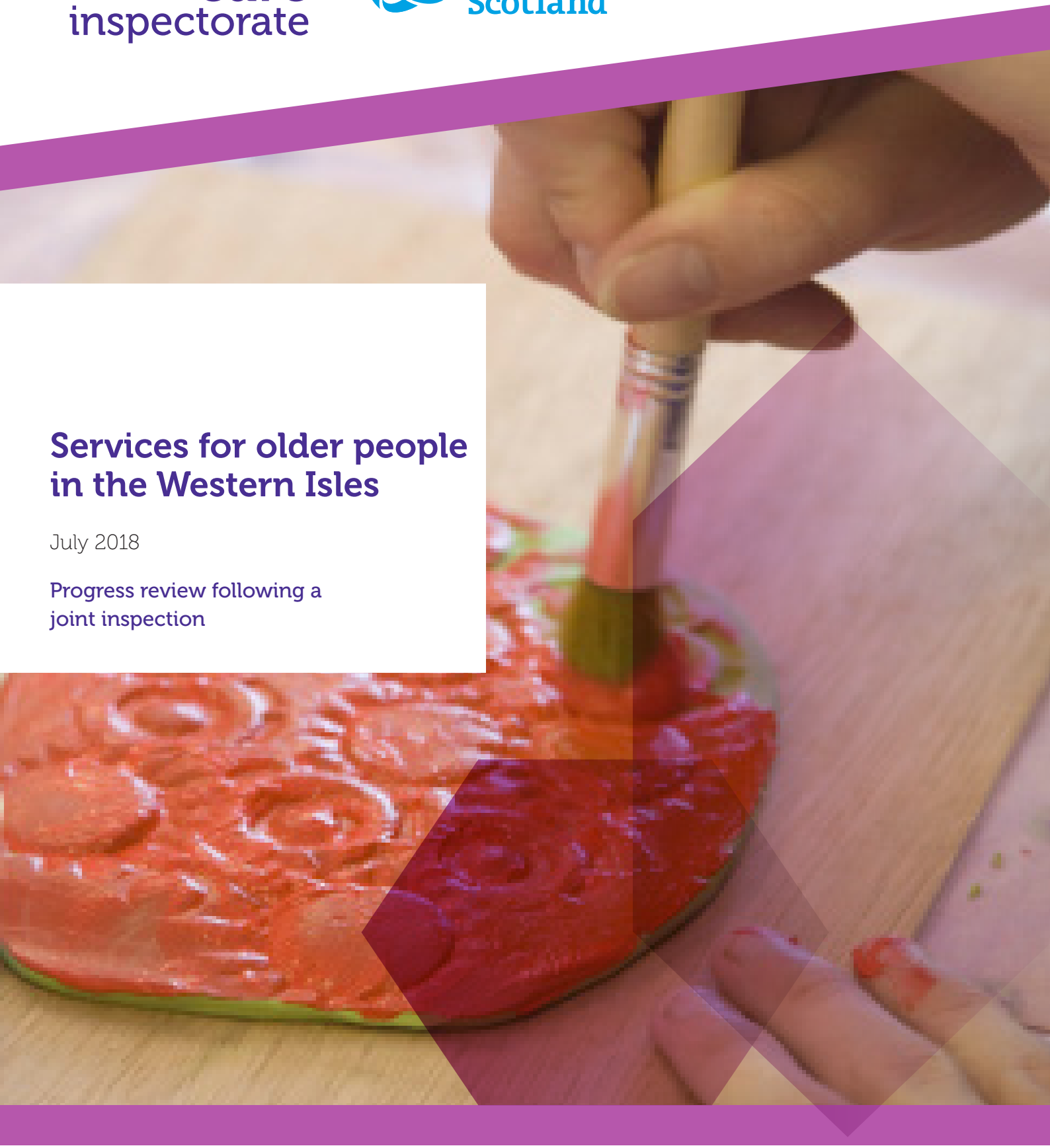
care inspectorate

Healthcare Improvement Scotland



Services for older people in the Western Isles

July 2018

Progress review following a joint inspection

HAPPY TO TRANSLATE

Contents

1. Background to this progress review

The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of services for older people in the Western Isles between May and June 2015. We published the inspection report in March 2016, which is available on our websites. The report highlighted some important weaknesses in the partnership's performance and, given this, we decided to carry out a review to assess and report on the improvements it had made.

Following the inspection, the partnership drew up a detailed action plan in 2016 to address the recommendations we made. We were satisfied that the action plan had the potential to deliver the required improvements. The partnership was also willing to receive some external support with its improvement agenda. Given this, we agreed with the partnership to undertake the progress review in 2018 so that it had sufficient time to make demonstrable improvements.

2. How we conducted this progress review

We undertook the progress review over five days during May 2018. Prior to this we examined a range of documentation submitted by the partnership and reviewed the most recent, nationally-reported performance data for the partnership. During our scrutiny week we met with some older people who used services and with carers. We also met with a range of staff and with representatives from third sector and other stakeholder organisations. The focus of our activity was on the extent of progress made by the partnership in meeting the twelve recommendations from the original inspection. We also visited some services that had been developed since the inspection, in order to assess the impact they were having on improving outcomes for older people.

3. Progress made: the partnership's approach to improvements and what we found

Overview

Historically, there had been difficulties in aspects of partnership working between NHS Western Isles and the Comhairle (the council for the Western Isles). At the time of the original inspection, we could see that this meant that the organisations had not worked together effectively to develop a range of community services to support older people. When we undertook our original inspection, senior managers, elected members and board members said these difficulties were now in the past. Most staff, third sector partners and other stakeholders we met at the time were sceptical about this. The partnership had been working on a number of important service development and redesign initiatives, but for most of these, it was going to be some time before the potential benefits would be experienced by older people and their carers. In undertaking this progress review, we were able to assess how things had progressed generally in the delivery of services for older people and reviewed in detail the progress made on the previous inspection's recommendations.

