-wide quick access service. They told us that it enabled older people who were able to return home to be discharged quickly knowing that support and help would be in place.

We found that older people and carers were happy with the amount of personal care and support received from Cordia staff. Older people and carers told us that, although there was generally consistency of Cordia staff providing care, this was not always the case. Occasionally, care at home staff were deployed whom the older person did not know. Carers told us that this was very unsettling for older people who had dementia. We also heard from carers that changes in the timing of visits at the weekend would result in changes to routines for both the carer and the older person. As staff who were not familiar with the older person had to read their care plan before carrying out care duties, this also impacted upon the time allocated to spend with and care for the older person. Cordia focused on achieving general consistency in providing staff within the limitations of the rota system. Cordia advised that they were about to implement new major organisational development plan which would introduce more flexible rotas.

The reablement service worked in partnership with Cordia to support older people to enable them to get home from hospital. Other services such as occupational therapy and physiotherapy were set up swiftly for older people when reablement was required. We met with older people who had experienced the reablement process and found the service to be valuable and supportive. Cordia's reablement staff had been trained in the referral pathways for the 'Good Move' project. This was an initiative to reduce social isolation, improve activity levels and support the management of long-term conditions. We discuss this initiative more in Quality Indicator 4.

A number of staff across the Partnership told us that there were difficulties getting occupational therapy assessments for older people in the community. In some cases, this resulted in older people struggling to manage at home. There were difficulties in accessing aids and adaptations to help people to safely remain at home. Occupational

therapists gave us examples of where care at home packages had to be increased due to the lack of aids and adaptations.

Staff said that social work occupational therapy services designated older people as priority 1–3 depending on how critical their needs were. Priority 1 classifications were palliative care needs, continence difficulties and high falls risk. Priority 2 classifications were general bathing requirement and general transfer difficulties. Due to lengthy waiting lists only people classed as priority 1 or priority 2 received an occupational therapy assessment. Priority 3 had needs that were classified as low risk and had lengthy waiting lists for assessment and some did not receive an occupational assessment as a result.

The social work services occupational therapists in some localities also told us that the budget for equipment and adaptations had run out and no new funding would be available until the next financial year. Across the Partnership, we heard that due to the lengthy waits for an assessment from a social work occupational therapist, some health occupational therapists from psychiatric services were asked by social work services staff to carry out assessments on the older person. We heard that this was because health occupational therapists had budgets available for the provision of equipment and adaptations.

Recommendation for improvement 4

The Glasgow Partnership should make sure that older people have timely access to occupational therapist assessments to enable them to get the support they need to remain within the community.

NHS Greater Glasgow and Clyde had developed for GP practices an effective service for patient medicines management and reviewing patients with multiple medications . This promoted safe, effective, evidence-based use of medicines for patients considered most at risk of adverse effects. A number of GP practice clinical pharmacists also provided input into the multidisciplinary medication review process. They also delivered medication reviews for at-risk patient groups, including patients in residential care homes.

The Glasgow rapid response and resettlement service (GRRRS) was a good example of the Partnership and the third sector working together to develop and deliver an initiative that could improve the health, wellbeing and outcomes for older people (see good practice example on page 41).

The First Through the Door initiative encouraged all agencies to take a proactive approach to identifying older people who may be vulnerable and would benefit from some level of support. This involved a range of statutory services, housing providers and

third sector organisations who were given training on how to identify older people that would benefit from additional support.

The Partnership provided a community falls prevention programme. This consisted of a specialist team of technicians, occupational therapists, physiotherapists and pharmacists. The team visited the older person at home and, following a home assessment, provided a programme suited to the older person's own needs . This service promoted independence and improvement in physical health and helped older people to manage their fear of falling. Through speaking with staff, it was clear that the service was well used by community staff. They thought it was invaluable in helping to maintain an older person's safety and independence once they were susceptible to falls. Due to eligibility criteria, older people could only be referred to the service if they had experienced a fall. Therefore, older people deemed at risk of falling but who had not yet had a fall could not access this service.

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

The Partnership started offering self-directed support options for older people on 1 April 2014. From our review of health and social work services records, we found that 76% of older people were not offered self-directed support options where we would have expected them to be offered. We met with self-directed support development officers from Glasgow City Council. They told us that self-directed support was being delivered to older people through Glasgow City Council's 'personalisation' model. Personalisation is a social care approach described by the Department of Health as making sure that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings".[9] Glasgow City Council's personalisation model has seven steps to complete with the person completing the steps being supported to do so by social work services. It involves self-evaluation, devising and agreeing a care plan and allocated budget, and regular review of the plan to ensure it is working.

Glasgow City Council's social work services had adopted a targeted approach to self-directed support for older people. This made a distinction between those with non-complex and complex social care needs. (This will be discussed further in Quality Indicator 5). Those that presented with more complex needs would be referred immediately for a social work assessment and this would be carried out within the personalisation framework, be allocated an individual budget and have an outcome-based support plan put in place.

9 An introduction to Personalisation. Department of Health (2008)

All older people go through the reablement route. Older people with non-complex needs who complete the reablement process and require a continuing mainstream low level service would be offered the four options for self-directed support at their first care service review.

Carers, older people and advocacy groups told us they were concerned that self-directed support would be used solely as a money saving exercise to reduce expensive care packages, as only complex and expensive care packages would go through the personalisation process. Concerns were also raised about the choice of care providers for older people. Cordia mainstream care at home services were the main provider of care at home in Glasgow.

Older people, carers and staff said that Glasgow City Council had introduced a charging policy for day care attendees in April 2014. This meant a number of older people no longer attended day care services, or had reduced the number of days that they attended. There was general dissatisfaction from older people and carers at the way the charging policy had been introduced and the limited availability of information. Older people and carers spoke about a lack of clarity and support about the means testing assessment element.

We spoke with older people who attended a new day care service. Following the planned closure of the day centre, older people who had attended this centre now had to make their own way to a central pick-up point to be taken to the new day centre. All other older people were picked up from their homes. Older people we spoke with were unhappy about this, and it had resulted in changing the number of days and times they attended. Staff told us that this was an agreement made at the time of the day care centre closure as the older people affected were outwith the catchment area. However, this decision would be reviewed.

Example of good practice

The Glasgow rapid response and resettlement service combined supported patient transport with follow-up help for older people discharged from accident and emergency departments and wards. The primary aim of this service was to help prevent avoidable admissions and re-admissions to hospital and promote resettlement at home by providing practical and emotional support. This service provided two trained patient transport crew (2.00pm–2.00am, seven days a week) to return the patient home. Patients were then helped to settle back into their home and, where needed, provided with a short period of support to assist their independence and enable them to remain at home. This service was initially funded by change fund monies. The Partnership had agreed that the service would continue and a commissioning process was underway.

Quality indicator 3 - Impact on staff

Summary

Evaluation – Adequate

Staff across the Glasgow Partnership were committed to providing high quality support and services to older people. Staff in more specialist teams were most positive about the difference they were making to the lives of older people.

However, morale was relatively low among some staff groups across the Partnership. This was more widespread within social work services.

The consistency and frequency of communication and joint engagement with staff across all sectors needed to improve.

Staff across health and social work services had mixed views on joint working. There were positive working relationships among health and social work practitioners but these varied between teams and within the three sectors of Glasgow (North East, North West and South Glasgow).

3.1 Staff motivation and support

Motivation

In assessing how the Partnership was progressing against this quality indicator, we looked at a range of documentation submitted by the Partnership. This included employee surveys carried out by Glasgow City Council and NHS Greater Glasgow and Clyde. During our inspection, we also carried out our own staff survey and had face-to-face meetings with 382 staff. This included a range of managers and staff groups from across health and social work services.

Our staff survey was sent out to 2,363 staff, with 665 (28%) responding. This broke down to:

- almost two-thirds (65%) of the 665 respondents were employed by the NHS
- 31% were employed by the Council
- the remaining 4% were employed in 'other sectors' such as GP practices.

Most staff who responded to our staff survey were motivated and committed to providing high quality care and services. Results from our staff survey showed that:

- 86% of staff said that they enjoyed their work

- 75% agreed they were well supported in situations where they may face personal risk
- 69% of staff said they felt the service had excellent working relationships with other professionals (23% disagreed with this view)
- 65% felt valued by their immediate managers (26% disagreed).

Staff morale across the Partnership was higher within more specialist teams, carer services and those in more specialist posts. For example, we met staff from Social Care Direct. This was a call centre for referrals to social work services. Staff were enthusiastic, had a clear direction and sense of responsibility, role and ownership of their service. We also met staff from the step-up care service who were well motivated and there was good communication across different staff groups in this service.

In contrast, we met with a range of frontline staff and managers from across health and social work services, who were responsible for delivering a range of services for older people. They told us about a number of demotivating factors which they said impacted on their ability to do their job. These included:

- the level of uncertainty over health and social care integration plans
- increased pressure as a result of increasing workloads
- pressure to make financial savings.

Whilst a relatively small number of staff had been identified to move to Cordia, social work frontline staff we met were particularly concerned and anxious about the intention to move staff. Cordia provided a range of care at home services on behalf of Glasgow City Council. This independent customer service/business support service operated as an arm's length external organisation (ALEO). The social work services frontline staff that would transfer into Cordia were responsible for completing less complex care at home assessments for older people and other client groups. Staff who were transferring were worried about the impact this might have on their ability to be responsive and provide flexible services when trying to improve outcomes for older people.

Staff we met expressed similar views to the responses to staff surveys carried out by the Partnership. A staff survey carried out by Glasgow City Council in 2012 found 67% of staff believed the experience of working for the council had deteriorated. A staff survey carried out by NHS Greater Glasgow and Clyde in 2013 showed that 89% of staff were happy to go the extra mile at work when required. However, only 43% of staff thought that they could meet all the conflicting demands on their time at work.

We were also given information on workplace stress surveys carried out by Glasgow community health partnerships across North East, North West and South Glasgow during December 2013, January and April 2014. Staff across different specialisms were represented, including those who worked within older people and physical disabilities

teams. Staff responded positively about peer relationships and support from frontline managers. Most responded less positively about the volume of work and insufficient opportunities to question managers about changes at work. While we read that action plans from these surveys were being developed to address areas identified for improvement, no evaluation of progress was available.

The Partnership was robust in monitoring staff attendance with levels within social work services in 2014–2015 showing slight variation across services from 4.7% and 7.1%. Staff sickness levels within health for the city were an average of 5.5% with a national NHS Scotland target set at 4%.

Some frontline social work staff told us that they had experienced difficulties in sustaining their motivation due to the frustration at recently introduced changes in the resource allocation and assessment systems that they used daily.

Teamwork

Staff were clear about their own roles and responsibilities, but were often less clear about those of their colleagues across the Partnership. However, they observed a loss of opportunity for more strategic joint working since the dissolution of Glasgow's five community health and care partnerships in 2010. Staff were hopeful that joint working was likely to improve as services became more joined up after integration
Of the staff who responded to our survey, 76% agreed or strongly agreed that they had access to effective line management (regular professional specific clinical supervision within the Partnership). Sixty three per cent of those who responded agreed their workload was managed to enable them to deliver effective outcomes to meet individual's needs. This percentage was lower for social work services staff. Thirty-seven per cent agreed that there was sufficient capacity in the service to undertake preventative work. Reasons given by staff we met across the Partnership for this included difficulties in finding time to prioritise preventative work when there were many complex cases waiting for assessment.

Some health service managers spoke positively about their work with older people but were less positive about other aspects of their work. This included duplication of work effort and assessment processes. A number of frontline health and more specialist staff groups said they were not being enabled to use their specific skills. We found most staff were uncertain about what the future integration might mean for their work.

We talked to a wide range of frontline staff across the Partnership who described the lack of communication from senior managers about proposed changes to structures and service delivery. Some concerns were also raised from acute service staff about the need

for improvement in communication within health services. They suggested there was a lack of clarity around general issues such as the definition of intermediate care .

Senior managers we spoke to were aware of the uncertainty amongst staff and of the need for good communication and to be open and transparent in their dialogue with staff across the Partnership. They believed they communicated well. They described efforts they were making to improve communication.

Within health, an open invitation from the interim chair of the shadow integration joint board had been issued to all staff to attend briefing sessions on integration with the chief officer designate.

