care inspectorate

Healthcare Improvement Scotland

Services for older people in the city of Edinburgh

December 2018

Progress review following a joint inspection

HAPPY TO TRANSLATE

Contents

This report should be read alongside our original inspection report on which this progress review is based on. This can be found at: www.careinspectorate.com/images/documents/3831/Edinburgh%20services%20for%20older%20people%20joint%20inspection%20report%20May%202017.pdf

The Care Inspectorate and Healthcare Improvement Scotland jointly publish this progress review report. To find out more go to www.careinspectorate.com/ or www.healthcareimprovementscotland.org/

1. Background to this progress review

The Care Inspectorate and Healthcare Improvement Scotland jointly carried out an inspection of services for older people in the city of Edinburgh between October and December 2016. We published a joint inspection report in May 2017, which is available on both scrutiny bodies' websites. 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].

The report highlighted important weaknesses and where performance was unsatisfactory. We stated that we would monitor improvement and return to the partnership to review progress in 2018. The purpose of this review is to scrutinise and assess the progress that the partnership has made towards meeting the recommendations contained within the joint inspection report.

The Edinburgh health and social care partnership mainly comprised 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.

2. How we conducted this progress review

We undertook this progress review in June and July 2018. Prior to this, we examined a range of documentation submitted by the partnership and also reviewed the most recent nationally reported performance data for the partnership. The inspection team collated and analysed this information before the inspection period started.

We issued a survey to health and social work staff to make sure we heard about their views about how services were delivered and the impact of their work on improving outcomes for people. The survey was issued to 3,600 staff, of whom 666 responded.

We held scrutiny sessions that consisted of focus groups and interviews with individuals, managers and staff. We met with over 200 staff and with 30 older people who used services and with carers. We also met with staff and representatives from third and independent sectors and other stakeholder organisations. The main focus of our activity was on the extent of progress made by the partnership in meeting the 17 recommendations from the original inspection.

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

3. Progress made: What we found overview

We provided detailed feedback to the partnership on our recommendations for improvement in February 2017, before formally publishing our inspection report in May 2017. Yet the partnership's formal planning for making improvements following the inspection did not fully begin until September 2017. The partnership's reasons for this delay included preparation for local government elections and the new administration, organisational restructuring, turnover in senior staff and a reduction in organisational capacity. The delay in responding to the inspection findings had impacted on the pace of change, which had been found to be slow.

The partnership had not taken a strategic approach to the development of an improvement plan. Its approach to addressing the inspection's recommendations was reactive and short-term rather than as part of a wider, whole-systems approach. It had addressed individual recommendations from the original inspection report rather than develop and deliver an overall programme of improvement.

The partnership was able to demonstrate that it had taken forward work to improve the falls pathway, quality assurance arrangements, risk assessment and management. A number of individual good service developments were emerging, including some pilots and tests of change. However, these had not always been rolled out or standardised across localities.

The partnership had not made enough progress in key strategic areas for improvement. It had made limited progress in producing a revised and updated joint strategic commissioning plan with no real progress in developing the market to meet needs. The partnership's expenditure profile remained too heavily focused on bed-based facilities and institutional care. We found limited progress in areas such as developing intermediate care services, improving assessment and care planning.

The partnership had taken little action to improve information sharing, care pathways, applying eligibility criteria, tackling waiting lists and self-directed support. There was limited evidence of tangible progress in improving engagement and consultation with stakeholders and enabling early intervention and prevention services. This was also the case with developing exit strategies from existing interim care arrangements, improving how carers' needs were identified, assessed and met, and workforce planning. There was some way to go to ensuring people with dementia received a timely diagnosis and post-diagnostic support.

From the time of the original inspection to the progress review, the partnership's performance in important areas of service delivery had deteriorated. This included increases in delays in hospital discharge levels and in the number of people waiting for services. Many older people and carers were unable to get help even when their needs were critical or substantial. It was not uncommon for older people to wait for lengthy periods before getting the support they needed.

At the time of the inspection the senior leadership provided by the partnership was evaluated as weak. When we reviewed the partnership's progress we found leadership weaknesses had continued following the inspection.

There was a lack of evidence showing that senior leaders in the partnership were taking shared ownership of the challenging agenda, or driving and delivering the changes required to improve services for older people. There was an ongoing significant risk that the partnership would be unable to deliver on its strategic priorities without structured and concerted action to address the improvements required.

In May 2018 a new chief officer and operations manager were appointed. They had signalled their intent to change the leadership and organisational culture and develop the partnership towards one which was continually striving to improve.

Through our progress review, we concluded that the partnership had made limited progress overall in meeting our recommendations.

4. Progress on recommendations for improvement

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.

At the time of the inspection we found that the partnership's leadership was weak. It needed to improve its approach to engagement and consultation with stakeholders. Understanding and ownership of the partnership's vision was not well embedded with staff. We made this recommendation as the partnership's leadership team needed to better communicate its vision and values alongside developing its capacity to improve.

Since the inspection, senior managers had continued to hold a shared vision and to understand the need for change in the delivery of services for older people. They had made further efforts to communicate this vision to staff, to people who use health and social care services and to the wider public. The partnership had developed a range of communication methods such as newsletters, briefings, workshops and blogs. These had not been wholly effective.

Many staff were still dissatisfied with the communication from senior managers. They did not feel as involved in the integration process as they would have liked. They were enthusiastic about the possibilities that health and social care integration could bring about in delivering good outcomes for older people and their carers. Staff were looking for more visible and positive leadership to take them through a critical period of change. The partnership's vision and values had not been communicated effectively and were not well understood or owned by staff.

The partnership continued to lack its own identity. Senior managers and the integration joint board (IJB) were not visible to many members of staff and the public. The partnership did not have its own branding, logo or a dedicated website. Its communications continued through the parent organisations' established channels. It was difficult for staff and the public to identify with the partnership.

The partnership's engagement with stakeholders was an area for improvement at the time of the inspection. There was little evidence that this had improved. For example, the council had been progressing a transformation programme at the time of the inspection. This involved moving to operational locality arrangements (see appendix 1). Consultation and engagement with staff had been ineffective in this process.

The partnership had still not engaged effectively with key market sectors nor had it invested in cross-sector relationships in a planned and strategic way. This was, in part, a contributing factor to the ongoing capacity issues in care at home and care homes, and in the growth in unmet need.

The experience of service providers in consultation, engagement and involvement was still very mixed. While some providers were content with the level of involvement, others told us that they were not engaged by the partnership and that communication with it was reactive. The partnership's view of joint working with the third and independent sectors was more positive than was reflected by third and independent sectors themselves.

Summary

IJB members and senior managers continued to have a positive view of their intended direction of travel. However, the actual strategies pursued did not always take them closer to their intended objectives. Staff wanted to understand more about decisions made and to contribute their knowledge and experience to the redesign of services. Service providers had not been involved in enabling market facilitation. **We concluded that the partnership had made limited progress in addressing this recommendation.**

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.

We made this recommendation as the partnership's approaches to intervention and prevention were underdeveloped. This was not helping older people to remain in their own homes where appropriate and was a contributory factor to hospital admissions. At the time of the inspection, the partnership had recognised the importance of prevention and early intervention services but it had been slow to develop a range of, and access to, these services.

Since the inspection, substantial funds had been spent on maintaining and expanding the existing profile of services at the cost of developing prevention and early intervention services. This had contributed in part to older people experiencing unscheduled care and delayed discharge. The number of bed days occupied by people over 65 years following an emergency admission was higher than the Scotland average. For all adult age groups, performance was better. There had been improvements in 2017/18. However, the partnership's own relevant targets had not been met. Rates of bed days occupied by older people aged over 65 years subject to an emergency admission were higher than the Scotland average, as was the proportion of health expenditure on services for emergency admissions for the same age group.

The partnership had made some further investment in its range of community-based multi-agency services with the aim of supporting older people at home, avoiding unnecessary hospital admission and supporting hospital discharge planning. It had invested in developing reablement, hospital at home, care at home and telecare services. The partnership had made some progress with providing help and support to some older people with long-term conditions. It had developed some good initiatives. For example, increasing the numbers of older people with anticipatory care plans.