In April 2016, the integration joint board and health and social care partnership were established. Shadow arrangements had been in place for a year prior to this. The

integration joint board was responsible for overseeing the services delegated to the health and social care partnership by NHS Western Isles and the Comhairle.

We were pleased to find that the partnership was in a much better place than when we visited in 2015. From our meetings with staff and managers at all levels, partner organisations, and with community representatives, we witnessed a much stronger sense of integration and a determination to work collaboratively and take a whole-system approach.

Encouragingly, we found that leadership at key senior strategic levels was much improved. The requirement to make a success of implementing health and social care integration (which was still pending at the time of the original inspection) and the appointment of the partnership's chief officer shortly after our previous scrutiny visit in 2015 were widely identified as being key factors in this improvement.

We saw good evidence and examples of the partnership being willing to look externally for support and learning. This included the other island authorities, national and government agencies and other countries. There was also a clear commitment and determination by the partnership to involve and engage meaningfully with its range of stakeholders.

The commitment of frontline staff had been a strength at the time of the original inspection and we found that this remained the case. The partnership continued to face a number of staff recruitment and retention challenges but had taken a number of positive initiatives, including a large-scale apprenticeship scheme. As well as internal approaches, it was exploring ways it could attract people, especially families, to move to the Western Isles, to live and work.

Problems in recruiting to some posts and in particular some specialist posts remained. We saw that difficulties in this area had hindered the speed with which the partnership had been able to address some of the inspection recommendations. Elements of the recommendations covering adult support and protection, dementia support, and care at home and intermediate care were examples of this. In addition, the small size of the health and social care workforce in the Western Isles meant that many staff in management positions had to juggle a range of operational and developmental roles.

We saw that the partnership had some innovative and exciting approaches to the use of technology. There was a keenness to try to find solutions to some of the ICT (information and communications technology) difficulties that have challenged integrated working between health and social work staff nationally. The partnership had developed a digital health platform called MORSE. This was being used by health staff to communicate with each other and with patients and it had the potential to be compatible with the council's social work care management system once its upgrade was completed. The partnership believed itself to be the only one in Scotland to be using a robotic diagnostic tool that was manufactured in the USA and which allowed consultants based anywhere in the UK to undertake and share the results of diagnostic tests and to undertake clinics remotely. This avoided the need for patients having to undertake lengthy and stressful travel to the mainland. The equipment was operating effectively as part of a wider pilot project.

The redesign of mental health services and the completion of the St Brendan's project were two of the partnership's main strategic objectives and priorities. The redesign of mental health services was aimed at shifting the balance of the provision of mental health treatment and support from the acute sector to a much more community-based approach. The completion of the St Brendan's project involved the replacement of the hospital facility on Barra with a new health and social care hub on the island. Both were legacy projects in that they considerably predated the establishment of the integration joint board. Both had been subject to considerable delays and needed to be taken forward as a matter of priority, not least because both were key priorities for improvement with significant implications for older people. For the St Brendan's project, this was for the quality of health and social care services available to the 1,200 people living on Barra. For the mental health redesign, this was to achieve a shift from a hospital-based model of care to a much more community-based model, closer to peoples' homes.

We took some encouragement from more recent progress made on both of these initiatives. The Scottish Government had now approved the partnership's outline business case for the St Brendan's project with an investment of £2.9 million from the Comhairle and £15.2 million from the NHS and Scottish Government. Progress had also been made towards discharging the remaining patients from the Clisham hospital ward at the Western Isles hospital, which was integral in the partnership being able to complete the mental health redesign and the establishment of a community-based service.

Overall, we considered that the partnership had progressed well since the original inspection, something that was also evident for our findings on the progress implementing the inspection's recommendations as detailed below.

Progress on recommendations

Recommendation 1

The Western Isles partnership should continue to progress with the strategic and operational improvement actions it has identified to ensure that older people are not delayed in hospital after they are fit to be discharged. The partnership should ensure that a whole-systems approach to delayed discharge is a fundamental aspect of its strategic commissioning plan for health and social care integration.

We made this recommendation because a significant number of older people were subject to delayed discharges from hospital and having to wait, sometimes for significant lengths of time, to receive care at home support or to access a place in a care home.

We could see from reviewing current nationally-reported data that the partnership's performance in addressing delayed discharges of older people from hospital had improved significantly since the original inspection, and especially since early 2017. Positively, this improvement had been sustained since then. For the period from July 2016 to January 2017, the partnership had on average 25-30 delayed discharges each month. Since February 2017, the average figure had dropped to an

15 delayed discharges each month, with most delays being less than four weeks in duration. The partnership's improved performance is shown in Chart 1 below.

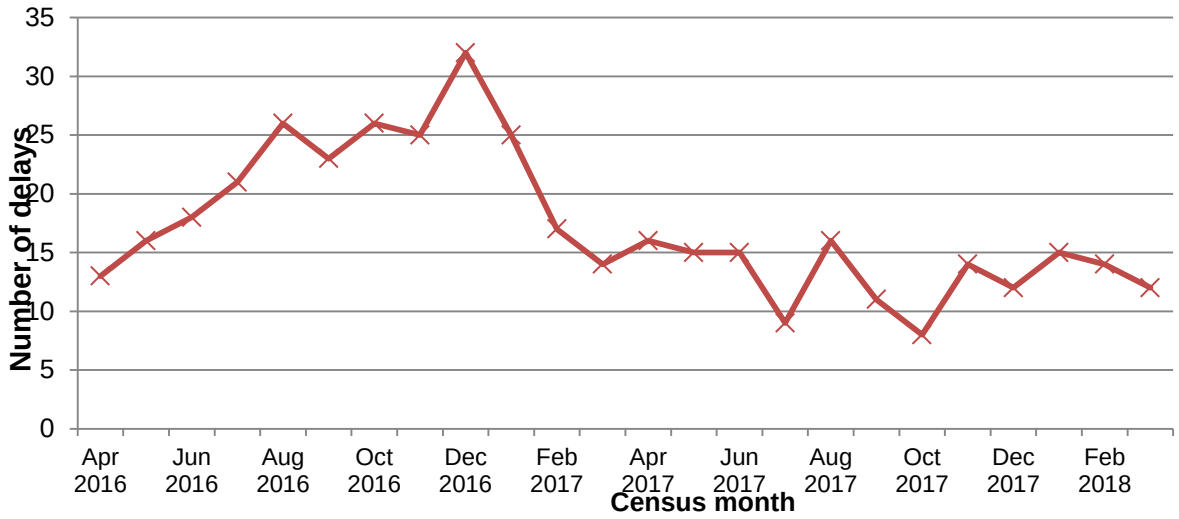


Chart 1 Number of delayed discharges (all delay reasons) Western Isles 2016/17 – 2017/18

