

Services for older people in Aberdeen City

October 2018

Progress review following a
joint inspection

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1. Background to this progress review

The Care Inspectorate, jointly with Healthcare Improvement Scotland, carried out an inspection of health and social care services for older people in the Aberdeen City between November 2015 and February 2016. We published a joint inspection report in September 2016¹, which is available on both scrutiny bodies' websites. The report highlighted some important weaknesses in the partnership's performance and, given this, we decided to carry out a review of the partnership's progress.

Following publication of the joint inspection report, the partnership drew up a detailed action plan to address the recommendations we had made. We were satisfied that the action plan had the potential to deliver the required improvements.

2. How we conducted this progress review

We undertook this progress review over five days during June 2018. Before this, we examined a range of documentation submitted by the partnership, and we also reviewed the most recent nationally reported performance data for the partnership.

We stated in our joint inspection report of September 2016 that we would revisit the partnership so that we could be assured that the significant issues in relation to adult support and protection had been fully addressed. We subsequently agreed with the partnership that we would also review progress with all of our recommendations for improvement in order to ensure a consistent approach to progress reviews.

To check progress with adult support and protection we sampled and read some records of adults at risk of harm whose adult protection journey had progressed to the investigation stage and beyond. We met with staff who carry out adult support and protection work (council officers²) in a focus group. We also met with team leaders who have direct responsibilities for adult support and protection.

To check progress with our other recommendations we met with health and social work staff in focus groups, including locality managers. We met with a group of unpaid carers. We met with representatives of the chief officers group and the convener of the adult protection committee.

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

Overview

We considered the partnership had made good progress in relation to five of the recommendations, reasonable progress in relation to two, and limited progress in relation to one.

¹<http://www.careinspectorate.com/images/documents/3381/Joint%20inspection%20report%20of%20services%20for%20older%20people%20in%20Aberdeen%20City.pdf>

² These were council officers specifically trained to carry out adult support and protection work.

The partnership had worked diligently to reduce delayed discharges of older people from hospital and prevent the consequent highly negative impact on older people's health, wellbeing and quality of life.

The partnership had made good progress carrying out carers assessments for unpaid carers. It was reasonably well prepared to implement the Carers (Scotland) Act 2016, which came into force in April 2018.

The partnership had made improvements to its delivery of care at home to older people. However, its capacity to promptly deliver care at home to older people remained a persistent issue, and a significant risk to the partnership.

Due to the concerns we raised in our joint inspection, the partnership commissioned an independent review of adult support and protection. Broadly, the review's findings were congruent with our findings. The partnership had made progress implementing our recommendations on adult support and protection, and the recommendations of the independent review. It needed to deliver faster initial inquiries and investigations into adult protection concerns.

The partnership had made limited progress with the creation of locality teams. It needed to considerably step up its efforts to put locality teams in place and make them operate effectively.

Progress on recommendations for improvement

Recommendation for improvement 1

The partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to deliver the Scottish Government's delayed discharge target of no delays over two weeks duration, and ensure fewer older people experience delayed discharge from hospital.

We made this recommendation because a significant number of older people in Aberdeen City were subject to delayed discharges from hospital. We identified that capacity for delivery of care at home was an important factor contributing to delayed discharges. The number of delays, the number of bed days lost standard delays and code nine delays³ were significantly high compared to the Scottish average.

At July 2018, the Scottish Government had no specific targets for delayed discharge, other than that partnerships should continuously strive to reduce delays. The partnership had however indicated to the Scottish Government's Management Steering Group that it was working to improve delayed discharges further over 2017-18 by a further five percent.

The partnership's performance in addressing delayed discharges of older people from hospital had improved significantly. They had delayed discharges well controlled. Staff we met agreed with our analysis.

The partnership had put a number of measures in place to help reduce delayed discharges for older people. The discharge hub was fully functional at Aberdeen Royal Infirmary. Staff reported that the hub was a useful platform to support timely hospital discharge for older people. They had recruited a service manager, dedicated to reducing delayed discharge. They had increased the number of social work staff working in the hub at Aberdeen Royal Infirmary.

The discharge hub provided a robust system for monitoring capacity and flow in the acute hospital. It had team members with previous district nursing experience, which helped to build on existing relationships within the community for more effective discharge planning. Older people were able to access care packages from a range of providers quicker because of the new care portal. This care portal was an electronic application that enabled staff to source care for people from a range of providers. The partnership effectively used interim care home and nursing home beds to transfer older people from hospital when they were medically fit for discharge.