The partnership had made limited progress in the accessibility and delivery of services such as reablement, particularly in areas such as eligibility and referrals. This meant that services were not being targeted to those who were assessed as needing them most. The partnership had a number of telecare development projects but these were in the early stages of implementation.

Staff were still enthusiastic about early intervention and prevention and there were several projects underway. These included Fit for Health, developed in cooperation with Edinburgh Leisure (aimed at those with long term-conditions) and the Digital Blood Pressure and My Chronic Obstructive Pulmonary Disease (COPD) services. These projects had delivered measurable positive outcomes. These services were limited and capacity was insufficient to meet demand.

Some projects to prevent hospital admission and provide interventions at an early stage in illness had been evaluated positively but relied on short-term funding and grants. These included access to Scottish Government funding to assist with greater demand for services in winter and Healthcare Improvement Scotland improvement grants.

There was a tangible frustration amongst staff who had delivered projects that had demonstrated measurable financial savings and positive outcomes that they were unable to continue due to a lack of sustainable funding. There was no forum in the partnership to discuss project evaluations or to consider whether these would provide better alternatives to traditional models of delivery supported through mainstream funding.

Frontline staff were still mostly concentrating on dealing with the most urgent cases and were unable to give attention to preventative work and early intervention. There was an overriding focus on reducing delayed discharges and addressing immediate crisis demands. In our staff survey, the views about access to prevention and early interventions were disappointing. This was particularly so with regard to access to the range of preventative and enabling services to meet identified needs. There was insufficient capacity in the service to undertake preventative work. While the partnership had developed some early intervention and prevention initiatives, it had a long way to go to fully deliver the range of accessible preventative services required.

Summary

The partnership had developed some positive initiatives but lacked a clear vision and approach to developing preventative and early intervention services. Its ability to shift the balance of care by delivering capacity for community-based services had made little headway. The expenditure profile had not changed at a cost to the development of prevention and early intervention services. **We concluded that the partnership had made limited progress in implementing this recommendation**.

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.

We made this recommendation as interim care arrangements were not assisting older people and their carers to experience choice and a high quality of care and support within their own homes or a setting of their choice. The partnership needed to develop exit strategies from these bed-based, high-cost facilities with a view to developing a range, choice and good quality of community-based services.

Prior to the inspection, interim care resources such as Gylemuir House care home had been developed 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. The development of these services was reactive and not part of a long-term planning approach to address unmet need.

When we returned, the partnership's approach to preparing an exit strategy from the interim care arrangements in Gylemuir House care home was in its very early stages. Operationally, there were high costs involved in the delivery of the service at Gylemuir House and ongoing concerns about the quality of care and support. The quality concerns were evidenced by the Care Inspectorate scrutiny and the partnership's own quality assurance work. Poor inter-agency working continued to impact on the outcomes for people transferred from acute sites. Staff recruitment and retention challenges impacted on the quality of the service.

While the residents we met at Gylemuir House talked positively about their stay, they also spoke about a lack of clarity and choice regarding their future long-term care. There was a lack of clarity and a limited choice for those moving on to a permanent care home placement. In 2018, the partnership stated its aim was to provide a transitional service at Gylemuir House until June 2021, to allow time for the development of an intermediate care service model and to address care home capacity pressures.

The outcomes for those who were moved to Liberton hospital to await a care at home service were still mixed. For some, an intense period of rehabilitation had delivered positive outcomes, resulting in a quicker discharge and a reduction in the home care package required. For others, an extended stay had resulted in disengagement from service provision, deterioration in their health and an increased need for care on discharge. Some people did not have enough information, did not feel appropriately consulted about or involved in the plans for their longer-term care.

An exit strategy for the Liberton hospital service had been progressed during early 2018. The partnership intended to move resources from Liberton hospital to another bed-based facility by January 2019. This new service, to be provided at the former Jardine clinic at the Royal Edinburgh hospital, would include a rehabilitation service approach. The partnership had missed successive timescales in the planning for this project. This was due in part to work being completed by external partners.

At both Gylemuir House and Liberton hospital, service planning and development had been largely reactive. It was determined in part by the demand and pressures on acute services, rather than as part of a whole-systems approach to longer-term planning. There was no comprehensive assessment and understanding of the current and future demand for care homes and related services. There were no detailed costed action plans in place. Timescales for the preparation and delivery the plans for Gylemuir House and Liberton hospital had been consistently delayed.

Summary
The partnership had made limited progress in moving away from temporary services and on to the development and 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. Considerable work was required to develop plans and implement new models of care and support. **We concluded that the partnership had made limited progress in implementing this recommendation.**

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.

We made this recommendation as there were gaps in the delivery of intermediate care that had adversely contributed to higher levels of hospital admissions and subsequent delayed discharges. Prior to the inspection, intermediate-care beds had been piloted using the integrated care fund but for reasons such as financial sustainability and difficulties with patient flow, these had ended. No alternative options had subsequently been tested or implemented.

Following our inspection, the partnership produced a strategy paper in 2017 titled Towards a model of intermediate care in Edinburgh – the use of the Jardine clinic and Gylemuir House. This concentrated on the potential opportunities that these two establishments could potentially provide for bed-based provision of intermediate care. The partnership's short-term focus was on developing bed-based facilities.

The longer-term vision was to develop integrated care facilities that would incorporate a wider range of resources and approaches. The vision for the future provision included extra care housing, end-of-life care, day care facilities, intermediate-care facilities and a teaching and research-based care home. These services would be provided at the Royal Edinburgh and Liberton hospital sites. The partnership's vision for intermediate care was still a high-level strategy and did not have detailed plans to support service development.

The emergent outline strategic commissioning plan for older people, produced in 2018, indicated that the partnership would confirm its approach to intermediate care facilities by December 2018. This plan included a commitment to invest in downstream beds. There was no confirmed strategy aligned to the strategic needs assessment for how intermediate care, including bed-based care, reablement, hospital at home, care at home, aids, adaptations and equipment as well as telecare services could be developed. Nor did it show relevant time scales or costs, or how this approach would address demand in each of the four localities across Edinburgh.

The partnership had not engaged fully with its own staff, care home and care at home providers and other stakeholders to discuss how it might move from its current range of services to the delivery of a wider set of intermediate care resources. A consultation event had taken place in 2017 involving real case examples. It had not set out how any learning from that event informed the partnership's thinking on planning for intermediate care.

Summary

The partnership had not articulated clearly how it would deliver appropriate levels of bed-based capacity to support hospital discharge whilst also developing and implementing plans for alternative service provision. **We concluded that the partnership has made limited progress in implementing this recommendation**.

Recommendation for improvement 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.

We made this recommendation because there was an insufficient understanding of the needs of carers and the delivery of related services to help them maintain their caring role.

At the time of the inspection the partnership's joint carers' strategy (2014-17) set out the priorities to support those who provided unpaid care. The partnership subsequently commissioned Edinburgh Voluntary Organisations' Council (EVOC) to undertake an independent review of the joint carers' strategy in 2017. The review indicated that both carers and practitioners felt the strategy's priorities were correct and that the strategy had a positive impact at a strategic level. However, EVOC reported widespread uncertainty regarding the extent to which the strategy had improved outcomes for carers. Unpaid carers felt the services that supported them had stayed the same or worsened since the strategy was developed.

The EVOC review made a series of recommendations for the development of an updated carers' strategy, including broadening ownership of the strategy, focusing on implementation, maintaining the existing priorities and measuring its impact. The preparation of the updated strategy had not been progressed due to the work involved in implementing the Carer (Scotland) Act 2016. The original joint carers' strategy (2014-2016) had not been updated.

At the time of our review, carer representatives were included in relevant strategic planning forums such as the outline strategic commissioning plan work streams**.** These representatives felt involved in strategic planning events and the future development of services. Carer support organisations that did not have representatives in formal planning forums did not feel involved and knew little about the changes taking place. Many carers we spoke with were unaware of events that had been held to capture carers' views about the delivery of services in their local community.

