care inspectorate

Healthcare Improvement Scotland

Services for older people in Edinburgh

May 2017

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

HAPPY TO TRANSLATE

Services for older people in Edinburgh
May 2017
Report of a joint inspection

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

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

We can also provide this report:

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

Contents

1. About this inspection

From October until December 2016, The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work for older people in Edinburgh.

The Edinburgh Health and Social Care Partnership comprises mainly the City of Edinburgh Council and NHS Lothian and is referred to as 'the partnership' throughout this document. Social work services, most community health and acute hospital services were delivered by the City of Edinburgh Council and NHS Lothian.

The purpose of the joint inspection was to find out how well the partnership achieved good personal outcomes for older people and their unpaid carers[1]. We wanted to find out if health and social work services worked together effectively to:

- make sure people receive the right care at the right time in the right setting
- deliver high quality services to older people
- support older people to be as independent, safe and healthy as possible and have a good sense of wellbeing.

As with partnerships across Scotland, many of the changes introduced as part of the integration agenda were at too early a stage to show impact, although they will provide the building blocks to help address the areas for improvement set out in this report. We hope that this report will be a useful contribution for the Integration Joint Board, NHS Lothian and City of Edinburgh council in their continuous improvement journey. In particular, we hope that it will assist the new senior management team in determining priority actions to strengthen health and social work support for older people living in the City of Edinburgh.

Our joint inspection involved meeting 90 older people and carers who cared for older people, and over 600 staff from health and social work services, the third[2] and independent sectors. We studied a lot of written information about the health and social work services for older people and their carers in Edinburgh. We are very grateful to all of the people who spoke with us during this inspection.

[1] In this report when we refer to carers this means unpaid carers.
[2]The third sector comprises community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

2. The City of Edinburgh context[3]

Edinburgh is Scotland's capital city. Its economy has a focus on financial services, public services, technology and software, retail and tourism services. Employment rates are higher than for Scotland as a whole and the city has a low percentage of working age residents claiming jobseeker's allowance. Edinburgh is second only to London in average gross annual earnings per resident in major UK cities. Overall, Edinburgh is an affluent city with average household incomes estimated at 9% above the Scotland average. However, 22% of all households in the city live on incomes below the poverty threshold, slightly above the Scotland average. There are significant differences within localities as well as between them. All localities in the city record areas of high poverty alongside areas of relative affluence.

Edinburgh's population is projected to experience rapid growth, rising from 482,600 in 2012 to 537,000 in 2022 and 619,000 in 2037. Over this period, the number of households in Edinburgh is projected to increase from 224,875 to 313,033 (a 39% increase). Edinburgh is projected to have a faster growing population than anywhere else in Scotland. Approximately 70% of Edinburgh's future population growth is due to more people coming to live in the city, and 30% resulting from more births than deaths. Over the next 20 years, the number of people aged 65-74 years, 75-84 years and over 85 years will increase significantly. More people will be living with long-term conditions, disabilities and complex needs. The number of older people requiring intensive levels of support is expected to increase by 61% over the next 20 years due to estimated population trends. Within 20 years the number of people living with dementia could rise by 61% to over 11,000 people in Edinburgh.

As more older people are supported to live at home, this puts additional demands on unpaid carers who are a key part of the health and social care workforce. There are estimated to be 65,084 carers in Edinburgh, or 13.7% of the population. One in five of these carers provides over 50 hours of care a week. It is expected that the numbers of carers will rise due to the rising population, the increasing older population and more people living with disabilities.

Around 8% of Edinburgh's population is 'white other' (non-British or Irish), the fifth highest proportion in the UK. The city has significant communities of people of Chinese, Indian, Pakistani, other Asian and African heritage.

Many older people's services were provided on a locality basis with access to services through sector teams. At the time of the inspection, the partnership was about to reorganise its services based on locality hubs and clusters. This would help align services with 12 community planning neighbourhood partnerships that involve local communities to identify local needs and priorities.

[3]Edinburgh Partnership Community Plan 2015-18/Joint Strategic Needs Assessment 2015

3. How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against (Appendix 1). Our findings on the partnership's performance against the nine quality indicators are detailed on page 5. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for older people and their carers. The inspection also considered the role of the independent sector and the third sectors to deliver positive outcomes for older people and their carers.

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

Our inspection process

Phase 1 – Planning and information gathering

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

Phase 2 – Scoping and scrutiny

We issue a survey to health and social work staff to make sure we hear about their views about how services are delivered and the impact of their work on improving outcomes for people. In Edinburgh we issued a survey to 3,300 staff, of whom 933 responded. The inspection team looks at a random sample of health and social work records for 100 people to assess how well the partnership achieved positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. In Edinburgh we met with over 600 staff.

Phase 3 - Reporting

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

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

[4] Experienced professionals from service providers seconded to joint inspection teams.
[5] Public partners are people who work with Healthcare Improvement Scotland as part of its approach to public involvement to ensure that it engages with patients, carers and members of the public.

4. Evaluations and recommendations

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

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

Quality indicator		Evaluation	Evaluation criteria
1	Key performance outcomes	**Weak**	**Excellent** – outstanding, sector leading **Very good** – major strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important Weaknesses **Unsatisfactory** – major weaknesses
2	Getting help at the right time	**Weak**	
3	Impact on staff	**Adequate**	
4	Impact on the community	**Adequate**	
5	Delivery of key processes	**Unsatisfactory**	
6	Strategic planning and plans to improve services	**Weak**	
7	Management and support of staff	**Adequate**	
8	Partnership working	**Adequate**	
9	Leadership and direction	**Weak**	

Recommendations for improvement	
1	The partnership should improve its approach to engagement and consultation with stakeholders in relation to: • its vision • service redesign • key stages of its transformational programme • its objectives in respect of market facilitation.
2	The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.
3	The partnership should develop exit strategies and plans from existing interim care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice.
4	The partnership should engage with stakeholders to further develop intermediate care services, including bed-based provision, to help prevent hospital admission and to support timely discharge.
5	The partnership should work in collaboration with carers and carers' organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating its carers' strategy.
6	The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.
7	The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.
8	The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.
9	The partnership should work with the local community and other stakeholders to develop and implement a cross-sector market facilitation strategy[6]. This should include a risk assessment and set out contingency plans.
10	The partnership should produce a revised and updated joint strategic commissioning plan with detail on: • how priorities are to be resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • fully costed action plans including plans for investment and disinvestment based on identified future needs • expected measurable outcomes.

[6] A market facilitation strategy sets out in detail the partnership's priorities for the commissioning of services

11	The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.
12	The partnership should ensure that: • there are clear pathways to accessing services • eligibility criteria are developed and applied consistently • pathways and criteria are clearly communicated to all stakeholders • waiting lists are managed effectively to enable the timely allocation of services.
13	The partnership should ensure that: • people who use services have a comprehensive, up-to-date assessment and review of their needs which reflects their views and the views of the professionals involved • people who use services have a comprehensive care plan, which includes anticipatory planning where relevant • relevant records should contain a chronology • allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.
14	The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing is maintained.
15	The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.
16	The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skills mix that delivers high-quality services for older people and their carers.
17	The partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model.

5. Key messages

The Integration Joint Board (IJB) had appropriate governance arrangements in place to support the integration of health and social care and demonstrated a commitment to engagement with the community. It was facing very considerable challenges in rising demands and expectations from the local community, within the context of diminishing resources. There were significant financial risks to the long-term sustainability of the partnership.

Senior managers demonstrated a shared vision for services for older people and had embarked on an ambitious exercise to transform the culture and the way in which services in the city are provided. We recognise that this would take some time to deliver.

To date, the vision had not been communicated effectively to all staff. Restructuring had involved a reduction in the workforce. Staff were working to capacity and were stretched and frustrated by inefficiencies and barriers to effective joint working. Many were anxious about what the changes would mean for them and for services. More visible leadership and effective communication was needed to keep staff motivated and engaged throughout this period of change.

When people received services, they were generally of good quality and made a positive difference. However, many older people and carers were unable to get help unless their needs were critical. It was not uncommon for older people to wait for lengthy periods before getting the support they needed. Performance against some important national indicators was poor.

There was substantial work to do to improve access to services. We found important weaknesses in assessment, care planning, risk management and information-sharing. Processes to identify and protect adults at risk of harm needed to improve. Quality assurance, self-evaluation and performance frameworks all required updating and improvement.

The partnership had invested substantial funds on maintaining and expanding the existing profile of services at the expense of investment in early intervention and preventative services. This was contributing to demand pressures elsewhere in the system. Managers had set up an improvement team to address recent service delivery problems in the care at home service.

There were a number of promising initiatives delivering positive outcomes in different parts of the city. It was not often clear why projects were being continued or ended. There was a very complicated landscape of service delivery, which staff and older people struggled to understand and navigate. Change plans lacked detail, including funding arrangements. A more strategic approach to planning and commissioning was required.

Despite the challenges, most staff remained positive about their jobs and felt supported by their line managers. With a few exceptions, most had good access to learning and development opportunities and were highly committed to better joint working and the possibilities afforded by integration.

6. Leadership

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

We evaluated the leadership provided by the partnership as weak. While we were confident about the commitment to health and social care integration and the governance arrangements that had been put in place to support it, the new leadership team now needed to take forward planning and delivery of services on an integrated basis to tackle barriers to good experiences and outcomes for older people and carers in the city and to make the step change required. Ownership of the partnership's vision was not well understood by staff who needed their leaders to be more visible and keep them engaged and motivated through an ambitious change process. Substantial funds had been spent on maintaining and expanding the existing profile of services at the cost of investment in the prevention and early intervention services urgently required to meet the considerable challenges facing the people living within the city. There was a range of initiatives, with some achieving positive results locally, but a more strategic approach was needed to identify and meet gaps, eliminate unnecessary duplication and ensure better outcomes for older people and their carers across the whole city.

Vision, values and culture across the partnership

We acknowledge that at the time of inspection the partnership was in a period of significant transformation. A recently established integrated senior management team was in place. The partnership was about to reorganise its services based on locality hubs and clusters (see Appendix 2).

Leaders of health and social work services collectively understood the need for change in the strategic delivery of older people's services and had identified many of the future challenges in delivering integrated services for older people. The partnership had made efforts to communicate its vision for health and social care integration to people who use health and social care services, staff and the wider public. However, these had not been communicated effectively and many staff were uncertain about key issues. As a result, there was not wide ownership of, and buy in to, the vision.

Recommendation for improvement 1

The partnership should improve its approach to engagement and consultation with stakeholders in relation to:

- its vision
- service redesign
- key stages of its transformational programme
- its objectives in respect of market facilitation.

Less than half (45%) of respondents to our staff survey agreed that there was a clear vision for older people's services with a shared understanding of the priorities.

We asked staff if the vision for older people's services was set out in comprehensive joint strategic plans, alongside strategic objectives with measurable targets and timescales. Again, less than half agreed with the statement. We also asked staff whether their views were fully taken into account when services were being planned. Less than a third of respondents agreed that they had.

From our staff survey, under half agreed that the quality of services offered to older people had improved in the previous year. Just over a third agreed that changes which affected services were managed well.

Around half (52%) of respondents agreed that high standards of professionalism were promoted and supported by all professional leaders, council elected members and NHS board members.

The chief social work officer is a key post, which should play a critical role in helping partnerships deliver on their statutory responsibilities. In Edinburgh discharging this role relied heavily on influence, rather than on direct operational management. We found limited evidence that the position in Edinburgh was allowing the chief social worker to exercise their influence and play an active role in providing strategic and professional leadership.

Partnership working

The partnership understood the importance of prevention and early intervention but acknowledged it had been slow in the development of such services. A genuine attempt to forge a strong partnership was evident, while tackling legacy issues in respect of culture and differing priorities. We met with the partnership's joint chief officer, IJB members, managers and relevant staff. It was clear that the chief officer was well regarded by those we met. Senior managers were mostly relatively new in post but there were early indicators to suggest they were starting to work effectively together to shape services. The chief officer, alongside the IJB members, was genuinely pursuing a shared vision and agenda. This had been partly effective in its delivery.

IJB members were aware of the need to concentrate efforts on engaging and involving staff. Most staff we met with told us they had been involved in consultation exercises for a variety of initiatives, including integration.

We were confident from our inspection activities that the majority of staff in both health and social work services had positive and constructive professional relationships with each other. Most staff said that joint working was supported and encouraged by managers. In addition, 64% of staff told us that there were positive working relationships between practitioners at all levels.

Governance

The partnership had given detailed attention to the structures and governance arrangements to support integration. The IJB was firmly established with its core membership of 10 voting members and additional non-voting members. The IJB and its subgroups included appropriate representation of relevant stakeholders. The supporting subgroups were:

- audit and risk
- strategic planning
- performance and quality
- professional advisory.

These subgroups had not yet fully matured and work was still required to ensure they delivered on their anticipated outputs. The partnership was at a stage where it was acting increasingly as an integrated body in adopting a joint strategic approach to service planning and delivery. A new operational management structure had been agreed, to take account of the wider adult health and social care agenda. Implementation was still at a very early stage.

IJB members acknowledged that they needed to further develop their understanding of integrated services, particularly service areas with which they were less familiar. Briefings and development had supported board members. Senior management leadership programmes were also being designed.