From our scrutiny activity and discussions, we were able to confirm that there had been a number of reasons why this improvement had been made.

- The partnership had decided to take a determined, integrated and whole-system approach to tackling this longstanding issue and had developed a detailed delayed-discharge action plan which was subject to regular monitoring and review. In doing so, it worked productively with Healthcare Improvement Scotland. The chief officer told us that when he took up post in the summer of 2016, he attended the weekly delayed-discharge meeting at the hospital and observed this to be a rather passive process of information sharing about the older people.

  By moving to an approach where health and social work staff worked together at looking at everything that could impact on hospital discharges, the meetings had become much more productive. We attended the discharge meeting during our review. We saw that staff and managers present were actively working together to find solutions that would enable the older people concerned to be provided with the necessary care, support and treatment to allow them to discharged from hospital as soon as possible.

- At the time of the original inspection, the partnership had a number of service development and redesign plans in place, aimed at preventing unnecessary hospital admission and facilitating discharge from hospital. However, these had been at an early stage of implementation. We saw that the partnership had subsequently been able to make good progress in taking these forward. Most notably, it had increased the available care home bed capacity by commissioning an additional nine permanent care home beds. It had also largely completed its redesign of the care at home service in 2017 and, among other things, this had

helped to significantly reduce the number of older people whose discharge from hospital was delayed until a homecare package could be put in place.

As part of the progress review we were able to meet a few older people (and their families) who had recently been discharged from hospital. All of them had circumstances that were complicated in one way or another. However, they all spoke in largely positive terms about their experience of being discharged from the Western Isles hospital and of how staff had worked with them in planning their discharges, all of which happened with little or no delay. This was very different from what older people and their families told us about their experiences at the time of our original inspection.

A key element of the partnership's strategic plan was the Lewis residential care review, which involved the replacement of two ageing care homes in Stornoway with a new campus consisting of 50 extra care housing units, a 52 bed residential care facility and some social housing. The campus would also include day care provision for older people with dementia and some respite and intermediate care provision. This project would make a further contribution to the partnership's approach to preventing delayed discharges. More than this, it would provide a broad range of accommodation and support options for older people on Lewis. For example, the social housing would allow older people who wanted to downsize to suitable, smaller accommodation, which was currently a gap in the local housing market.

The partnership intended to treat the new care home and the extra-care housing as a single campus for some staffing purposes and the out-of-hours service for social work, Faire, was also to be relocated there. A site for the development in Stornoway had been identified and it was anticipated that it would be operational by 2020. We read documentation about the review project and met with members of the review group. We concluded that it was an ambitious project being taken forward in a positive manner and one that demonstrated very good partnership working between the Comhairle's social work service, its planning department and the Hebridean Housing Partnership.

We concluded that the partnership had made very good progress in addressing this recommendation.

Recommendation 2

The Western Isles partnership should complete its redesign of care at home services without delay, including a focus on reablement approaches. The partnership should also press ahead with plans to develop intermediate care services and implement these as fast as possible.

We made this recommendation because we found the partnership faced significant challenges in meeting the need and demand for care at home services. A significant number of older people and their families were having to wait for lengthy periods for a care at home package and sometimes being placed under considerable pressure as a result. This could be a particular issue in the most remote areas where the distances staff had to travel were also a factor.

A major redesign of the care at home service was underway at the time of our original inspection. We had been impressed with the careful planning and the strategic approach to the redesign. However, it was still at a relatively early stage and needed to be driven forward as a matter of urgency if the desired improvements in outcomes for older people were to be secured.

On returning for this progress review, we were pleased to find that the full redesign of the service, including the workforce, had been completed in October 2017 at which point local and locally managed care at home teams were in place for the localities in the Western Isles. The redesign had been informed by extensive service user and staff engagement. Care and support supervisors were now undertaking quality assurance visits to older people and their families and reported that they were receiving positive feedback at these. They said that families spoke highly of the way the service was now being delivered, which reflected a stronger focus on tailoring services to meet individual needs and preferences.

We looked at the Care Inspectorate's regulatory inspection reports for the care at home service and spoke to inspectors. This confirmed that inspection grades had improved as a result. We saw evidence that there had been a significant reduction in the number of older people delayed in hospital waiting for a care at home service. At the time of our review there were only three individuals waiting any amount of time for a service to be put in place. They were waiting for a service that would involve support three of four times a day. Care at home managers said the situation now, compared to 2015 (the time of the original inspection) was "night and day".

As well as benefits for older people, the redesign also resulted in positive changes for the workforce and the partnership. For example, the proportion of care at home staff now who were required to work split shifts had fallen from 100 per cent to nearer 20 per cent. Staff also had access to local care at home managers including out of hours. Staff sickness levels had also fallen, partly as a consequence of this.

The exception to the completion of the care at home redesign was Barra as this was linked to and held up because of a delay in concluding the St Brendan's project and the development of a new health and social care hub. Consequently, getting the right levels of staff on Barra with appropriate contracts was a struggle with some still working split shifts and working to old job descriptions. However, there was a good history of joint working on Barra and a strong third sector presence, which to some extent offset the problems associated with the delay in implementing the redesign there.