Positively, older people in Aberdeen City continued to be supported at home or in a homely setting at end of life. The partnership had developed a clearer process for accessing beds and care for older people that prevented their admission to hospital. This and the work of the care management screening team prevented unnecessary admissions of older people to hospital.

³ code nine delays are mainly due to reasons related to the Adults with Incapacity (Scotland) Act 2000

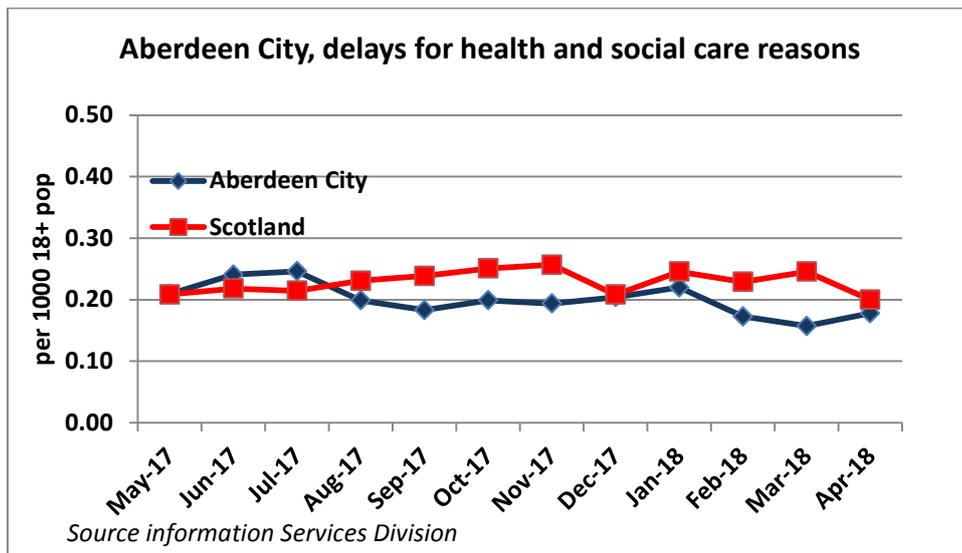


Chart 1

Chart 1 shows that the partnership had reduced its number of delayed discharges (for health and social care reasons) to below the Scotland average.

In the period July 2016 – April 2018 the partnership had an average of 8.5 code nine delays per month. These fluctuated from month to month. They had recently appointed a mental health officer tasked with reducing the number and duration of code nine delays. It was too early to tell if this was effective.

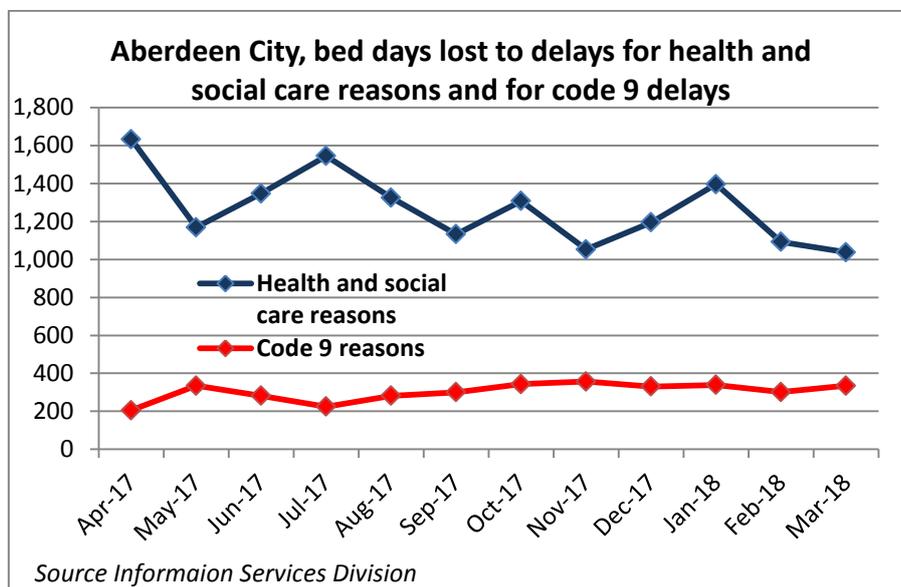


Chart 2

There was a downward trend in the number of acute beds occupied each month by delayed discharge patients. In April 2018, the partnership had 25% fewer acute beds occupied by delayed discharge patients than in April 2017.