In our discussions with IJB members they acknowledged that the partnership needed to develop more autonomy from their two parent organisations in respect of decision making.

Both NHS Lothian and the council had separate corporate risk registers. The IJB was preparing a draft risk management strategy. There was appropriate acknowledgement of the risks presented by potential imminent changes to the IJB membership and a change of chairperson. Action was being identified to mitigate these risks.

IJB members had forged constructive working relationships and were committed to taking forward the work of the board and the delivery of integration. They demonstrated a range of experience and expertise that would be invaluable in overseeing integration governance. From the focus group we carried out with IJB members, it was clear that they felt that members and officers were working together in a trusting environment.

7. Outcomes and experiences

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

The partnership's performance in ensuring positive experiences and improving outcomes for older people was weak. Performance based on a review against key national outcome or proxy outcome performance indicators was mostly poorer or at around the Scotland average. Too many older people had their discharge from hospital delayed because of a lack of appropriate support for them at home, or because they had a lengthy wait for a care home place. Some older people experienced unnecessary moves, between hospital, interim care and care homes, so that pressures on acute hospital services were relieved. Being in a setting that was not best placed to meet their needs contributed to poor outcomes, such as a loss of confidence and capacity for self-care. Carers often found it difficult to access support such as respite to help them continue in their caring role. Overall, older people and carers experienced long waits for assessment and intervention. However, when they did get services, these were generally valued.

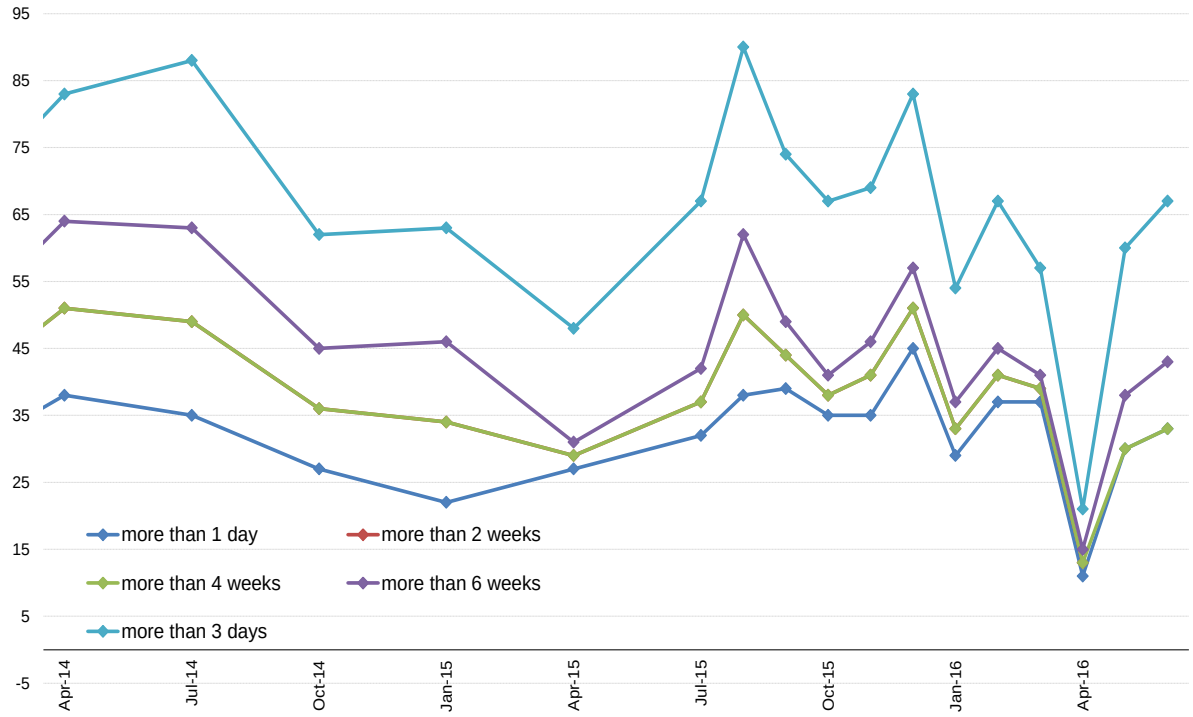
Admissions to, and discharge from, hospital

The partnership was performing at comparable levels with the Scotland average in emergency admissions and multiple emergency admissions for people aged over 65 years. However, rates of bed days occupied by older people aged over 65 years subject to an emergency admission were higher, as was the proportion of health expenditure on services for emergency admissions for the same age group. As already stated, there was a lack of services that helped the prevention of emergency admissions. Less than half of respondents (42%) to our staff survey agreed that there was a broad range of services available to offer alternatives to hospital admission.

Performance in relation to delayed discharges and the associated bed days that were occupied had been substantially poorer than the national average. The partnership acknowledged this as an area in which it needed to improve. The most common reasons for delayed discharge were lack of a care at home service or a suitable care home placement. A high proportion of delays were caused by problems in allocating and completing community care assessments. The impact of this on older people is discussed further in section 10 of this report.

There was a range of community based multi-agency services which had been put in place with the aim of supporting older people at home, avoiding unnecessary hospital admission and supporting hospital discharge planning. These included intermediate care, reablement, hospital at home and the prevention of admission to hospital/discharge teams.

Figure 1: City of Edinburgh numbers of delayed discharges by length of delay April 2014 – June 2016



Source: Information Services Division

Several initiatives were underway to help individuals access these community services including multidisciplinary discharge teams, multi-agency triage teams (MATTS) and Comprehensive Management and Assessment (COMPASS). While there was evidence these services achieved some positive impact, generally these programmes were unable to meet demand. A front-door discharge service (FDDS) and daily dynamic discharge had been recently introduced, but it was too early to evaluate their impact. Potential positive impact was hindered by the multiplicity of teams and services. Some programmes operated only in certain parts of the city, which confused both staff and older people and their families. While there were gaps in services and inequity of distribution, in other areas services overlapped and led to duplication and inefficiencies. There was long-standing confusion among staff about systems and processes for accessing these services, which had been put in place in response to immediate needs rather than as part of a well-considered and informed strategic plan. The majority of staff responding to our survey did not feel that there was a fair geographical coverage of services to support older people across the city.

Multidisciplinary discharge teams aimed to help speed up hospital discharge and provide an improved link between acute and community services. They were working effectively overall but there were several notable examples of a lack of co-ordinated planning and support for hospital discharge. Problems included short notice when older people were discharged and limited discharge planning information.

Where this happened, the outcomes for the older people involved were poor, with older people coming home or going into a care home without an appropriate package of support in place in advance. Some older people were delayed in hospital because existing arrangements had stopped on admission to hospital and there was a delay in reactivating them.

Older people were sometimes transferred to interim care while a care home or care at home services could be organised. While this helped reduce pressure on the acute hospitals, staff realised that this was often not in the best interests of the older person. Their frustration about this practice was a consistent and powerful theme throughout the inspection.

We could see that staff from different services were not always working effectively together to provide an appropriate level of care and support for vulnerable older people who were in crisis. This was evident in around 20% of the cases we read. In nearly 10%, the care and support provided had not been sufficient to prevent a hospital admission when we might have expected it to be so.

Bed days lost to code nine[7] delays were below Scotland average levels but we did hear of instances when individuals who lacked capacity experienced delays in being discharged from hospital. The partnership had initiated action to reduce this by recruiting two temporary mental health officers to address diagnosis, capacity and legal and guardianship issues for older people moving from acute hospitals to care homes, in line with the Adults with Incapacity (Scotland) Act 2000. This was having a positive impact, for older people and on the number of bed days lost.

Recommendation for improvement 2

The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.

Care at home

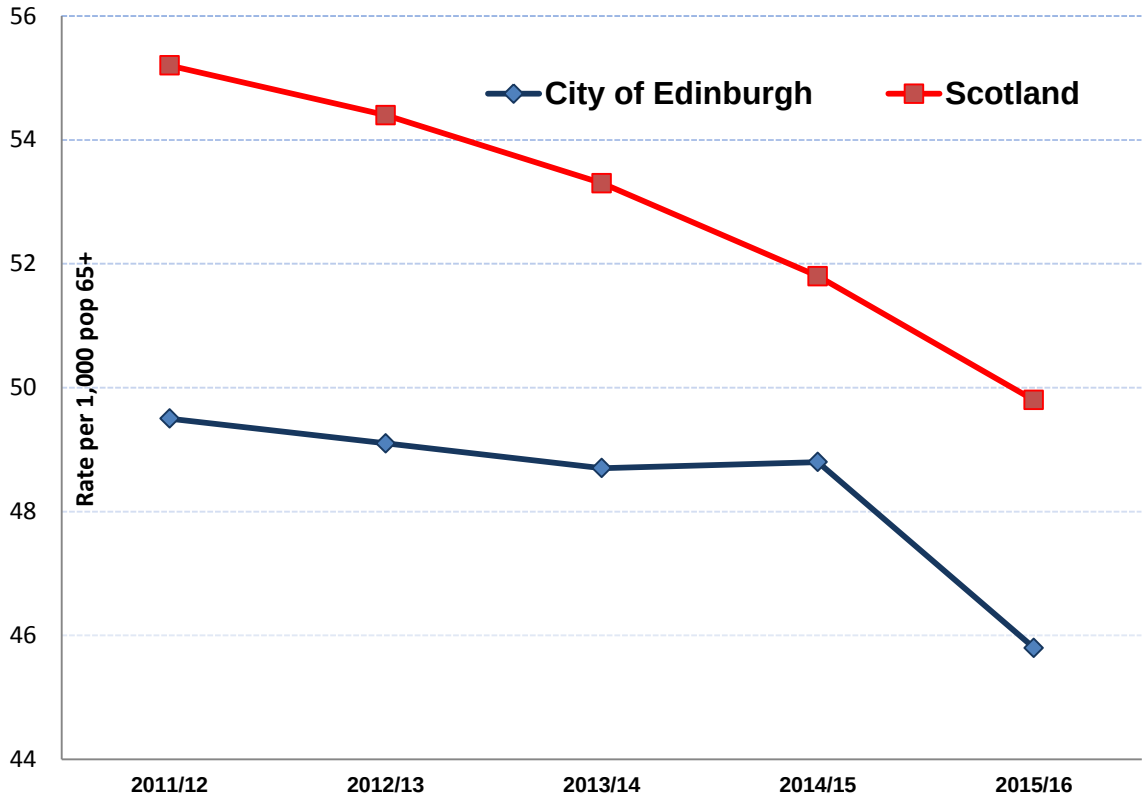
Care at home provision lies at the heart of making a shift in the balance of care from hospital and care home settings, and to achieving the aspiration of helping older people remain in their own homes, safely, for as long as possible. Nationally there has been a downward trend in the numbers of older people aged over 65 years receiving care at home. This was partly because of challenges such as recruitment to care at home services, but also because care at home was increasingly targeted towards supporting people with more complex needs. This means that a smaller number of people are getting more hours of support to meet their needs. Edinburgh's figures broadly mirror this national trend, but in addition, provision overall has been consistently below the Scotland average.

The partnership was continuing to provide higher levels of intensive home care (more than 10 hours per person per week).

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

Around the time of the inspection a new care at home contract had been introduced. The way in which it was implemented raised concerns about capacity, quality and choice. We say more about this in section 9 of this report. The lack of care at home capacity in the city was a major theme throughout our inspection. It impacted directly and very significantly on the experience of and outcomes for older people and their carers, the ability of other services to operate efficiently and effectively, and on staff morale and confidence.

Figure 2: Numbers of care at home users, rate per 1,000 population aged over 65 years, 2012–2016, City of Edinburgh and Scotland



Source: Scottish Government

The experience of older people using care at home services was very varied. Carers had concerns about continuity of care at home staff as some carers had experienced frequent changes in staffing which were confusing to older people, especially to those with dementia. Communication between care providers when more than one service provider was delivering care was problematic at times. Care at home provision was in the main service-led rather than person-centred in the manner it was delivered. Service-led provision often means people not being able to get the right help at the right time for them, being unable to shape the support they need, and instead having to accept the service that is on offer.

