care inspectorate

Healthcare Improvement Scotland

# Services for older people in the city of Edinburgh

November 2021

Progress review following a joint inspection

HAPPY TO TRANSLATE

**Contents**



This report should be read alongside our original inspection report and the subsequent progress review report on which this review is based. These can be found at:
www.careinspectorate.com

## 1. Background

The Care Inspectorate and Healthcare Improvement Scotland jointly carried out an inspection of services for older people in the city of Edinburgh in 2016 and published the report in May 2017. A subsequent progress review was published in December 2018. The reports are available on both scrutiny bodies' websites.

The purpose of the original joint inspection was to find out how well the partnership achieved good personal outcomes for older people and their unpaid carers. As important weaknesses were found and recommendations for improvement made, a further review was undertaken in 2018 to check progress. Overall, the review concluded the partnership had made limited progress in meeting the inspection recommendations.

As a result, a further progress review was scheduled during 2019/20. This was moved forward to 2020/21 in response to the additional pressures brought about by the impact of the Covid-19 pandemic.

This report makes repeated reference to the partnership's Transformation Programme, which is described in detail in the City of Edinburgh Health and Social Care Partnership's Strategic Plan (2019-2022). This is a long-term programme of change and service redesign related to all adult health and social care. The programme is supported by a project management team and includes a range of work streams. It is important to note that the recommendations for improvement made in the 2017 joint inspection report for older people's services are incorporated into the broader agenda and individual work streams of the Transformation Programme.

## 2. Approach

This review was carried out jointly by the Care Inspectorate and Healthcare Improvement Scotland between January and September 2021. Due to working restrictions because of the pandemic, the review was carried out remotely as a desk-top exercise. Evidence analysed included documents from the Edinburgh Health and Social Care Partnership (EHSCP) and national data.

Our approach included:

- Meetings with relevant officers in the partnership to discuss each recommendation and review the work completed or underway to progress these.
- Analysing a detailed written submission and accompanying evidential documents compiled and provided by relevant officers in the partnership.
- Meetings with officers as needed to receive updates, request additional evidence, and seek clarification.
- Reviewing publicly available national performance data.

## 3. Overview of progress made

Since the progress review of 2018, senior leaders in the partnership had driven forward the change agenda. They had invested resources to progress strategic planning, which had previously lacked vision, direction, and pace. There was a positive shift from a reactionary to a more planned and structured approach.

From the evidence provided for the purpose of this review, the partnership demonstrated good progress against most of the recommendations for improvement. The conclusion highlights the areas of strength and where further improvement is required. There continue to be significant operational pressures, in part because of the challenges brought about by the pandemic. Positively, the partnership has acknowledged these pressures and is working with NHS Lothian and City of Edinburgh Council to identify and manage these and the associated risks.

## 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**

We made this recommendation as the partnership's leadership team needed to better communicate its vision and values alongside developing its capacity to improve.

**What the partnership has done:**

- Produced a revised Strategic Plan (2019-2022) which clearly sets out the vision and values for the EHSCP. This was underpinned by engagement and consultation with a broad range of stakeholders using a variety of approaches. The partnership highlighted seven guiding principles within the Strategic Plan, one of which is engagement, with a stated commitment to generating and improving a culture of engagement and collaboration at all levels.
- Initiated a programme of consultation in February 2021 to inform the revised Strategic Plan for 2022-2025.
- Established a Transformation Programme to take forward plans for service redesign and committed to taking this forward in a spirit of involvement, engagement, and co-production.
- Created a new post of Communications and Engagement Manager.
- Developed its own branding, logo and website and created new communication platforms.
- Held public engagement sessions with members of the Edinburgh Integration Joint Board (EIJB), with plans for more.
- Developed a draft high-level Communications and Engagement Strategy.
- As part of the Transformation Programme the partnership has:
    - taken forward work on the 'Edinburgh Pact', including the community mobilisation project (The Edinburgh Wellbeing Pact or "The Pact", is the EIJB commitment to redefining its relationship with the citizens of Edinburgh and partners. It is underpinned by a shared common purpose: to achieve and maximise the wellbeing of all citizens)[1]
    - begun a process of stakeholder consultation around the redesign of home-based care.