The partnership (as nationally) still faced challenges in meeting the demand for care at home, especially in the very rural and remote areas. It was working hard to recruit to these areas using traditional approaches, but also imaginative initiatives such as the apprenticeship programme. Prior to the redesign, the service did not have the mentoring capacity to adequately support apprenticeships. However, the new management structure for the care at home service had created the capacity for apprentices to be well supported and mentored.

The partnership had introduced a new service-wide model of reablement. It was now at the stage where it was moving to increase the proportion of care at home it

provided using a reablement approach (in contrast to more traditional homecare). Care at home supervisors and staff had undergone reablement training to support this approach. The Erisort ward in the acute hospital continued to be used as a rehabilitation and assessment unit to help prepare older people to return home following hospital discharge.

The short-term assessment and reablement team (START) had replaced the previous early supported discharge (ESD) team that had only had limited impact partly due to the temporary nature of its funding. START launched at the end of April 2018. The full staff complement was still being recruited to at the time of our progress review. However, the START team was already five times bigger than the ESD team had been.

The START service included a building-based intermediate care[1] model, to cover the Stornoway and Broadbay areas initially. It would have four step-up and step-down intermediate beds in Dun Berisay care home to support older people coming out of hospital and who lived in rural and remote areas (and where it would not be possible for the intensive level of reablement support required to be provided in their own homes). This part of the service was to become operational once the staff recruitment process (including the remaining reablement practitioners) had been completed. We considered the launch of the START service was a positive development as it was a truly integrated team with the clear potential to support older people at risk of unnecessary hospital admission to remain at home, as well as supporting good quality discharges home from hospital

We witnessed a real sense of commitment and enthusiasm from the staff and managers we met to drive forward the improvements needed to develop a more equitable and person-centred approach to the care at home, reablement and intermediate care services. While there was still more to be done we concluded that the partnership had made very good progress on implementing this recommendation.

Recommendation 3

The Western Isles partnership should take action to provide one-year, post-diagnostic support for people newly diagnosed with dementia, in line with the National Dementia Strategy (2013-2016).

We made this recommendation because older people newly diagnosed with dementia did not receive at least one year of post diagnostic support service in line with the National Dementia Strategy (2013-16).

We saw that the redesign strategy for mental health services was a key partnership strategic priority and was central to its plan to deliver mental health services in communities. Its ambition included achieving a system-wide approach to the delivery of support for people with dementia. The partnership had established close

[1] Intermediate care: a type of short term care to avoid unnecessary hospital admission, to help people become as independent as possible after a hospital stay, or to prevent a premature, permanent move into residential care. It can be home-based or bed-based in a care home or community hospital – Intermediate Care and Reablement. Age UK May 2018

links with Alzheimer Scotland over a number of years and now had constructive engagement with GPs in order to move dementia diagnosis closer to primary care.

A dementia services team had been established to provide post diagnostic support (PDS) for people newly diagnosed with dementia. A nurse consultant (part funded by Alzheimer Scotland) was recruited in 2016 to lead on this work and two bank staff trained to an enhanced level in line with Scottish Government's Promoting Excellence framework had been recruited to deliver post diagnostic support.

This was an interim arrangement until additional resources could be put in place. The partnership recognised this was not a sustainable model to meet the level of need and planned to build post diagnostic support into other roles as part of the broader mental health redesign. The integration joint board had recently approved additional funding to expand the clinical nurse specialist role to cover this work in the Uists and Barra as well as a full-time mental health support worker. The longer-term ambition as part of the mental health redesign was to further develop and embed the provision of post diagnostic support in the localities. For example, the Barra mental health support worker was going to provide some support in the Uists as well, on a temporary basis until further resources could be released from the mental health redesign for the Uists.

The partnership had completed its local dementia strategy. We saw this was a comprehensive document accompanied by a measurable action plan. The nurse consultant represented the partnership on the national post diagnostic support leads group, which was facilitated by Healthcare Improvement Scotland's improvement hub to share new learning and consult on national improvement work in dementia. The Managed Clinical Network (MCN) was a multi-agency group which met bi-monthly to drive improvement in dementia services and to monitor the implementation of the strategy.

At the time of our original inspection, we found that some older people recently diagnosed with dementia by a consultant psychiatrist were discharged with no post diagnostic support offered. We heard similar comments to this effect during our progress review and also that the few older people who were referred to the post diagnostic support service were too far on in their diagnosis to benefit from post diagnostic support. Although the partnership was committed to addressing and improving this situation, we considered it could usefully consider investing in an old-age specialist consultant psychiatrist to enhance and support the promising work to developing community-based dementia support services.

We were encouraged by recent developments to ensure that older people presenting with dementia had access to an early diagnosis. The long wait that older people had historically faced before receiving a diagnosis had led to GPs in all nine of the islands' practices becoming more involved in diagnosing people with dementia. Nurse-led memory clinics had been established to further complement this initiative. Our analysis of the most recent performance data showed that primary-care-led diagnosis had resulted in same day referrals to the PDS service. The average waiting time from referral to contact with PDS was now four weeks, which was a substantial improvement on the previous months.

We concluded that after a slow start the partnership was now making some good progress in addressing this recommendation.

Recommendation 4

The Western Isles partnership should review and make explicit how it can further develop arrangements for third sector and local community involvement in strategic planning. The partnership should also explore opportunities to promote inclusion of a wider range of people within the older person's network (co-production activity).

We made this recommendation because we had found little evidence of a strategic approach to community capacity building or of an established approach to engaging with communities as part of this.

Evidence provided by the partnership for the progress review showed that it now had a robust participation and engagement strategy; Your Views Matter 2016-2019. It had been co-developed with public representatives and third sector umbrella organisations, ensuring coverage of a wide range of service user interests. The strategy included an approach with different types and levels of engagement and a strong focus on co-production. We saw evidence of the partnership using all of these and of the strategy having a positive impact on improving the involvement of the third sector and the local community in strategic planning.