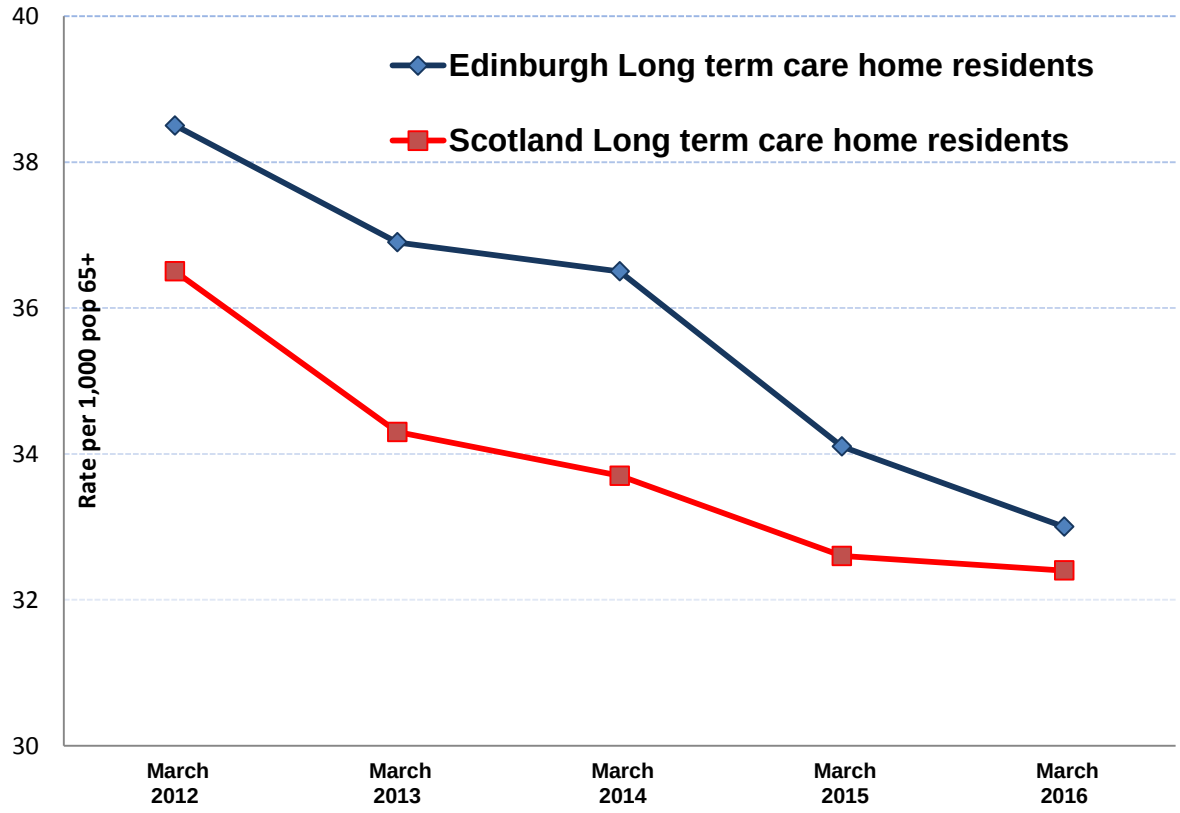
Care homes

Edinburgh had a higher than national average number of care home places per head of older people population overall, and in relation to care home places supported by the local authority. Despite this, inability to find a care home place when needed was contributing to people being delayed in hospital when medically fit for discharge.

To compensate for a shortage of care at home services and care home placements to meet assessed need, interim care services had been, or were being, developed. These were Gylemuir House (60 places), a care home for people waiting for a permanent care home placement, and Liberton Hospital (up to 78 places) for those waiting for a care at home package.

These services were of an intermediate care nature, in order to help refine the model for future implementation on a sustainable basis as part of the wider community capacity. Inspections of Gylemuir House, carried out by the Care Inspectorate had highlighted concerns especially in respect of the quality of the environment and also with management and leadership within the service. There were also concerns that the service was dependent on high levels of agency staff. Some older people experienced lengthy waits in what should have been a temporary service. This was not beneficial for older people and their carers, not least as they had very restricted choices and options.

Figure 3: Permanent residents, (aged over 65 years), of care homes supported by councils, (rate per 1,000 population), 20012–2016, City of Edinburgh and Scotland



Source: Scottish Government

Recommendation for improvement 3

The partnership should develop exit strategies and plans from existing interim care arrangements, to help support the delivery of community-based services that help older people and their carers to receive quality support within their own homes or a setting of their choice.

A review of the care homes service delivery for older people was underway as the partnership considered the need to increase the number of care home places to meet current and future demographic demand. The partnership saw a role for care homes in managing complex care, set within local integrated care environments, as potential future service developments. As yet, these were outline proposals only, without details.

The partnership was acting to improve the quality of care in care home settings. Local enhanced GP services for care homes meant more proactive engagement in areas such as anticipatory care planning. Care home liaison nursing services were viewed very positively by care home providers.

Intermediate (step up and step down) care beds had been piloted as part of the Integrated Care Fund but for reasons such as affordability and ongoing flow (people's journey through services) were described as not being successful. There was no developed strategy for how intermediate care, including bed-based care, could be developed to help meet demand going forward in each of the four localities across Edinburgh.

Recommendation for improvement 4

The partnership should engage with stakeholders to further develop intermediate care services, including bed-based provision, to help prevent hospital admission and to support timely discharge.

The Care Inspectorate inspects registered social care services delivered by local authorities and the voluntary and independent sectors, and evaluates the quality of care and support, the environment, staffing, and management and leadership. Registered services include care homes, housing support services and other support services for older people, for example care at home and day care services. In the main, at the time of inspection, regulated services were performing reasonably well across sectors and provision types and achieving positive grades.

With the exception of Gylemuir House, local authority care homes were achieving grades of at least adequate across the range of indicators listed above. Most local authority care at home and day care services were performing at levels of good or above. All services, except one directly provided housing support service, were also performing at levels of good or above.

Care homes run by third sector providers were receiving mostly good grades in the quality of care and support and the environment, and at least adequate for staffing and management and leadership. Most third sector care at home services were achieving good or better grades across all four indicators. All day care and most housing support services run by the third sector had good or better grades.

Independent sector care homes had a much wider range of grades. Many care at home and day care services provided by the independent sector and most housing support services achieved good or better grades, though there were a few exceptions where performance was significantly poorer. It was concerning that a provider with poor grades had been included in the group of providers awarded the new care at home contract.

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

Some outcomes for people had improved as a result of the services they received in around three-quarters of the cases we read. Most commonly, this was about the older person living where they wanted (62%) and could often be attributed to effective partnership working across services. Just over half of people were staying as well as they could (52%) or living as they wanted to (52%). Under half (49%) of older people felt safe.

However, around one in four older people did not experience the improvements in their circumstances that one would have reasonably expected to see. Nearly a third of older people in our sample had experienced one or more poor personal outcomes. Of these older people, over half (52%) were not staying as well as they could, over a third (35%) did have things to do, 26% were not living as they wanted and 23% were not feeling safe.

8. Providing the right help at the right time

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

We evaluated how the partnership provided the right help at the right time to older people as weak. It was not always as easy as it should be to get information about sources of help. Routes for referral to some services were complex and confusing for older people, their families and for staff. Demand for home care services outstripped supply, which had a significant knock-on effect in other parts of the system of care and support. There were a few positive initiatives and examples of innovation, such as the hospital at home service which benefited some people in parts of the city. There was insufficient recognition of the need to assess the needs of carers and provide timely support to help them maintain their caring role and improve outcomes for both carer and the person for whom they were caring. The partnership had made limited progress in the completion of anticipatory care plans and in falls prevention and management.

Access to information

It was not always as easy as it should be to access information about services. The websites of the partnership, NHS Lothian and the local authority were not all kept up to date and information about some services was very limited. However, a range of leaflets was available in settings such as social work offices, GP practices and hospitals. Advice, information and brokerage support (where organisations act as a go-between for people needing support to liaise with services) was available from organisations such Lothian Centre for Inclusive Living and Partners in Advocacy, provided people knew to look there.

Most older people and carers we spoke to said they would know where to go if they needed to find out about services. However, some had experienced difficulties obtaining information about sources of help such as respite and post dementia diagnostic support. Getting information about help for carers in their own right as well as support for the person they were caring for was particularly problematic. Staff and carers told us that getting information about services was highly dependent on the awareness of individual staff members.

Experience of individuals and carers

The majority of older people and carers we met told us they were satisfied with the services they received. Those who did express dissatisfaction most often cited poor communication, delays in assessment and lack of co-ordination of services as the main reasons. Overall, satisfaction levels with social work services were well below the Scotland average.[8]

[8]Improvement Service Benchmarking Network

In 2016, a national NHS inpatient experience survey[9], which covered Lothian hospitals, took place, in which 58% of respondents were older people. While responses were broadly positive, some NHS Lothian results were not as positive as the Scotland average figures. This included questions about patients staying in hospital longer than expected (those who were waiting for their care/support services to be organised). A separate national health and care experience survey[10] showed that responses in some areas, for example 'I am able to look after my own health', were positive. However, the partnership received, comparatively to the national average, lower positive responses for most statements, such as:

- people who use services are supported to live as independently as possible – 82% (2% under the Scotland average)
- people who use services have a say in how their help, care or support is provided – 76% (3% under the Scotland average)
- health and care services seem to be well co-ordinated – 70% (5% under the Scotland average)
- rating of overall help, care or support services – 77% (4% under the Scotland average)
- the help, care or support has improved service users' quality of life - 82% (2% under the Scotland average)
- carers feel supported to continue caring - 37% (4% under the Scotland average)
- people who use services users feel safe 82% (2% under the Scotland average).

The partnership received low percentages of positive responses for the following statements:

- local services are well co-ordinated for the people carers look after (48% positive)
- carers have a say in the services provided for the person they look after (46% positive)
- carers feel supported to continue caring (44% positive)
- caring has had a negative impact on carers' health and wellbeing (42% positive).

Carers

Support to carers was promoted and delivered by a range of carers' organisations, including the Edinburgh Carers' Council, the Edinburgh Carers' Partnership and the Voice of Carers Across Lothian (VOCAL). Voice of Carers Across Lothian took referrals from a wide range of sources to help co-ordinate assistance for carers. Edinburgh Carers' Council and the Edinburgh Carers' Partnership members told us of their involvement in strategic planning events and the development of services. Members told us they felt actively involved in the planning of future services for carers.

The Joint Carers' Strategy (2014-17) set out the priorities to support those who provided unpaid care and was backed up by a range of services offering support to carers.

[9] 2016 NHS Lothian Hospital Inpatient Experience Survey
[10] 2015/16 NHS Scotland Health and Care Experience Survey

Good examples included services delivered by Voice of Carers Across Lothian, the carers' support team, the integrated carers' team and Stepping Out, a city-wide service offering respite weekends away.

However, getting access to services could be problematic. Many carers were unaware of their right to an assessment for the person they cared for, or for themselves. When they asked for an assessment, some carers did not get a response from social work services. Delays in getting a carer's assessment were commonplace. Not having a carer's assessment precluded some carers from accessing services, for example respite. We found confusion among frontline staff about whom one should refer to for the completion of carer assessments. Requests made to Social Care Direct were usually allocated to either a social worker or occupational therapist but the referral and allocation process could take several months.

Some carers whose needs had been assessed found no additional support was provided. It was not uncommon for carers' health needs to be overlooked when they did not meet the criteria for social work support in their own right. Information was not always shared or co-ordinated across the relevant organisations to ensure the needs of both carer and cared for person were considered and the necessary supports put in place. Forty per cent of older people whose records we read had a carer who provided a substantial amount of support. Of these, more than half had never been offered an assessment. Where an assessment had been offered and accepted, only half had been completed.

There was a need for much greater awareness of, and focus on, the critical role played by carers. In our sample, only half of carers had been given relevant information or advice on equipment or adaptations. Almost none had attended training organised by health or social work services and none had been offered advocacy when they required it. The partnership's respite provision levels for older people and their carers were well below the Scotland average and declining. This was particularly true for overnight provision. Access to respite care was very limited, with little choice of options for respite. Carers spoke particularly of difficulties when seeking respite for the first time, describing the process as very complicated and taking a long time. This could intensify the pressure they were under.

Planned respite often had to be booked many months beforehand and it was particularly hard to find emergency respite. Staff consistently told us that respite was very difficult to get, even in a crisis. They spent a lot of time trying to secure a service by means of numerous phone calls to providers. The limited availability of local overnight respite options meant that it was often secured outside the city.

More positively, when respite was provided, carers told us how much they valued the service and how it had helped them. Some older people had used self-directed support to access respite as part of their care package.

On occasion, respite care placements had been used to bridge the gap between providers when a suitable care at home package was unavailable. These arrangements sometimes lasted for several weeks.

While a pragmatic solution in the short-term, this may increase the chances of a care home placement becoming a permanent move. We also heard examples where older people had been admitted to hospital as a 'social admission' because their carers had been hospitalised.

Senior managers told us that they recognised the need to develop a wider variety of locally available respite options but there had been little progress in doing so to date.

Recommendation for improvement 5

The partnership should work in collaboration with carers and carer's organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating its Carer's Strategy.

Day respite at home was popular but limited in supply. Services were mostly centre-based models. A decrease in the availability of day care places meant longer waits for people who needed this service. A monthly day care provider panel assessed referrals and allocated places but there was a lack of clarity about allocation criteria. Despite demand, there were vacancies in services that could not be taken up because assessments had not been carried out in good time. The Milan day centre provided a dedicated service for black and minority ethnic older people and the quality of this particular service was good.

Example of good practice – City of Edinburgh Council Be Able day service

For older people aged over 65 years the service helped to:
- improve their mobility both indoors and outdoors
- regain or increase their confidence and motivation to manage everyday tasks
- take part in social activities again
- keep them as independent as possible for as long as possible.

Courses ran for around 14 weeks where trained staff offered:
- exercise programmes to improve strength, balance and stamina
- memory programmes to help stimulate, improve and maintain memory
- help to reduce the risk of falls.

Prevention, early intervention and intervention at the right time

The partnership had strategic plan 2015-18 for prevention, which focused on promoting the shift in balance towards community support services. Services were in the process of development to support older people to remain independently at home, including reablement, care at home and telecare. However, it was clear that the partnership had a long way to go to fully deliver the range of accessible preventative services required. Almost two-thirds of staff had significant reservations about whether there was sufficient capacity within their teams to cope with future demand.