We also read Issue 2 of the Social Work Services Staff Newsletter July 2014 which included a wealth of relevant information. Health staff had access to the staff net (Greater Glasgow and Clyde internet home page) and were kept informed through team briefings. Senior staff also said that the progress of integration of health and social work and communication were standing items at the senior management team meeting. Senior managers were taking steps to improve communication. This was important as staff that feel well informed are more likely to demonstrate commitment to an organisation. However, the role, profile and visibility of senior managers in supporting and communicating with employees to promote the delivery of effective services should be developed and enhanced as integration progresses.

Learning and development

Learning and development opportunities varied between health and social work services, across teams, staff groups and within the three sectors of Glasgow. From our staff survey, and from meeting with a range of health and social work services staff, health services staff were more positive about development opportunities open to them. More specialist staff, such as lead pharmacists, described good access to learning with opportunities to test and change services. Some senior health services staff we met described opportunities for senior managers to shadow and question the executive director and saw this as a positive way of improving their learning. We read NHS Greater Glasgow and Clyde's Facing the Future Together strategy[10]. This encouraged the whole organisation to work better together.

Frontline social work services staff described variable development opportunities across the Partnership. Some staff told us they had less opportunity to access meaningful training than previously. Social work services staff said they had less opportunity for professional development and less control over their work than previously.
Glasgow City Council and NHS Greater Glasgow and Clyde community health

[10] Facing The Future Together' 2012, NHS Greater Glasgow and Clyde corporate strategy.

partnership had separate learning and development plans. However, these were yet to be embedded. Senior social work services managers told us that protected learning, workshops and discussion forums were being rolled out to support teams and allow them to have
time together.

Example of good practice

Staff spoke positively about the designated carer teams in place across Glasgow. These teams were very enthusiastic and passionate about taking forward carer services and had a strong commitment to driving forward further improvement. Good joint working between social work services, the NHS and third sector carer partnership leads was evident in taking this whole systems approach with clear pathways forward.

Recommendation for improvement 5

The Glasgow Partnership should take immediate action to improve the engagement with frontline practitioners and their managers. They need to improve quality, consistency and frequency of communication and engagement with staff across all sectors. Thereafter the partnership should put systems in place to measure if the desired improvements are realised.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

The Glasgow Partnership was committed to developing community capacity for supporting older people across Glasgow. A good range of community supports was already in place to enable older people to have healthy and fulfilling lifestyles at home or in a homely setting in their local community.

A variety of pilot projects had been funded through change fund and transformation fund monies. The Partnership had consulted with local communities about meeting the health and social care needs of older people. Glasgow Council for Voluntary Services facilitated a series of engagement events for older people, carers and providers to inform and develop future service improvement plans and priorities.

Elected members and senior managers from health and social work services acknowledged that they needed to do more to develop a cohesive approach to locality planning and community capacity building.

4.1 Engaging with the community

The Partnership was committed to engaging with the public and local communities about meeting the health and social care needs of older people in Glasgow. Older people and carers were delegates on local and city-wide committees for older people and consultation forums.

We read the Partnership's draft joint strategic commissioning plan for older people. This was co-produced with the third and independent sectors. There was a clear theme of building community capacity in the plan. We were impressed by the Partnership's commitment to redesigning future care services for older people to shift the balance away from institutional settings to supporting older people to live at home.

The Partnership had invested in the third sector as a key partner to sustain and grow new community-based services for older people. Third sector and independent sector reference groups were involved in the planning for Reshaping Care for Older People. There was a good history of community involvement in Glasgow. Dedicated workers had also been appointed to improve engagement with the third and independent sectors. A compact with the third sector, published in 2009, had helped to consolidate

their engagement. Some third sector initiatives received funding, at least in part, from the change fund to deliver community supports to older people .

Planning for Reshaping Care for Older People had input from third sector and independent sector reference groups. Glasgow Council for Voluntary Services led on the community capacity-building programme on behalf of Glasgow's third sector. This assisted with the early intervention and prevention agenda. Reshaping Care for Older People had a strong focus on tackling social isolation, maximising independence and improving the health and wellbeing of older people. This was a good example of how the Partnership supported older people to have active, healthy and fulfilling lifestyles. The Partnership had sought the involvement of older people and carers in the future design of services in their local community.

The reshaping care for older people group used a co-production approach to develop services for older people and enhance community capacity.

Following consultation, the Partnership intended to amend the draft joint strategic commissioning plan by 1 April 2015. The Partnership's equality impact assessment of previous public engagement activity revealed that local events were not enough to reach the number of older people affected by the changes. A programme of roadshows in shopping centres, libraries and health centres was underway to improve and develop future engagement activity. The Partnership had also produced a detailed web based services directory called Your Support Your Way which included extensive information about how to access health and social care services across the city.

The key messages from the Partnership's consultation were that people supported the Partnership's vision and direction for the plan. However, respondents were anxious about its delivery in the current economic climate and the level of need in Glasgow. Overall, people wanted more detail about how the Partnership would bring about the proposed changes and what this would mean for their local communities.

Glasgow Council for Voluntary Services supported a mix of small local groups and bigger national provider organisations with their funding bids and business models. This ensured there was a focus on key priorities and outcomes. A city-wide third sector mapping exercise, completed in 2012, highlighted the scope and variety of small non-commissioned services such as lunch clubs and befriending services that relied on volunteers.

Senior managers within the Partnership said the structure and leadership across the localities was progressing. The locality planning group produced a comprehensive report about its progress, which outlined the plans to develop a management structure to support health and social care partners with locality planning. The draft structure

continued with three service delivery sectors - North East, North West and South Glasgow. In our staff survey, we asked about community involvement.

Partnership managers and staff acknowledged that some areas had a better range of resources for older people than others. For example, a South sector care and repair project provided a handy-person service for minor adaptations. This was funded through change fund monies, but was not a city-wide service. The Partnership was carrying out an evaluation of change fund initiatives across the city. It had identified the need to carry out some additional targeting of services particularly in the North East sector as this was less well resourced.

Older people told us they were very satisfied with the community support services available to them. They spoke highly about the assistance they received from staff and volunteers to enhance their quality of life and wellbeing.

The carers' centres helped carers to access a range of services to support them in their caring role. This included training in understanding dementia, and moving and assisting techniques. Community nurses funded by the carers information strategy were co-located in social work services carer teams and they worked closely with the carers' centres to monitor and review the individual health care needs of carers and to provide support and advice about their health and wellbeing. This was a positive approach to enhancing carers' wellbeing and addressing their physical and mental health needs.

Community initiatives

The Third Sector Transformation Fund (change fund monies) supported third sector initiatives to enhance community capacity to support older people and improve their health and wellbeing.

The Transformation Fund supported 20 organisations from the third sector to deliver projects for older people and carers in the city. These helped to deliver positive outcomes for older people. Some examples of projects included the following.

- Castlemilk Pensioners Action Centre assisted older people to live independently at home. This community-based centre offered a range of activities including subsidised cafes to support healthy eating, advice, guidance, companionship and a variety of entertainment and learning opportunities.

- The Glasgow Food Train provided a volunteer-led grocery shopping delivery service to local older people in the South sector who were experiencing difficulty with shopping. This vital service promoted partnership with local supermarkets

with additional arrangements made as necessary to support older people from ethnic minority backgrounds. There were plans to extend this service across Glasgow.

- The Carers' Emergency Planning Service supported carers to develop emergency plans and this included a carer emergency card. This was highly valued by carers as highlighted in outcomes evaluations.

- Southside Housing Association had identified a number of older vulnerable people resident within their housing stock. The housing association had taken action to reduce social isolation by developing four community bases for their older tenants.

- Glasgow Association for Mental Health provided over 2,000 hours of community-based support every week to older people in Glasgow. The organisation had expanded its range and volume of services and had developed a 'Calm Project' in the North of the city. The aim of the project was to improve the mental health and wellbeing of older people by supporting them to gain skills in managing stress through complementary therapies and mindfulness.

Example of good practice

The Good Move project was a change fund initiative to launch a campaign to advertise the various activities available for older people in Glasgow. There was an emphasis on early intervention to prevent health difficulties and reduce health inequalities for older people.

The aim of the programme was to encourage older people to remain active with the support of free, coach-led physical activity. Vitality classes designed specifically for older people with long-term medical conditions included local and volunteer-led health walks in the city's parks. The service was free and available across Glasgow.

Example of good practice

The Power Of Attorney Public Awareness Campaign provides a good example, related to individuals who lack capacity, of a whole systems response to AWI delayed discharges. It was anticipatory and supported people to take control of their future affairs while seeking to reduce the risk of unnecessary future hospital delays due to incapacity.

The campaign used television and radio channels, phone boxes, bus shelters and digital screens in GP surgeries. It commenced December 2013 and is supported by a telephone helpline, dedicated website and Twitter.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

A good range of information was available to older people referred for services about how to access support. Social care direct provided an efficient first point of contact for many individuals and agencies. However, waiting times for assessment and the availability of some services meant older people and their carers sometimes had to wait too long to get the services they needed.

Financial pressures also meant that sometimes older people had to wait until funding was available to access the support they needed.

Effective processes were put in place by Glasgow City Council to support adults at risk of harm and management of risk was improving. However, managers and staff were concerned about some delays in progressing adult protection referrals.

Older people were prioritised, as part of the reablement approach, for assessment and support.

5.1 Access to support

A good range of public information was available through Glasgow City Council's website. This provided details of the health, care and support services available to older people and their carers. It also included information about eligibility criteria, charging policies and personalisation, as well as the range of care and support services in different localities. Links to the most recent Care Inspectorate report for registered care services provided easy access for individuals to information on the quality of these services. However, some of the information available online for older people was out of date.

The Council also needed to be clearer in the information that it provided to make sure that individuals making a referral or being referred for assessment were aware of timescales and likely actions.

The Council's eligibility criteria set out the different priorities that it considered. Priority was given to people who had critical needs that indicated there were major or substantial risks to the individual's independence or health and wellbeing. These risks meant there was a need for the immediate or imminent provision of social care services.

Some frontline health services staff we spoke with were unaware of the changes to the social work services' eligibility criteria. The Partnership needed to make sure health services staff were fully briefed on any changes to social work services eligibility criteria and relevant service changes.

Frontline social work services managers told us that sometimes older people assessed as having a critical or substantial need (priority 1 or priority 2) had to wait for assessment., In these situations, services were provided to the older person and their carer to meet needs and mitigate risk until the assessment was completed and the subsequent level of support needed was identified. Health staff also told us there were increased waiting times for social work assessment, even for some high-priority individuals. Information provided to us by social work services showed that around one third of people initially assessed by Social Care Direct as having substantial needs waited for one month or more for further assessment of their care and support needs. We were concerned that the Council did not routinely gather information about waiting times to determine the impact on individuals and inform service prioritisation, planning and review.

Recommendation for improvement 6

The new Glasgow Health and Social Care Partnership should routinely gather and report on comprehensive data on the numbers (and eligibility criteria categories) of older people waiting for an assessment or review, the length of time they have to wait, and the length of time for service deployment following completion of their assessment.

Financial pressures meant that sometimes older people had to wait until funding was available to access the support they needed. We observed staff having to make decisions about which individuals should be prioritised to receive services. Social work services needed to clearly inform older people when they did not meet the eligibility criteria for assessment and subsequent service provision. These older people should then be given information about mainstream services and community supports to help to meet their needs, as some older people did not understand where to find information from existing sources.

Glasgow City Council sought to minimise the impact of the introduction of charges through an appropriate income maximisation approach with a means test that set a £15 limit on charging and a waiver of charges.

Glasgow Community Health Partnership provided a range of information on its website about services available in each locality, as well as some links to community-based activities. Community health services also had eligibility criteria and published response

times on their website. Some had options for self-referral, for example the rehabilitation service.

Access to social work services was mainly through Social Care Direct. This was a centralised call centre that screened all referrals to social work services. A dedicated line was available for professionals to call to help them make referrals quicker. The 'Your support your way' online information portal helped staff direct older people to the range of suitable services in their local area. However, the portal could be improved to highlight where further assessment was required to access some of the services. Social Care Direct had been in operation for two years and had improved access to initial assessment for a number of older people. The service was being reviewed to consider what worked well and what could be further improved. This review would need to consider the effectiveness of the signposting and early intervention elements of the service as well as its response to adult protection referrals.