In trying to learn from and improve how it involved and consulted its communities, the partnership had engaged the Scottish Community Development Centre, which evaluated the effectiveness of the partnership's consultation processes. We read the evaluation report, which included an evaluation against eight engagement standards (for example, working together, methods and impact). The partnership's performance was evaluated as very good for three of the standards, good for two and satisfactory for two. The standards for working together, methods and impact were all evaluated as very good. The standards for a shared understanding and support – identifying and overcoming barriers to participation - were both evaluated as satisfactory. The partnership was aware of the need for improvement in these areas and it had used the evaluation findings when reviewing and updating its participation and engagement plan.

The more embedded level and quality of third sector and user and carer involvement was having a positive impact as reflected in a number of creative local community based projects being considered. An example of this was the joint working with the Galston Estate Trust[2] where purposeful local community involvement had resulted in a feasibility study for the development of an intergenerational community hub.

We concluded that the partnership had successfully met this recommendation.

Recommendation 5

The Western Isles partnership should make arrangements to ensure that older people whose discharge is delayed receive services in hospital that maintain or improve their independence in line with their personal outcomes.

[2] The Galston Estate: A community-owned estate in rural north-west Lewis covering 55,000 acres, 22 settlements and a population of 2000 people.

We made this recommendation because we were concerned that the health of some older people whose discharge from hospital had been delayed for a long time had then deteriorated to the point that they needed further medical treatment and prolonged hospitalisation.

We found that the action the partnership had taken in respect of recommendation 1 had largely addressed it in that older people in the Western Isles were no longer subject to the very lengthy delays that were evident at the time of the original inspection. When we examined the nationally reported data on the length of delays, we saw that during 2016, there were on average 10 older people who had been delayed in hospital either for 3-5 months or for 6-11months. Encouragingly, we saw from the data that delays over six months had effectively been eradicated by February 2017 and delays over three months by December of that year.

However, there remained two issues that required further attention by the partnership. The Clisham ward at the Western Isles hospital had become the permanent residence for a number of older people who had dementia that was not of a nature which required hospital detention and treatment under the mental health legislation. Reasons for this were the absence of suitable mental health support and treatment services in the community and capacity issues in the residential sector. Being in a hospital ward on a quasi-permanent basis was not a suitable environment for these older people. The partnership had successfully taken action to make alternative arrangements for most of the older people concerned, but a small number remained on the ward. In order that they too could move to more appropriate accommodation, the partnership needed to implement its plans to redesign the delivery of mental health services and, as we say elsewhere in this report, the partnership needed to press ahead with these.

In our inspection report of March 2016 we highlighted the need for the partnership to ensure it gave effect to the 2013 Scottish Government guidance on choice in relation to care home placements for older people moving there from hospital[3]. This guidance included the need for interim care home placements and robust consideration of capacity issues, including the use of the provisions of Section 13Za of the Social Work (Scotland) Act 1968. Comments made by staff we met indicated that consideration was now being given to the use of options, including the use of Section 13Za, but that this might not always have been the case since the original inspection. The partnership should ensure that this is always given consideration where appropriate.

The partnership needed to prioritise the move for remaining older people in the Clisham ward to more appropriate settings and it needed to maintain its focus on preventing older people being delayed for lengthy periods in hospital. However, we concluded that it had made substantial progress overall in meeting this recommendation.

[3] Scottish Government Guidance on Choosing a Care Home on Discharge from Hospital, December 2013

Recommendation 6

The Western Isles partnership, through its involvement of the public protection chief officers' group and the adult protection committee, should ensure that action is taken to improve data collection, its use for improvement purposes and the quality of CareFirst recording. It should also ensure that a clear programme of self-evaluation is undertaken. This should include an audit of the effectiveness of its screening arrangements for adult support and protection referrals.

We made this recommendation because we found that the collection and use of management information and self-evaluation activity required attention. We also had some concerns that the low number of adult protection referrals being made to and dealt with by the partnership might be reflective of an insufficient awareness and focus on adult support and protection.

The partnership had undertaken a good amount of work to ensure that the quality of CareFirst recording had improved. Adult protection CareFirst forms had been introduced and used to capture more meaningful local performance data. They were being used to improve the quality of reports to the adult protection committee. The council was in the process of procuring more user-friendly software, which, we were told, would support more effective running of data reports. For some time, the adult support and protection lead officer had been preparing quarterly data reports on adult protection concerns received from the police hub, information on referrals received, and an overview of adult support and protection cases. Staff we met who were involved with the adult protection committee confirmed this data was now considered routinely at the committee's meetings to encourage discussion and identification of improvement actions. The partnership had also established links with both the Orkney and Shetland Islands to allow benchmarking to done on adult support and protection on an inter-island basis.

While partners had made good progress in improving the quality of the data collected, they acknowledged there was still work to be done to sustain continued improvement. While data provided basic information, the partnership recognised it needed to improve the range of data collected, for example monitoring case conference timescales and outcomes as well as qualitative data to support more robust, evidence-based joint self-evaluation.

Senior officers were now screening referrals more effectively. A weekly screening meeting had been established with the Inverness police hub and health colleagues, which assisted a multi-agency approach. All partners were described as engaging well with this process, which had been instrumental in identifying more meaningful data and trends as well as identifying staff training needs. The council and police lead officers for adult protection also played a key role in screening their own single-agency referrals. However, these processes were yet to be audited to assess their effectiveness.

The partnership acknowledged that staff vacancies and recruitment challenges had significantly impacted on the progression of parts of this recommendation, particularly in relation to self-evaluation. As a result of key personnel leaving the council, vacancies in health and challenges in recruiting new staff the improvement agenda had stalled. To address this, the Comhairle restructured by merging the lead

officer role with a social work team manager post. We saw that the post holder played an active role in screening adult protection referrals and providing support to staff who commented positively about this. However, this was not a temporary arrangement and we considered that the partnership should ensure that its sustainability was kept under review.