A few unscheduled admissions of older people to hospital were related to medicines management. Some positive work was being carried out by local pharmacy services, including participating in reviews of medicine management and polypharmacy reviews[11], particularly in care homes. Other areas where pharmacy was helpfully involved included the long-term conditions programme, falls prevention and carer support to help link carers with primary care.

Anticipatory care planning and end of life care

Anticipatory care plans support prevention, early identification and intervention at the right time. The partnership had made some progress in developing anticipatory care plans for older people.

GPs were increasing the number of anticipatory care plans they completed. Having GP practices allocated to each care home was also proving helpful. There was only a small number of anticipatory care plans in our sample and the quality varied widely. Where they existed, they were a useful vehicle for older people and their carers to set out their wishes and preferences if their health deteriorates or their circumstances change in other significant ways.

An anticipatory care planning clinical lead had been recruited alongside anticipatory care facilitators, with the aim of increasing the number of plans and improving quality and access. A patient experience anticipatory care planning team (PACT) was being piloted at the Royal Infirmary of Edinburgh and the Western General Hospital. Their approach demonstrated an outcomes-focused and patient-centred approach, enabling better case identification and proactive intervention as well as a focus on the efficient use of NHS resources. An independent evaluation showed reductions in unplanned hospital admissions for frail elderly patients and for patients with multiple morbidities which had led to a reduction in the use of acute hospital beds.

Anticipatory care plans were mostly single agency (health) plans, with limited contributions from social work services. Many social work staff believed that these plans were primarily a health tool, though care home staff described how they could be used to good effect to prevent unnecessary transfers to hospital. Many staff we met were unclear about what arrangements were, or should be, in place for sharing information contained in anticipatory care plans. Plans were available to health services through patient key-information summaries but could not be shared readily or electronically with social care and other services.

Around 84% of people spent their last six months of life at home, or in a community setting. This was below the Scotland average but performance was improving. The partnership would be the host for palliative care for the four integrated joint boards in Lothian from April 2017. The partnership was reviewing the palliative care governance process which included representation from social care. There was an established managed clinical network for palliative care within NHS Lothian.

[11] Polypharmacy – the use of multiple medications

The partnership was operating a model for palliative care where community nursing and care at home staff were supported by specialist Marie Curie nurses. Other staff such as pharmacists, GPs, occupational therapists and physiotherapists helped deliver co-ordinated care as required.

Where palliative care needs had been identified, staff reported that services generally worked well to support the older person and carer to enable people to die at home. However, we heard from a number of staff and carers of older people with palliative care needs about having to wait for care at home services. We heard concerns from several sources about incidents of avoidable admissions to hospital for people in this critical period of their lives due to a lack of co-ordinated care planning or availability of care at home or equipment.

Poor quality information provided by hospital staff to community services was a recurring complaint. It had an impact on getting the right supports in place quickly for someone in their last weeks and months. We heard accounts of people's conditions deteriorating significantly before receiving appropriate services in the community.

The partnership was able to commission specialist palliative care beds from Marie Curie and Saint Columba's hospices. Marie Curie nursing was available on a commissioned basis. GPs aligned with care homes helped with medication and palliative anticipatory care planning.

Telecare

The partnership provided lower levels of community alarms and telehealthcare to older people compared to the national average. The potential for telecare and telehealthcare to deliver a range of preventative options and assisting with supported discharge had not been fully pursued. Where telecare was being used, including community alarms, it was having a positive impact in supporting vulnerable older people to live independently and safely at home. Older people we met who used telecare said it helped them feel safe when they were in their own homes and gave them confidence that they could get help quickly if they needed it. Local telehealth developments had included a text service to help support the management of long-term health conditions and trying to incorporate telecare into assessments.

Self-management and the management of long-term conditions

The partnership's long-term and multiple conditions programme focused on improving care by developing integrated service models that aimed to focus on technology, prevention, anticipatory care and supported self-management approaches. Five specialist community-based health teams provided support for complex care in the community and tried to prevent avoidable hospital admissions and embed anticipatory care and self-management approaches. These were:

- community respiratory team with a focus on chronic obstructive pulmonary disease
- pulmonary rehabilitation

- an IMPACT[12] nursing team focusing on multi-morbidity and anticipatory care
- falls prevention and management
- diabetes specialist nurses.

The partnership had made some progress with providing help and support to older people with long-term conditions. This had enabled some older people to have more control and choice by planning for their preferred support and care intervention should there be deterioration in their condition. However, the partnership's five specialist community-based health teams' capacity was insufficient to meet demand.

A few older people we spoke with in self-management groups were positive about how they had been signposted, when they were diagnosed, to a helpful activity by staff. One such project was Fit for Health physical activity programme, developed with Edinburgh Leisure.

The partnership was unable to show evidence of its progress in addressing the Scottish Government's Public Health Review[13], or of the contribution made by public health to strategic planning of prevention and early intervention approaches.

Dementia support

There was widespread consensus among carers and staff that obtaining a diagnosis of dementia, where the involvement of a consultant psychiatrist is required, felt a lengthy process (average 12 weeks) although the partnership's performance in diagnosis of dementia was in line with the national average. Pathways to diagnosis were not straightforward however, often involving a GP, the community mental health team and the memory assessment team before getting to a consultant. For some older people and carers, this was confusing and distressing and had caused some to disengage from the process. GPs and community nurses sometimes provided information and support in the interim.

The wait for post-diagnostic support from a community psychiatric nurse or Alzheimer Scotland's post-diagnostic support-link workers could be several months. The partnership's ability to provide post-diagnostic support was influenced by the capacity of the community mental health team and post-diagnostic link-support workers. Staff concerns about insufficient resources to meet need as the demand continued to increase was a strong theme during the inspection.

Several carers of people with dementia told us that support had declined one year after diagnosis[14] although the condition had deteriorated. Difficulties obtaining information about services, particularly respite, were commonly reported.

[12] The IMPACT (IMProved Anticipatory Care and Treatment) service was a nurse-led service which was set up to improve the quality of life for people with long term conditions, offer support to their carers and reduce preventable hospital admissions.

[13] Public Health Review 2016 commissioned by Scottish Government to look at how Scotland's public health community could work better together and bring about further improvements in the nation's health and wellbeing and tackle health inequalities.

[14] Scottish Government target -To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker, including the building of a person-centred support plan.

The partnership was trying to encourage focused responses to dementia through implementation of the Promoting Excellence framework[15], particularly in care homes and day care.
GPs and district nurses were seen as accessible by care home staff; psychiatric services less so. There could be lengthy waits for community psychiatric nurse services or Alzheimer Scotland's post-diagnostic support-link workers.

Some initiatives were planned or in place. The Edinburgh Behavioural Support Service (EBSS) offered advice and training to staff following a GP referral and was mainly aimed at care homes. A community-based rapid response service was planned for people aged over 65 years with a mental health diagnosis to provide support in a person's own home. Prospect Bank ward, part of Findlay House NHS facility for people assessed as needing hospital-based continuing care, had been selected as a dementia demonstrator site as part of a national initiative. As one of four sites across Scotland, the aim was to improve the older person's experience and satisfaction levels. The scheme was at an early stage of development.

Recommendation for improvement 6

The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.

Falls prevention and management

Falls can be a significant factor in older people being admitted to hospital. Preventing falls wherever possible is therefore critical to improving outcomes for older people. Edinburgh's performance in falls resulting in hospital admission was below the national average with higher levels of admission.

Later in this report, we discuss weaknesses in assessment practice generally. Where assessments are not carried out in good time, opportunities are missed to prevent a fall in the first place. Where older people had fallen, there was more evidence that staff were focused on preventing further falls, and, where needed, provided helpful equipment or adaptations. Ten per cent of older people in our case sample were receiving support for falls. Staff told us that they complete management plans after an individual has a recorded fall but we did not find many risk assessments and risk management plans in case records for older people who had a documented history of falls. It was clear that information about plans to manage and reduce the risk of falls was not routinely shared with either the older people themselves or their carers, nor with staff in other services with responsibility for supporting the older person.

A specialist falls team was in place. Most falls notifications were through NHS 24 and usually occurred out of hours. Older people were referred to the service by a range of professionals such as GPs, district nurses, occupational therapists and social workers. Efforts had been made to improve awareness and training. However, the team was not confident that there was a sufficient level of awareness among staff working with older people about when they should make a referral.

[15] Promoting Excellence – A Skills and Knowledge Framework for Dementia – Scottish Government (2011)

The team was also concerned about the quality of the information provided to them. On some occasions, referrals noted one fall, when in fact this fall could have been one of multiple falls over a number of months. This could make a difference to speed of response and the type of help provided. This impacted negatively on the overall falls management service.

Assessments and management plans that were produced after a person had a recorded fall were not routinely shared with them or with other services. There were further areas for improvement in respect of falls information recording, better communication and information sharing between services.

At the time of the inspection there were three different falls pathways. These needed to be reviewed and streamlined in light of the developing locality model. The falls strategy needed to be updated, with greater involvement of a range of agencies such as third sector organisations, intermediate care, care at home providers, housing services, multi-agency triage teams and the Scottish Ambulance Service.

Recommendation for improvement 7

The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.

Reablement and intermediate care

The purpose of the reablement service was to deliver short-term (up to six weeks) improvement in the level of independence of an older person before referring on to mainstream care at home, if required. A key aim was to facilitate hospital discharge but often lack of care at home provision meant the reablement service remaining involved well after the older person's rehabilitation goals had been achieved. Older people could sometimes wait for months for a move from reablement to a mainstream service. This was having a significant impact on the team's capacity to pick up new referrals and it was creating a backlog in the system, leading to further delayed discharges.

Recently, changes had been made to reablement criteria to allow better targeting of the service to those who were assessed as needing it most. This was showing positive results in improving the flow of people using services and reducing demand on mainstream care at home services. However, criteria could be inconsistently applied when responding to delayed discharges from hospitals. Reablement staff also told us of their concerns about how able they were to meet the needs of people with dementia and those who had palliative care or complex care needs.

A 'prevention of admission to hospital/discharge from hospital' team received referrals from GPs, district nurses, community occupational therapists and community social workers. These were urgent referrals with an expectation of being dealt with within 24 hours. However, here again, capacity to take new referrals was constrained by the team needing to support some older people with complex care needs for up to a year. Some older people had to return frequently to this service because they did not receive adequate, or indeed any, care at home provision.

Around 70% of the workload of the intermediate care team was related to older people waiting for care to be put in place. This was in part due to a lack of capacity in care at home and also to the impact of the recently introduced care at home contract.

The pressure on services and the backlogs created also impacted negatively on smooth working between the reablement and intermediate care teams. We found confusion among staff about care pathways, referrals and the delivery of services. The capacity of the reablement and intermediate care teams needed to be protected so that, in time, they could help reduce pressure on the care at home service.

The hospital at home service was co-located with a day hospital service at Liberton Hospital. This positive initiative enabled access to diagnostic services to follow up older people on the same day if required, for around 30 referrals a month, and opportunities to assess service users quickly and prevent admission to hospital. Unfortunately, it operated only in the south of the city. Intermediate bed care facilities (step up and step down) had also been piloted and discontinued, leaving a significant gap in service provision.

9. Strategic planning

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

The partnership's approach and delivery of strategic planning was evaluated as weak. The partnership had completed a joint strategic needs analysis, supporting the development of its joint strategic plan. It had set out an overall direction for the future planning and delivery of services for older people but implementation plans lacked detail on how they would be achieved. Development of prevention and early intervention now needed to be taken forward rapidly. Quality assurance and self-evaluation approaches required improvement as did performance frameworks. Joint planning arrangements helpfully involved older people and carers and key stakeholders, including the third and independent sectors, but needed to become meaningful at an earlier stage, when services were being designed. The partnership market facilitation, commissioning approaches and procedures required significant improvement. Effective budget management was evident but significant financial risks to the long-term sustainability of the partnership remained. The inability of partners to share key information electronically between staff in different services was creating inefficiencies and adversely impacting on experiences and outcomes for older people and their carers.

Strategic plans

NHS Lothian and City of Edinburgh Council, in co-operation with Edinburgh Voluntary Organisations Council and Scottish Care, had set out their shared vision for older people's services in Live Well in Later Life (2012 – 2022). The partnership's joint strategic plan (2016-19) was a high level strategic statement of intent which included needs profiles, identified strategic priorities and action plans based around the priority themes of:

- tackling inequalities
- prevention and early intervention
- person-centred care
- providing the right care in the right place at the right time
- making best use of capacity across the whole system
- managing resources effectively.

These complemented well other relevant strategies such as the NHS Lothian strategic plan, NHS Lothian's annual local delivery plan and the joint carer's strategy. Consultation on the joint strategic plan had been ambitious but the response was low and the IJB recognised it needed to revisit its engagement approach. The joint strategic plan lacked a detailed implementation plan for investment and disinvestment. Those plans that were in place outlined the direction of travel well but lacked detail on how they would be achieved. This limited their use as delivery management and accountability tools.

They tended not to be fully costed and clear delivery timescales were not always clearly identified. This was, in part, due to delays in reaching agreement about overall partnership financial plans.