Many social work services staff spoke positively about the screening services provided by Social Care Direct. This reduced the range of referrals to social work teams. Staff in Social Care Direct carried out some initial screening of assessments before those individuals that required further assessment were passed to social work teams. However, some health and social work services staff expressed concern about delays in referrals being passed to them when further assessment or services were needed. Social Care Direct did not regularly meet its own target response times. This included both general referrals and referrals about adults at risk of harm. Staff in Social Care Direct carried out some initial screening of assessments before those that required further assessment were passed to teams. An interim increase in staffing had helped to reduce some of these delays. Referral pathways were being considered as part of the review of the service.

Managers in social work services needed to improve their communication with the main referring agencies to ensure that all involved were aware of the work carried out by the Social Care Direct service.

We found some differences in the availability of services and waiting times for services across the different localities. Day care provision across Glasgow had been reduced through the closure of some services although befriending and home care were used where appropriate to support older people with assessed needs who were on waiting lists for day care. Approximately 250 older people were waiting for day care services and 40% had been waiting for three months or more. Waiting times varied across the city. Older people had to wait longer in the south due to a lower level of day care provision. Older people with critical and substantial needs and people with dementia were prioritised for day care support and may impact further on the length of delays. The Partnership was testing some new models of care and support. This meant that, in some areas, additional

services and support options were available. Discussions on when or how these options of care and support would be extended across Glasgow had not concluded.

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

We saw assessments in both the health and social work services records we read. The assessments in the health records mainly related to people's individual health conditions. Our findings on assessments were mainly positive in that:

- 92% of records contained an assessment and the majority of these were up to date
- 96% of the assessments took account of the individual's needs
- 60% of the assessments we evaluated as very good or good quality and none were evaluated as unsatisfactory.

The use of personalised approaches to assessment and care planning was well established in Glasgow. This approach was aimed at supporting older people to maintain their independence. The Partnership was beginning to shift to early intervention and preventative support to enable more people to receive the right service,at the right time, to deliver the right outcomes. Direct referral from hospital to Cordia and the reablement service had helped many older people with less complex needs to get timely access to these supports. This then helped them to quickly achieve their desired outcome of returning home.

A range of in-house audits of records had helped managers understand how well assessment and planning processes worked. Over the last few years these audits have sampled the case records of around 500 individuals. From the health and social work services records we read, we saw evidence of management scrutiny of files in only 21% of the records we reviewed. Some positive improvements had been put in place following these in-house audits, for example improved risk assessments and recording.

We found that staff shared information held in records routinely but did not work together as often when jointly preparing shared assessments. The majority of older people's records we read had some evidence that health, social work and other services shared information to help inform the care and support needs of these individuals. In our staff survey, less than half of the staff agreed that key professionals work together to inform a single user friendly assessment. Staff in focus groups we held also confirmed this.

Staff in both health and social work services were not clear about how referrals were progressed from initial point of contact to the delivery of services. The processes put in place to manage resources meant that staff often had to pass re-assessments through numerous panels before a service could be agreed. Even after the assessment and service requirement was agreed, there could be a further delay in the older person getting the service they needed when there was a waiting list for services such as care at home.

From our review of health and social work services records, we found:

- 31% of individuals had a comprehensive care and support plan
- 47% had a care plan, which was not comprehensive
- 22% did not have a care and support plan.

Chronologies can give an early indication of emerging patterns of concern and risk. In general, a chronology should be prepared for individuals:

- who have complex circumstances
- are subject to significant risks
- have had a lot of involvement with social work and health services over a lengthy period or where professional judgement determined a chronology was necessary.

From the health and social work services records we read where we considered a chronology was needed, only 5% had a chronology of key events. For 58% of the records, we considered that a chronology was not needed. Of these records that had a chronology less than half of the chronologies were of an acceptable standard. Managers needed to make sure that proper chronologies were in place and were used effectively in the planning of support for older people and the assessment of risk.

Recommendation for improvement 7

The Glasgow Partnership should make sure that proper chronologies are prepared and placed in the individuals' electronic or paper record.

People who were being discharged from hospital and who required support following discharge were either referred directly to Cordia if they were returning home, or were placed in a care home for further assessment or reablement. This allowed more time to see how much support they might need in the future.

Many of the care plans for people referred to Cordia were task based and were not focused on individuals' desired positive personal outcomes. However, this part of the system worked well. Cordia managers told us that no older people were waiting for their care at home service. Staff reported there were delays when older people requested a review. Discussions were under way to transfer some assessment and planning staff into the Cordia service. Discussions were not at a stage where we could determine the potential impact of this proposed development.

The managed medication service, supported by training from NHS pharmacists, effectively supported frontline care at home staff to administer some medications and enable older people to return or remain at home. Staff were trained to meet older people's medication needs and were supported until competent and confident.

We heard from a range of staff about the level of engagement with carers through carers support teams and carers' centres. However, there was little or no evidence of this in the records we read. The Partnership needed to improve how it recorded the impact of its support to carers including how the information was used where carers completed self-assessments.

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

A well-structured and shared approach to adult support and protection arrangements was in place. The Partnership had clear multi-agency adult support and protection guidance. It had recently published the learning from two significant case reviews to help with its continued improvement identifying and supporting adults at risk of harm. The adult support and protection committee and adult protection locality forums had prepared improvement plans for their approach to supporting adults at risk of harm who lived at home and those who lived in care homes. A service user sub group had been formed and service users had felt more confident to be formal members on committee following this involvement.

In our reading of files we found that:

- 72% of case records with protection-type risk identified (current or potential issues regarding adult protection or protection of the public) had risk assessments
- we rated 83% of the protection-type risk assessments as good or better, with 17% rated as adequate or less
- 83% of the protection type risk assessments had evidence of multi-agency input
- in 89% of the applicable records, the timing of the most recent assessment was in keeping with the needs of the older person
- we rated 63% of the protection-type risk management plans as good, with 37% rated adequate or less.

We found there had been a considerable improvement (from previous external scrutiny exercises conducted by the Social Work Inspection Agency) in the number and quality of risk assessments.

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

- Fifty per cent of case records with non-protection type risk identified had a risk assessment.
- Sixty-one per cent of the non-protection type risk assessments had evidence of multi-agency input.
- The timing of 88% of the non-protection type risk assessments was in keeping with the needs of the older person.
- We rated 67% of the non-protection type risk assessments as good or better, with 33% rated adequate or less.
- We rated 72% of the non-protection risk management plans as good or better, with 28% rated adequate or less.

Where risk assessments were completed, these were accessible to relevant social work services staff and Cordia staff on CareFirst, the social work services electronic information management system.

More work was needed to make sure that sufficient information was gathered at the initial referral stage. This would enable a quicker response and make sure that adults at risk of harm were not left unsupported. Dedicated locality teams carried out initial assessments of high priority (priority 1) individuals. This included adults at risk of harm.

Management teams in each locality monitored the adult support and protection processes and identified areas of variation in practice. This work included different approaches to carrying out case conferences. Some areas reported a low number of case conferences taking place. There was an increased number of referrals of adults at risk of harm from Police Scotland. Social work services managers were working with Police Scotland to agree an improved referral process.

5.4 Involvement of individuals and carers in directing their own support

Self-directed support (SDS) is about offering individuals and their carers choice, control and flexibility over how their support is planned and provided. Practitioners must have regard to the set principles when engaging with older people who are assessed and who then require support. To do this, local authorities must promote a variety of providers of support and a variety of support options.

Since 2010, there had been a phased roll-out of personalisation in Glasgow starting with adults with physical or learning disabilities.

The Partnership had clear policies and procedures for accessing self-directed support. These were supported by an online self-assessment tool available to download from the Council's website.

The process involved in the delivery of SDS for every individual requires a co-produced assessment of need, allocation of an individual budget, offering the four options outlined in the legislation and the development of an outcome-focused support plan.

We found that older people were being prioritised for assessment based upon whether they had complex needs or required long-term support. In response to the high volume of referral annually to Glasgow social work services, access to SDS was being managed by prioritisation. The Partnership told us this was in order to achieve a fair and equitable basis for the implementation and delivery of SDS in Glasgow.

The emphasis in Glasgow was to focus on recovery, reablement, rehabilitation and recuperation. By channeling all older people through the reablement route, older people with complex needs were to be referred immediately for social work services assessment and this would be carried out within the personalisation framework. The Partnership stated that "older people with non-complex needs who completed the reablement process and required a continuing mainstream low level service would be offered the SDS four options at their first care service review". Senior managers confirmed that "Cordia staff, following transfer of assessing staff in 2015 would through their normal review activity, highlight those cases which would be shared with social work services via the agreed interface/ referral process. Social Work Services staff will then take the appropriate action as per existing Glasgow city Council Social Work Services practice in relation to SDS".

In addition, senior managers stated "the operational procedures in relation to review activity would be used to ensure that all service users receive written notification of upcoming review and their right to choose their support provider via personalisation at the end of reablement. Service users would receive a leaflet explaining their options and in advance of a review assessment meeting. Social Work Services would also monitor and review the application of the above process".

When we talked to third sector and independent sector staff they expressed doubts that large numbers of older people would have access to self-directed support in the future. Partnership staff told us that the opportunity for older people to manage self-directed support was compromised by a complex process to administer. Older people were also offered limited choice in care providers.

Advocacy providers said that older people with care packages of under 23 hours' care supplied each week could only use services provided by Cordia, unless the care package was assessed as having complex support needs.

The Partnership successfully involved older people in their care and treatment. From the health and social work services records we read, there was evidence that services actively sought the views of the most of these older people at the assessment, care plan and review stages. This was confirmed by the older people and their carers we met. They told us they felt very involved in the assessment of their needs and the development of their care plan. However, others told us that some of their choices were limited, including the time that they received support.

We found the offer of independent advocacy was considered by staff. Sixty seven per cent of applicable older people had received advocacy support. For 83% of these individuals, the advocacy had helped them to articulate their views.

Support to carers was well embedded and was delivered through Glasgow Carers' Partnership, which was intended to bring together health, social work and the network of carer centres. This was underpinned by a universal offer of information and advice to all carers in the city through a telephone information and support line, a carer's information booklet "Are you looking after someone?" and a carer self-assessment form. The carers' initial screening process determined a priority rating based on the risk to sustainability of their caring role. Carers identified as Priority 1 and Priority 2 were offered a statutory carer's assessment and, if required, services provided to support the carer. Carers assessed as Priority 3 were signposted to carers' centres, condition-specific organisations, and/or community supports. However, social work services needed to improve their recording of the outcomes of completed carers' assessments .

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

Summary

Evaluation – Good

The Glasgow Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked detail on how they would be achieved. The Partnership did not have joint formal strategies and costed action plans for themes such as carers, dementia, palliative care, telecare and management of assets. The Partnership needed to update its strategic priorities for these areas in the context of health and social care integration. A programme of service reform had been prioritised using the joint services development plan.

Using change fund monies, the Partnership had taken a joint approach to the deployment of resources to support improved personal outcomes for older people. This was beginning to be used to inform the future shape of health and social work services.

A wide range of performance information was produced, reported and made available for the Partnership's senior and local management, as well as elected members and NHS board members. A draft joint performance framework linked to national outcomes was being developed. The Partnership needed to be sure that the framework contained challenging but achievable targets.

We saw evidence of cross-sector engagement and involvement of health and social work partners in joint strategic commissioning. The Partnership needed to develop its commissioning approach to support its commitment to further shift the balance of care.

6.1 Operational and strategic planning arrangements

The Community Planning Partnership had set out its joint vision for Glasgow in the single outcome agreement. This identified 'vulnerable people' as one of its main three themes. A 'One Glasgow' planning approach was being set out by the Community Planning Partnership (see Quality Indicator 9.2). Informed by the single outcome agreement, the plans for services for older people were set out in the following documents:

- the Partnership's joint strategic commissioning strategy
- the Partnership's joint adult services plan

- NHS Greater Glasgow and Clyde's corporate plan
- Glasgow City Council's strategic plan.

The draft joint strategic commissioning strategy for older people, 'Reshaping Care for Older People', was published in February 2013. The strategy was then circulated widely for consultation. It contained overviews of health and social work needs analysis, the strategic direction and identified strategic priorities. It also set out an implementation plan and financial information. A finalised plan was not yet produced following consultation. The strategy's key themes were to:

- enable older people to exercise choice and keep control over their own lives
- support older people, carers and communities in improving their health and wellbeing
- provide older people and their carers with access to care and support when needed
- change the focus of care towards early intervention, preventative and anticipatory care to support older people and their carers to live independent lives in their own communities
- provide access to hospital services and care home services when needed, and support people to recover following discharge.