Since the inspection, the partnership had made preparations for the implementation of the Carer (Scotland) Act 2016, which came into effect on 1 April 2018. Work had progressed that focused on local eligibility criteria, carers' assessment and support plans, communication and finance. This work was reported to the strategic carers' partnership. It had adopted the Scottish Government's readiness toolkit for monitoring the Act's implementation.

The partnership had put a communications plan in place to consult on the proposed changes, publicise the results of the consultation, report how it had influenced implementation and engaged with professionals and frontline staff whose role had been impacted by the changes. There had been consultation with carers and staff working to support carers in key areas such as carer support eligibility criteria, carers' assessments and reviews templates. The numbers involved had been small.

New arrangements for carers were piloted in the north-west locality to test new ways of working across partners, team communication, the proposed eligibility criteria, assessment and the allocation of services and funding. The partnership had also delivered in-house training that focused on the eligibility criteria, planning carer support and engaging in conversations with carers. These approaches had not been fully rolled out across Edinburgh.

A range of services offering support to carers were still available, subject to assessment and eligibility. These were 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). They included the NHS carer support team, Carr Gomm respite service, and council and third sector delivered day services. Carers often found it difficult to access support such as respite and care at home to help them continue in their caring role. This impacted adversely on the experience of carers

As part of our review we met some carers who were unclear about the eligibility criteria to receive a carer's assessment and related support. There was general dissatisfaction with Social Care Direct, the main point of referral to access services. Most carers stated that if they were unhappy they did not know who to complain to.

Carers and the staff who were trying to assist them were experiencing delays in the assessment and care management process. Some carers whose needs had been assessed found no additional support was provided, which had an adverse impact on outcomes for older people and carers as a result. Some carers had experienced difficulties obtaining information about sources of help and long waits for assessment and intervention. When they did get services, carers valued them. Carers who expressed dissatisfaction mentioned delays in assessment and lack of co-ordination of services as the main reasons.

Summary
Carers receiving support were concerned about the length of time it took to get an assessment and lack of access and availability of the support to match the assessment. There was still an insufficient understanding of the needs of carers and the delivery of related services to help them maintain their caring role. **We concluded that the partnership had made limited progress addressing this recommendation.**

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.

We made this recommendation because people with dementia did not always receive a timely diagnosis and that post-diagnostic support was not always readily available.

At the time of the progress review, there was still a consensus among carers and staff that obtaining a diagnosis of dementia could be difficult. Pathways for people with a potential diagnosis of dementia were still not straightforward, which resulted in some people disengaging from assessment. Where diagnosis was provided at the memory clinic, a referral was made for post-diagnostic support. However, in other care settings such as care homes or hospital there remained uncertainty about the route to access post-diagnostic support.

There were still delays for those receiving a diagnosis of dementia and their carers in accessing post-diagnostic support. There could be lengthy waits for community mental health nurse services and for Alzheimer Scotland's link workers to deliver post-diagnostic support. The partnership's performance in relation to the diagnosis of dementia was in line with the Scottish average but the delivery of post-diagnostic support was below the Scottish average levels. For people with dementia, access to care at home was below the Scottish average too.

Since the inspection, the partnership had not developed the capacity to deliver a full range of support at a time that is right for a person with a diagnosis of dementia. Access to post-diagnostic support was not consistently available across Edinburgh. Staff were concerned about insufficient resources available to meet older people's needs. Our staff survey reflected this, with low numbers of staff agreeing that services did all they could to ensure that older people received a timely diagnosis of dementia or that older people had timely access to post-diagnostic support.

The partnership had developed resources to provide post-diagnostic support and a number of initiatives had been taken forward. The partnership had commissioned three additional post-diagnostic-support link worker posts. A recruitment process was underway and these posts were to be provided by Alzheimer Scotland for a three-year period. In another initiative, primary care funding was used to employ a dedicated worker to deliver post-diagnostic support. This pilot project was based within a GP practice and provided dedicated support following a dementia diagnosis. This project aimed to support people who were worried about their memory and provide support following diagnosis. It had not been evaluated as yet. The testing of post-diagnostic support group-work sessions for people and their carers from GP surgeries was underway.

In the north-east locality there was an initiative for the delivery of post-diagnostic support services within a primary care setting that covered eight GP practices. This work had been commissioned in cooperation with the Scottish Government's Dementia Innovations Unit, Healthcare Improvement Scotland's ihub, NHS Education for Scotland and Alzheimer Scotland.

The outline strategic commissioning plan for older people included draft proposals for the development of improved pathways through assessment, diagnosis and post-diagnostic support.

Within the partnership, there was an awareness of the increased expectations of the updated Scottish Government's National Dementia Strategy 2017-2020. There was recognition of the need to develop appropriate support for people diagnosed with dementia, which included access to both the current model of post-diagnostic support and to care coordination based on the 'eight pillars' model of integrated community support[2].

Summary
A number of initiatives and projects had been developed to try to improve access to post-diagnostic support. The partnership was trying out and testing new models of delivery. These were yet to be evaluated. It remained the case that across Edinburgh people with dementia did not always receive a timely diagnosis and services were not always coordinated to ensure that diagnostic support was available at the right time. **We concluded that the partnership had made limited progress addressing this recommendation.**

[2] This model builds on the resilience of people with dementia and their carers to help ensure that the impact of post-diagnostic support and early intervention is not lost.

Recommendation for improvement 7

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

We made this recommendation because there was a need to streamline referral and care pathways to improve outcomes for older people at risk of falling or who had experienced a fall. The falls strategy needed to be updated with a greater level of involvement from supporting agencies.

Following the inspection there was a renewed focus on falls prevention and falls risk reduction. The partnership had redeveloped falls pathways and service provision. Dedicated falls co-ordinators posts, aligned to localities, had been put in place. Recruitment of a dedicated practitioner to provide earlier falls screening was underway.

Since the inspection, the partnership had worked collaboratively with the Scottish Fire and Rescue Service and Edinburgh Leisure to introduce the Steady Steps test of change. This service model aimed to improve the strength and balance of people who experienced care. Work had also been undertaken with the Scottish Ambulance Service. This included training that had resulted in a demonstrable increase of referrals for falls assessment from the Scottish Ambulance Service. Additional work by the Scottish Ambulance Service included deploying a paramedic at the entry point of Edinburgh Royal infirmary. A screening tool was developed for accident and emergency and ambulance staff to work through with people attending who had fallen but were uninjured, to identify an appropriate response. Originally piloted for six months, this project was extended to 12 months. Paramedics had a pocket book with contact details for falls response teams. Scottish Ambulance Service staff were encouraged to consider the minor injuries unit at the Western General hospital when appropriate, rather than accident and emergency at Edinburgh Royal infirmary. These measures had helped to reduce the incidence of admission.

Admission rates for people aged over 65 years who had fallen then attended accident and emergency had reduced. There had been a small but steady decrease in the number of falls resulting in admission. Improvement data, (six-weekly reporting) was available across the partnership, which had resulted in better performance analyses to help inform areas for improvement. For example an analysis by postcode highlighted areas with the highest hospital transfer rate and included those areas with high numbers of care homes. This resulted in a project in local care homes to promote the use of the falls pathways.

Since the inspection, the Be Able day services programme had provided additional preventative work for falls prevention and early intervention. There was also a clear plan for continued improvement and training within locality hubs and clusters (see appendix 1). This had helped to deliver good outcomes for people at risk of falls.

Summary

The partnership had introduced and rolled out a range of falls-related initiatives with positive impacts. **We concluded that the partnership had made good progress addressing this recommendation.**

Recommendation for improvement 8

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

We made this recommendation because the partnership did not have strong joint approaches to quality assurance that led to service improvements. At the time of the inspection, service quality was assessed and feedback received through a range of reactive means including caseload management and clinical supervision. There were no shared approaches to quality assurance and improvement

Since the inspection, the partnership had introduced more proactive measures to assuring quality. It had established a group to co-ordinate quality assurance and improvement. Its purpose was to oversee clinical and care governance and to provide assurance to the senior management team, the IJB, NHS Lothian's healthcare governance committee, the council's governance committees and the adult support and protection committee.