The IJB's strategic planning subcommittee was the main supporting forum for joint planning and commissioning. Its work was at an early stage so it had yet to deliver fully on its remit. A number of work streams were underway including a whole system capacity and demand review with support from Healthcare Improvement Scotland, the Scottish Government and external business consultants. This work was recognised as critical to allow the partnership to fully gauge future demand for a range of services and the flow of people between them.

The partnership was at an early stage of locality planning, commissioning and operational service delivery. Locality leadership teams were being established. It was anticipated that these teams would link with neighbourhood committees as well as the partnership's governance structure.

The IJB performance and quality subgroup led on governance for assurance on service delivery and quality. This was part of the wider governance of performance and quality for the partnership which also included the quality improvement clinical governance group and the audit and risk board subgroup. The performance and quality subgroup scrutinised delivery against indicators, targets and improvement plans. The partnership brought together elements from established quality assurance models rather than following a single framework. NHS Lothian had recently appointed a chief quality officer and GP clusters (geographical groupings of GP practices) had quality leads with the aim of embedding quality assurance at locality level. Performance scorecards for localities were to be updated following the appointment of locality managers.

Statistical process control (SPC)[16] monitoring had been developed in areas such as emergency admissions and delayed discharge but was not yet locality based. New models of care were being tested. It was challenging for the partnership to do so while experiencing continued demand on services in the context of significant funding constraints, but change was recognised as necessary. There was no clear line from tests of change to evaluation, decision and roll out. For example, an interim evaluation had been undertaken on the hospital-to-home test of change but it was not evident how the evaluation had influenced decision making about the future of this project. Throughout the inspection, we continually heard staff say that pilot projects were often abruptly closed without explanation and with little or no advance warning. This was due to, in part, to some being funded from non recurring funding. However, communication with staff about project cessation need to improve.

There was a lack of progress against the partnership's own targets in areas such as falls management, delayed discharges and absenteeism. Indicators tended to focus mostly on input/output measures rather than person-centred qualitative measures.

[16] Statistical process control (SPC) is a method of quality control using statistical methods and is applied in order to monitor and control a process to ensure that it operates at its full potential.

A joint strategic plan performance framework linked to national outcomes and some local indicators had been prepared. Partners recognised that service monitoring needed to monitor outcomes and not just outputs, at a locality level.

The partnership had carried out a series of self-evaluation exercises on learning from change/integrated care fund projects. Regular multidisciplinary quality assurance meetings were in place for care at home and care home services.

There was little evidence to assure us that health and social care audit processes were robust and leading to improvements. The partnership had previously undertaken quality assurance case file audits and audits of care home services. However, improvement plans arising from these audits had not been delivered. Some small-scale review of case records had taken place for adult support and protection cases but it was not clear whether or how practice had improved as a result. There was no routine review of practice in other care areas to assure and improve practice. Only in 14% of all files we read, was there evidence of line manager scrutiny.

Recommendation for improvement 8

The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.

Before our inspection, an older people's acute hospital inspection had been carried out by Healthcare Improvement Scotland of all the NHS units in Edinburgh providing hospital based complex clinical care. Recommendations for improvement within the report issued in May 2016 were being taken forward.

NHS Scotland and the local authority carried out surveys of people who use services but feedback was not always sought from older people across all care settings or how the views of people who use services could influence service development. The local authority had contract supplier management and procurement procedures and contract monitoring and contract compliance arrangements. However, we were not confident that these arrangements were wholly effective. For example, a contract was awarded to a care at home provider with full knowledge that this provider was performing at a poor level.

The IJB performance and quality subgroup was using a rubric scoring system[17] to evaluate the implementation of the strategic plan and its impact on people's experience and personal outcomes. This showed promise. Managers and staff recognised that they needed to do more to evidence the positive personal outcomes and impacts of some of the supports delivered to older people and their carers.

The IJB audit and risk subcommittee had begun to develop an integrated risk management strategy but partners were still working with separate strategic risk management registers. The intention was to have local risk registers. This work had yet to gain momentum.

[17] A rubric is a scoring tool that aims to achieve accurate, fair and ongoing assessment that indicates a way to proceed.

The council's chief internal auditor was currently acting in the role of the chief risk officer, on an interim basis, for the IJB. There was very limited evidence of joint systems in use for quality assurance, evaluation and risk management.

The care at home contract was a significant procurement exercise. It was evident that the risk assessment and management plan that was in place had given limited consideration to operational risks and actions for improvement. This had led, in part, to significant difficulties in the contract's implementation. For example the vision of the new contract was to have a smaller number of providers working on a locality basis. The strategy was that all existing provision would transfer to the provider(s) awarded the new contract. This had not materialised as some older people had refused to accept a new provider. This has led to much less business than expected for the contracted providers and left the majority of the hours not being provided under the new framework.

Needs analysis

A comprehensive joint strategic needs assessment had been prepared in co-operation with a wide range of stakeholders (phase one). The joint strategic needs assessment stakeholders group had suitable representation including public health, third and independent sector providers and reported to the IJB strategic planning subgroup. This work was to be further developed to create locality profiles (phase two), including personal outcomes evidence, which in turn would inform locality commissioning. There was a risk that there was insufficient capacity to carry out phase two within the identified timescales.

The partnership did not have a regular flow of accurate and up-to-date data about unmet need across the city and in each locality to inform risk assessment and management, strategic planning and decision making. A review team had been set up to help improve data collection and analysis. The partnership was unable to demonstrate how it had used data and worked collaboratively with public health services to identify needs and reduce inequalities when developing strategic and locality plans.

Strategic commissioning

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

A draft five-year market-shaping strategy, which set out how the partnership intended to structure the market place in which care services operate, was drawn up in 2013 but was never completed and was now out of date. It had been superseded to some degree by the joint strategic plan. The partnership recognised the challenges in local supply and capacity of some care markets. Ensuring sufficient supply and high standards of quality in the care home and care at home sectors were priorities.

At the time of the inspection, the local authority was providing around 15% and 25% of care home and care at home markets respectively. Therefore, relationships with the third and private external providers were essential. Revisiting the market facilitation strategy and the approach to commissioning in line with integration and the move to localities would be helpful.

The partnership had been unable to deliver sufficient care at home and care home places to respond to assessed need. As a result, interim resources had been developed. These included Gylemuir House to accommodate people waiting for a care home placement and Liberton Hospital for those awaiting care at home. These had been developed using non-recurring funds originally intended for the development of longer term, alternative services. Funding for Gylemuir House had subsequently been included in the mainstream budget. The partnership intended to reinvest Liberton's recurring funding in community supports in the long term.

While a review of care homes was underway, we were concerned that there were no exit strategies in place for either of these interim resources. There was an evident need for the partnership to develop sustainable capacity in both care at home and care home services to cope with current and future demand.

Work had been carried out to review and update care at home services with a focus on reablement and promoting innovation. A new contract was designed on the basis of locality provision and implemented in October 2016. Eight providers had been awarded the new contract covering 11 neighbourhoods across the four localities. Key aims were to create efficiencies by reducing travel time and cost and to support recruitment of a local workforce. The bulk of care at home services were provided by external providers. Care packages were focused on those assessed as having critical or substantial need with a high proportion of recipients needing a minimum of 10 hours of care per week. Ten per cent of the care at home budget had been protected to support innovative third sector provision. This was due to come online early in 2017.

Though at a very early stage of implementation at the time of our inspection, it was clear that this new contract was posing some challenges. These related to general high levels of demand, recruitment and retention, ability of providers to build up volume and unrealistic clauses and penalties within the new framework. There was evidence of adverse impacts on outcomes for older people. Care at home is critical to the overall system of care and support for older people. Failures in care at home had a major impact on other services. Recognising the significance of the crisis, the partnership put in place a rapid improvement team to improve working relationships with care at home providers and foster a more collaborative approach. We considered this remained an area of significant risk.

Recommendation for improvement 9

The partnership should work with the local community and with other stakeholders to develop and implement a cross-sector market facilitation strategy. This should include a risk assessment and it should set out contingency plans.

Recommendation for improvement 10

The partnership should produce a revised and updated strategic commissioning plan with detail on:

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

Consultation and involvement

The partnership had a communication and engagement plan for engaging with people who were using their services as well as with other stakeholders including staff and external providers. At a strategic level, the views of older people were represented. There was dialogue with stakeholders, including Edinburgh Voluntary Organisations Council (EVOC) representing the third sector, and a commitment to ensuring that it would continue. Innovative approaches such as working with advocacy groups to seek the views of people who had a diagnosis of dementia had been undertaken. This approach was also used as part of the day care review where the carers' opinions were explored. Carers' representatives were party to relevant strategic planning forums. There was less evidence that the views of key stakeholders were informing and influencing at operational planning levels and in service review and evaluation.

Trust between commissioners and providers is often an issue during periods of major transition and redesign, such as that taking place in Edinburgh. Third and independent sector representatives raised concerns about short-term decision making and a lack of involvement by service providers at the right time. They needed to be more confident that key decision makers in the partnership understood how they were able to contribute to improving services for older people and carers, and what they needed to do so effectively.

A few providers were highly critical about a lack of support from the partnership to improve their performance. Care home and care at home provider liaison forums took place irregularly. Managers gave a commitment to restarting them.

There was little evidence that operational staff and managers were being engaged in service planning or informed of developments. The consultation on the recently introduced care at home contract had been carried out at senior level and had not involved staff with experience in the management and delivery of care at home. Staff consistently identified lack of capacity in community support services as a major problem but had little knowledge of plans being developed to improve the position. Hospital and community based consultants felt particularly disengaged and side-lined. GPs were keen to be more involved in integration planning.

Housing provider representatives were encouraged to participate in joint strategic planning. The past year had seen a much more productive and co-operative relationship between health, social care and housing than previously. The care at home innovation contract bidding process had resulted in four housing associations managing the delivery of care at home to their own tenants. It was envisaged that these would develop into local service centres with, for example, social activities. However, there had been delays in the bidding process.

The partnership had secured a policy commitment from the council that there would be substantial capital investment in building new housing for older people, though a number of critical details such as land price and availability, capital grant and revenue funding levels had still to be agreed. There had been very limited allocation of change fund money for housing related projects. Housing providers wished to have a greater input to joint working at hub/cluster level and in service redesign but were not engaged as yet. They saw this as a missed opportunity to develop further innovative preventative models particularly for frontline service delivery.

Management of resources

Both the council and NHS Lothian health board had a firm understanding of the financial pressures affecting their organisations. Relevant reports were presented to the IJB for their consideration. Individual budget monitoring reports from each of the partners were comprehensive and gave a clear picture of the financial performance of health and social care services against each budget heading. Work was underway to amalgamate this budget information into a single budget monitoring report to provide the IJB with an overall understanding of their current financial information and future financial challenges.

There was evidence that joint working between both partners' senior finance officers was taking place through the IJB network of finance leads. This network included the directors of finance from both partners as well as the IJB chief finance officer. Operational finance officers from both partnership organisations held informal meetings with the chief finance officer on a regular basis.

The partnership had not yet allocated budgets to locality managers. For the locality managers to effectively manage their resources, it would be essential that they had a good grasp of the budget they were allocated. Difficulties with combining budget information from each partner's financial ledger to establish baseline budgets and staffing shortages were cited as the main contributors to these delays. Finalising locality budget allocations would help strengthen the partnership's future financial accountability and support locality managers inform locality commissioning and service delivery.

Finance

The council recorded an underspend of £3.446M for social care services delegated to the IJB at the end of 2015/16 following the funding transfer of £9.785M from other non-delegated services. With the delegation of the social care services to the IJB it would be more difficult to achieve cross subsidisation from other non-delegated services.

The largest budget pressures in 2015/16 were third party payments expenditure for care at home, care home and day care services. The saving target for council services was £7.515M of which £6.391M was achieved.

As at September 2016, the IJB was predicting an overspend of £3.376M in relation to delegated social care services by the end of the financial year. Costs for care at home, self-directed support and agency staff in care homes were budget pressures as the result of slippages in approved savings in the social care transformation programme.

The council had an overall savings target of £49.688M for 2015/16 which was achieved in full. The council projected a total savings requirement of £147.6M over the four-year period from 2016/17 to 2019/20 in order to maintain a balanced budget. This presented a significant challenge to the council.

A savings target of £85.4M had been set for 2016/17, £15.018M of which was to be delivered from the council services delegated to the IJB. Savings were planned to be achieved through an organisational review of staffing (£5.808M), contract management (£1.4M) and through the transformation programme (£4.137M).

The transformation programme comprised a number of work streams. These included reducing the use of agency staff, increased use of telecare, improvements in the management of demand, and increasing reablement. As at September 2016, it was projected that there would be £3.5M of slippages against the 2016/17 savings plan. The IJB agreed to cover the projected savings through using part of the Social Care Fund allocation on a non-recurring basis. The identification and achievement of recurring savings was essential to ensure long-term sustainability of services. The council expected the financial position to become even more challenging with reduced levels of funding in future.

All NHS boards are required to meet various financial targets set by the Scottish Government, including remaining within its revenue budget and achieving a break-even position. For 2015/16, the NHS board met its financial targets, including achieving an overall underspend of £0.349M. This position was achieved through the use of over £17M of non-recurrent resources. The main cost pressures were the increased use of supplementary staff and high prescribing costs.

The health board achieved £24.9M (79.6%) of efficiency savings against their target of £31.3M. Of these savings, 74.3% (£18.5M) were achieved on a recurring basis with the remaining 25.7% (£6.4M) delivered on a non-recurring basis. The identification and achievement of recurring savings was essential to ensure long-term sustainability of services.