[1] The Edinburgh Wellbeing Pact - Edinburgh Health & Social Care Partnership (edinburghhsc.scot)

**Assessment of progress**

The partnership has made good progress in taking forward this recommendation and embraced new ways of engaging with people. It continued to do so despite the restrictions put in place because of the pandemic, which resulted in more engagement occurring remotely. It developed a range of approaches to ensure the partnership has a clearer public identity and stakeholders have an awareness of the overall vision and the plans taking shape around service redesign. There was evidence of investment in, and a commitment to, engagement and consultation. This was most apparent in the creative and progressive work undertaken to develop the Edinburgh Pact and the consultation carried out to date in respect of the home-based care review.

Significant concerns were raised with the partnership by some stakeholders in respect of the approach taken to the engagement and consultation around phase one of the bed-based strategy. There was a recognition and acknowledgement by the partnership that lessons needed to be learned from this. Investment in meaningful and timely engagement with all affected stakeholders will be required going forward to ensure the partnership's actions reflect the intentions and principles within the Strategic Plan, the Edinburgh Pact and the Health and Social Care Standards. In line with the partnership's communication and engagement vision, the citizens of Edinburgh should be able to have trust and confidence that their views will be sought, heard, and considered.

The partnership acknowledged it has yet to develop and publish a market facilitation strategy. This is discussed in greater detail later in the report under recommendation 9.

**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 early intervention and prevention were under-developed. This was not helping older people to remain in their own homes where appropriate and was a contributory factor to hospital admissions.

**What the partnership has done:**

- Developed a three-year Community Mobilisation Plan.
- Provided alternatives to hospital admission and delayed discharges through the development of 'Home First'.
- Increased the use of Anticipatory Care Planning (ACP) in care homes through use of the 7 steps to ACP approach.
- Recognised the need for, and began to act on, co-production and a partnership approach across the full range of stakeholders to progress improvements and early intervention through the Edinburgh Wellbeing Pact.

- Implemented a Three Conversations (3Cs) model. Three Conversations is an approach enabling open and interested conversations with people and families who need support. [2]It is also about the conversations that people working in the sector have with colleagues and partners – working out how to collaborate to make things happen to help them get on better with their lives. There are three distinct conversations:

    Conversation 1: Listen and connect
    Conversation 2: Work intensively with people in crisis
    Conversation 3: Build a good life**.**

**Assessment of progress**

The partnership progressed the Home First model of service delivery to enhance the availability of support within an individual's own home or in a homely setting. This has contributed to reductions in unnecessary admission and delay in discharge from hospital. The Home First model, together with the Three Conversations and the Edinburgh Wellbeing Pact, are key elements of the Transformation Programme, which aims to support individuals and the workforce across the partnership to improve their own lives and service responses respectively. It is positive to note the particular success in identifying a range of supports and reduced need for paid support demonstrated for people accessing Conversation 1.

Identifying areas where improvement could further support early intervention through planning was demonstrated across 20 care homes and aligned GP practices. Through improving anticipatory care planning the partnership demonstrated a reduction in the number of avoidable admissions to hospital in these services during 2019, enabling residents to continue to receive their care within a homely setting.

By working across the full range of stakeholders together with measuring success in improvement initiatives, the EHSCP extended the scope and range of measures available to improve early intervention and prevention across the partnership. This positive progress demonstrated the application of transformative approaches to deliver on the strategic intention. In addition to the progress made against this recommendation, the intention to review and refresh the commitment to early intervention and prevention will remain in the next iteration of the Strategic Plan. This demonstrated a commitment to finding solutions and approaches that will support sustained progress.

[1] The Three Conversations® – Partners4Change home

**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.**

**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 these recommendations because:

- 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
- there were gaps in the delivery of intermediate care that had adversely contributed to higher levels of hospital admissions and subsequent delayed discharges.