Members of the chief officers' group described an improving picture of working relationships across the partnership. They were happy with the reports produced by the independent chair of the adult protection committee and were able to describe some improvements made as a result of the data collected. For example, in recognition of the number of referrals where mental health issues were a factor, specific training had been developed for police officers. They expressed their commitment to attending the chief officers' group and would make sure a substitute attend in their absence. However, they were less well-sighted on the commitment of partners in prioritising attendance at adult protection committee meeting. Minutes of meetings highlighted some variability of attendance by partners with lack of a consistent representative from health being reported to the chief officers' group in 2017. More positively, staff we met were hopeful that now the dementia lead nurse had been given the lead role for health on adult protection this would improve consistent representation. They were also positive on the difference made by now having both a GP and an advocacy services representative on the committee, in improving its capacity to take forward improvement work.

We found evidence to confirm that some significant progress had started to be made in the preceding six-month period. For example, the:

- completion of some early self-evaluation work that identified themes for improvement; this exercise had informed the most recent, more robust and SMART adult support and protection improvement plan
- adoption of more robust adult support and protection processes across all stages from initial inquiry or referral to case conference
- introduction of a range of adult support and protection training, both on a single- and multi-agency basis as well as bespoke training for care at home and third sector staff.

Our discussions with staff and managers involved in adult support and protection indicated that there had been an increase in the number of adult protection referrals being dealt with by the partnership. National statistical data on adult protection is limited, but what data there is, indicated that referral rates for the Western Isles remained relatively low and that the partnership still needed to focus on raising awareness of adult protection across the Western Isles.

We concluded that after a slow start to address this recommendation, largely due to recruitment and retention challenges, the pace and extent of action for improvement had picked up markedly. Given this, we concluded that the partnership had made reasonable progress on implementing this recommendation.

Recommendation 7

The Western Isles partnership should take steps to ensure that the draft joint commissioning strategy for services for older people is finalised. A SMART joint strategic commissioning plan should also be developed in consultation with all

stakeholders to deliver a range of services to help support older people to remain at home successfully. The plan should include detailed costs based on identified future needs.

We made this recommendation because, although the partnership had a joint commissioning strategy for older people, it did not include risk analysis and had yet to be developed into a joint strategic commissioning plan with an integrated resource framework. This made it difficult for the partnership to move forward with planning and implementing service changes in response to the presenting levels of need and the demographic pressures of an ageing population.

The partnership now had a robust and detailed strategic plan in place; Western Isles Health and Social Care Partnership Strategic Plan: 2016 – 2019. It had been developed with stakeholders through a process of engagement with local communities across the islands and with staff. The vision and priorities of the strategic plan were built on the views of people that used and delivered services. The plan clearly identified the partnership's vision for health and social care integration, challenges within Western Isles and how these were being addressed through the partnership's strategic priorities. The partnership had also recently developed its Strategic Plan Refresh: 2018 -2020, which was a companion document to the original plan.

We found that the partnership had involved stakeholders and worked effectively to develop and implement the strategic plan, which was now embedded in the work of the integration joint board. Five locality planning groups had been established that met routinely and contributed to the partnership's strategic planning activity. The strategic plan and its refresh identified the need for developments within the Western Isles linked to demographic changes, increasing levels of need and the projected financial outlook. The partnership demonstrated commitment to addressing these challenges. Twelve priority areas of action were identified in the plan and were underpinned by 25 key deliverables; the actions needed to make the changes happen. We saw several examples and evidence of the partnership progressing the priority actions, for instance work towards diversifying its residential care estate and creating additional new capacity in extra care housing.

As we state at the section of this report dealing with recommendation 10, the partnership had developed an investment strategy for the integration joint board that clearly reflected the strategic plan's objectives and priorities. Moving forward, the partnership needed to ensure that these remained aligned and were specified in growing levels of detail.

The partnership was committed to a responsive approach to strategic planning and was cognisant of developing and changing national priorities and legislation. The development of the strategic plan refresh was an example of this. It had kept the priority actions under review, positively acknowledged actions that had been successfully achieved, and identified continuing priorities. Stakeholders we met confirmed that relevant planning groups for key service areas had been established, were active and that their contribution to them and to service planning, and development more broadly, was valued by the partnership

Given the partnership had completed a detailed strategic plan and was able to demonstrate an ongoing and inclusive approach to strategic planning we concluded that it had fully met this recommendation.

Recommendation 8

The Western Isles partnership should develop a comprehensive and strategic approach to how it involves all relevant stakeholders in its strategic planning activity.

We made this recommendation because although some stakeholder engagement had been taking place, this had been limited. The partnership needed to develop its approach to involving and engaging with its stakeholders. Staff at practitioner level had felt distanced from the integration agenda.

As reported at recommendation 4, the partnership had developed a comprehensive participation and engagement strategy. Stakeholders we met confirmed they were now established and welcome members of relevant strategic groups including the integration joint board and the strategic planning group. We were told by representatives that "when we make sensible suggestions these have been warmly received and listened to". They also confirmed having good representation within specific forums set up to take forward initiatives such as the Lewis residential care redesign. Broader public consultation events had also supported more meaningful engagement with local communities. Senior officers were committed to regularly attending and contributing to partner forums. These included the five locality planning groups, the establishment of which the partnership had invested considerable time and effort. The groups were meeting regularly and a member of the senior management team always attended to ensure information was shared and dialogue encouraged in addressing local issues and concerns.

The partnership undertook an online survey of staff, stakeholders and locality group members during 2016. There were 125 responses and the analysis of these was reported as part of its annual report for 2016-17. The survey sought feedback on the contribution of the locality planning groups to the health and social care agenda. Positively, 11% of respondents said the groups made an excellent contribution, 39% a good level of contribution and 30% said the groups made some contribution.