Chart 2 shows a downward trend in the number of bed days lost to delays. This was further evidence of the partnership's progress on reducing the number of

delayed discharges. There was a rising trend in the number of bed days lost for code nine reasons (a 63% increase between April 2017 and March 2018) and this remained an area for improvement.

Senior managers, including the former chief officer, had prioritised reducing delayed discharge and this had proved effective. The integration joint board effectively supported this work.

As part of the partnership's transformational change arrangements, there were some innovations to support improvements in reducing delayed discharges and unscheduled care. These included acute care at home, which had only just recently started. The multidisciplinary health and social care team, aimed to prevent unnecessary admissions to hospital. Another initiative was Integrated Neighbourhood Care Aberdeen (INCA)⁴ (see link in footnote for details of this model of health and social care). There were two pilots underway in Cove and Peterculter. These self-managing teams were made up of health and social care staff, in line with the Buurtzorg model⁵. The West Unscheduled Care Project⁶ aimed to test a daytime urgent afternoon home visiting service for patients in the West Locality. An advanced nurse practitioner did these visits, which otherwise a GP would have carried out. These initiatives were in early stages of implementation and had not yet made an impact on delayed discharges.

Overall, we considered that the partnership had implemented this recommendation effectively. It had made good progress reducing the numbers of older people who could not be discharged from hospital, despite being medically fit for discharge.

Recommendation for improvement 2

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

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

In our joint inspection report published in September 2016, we found the partnership's delivery of support to unpaid carers was mixed and some carers we met found it easier to access services than others. The older people's records that we read in 2016 showed that half the carers were not offered a carers assessment and a third of those who had requested a carers assessment did not get one. The practice of offering carers assessments varied across the teams.

The partnership was working to address inconsistencies in practice across the teams when unpaid carers needed support to help them fulfil their caring role. Our analysis of the documentary evidence submitted for this recommendation

⁴ <https://www.aberdeencityhscp.scot/our-innovations/inca/>

⁵ A model of self-managing health and social care teams that emanates from the Netherlands.

⁶ <https://www.aberdeencityhscp.scot/our-innovations/west-visits/>

showed there was a strong emphasis on engagement and participation of unpaid carers. This included their meaningful involvement in the planning and future design of services for carers. The implementation of the Carers (Scotland) Act 2016 in April 2018 had enhanced the partnership's focus on the needs of unpaid carers.

The carers strategy was co-ordinated by a steering group with representatives from the partnership, third and independent sectors, and carers. It was informed by various workshops, a carers' conversation programme, a citywide survey, and the work of various sub groups. Positively, the partnership received feedback from around a thousand unpaid carers at these events. Their views had strongly influenced the development of the carers strategy.

The partnership established robust eligibility criteria for unpaid carers in June 2018, in line with the requirements of the new legislation. They reviewed the carers assessment and support documentation in consultation with carer representatives. They were in the process of creating a new adult carer support plan to replace the existing carer assessment. They anticipated completing this documentation, with full implementation across the city, by the end of 2018.

The partnership undertook a review of its commissioned carer support service for adults from Voluntary Services Aberdeen (VSA), a third sector provider. The integration joint board approved a variation of the VSA contract, which commenced from November 2017. This revised contract set out arrangements for providing adult carer support plans (including emergency and future planning) for unpaid carers. Unpaid carers were referred to the VSA service when the person they cared for needed a care management assessment. Unpaid carers received support from this service if the person they cared for had their hospital discharge delayed.

We met with a number of carers who were members of a specialist Parkinson's disease carers support group and some of the people they cared for. They had mixed views about their experience of care at home services. Some said the care at home service was unable to provide the level of support that they considered was needed to support the person they cared for at home. Some carers had waited more than three months to get home support in the morning. Although end-of-life care was prioritised, access to this could vary depending on where you lived. They made positive comments about access to respite and daycare services. Some of the individuals who were cared for spoke highly about the range of support available to enable them to lead fulfilling lifestyles and participate in favourite pastimes. Carers who cared for a person with dementia said they had very good post-diagnostic support for a year. The dementia resource centre provided this support.