**What the partnership has done:**

- Decommissioned the interim care service based in Gylemuir House.
- Developed community services including Home First, to provide an alternative to hospital admission where appropriate.
- Expanded Hospital at Home provision.
- Reviewed bed-based provision through a whole system approach and plan for service change.
- Taken an eight-stage phased approach to changes in bed-based provision, giving priority to five areas:
    - Relocation of services provided in 40 beds at Liberton hospital.
    - Identification of use and needs of people accessing Hospital Based Complex Clinical Care (HBCCC) beds in Edinburgh (the use of which is proportionately the highest in Scotland). [3]
    - Review of care home provision and estate.
    - Respite delivery (inability to deliver during the pandemic resulted in looking at solutions/different ways of providing respite).
    - Sought alternatives regarding the use of premises at the Astley Ainslie Hospital and the reprovision of care currently delivered there.

[3] DL(2015)11 - Hospital based complex clinical care (scot.nhs.uk)

**Assessment of progress**

The partnership made significant efforts to offer alternatives to hospital admission and identify and develop a bed-based strategy that is part of a whole system review of care within the Transformation Programme. Phase one of the bed-based strategy was presented to the EIJB in June 2021. By adopting a phased approach to a complex process and prioritising each phase, the partnership demonstrated confidence that further improvement can be delivered in the provision of intermediate care.

The move out of Liberton Hospital is yet to take place. The original recommendation has been met in part by the closure of Gylemuir House. The EHSCP adopted a strategic approach to intermediate care across the whole system which was positive. The completion of a clear plan for bed-based resources provided a basis for change. The EIJB requested some additional detail and wider consultation take place around phase one of the bed-based strategy following the Board meeting in June 2021. This was being taken forward and further reports will be presented to the EIJB.

**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.

**What the partnership has done:**

- Re-established the Carer Strategic Planning Group in 2019.
- Developed a Joint Carer Strategy (2019-22) through engagement with relevant stakeholders. This included a short breaks services statement as required by the Carers (Scotland) Act 2016.
- Produced a Joint Carer Strategy implementation plan.
- Invested in areas identified by carers, such as adult carer support plans, independent advocacy, and the further development of short breaks.
- Committed to funding a Carers' Planning and Commissioning Officer.
- Appointed a second carer representative to the EIJB.

**Assessment of progress**

The partnership made good progress with this recommendation. It was positive to note that the clinical, care and governance committee has oversight of the implementation plan for the carer strategy. It is anticipated that the committee will canvass the views of unpaid carers as part of the ongoing oversight of the strategy to ensure the outcomes identified in the implementation plan are successfully delivered.

From the performance data provided it was evident that the number of carer assessments completed was consistently low across all localities over 2020/2021. Though this may be linked to the impact of the pandemic, it is an area which the partnership should review.

**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.

**What the partnership has done:**

- Tested relocation of post-diagnostic support (PDS) within primary care.
- Resourced eight GP practices to provide PDS through one full-time Dementia Support Facilitator.
- Simplified the process for referrals to the memory assessment and treatment service from acute hospitals.
- Increased training and awareness for those staff working in care homes in respect of people who may become stressed or distressed.
- Enhanced access to diagnosis of dementia and support for people living in care homes.
- Identified learning from the Covid-19 response to include a blended approach to PDS delivery within the Alzheimer Scotland contract up to 31 March 2023.

**Assessment of progress**

National data indicated that during the period of the 2018 review, the percentage of people estimated to be newly diagnosed with dementia in NHS Lothian who were referred for PDS (37%) was similar to the Scotland level of 42%. This indicated an improvement in referral rates, though the percentage of patients referred for PDS living in Edinburgh who went on to receive a minimum of 12 months of support was notably lower than in Scotland as a whole. This was recorded as being below the national average (43% compared to a Scotland percentage of 72%). [4]

In the period since 2018 there was evidence of progress in providing a model of care and pathway to support timely diagnosis and support. This work was taken forward by the transformation team within primary care, building on learning from a test of change in North East Edinburgh and strengthening links with the statutory and voluntary sectors to improve access to PDS. The information on performance within local delivery plans provides the evidence, increased level of oversight and awareness within the partnership of the needs of people with dementia. The developments evident reflected the commitment within the partnership to deliver continued improvement for people requiring diagnosis and PDS across all community and care settings.