We found that the draft joint strategic commissioning strategy gave a clear view of the direction of travel. However, it lacked some of the detail on how this would be achieved. This restricted its use as a delivery management and accountability tool. It did not contain detailed costings, delivery timescales were not always clearly identified, and areas for growth or disinvestment were not always clarified. Commissioning officers and managers we met acknowledged this.

Planning for the future effective and cohesive delivery of services took place on a care group basis. An individual planning and implementation group for older people (Reshaping Care Strategy Group) was set up as well as separate cross-cutting themed groups for carers (Carers' Planning and Implementation Group). In each locality, a carers' forum informed the carers' reference group. In turn, the carers' reference group informed the carers' planning and implementation group. The older people's planning and implementation group, and the carers' and service user involvement groups reported progress every six months and every year respectively to the adult services executive group who in turn reported to the Joint Partnership Board.

The Partnership was working towards developing a locality-based approach for the planning and delivery of services. Partnership agencies had the same geographic locality boundaries. This should make the planning and delivery of services more straightforward. As locality plans developed, the Partnership needed to set out a quality assurance framework for localities.

At the time of our inspection, the Partnership did not have joint formal strategies and costed action plans for themes such as carers, dementia, palliative care and telecare. For example, the lack of an overall strategy for telecare meant the Partnership had not engaged with the third and independent sectors on the development of services. This excluded nearly half the overall provision of housing support from joint development of telecare services. The Partnership needed to update its strategic priorities for these areas in the context of health and social care integration timescales.

Health and social work services had carried out some work on the development of joint strategic needs assessments. However, this was at a relatively early stage. Senior staff told us they thought there was enough existing information available to set the strategic direction.

A clear joint approach was needed to improve the joint management of assets, such as premises. Joint capital investment was on a project by project basis rather than as part of a jointly agreed strategic approach. Plans were in place to develop new services using the West of Scotland Hub, a structured development service organisation which delivered some co-located services through public and private partnership. There also needed to be links between assessing future demand for services and corresponding capital investment. A substantial new build programme of care homes was in place too. Glasgow City Council had provided significant investment in directly provided older people's residential and day care services through Tomorrow's Residential and Day Care Modernisation Programme to improve the environment within which services were provided to the highest quality. The standard of buildings was regarded as crucial in providing staff with appropriate resources to deliver high quality services.

The Council recognised that investment in buildings alone would not achieve the clear strategic vision to improve the health and wellbeing of our service users and carers in line with national outcomes. This investment in new care homes was to provide rooms for residents that could both cater for all levels of dependency and allow the resident their own space and privacy ensuring older people are supported effectively within these community based resources and not admitted to hospitals inappropriately.

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

Across health and social work services, the development of services included a major emphasis on reablement and rehabilitation, alongside care at home and telecare that helped to support older people to remain independently at home. The tiered eligibility for services model formed the basis of the approach to early intervention and prevention. This aimed to provide an incremental approach to the delivery of care and support.

Through the change fund, the Partnership had taken a joint approach to the deployment of resources to support improved outcomes for older people. This funding had been used to test different working models for care and support. The Partnership had used the Scottish Government's joint improvement team's evaluation tool to review and evaluate the progress of individual change fund projects. This was beginning to be used to inform the future shape of how health and social work services would be delivered. Learning from change fund investments had led to service redesign in areas such as:

- prevention of falls
- reablement
- rapid response and resettlement
- supporting carers
- medicines management.

The Partnership's change fund expenditure supported preventative and anticipatory care, and care and support at home. Some change fund projects had a clear health promotion and prevention approach. However, more work was needed to set out how change would be implemented using the approaches that had been tested.

Health improvement staff were increasingly engaged at an early stage to support older people to live independently at home. They worked closely with older people on the personal outcomes they wished to achieve, staff reported they had helped to reduce the level of support needed by older people.

6.3 Quality assurance, self-evaluation and improvement

A wide range of performance information was produced, reported and made available for the Partnership's senior and local management, as well as elected members and NHS Board members. A suite of performance information based on local plans, national and local indicators formed the basis of the approach. These were made available at locality and sector level in organisational performance reviews.

All council services produced an annual service performance and improvement report. This reported progress on the delivery of the Council's strategic plan, alongside single outcome agreement and service priorities. Social work services also provided information on areas included within the council's 'corporate scorecard'. This included attendance management, budget monitoring and complaints. Progress on the delivery of the social work element of the Council's service reform programme was reported every four weeks to the Council's management group. Organisational performance reviews were held for each of the three localities and 'direct services' every six months.

The Council had detailed locality service monitoring information available on services such as:

- care homes
- care at home services
- adult support and protection
- assessment and review
- personalisation
- occupational therapy
- carers
- complaints.

There was uneven performance between localities. The Partnership's own targets were not being met in areas such as:

- reviews of older people's care
- delayed discharges
- reablement
- personalisation
- adult support and protection.

The Partnership's performance indicators tended to focus on input and output measures rather than the quality of the service.

Arms-length organisations such as Cordia, which provided care at home services and telecare, and Equipu, which provided telecare equipment had detailed monitoring activity. Again, these were mostly focused on output monitoring. There was a need to incorporate more personal outcomes based information into the monitoring and performance activity.

Social work services performance officers told us that the CareFirst system had brought about challenges for performance monitoring. They were concerned about the quality of data input. They told us that the ability to accurately monitor service delivery was adversely affected as a result. The Partnership needed to address this.

NHS Greater Glasgow and Clyde carried out organisational performance reviews every six months. These included national HEAT targets, NHS board and local community health partnership key performance indicators, as well as outcomes for each of the NHS board's priorities. These were:

- early intervention and preventing ill health
- shifting the balance of care
- reshaping care for older people
- improving quality, efficiency and effectiveness

- tackling inequalities
- promoting an effective organisation.

The community health partnership reported performance on its development plan. A performance scrutiny group reviewed its performance on issues such as:
- finance
- development plan delivery
- staff governance
- organisational development
- service improvement and quality.

Service monitoring information was available in themes including:
- reshaping care for older people
- improving quality, efficiency and effectiveness
- tackling inequalities
- promoting an effective organisation
- capital projects.

Based on the community health partnership's own target information, progress was being made in areas such as reducing emergency inpatient and delayed discharge beds days occupied, as well as diagnosis of dementia. Further improvements were needed in meeting its own targets in areas such as staff appraisal knowledge and skills framework, and attendance management.

Local monitoring arrangements were also in place within each locality sector. A sector variation report was produced. However, some of the actions had unclear or incomplete baseline or monitoring information. Clinical governance was reviewed through a separate forum.

Like many Partnerships across Scotland, work on developing the joint integration scheme was taking place. A draft joint performance framework linked to national outcomes was also at an early stage of being prepared. This would help the Partnership to identify areas where performance was improving or where improvement was needed.

Joint performance measures would be based on national and local indicators. This would cover areas such as:
- reshaping care for older people
- reablement
- carers
- telecare
- long-term care

- adult support and protection
- national HEAT targets.

It was intended that the joint performance framework would focus on personal outcomes as well as input and output measures. Outcome-focused and qualitative measures were still to be agreed. These would then be extended out across all externally commissioned services. The Partnership needed to be sure that the joint performance framework contained challenging but achievable targets.

In recent years, the Council had carried out major service reviews in areas such as day care and residential care. Action plans had been produced to progress the findings of their evaluations. The council had an ongoing self-evaluation programme. This had recently covered topics such as staff supervision, and assessments and outcome-focused approaches. At the time of the inspection, children's services were prioritised for self-evaluation. It was anticipated that future self-evaluation activity would include integrated working in health and social work services. However, a start date for this self-evaluation had not been determined. The Council also had a practice audit programme. Recent audits had included appropriate admissions to 24-hour services for older people. 'Scrutiny' sessions had taken place, for example on personalisation and had included representatives from council staff and the third sector. Senior social work services managers told us that audit and review of case files was already in place.

Examples of direct service user feedback included annual Council household surveys. Satisfaction levels with social work services were similar to the Scottish average at 55%. NHS Scotland carried out an annual survey of patient experiences. Results for NHS Greater Glasgow and Clyde showed levels of satisfaction broadly comparable with Scottish averages.

The Partnership had carried out service mapping and some needs analysis exercises to inform the draft joint strategic commissioning strategy's priorities for improvement. However, we were unclear how information from service user feedback was used to improve and assure practice or to strategically develop services. The Council had a detailed strategic risk management register which identified possible risks and mitigating actions. Health and social work services managers and staff recognised that more needed to be done to evidence the outcome and impact of some of the supports delivered to older people and their carers. Links between learning from self-management and self-directed support initiatives could be used better to inform this work.

6.4 Involving individuals who use services, carers and other stakeholders

Both health and social work services had policies for engaging with people who were using their services, as well as with other stakeholders, including staff and external service providers.

However, senior managers needed to better engage and communicate with staff and other stakeholders on the future direction of health and social work services and how change would be implemented. Results from our staff survey showed that:

- 41% of staff agreed that the views of older people and their carers who used services were taken into account fully when planning services at a strategic level
- 40% of staff agreed that there were effective partnerships which focused on delivering key policies and plans for older people and included relevant stakeholders
- 38% of staff agreed that priorities set at partnership, team and unit levels reflected jointly agreed plans
- 34% of staff agreed that the views of staff, service users and their carers were taken into account when planning services at a strategic level.

We found that senior managers felt involved in development and improvement activity. However, frontline staff were less positive about their involvement in development and improvement activity.

Overall, independent sector providers considered the Partnership could offer them more support to improve their performance. Commissioning officers told us that consultation and engagement with providers tended to be one-off events with care home and care at home providers rather as part of ongoing forums. Such forums could help to look at the requirements of providers including those outwith the care home and care at home sectors, for example training requirements. We found that engagement with service providers could be improved. This would make sure they were better engaged in reshaping how they provided services to meet future challenges.

Housing staff reported that they welcomed the attempts made to enhance their participation in joint planning on issues such as housing support and supported living. However, they wished to have a closer involvement with the setting of priorities across the wider joint commissioning agenda. The Council's local housing strategy had identified housing access and support as a major theme. This included working with the Partnership to develop and improve services for older people. The Council's draft strategic housing investment plan had set aside a proportion of available capital investment (13%) for housing for people with particular needs, including older people.

A proportion of the transformation fund monies had been aimed at services delivered by local housing providers, including health promotion and condition self-management. At the time of the inspection, the Council was consulting with stakeholders including service users on redesigning housing support services including sheltered housing. There was a perception from housing support providers that this would lead to a substantial reduction in services.

6.5 Commissioning arrangements

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

The Scottish Government expected health and social care partnerships to produce joint commissioning strategies for older people's services during 2013. Informed by Scottish Government guidance, these aimed to set out jointly assessed and forecasted needs, desired outcomes and plan the nature, range and quality of future services. This strategy should focus upon delivering improved outcomes for older people and carers through better aligning investment with what the evidence tells about the needs of service users in local communities through strategic plans. In 2014, additional Scottish Government guidance advised that these plans were to be developed further to include detailed financial planning as well as extending to all adult groups. This would be a joint strategic commissioning plan.

Implementation of the Partnership's draft joint strategic commissioning strategy for older people included supporting the care at home, care home and housing support markets. However, some service providers told us that they were not always fully consulted and involved in how services might be reshaped or enhanced.

The Council had a comprehensive contract management framework. This included very detailed contract compliance procedures, including contract monitoring and service review. Each care group had dedicated contract compliance officers. Commissioning officers told us that externally commissioned services had quality assurance measures in place as part of contractual compliance procedures. However, the contract management framework was not being implemented as it should. As a result of this, a Council internal audit had identified that the Council was exposed to risks. These risks included:

- the inability to deliver best value due to service reviews not being carried out in line with the framework
- external providers not delivering on improvement actions within deadlines

- service deficiencies not being investigated comprehensively
- providers' financial viability not being tested thoroughly.

To minimise the risks, the Council had identified a series of recommendations for improvement with delivery timescales.

When meeting with Cordia staff, we heard that service user feedback was a key element in how the service was delivered and developed. They carried out a manual questionnaire survey of all service users with around a 38% response rate. They also held service user focus groups twice per year and Cordia staff reported positive results of their survey with high levels of service user satisfaction at the services being provided by Cordia (94%).