At the time of the progress review, a joint quality assurance framework was in preparation to help ensure compliance against assurance standards. This was designed around national health and social care standards. The intention was that the quality assurance and improvement group would be supported by locality quality improvement teams. There were also plans for professional quality improvement teams in areas such as allied health professionals, social work and district nursing, as well as hospital and hosted services. This structure was still in its infancy. The partnership was working to articulate its quality standards across all services and was testing different methods.

Additional approaches included the development of NHS Lothian's quality academy training and coaching network. The partnership's quality assurance team had a close relationship with NHS Lothian's quality team. There were social work quality assurance groups and forums also.

Since the inspection the partnership had developed a quality 'dashboard' system to capture information and inform strategic and local service planning. A joint complaints recording system had also been implemented. From this, complaints that were upheld and partially upheld were required to have an improvement plan.

Future developments planned included the appointment of locality quality assurance officers to assist with quality assurance work at a locality level. These would, for example, support locality staff to understand performance data trends to inform the redesign of services. A dedicated quality assurance officer would work for a period of between 12 – 18 months alongside each locality, eventually becoming the locality's improvement champion and critical friend. These would assist each locality to establish a programme of self-evaluation leading to a standardised and annually updated self-evaluation programme. This work was at an early stage. Locality quality assurance and improvement groups had been established and were being held quarterly in each of the localities at the time of the review.

Following the inspection, the partnership had carried out case file audits at Gylemuir House and audited an additional 100 health and social care case files from across Edinburgh. From these audits they developed action plans for the localities.

It was not evident how successful the implementation of these plans had been. The partnership was unable to demonstrate how audits were leading to positive change. Staff were unsure about senior management buy in to delivering improvement plans.

The IJB and its strategic planning subcommittee were generally unaware of audit and self-evaluation work undertaken. There was limited evidence of regular reporting on self-evaluation and quality assurance exercises to the IJB and its strategic planning and audit and risk subcommittees. Audit reports were not escalated beyond the senior management team when appropriate. The IJB decided that its performance and quality subgroup was not fully delivering on its remit and its operation had been suspended. It was unclear how this subgroup's functions would be discharged in the future. Partnership internal auditors were undertaking reviews of service areas. It was unclear how these were prioritised.

Nearly two-thirds of the staff who responded to our staff survey agreed that the service regularly evaluated its work and took appropriate action for improvement. Over half agreed that there were measures in place to ensure the quality of the services they delivered. Less than one-third agreed that the quality of services had improved over the last year. These were much lower levels of positivity compared to the survey undertaken at the time of inspection.

The partnership had yet to fully show that there was monitoring and evaluation of investment in all services (whether in-house or externally commissioned) and across care settings that was robust and consistent to inform future service redesign. There was still a disparity between the quality assurance processes for in-house and externally provided services. Externally commissioned services had quality assurance measures in place as part of their contractual compliance procedures. Quality assurance of externally commissioned services was undertaken by the partnership's contracts team. A locality team manager chaired quality assurance meetings for care homes and care at home, at which issues, themes and patterns were identified. These meetings were subject to an evaluation at the time of our review.

There were very limited links between the development of the outline strategic commissioning plans and quality assurance measures. Work was still required to develop and measure the outcomes being delivered.

The partnership had demonstrated that it had made progress in developing performance management frameworks. Performance information was produced, reported and made available for consideration to the partnership's senior and local management. Performance information based on national and local indicators formed the basis of the approach. This helped the partnership to identify areas where performance was improving or required improvement.

The partnership was unable to demonstrate fully that it was routinely using performance management information effectively to identify priority areas for self-evaluation or to evidence that a joint strategic approach was being employed to ensure that intelligence gained from quality assurance mechanisms influenced improvement.

The dashboard was a useful performance monitoring tool but there was more scope to enhance its use. Individual outcomes were not measured, or used to influence service delivery. Managers within the partnership were potentially able to review data yet much of this information was difficult for middle and some senior managers to access, retrieve and understand. The information did not include a narrative to explain recent progress and further detail such as exception reports.

Managers and staff still recognised that they needed to do more to evidence positive personal outcomes and the impact of service delivery for people who experienced care and carers. Activity and performance information was not fully used and linked to drive improvement. The dashboard was not updated to include personal outcomes and other qualitative indicators. There was limited evidence of the partnership undertaking benchmarking against other partnerships.

Summary
There was evidence of progress in moving towards an integrated strategic approach to gather feedback from people with experience of services and their carers. There was limited evidence of how this might bring all of this information together and ensure it feeds into service improvement further. **We concluded that the partnership had made reasonable progress addressing this recommendation.**

Recommendation for improvement 9

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

We made this recommendation because there were underdeveloped approaches to market facilitation and the risk assessment and contingency plans to accompany these. These would have helped to develop sustainable capacity across care settings to cope with current and future demands.

Following our inspection, the partnership had set out in its 'statement of intent' of October 2017 that the development of a market facilitation strategy and outline strategic commissioning plans would be taken forward together. The stated completion date was April 2019. Subsequently, the preparation of the market facilitation strategy had been paused to focus on the development of the outline plans. Work on the accompanying risk assessments or contingency plans were at a high level and were in their very early stages. The previous draft market facilitation strategy (2015-18) had not been updated.

At the time of our inspection, the partnership had not engaged effectively with key market sectors or significantly invested in cross-sector relationships in planned and strategic way. Little had changed. For example, a detailed review of care home capacity had not been completed. There were issues about choice, quality, contract rates and capacity in care home market. The partnership had been reactive in its response to demand and market pressures by commissioning relatively high cost care home places. This had in part impacted on the partnership's ability to take forward essential developments in the care at home market where capacity remained insufficient to meet demand.

The partnership had a minority market share across care home and care at home services. With a mixed economy in key care markets, the development and maintenance of effective relationships with the third and independent sectors was essential. Since the inspection, the experience of service providers in consultation, engagement and involvement was very mixed. A few providers were satisfied with their level of involvement. However many providers told us that engagement with them could be significantly improved. Service providers had not been involved in forming a strategy for market facilitation. This was particularly evident in the care at home and care home sectors.

There were ongoing and significant challenges in local supply, capacity and quality in areas such as care homes, care at home services, day care, respite care and self-directed support market segments. There were no cross-sector long-term approaches to address changing demands in these care sectors. There was limited evidence to suggest that the partnership had a clear sense of how it understood or intended to influence care markets or how it planned to work across care settings and sectors to achieve a stable and sustainable mixed economy of care that offered choice and equity of access.

There were gaps in how joint strategic planning, commissioning and contract monitoring were promoted and integrated. There were mixed views from the independent and third sector providers about the level of support available from the partnership to improve their performance.

At the time of the inspection a new care at home framework contract had been introduced and since then some innovative third sector care at home services had been delivered. However, it was acknowledged by the partnership and by care at home providers, that the care at home framework contract was not delivering, on the whole, good quality services. Some services were not delivering minimum levels of quality and were struggling to recruit sufficient numbers of staff. A few providers had cancelled their registrations.

The care at home contract implementation had significant challenges such as high levels of demand, recruitment and retention of staff, ability of providers to build up volume and penalties within the framework. There was evidence of adverse impacts on outcomes for older people. Care at home was critical to the overall system of care and support for older people. Failures in care at home had a major impact on other services. This remained an area of significant risk.

A lack of community support services and the demand on existing capacity resulted in a lack of choice and limited options for those service users who wished to choose to self-direct their support. Managers had an awareness of the important role that local communities could play and that there was unrealised potential to deliver services in the third sector. The partnership's preparations for influencing locality markets remained underdeveloped.

Summary
The development of market enabling and facilitation including accompanying risk assessments and contingency plans were not in place. There was an overall lack of development of the market across all care market segments. **We concluded that the partnership had made poor progress addressing this recommendation.**

Recommendation for improvement 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.

We made this recommendation because the partnership's strategic planning, commissioning, consultation and involvement needed to improve. At the time of the inspection, the main strategic plans were the joint commissioning plan (2012-22) and the strategic plan (2016-19). There was very limited evidence, since the inspection, that the partnership had implemented, reviewed or tracked progress of the actions detailed or the intentions outlined within these plans.