[4] Dementia Post-Diagnostic Support (publichealthscotland.scot)

**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.

**What the partnership has done:**

- Reviewed the falls pathway.
- Identified responsibility for continuous improvement for older people at risk of falls within the Long-Term Conditions programme.
- Established dedicated Falls Co-ordinators aligned to localities.
- Provided support to identified care homes to improve the prevention and management of falls.
- Increased cross-sector working to enhance community opportunities to prevent and reduce falls.
- Improved the use of measuring performance to inform planning for improvement.
- Circulated falls prevention information to the public, staff, care homes and GP practice teams. Information had been published on the internal webpage for practitioners. The falls prevention pathway was interactive within the website. The updated website had a section on long-term conditions with access available to care homes.
- Created access to a falls service through the Lothian Flow centre. GPs can refer to the HUB in localities and receive a response within four hours. This supported increased profession to profession contact. (Locality HUBS provide short-term input by a multi-disciplinary team). [5]
- Worked with Perth and Kinross HSCP to develop a training resource (poster) for staff working within care homes when someone falls.
- Delivered training to 200 staff working across health social care and in the third sector. This was based on the national falls pathway and was adapted to suit a range of professions and practice.

**Assessment of progress**

The partnership made significant progress in both streamlining the falls pathway and enhancing access to rapid specialist support through the Lothian flow centre. This access had the potential to benefit patients not conveyed to hospital by the Scottish Ambulance Service (SAS) and was an area that should be further developed within the partnership. Data collected by care homes and locally on community alarm responses had informed some targeted activity. However, the data available was

[5] https://services.nhslothian.scot/ecps/PhysioAtHomeAndAssociatedServices/EdinburghHub

limited in its scope and therefore negatively impacted on the ability of the partnership to plan effectively for continuous improvement. An example was a lack of clearly identified reasons for the conveyance to hospital of people experiencing a fall.

It was positive that the partnership had developed an outcomes framework across the Long-Term Conditions programme to improve their ability to assess and measure the impact of the falls programme, using local data, experience, and impact on outcomes.

Increased opportunities to work within the community with the third sector were evident and were successfully utilised during the Covid-19 pandemic, with the risks for those shielding addressed through Staying Active packs in partnership with the Red Cross. This was an example of good practice.

**Good practice example**

**Working in partnership with the British Red Cross, 250 'Staying Active' packs were provided to people who were shielding, and at risk of falls during Covid-19 pandemic. These were widely distributed, through key frontline colleagues, and included crosswords, and suggested exercises to do at home. A further 600 Staying Active leaflets distributed via the City of Edinburgh Council, through the dedicated local assistance/shielding line during lockdown 2020, and the information was also passed onto both internal and external housing support teams.**

The fact that interactive information was available for care homes was positive, but it was not yet in place for care at home services. This was an area which could be extended to benefit people accessing care within their own homes.

Overall, the partnership had put in place a wide range of measures to improve the delivery of falls prevention and response. By utilising local data and identifying responsibility for improvement within the Long-Term Conditions programme, the basis for continuous improvement was substantially improved.

**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.

**What the partnership has done:**

- Worked with the Good Governance Institute to review and improve EIJB governance arrangements.
- Established the EIJB Clinical and Care Governance Group.
- Established the EIJB Clinical and Care Governance Committee in 2019, with the aim of establishing an integrated approach to clinical and care governance.