Frontline health and social work staff and managers we met said that good conversations had always taken place with carers. But there were inconsistencies in how this information was recorded and acted upon across the city. Staff viewed the enhanced VSA contract as a positive step to streamlining the referral process for carers in line with the newly developed eligibility criteria. Health and social work staff had attended training in preparation for the implementation of the carers legislation. Senior managers affirmed that a huge

amount of work had been done around supporting unpaid carers, and the legislation had sharpened the partnership's focus on unpaid carers.

Overall, the Aberdeen health and social care partnership and its third sector partner Voluntary Service Aberdeen completed a substantial number of carers assessments – 358 over a two-year period (2016 – 2018).

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

Recommendation for improvement 3

The partnership should ensure that:

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

We made this recommendation because our joint inspection found that some older people had a lengthy wait to get the care and support services needed to deliver their desired personal outcomes in respect of safety, health and improvements to their quality of life and wellbeing. The partnership did not apply its eligibility criteria consistently. Older people who used services, their unpaid carers and other stakeholders were unclear about how to access health, social work and social care services.

One area where there was clear improvement was with staff recording that their conversations with older people about their self-directed support (SDS) options⁷ had taken place. Staff completed a form noting that they had this conversation. The numbers of people⁸ recorded to have had these conversations had risen exponentially since the start of the form system. The partnership achieved an increase for this indicator of over 1000% between June and September 2017.

The published figures from the number of direct payment recipients showed that Aberdeen City was around the Scotland average for this indicator. There was a rising trend of direct payment recipients.

Staff had to submit their recommendations for packages of care for older people to the resource allocation panel (RAP) for approval. They did not have to do this for all packages of care, and the criteria for when they did have to get approval from the RAP were somewhat complex. Some of the frontline staff we met said the arrangements for the RAP were bureaucratic and could cause delays in some instances. All self-directed option one and option two packages had to go to the RAP, while option three packages did not. Managers said that if an individual was in urgent need then care could be deployed immediately, in advance of approval by the RAP. The service managers that we met were largely positive about the RAP as a conduit to ensure:

⁷ Option 1 – direct payment, option 2 – supported person chooses service and service provider, option 3 – HSCP arranges the service, option 4 – any mixture of the first three options.

⁸ Older people and people with physical disabilities.

- equity of access to resources
- consistency of access to resources by people using services
- control of costs
- consistency with assessments and recommendations for people's care requirements.

The partnership referred to the number of care at home hours that they were not able to deliver as unmet need. The figure for unmet need had fallen by around half in early 2018, from around 1000 hours each month to around 450 hours each month. This showed that they were making progress.

The Scottish Government's published care at home statistics (2017) show, positively, that in 2017 the partnership increased the volume of care at home hours it delivered to older people by 11% compared to 2016. There was a marginal decrease in the number of older people who received care at home – 4% between 2016 and 2017. Overall, this data evidences the progress providing care at home to older people, with a related improvement to older people's ease of access to care at home. However, the number of care at home hours that the partnership acknowledged it could not deliver, along with the comments of the unpaid carers and the staff that we met, was evidence that this was an area for continued improvement.

Some older people still had to wait for lengthy periods for care at home. This problem could be exacerbated by people's location or if there were complexities with the aspects of the care that they required for example, double-up care at home⁹ or care at very specific times.

Frontline managers reported that there were clear pathways for accessing palliative care services. We did hear some negative views about the availability of palliative care from some of the unpaid carers we met:

The partnership had made progress with the equitable allocation of day care places for older people. They had also reduced the amount of time that older people, who required a care home place, had to wait for one.

There has been progress implementing this recommendation in terms of:

- reduction in unmet need (care at home hours that could not be delivered)
- far more individuals recorded as participating in SDS "option choice" conversations
- views of some in respect of the efficacy of the RAP
- pathways to palliative care services
- access to day care places and faster access to care home places.

The partnership had made reasonable progress implementing this recommendation. It had made improvements to its timely delivery of care at home to older people. Increasing the capacity of care at home services was an area for continuous improvement.

⁹ Two care at home workers are required at the same time to support the person.