Since the inspection, the partnership had started to develop outline strategic commissioning plans. This included plans for older people, mental health, learning disability, physical disability and primary care. These were expected to be finalised by the end of 2018 and would inform the emergent and updated strategic plan (2019-22). The outline strategic commissioning plans were high-level plans. They did not yet have detailed delivery plans setting out how expected outcomes would be achieved and measured. These plans were not fully costed and did not include action plans for investment and disinvestment. The partnership advised this supporting information was in preparation and would be available by December 2018.

The outline strategic commissioning plan for older people had five supporting work streams. These were: (1) health and wellbeing; (2) access and assessment; (3) short-term care and support; (4) long-term care and support and complex care, and (5) accommodation and bed-based services. Issues and risks from the work streams were reported to an older people's working group and in turn to a reference board. The older people reference board had met once. Senior staff advised that the work streams for older people were moving forward rapidly.

Each care group had a separate working group and a separate reference board. These in turn reported to the IJB and its subgroups and then the IJB (see appendix 2). While it was positive that governance arrangements were in place to support strategic planning, the structure was complex. There were inconsistencies in how well these were working. The planning groups were not sufficiently resourced to progress work within the required timescales. There was insufficient business support capacity to support the existing strategic planning work.

The partnership was still at an early stage of locality planning and commissioning that was linked to operational service delivery. Locality plans had been produced but were not clearly linked to locality commissioning.

Plans for cross-cutting issues such as housing, technology and equalities were to be developed alongside the outline strategic commissioning plans. This work was at very early stage.

Strategic planning and commissioning was a key area for improvement at the time of the inspection. Since the inspection, the partnership has demonstrated a reactive approach to strategic commissioning and market facilitation. There was a lack of medium and long-term planning to inform future commissioning approaches. This was evident across many care settings including hospitals, care homes, intermediate care, respite, care at home, day care, early intervention and preventative services.

Following the inspection, the partnership had set out its intentions to prepare and deliver a whole-system approach for service planning for older people. The partnership had set out its intention to progress a review of capacity and demand and associated action plans. These were to be complemented by a frailty strategy (to shift balance of care), a review of care at home and an evaluation of the care at home contract. Timescales for these critical strategic programmes of work had slipped substantially. For example, care at home capacity was an area of significant concern at the time of the inspection and a pressing issue for the partnership. However, at the time of the progress review, the work to review care at home had yet to formally begin. It was not clear why this area of work had not been given more priority and commenced sooner. Performance, service quality and the delivery of positive outcomes had actually worsened since the inspection. There was limited evidence of risk management arrangements or contingency plans in place in the interim period before the review concluded.

The partnership was positive that governance arrangements had been put in place to support strategic planning and decision making (see appendix 2). These were not always effective in helping the partnership's capacity to improve. The IJB did not always have the necessary oversight of service developments that it needed to inform effective decision making.

Communication and engagement with stakeholders in strategic planning and commissioning were identified as areas for improvement at the time of the joint inspection. Following the inspection, the partnership had further developed its approaches to communication and engagement and involvement. Additional resources to support participation and engagement had been introduced but its impact had been limited.

Senior partnership staff reported strong and positive engagement with the third and independent sectors. However, the ongoing relationships with the third and independent sectors were not universally successful. There were limited opportunities for independent sector representatives to contribute to outline strategic commissioning plans' subgroups. Framework care at home providers were not fully engaged in developing existing service provision or developing strategy. Non-framework providers were not engaged at all. Care home and day care providers were of the view that information sharing, consultation and cooperation could be better.

The strategic planning group acknowledged there was more to do to engage with stakeholders and that the outline strategic commissioning plans' development could be a route to more collaborative working.

The IJB and strategic planning group stressed that the third sector had an important role in shifting the balance of care. The third sector was primarily represented by the Edinburgh Voluntary Organisations' Council (EVOC). At the time of our progress review, EVOC representatives were members of relevant planning forums. They were members of the strategic planning group and were a non-voting member of the IJB. They were also involved in outline strategic commissioning plan work streams. Some third sector providers thought that the strategic agenda was too large for the Edinburgh Voluntary Organisations' Council to adequately represent the entire sector. These providers did not feel fully consulted or engaged in service planning particularly in areas such as care at home and day care service planning.

When we returned to the partnership in June 2018, we found the IJB had initiated a review of it grants programme with a view to focusing future allocation on the two priorities of tackling inequalities and preventing poor health and wellbeing outcomes. From April 2019, grants would be focused on primary and secondary prevention to support needs that were not critical or substantial. Engagement sessions in relation to grant funding had taken place. Third sector interface senior managers were positive about recent meetings with the partnership on grant funding. A third sector strategy group had set out the principles (such as inclusion and working with communities) which the IJB should employ when commissioning services. These had been agreed by the IJB. It was too early to recognise if these were being delivered.

Housing provider representatives were encouraged to better participate in joint strategic planning forums to assist with their input to planning and service redesign. There were more productive relationships between the partnership and housing agencies. The partnership had secured a policy commitment from the council that there would be substantial capital investment in building new housing for older people. However, critical details such as land price and availability, capital grant and revenue funding levels had still to be agreed.

For staff employed by the NHS and the council, there was limited evidence that operational staff and managers were better engaged in service planning. They were not well informed about developments including the development of outline strategic commissioning plans. There was a disconnect between strategy development and operational delivery. Our review of staff survey findings confirmed that the partnership had a long way to go to successfully claim to have fully engaged with its own staff in service planning.

Summary
The partnership was preparing the main elements of its joint strategic commissioning plans. It had not yet developed full details on resourced priorities, organisational development, consultation and engagement and anticipated measurable outcomes. **We concluded that the partnership had made limited progress in addressing this recommendation.**

Recommendation for improvement 11

The partnership should develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved by the integration joint board.

We made this recommendation because there were insufficient detailed financial recovery plans to ensure a sustainable financial position for the IJB. The IJB's medium and long-term expenditure profile needed to change towards a balance of care with more community-based and preventative services rather than hospital and care home settings.

The partnership was not alone in facing ongoing significant financial challenges in the delivery of health and social care. The IJB faced an ongoing mismatch between the level of funding available and the projected costs. Demand-led pressures and non-delivery of savings were major factors in its financial position.

Since the inspection, the partnership had set out an agreed financial plan. This had included savings and recovery plans. These were a combination of cash releasing (where costs would reduce as a result of implementation) and productivity gains, (where additional capacity would be available for the same amount of money). The immediate priorities were reducing the backlog of assessment and reviews, reducing hospital delayed discharges and establishing efficient and consistent business processes.

A savings governance board had been established and met fortnightly, chaired by the chief finance officer with a highlight report reviewed by the partnership's senior management team. The full interplay between the recently established improvement implementation group and the savings governance board was just commencing. The IJB audit and risk subgroup assisted with scrutiny of progress. We were unable to assess how successful this was. Given the historic failure to achieve target levels of savings, the savings governance board had yet to look at alternative options.

There was substantial uncertainty on the anticipated achievability of the agreed savings programmes. The identification and achievement of recurring savings was essential to support the long-term sustainability of services. The partnership expected the financial position to become even more challenging with reduced levels of funding in future.

Both the IJB and the partnership had developed separate high-level risk registers. There was an appropriate acknowledgement of some of the financial risks. The actions identified to mitigate these risks were in need of updating and bolstering. The partnership was developing the detail for appropriate escalations.

In 2018/19, the partnership intended to use non-recurring funding and the achievement of savings plans to ensure that a year-end break-even position was achieved. Identified reserves were earmarked. This was to be reviewed to ensure that the earmarked purposes were aligned to the service priorities. The use of non-recurring funding to cover budget shortfalls was not viable on a long-term basis.

Before and following our inspection in 2016, the Scottish Government had provided funding to the partnership to help enable the redesign of services towards prevention, early intervention, anticipatory care and rehabilitation.

The partnership was continuing to use a large proportion of these funds on the maintenance and expansion of the existing profile of services rather than new or different services to better meet people's needs. This included the maintenance of interim care settings and purchasing additional care home placements to address immediate demands.