- Introduced the post of Performance and Evaluation Manager in February 2021.
- Developed and implemented a joint quality assurance framework with the intention of putting in place multi-disciplinary quality improvement teams, reporting into the Clinical and Care Governance Group.
- Reviewed the quality dashboard and created a new reporting template, with a focus on service delivery and its direct impact on the quality of care and support provided.
- Adopted a Quality Management System providing a single, shared approach to planning, assurance and control and improvement. This was successfully applied in one care home to support staff in taking forward the improvement agenda identified from regulatory inspection, resulting in improved grades.
- Reviewed case files.
- Established a virtual Quality Improvement Hub across localities to support on-going and sustainable quality improvement.
- Developed links with NHS Lothian quality academy, with some staff undertaking training.
- Implemented a single approach to managing complaints and supporting improvement.

**Assessment of progress**

Some good progress was made in taking forward this recommendation, improving the partnership's overall approach to quality assurance. The partnership also committed to establishing clinical and care governance teams to support the full implementation of the quality framework.

The partnership does not currently publish the reports submitted to committees, such as clinical and care governance and performance and delivery. This data had previously been published in the EIJB reports. In the interests of transparency, it is recommended that reports are made available on the website. This should include qualitative and quantitative data around waiting lists and waiting times for assessment, services and outcomes achieved as well as actions taken to address these.

The partnership acknowledged more work was needed to embed shared approaches to quality assurance. This was evident in the systems developed so far, which are more clinically focused than integrated.

**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.

**What the partnership has done:**

- Worked to improve relationships and engagement with service providers.
- Established the Sustainable Community Support programme to support improvement in capacity and quality of services under the current care at home contract.
- Carried out an extensive engagement programme around the process of developing a new care at home contract.
- Reviewed day opportunity and short breaks provision.

**Assessment of progress**

The partnership made significant efforts to engage with service providers and other stakeholders, especially given the challenges which arose because of the pandemic. Whilst there was a commitment to producing a market facilitation strategy alongside the development of the revised Strategic Plan (2022-2025), the proposed timescale comes well after the plan set out in the Statement of Intent of 2018 and the implementation of the Transformation Programme. The latter is central to the planning and decision-making around longer-term service re-modelling and provision.

The partnership has begun to report on proposals concerning the closure or repurposing of five of the eleven council owned care homes before developing a full and comprehensive understanding of the city's care home market and implementing a new care at home contract. Since the partnership has not yet developed a market facilitation strategy, there is no evidence to indicate that the partnership has a robust and whole system understanding of the care sector in the city.

Nor is it clear that the partnership has a detailed awareness of what opportunities or risks may be around the medium to longer-term resilience and sustainability of the full range of providers and services across the independent and third sectors. While discussions between agencies to explore these issues have been initiated, they are at a very preliminary stage.

Not having developed an agreed market facilitation strategy could result in over or under provision in some service areas. This could create unnecessary risk for the partnership around capacity and choice, particularly since the majority of Edinburgh's social care provision is purchased from the independent and third sectors.

The partnership acknowledged the importance of dynamic and ongoing conversations with providers. It should prioritise the development of a market facilitation strategy in partnership with communities and the third and independent sectors, which includes a risk assessment and contingency plans. Doing so will help provide a greater level of insight into the social care market in the city by informing proactive risk management, enhancing stakeholder engagement, and supporting robust planning and decision making around disinvestment, investment, and service redesign.

**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.

**What the partnership has done:**

- Reviewed the five outline strategic commissioning plans previously developed, mapping the commitments within these to the Strategic Plan (2019-2022) and the Transformation Plan.
- Consulted on and produced the Strategic Plan (2019-2022).
- Reviewed the progress being made to implement the commitments within the Strategic Plan (2019-2022).
- Established and resourced the Transformation Programme as one of the key mechanisms for delivering the commitments in the Strategic Plan.
- Appointed a Performance and Evaluation Manager in 2021 to support the assessment and impact of the Transformation Programme.
- Reviewed the Strategic Needs Assessment of 2015.
- Developed a high-level draft communications and engagement strategy.