Recommendation for improvement 4

The Aberdeen City adult protection committee should support improvement in adult support and protection by:

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

We made this recommendation because our joint inspection found the partnership had significant deficits with its adult support and protection processes and practice. There was widespread lack of clarity about the timescales for completing adult support and protection work, particularly those for initial inquiries and investigations. There were protracted delays, sometimes of many months, in carrying out adult protection work. Some adults at risk of harm suffered adverse impact because of these delays. We intimated these findings to the partnership and it commissioned an independent review of adult support and protection. The Care Inspectorate worked alongside the independent reviewers and directly supported the reviewer's analysis of the records of adults at risk of harm.

The independent review of adult support and protection commissioned by the partnership states "The clear view from staff and frontline managers is that management systems are currently driven by scrutiny and compliance".

The culture around adult support and protection had clearly changed for the better. Staff were much more confident about their adult support and protection practice. Council officers we met said that they were well supported for their adult protection work by their team leaders and other managers. They said that the punitive climate existing at the time of our joint inspection two years ago had been replaced by a much more supportive and facilitative approach.

One of the key findings of the commissioned review of adult support and protection in Aberdeen City was "The partnership needs to address delays and confusion in key aspects of adult protection processes and look at setting clear parameters for completion".

Council officers we met all knew what the timescales were for completing adult protection initial inquiries and investigations (eight weeks for each) even though they were not formally written down anywhere. They knew the timescales from their conversations with their team leaders and from the two-weekly monitoring reports carried out on adult protection work. If there were delays in carrying out initial inquiries and investigations this was flagged up.

The partnership had not formally written down the timescales for completing adult protection initial inquiries and investigations or properly intimated the timescales to all staff. They acknowledged that this was the case. The partnership should make sure that its adult support and protection procedures are updated to include a clear written statement of the expected timescales for the completion of:

- initial adult protection inquiries

- adult protection investigations
- all other phases of the journey of the adult at risk of harm for example, timescales for convening adult protection case conferences.

The updated procedures should be made widely available in an accessible manner to all staff across the partnership. This includes third sector and independent sector partners.

The partnership had recently started a pilot initiative in the learning disabilities team. This team had a higher number of adult protection initial inquiries and investigations compared to other adult teams. The objective of this initiative was to streamline the process of carrying out initial inquiries and investigations into adult protection concerns, and to shorten the timescale for completing these activities.

The partnership’s timescales for completing initial adult protection inquiries and investigations were eight weeks for each activity. Figure 1 shows the partnership’s evolving position on timescales for completing adult protection initial inquiries and investigations:

- at the time of our joint inspection
- at the time of our progress review
- for the pilot in the learning disabilities team (28 days to complete both initial inquiry and investigation, which was a 75% reduction in the time allocated for completion of these activities).