In the course of our progress review, we found that the IJB's medium and long-term expenditure profile had not changed towards more community-based and preventative services to ameliorate the demand for services in hospital, interim and care home settings. The partnership's progress with its high-level medium-term plans had been limited.

Following the inspection in 2016, the partnership had introduced a chief financial officer to oversee all financial planning. Joint financial planning took place within a 'virtual' finance team. NHS Lothian and the council had their own finance ledgers and finance teams, with a monthly meeting between the two teams. Finance staff from the council and the NHS were involved in the discussions regarding service redesigns arising from the outline strategic commissioning plans, with the exception of primary care. There was a senior finance representative on the respective reference boards. These looked at options to bridge financial gaps. There was a finance representative on the workforce planning group. This work was still in its infancy.

The partnership had not yet fully allocated budgets to locality managers. This might have helped strengthen the partnership's future financial accountability and support locality managers to inform commissioning and service delivery. The council had rebuilt its ledger on the locality structure. It was making changes to organise its ledger to locality cluster level. Around £160m would be delegated to cluster level by the end of 2018/19. NHS Lothian had already delegated budgets to localities.

Locality managers were yet to develop a good understanding of the budgets they were allocated to effectively manage their resources. The partnership planned to introduce monitoring of the updated locality and central expenditure by the partnership's chief financial officer. This would be reported monthly to the executive management team. This was at a very early stage.

Summary
The partnership had developed and was implementing financial recovery plans. There was a recent history of unachieved savings. There was a continuing and significant opportunity cost of not developing community-based and preventative services. There were significant financial risks to the IJB on the ability to fully deliver on the financial plan in the context of the prevailing financial position. **We concluded that the partnership had made limited progress in addressing this recommendation.**

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, and
- waiting lists are managed effectively to enable the timely allocation of services.

We made this recommendation because there were difficulties for people accessing the right services at the right time. There were weaknesses in the routes to access services. Service eligibility criteria were not always applied consistently or clearly articulated to the relevant stakeholders. Waiting lists were not managed effectively to help deliver services when older people needed them.

Since the inspection, Social Care Direct continued to be the main point of referral for locality hub and cluster services. This single point of access had reduced the complexity of referral pathways into healthcare services. The partnership was experiencing ongoing difficulties with Social Care Direct, causing older people to experience problems with access to the partnership's services. There could be delays in calls being answered, responses received and inappropriate referrals to hubs and clusters. Around a quarter of referrals from Social Care Direct to locality services were inappropriate.

At the time of the inspection there were problems with communication between services during the transition from hospital through to discharge. On some occasions, referral information to the community was inaccurate. Examples included people needing more carers than identified, issues with medication and letters not reaching the most appropriate person to arrange correct care. Since the inspection, a project had been established that aimed to improve communication and reduce a significant number of days delayed in hospital by implementing a NHS secure email address for care homes to allow immediate transfer of patient details. This positive initiative relied on short-term funding.

Eligibility criteria were in place for a number of services but there were important omissions. Social work and some healthcare services used eligibility criteria to prioritise older people who had critical or substantial needs. This did not prevent older people and carers in these categories experiencing significant delays for both assessment and the provision of services. Around a third of respondents to our staff survey agreed that joint eligibility criteria for services were consistently applied with nearly the same proportion disagreeing. Eligibility criteria in some services, for example reablement, could change frequently. Staff usually dealt with the most urgent cases. Priority was given to older people awaiting discharge from hospital, which meant older people in the community having to wait longer for services. There were lengthy waiting lists both from referral to assessment and from assessment to service provision. There was a significant backlog of reviews.

Summary

There were continuing difficulties experienced by older people in getting access to services. There were still weaknesses in access routes. Eligibility criteria were still not being applied consistently. There were lengthy waiting lists both from referral to assessment and from assessment to service provision. **We concluded that the partnership had made limited progress in addressing this recommendation.**

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 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, and
- allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.

We made this recommendation because too many people were not being assessed properly or timeously and did not have care plans that addressed their needs fully.

Since our inspection, the number of people in the community waiting for assessment had remained high, with approximately 1,500 people waiting in April 2018. The average time waiting for an assessment had reduced but was still high at 50 days in April 2018. At the time of our progress review, there were significant delays in older people being assessed for and receiving services. The numbers of older people with waiting delays for services was significantly increasing in hospital, interim care and in the community.

Following our inspection, an assessment backlog team was established to address the number of people waiting for assessment. This team was comprised of social workers, reviewing staff, community care assistants, occupational therapists and support staff. This team reported to the assessment and review board chaired by the chief officer. Using outcome-focused assessment approaches, the team had looked at the cases of over 750 people (50 had carers) who were on the assessment waiting list for more than 28 days. The team's work involved (re)screening, clearing out inappropriate referrals and process mapping.

Updated assessments were allocated to social workers and occupational therapists for progression towards service delivery. The assessment backlog team identified people who had experienced lengthy waits and referred them on to appropriate community resources when they did not need social work assistance. Few assessments were handed back to the backlog team. The exercise was completed ahead of schedule.

The team's next focus was to review 60 people with the highest cost care packages, 600 people with transport-related issues and people requiring overnight services. No cost benefit analysis or evaluation of the team's activities was conducted. There was no monitoring to identify whether older people who the team had signposted to community services were in due course re-referred.

The team's approach was not conducive to building skills and resilience in localities. The intention was that good practice and learning from this would be shared and cascaded to localities. The partnership had not developed a programme of learning from this. While the team had been operating, a new backlog of people waiting for assessment had accumulated almost to the same levels as before the team was established.

Following the inspection, the partnership had not carried out a systematic review of assessment and care management standard operating policies, procedures and associated tools. Standard assessment tools continued to be deficit-based and did not help encourage an outcomes-focused approach. Tools were not easy to use and did not support good practice. Information technology systems did not help enable good practice either. The partnership had not succeeded, in many cases, to successfully triage people on waiting lists. This had resulted in waiting lists that did not accurately reflect unmet need.

Senior managers acknowledged that there had been little progress since our inspection in assessment and care management practice. There were still inconsistences in assessment and care planning practice. Substantial numbers of people who experienced services had no recorded assessment of needs. Chronologies had been an issue at the time of the original inspection and remained so. Chronologies were completed more consistently in adult support and protection situations and where older people had a learning disability or mental health problem. The partnership had made some progress in increasing the numbers of older people with anticipatory care plans, particularly for those living in care homes.

The assessment process was still usually lengthy and not person-centred. There were no measures of assessment quality. Staff told us that records showing multi-agency contributions to assessments and care planning were not always available. Assessments and care plans were not always in a user-friendly format. A minority had a comprehensive care and support plan in place. Care plans were often not focused on outcomes but were time and task oriented. Our staff survey reflected this. The results were disappointing in areas such as assessment, care planning and review and the role of staff in delivering these.

Summary
There were major gaps in the prevalence of multi-agency, comprehensive, up-to-date assessments and reviews. Timescales for assessment, care planning and review were in many cases not met and there were significant numbers of people waiting for assessment. **We concluded that the partnership had made poor progress in addressing this recommendation.**

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.

We made this recommendation because we lacked confidence that risk management policies and procedures were being consistently applied and in the partnership's ability to deliver consistent positive public protection outcomes.

Since our inspection, steps had been taken to improve the quality and consistency of practice in risk assessment and risk management. This included the partnership carrying out audits of case records and reviews when there had been an adverse event or large-scale investigations. Case file audits had led to cases with concerns being discussed with locality teams. Locality quality assurance officers were contributing to local adult support and protection locality committees' improvement plans.

An adult support and protection improvement plan had been developed. Adult support and protection processes had been updated. Two adult support and protection lead officers had been appointed to lead on service development and practice improvement. A lead officer chaired every case conference. All inter-agency referral discussions were forwarded to the lead officers for their consideration. The improvement plan had a focus on audit and the management of related improvements. Training was focused on the legal definition of adults at risk, thresholds, risk assessments and escalating concerns.