**Assessment of progress**

The partnership made considerable progress in reviewing and taking forward its strategic planning. The focus on service redesign and the establishment of the Transformation Programme for all adult care and support was a positive step in taking forward the strategic commitments and reflected the shift in approach from reactionary to planned. There was also evidence of a better resourced approach to engagement and consultation. The temporary appointment of project management staff helped to increase the pace of progress with this work. The timeline of the

Programme extends well beyond the period of the non-recurring funding in place for the project team allocated from the EIJB reserves. It will therefore be important for the partnership to continue to resource the team so that pace is not lost, and progress continues.

The successful delivery of the commitments within the Strategic Plan is dependent on the management of the EIJB budget. The actions being taken to support this are outlined in the text below within recommendation 11. The partnership will also need to ensure it continues to embed robust, integrated systems and reporting mechanisms to evidence the impact of the changes delivered through the Transformation Programme on experiences and outcomes for older people. So that decisions made about service change and redesign are in line with the ethos of the Edinburgh Pact and the national Health and Social Care Standards, the partnership should continue to invest in and embed a transparent and person-centred approach to all engagement and consultation.

**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.

**What the partnership has done:**

- Strengthened systems and processes for the management and oversight of the EIJB's financial position to support a move away from short term to more planned responses, including the implementation of a Savings Programme Governance Framework in 2020. This was overseen by the Savings Governance Board which reported into the EIJB Performance and Delivery Committee.
- Developed an ambitious savings programme, closely aligned to the development and implementation of the Transformation Programme.
- Adopted an Integration and Sustainability framework aligned to the Strategic Plan in support of longer-term financial planning.
- Achieved financial balance in 2019/2020 and 2020/2021.
- Continued to work with partners to achieve a balanced budget for 2021/2022.

**Assessment of progress**

The partnership reviewed the systems and processes that were in place for monitoring and reporting on its financial performance to ensure these were robust and fit for purpose. The partnership worked hard to reach a balanced budget in 2019/2020 and 2020/2021. It acknowledged that ensuring a sustainable and balanced financial position will continue to be challenging and is dependent on the

successful implementation of changes to the delivery of health and social care for all adults through the Transformation Programme.

The financial challenges faced by the partnership were further exacerbated by the impact of the pandemic. The budget position reported to the EIJB in August 2021 showed a deficit. Tripartite efforts with NHS Lothian and City of Edinburgh Council to move to a balanced budget are continuing. The financial position will require to be closely monitored so that the savings identified, and commitments made within the Strategic Plan are successfully delivered.

**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.**

**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.**

**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 these recommendations because:

- there were difficulties for people accessing the right services at the right time
- too many people were not being assessed properly or timeously and did not have care plans that addressed their needs fully
- there were improvements needed to better enable choice and control for older people and staff should be trained in its delivery.

**What the partnership has done:**

- Invested in the Three Conversations (3Cs) approach as a means of reducing bureaucracy in the assessment process, with the end goal of reducing waiting times and improving personal outcomes. To date, these have been successfully introduced across 11 innovation sites involving around 100 staff. Fortnightly governance and engagement meetings were established involving representation from the third sector to oversee implementation. Evaluative reports were produced to record impact. Staff feedback was also being obtained. There were positive results reported around responsiveness to assessment and meeting need.
- Started to implement a Purchasing Improvement Programme in support of improved policies, procedures, systems, approaches and practice around assessment and care management. Part of this work involved establishing a Good Practice Forum as a platform for staff to engage with senior management, seek feedback, engage with subject matter experts, and support good practice and decision making.
- Started to develop a Learning and Development Programme to support staff. This included improving understanding and application of the eligibility criteria.
- Worked with the council's quality assurance team over 2018/2019 to support evaluation of social work practice.
- Started to pilot a Resource Allocation System to support staff in their conversations with individuals.
- Strengthened leadership and management in locality teams by creating the new post of Head of Operations and improving governance arrangements.
- Established the Home First team to avoid hospital admission and support people to return home.
- Implemented initiatives to improve outcomes for older people through Anticipatory Care Planning.
- Increased the uptake of Options 1 and 2 for self-directed support.