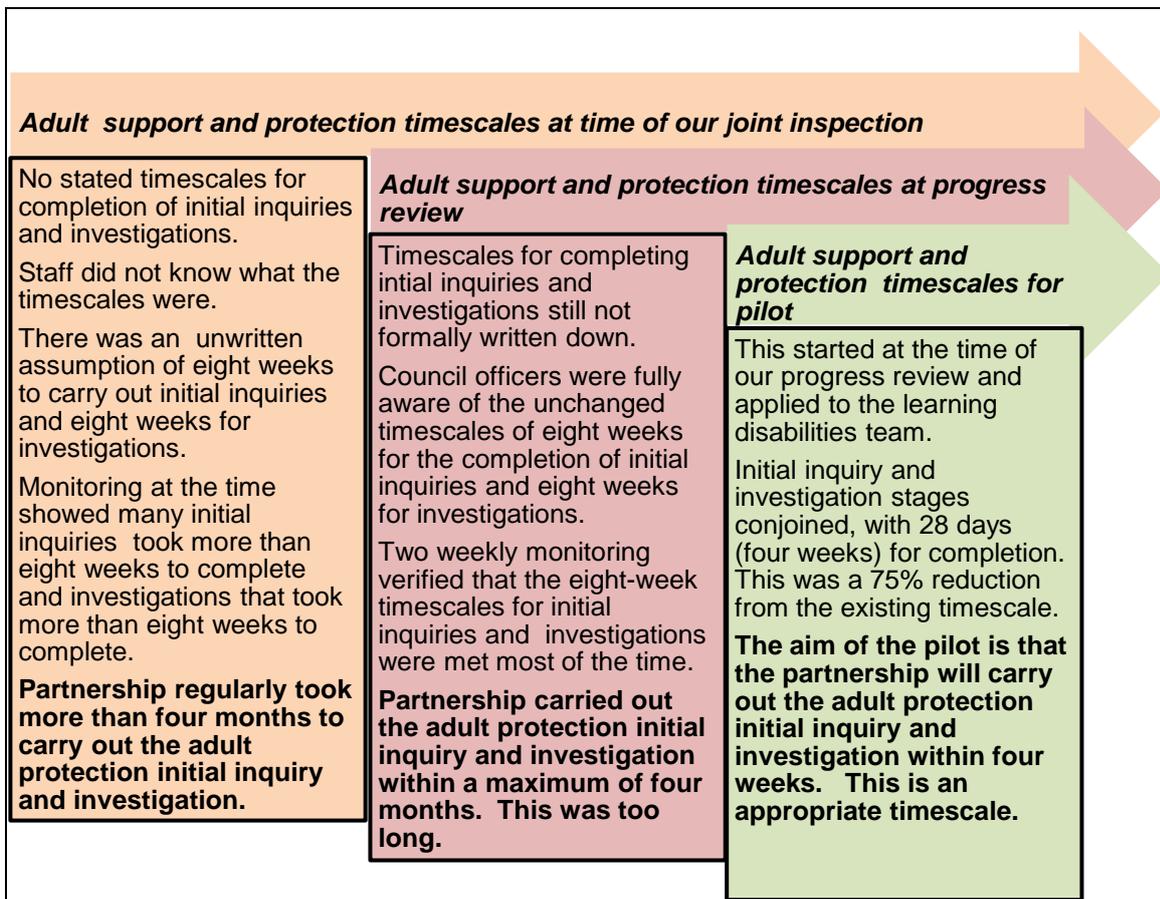


Figure 1

The council officers we met thought that the partnership's four-month timescale for completing initial inquiries and investigations into adult protection concerns was considerably too long. They said that prolonged initial inquiries and investigations could be unduly stressful for adults at risk of harm and their families. Council officers strongly supported the move towards much quicker initial inquiries and investigations into adult protection concerns.

Adult protection file reading results (see [Appendix 1](#))

We read eight records for adults at risk of harm (all were older people) from which it was clear that adult support and protection practice was variable across the records we read. As we only read a small sample¹⁰ of records our results are only applicable to these records and not to all adult protection records of the same type. We also read the records for two adult protection referrals and could see that these were processed effectively.

In October 2017, the adult protection committee approved the action plan for improvement activity prompted by the findings of the Review of Adult Support and Protection (June 2016). This took too long, with over a year between submission of the review report to the adult protection committee and the committee signing off the improvement plan.

The adult protection committee had made recent changes to its structure. It had put an operational subcommittee in place. A key remit of the subcommittee was to take forward action plans. It was too early to tell if this subcommittee was operating effectively. The adult protection committee should make sure that it exercises diligent leadership and governance of adult protection improvement activity.

We considered that the partnership had made good progress implementing this recommendation. It now needed to deliver and roll out its pilot initiative to dramatically reduce the time taken for adult protection initial inquiries and investigations.

Recommendation for improvement 5

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

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

¹⁰ Our sample of records was too small for the results to be statistically significant, that is to enable us to infer they applied to all adult protection records of the same type. We decided to read eight records to check on adult protection key processes in practice.

We made this recommendation for the same reasons that we explain for Recommendation 4. In addition, our joint inspection found that completion of risk assessments and risk management plans for adults at risk of harm and other individuals was a critical area that required improvement.

We report on timescales for completing adult protection initial inquiries and investigations in our findings for recommendation 4.

The partnership had created new guidance and documentation on risk assessment for adult protection. Some of the staff we met were not sure when they should use the adult protection risk assessment documentation and when they should use the generic risk assessment documentation. Some of the council officers we met had never used the adult protection risk assessment documentation. We considered that the partnership should quickly issue clear guidance to all relevant staff about which risk assessment documentation they should use for adults at risk of harm subject to the adult protection procedures.