It was unclear how contract values for each service were reported to elected members and NHS board members. Commissioning officers told us that individual contract amounts were aggregated for reporting purposes. The Partnership needed to be more transparent in reporting to elected members and NHS board members the detail of contract values of each provider and service in keeping with the principles of 'following the public pound'[11].

At the time of our inspection, the Partnership was carrying out a tendering exercise to procure care and support, day opportunities and short breaks for a range of care groups, including older people, to stimulate the market and extend choice. The aim of the exercise was, in part, to help provide a larger infrastructure for the development of personalised services. For care at home services, the Council's own arms-length provider, Cordia, had a very significant market share. Although other service providers did exist, they had a very small market share. Some had closed due to a lack of demand.

At the time of our inspection, the council was proposing that a number of social work services staff transfer to Cordia. This would include some staff responsible for assessment functions. The Council's contract with Cordia needed to ensure that the roles and responsibilities were clear. The Council had taken steps to ensure there were no potential conflicts of interest between Cordia's role as a provider and the Council's statutory assessment and care management role. These steps had included operational procedures outlining the obligations of both parties and the interface arrangements between Cordia and Social Work Services. Governance and scrutiny of Cordia's performance by Social Work Services was planned at a number of levels, including monitoring reports at political level, routine executive director-level strategic meetings, formal contract management and through local operational care management interfaces.

11 The Convention of Scottish Local Authorities / Accounts Commission 'Code of Guidance on Funding External Bodies and Following the Public Pound 1996' sets out the principles of best practice when councils establish funding relationships with external organisations.

A recent tender exercise held in early 2014 for care home services was stopped following challenge from some providers. The Partnership had decided to continue with the national care home contract during 2014–2015. The Partnership needed to detail how it will pursue its care home choice, quality and cost agenda beyond this date.

Senior managers reported that Integrated Resource Fund Framework information was considered in planning resource allocation, particularly the use of resources at GP practice level. However, it was uncertain to what degree it had, as yet, been useful to help inform financial planning and budgeting.

To date, joint strategic commissioning activity had primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners. Further work was required on how joint strategic commissioning developments would be progressed and how these would be led. The Partnership needed to develop its commissioning approach to further shift the balance of care.

In line with Scottish Government guidance, the Partnership should produce a 'SMART' (specific, measurable, achievable, realistic, time-bound) joint strategic commissioning plan. This should make sure that future joint commissioning plans for older people give more detail on:

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

Quality indicator 7 - Management and support of staff

Summary

Evaluation - Adequate

Some staff recruitment and retention services across health and social work were being reviewed. New staffing structures were being shared with staff. Restrictions applied to recruitment in social work services to mitigate budget pressures. This was having a negative impact on staff's ability to deliver the volume of work required of them. Views varied across the Partnership on whether recruitment practices had been successful.

The Partnership had focused on developing its leadership programmes and strengthening senior management skills. Training and development opportunities were generally good, although some social work services staff were less positive about recent training opportunities than health services staff.

The Partnership had not yet established a strategic approach to joint training and development, and support of staff. Frontline social work services staff were circumspect about the range and quality of training offered to them.

7.1 Recruitment and retention

We read a range of comprehensive and clear policies and procedures about recruitment and retention. Within Glasgow community health partnership, NHS Greater Glasgow and Clyde, and social work services, there were concise written policies and processes in place to support safe recruitment in order to protect service users, including older people, and to help retain staff. Less positively, we found limited evidence of any initiatives to develop a joint approach to recruitment and deployment of staff. However members of the Partnership's shadow integration joint board told us they were beginning to work towards a single workforce plan. This plan would support staff terms and conditions of employment that would remain the same for both organisations.

We read detailed and up-to-date individual workforce plans. Health and social work services partners acknowledged these plans were separate in terms of staffing numbers and roles. However, some managers told us some joint operational policies and priorities were being produced. The community health partnership had an up-to-date and detailed learning and education and development plan (2014–2015). Glasgow City Council had an

employee performance improvement framework, which linked to its 2012–2017 strategic plan.

Social work services managers told us the workforce planning group was responsible for prioritising vacancies and made decisions about any critical posts that needed to be filled. They believed there were no issues with filling vacancies and that the organisation was large enough to enable resources to be moved around. Health and social work services had separate measures in place to address areas of particular staff shortages and pressures. Senior managers across the Partnership told us there was not a large staff turnover in their individual organisations. They thought this was partly due to good staff terms and conditions of employment. We found evidence to confirm that retention of staff within the Partnership was generally good. Over the period 2012–2013, health staff turnover was 7.09%, and the overall staff turnover rate for social work services was 3%. This was replicated across a range of more specialist teams, for example Cordia also reported low staff turnover at 0.6%. Social Care Direct reported no issues with recruitment and had good retention of current staff.

However, these findings contrasted with the views of most frontline social work services staff and team leaders we met. They told us that vacancies across a number of areas were not being filled, with recent recruitment drives failing to recruit new workers to posts. Social work services staff believed that restrictions applied to recruitment to mitigate budget pressures within social work services was impacting on the pressure on staff and increased volume of work carried out by frontline staff. This, and the movement of some staff to more specialist teams, had resulted in some older people's teams being depleted of staff.

Managers reported that community health staffing was stable, with limited use of agency staff. Older people's mental health teams used agency nurses to fill vacancies on occasions. Some health services staff told us that posts were generally slow to be filled, for example one team was about to fill a nursing vacancy after a delay of one year. Agency staff had been used to backfill frontline health vacancies. However, a recent policy update stated that agency staff should not continue to be used in this way. Staff comments from the community health partnership stress surveys mirrored the view that carrying vacancies had a negative impact as it created unrealistic demands on staff in post. Senior managers told us that (in common with many other areas in Scotland) there were some difficulties recruiting GPs. In addition, Social Work Services residential staff told us that they also had vacancies within their service. This had resulted in reduced numbers of senior social care workers being appointed.

There had been some good initiatives in recruitment to more specialist posts. We also

heard about a positive drive towards joint recruitment to some posts. A head of primary care and community services was recently appointed on a fixed term contract.

The Partnership was piloting a new 72-hour fit for discharge initiative in North East Glasgow. Three resource workers had been recruited to work in the acute hospitals and provide information, advice and support, assessment and discharge planning for older people.

Some staff based in more specialist teams told us that, while restrictions applied to recruitment to mitigate budget pressures, managers could apply for special consideration to be given to some posts. As a result of this, more occupational therapists had recently been appointed to support enablement and rehabilitation teams. Staff in specialist teams were very positive and enthusiastic about their work and clear that the services they provided made a positive difference to older people's ability to live more independently.

7.2 Deployment, joint working and team work

Members of the Partnership's shadow integration joint board told us that the Partnership had put senior management staff arrangements in place. A process was in place to match senior staff in to joint posts within the new structure, and the results of this matching process were expected to be published by late 2014. We attended some senior managers meetings with representatives from health and social work services who were working together to plan for future services. Senior managers told us of the multi-agency groups being developed to focus on key themes including intermediate care, and implementation of the comprehensive 72-hour fit for discharge initiative.

Social work services had shed approximately a quarter of its staff over recent years through early severance exercises. This included key posts such as frontline managers. Some managers felt these staff losses had negatively impacted on the delivery of services. Other managers reflected that the service now had more qualified staff in post and there were more efficient working practices. NHS Greater Glasgow and Clyde and the Council's social work services used a resource allocation model to distribute staff resources. This involved equating staff needed for each sector, based on population and a range of other local indicators.

The national Modernising Nursing in the Community programme was established by the Scottish Government to provide support and direction to community nursing. A review of the community nursing service was under way in Glasgow.

Managers across the Partnership told us they were working to make sure teams had the right blend of professionals to deliver services effectively. They were also working

to give employees roles that reflected their level of competence and qualifications. For example, Cordia had 250 specialist staff delivering reablement effectively. Cordia managers spoke positively about the benefits to older people of having specialist staff with a good skill mix in the teams. Managers told us that, where there were new joint initiatives, staff were being specifically recruited. However, other staff we spoke with raised concern about the lack of consistent practice and described recruitment inconsistencies across Glasgow.

Cohesive joint working between health and social work services had been developed within the reablement service. Rehabilitation teams from the health service worked effectively with care at home staff to support older people to live independently at home, and maximise their capacity for self care. Frontline reablement staff spoke positively about their work. They believed reablement and rehabilitation services were good examples of efficient joint teams. They acknowledged some variations in how the services operated across Glasgow, but said that they all operated efficiently. A Glasgow-wide reablement/rehabilitation steering group monitored the difference these teams were making to older people. Health and social work services staff worked well with Cordia to deliver effective reablement to older people.

From the health and social work services records we read, we saw evidence of joint working or multi-agency working for 80% of older people. From our staff survey, 79% of staff agreed or strongly agreed that they felt valued by other practitioners and partners when working as part of a multidisciplinary or joint team. Sixty-nine per cent of staff agreed or strongly agreed that they felt the service had very good working relationships with other professions.

All staff we met were clear about their role and responsibilities and were aware of the need for the focus of their work to shift to delivering the positive personal outcomes that older people desire. Health and social work services staff described how they worked well together to achieve positive outcomes for older people and their carers. Managers across the Partnership were aware of the need to consider changes to team deployment as a result of changes in legislation and continued pressure on services. For example, they were considering how staff could be deployed more effectively to manage the process of older peoples' timely discharge from hospital. As this was at an early stage of development, it was not clear if a dedicated team would complete assessments or whether links would be made from existing care managers within social work teams.

Health and social work services staff were mostly positive about the support they received from their immediate line managers. This was supported by staff survey results from health services and the Council, as well as results from the Council's self-evaluation exercise to look at the management function of supervision.

Recommendation for improvement 8

The Glasgow Partnership should develop a joint workforce development strategy during the first year of integration, which sets out clear joint priorities. This should identify possible staffing shortfalls and outline measures to address these as the integration of health and social care agenda progresses.

7.3 Training, development and support

NHS Greater Glasgow and Clyde and the Council's social work services had their own arrangements for supervision and appraisal. Managers understood the importance of supervision (or equivalent) and delivered this regularly. Staff understood and worked within delegated limits of authority. Staff demonstrated a sound knowledge and understanding of the values and principles of person-centred and outcome-focused approaches. From our staff survey, 71% of staff agreed or strongly agreed that they had good opportunities for training and development. Results were lower for social work services staff.

Clear single agency strategies were in place to develop staff. The Partnership had supervision and employee development systems in place. These attempted to link individual performance to service objectives.

Social work services had recently carried out a thorough and detailed staff supervision self-evaluation exercise across adults and children's services which confirmed that the management function of supervision was given priority and was well embedded in practice. We read reports on an extensive social work services self-evaluation exercise carried out in 2013. This looked at the quality of support and supervision provided to staff. Positive results were found on the substantial emphasis placed on the management function of supervision.

The main focus of supervision was discussing caseloads. The inclusion of professional development plans was less apparent during supervision sessions, although this varied depending on the line manager. NHS Greater Glasgow and Clyde had staff personal development plans and review processes in place. The NHS knowledge and skills framework (KSF) was used to support staff learning and development. Glasgow City Council was implementing a performance improvement framework. This linked to its supervision and personal development plan processes.

Results from Glasgow City Council's own 2012 staff survey showed that only 46% of social work services staff had completed a personal development plan. From the NHS staff survey carried out in 2013, 82% of NHS Greater Glasgow and Clyde staff said they had received a knowledge and skills framework review or had a personal development plan meeting within the previous 12 months. Only 44% of health services staff thought it had helped improve how they did their job. Results from the community health partnership stress surveys showed that only 53% of staff saw a link between supervision and personal development plans. A number of staff from across the Partnership told us they found it difficult to take time away from their work to carry out training due to work priorities. Social work service managers were trying to promote a workload performance tool. However, implementation of this tool had been limited. They acknowledged that the tool was more helpful when used with unqualified staff.

An NHS Greater Glasgow and Clyde five-year workforce development plan 2013–2018 was in place to deliver services in line with the dementia strategy. Key stakeholders were consulted, and local authority partners and the third sector were included in this plan. The development plan was clear and concise as to how NHS Greater Glasgow and Clyde planned to develop, enable and equip their workforce; it was also encouraging to see that the plan, in line with the Promoting Excellence Framework (NES and SSSC), made a commitment to train all staff that may have contact with a service user with dementia including reception staff, and patient services staff. This training was for health staff only and did not include local authority partners or the third sector. However, when we met with social care services staff, we heard that training courses on understanding dementia were offered routinely to all social care staff. We were told by staff that there were very limited opportunities across the Partnership for joint development events.