**Assessment of progress**

The joint inspection completed in 2017 evaluated systems for supporting assessment and care management as unsatisfactory. Little progress had been made by the time of the 2018 review. The negative impact on people waiting for assessment or a service response was significant, with some people not receiving a service at all. The approach taken by the partnership to locality working at the time also had a detrimental impact on operational performance.

Data provided by the partnership shows evidence of progress between 2019 and March 2021. There was a substantial increase in care at home provision from 104,000 to 121,000 hours per week. Operational performance also improved in this period around the number of people waiting in the community for a package of care, waiting times for assessment of need, completion of carers assessments and reducing delays in hospital discharge. New initiatives were adopted aimed at reducing bureaucracy, avoiding admissions to acute care, and providing a person-centred and asset-based approach to assessment.

By providing the direction and systems to support improvement, the EHSCP had made progress prior to the Covid-19 pandemic. However, the ability to sustain progress in assessment and provision of new and existing services has been acknowledged by the partnership as an area of significant risk. The longer-term impact of the pandemic across the whole health and social care system both nationally and within the partnership, including workforce challenges, is placing severe stress on service resilience and sustainability. The partnership is working with NHS Lothian and the City of Edinburgh Council to identify, manage and respond to these risks and maintain service responses during the pandemic and Covid-19 recovery.

In the longer term, further work will be needed to fully implement the 3Cs approach and to ensure more extensive and meaningful information is gathered and analysed to understand the impact on personal outcomes and people's experiences. Other areas for further improvement also include reviewing and updating all relevant policies and procedures; more effectively managing waiting lists for care reviews; supporting more individuals to self-direct their care and support and managing staff absence.

**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.

**What the partnership has done:**

- Provided EIJB members with briefings and additional information as requested around adult support and protection.
- Explored the issues behind the number of large-scale investigations, significant case reviews and inter-agency referral discussions with a view to acting on these as required.
- Developed and implemented a new safety risk assessment tool and safety plan in support of easier to use documentation and improved consistency.
- Improved professional supervision for adult support and protection work.
- Improved the identification, assessment and recording of non-adult protection risks.
- Reviewed adult support and protection training across all sectors, with all courses evaluated as a means of checking levels of understanding pre and post training.
- Progressed the involvement of health colleagues in Initial Referral Discussions and associated training needs.
- Improved involvement of people with lived experience of adult support and protection procedures.

**Assessment of progress**

The partnership made good progress in taking forward this recommendation. It acknowledged there is work to do to ensure any further areas identified for improvement are addressed, including learning from significant case reviews.

There will be further exploration of this through the Adult Support and Protection joint inspection programme, which is currently underway across Scotland.

**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 skill 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.

**What the partnership has done:**

- Reported on base line information and data on the workforce to inform planning.
- Extended work within North West locality to include care at home and care at home staff.
- Identified workforce modelling through a recognised methodology ("6 Steps").[6]
- Aligned strategic and operational focus on workforce within a strategy and operations forum.
- Identified recruitment and retention as a key priority within workforce planning.
- Strengthened professional leadership responsibilities across the HSCP
- Increased opportunities for staff engagement, comment, and involvement on 'Working Together' as part of the transformation work.
- Developed strategic workforce plans for Scottish Government.

**Assessment of progress**

The partnership made some progress towards meeting this recommendation through gathering base line data on the workforce across NHS Lothian and the City of Edinburgh Council delivering health and social care services within the EHSCP. A more detailed picture has been gathered for the North West locality by including care at home and care home staff and this was helpful.

[6] http://www.knowledge.scot.nhs.uk/workforceplanning/resources/six-steps-methodology

Following the Scottish Government workforce planning framework an interim plan was developed for approval in August 2021, with a three-year plan in progress for 2022. While the partnership acknowledged medium and longer-term plans may be subject to external changes, the principles of having a 'skilled, supported and sustainable workforce' were central to both planning and the increased communication between strategic and operational activity.