There was an adult support and protection learning and development plan. Training was targeted at social workers, occupational therapists and their respective seniors. Further sessions were planned on capacity assessment and reflective practice. Most health and social care staff were aware of adult support and protection referral and escalation procedures. Awareness training had been positively received. There had been less of a focus on training for the third, independent and housing sectors.

The partnership had delivered locality adult support and protection workshops with managers and senior social workers on practice standards, barriers to improved performance, support and expectations, thresholds, screening decisions and the need for accurate record keeping. Monthly adult support and protection performance reports were available to hub and cluster managers. The involvement of people who used services in case conferences was improving.

Inter-agency referral discussion and chronologies guidance had been updated. The proportion of chronologies in adult support and protection case records was increasing. The initial assessment included a mini chronology leading to an inter-agency referral discussion. Complex assessments were part of the My Steps assessment. The partnership was developing a replacement tool for assessing risk in adult support and protection.

Risk assessment tools were still not easy for some staff to use and could act as a hindrance to good assessment practice. There was no risk assessment tool outside the My Steps assessments. A high proportion of non-adult support and protection risks, such as the potential for slips and trips, were not identified and recorded. Information technology systems did not help enable good assessment practice. In our staff survey, around two-thirds of staff commented that there was appropriate guidance and tools protect to people from the risk of harm. Some staff reported they did not have suitable professional supervision for adult support and protection work.

At the time of the review, there were six large-scale investigations in care homes underway. There were significant case reviews and inter-agency referral discussions in care homes too. Senior managers had not fully explored the issues behind this.

Adult support and protection governance arrangements were undertaken by the chief officers' group attended by the chief officer. IJB members did not have a good understanding of adult support and protection and had requested briefings and additional information.

Summary
The partnership had made progress in trying to ensure that risk assessments and management plans were recorded appropriately and were informed by relevant agencies in statutory adult support and protection cases. Much work was still to be done to identify, record and mitigate non-adult support and protection risks. **We concluded that the partnership had made reasonable progress in addressing this recommendation.**

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 in staff in all settings so that they can discuss the options of self-directed support with people using care services.

We made this recommendation because there were improvements needed to better enable choice and control for older people and staff should be trained in its delivery. At the time of the inspection, the partnership recognised that despite being committed to making self-directed support[3] a reality, it had not made the progress that it wished to make. Achieving this required a significant culture change.

Following the inspection, the partnership cooperated with the Thistle Foundation to deliver training in good conversations to frontline staff. This aimed to better promote greater choice and control for older people. It took an asset-based approach asking questions of older people and their carers that helped unlock potential additional resources. It helped allow people to explore what really mattered to them and how resourceful they already were.

A small number of staff in particular localities had accessed the good-conversations training and had welcomed it. The training helped staff to deliver more person-centred assessments by moving away from a task-and-time approach. It encouraged staff to think about community support and alternatives to statutory services to help deliver positive outcomes. There were plans to ensure a sustainable model of learning, including training the trainer. The good-conversations training had not been rolled out to larger numbers of staff in all localities. There was ongoing staff frustration at the lack of a suitable asset-based assessment tool to promote an outcome-focused approach to help deliver self-directed support. The partnership had begun to develop such a tool.

Less than half of the respondents to our staff survey agreed that the service worked well with partners to promote the implementation of self-directed support. Long waiting times for assessment or review were adversely impacting on people ability to choose how their care was arranged. There were difficulties accessing information about self-directed support from Social Care Direct. Work was underway to develop a script for Social Care Direct that would help people identify their own strengths rather than the current deficit-based model.

When we returned in 2018, good conversations underpinned a support planning and brokerage pilot in the north-east locality. This aimed to support people to exercise a greater degree of choice over how their care and support needs were met. Early indications showed that in some cases, better outcomes were being achieved at a lower cost to the partnership.

Additional advice, information and brokerage support was available from the Lothian Centre for Inclusive Living to support people who wished to manage their own care and support through a direct payment. The success of this approach relied on community resources being available to meet need.

[3] Self-directed support puts the person experiencing care at the centre of support planning. Options to help deliver the care are: one (direct payments), two (individual chooses the service and the service provider), three (provided for them or on their behalf by the council) or four (a combination of the other options).

On our return, we found that the partnership had made small advances in the total number of people choosing self-directed support options one or two. It had higher than Scottish average rates of people aged over 65 years using direct payments and the related expenditure. However, a lack of community support services had resulted in a lack of choice and limited options for those service users who wished to choose to self-direct their support. The partnership lagged behind the Scottish average on the proportion of people needing support who were choosing how their needs would be met.

Summary
Many staff were not trained to enable self-directed support and practice was not usually underpinned by the values and principles of self-directed support. Standard tools, processes and business systems did not support practice that could have enabled people who experience services to have choice and control. **We concluded that the partnership had made limited progress in addressing this recommendation.**

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.

We made this recommendation because the partnership lacked a shared approach to workforce development that included the third and independent sectors. Identifying the necessary workforce to meet the needs of older people and their carers by attracting, recruiting, retaining and training staff was a significant challenge yet critical to improving outcomes for older people. The strategy's implementation would be critical to the delivery of high-quality services for older people and their carers.

Following our inspection, the partnership's approach to developing workforce planning had initially had a slow start. In late 2017, a workforce development working group led by the chief nurse had been established to develop the workforce strategy. This group had representation from across the partnership. It had agreed the use of a 'six steps' methodology to develop integrated workforce planning. The group identified five key areas for development with subgroups formed to develop plans on workforce data, staff experiences, workforce development, recruitment and retention and third and independent sector issues.

The workforce strategy was due for completion by December 2018. Baseline data on the partnership's workforce had been produced to help inform each subgroup's work. Plans from each subgroup would inform the workforce development working group, the IJB and the emergent strategic plan (2019-22). Priorities included reducing expenditure on agency staff, introducing performance management, the continued monitoring of sickness absence, delivering joint induction and developing recruitment. This work was at an early stage.

Knowledge of this work had not reached all levels of senior or middle management. Other stakeholders were aware of the group but were not always clear about how to contribute. Links between workforce planning and the outline strategic commissioning plans were limited. The pace of change was constrained by the available resources within the locality clusters.

Since the inspection, workforce planning and management had not had the necessary focus and detail. The move to locality hub and cluster structures had occurred without a comprehensive impact analysis on operational procedures or sufficient consideration of the resources required to meet local population needs within each locality. There had been a lack of preparation and support for the development of locality hubs and clusters. Some areas where this was working less effectively had returned to previous ways of working. The partnership's implementation of its new structure had created instability at management and frontline levels across the partnership. This had impacted on the ability to deliver services. There was a lack of confidence evident across a range of staff groups that the partnership had sufficiently identified the effect of the new structure both in terms of numbers of staff and skills.

The reduction in workforce that had occurred through the council's transformation programme was having a significant impact on the ability of the workforce to deliver services. NHS Lothian had made reductions in staff numbers too.

On our return, we found that there was a strong consensus among staff and managers about the difficulties in delivering services. Reductions in staff had led to increased workloads for remaining staff. The loss of professional knowledge and skills had also impacted on the delivery of services, including some strategic planning processes. Morale was low in some professions and locations as staff struggled to cope with demand in the context of reductions in the total workforce.

The local authority social work services' and NHS Lothian's average absentee rates continued to be above local and national targets. The use of agency and bank staff had helped in the short term but this was not sustainable in the long term. This had adversely affected the quality and consistency of care older people received particularly in care homes.

Staff in some areas, for example social workers and allied health professionals, had ongoing concerns regarding professional governance. This had been reviewed and as a result professional leadership for some disciplines was enhanced within the hubs. The professional advisory subgroup of the IJB was consulted on service redesign and consequent staff learning and development. The group had membership from a wide range of professions.

At the time of the inspection, staff were generally well motivated and most felt supported by their immediate managers and colleagues in their own and partner's services. There was a positive approach to integration, based on existing good joint working between health and social work staff at an operational level. There were generally positive working relationships between colleagues across services and this was certainly the experience reported by most staff. Staff were largely positive about how they were supported and about the training they received. Most health and social care staff felt there were opportunities for training and professional development and these generally met professional development needs. Third and independent sector representatives had access to good-quality training but opportunities to participate were very limited.