As at September 2016, the delegated healthcare services, including set aside acute services, projected a year-end overspend of £6.7M. A £20.9M gap in the health board's financial plan, of which £5.8M related to the services delegated to the IJB, was the main cause for this projected position. Other areas of budget pressure included high cost of supplementary nursing staff and increased volume and price of prescribing.

In 2016/17, both the council and NHS Lothian were projecting overall overspends for the services being delegated to the IJB. The partnership intended to use non-recurring funding set aside to support budget overspends and the under achievement of savings plans to ensure that a year-end break even position was achieved for 2016/17. We concluded it was essential (as required as part of the integration scheme) that the partnership developed comprehensive recovery plans to address the projected overspends. These would be required in order to achieve a sustainable financial position that did not rely on the use of non-recurring funding.

Recommendation for improvement 11

The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.

The Scottish Government had provided funding to the partnership through a number of funds. These were to help enable the redesign of services towards prevention, early intervention, anticipatory care and rehabilitation.

The Scottish Government allocated to the partnership £8.2M from the Integrated Care Fund. Projects receiving monies from the Integrated Care Fund were assessed against the nine national health and wellbeing outcomes. Some of the monies from the Integrated Care Fund had been used towards mainstream activities with the permission of the Scottish Government. All 2016/17 Integrated Care Fund monies had been allocated. The largest projects related to reablement, care at home, community therapies and step down care.

The partnership was allocated £20.18M from the Social Care Fund. This funding would be split equally between meeting existing and additional financial pressures. For 2016/17, the partnership approved the use of up to £7.8M from this fund to contribute towards unmet savings targets and overspends within social work budgets. The partnership recognised that the use of non-recurring funding to cover budget shortfalls was not sustainable on a long-term basis and that robust savings plans were required.

The partnership had used a large proportion of Scottish Government Integrated Care and Change Fund monies to maintain and expand the existing profile of services rather than on new or different services to better meet people's needs. This included the development and maintenance of interim care settings at Gylemuir House and Liberton Hospital in order to address short-term demands.

This meant that there had been a significant opportunity cost of not developing community based and preventative services. It was essential that the balance of the IJB medium and long-term expenditure profile changed towards more community-based and preventative services to ameliorate the demand for services in hospital and care home settings. At the time of the inspection we did not see how this could be realised in the medium term.

Asset management

The IJB did not have joint asset/property management strategy in place. Although this is not a requirement of the partnership by the Scottish Government, a joint approach to the management of assets would facilitate the co-ordination and best use of existing and planned assets. Partners expressed the intention to move towards co-location where appropriate and to use buildings flexibly across the health, social care and wider estate. This work was at a very early stage.

The council had a revenue and capital budget framework in place, approved in January 2016, covering 2015-2020. For 2015/16, the social care capital programme spend was £5.680M against a budget of £5.039M, representing an overspend of 12.7% (£0.641M). The majority of capital expenditure within 2015/16 and planned for 2016/17 related to the new-build Royston care home. A total of £8.951M had been allocated to this build with an expected completion date in 2017/18. The health board's property and asset management strategy was approved in May 2016. Both these plans were individually subject to ongoing scrutiny through relevant committees as part of each partner's governance arrangements.

Information systems and technology

Across Scotland, the development of integrated data sharing arrangements is a major challenge. In Edinburgh, the partnership's information technology systems were a major and direct contributor to inefficiencies in the assessment and care management arrangements that were leading to poor outcomes for people. There were problems with multiplicity of systems, permissions, access, quality of data entry, and tools for assessment, planning and recording. Problems were exacerbated by poor connection speed, periods of downtime and a lack of mobile information equipment.

The partnership had produced a road map to improve electronic information systems. Improving information governance, connectivity, mobile technology, pathways through the care system, access to real-time information and joined up electronic communication between NHS Lothian and Council staff were all priorities. To support joint assessment and planning, the partnership had established an approach to electronic information sharing through an inter-agency information exchange. This aimed to enable health and social work staff to see, share and store information in various forms in a central repository. The main assessment and care management software systems were SWIFT/AIS (social work) and TRAKcare (community health and acute hospital). However, the two systems were unable to 'speak' to one another.

Many frontline staff and managers had little confidence that information systems were supporting them to communicate effectively and felt there had been limited value in the inter-agency information exchange. Information was often out of date, incorrect or absent.

Assessment documentation held by each agency was not shared either electronically or in paper format between relevant staff. Staff were frustrated by the duplication required by incompatible electronic systems and the risks of working with only a partial picture of the older person's needs. Staff in multi-agency triage teams needed two different computers to allow them to exchange information.

Partners were realistic that an incremental approach would be required to drive improvement, while recognising financial and organisational challenges may hinder progress. In the meantime, staff used telephone, email, meetings and informal networks as well as they could to support their work together.

Healthcare and social work systems had the ability to generate performance information and generate reports. Managers within the partnership were able to review data and access reports regularly, although performance data was not always accurate and up to date.

Nonetheless, we did see an improving picture of how the partnership was using its performance data. From being previously data rich rather than data specific, there was a shift in ensuring that the right data was being sought and used. An example of improved use of data was at the Patient Flow Programme Board.

We were confident that there was a commitment to share information and a willingness to find solutions to enable effective sharing of electronic information. A joint information technology strategy would be a helpful next step.

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

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

The partnership's performance in the provision of care, support, treatment and protection was unsatisfactory. There was substantial work for the partnership to do to improve the pathways for accessing services. Overall, assessment and care management practice was poor. Older people and carers, and the staff who were trying to help them, experienced substantial delays at all stages of the process – responding to referrals, completing assessments and reviews and providing appropriate intervention, with adverse impact on outcomes for older people and carers as a result. Processes to identify and protect adults at risk of harm required strengthening and updating, with better oversight and quality assurance on a multi-agency basis. More attention was needed to ensure all staff involved in providing support and care for older people were working collaboratively to manage and reduce risks. The implementation of self-directed support for older people was limited and further development was needed in areas to support choice. Advocacy services were providing very useful support quickly on referral although more work was required to raise understanding of the benefits of advocacy and when it should be suggested.

Access to support and services

There were weaknesses in routes to access services. Access to social work services was primarily through the local authority's central telephone contact centre Social Care Direct. Staff there provided initial screening and onward referral to sector teams, or signposted callers to other community resources. Screening decisions were not supported by advice from social work staff. Older people contacting Social Care Direct to make a referral frequently experienced difficulties in getting through, though a dedicated telephone line had been set up to help reduce delays for staff. Senior managers told us that arrangements for Social Care Direct were under review. Access to NHS primary and secondary services was through a variety of routes such as GP practices, community health and accident and emergency services. Pathways to health services were complex with a great deal of confusion about referral routes.

There was no single point of contact in place for someone to access both health and social work services. Callers needed to know what services they required. During our review of case records we identified a number of missed opportunities to appropriately refer older people to health services including falls assessment and mental health services. Plans for an integrated central contact point, Care Direct, were at a very early stage.

The city had a very complex landscape of service provision and there was compelling evidence that this was creating confusion for staff and service users, inefficient processes and wasted resource. Many staff found it difficult to keep abreast of the services available, their eligibility criteria and their individual referral pathways.

The partnership's inter-agency electronic portal was not living up to its aim of simplifying and facilitating access to services. It was ineffective and inefficient. Staff consistently told us about barriers to navigating easily through the system, such as poorly designed referral forms that omitted critical information.

Eligibility criteria were in place for a number of services but there were important omissions. Multi-agency triage teams did not have any agreed eligibility criteria. Just 36% of respondents to our staff survey agreed that joint eligibility criteria for services were consistently applied. Almost half said they did not know how eligibility criteria were interpreted and that they changed frequently in response to pressures to reduce delayed discharges. Social work and some health services using eligibility criteria were prioritising older people who had critical or substantial needs. However this did not prevent older people and carers in these categories experiencing significant delays for both assessment and the provision of services.

A serious concern was the difficulty experienced by older people in getting services before their conditions had deteriorated. Most frontline staff told us they could deal only with the most urgent cases and were unable to give attention to preventative work through early intervention. Priority had to be given to older people needing to be discharged from hospital, which meant people in the community missing out or having to wait much longer for services to meet their needs. It also meant that the needs of older people with complex needs were being assessed at a later stage than was desirable.

There was a strong and consistent message from frontline healthcare staff about difficulties in accessing social work services. They told us of waiting lists both from referral to assessment and from assessment to service provision. There were significant delays in accessing social work assessments and care at home services. There was also evidence of difficulties in accessing some health services, including allied health professional services. Physiotherapy at home and community occupational therapy were unable to meet target response times.

Recommendation for improvement 12

The partnership should ensure that:

- there are clear pathways to accessing services
- eligibility criteria are developed and applied consistently
- pathways and criteria are clearly communicated to all stakeholders
- waiting lists are managed effectively to enable the timely allocation of services.

Assessment of needs and wishes

Individuals' case records demonstrated poor standards of practice in respect of assessment and care management. There was no recorded assessment of needs for one in three older people in our sample. Only 57% were in a format which meant they could be easily shared with all of the staff with responsibilities for supporting the individual.

Where an assessment had been completed, the majority was of a good standard. Almost all assessments (99%) we read had taken account of the individual's needs and the vast majority had taken account of the individual's choices (91%).

Chronologies should set out key life events that can influence the care and support offered to individuals. There is widespread acceptance, across the country, of the importance of chronologies in assessing risks and needs and understanding the experience of people who use and need services. There was a chronology in only one out of 28 cases we read where we would have expected to see one.

Assessments should clearly show the contribution different staff need to make to support the older person but in 40% of assessments, this was missing. Our staff survey showed almost half of respondents unable to agree that key professionals worked together to inform a single, user-friendly assessment for older people. In the majority of cases (63%) it was clear that relevant information had been appropriately shared across services but this left a sizeable minority where there was no evidence of this happening. There was evidence that staff had obtained agreement to share relevant information across agencies in less than half of cases.

Most frontline staff spoke of significant delays in older people being assessed for and receiving services and this was acknowledged by managers. When reviewing case records, we noted unreasonable delays in the completion of assessments in 11% of cases, but we could only make this judgement in cases where there was evidence of an assessment having been done. We were confident from all of our activity across the inspection that the impact of delays in getting needs assessed in the first place, especially on older people with critical and substantial needs, was particularly significant. It meant that there were increased risks because services were unable to judge the priority which should have been given to risks and needs. The average time from referral to assessment in the cases we reviewed was 100 days. Furthermore, we noted a lack of communication with older people and their families when they were waiting for services. This is something which could be improved without requiring significant system change.

Following assessment, actually getting resources into place and starting intervention was also problematic. Time-consuming and cumbersome approval processes were a persistent issue for staff across different professions and across the four localities of the city.

Care planning

There was a striking difference between the perceptions of staff responding to our survey about how well care planning processes and practice in Edinburgh was supporting appropriate and timely intervention for older people and their carers, compared with our assessment of practice through reviewing case records. While staff were broadly positive, we found significant weaknesses.

Fewer than one in three older people had a comprehensive care and support plan in place to direct staff in meeting their needs. More than a third (36%) had no care plan at all. Where there was a plan in place, almost half (44%) were not SMART, making it difficult to measure how well it was being implemented and the progress made. In more than a third of cases (37%) the health and social care support being provided was not subject to regular review. Managers acknowledged there was a significant backlog of annual reviews to carry out.

In a number of cases (16%), we found unreasonable delays in older people receiving services following assessment. The older people for whom reviews were not conducted resulted, in some cases, in care provision not changing to meet improvements or deterioration in their condition. This meant that older people were receiving provision that was inappropriate to meet their needs. It also meant missed opportunity to take a preventative approach. In nearly a quarter of cases we read, there was no evidence that early intervention and prevention options been considered when needs were being assessed.

Care plans were often not person-centred and it was commonplace for there to be multiple care plans, each relating to a specific task. Most of the care plans were aligned to services, such as day care and care at home, rather than to the person, although the majority of these plans (70%) did set out the desired outcomes for the older person. Overall, we assessed 21% of care and support plans we read as wholly meeting the needs of the older person concerned. Fifty-three per cent were evaluated as meeting them partially.

Recommendation for improvement 13

The partnership should ensure that:

- people who use services have a comprehensive, up to date assessment and review of their needs that reflects their views and the views of the professionals involved
- people who use services have a comprehensive care plan that includes anticipatory planning where relevant
- relevant records should contain a chronology
- all work allocated following referral, assessment, care planning and review is completed within agreed timescales.

Shared approach to protecting individuals who are at risk of harm

There was a lack of confidence among staff that policies and procedures were being consistently applied and there was limited confidence in the partnership's ability to deliver consistently on positive protection outcomes. The adult and support protection committee was aware of this from self evaluation and quality assurance activity. Contributory factors were the awareness, knowledge and capability of agency staff, of whom there were significant numbers, as well as demand pressures on the social work service.

Steps had been taken to improve the quality and consistency of practice in relation to some issues, for example, by undertaking audits of case records and carrying out reviews when there had been an adverse event and large-scale investigations. This had led to some improvements. However, it was not always clear what had changed as a result of these exercises. Examples included persistent difficulties in assessing the capacity of individuals despite investment in staff training and the development of a specialised assessment tool. If someone is deemed not to have capacity, this means they are unable to make their own decisions due to illness or disability.