Our indicative findings on risk assessments and risk management plans from our file reading analysis were variable (see summary of our file reading findings). Our results were more positive for risk assessments than for risk management plans. The partnership acknowledged there was room for improvement on their preparation of risk management plans for adults at risk of harm. We read some very good risk assessments for adults at risk of harm that identified all the pertinent risks for the adult, set out these risks in sufficient detail, analysed the likelihood of these risks occurring, and their impact on the adult at risk of harm. The risk assessments we read that we rated worse than adequate failed to address these key elements. In six cases out of eight, a risk management plan was present. One should have been present for all eight cases. The quality of these plans was variable.

The partnership had introduced a form to give feedback to health staff who had raised an adult protection concern about an individual (made an adult protection referral). Health staff we met said that this mechanism to improve feedback was effective and helped them to feel more included and involved in adult support and protection.

The development of the police concern hub was a very positive development for adult support and protection. The hub acted as central repository for adult protection information and intelligence, and screened, and triaged this information timeously, efficiently and effectively.

We concluded that the partnership had made reasonable progress implementing this recommendation.

Recommendation for improvement 6

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

- offer opportunities beyond mandatory training
- include the third sector to enhance a shared knowledge of roles and responsibilities, and

- achieve a cohesive approach to care delivery for older people.

Our joint inspection of 2016 concluded the partnership needed to review its strategic approach to joint training. There were a few positive examples where joint training was delivered but this needed to be strengthened to support health and social care integration.

The partnership organised a staff engagement event that brought health and social work and social care staff together. Staff we met found the messages too high-level and confirmed that to date this had not resulted in meaningful change in practice for those working at the frontline.

Senior managers in the partnership supported the adult protection committee to look at improving initiatives for shared learning and further opportunities for training. NHS Grampian had purposefully developed an adult support and protection good practice guidance document. Their evaluation of multi-agency adult support and protection events and workshops confirmed the guidance effectively supported primary care staff (including GPs). The creation of a learning and development post in health had strengthened the role of NHS staff in adult support and protection. The adult support and protection committee biennial report highlighted the positive contribution made by GPs to adult support and protection

Frontline managers said there was a big improvement in multiagency adult protection training. The partnership was piloting training of health staff to be the second person to support council officers with adult support and protection investigations.

Health staff made around 18 adult protection referrals a month. This was when health staff considered that an adult might be at risk of harm. Nationally, there are relatively few adult protection referrals from health professionals. The level of health-generated adult protection referrals a year was evidence that the partnership's joint adult protection training was effective.

Specialist training was underway to address the increase in the number of older people living at home with complex care needs. The district nursing service had started this training, with a planned roll out to other health and social care professionals.

The partnership had improved joint working arrangements with third-sector and independent-sector partners. Monthly meetings with providers were established and frontline staff and managers reported that better communication with providers and more cohesive working had emerged as a result.

Staff from both health and social care had received some training on the new carers' legislation and they demonstrated a reasonable understanding of the duties this placed on the partnership in respect of unpaid carers. Representatives from Voluntary Service Aberdeen were part of the training and partnership staff were well informed about the new contract arrangements to deliver an enhanced carer support service.

We concluded that the partnership had made good progress implementing this recommendation.

Recommendation for improvement 7

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

We made this recommendation because our joint inspection found the partnership had not yet developed detailed plans for how it would allocate integrated care fund¹¹ monies and evaluate projects funded by these monies.

The partnership had a clear detailed strategy and an established approach to the use, management and review of the integrated care fund. It designed the approach to make sure that projects funded by the integrated care fund were fully compliant with the stated objectives for this fund. It could then evaluate projects using the success criteria set out in the Scottish Government guidance¹² on the use of this fund.

Staff who wanted to make a bid to the integrated care fund for funding for initiatives had to create a detailed business case. Managers said that they had found it hard to prepare business cases that led to the allocation of integrated care fund funding. Senior managers said that the partnership was developing training on how to prepare business cases that met all of the defined criteria. The integrated care fund was underspent. It also needed to make sure that the process for accessing the integrated care fund was as streamlined and user-friendly as possible. And make sure that appropriate, viable and outcome-focused initiatives received funding from the integrated care fund.

There were challenges with the Integrated Neighbourhood Care Aberdeen (INCA) team, which was funded from the integrated care fund. Senior managers said that they were reviewing this model of working. There were significant challenges associated with importing a model of care and support from the Netherlands that has a very different structure of health and social care services, and a different culture to Scotland. It may be that the learning from the INCA team experiment can be used for future service developments.