Glasgow City Council had a Delivering Tomorrow's Council programme to support the development of senior managers. This had been designed as a direct result of the findings from the 2012 staff survey. NHS Greater Glasgow and Clyde also had management and leadership development provision. This included tutor-led courses as well as a wide range of materials to support leadership and management development.

Joint performance and monitoring officers for older people had good access to training. However, they acknowledged difficulties in finding the time to attend due to their workloads.

Care at home staff received and valued training advice and support from the step-up service. Cordia staff were trained and monitored in medicines management and administration by lead pharmacists as required. Cordia staff had their own bespoke training programme. We were told by managers that the reablement teams were perceived as having more professional status, more autonomy and ability to make

decisions, partly due to this training.

In contrast, the majority of frontline social work services and residential staff told us that training and support was of a variable standard and was less accessible. Single agency training courses were offered to staff on understanding dementia. More specialist training was provided for staff in residential settings. However, staff told us that, in comparison to previous years, general training and development opportunities had diminished. Some recent training courses, such as moving and handling, had been cancelled.

A range of training and support was available to staff involved in adult support and protection work. However, evaluations from recent training events showed a mixed response from staff on their confidence in dealing with adult protection. Members of the adult support and protection committee told us that training and development of staff and their attendance at development events continued to be a challenge. We were told about a multi-agency training group, chaired by social work services staff, which was looking at the delivery of joint training.

Social work services managers' views appeared disconnected from frontline staff views about the quality and range of training offered. Managers believed there was a good range of training available, with investment and support into training staff. They gave examples such as the self-directed support training and training to improve the quality of assessments and risk assessments. However, frontline staff described a recent reduction of opportunities for professional development. They told us that when training opportunities had been available they were often unable to attend because of workload pressures.

Quality indicator 8 – Partnership working

Summary

Evaluation – Good

The Glasgow Partnership had made progress developing joint financial arrangements. However, there were considerable financial pressures affecting both health and social work services that will need to be addressed.

Both health and social work services had a commendable history of achieving savings targets. As the budgets continued to decrease, savings would become more difficult to achieve. Senior managers acknowledged that service redesign would be needed.

The Partnership was moving in a very positive direction in relation to information and communication technology development. However, it acknowledged that the resourcing for developing information systems had been difficult. This had delayed activity in some areas.

In terms of partnership working, the impact of the dissolution of the five community health and care partnerships in 2011 in Glasgow was still keenly felt by staff. This would present a considerable challenge for the effective delivery of health and social care integration, and consistent, effective operational joint working between health and social work services staff.

8.1 Financial performance of Glasgow City Council and NHS Greater Glasgow and Clyde

Glasgow City Council had identified a total spending gap of £43 million for 2013–2015. This would be met by planned efficiency savings of £22.1 million in 2013–2014 and £20.5 million in 2014–2015 from service-specific programmes and corporate council-wide projects. For 2014–2015, these were broadly similar to 2013–2014 and included:

- £13.7 million in savings from service reforms
- £1.0 million from efficiencies
- £5.8 million from reviews of commissioning and charging policies.

The social work services budget for 2013–2014 was overspent by £5.4 million. This was attributed to overspends on homelessness, personalisation and older people's care. The latest social work services budget monitoring report to the end of September 2014

showed that the expected outturn was a £2.8 million overspend. Of this, £874,000 and £747,000 was attributed to children's services and to homelessness respectively.

An action plan was in place to mitigate the budget pressures outlined. This was as follows:

- review of purchased services
- review of personalisation, including high costs homecare packages - a full year budget pressure of £3 million remains in personalisation.
- review of home care
- review of new demand, focusing on critical risk
- further restrictions applied to recruitment
- review of transport costs
- work in partnership with City Building to ensure a more efficient turnaround in homelessness temporary furnished flats, reducing the requirement for more costly bed and breakfast accommodation
- a more robust approach to non-payment of care charges.

As part of the planned action above, the Council had recently approved the transfer of additional services to Cordia. This was due to take place in October 2014. However, this had been delayed due to ongoing discussions with the trade unions and was now scheduled for implementation in 2015–2016. The aim of this change was to make reablement the first step for everyone requiring care at home support. The council was anticipating an increase in capacity of up to 10% of the budget to be achieved through targeted efficiencies in year one, enabling higher numbers of older people to be supported at home within the same overall budget.

In relation to the review of purchased services outlined in the action plan, the Council's internal audit section had reviewed adherence to the Council's contract management framework within social work services. Their assessment was that the control environment was unsatisfactory. Serious control deficiencies existed with the social work services' application of the contract management framework. The Council had also withdrawn from the new contract management framework that it was developing for purchasing older people's residential and nursing care. The Council was now relying on the National Care Homes Contract[12]. From discussions with senior managers, this contract had been extended for one year. However, the annual chief social work officer report of August 2014 reported that the National Care Homes Contract value was concluded after the council budget was set in February 2013. This had impacted negatively on the budget by £2.5 million.

[12] The National Care Home Contract (NCHC) for Care Homes for Older People was established by COSLA in 2006/07 as a model contract to be used by local authorities for the purchase of care home places for publically funded clients.

Within Glasgow community health partnership, the main cost pressures for older people's services were currently in the North East of the city. This was mainly attributed to the delay in the capital programme and the costs associated with still maintaining Parkhead Hospital, Glasgow, and the wards at Ruchill Hospital, Glasgow. There was a shortfall of approximately £600,000 for 2014–2015. This was likely to be met by non-recurring savings.

Delayed discharge was a significant challenge facing NHS Greater Glasgow and Clyde and the Council's social work services. Financial pressures were now being felt by services at the start of the financial year. This was a trend which was causing concern. With the opening of the new South Glasgow University Hospital in June 2015, there will be a reduction of 300 acute adult hospital beds across Glasgow. Progress was being made to reduce the number of delayed discharges. Additional funding of £700,000 had been provided by NHS Greater Glasgow and Clyde. The Council had also provided an additional £3 million in 2014–2015 to bring forward the early introduction of new step-down care services as part of the reablement model.

Nationally, discussions were under way to address these budget pressures. The concern was that current services cannot sustain the current and increasing level of savings required. Service redesign would be required. The Council had recently started this process with changes to housing support for older people. This had resulted in a reduction in the budget for housing support of £2 million for 2015–2016. The rationale for reducing care home expenditure was to re-direct funding towards the Council's savings targets and into other models of support. These would be a better strategic fit with the Council's vision for older people services. This included reablement and care at home services, step-down care and day care services, and use of telecare.

Capital programme

Both NHS Greater Glasgow and Clyde and the Council had their own capital and asset management plans. The Council had a substantial capital programme for older people's services. There was a £65 million capital programme to build eight new residential care homes and day care centres. The new care homes would provide 600 spaces with the aim of improving choice and quality for older people. NHS Greater Glasgow and Clyde's revised capital budget for 2014–2015 totalled £179 million. This would be reduced to £82 million in 2015–2016 and £72 million in 2016–2017. The main capital project was the construction of the new South Glasgow University Hospital. There was evidence of delays in some capital projects currently carried out by both partners. These delays may have an adverse impact on revenue expenditure.

Joint capital planning between NHS Greater Glasgow and Clyde and the Council currently took place on a project by project basis rather than as part of integrated plan through the HUB initiative. This is a Scottish Government initiative to deliver, through a joint venture between public and private sector bodies, facilities, facilities management, strategic service planning, and asset planning and delivery. HUB projects are intended to support long-term investment in community infrastructure for local authorities, NHS boards and other public sector bodies across Scotland. There were currently two projects ongoing in Glasgow at Woodhill and at the Gorbals. A third project was being developed at Parkhead Hospital.

The Community Planning Partnership executive group had recently agreed to set up a capital planning working group for Glasgow. This would lead to the development of a joined-up approach to capital planning across Glasgow. However, it was too early to assess the impact this group would have on capital programmes within the city.

Joint commissioning strategy

A draft joint strategic commissioning strategy for older people's services had been prepared for 2013–2016. There was some evidence of joint financial reporting in the strategy. A joint financial report was prepared and submitted to the adult services executive group. This group was set up to consider adult services within the city. The purpose of the joint financial report was to inform the group of the financial performance within Glasgow community health partnership and Glasgow social work services in relation to adult services at care group level. The overall adult services net revenue budget for 2013–2014 was £505.4 million. The budget allocation for the community health partnership was £248.6 million and for social work services was £256.7million.

The Integrated Resource Fund Framework figures prepared for Glasgow City showed a spend of £1,480,809,788 for 2012–2013. This was £814,912,062 (55%) for institutional-based care and £665,897,726 (45%) for community-based care. These figures had been used to develop the draft joint strategic commissioning strategy and other care groups planning. Older people's services were considered to be making more use of the Integrated Resource Fund than any other service area. This was used to get a feel for the forecast data and to set out pathways for levels of consumption and the strategic direction of services and finances. This highlighted that neither partner would have the funding in the future and that the current levels of services might not be sustainable.

Change Fund

Since 2011–2012, the Scottish Government had provided specific funding through the change fund to help and support Partnerships to move to more community-based care.

The Scottish Government expected the change fund to be used as 'bridging finance' to enable the redesign of services and facilitate achievement of national policy. It was also expected the monies should be used to influence decisions on the nature of Partnership spending, with a significant shift to anticipatory and preventative approaches to achieve and sustain better outcomes for the care of older people.

Access to the funding required the formation of a formal partnership involving the NHS, local authorities and third and independent sectors. Within Glasgow, this had been carried out through the reshaping care strategy group. By the end of 2014-2015, the Partnership would have received £33.94 million in funding. Work was now under way to evaluate the projects and develop exit strategies for them. However, at the time of the inspection, this was at a very early stage. An additional £13.27 million of Integrated Care Fund monies may be available to further support some change fund projects. However, this was not a replacement for the change fund as it was not specifically aimed at older people, but as a support for adults with long-term conditions.

Health and social care integration

In February 2014, Glasgow City Council and NHS Greater Glasgow and Clyde approved the establishment of a 'body corporate model' with for health and social care integration. This would be a full and equal partnership between both parties with all current social work services included. It involved the setting up of an integration joint board. This board would be a strategic and commissioning body with responsibility for overseeing the delivery of health and council social work services to meet the agreed strategic priorities.

A shadow integration joint board had been established. This met for the first time in June 2014. A governance model for the board had been prepared and work was now under way on developing an integration scheme and a strategic plan for the shadow integration joint board. Dedicated working groups were set up to focus on planning and performance, and locality planning. These groups reported to the integration project team and, in turn, to the integration strategic governance group .

Overall, health and social care integration was seen by both partners as a positive development. However, both partners acknowledged that it will not completely address the continued increases in demand for service.

Financial arrangements

The Scottish Government's integrated resources advisory group was set up to provide guidance on the financial requirements for integration. Further guidance was also

provided in a Regulation Relating to Public Bodies (Joint Working) (Scotland) Act 2014. The financial requirements included:

- financial regulations
- financial planning
- financial management and reporting
- accounting requirements and systems
- insurance and risk management
- internal and external audit
- asset use issues
- the treatment of underspends and overspends.

The Partnership had set up a health and social care integration technical finance working group. Work was now under way with three finance workstreams to develop the integrated resources advisory group guidance and clarify the services which would be included within the scope of the shadow integration joint board. Both the Council and NHS Greater Glasgow and Clyde would maintain their own financial ledgers, with budgets being aligned rather than pooled. A new chief finance officer post would be created to manage both budgets. Guidance on budget virements would be considered under the current finance workstreams.

8.2 Information systems

A number of information technology solutions were being explored by the Partnership to support better workflow across the systems. A joint information and health systems group was taking forward activity from the NHS Greater Glasgow and Clyde data sharing partnership. This partnership comprised of NHS Greater Glasgow and Clyde and the five local authorities within the NHS board area. The joint information and health systems group had senior representation from NHS Greater Glasgow and Clyde and the Council services. The terms of reference for this group were amended last year to reflect the period of transition prior to full integration of health and social care .