Governance arrangements were in place for adult support and protection that were in line with legislation and national guidance. There was inconsistent stakeholder representation at adult support and protection committee meetings. Adult support and protection procedures need to be updated in light of the forthcoming organisational restructure.

The committee acknowledged the need for improvement in the implementation of the adult support and protection processes. There was a lack of consistency in the application of the threshold for adult support and protection across the city. There were also concerns about recording of adult support and protection across localities and how incompatible systems were creating a barrier to responding to concerns efficiently. Frontline staff were concerned about differing interpretations between agencies of thresholds for triggering adult support and protection processes.

The committee, through the work of the quality assurance subgroup, noted the need to improve accountability for threshold decisions and adherence to procedures. The committee was seeking to address practice performance by using performance data, workshops with managers and the promotion of the protection duty-to-inquire summary questionnaire tool. Attendance at case conferences was not always appropriately prioritised by all and this had resulted in delays in the process. This has been addressed, in part, by attendance monitoring by the adult support and protection quality assurance group.

Staff were aware of adult support and protection referral and escalation procedures, and awareness training had been positively received. There was a high level of uptake of training from NHS staff. NHS and local authority staff described having regular access to the training but access to training for third sector agencies or housing staff was less readily available.

Where there were adult support and protection concerns, there was a clear policy in place that social workers must have had two and a half years of experience before they were able to act in an authorised investigative role. While this appropriately recognised the importance of the role and the skills required to fulfil it, in some sectors only a small minority of social workers had this level of experience. This was impacting directly on the ability of the social work service to respond to adult support and protection concerns promptly.

Similarly, concerns around adult support and protection allegations, adherence to policies and processes, communication and the implementation and monitoring of protection concerns in care homes were areas for improvement.

Good quality risk assessments and risk management plans that are shared across all relevant staff are essential to the effective support and protection of adults at risk of harm. We have described earlier our findings of poor assessment and care planning practice overall. Reading case records, we could see that practice was not always consistent with the partnership's procedures and guidance. Staff described risk assessment tools being unique to their own agency or service, or specialist for their profession, rather than common tools that supported a common language and understanding. Risk assessments were not routinely shared between the staff with responsibility for supporting the older person. Senior managers acknowledged risk assessments were generally completed on a single-agency basis.

While some caution needs to be exercised with the analysis, given the small sample size of adult protection-type cases, we found that risk assessments and plans were absent in records in a number of cases. In nearly half of cases where this was relevant, there was no evidence of risks being dealt with appropriately. Managers and staff made the case that staff were completing risk assessments where these were needed, but had insufficient time to complete the paperwork. Frontline staff reported that adult support and protection cases were prioritised for review. Nonetheless, we do not agree this is acceptable practice.

Seventy-eight per cent of case records we read had adult non-protection type risks identified, such as a frail older person at risk of falling and sustaining an injury. Of these, only 56% recorded a risk assessment. Where there was a risk assessment for this type of risk, over a third was weak in quality. We assessed one in three as cases where these types of risks had not been managed appropriately. In many cases, there was limited evidence of multi-agency partner input to manage and reduce risks of this kind.

Recommendation for improvement 14

The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing is maintained.

Involvement of individuals and carers in directing their own support

Our review of case records found low levels of engagement with older people in planning their own support. However, most older people we met told us they felt involved in discussions, where these had taken place, about their support needs and able to help plan their own support, albeit a number said their choices had been limited.

With regard to self-directed support, the partnership had a much higher level of older people in receipt of direct payments (option one) than the national average. The associated relative expenditure was also higher. Some older people were employing personal assistants. However, the partnership lagged behind the national average on the proportion of people needing support who were choosing how their needs would be met.

In our review of records, in a substantial minority (40%) the four options had not been discussed with services' users. Where discussions had taken place, local authority-arranged support (option three) was the most popular choice. Implementation of self-directed support for older people was restricted by the lack of care provider choice and limited capacity of third and independent sector service providers. This meant that the ability to select option two (individual chooses the service and the service provider) or option four (a combination of the other options) was restricted.

There was not a significant uptake of self-directed support within older people's services. The expectation was that self-directed support would be discussed when social workers were carrying out the My Steps to Support assessments (that is, when considering longer-term support) or at reviews. We have noted earlier in this report the backlog of reviews to be undertaken. Self-directed support options were not offered to prospective users of care home services.

Advice, information and brokerage support was available from the Lothian Centre for Inclusive Living, (particularly for option one) and to a lesser degree Voice Of Carers Across Lothian (carers' organisation). Independent advocacy was not routinely offered to prospective self-directed support service users. We found some awareness among older people and carers of self-directed support. Many of them said it was too complicated and they were used to services being provided for them by the council, or the council acting on their behalf. A few older people told us about difficulties accessing information about self-directed support from Social Care Direct and from social work staff. A few older people had used option four to access respite.

Whilst some staff were confident in explaining self-directed support to older people, others were much less so. There were particular concerns from frontline staff about a lack of training for agency staff who were regularly undertaking assessments. Staff found the self-directed support assessment tool useful but reported the recording tool to be cumbersome and not fit for purpose.

There had been a reduced focus on self-directed support during the transformation period in the partnership. The self-directed support champion initiative had stalled. There was a need to refresh training for social work staff and there had been very limited training for health colleagues.

Some quality assurance peer file audits of self-directed support had taken place and improvement plans had been drawn up as a result, which now need to be taken forward.

Recommendation for improvement 15

The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence of staff in all settings so that they can discuss the options of self-directed support with people using care services.

Advocacy

The partnership had a number of arrangements in place with advocacy providers such as Partners in Advocacy and Advocard. Advocacy services provided support to older people to help articulate their views and wishes. This had included support to engage in developing care plans, housing services and with adult support and protection.

The need for independent advocacy was not being routinely considered. In our review of case records, of 27 people who might have benefited from independent advocacy, only seven were offered it and it was provided in three cases. Referrals for independent advocacy services were usually linked to statutory mental health and adults with incapacity legislation. Advocacy services had received low levels of referrals for older people subject to adult support and protection procedures, despite a programme of staff training to raise awareness about adult support and protection.

Where advocacy was requested, advocacy services were able to respond quickly. Referral procedures were simple to understand and follow by staff across a range of services. There was easy navigation to get information about independent advocacy services from both the local authority and NHS Lothian websites. The Voice of Carers Across Lothian was the main contributor of informal advocacy support for carers. Minority Ethnic Carers of Older People Project acted as an effective independent advocacy service for black and minority ethnic communities. However, independent advocacy for other minority groups was under developed. Where advocacy support had been received there was strong evidence that it had helped the older person to articulate their views.

11. Impact on staff and on the community

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

The partnership's management and support of staff and its impact on staff, were both adequate. Staff were generally well motivated and felt supported by their immediate managers and colleagues in their own and partner's services. Morale was low in a number of places as staff struggled to cope with demand in the context of reductions in the total workforce, vacancies and the inevitable uncertainty of service redesign and restructuring. Staff needed managers to communicate more effectively with them during this period. An integrated approach to workforce planning was at an early stage. Recruitment and retention, particularly in some key posts, was an ongoing challenge and there was continued reliance on bank and agency staff. Deployment of staff remained at a largely individual agency level although almost all staff were positive about joint working. Staff were largely positive about how they were supported and the training they received but further development was needed around joint learning opportunities.

Staff motivation and support

We considered a range of evidence, including documentation submitted by the partnership, (for example training plans), partnership staff surveys and a staff survey we conducted as part of the inspection. We met with over 600 health and social work services staff. This included face-to-face meetings with managers and staff groups in health and social work and other care settings. Over 3,300 health and social work staff were asked to complete our survey with 933 responding. Of those who returned our questionnaire:

- 56% were employed by the local authority
- 44% were employed by NHS Lothian
- the remaining 1% were from other services (for example GPs).

Most staff were clear about their roles and responsibilities. Staff were committed to delivering and improving the care, support and treatment for older people and their carers. However a range of staff we met were less certain of what the changes to structure would mean to their roles and responsibilities in the future. Responses to our survey showed that a large majority (85%) enjoyed their work while 70% felt valued by their managers.

There were slight differences in the responses between NHS and local authority staff to our survey. However, a higher proportion of local authority staff were more positive in areas such as performance outcomes, the impact on older people and their carers, community wellbeing, policy development, partnership working and leadership and direction.

We found staff morale was very variable across the partnership. There were some factors which staff told us impacted negatively on morale. Many staff described themselves as continually 'fire-fighting' rather than adopting a planned approach to meet the needs and desired outcomes of older people and their carers. Staff from across different parts of the partnership identified the following as pressures which were impacting adversely on their ability to perform effectively and efficiently:

- high volume of work
- redesign of services which meant a constantly changing landscape
- gaps in community services provision
- cumbersome paperwork
- staff vacancies and high turnover
- ongoing reliance on use of agency and bank staff
- poor information systems
- inequitable distribution of services for older people.

The most positive comments about morale in their service came from social care workers and social care assistants, with social workers, community nurses, occupational therapists and clinical consultants being notably less positive. Many staff told us they did not feel fully engaged or have enough information about integration. They were uncertain about how integration would develop and what it might mean for them and the impact of this on service delivery and older people.

Staff surveys conducted separately by both NHS Lothian and the local authority also pointed to low staff morale in some areas and dissatisfaction with communication from senior managers. This view was reinforced by many staff we met who told us they did not feel as involved in the integration process as they would have liked.

The partnership had developed a range of communication methods to help engage staff on key health and social care integration developments. These included newsletters, briefing events, locality workshops, 'hub' development events and websites. The mixed views from staff who responded to our survey on policy development, leadership and direction suggested that the communication methods used to date had been partially but not wholly effective. The partnership's communication and engagement plan (2016-2019) recognised the need to address communication city-wide and at a local level using a range of tools. An accompanying activities timetable had been developed.

There was a track record of informal joint working between health and social work staff at an operational level. Most staff said they felt valued by their colleagues, partner agencies and line managers. They welcomed the prospect of integration and saw this as the formalisation of a joint working approach that already existed in some parts of health and social work services. Seventy-six per cent of respondents to our staff survey felt they had excellent working relationships with other professionals. Their view was that they worked well across agencies to provide care and support for older people.

There was a positive history of joint working between staff responsible for workforce development across the partnership. Specific groups had been established to focus on workforce and organisational change including a staff governance committee and workforce organisational change group.

Senior managers acknowledged a hiatus in the work of these groups over the past year. The designated health and social care workforce development staff were being moved to other services. Senior managers made a commitment to re-establishing meaningful workforce development groups in the future.

Phase two of implementation for the service restructure was underway at the time of our inspection (see Appendix 2). Very few staff we met could articulate what this might mean for them or people who use services. There was almost universal anxiety among staff about service restructuring. There remained significant decisions still to be finalised including composition and allocation of staff to localities. Almost all staff reported this prolonged uncertainty continuing to adversely affect morale across services. A further restructure, phase three, was planned. However, all staff were unaware of the detailed potential impact of this. Senior managers acknowledged the risks involved in implementing changes within very tight timescales but recognised they needed to continue to improve how they communicated change to staff during the transformation period.

Most staff told us that they felt supported by their line manager or team leader. The majority said they had access to regular professional-specific supervision and reviews of their work. However, some told us that they had waited many months for supervision, certainly on a one-to-one basis. Staff groups such as managers, physiotherapists and community nurses reported much lower levels of supervision. Supervision and support was affected by workload pressures and the regularity and quality was variable in different services. Some staff told us they regretted the loss of some previously existing multidisciplinary practitioner forums that they had found supportive and which they felt helped promote improvements in practice.

Recruitment and retention

As to be expected at this early stage of integration, the local authority and NHS Lothian were still working to their own separate policies, procedures and strategies for safer recruitment, retention and the management and support of staff. These were robust and fit for purpose. While recruitment policies were also separate for each partner, a joint appointment policy had been developed and joint senior staff tiers were already established, with others about to be appointed. There were detailed and robust joint profiles and job descriptions in place to support these joint appointments. Below senior and middle management levels, most staff were deployed on a single agency basis. This was to be addressed in part by phase two of the restructure.

Recruitment and retention was a significant constraining issue for the partnership. Third and independent sector providers also reported difficulties with recruitment of nursing and social care posts, as is the case across much of the country. The partnership had identified some helpful recruitment initiatives, with some having been put in place already. However, more needed to be done to improve resilience in services.

Senior managers told us that the labour market in Edinburgh was near to full employment and this contributed to recruitment difficulties. High housing costs in the city may also have been contributing.

Some posts were proving particularly hard to fill. These included district nurses, GPs, social workers, staff for residential care homes and care at home. Prolonged uncertainty and insecurity created by the restructure and the suspension on permanent recruitment due to the council's transformation had impacted on the ability to deliver existing services. As part of its transformation, the council had substantially reduced its workforce.

There was a strong consensus among staff and managers of the difficulties in delivering services with fewer staff, before any demonstrable benefit could be felt from new systems which may be put in place. There was shared anxiety across services about the impact of a loss of professional knowledge and skills and the impact of increasing workloads for those staff remaining. This had led to a loss of momentum in some planning and strategic processes at a time when it was most needed in planning and delivery of health and social care.