The survey also sought feedback on the effectiveness of the partnership's overall approach to community engagement. The results were mixed and although the majority of responses pointed to the engagement being reasonably effective, a number of responses highlighted the need for further improvement. The partnership was about to undertake a further survey for its 2018-19 annual report. While the undertaking of surveys on an annual basis was positive, we considered that there was scope for the partnership to develop a more comprehensive and ongoing approach to consultation.

In the original inspection, we found community groups, organisations and third sector organisations had an appetite to be involved in service planning and development. However, the partnership had only harnessed this to a limited degree. We found a very different and much more positive picture from our progress review. We concluded that the partnership had made very good progress on implementing this recommendation.

Recommendation 9

As part of health and social care integration, the Western Isles partnership should develop an integrated training strategy. In doing so, it should consider ways to jointly develop and provide access to a range of training and education for staff which can be accessed easily and provided in a range of formats. This should be informed by staff views and through a training needs analysis.

We made this recommendation because although some joint training had been provided for staff, it had been limited to a few specific subject areas and often organised on an ad-hoc basis. This meant that some staff could not always find time to attend as there was no protected time set aside for training.

Documentation we saw and our discussions with staff and managers confirmed that the partnership had taken positive steps to address this recommendation.

A three-year workforce and organisational development strategy had been produced in 2016. It identified a number of measurable actions to address the key workforce development activities identified in the partnership's strategic plan. It also included a commitment from the two partner agencies to work across organisational boundaries to develop shared training opportunities for the workforce. It also included commitments to enhance the number of co-located teams and to develop innovative models whereby staff would work across the organisations.

We found that there were a number of examples where the partnership had made some encouraging progress in developing a unified workforce that was appropriately skilled, trained and supported to continuously improve practice. These included the following examples.

- An integrated human resources forum established to oversee workforce planning for integrated services delegated to the integration joint board.
- The involvement of staff-side representatives who were now well engaged in the organisational change processes.
- Staff engagement events held in all five localities for health, social work staff and third and independent sector personnel to promote the development of localised teams.
- Continued financial investment approved to double the number of apprenticeships in health and social care by end of 2018 to support succession planning and address skills gaps. The number of apprentices taken on by the Comhairle as a whole had already reached 300. At time of our review further recruitment was underway for apprenticeships in social care. This would mean eight apprenticeships being available as reablement practitioners, twenty as support workers and a further four within leadership and management services.
- A generic healthcare support worker job description had been developed and a recruitment process had commenced. These posts would initially sit within the community nursing service.

Staff and managers said there was now a much stronger emphasis on joint training, although workload pressures and sickness absence could still sometimes impact on attendance. Nonetheless, a series of themed, joint training events were being rolled out to health and social care staff which focused on dementia, stress and distress, reablement, speech and language therapies and multi-agency adult support and protection training.

We concluded the partnership had made good progress with this recommendation.

Recommendation 10

The Western Isles partnership should jointly produce and monitor a forward looking combined budget for the services that will become integrated to ensure that the financial monitoring arrangements are bedded in, in preparation for the integration joint board going live. A plan should also be produced for how the integrated care fund will be used for each of the three years of the fund's life and this should be jointly monitored on a regular basis.

We made this recommendation because there were a number of significant financial challenges and pressures on the provision of more integrated services, particularly in relation to providing services on a sustainable financial footing and remaining within budgets. A combined budget for services that would become integrated was still to be agreed.

The Care Inspectorate's strategic inspector for finance who had been part of the inspection team for the original inspection studied a range of finance and related reports, which had been submitted to the integration joint board in advance of the progress review. From this analysis, we were able to see that the board had established sound financial planning, monitoring and governance arrangements. The board's chief finance officer was also the depute director of finance for health board and this was clearly seen by board members and by other senior managers as being positive. We noted that the board had been able to fulfil its responsibilities and deliver the services delegated to it within budget. We also noted that the board had developed a clear investment strategy with priorities and a risk register which were both subject to review.

Importantly, and based on our discussions that the health and social care partnership and the parent bodies (the health board and the council) had been able to establish a meaningful and productive joint approach to the management and deployment of resources. There was a real sense that the budget was seen by all as truly pooled and that they worked together to deliver financial efficiencies in an open and transparent manner. Such a joint approach had not been evident at the time of our original inspection

We concluded that the partnership had met the requirements of this recommendation.

Recommendation 11

The Western Isles partnership should ensure that its strategic plan for health and social integration provides detailed and measurable actions of how its higher level visions and objectives for older people will be delivered.

We made this recommendation because the partnership needed to develop a strategic plan with a greater level of detail, including measureable targets and timescales so that it could monitor and ensure that its key service developments were delivered effectively.

We saw that the partnership's strategic plan referenced an integrated performance framework to report on national and strategic plan indicators and priorities. The measurement of progress of the partnership's strategic objectives and key deliverables was being reported to the integration joint board through a strategic plan implementation report.

The partnership had implemented a range of approaches to obtain relevant performance data across services. We found that it was able to produce some good quality and volume of data. Senior managers expressed confidence in the interrogation and analysis of data. Performance information was routinely discussed and the partnership was committed to using performance information systematically to inform and progress service developments, including within the localities. Examples of this that we saw included the planning for dementia services, the delivery of post diagnostic support and the redesign of home care services.

Partners considered performance across the whole health and social care system rather than purely on a council or health basis. This had facilitated discussion and had been fundamental in leading to changes and improvements in a number of areas. The significant improvements made in reducing delayed discharges were a clear example of this. Using data, senior managers had engaged groups of staff across health and social care ensuring that they had a greater understanding of the impact of different parts of the system and how this could result in people experiencing delays in being discharged from hospitals. We heard that this resulted in increased accountability for performance across health and social services. Managers' confidence in their knowledge of the health and social care system, why delayed discharge occurred and their ability to manage this in the longer term had also improved.