We saw that progress was being made to integrate CareFirst, the social work case management system, into NHS Greater Glasgow and Clyde's clinical portal. This would mean that information would be more readily accessible and available to health services staff. CareFirst had also recently been updated to provide a single source of comprehensive data so that all system users would have access to consistent data. The update was also used as a catalyst to look at how information on adult support and protection was recorded and shared, as well as how to improve and change the associated paperwork and electronic system.

These developments were hoped to reduce duplication of information, aid better collaborative working and improve outcomes for older people. However, a number

of staff we spoke with were very concerned about the difficulties presented sharing information between health and social services staff. Despite both organisations having security compliant email systems, some staff told us they were not permitted to use these systems to share information about service users. This was due to data protection and service user/patient confidentiality protocols. This was having an impact on delayed discharges. Senior managers across both organisations told us that information could be shared through the secure email systems. However, a considerable number of staff were not aware of this. This meant that a lot of information about older people that could have been shared between health and social work services to facilitate better joint working was not being shared. We found a varied understanding of what could and could not be shared through the secure email systems.

The Partnership was moving in a very positive direction in relation to IT development. However, it acknowledged that the resourcing for developing information systems had been difficult, and this had delayed activity in some areas. However, there were some key areas of activity, such as the appointment of a dedicated programme manager and a technical analyst specifically working on integration issues, which would help drive developments forward.

Recommendation for improvement 9

The Glasgow Partnership should reinforce and communicate their organisation's information sharing protocol so that there is a shared understanding among all staff about the confidential information they are permitted to share through secure email systems.

8.3 Partnership arrangements

Compliance with integration delivery principles[13]

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

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

From 2006 to 2011, there were five community health and care partnerships in Glasgow City. These partnerships between health and social work services had integrated commissioning and service delivery.

While both organisations were keen to retain the five partnerships, the Council also wished to action inspection and audit recommendations. Therefore, it put forward the option of a revised scheme of establishment[14]. This was seen as a means of retaining the five partnerships with incremental social work budget and managerial devolvement. However, NHS Greater Glasgow and Clyde felt this option would not be viable. The community health partnership were established to provide health only services and social work services were returned to their previous functions.

During the inspection, it was clear that the impact of the dissolution of the community health and care partnerships was still keenly felt by staff. Despite having a strong legacy of joint working on the ground, it was inevitable that the new health and social care partnership would have to put into place strong joint strategic governance arrangements. These would need to demonstrate shared and agreed aims whilst allowing each organisation to retain their own strategic functions. Senior management staff in both organisations acknowledged that, in moving forward, they would have to demonstrate joint decision making, clear lines of accountability at both a central and local level, as well as jointly agreed budgetary and management arrangements at locality level.

The chief officer designate of the shadow integration joint board stated that they hoped to learn from the experience of the community health and care partnerships. They were confident that there was a shared vision which had been absent with the community health and care partnerships. They believed the shadow integration joint board would be fundamental in ensuring that the Partnership would deliver on the shared aims.

The shadow integration joint board presented as a cohesive, mature, well-functioning group. There was appropriate representation of stakeholders within the group. Glasgow City Council's executive director of social care services had been appointed chief officer designate in July 2014. They appeared confident in their role in getting the shadow integration joint board to the point of being functional as an integrated joint board.

The Partnership's draft integration scheme would be completed and submitted to the Scottish Government by end of January 2015. The integration scheme was a high level document. A body of work was being developed through key workstreams that underpinned the integration scheme. This would provide a degree of assurance to the shadow integration joint board.

[14] The basis for the creation of any CHCP is a Scheme of Establishment. This details the responsibilities, structures, financial and governance arrangements for the Partnership.

The Partnership had carried out a lot of work within these workstreams, which reported to the shadow integration joint board. A project management approach was being taken with the workstreams. However, while strategies from these workstream groups were now being produced, it was still difficult to see the full direction and intent of the Partnership. The chief officer designate acknowledged this. However, they felt that the Partnership's focus at the moment was on bringing key personnel together to look at the workstream issues and to develop and embed these groups. These issues included information communication and technology, personnel, finance, clinical and professional governance, and workforce planning.

The Partnership felt that key to delivering the integration scheme was good locality planning. Critical to this was good locality work and the Partnership intended to build on this. Many staff we spoke with felt that there was already good locality work in some areas. The Partnership was committed to ensuring that all key locality stakeholders were engaged and involved. It intended to put frameworks in place that would identify communities of interest as well as geographical groups.

However, in terms of locality planning, it was acknowledged that the structure and leadership across localities still needed to be developed.

The Partnership was proposing that the localities would be the three geographical sectors currently delivering services (North East, North West and South Glasgow). Budgets would then be devolved to these three areas. Recruitment was still to take place for the management teams who will work with stakeholders in the localities. They would ensure that locality planning aligns itself with the strategic planning of the Partnership.

The Community Planning Partnership had been considered key in locality planning as it brought together community interests together with partnership representatives to jointly plan services . It was recognised that the Community Planning Partnership had to work more effectively with local community groups representing older people's interests particularly for vulnerable communities. There was also a need to further develop the engagement of, and focus on, GP practices and how they were included within locality planning. GPs we spoke with were very keen to be involved at an early stage. This would ensure they were involved in informing and shaping locality planning.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Good

The Glasgow Partnership's vision for integrated health and social care services was well developed. This was outlined in its draft joint strategic commissioning strategy. The actions and aims from the vision reflected national and local priorities. This vision for joint working was owned by Partnership senior and middle managers. However, although frontline staff were positive about joint working, the vision was not as clear for many frontline staff.

The shadow integration joint board was committed to the integration of services. It was engaged in debate on specific issues such as care governance and staff governance.

The draft joint strategic commissioning plan had been co-produced by many older people. Other agencies and stakeholders had also been involved. This demonstrated a shared approach to leading strategic development and direction.

The Partnership was confident it would meet the Scottish Government timescales for health and social care integration. We considered the development of a risk register would be beneficial.

The Partnership was concerned about how it would maintain the stability of currently funded services in the community while driving strategic change in service delivery to achieve savings. These concerns were also evident when considering the governance of acute services in future integrated services.

The Partnership had made some progress reducing the number of older people who experienced an unnecessarily lengthy stay in an acute hospital bed.

Staff morale and motivation were being adversely affected by the need to make financial savings. Radical redesign of services has left some staff uncertain about the future. However, leaders were confident that they were working hard to resolve this.

The Partnership had well-developed improvement plans for a variety of workstreams in support of integration. Positive changes had been made to planning structures in organising change and improvement into locality areas. However, these arrangements were at an early stage.

9.1 Vision, values and culture across the partnership

The Partnership was providing services under the health and social care strategy for older people in Glasgow as set out in the draft joint strategic commissioning plan for older people in Glasgow[15]. This was published in February 2013.

The Partnership's vision in this strategy was:

- help older people and their carers take responsibility for their own health so that people can stay healthy, active and live well, be independent, exercise choice and are fully involved and engaged in decisions that affect them
- ensure that health, housing and social care is focused on those older people who are in greatest need because of their health, social and economic circumstances increase our focus on prevention and anticipatory care to help people stay well
- deliver integrated and person-centred care
- build community capacity to ensure older people continue to be contributors to care provision and wider society, to ensure overall community cohesion that achieves a mutual care approach across generations and different sections of society.

Staff from the Partnership and the third sector told us the strategy was informed by extensive consultation with older people, carers and other key stakeholders as well as with Partnership staff.

The Partnership told us the strategy was developed to ensure new and more effective ways would be used to make sure that older people would receive a service which kept them safe, promoted independence and wellbeing. These aims were stated in the City of Glasgow joint adult services plan vision[16]. This sets out a model of health and social care that improves the outcomes of vulnerable adults and older people. The key objectives of this were:

- early prevention and harm reduction
- providing greater self-determination and choice
- shifting the balance of care
- enabling independent living for longer
- quality care management.

The Partnership had developed a cohesive joint approach to developing integrated health and social care services in the future. However, our findings from the staff survey were

[15] 'Let's make Glasgow a great place to grow old ' Joint Strategic Commissioning Plan 2013-2016 for older people in response to the Scottish Government's Reshaping Care for Older People initiative.
[16] Glasgow City Joint Adult Services Plan 2013/15

mixed in relation to the development of integrated services.

Forty-eight per cent of staff thought that there was a clear vision for older people's services with a shared understanding of the priorities. Twenty-seven per cent disagreed or strongly disagreed and 25% said they did not know.

More than half of the Partnership staff (54%) thought that the vision for older people's services was set out in comprehensive joint strategic plans and strategic objectives with measurable targets and timescales. Sixteen per cent disagreed or strongly disagreed and 30% did not know.

9.2 Leadership of strategy and direction

A shadow integration joint board had been established in June 2014. This was comprised of board members from NHS Greater Glasgow and Clyde and elected members from Glasgow City Council, as well as representation from service users, third sector provider organisations, and staff from NHS Greater Glasgow and Clyde and Glasgow City Council. The shadow joint integration board was supported by officers from health and social work services. The Partnership had recruited a jointly accountable officer who was originally a member of the Council's senior management team.

The shadow integration joint board's primary remit was to advise on the creation and development of an integrated health and social care partnership and the integration joint board. To do so, the shadow integration joint board was to function as a full and equal partnership between Glasgow City Council and NHS Greater Glasgow and Clyde while operating within the existing council and NHS strategic frameworks. The shadow integration joint board had developed an initial integration work plan. It expected to develop the integration scheme and integration strategy in time to meet the deadlines for submission to the Scottish Government (1 April 2015). This work plan included a preparatory period to support shadow Board members to help them fulfil their roles. The integration work plan included eight key workstreams:

- quality care and professional governance
- finance
- human resources
- locality planning
- organisational development
- governance and accountability
- communication
- performance and planning workstream
- establishment of a body corporate model.

We observed meetings of the shadow integration joint board. The level of commitment shown by board members for the integration of services was clearly evident. There was a willingness to engage in debate on specific issues such as care governance and staff governance.

The Partnership had committed to develop a detailed workforce plan for both organisations. However, the development of this plan was expected to take a considerable period of time in order to resolve issues in relation to terms and conditions of employment for staff. Work had been carried out to develop firm proposals for recruitment to joint posts at management level. However, challenges remained in the development of joint recruitment processes.

The Partnership acknowledged that the pace of progress in the development of the integration work plan was slow in some areas. A project management approach was being taken to the eight workstreams. Senior managers told us that the focus was on bringing key personnel together to look at the issues. Most workstreams had made some progress in forming plans for key activities in the coming months. However, considerable challenges remained with the timescales for introduction of health and social care integration. Key strategic decisions remained outstanding. Each project workstream identified risks in its regular reports to the shadow joint integration board. However, no overarching risk management plan was in place to address issues that might impede implementation.

Senior managers identified a significant risk with the Partnership possibly not having adequate time to consult on the Partnership's draft joint strategic commissioning strategy. Any delays in the approval of the integration scheme could lead to delays in forming the integrated partnership with the necessary powers to adopt the joint strategic commissioning strategy.

The complexity of integration was made more difficult by the need to coordinate strategic development with the five other local authorities within the NHS Greater Glasgow and Clyde boundary. Joint work was taking place in the finance workstream across the six local authorities. They were submitting their draft integration schemes to NHS Greater Glasgow and Clyde's Board for approval within similar timescales.

We saw that the shadow integration joint board was working well with senior officers to enter a state of readiness for the move to integrated services in 2015. However, there were areas where the shadow integration joint board would benefit from having stronger risk management frameworks in place. This would help to steer and direct the changes needed to be made within the challenging timescales. The shadow integration joint board should take steps to develop more robust risk management frameworks.

Recommendation for improvement 10

The Glasgow Partnership should ensure that development of a comprehensive risk register is aligned with the shadow integration joint board's function in overseeing the integrated arrangements and onward service delivery. This should be maintained when the integration joint board is established.

We found that third sector groups and older people had increased expectations following development of the draft joint strategic commissioning plan for older people and the Community Planning Partnership's 'One Glasgow' plan. The One Glasgow plan had a vision of improved prevention and early intervention for older people's services. Some third sector groups told us they hoped there would be a stronger emphasis in joint commissioning plans on early intervention and prevention within localities. Whilst acknowledging that the shift in emphasis was difficult when the Partnership had to make difficult decisions on priorities for spending, the third sector groups were anxious that the current level of commitment to early intervention and prevention would be able to continue. Elected members were aware of the need for community capacity building and the development of locality planning within communities. This had been a focus for elected members for a number of years. Elected members told us that they relied on Council officers to provide the direction, leadership and vision for taking forward the capacity building within communities.