As was the case across much of the country, recruitment and retention was a significant constraining issue for the partnership. Third and independent sector providers reported difficulties too. Some posts were particularly hard to fill. These included district nurses, social workers, staff for residential care homes and care at home. In response, the partnership had identified some key recruitment initiatives.

Summary
The partnership had been slow to start developing its joint workforce development strategy that involved the third and independent sectors. It aimed to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skills mix. Reasonable progress had been made by the workforce development working group. However, a lack of locality preparation, high absentee rates, recruitment and retention remained significant challenges. **We concluded that the partnership had made limited progress in addressing this recommendation.**

Recommendation for improvement 17

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

We made this recommendation because the partnership needed to better influence the improvements required in the co-ordination of volunteer recruitment, retention and training.

Since the inspection, the previous volunteering strategy, Inspiring Edinburgh's Volunteers – Building on Success 2012-17, had ended. Preparation for the publication and delivery of the new Volunteering and Active Citizenship Strategy 2018-22 was underway. A delivery group had been established to take forward the development of the new strategy to be completed in 2018. The group was undertaking research on volunteer profiling, service mapping, stakeholder consultation and engagement surveys. It had held focus groups with stakeholders including the older people's service provider's forum, NHS Lothian, the council, the partnership's localities and the third sector.

Some third sector organisations who hosted volunteers were facing statutory agency funding reductions and that affected their ability to train and support volunteers. Volunteers were undertaking increasing complex tasks that previously would have been undertaken by paid staff. The loss of the council's dedicated health and social care volunteering team had an adverse impact on co-ordination of volunteers and on the numbers of available volunteers. Funding was not always available within organisations for suitable training.

Volunteering was identified as a cross-cutting theme as part of the outline strategic commissioning plans' preparation. There were very limited links between these plans and actions to support sustainable volunteer recruitment, retention and training. The partnership had yet to work more closely with the third sector interface to better deliver this.

Summary

Managers had a continued awareness of the important role that local communities, including volunteers, could play in the delivery of health and social care. The partnership still did not have a fully shared approach to co-producing and developing community capacity. It was unable to show how local community support services, including volunteering, were supported with measurable actions. **We concluded that the partnership had made limited progress in addressing this recommendation**.

5. Conclusion and what happens next

The joint inspection published in May 2017 identified some strengths in the delivery of services for older people in the city of Edinburgh. It also identified a number of significant weaknesses and where performance was unsatisfactory. We made seventeen recommendations for improvement.

On returning to Edinburgh in June 2018, we saw where the partnership had made progress in areas such as improving the falls pathway, quality assurance arrangements, risk assessment and management planning. The commitment of frontline staff and some managers had been a substantial strength at the time of the original inspection. This remained the case at the time of the review. Where we could see that improvements had been made, these were usually initiatives taken forward by frontline staff and middle managers.

However, we found limited progress overall towards improving the outcomes and experiences of many older people. Key areas for improvement had not been progressed by the partnership. Many older people and their carers did not have the appropriate support when they needed it. It was still not uncommon for large numbers of older people to wait for lengthy periods before getting the support they needed.

We found that there had been a lack of strategic leadership and ownership of the improvement agenda. There was evidence of individual areas of improvement but no overall sense that the most important challenges had been prioritised and planned for strategically. The partnership still had much work to do to make sure that it delivered:

- the right care at the right time and in the right setting
- high-quality services
- care and support for older people which enabled them to be independent, as safe and healthy as possible and have a good sense of wellbeing.

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 discuss with the partnership and key stakeholders the scale and nature of the improvements required, how it intends to make the necessary improvements and what support they will seek to do so. We will report on progress achieved in 2019/20.

December 2018

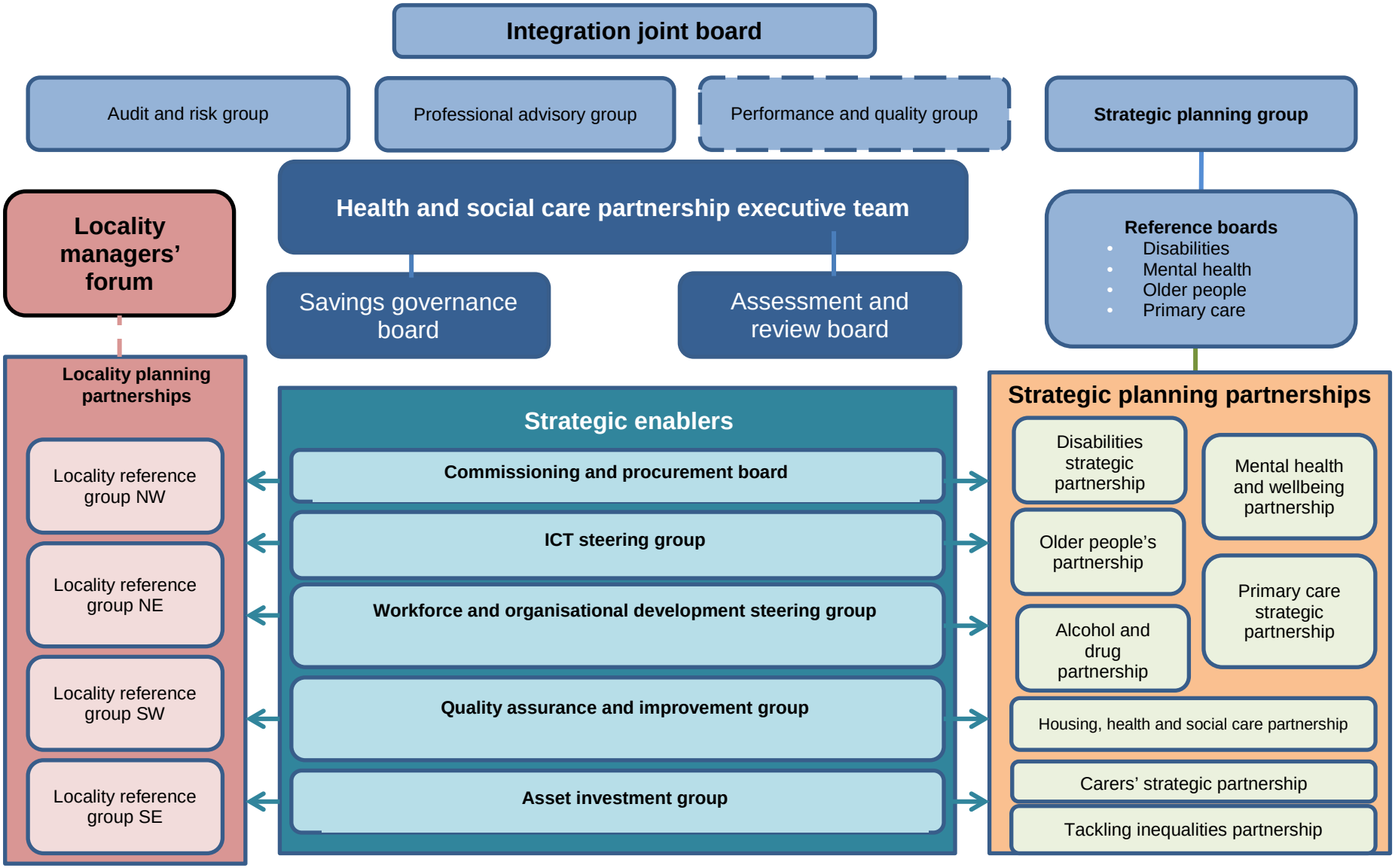
Appendix 1: city of Edinburgh health and social care partnership locality operational structure

The structure comprised of a hub and cluster in four Edinburgh localities.

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 six 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 ongoing care
	• 7-days-a-week out-of-hours GP services, district nursing, emergency out-of-hours social work and emergency homecare

Appendix 2: city of Edinburgh health and social care partnership planning and governance structure



To find out more about our inspections go to www.careinspectorate.com and www.healthcareimprovementscotland.org

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

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

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

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

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.