The partnership continued to develop approaches to obtaining and using performance information and had recently developed a real-time systems monitoring dashboard. They were optimistic this would start to generate some good quality information about the partnership's overall performance and allow them to benchmark more effectively with other areas. In common with other partnerships, the Western Isles had received some support from an analyst from NHS Education for Scotland. However, unlike other partnerships, this individual had been fully absorbed within NHS Western Isles which meant they were able to provide a greater level of input than elsewhere.

We concluded that the partnership had made significant progress on this recommendation. It had established a performance framework, which it was continuing to develop and improve. We saw evidence that it was using this to support service delivery and improvement.

Recommendation 12

The Western Isles partnership, as it moves into the new integrated partnership, should review how it communicates with its staff and with the wider community.

We made this recommendation because although the partnership had made some efforts to communicate with staff and the wider community there was a need for a significant improvement in how its senior managers in their leadership role communicated with and involved stakeholders.

As stated earlier, the partnership had introduced a robust participation and engagement strategy in 2016. In support of this, a range of mechanisms had been implemented to involve and communicate with staff and other stakeholders in the work and development of the partnership.

Staff and other stakeholders we met during the progress review confirmed that senior managers were visible across the Western Isles and that formal engagement had improved.

The establishment and impact of the integration joint board, and the appointment of the chief officer in the summer of 2015, were widely regarded favourably by staff and were credited with advancing partnership working at a senior level. Staff commented on the chief officer as being very approachable and responsive. They also described the heads of service as providing positive leadership and communicating effectively with service teams. Joint working between health and social care colleagues was encouraged by leaders. Staff considered that joint working was more developed than it had been at the time of the original inspection with increased multi-disciplinary meetings and partnership working by staff.

Stakeholders and staff said senior managers used a variety of approaches to communicate and engage with them, including face-to-face meetings, convening open agenda meetings in various locations throughout the islands and using video-conferencing to engage where this was appropriate. The chief officer provided staff and other stakeholders with a weekly update in the form of a blog. This approach was embedded and provided staff with an easy read about developments in the partnership as well as offering opportunity to comment on consultations.

The chief officer had received informal feedback and formal feedback from staff and other stakeholders when he posed a question within the blog. Staff we met appreciated the purpose of the blog as a genuine attempt at communication, but we heard some mixed views about whether or not they liked it. Some indicated that it came out too frequently, and was predominantly a one-way form of communication. Some suggested there would be benefit in the partnership providing a suggestion box or email address as a further mechanism for staff to provide their views. The chief officer was aware that the blog was not “everyone’s cup of tea”, but saw it as his responsibility and privilege, given his role, to communicate directly with staff.

The establishment of the integrated corporate management team (ICMT) and senior management team (SMT) meetings facilitated joint communication across the partnership. The ICMT was chaired on an alternating basis by the NHS Western

Isles and the Comhairle chief executives. Membership of the SMT extended beyond integration joint board delegated services with representation from NHS acute and secondary services, which facilitated broader discussion and consideration of wider systemic issues. SMT members said they now saw themselves as if they were the managers of a single department, rather than as a group of health and social work managers seeking to work jointly together. We attended meetings of both the ICMT and SMT and observed a much more developed and mature level of integrated working than had previously been the case.

The partnership meeting structure promoted two-way communication between frontline staff and senior managers. Staff we met confirmed they had the opportunity to express views through this structure. We saw evidence that the partnership considered and took on board the views of staff and other stakeholders from consultation and engagement events and through locality planning.

NHS Western Isles used an iMatter staff survey to consult and engage with staff, however it had not been fully implemented. NHS Western Isles was reviewing how to implement iMatter to improve staff response. The council sought staff views through a staff survey every three years. Consideration was being given by the council to implementing iMatter with health and social care staff in the future. As stated earlier the partnership had undertaken a survey with stakeholders as part of the completion of its annual report.

We met with the chief executives of NHS Western Isles and the Comhairle who had been in post at the time of the previous inspection. They said they had found some of the inspection findings difficult, but had listened to the messages and jointly determined to make their commitment to health and social care integration clear. They used the establishment in April 2016 of both the integration joint board and the health and social care partnership as a fresh start. They cited as examples the work they had done around finance (NHS Western Isles had contributed to the costs of the additional care home beds), pooled budgets and the creation of joint posts. They said they had been able to establish a very good joint working relationship with the partnership's chief officer who echoed this when we met with him.

We saw written documentation that showed that the partnership had worked hard to improve communication with staff and other stakeholders. We had the opportunity to meet with a significant number of partnership staff, community representatives and staff from partner organisations. The very clear consensus was that there had been a marked improved in communication, engagement with staff and stakeholders and in leadership in general since the original inspection. We concluded that the partnership had made very good progress in addressing this recommendation.

4. Conclusion and what happens next?

The original joint inspection had identified some strengths in the delivery of services for older people in the Western Isles. These included a committed workforce and some able managers at the service manager and heads of service level. However, it also identified a number of significant weaknesses and we made twelve

recommendations for improvement. In this progress review, we found that the partnership had responded well to the recommendations and had made either very good or good progress in addressing almost all of them. We also found that more broadly the partnership was now in a much better place than it had been back in 2015.

An important reason for this appeared to be a determination by the council and the health board to put past differences behind them and not only to respond to the challenges of health and social integration, but also more positively, to work together to take advantage of the benefits which integration could offer. Also key to this was the appointment and impact of the chief officer for the partnership in 2016. He was undertaking this role effectively, establishing positive and constructive working relationship with the range of stakeholders and galvanising support for better and real integrated working and approaches. Within this environment, the strengths that were already evident had been able to prosper, resulting in an impressive amount of improvement.

Given the positive findings from our review, we do not intend to conduct any further scrutiny in relation to this inspection. Instead, the Care Inspectorate and Healthcare Improvement Scotland will continue to engage with the partnership about the possibility of offering further support for improvement.

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Contact us:
Telephone: 0345 600 9527
Email: enquiries@careinspectorate.com
Write: The Care Inspectorate, Compass House, 11 Riverside Drive, Dundee, DD1 4NY.

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

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

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

www.healthcareimprovementscotland.org

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