The integrated care fund administered by the Community Planning Partnership was under review. A move from one- year to three-year funding was anticipated. Third sector organisations viewed this as a positive move to add stability to the funded organisations. However, service providers told us there was uncertainty as to what level of grant funding was available for allocation to partnership initiatives in the 2015-2016. This made it difficult to plan for reduction or development of services in time to meet the statutory requirements such as giving notice to staff under employment legislation.

From attending the Partnership's executive group, we saw the partners worked well together and were focused on issues of integration planning and finance. This was outlined in the Glasgow City joint adult services plan 2013–2015. We saw this group carrying out detailed financial management, including having an overview of each areas' actions in controlling cost.

We were not clear how the senior managers within the Partnership were communicating their immediate plans to meet demanding financial targets in the coming year. We were told by service providers of an example where there had been no consultation from the Council before charges for services were introduced.

Wider communication was managed through the health and social care communication plan which had a more strategic role. The shadow integration joint board had plans in place to develop locality-based working and support but these were at an early stage of implementation with lack of attention given to realistic timescales thus the plans were not SMART. Results from our staff survey showed that:

- 40% of staff agreed or strongly agreed that there was a strong positive engagement between the partners and local third sector groups
- 25% disagreed or strongly disagreed, and 36% said they did not know.

Housing providers were key strategic partners in taking forward the move towards integration. They were involved with the prioritisation of city-wide supported accommodation for vulnerable older people, and development of proposals for intermediate and anticipatory care. Senior managers from the Partnership were expecting the proposals to be funded through the Integrated Care Fund. A review of sheltered housing was under way. This was looking at the most effective and affordable models of housing support for older people. Significant changes to existing provision were anticipated. The use of the Integrated Care Fund to develop intermediate and anticipatory care was critical to meeting the demand created by the reduction in sheltered housing provision. It was uncertain if the need to achieve savings would result in funding reductions for sheltered housing being introduced before alternative capacity was created.

Clinical leaders in Glasgow City were overseeing a number of health led initiatives such as the introduction of the eight pillars model of community support which sets out an integrated and comprehensive, evidence-based approach to supporting people with dementia living at home during the moderate to severe stages of the illness. This model of community support developed by Alzheimer Scotland was being introduced as a pilot in the South of Glasgow.

As clinical leads within their localities, GPs told us they should have a strong role in reshaping local services to support older people in their homes for longer. However, they told us their ability to lead and deliver the reshaping of local services was dependent upon the release of resources from the acute to the primary care sector. Releasing resources from the acute sector was a long-term plan held by the Partnership's senior management. However, GPs were sceptical and thought that this might not be achieved due to the pressures that the acute sector faced.

9.3 Leadership of people across the partnership

The Partnership had held a number of key engagement and consultation staff events. Initially, these were aimed at senior staff to develop the Partnership's shared vision and priorities. An event was held in 2014 with third sector chief executives and officers. This presented the next steps towards integration and the Partnership's plan for developing and working with the third sector. Progress with the development of the integration strategic plans were reported to staff in a series of newsletters. Since September 2013, these had been issued every two months. Staff engagement events had also been held.

Staff engagement regarding integration plans was being addressed at big events. Places were allocated on application. This approach had had limited success as a significant proportion of the staff we met were unaware of the partnerships integration plans.

This was part of an extensive communication plan in support of health and social care integration. Senior staff were confident that staff had been involved and informed about the integration process. Trade unions were involved and sat on the shadow integration joint board. Senior staff told us that staff were being told that things have change and that the shadow integration joint board and senior staff were providing staff with positive and upbeat views about integration. Officers told us there was a shared overall vision within the shadow integration joint board. Senior managers said that they thought this was 'trickling down' to all staff however staff described a lack of communication from senior managers about proposed changes to structures and service delivery.

The Partnership introduced a proposal to integrate the senior management teams into a single structure and to streamline job titles and functions across the senior management grades. The report prepared in October 2014 proposing this revised structure had been shared with senior managers and with social work team managers for comment. The report was described as a setting out the way forward for future Partnership structures. Staff had mixed views on how change was communicated.

Results from our staff survey on how change was communicated to staff and whether their views were fully taken into account showed that 53% of staff thought that senior managers had communicated well with frontline staff, while 37% disagreed and 10% did not know.

Senior managers told us there were challenges in leading change with differing challenges on resources and demographics across the different areas. Results from our staff survey appeared to support this view as only 37% of staff agreed or strongly agreed that changes which affect services were managed well. Forty-six per cent of staff disagreed or strongly disagreed that their views were taken into account fully when planning services at a strategic level.

Social work services planned to transfer staff who carried out care at home assessments for older people and other client groups to Cordia. The transfer arrangements had been under extensive discussions with trade union representatives. As a result, the process had been delayed. Senior managers described workforce motivation as being difficult to deal with due to these delays in implementation, as staff were concerned about the implications for them.

Senior managers and elected members told us that staff were being supported to look at the opportunities within the Council and were being encouraged to be more flexible in terms of their work. They told us that a lot of work was being done to recognise staff. Senior managers told us radical redesign of services had left staff mistrustful. However, they were confident that they were working hard to resolve this.

Elected members told us they were taking every opportunity to spread a positive message about integration and its overall philosophy to staff. They acknowledged it may take time to bring staff on board. However, they were aiming for consistency of message across the Council and NHS board.

9.4 Leadership of change and improvement

Workstream and planning group papers showed a wide-ranging commitment to service improvement activity across the Partnership. Well developed improvement plans were in place for a variety of workstreams. Each workstream reported on progress and activity in organisational performance reviews every three months to the Partnership executive group. The community health partnership reported on performance every year to NHS Greater Glasgow and Clyde. The lead on scrutiny of performance was provided by the shadow integration joint board.

We saw papers that supported the development of change plans for the introduction of health and social care integration. However, a lot of implementation detail still needed to be decided by the Partnership. Managers acknowledged that there were concerns about effective change management. The agenda for integration was challenging and was possibly made more difficult due to the changes in direction taken in the last three years as a result of the dissolution of the five community health and care partnerships in Glasgow.

Managers told us that the rehabilitation and reablement services had shown improvement in the last year, and that joint working was improving in localities. Frontline nursing and social work services staff told us that improvement was hampered by funding restrictions. They said targets were often to address budgetary shortfalls and targets, rather than individual's needs. This meant that staff had less time to develop new ways of working

jointly as they had to focus on immediate priorities. Results from our staff survey showed that 41% of staff agreed or strongly agreed that the quality of services offered to older people jointly by partner's staff had improved over the last year. Thirty four per cent disagreed or strongly disagree and 26% said they did not know.

Locality-based planning and implementation groups were responsible for the delivery of improvements in health and social care, and integration. Membership of these groups included staff representatives and local stakeholders, as well as Partnership officers. The groups had recently been set up and were in the initial phases of considering the localised changes in support of the integration of health and social care.

Previous planning structures had been less successful in incorporating views of staff in to future service planning. Results from our staff survey showed that 34% of staff agreed or strongly agreed that the views of staff were taken into account fully when planning services at a strategic level. Forty six per cent disagreed or strongly disagreed and 20% said they did not know.

The role of the third sector and local communities in developing plans was well defined in the development of the draft joint strategic commissioning strategy. Service users, and carers also engaged successfully with development of the strategy. Staff confirmed that good locality planning was critical to good locality work. Members of the shadow integration joint board told us they were committed to ensuring that all key locality stakeholders were engaged and involved and systems would be put in place to make sure this happened.

Quality indicator 10 – Capacity for improvement

Summary

Challenges remained in delivering continuous improvment in outcomes for older people, particularly in the quality and choice of services available to older people, and in providing access to care.

The Partnership was making good progress towards integration of health and social care. The future redesign of services was a challenge. Good communication with staff and the wider community was needed to alleviate uncertainty and anxiety.

The draft joint strategic commissioning strategy was in place. However, it lacked detail, and key elements such as funding, delivery timescales and areas for growth or disinvestment were not always identified.

The issues of the large scale of service delivery needed, the high levels of deprivation and the associated higher morbidity levels for older people in Glasgow will continue to create challenges in delivering positive outcomes for the high numbers of older people who need health and social work services.

The task of successfully developing integrated health and social care services was made more critical as the Partnership was not meeting a number of existing performance targets for older people. The successful implementation of integration will continue to be a critical factor in supporting positive outcomes for older people.

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

The Partnership was delivering positive outcomes for many older people and their carers. This was evidenced through our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership, results from our review of individuals' social work services and health records, and from views expressed by service users, carers and the Partnership staff we met.

The Partnership provided proportionally more care at home and intensive care at home services to older people than the national average. Care at home services delivered positive personal outcomes for a large number of older people. However, some older people experienced poor outcomes such as those who had their discharge from hospital delayed or who had an avoidable admission to an acute bed.

The Partnership had a number of developments to support older people's independence by reducing social isolation and increasing activity, and helping older people to stay in their own home. However, many of these initiatives were pilot projects, were time-limited and were not accessible to all older people due to where they lived. Further implementation of services from these pilots was not consistently applied. As a result, we were not clear on the equity of access that older people had to services.

We found instances of older people having to stay in hospital while they waited for care home placements. The Partnership's extensive reablement initiative delivered good outcomes for older people. This was clearly supported by successful joint working. A number of initiatives were in place to make sure that older people received the right intervention at the right time with the right outcomes for older people. This included ease of access to care at home services by rehabilitation staff. This speeded up access to care at home support for older people at the point of discharge from hospital.

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

The Partnership had well-established performance frameworks. A wide range of performance information was produced, reported and made available to the Partnership's senior and local management, as well as elected members and NHS board members. A draft joint performance framework linked to national outcomes was being produced. The Partnership needed to ensure that the joint performance framework contained challenging but achievable targets.

Workstream and planning group papers showed a wide-ranging commitment to service improvement activity across the Partnership. Well-developed improvement plans were in place for a variety of workstreams. Each workstream reported on progress and activity in organisational performance reviews.

A joint financial framework was under development. There was broad agreement for what financial resources were included. Arrangements for financial monitoring were in place and had been adopted by the shadow integration joint board.

A draft joint strategic commissioning strategy for older people was in place. The Partnership anticipated that the strategy would be adopted by the integrated joint board when it was fully constituted.

Effective leadership and management

The shadow integration joint board was effectively supported by the Partnership executive group. Strong working relationships were evident, and these helped the Partnership to manage services, with a shared vision.

However, senior managers we spoke with were aware of the uncertainties among the wider staff group and of the need for good communication. They acknowledged the need to be open and transparent in their dialogue with staff across the Partnership. Communication about the progress with integration of health and social care also needed to improve.

Preparedness for health and social care integration

The Partnership had made good progress in developing joint arrangements for health and social care integration. The governance, planning and development infrastructure for the Partnership was well established. The shadow integration joint board was using a clearly written joint integration work plan with defined workstreams. This was being progressed using a project management approach. This offered a stable base from which future integration work plans would be delivered.

Considerable financial and service pressures were affecting both Glasgow City Council and NHS Greater Glasgow and Clyde. The shadow integration joint board was operating effectively. Decisions were being made on the development of integrated services and the resources to be used for development. Both partners had a commendable history of achieving savings targets. However, partnership working was affected by the impact of the dissolution of the previous five community health and care partnerships in 2010. It was clear that this was still keenly felt by staff. This presented a considerable challenge for the effective delivery of health and social care integration, and consistent effective operational joint working between health and social work services staff.

Future redesign of services was pressing due to continuing financial pressures. Senior managers acknowledged that service redesign would be needed. The capacity of the Partnership was sufficiently stable and robust to weather the onerous financial pressures and deliver the exacting agenda for change.

What happens next?

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

August 2015

Appendix 1 – Quality indicators

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

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

2.2 Prevention, early identification and intervention at the right time

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

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

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

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

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

6.3 Quality assurance, self-evaluation and improvement

6.4 Involving individuals who use services, carers and other stakeholders

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

9.2 Leadership of strategy and direction

9.3 Leadership of people across the Partnership

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

7.2 Deployment, joint working and team work

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

8.2 Information systems

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

care inspectorate

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

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

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