We concluded that the partnership had made good progress implementing this recommendation.

Recommendation for improvement 8

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

¹¹ The integrated care fund is money from the Scottish Government specifically for the development and transformation of integrated health and social care.

¹² <http://www.gov.scot/Resource/0046/00460952.pdf>

We made this recommendation because the partnership had made very little progress with the creation of locality teams. Localities and the delivery of health, social work, and social care services based on specific locality needs was a key element of the partnership's strategic planning.

One of the challenges with the creation of locality teams was the management of the relationship between these localities and the services and teams that covered the whole of Aberdeen City. Service managers we met were conscious of the need to forge a harmonious relationship with locality teams and their managers. They considered that they should have a clear role and input into the formation of the locality teams.

Two years after we made this recommendation the partnership had made very limited progress with the development of locality teams. Locality teams were not yet in place. Four heads of locality were in post from November 2017. The partnership initially considered that each locality needed to have an operational manager as well as a locality manager. It was reconsidering this view. Senior managers we met acknowledged that the creation of locality teams was a significant challenge. We considered that significant difficulties with the creation of locality teams remained.

The partnership had made limited progress implementing this recommendation.

4. Conclusion and what happens next

Our original joint inspection identified some strengths in the delivery of services for older people in the Aberdeen City. These included a strong commitment to engaging with and involving local communities in planning how to meet the health and social care needs of the older population. However, we also identified a number of significant weaknesses and we made eight recommendations for improvement in relation to these.

The partnership had responded well to our recommendations. It had made good progress in addressing delayed discharges, carers assessments, joint training, and its process for allocating money from the integrated care fund. It had made good progress supporting the frontline staff who carried out adult support and protection work. It had made limited progress developing locality teams.

Given the findings from our review and progress made by the partnership, we do not intend to conduct any further scrutiny in relation to our original recommendations. The Care Inspectorate and Healthcare Improvement Scotland will continue to engage with the partnership and support continuous improvement.

Appendix 1 file reading results - eight adult support and protection records (these results only apply to the eight records we read)

Chronologies	<ul style="list-style-type: none"> • 7 out of 8 records had a chronology • 5 chronologies were of an acceptable standard, 2 were not
Risk assessment	<ul style="list-style-type: none"> • All 8 records contained a risk assessment • 3 rated very good, 1 good, 2 adequate, 1 weak and 1 unsatisfactory
Risk management plan	<ul style="list-style-type: none"> • 6 records contained a risk management plan, 2 did not • 2 rated good, 4 rated adequate
Adult protection investigations	<ul style="list-style-type: none"> • All 8 records contained account of full investigation • 5 investigations effectively determined if adult was at risk of harm, 3 did not • 7 investigations completed within reasonable time, 1 was not • 2 rated very good, 2 good, 2 adequate, 1 weak and 1 unsatisfactory
Adult protection case conferences	<ul style="list-style-type: none"> • 6 ASP case conferences should have been convened, 5 were • 1 case conference did not invite health and police • 3 case conferences not attended by health, 2 not attended by police • No adults at risk of harm attended any of the case conferences, 2 unpaid carers did attend • 1 case conference rated very good, 2 good, 2 weak
Adult protection outcomes	<ul style="list-style-type: none"> • 3 adults at risk of harm better able to protect themselves • 2 clear, have someone to confide ASP concerns • 4 safe and protected • 2 living as they want • 3 ASP process delivered improved wellbeing
Financial Harm	<ul style="list-style-type: none"> • 4 of the 8 adults at risk of harm suffered financial harm • In 3 cases partnership acted to stop the financial harm, in 1 case it did not act • In 3 cases partnership's actions stopped the financial harm • Partnership's actions to stop financial harm rated, 1 very good, 1 good, 2 weak
Involvement of adults at risk harm	<ul style="list-style-type: none"> • Initial inquiry stage - 6 adults at risk of harm had views taken into account by partnership, 2 did not • Investigation stage - 7 adults at risk of harm had views taken into account, 1 did not • ASP case conference - 2 adults at risk of harm had their views taken into account, 4 did not • Post case conference activity and review case conference - 2 adults at risk of harm had their views taken into account, 4 did not



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