The partnership's intention was to develop a skills mix in localities to meet the future need and demand of services for older people. A joint workforce strategy group had been established which had produced a retention strategy for older people's services. This work, established 18 months before the inspection, had been put on hold because of priority being given to implementing phase two of the restructure.

The partnership had implemented a range of approaches to make health and social work jobs more attractive as career options. These included commissioning research to understand what works in recruiting and retaining care at home staff; encouraging new graduates to train as district nurses; and working with universities to improve district nurse training and recruitment campaigns. Potential future contingencies included increasing hourly rates, recruiting from outside the UK or facilitating access to housing for key workers. There was recognition by senior managers of the need to consider more creative initiatives to address recruitment challenges.

Absence information was reported regularly and monitored. The partners on a single-agency basis had implemented a range of measures to address and monitor staff shortages as well as to reduce staff absence levels. These included monitoring of sickness absence, vacancy levels, use of agency and bank staff. While these were having some positive effect, the local authority's social work services and NHS Lothian average absentee rates remained slightly above local and national targets.

We were concerned at the extent of the reliance on agency and bank staff and the potential impact on the quality and consistency of care older people received, particularly within care homes. The partnership had begun to take forward an integrated approach to workforce planning but because of restructuring, had agreed a hiatus. Senior managers gave a commitment that workforce planning groups would shortly reconvene.

Deployment, joint working and team work

Human resources and organisational development staff were supporting access to workforce development opportunities as these were identified, to respond to the changing needs of staff. At the time of the inspection, resource allocation and deployment of staff were largely at an individual agency level.

The partnership's organisational development approach for integration was being developed around the needs of the four developing localities. However, there were very tight timescales for implementation of the health and social care restructure. This had created instability at management and frontline levels across the partnership and almost all staff were concerned at the lack of preparedness for implementation.

Organisational development staff were using a six-step approach to joint workforce planning. Once the staffing model was in place, the intention was to progress locality-based workforce training plans. There were risks in moving designated workforce planning and development staff to a corporate section within the council, with resources given back to partnership functions, at a time of significant change.

We have noted earlier in this report, generally positive working relationships between colleagues across services and this was certainly the experience reported by most staff. Co-location, where it existed, had helped with improved communication. However, only a third of staff responding to our survey agreed that there were effective systems in place for allocation and management of work across the partners and teams.

Senior managers recognised staff capacity was stretched and that more needed to be done to build capacity in the workforce. While the use of agency and bank staff helped in the short term, managers were hopeful that moving to locality working would support efficiencies.

Training, development and support

The partnership's workforce challenges were among the highest integration risks, so ensuring staff are appropriately developed and supported is critical. In the main, health and social work services used their own training and development resources, with staff training delivered separately by each organisation, although there was a track record of joint working between the partners, including developing and delivering e-learning.

The professional advisory subgroup of the IJB was consulted on service redesign and consequent staff learning and development. The co-chairs of this group were non-voting members of the IJB. The group had membership from a wide range of professions but attendance was variable and the third and independent sectors were not represented. An enhanced group could play a more proactive role in bringing forward proposals to improve joint learning and development and promoting professional standards across all sectors.

A learning and development collaborative that helped plan and prioritise joint training programmes and events had been set up but had yet to get to grips with a training needs analysis. A training and development programme had been developed to support new locality managers.

Most staff felt there were opportunities for training and professional development, while naming difficulties in accessing them at times due to workload pressures. There were examples of training designed to meet teams' specific needs. Training and learning opportunities were of a good standard and generally met professional development needs. Third and independent sector representatives confirmed they both provided and had access to good quality training, although the opportunities were often offered at short notice.

We saw positive initiatives and examples of joint training in dementia awareness and palliative and end-of-life care. However, there was limited evidence of progress made rolling out the Promoting Excellence[18] framework. This needed to be refreshed.

Both health and social work services had suitable arrangements in place for supervision and clinical governance, performance management and professional development, though reality on the ground differed in some areas from managers' expectations. There was very limited evidence from case records of decisions taken as a result of staff supervision or management oversight. Different processes existed in health services. Health professionals had a different model of supervision, appraisal and auditing of care provision.

Recommendation for improvement 16

The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skills mix that delivers high-quality services for older people and their carers.

Impact on the community

The partnership's impact on the community was adequate. There was a clear commitment from the IJB to engage with key stakeholders and a communication and engagement plan was in place. Managers had an awareness of the important role that local communities could, and needed to, play but they needed to promote engagement with the community and third sector more with staff. The partnership had supported of a range of community groups and projects which were benefitting older people. Services for some minority groups were underdeveloped. The co-ordination of volunteer recruitment, retention and training could be improved.

[18] Promoting Excellence – A Skills and Knowledge Framework for Dementia – Scottish Government (2011)

There had been helpful engagement between the IJB and a range of stakeholders about integration, its benefits and its implications. Senior managers and IJB members placed importance on building the capacity of local communities and saw engaging them in service changes and developments as a priority. Involving the public in policy and service development was a theme in the partnership's joint strategic plan.

There was an explicit and implicit commitment by the partnership to the role of the third sector. Representative organisations from both independent and third sectors had a place on the IJB and subcommittees and other service planning forums. A communication and engagement plan (2016-2019) identified key stakeholder and methods of communication, though their effectiveness had yet to be fully measured.

Edinburgh Voluntary Organisations Council (EVOC) was the third sector representative body, representing most third sector providers through a series of forums and neighbourhood planning groups and into the city-wide community planning group. Two other voluntary organisations also sat on the IJB's strategic planning subgroup and a number of other third sector organisations were represented on the various planning forums. Despite this, not all third sector organisations felt equally represented in the arrangements. Processes to allocate grants to third sector organisations had been previously been managed in co-production but opportunities to work in this way had changed due to restructuring. Provider confidence had dipped, not least because of uncertainty about contract renewal processes as a consequence of financial constraints.

The very challenging financial situation and the process of service redesign and restructuring was also impacting on staff and volunteer retention. Differing approaches to volunteer recruitment and retention were taken between the three organisations that comprised the third sector interface, EVOC, Volunteer Edinburgh and the Social Enterprise Network. Volunteer numbers were lower than required and the quality of volunteer training was reported to be in need of improvement by many of the providers we met. Competition for resources militated against collaborative working.

Recommendation for improvement 17

The partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model.

Services for minority groups were underdeveloped in the context of anticipated population growth. Carers of South Asian and Chinese origin reported that their support needs were increasing but services were not developing to match these requirements or to meet particular cultural needs. Voice of Carers Across Lothian (VOCAL) and Minority Ethnic Carers of Older People Project (MECOPP) were examples of provider organisations which focused a significant part of their work on working with black and minority ethnic older people and carers. Their services were highly valued by older people and staff.

Example of good practice – Minority Ethnic Carers of Older People Project 'JEEVAN' Dementia Project

Working under the 'five pillars' framework, a link worker provided dedicated support to South Asian (Indian, Pakistani and Bangladeshi) people with a diagnosis of dementia, their families and carers. The project provided proactive advice, information and support to people with a new diagnosis of dementia for a minimum of one year. The link worker helped with:

- understanding the illness and managing symptoms
- support to keep up community connections and make new ones
- peer support – the chance to meet other people with dementia and their carers and family
- planning for future decision making, and planning for future support.

In the proposed hub and cluster model, the intention was for third sector and community groups to contribute to multi-agency triage teams. The aim was to facilitate access to preventative services, including those in the third sector. There was a lack of clarity about expectations of the third sector in each locality and this limited their contribution to forward planning. Third sector organisations spoke positively about their role in localities but had limited confidence that key decision makers in the partnership understood them well enough to confidently plan locality service provision.

The partnership was building community capacity by using the Integrated Care Fund to develop projects that complemented existing community groups. Local Opportunities for Older People aimed to strengthen service infrastructure, community capacity and the voice of older people in service development in each of the four localities. Early signs were promising. Projects were receiving increased referrals through Local Opportunities for Older People networks.

A Local Opportunities for Older People community wellbeing team had seven team members across Edinburgh, a community liaison worker in each of the four localities and a hospital liaison worker in three hospitals. It expedited hospital discharge, built community resilience and linked older people with third sector services with the aim of preventing readmissions. It was too early to assess its progress.

Older people and third sector staff told us that a lack of community transport in some areas had led to potential service users not accessing services. A review of community transport had been ongoing for a number of years with no clarity on outcomes. There was a need to refresh the partnership approach to community transport.

Better use could have been made by staff of the third sector red book directory to signpost older people and carers to sources of support. It would be helpful for the partnership to do more to promote the importance of staff engaging with local communities and other provider sectors.

12. Capacity to improve

Although the partnership achieved good outcomes for some older people and their carers, too many older people and their carers had poor experiences and poor outcomes. Where older people and carers did receive services, these were generally of good quality and made a difference. However, the partnership was not managing to provide the right support at the right time, delivered by the right people. Many older people did not have their needs thoroughly assessed. Many had to wait for lengthy periods until their conditions deteriorated to the point where they could be prioritised for a service. There were significant delays and lengthy waits in many parts of the system.

IJB members and senior managers had a clear view of their intended direction of travel and had embarked on an ambitious plan to transform the culture and the way in which services were delivered. However, actual strategies pursued did not always take them closer to their intended objectives.

We acknowledge that the partnership was operating in a context of cultural change and a significant management restructure, but we found there was a substantial amount of strategic development required to deliver better outcomes for older people in sustainable ways. Strategic planning was lacking detail, for example, in decisions about investment and disinvestment. Clear and consistent senior leadership would be needed to forge stronger links between activity, evaluation and investment and disinvestment decisions.

A whole-system approach to change management and planning for future commissioning was required. The partnership's view of joint working and in particular with the third and independent sectors was more positive than was reflected by third and independent sectors themselves.

The partnership was developing joint performance frameworks. Performance information was produced, reported and made available to senior and local management, as well as IJB members. Overall, the partnership demonstrated a level of self-awareness of the key challenges it needed to address. However, we found that the partnership was more able to identify where it needed to improve than to demonstrate how it had used that insight to make improvements.

It was essential that the balance of the IJB's medium-term and long-term service delivery profile changed towards more community-based and preventative services to address the demand for services in hospital and care home settings. It would strengthen the partnership's ability to shift the balance of care and deliver capacity for community-based services. The absence of exit plans for the interim arrangements in Gylemuir care home and Liberton Hospital was of concern. The new care at home contract now needs to deliver effectively to ensure the smooth running of this vital part of the care and support system for older people.

Frontline staff were committed to striving for the delivery of better personal outcomes for older people and their carers. They were enthusiastic about the possibilities that health and social care integration would bring. They were looking for more visible leadership to take them through a critical period of change.

They wanted to understand more about decisions made and to contribute their knowledge and experience to the redesign of services.

The partnership faced a range of major challenges, most notably how to meet the significantly increasing need and demand for services at a time of financial austerity. The continued impact of decreased staffing capacity within frontline services meant that developing the workforce to deliver new approaches, while maintaining standards of practice, would continue to be a considerable challenge into the future.

The partnership was at significant risk of not delivering on its intended strategic priorities without structured and concerted action to address the weaknesses identified in this report.

What happens next?

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

May 2017

Appendix 1- Quality indicators

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

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

2.2 Prevention, early identification and intervention at the right time

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

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

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

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

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

6.3 Quality assurance, self-evaluation and improvement

6.4 Involving individuals who use services, carers and other stakeholders

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

9.2 Leadership of strategy and direction

9.3 Leadership of people across the Partnership

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

7.2 Deployment, joint working and team work

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

8.2 Information systems

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

Appendix 2: City of Edinburgh Health and Social Care Partnership proposed phase 2 restructure

The partnership was undertaking, at the time of the inspection, a major 'phase two' restructure. Phase one involved the establishment of senior management roles. Phase two involved the vast majority of frontline staff. The new structure comprised of a 'hub' and 'cluster' model in four Edinburgh localities. A further phase three would involve central and 'back office' staff. The figure below illustrates the proposed structure.

Edinburgh Health and Social Care Partnership Proposed Phase 2 Restructure

Hub	Cluster

• Integrated Multiagency Services
• Supported by third sector and key providers
• New and Urgent Referrals
• Real time assessment, decision making by Multi-Agency Triage Team and immediate response allocated for:
  ➢ Crisis
  ➢ Admission prevention
  ➢ Hospital discharge
  ➢ Rehab and Recovery
  ➢ Hospital at Home
• Interventions up to 6 weeks
• Flexibility to work across the whole locality
	• Mapped around GP Practices
	• A range of co-ordinated, planned and complex services
	• A core group of multi-agency integrated services (may vary from cluster to cluster)
	• Co-ordinated work with communities, third sector partners and key providers
	• Longer term care, support, maintenance and on-going care
	• 7 days a week out-of-hours GP services, district nursing, emergency out-of-hours social work and emergency homecare

Wider Functions	
• Integrated Multiagency Mental Health and Substance Misuse Team, supported by Recovery Hub function • Long-Term Conditions • Community Equipment Service • Telecare/ Technology Enabled Care	

Source: City of Edinburgh Health and Social Care Partnership

In addition, the council was undertaking a major transformation exercise that aimed to achieve significant financial efficiencies. As part of this, a large number of staff would be leaving the council's employment.

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