The EHSCP workforce strategy 'Working Together' enabled identification of short-term goals for immediate improvement. This included prioritising recruitment and retention and enhancing staff skills. The partnership also identified areas where they can effect improvement, for example the modern apprenticeships for NHS Lothian and City of Edinburgh Council.

Communication and inclusion of third and independent sectors in discussions about workforce was evident. However, although the implications for these groups along with volunteers and unpaid carers were considered within "Working Together", this was at a less developed stage than the planning for statutory sector staff. The partnership had responded to the planning framework for Scottish Government's National Health and Social Care Workforce Plan (June 2017) with identified timescales for completion of plans. This was supported by clearly defined links between the Transformation Programme workstreams to retain the interaction between service development and workforce planning. This further allows for a response to pressures on services to be identified and adapted during the recovery phase from the Covid-19 pandemic.

**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.

**What the partnership has done:**

- Commissioned Volunteer Edinburgh up to March 2024 to provide support to older people, those living with long-term conditions and other support needs to contribute to improved outcomes by reducing social isolation, enhancing connections, improving self-worth, and improving health and wellbeing. These outcomes are monitored and reported annually and link to the work being carried out to develop the Edinburgh Pact, the Community Engagement Programme and Community Mobilisation.
- Through Volunteer Net, provided flexible support to unpaid carers.
- Reviewed the grant programme to third sector organisations in 2019 with a greater emphasis on the objectives of tacking inequalities, prevention and early intervention and building on community assets.
- Developed the mental health strategy (Thrive Edinburgh) with stakeholders including the third sector.

**Assessment of progress**

The partnership made good progress in taking forward this recommendation, with the development of the Volunteer Strategy currently underway.

## 5. Conclusion

Edinburgh HSCP has made good progress in taking forward the improvement plan developed from the recommendations in the original 2017 joint inspection of older people's services. This includes:

- Making a significant investment in improving its approach to engagement and consultation with stakeholders.
- Developing new approaches to early intervention and prevention.
- Decommissioning the interim care arrangements provided in Gylemuir House.
- Developing and implementing the Carer Strategy (2019-2022).
- Investing in support areas identified by carers.
- Improving access to diagnosis of dementia and post diagnostic support.
- Streamlining the falls pathway, with enhanced access to specialist support and improved delivery of falls prevention and response.
- Reviewing and improving governance arrangements in support of a more cohesive and integrated approach to quality assurance and supporting improvement.
- Updating the Strategic Needs Analysis (2015), consulting on and implementing the Strategic Plan (2019-2022) and progressing with and investing in the Transformation Programme.
- Making improvements to systems and processes which support risk assessments, management plans and training around adult support and protection and non-protection risks.
- Gathering base line data in support of a workforce plan and identifying areas for improvement.
- Implementing new approaches to assessment and care management, strengthening support to practitioners, and reducing waiting times for assessment and access to services.
- Improving links with voluntary partners.

There remain important areas which require further work and resources to support on-going improvement. These include ensuring a dynamic and collaborative market facilitation strategy is developed in consultation with stakeholders as a matter of priority. Additionally, the partnership's commitment to engagement and consultation with all stakeholders should be carried out in a manner that embeds trust and confidence in its actions and approach to decision making about changes to service delivery.

The partnership should continue to closely monitor its financial position, in particular the savings programme and the impact of this on the availability and quality of care and support, and the outcomes experienced by people. Adequate funding needs to be made available to resource the on-going work of the Transformation Programme to ensure pace and progress are sustained. Quality assurance approaches should be fully integrated and effective mechanisms put in place to provide assurance that areas identified for improvement are actioned and learning is shared.

There are extreme national pressures in health and social care currently. There has been acknowledgement by the partnership that there continue to be ongoing challenges, especially around service delivery and building a sustainable workforce. Crucially, there needs to be a continued focus on sustained improvement in overall operational performance. Waiting lists for reviews need to be more effectively managed and progress made towards an increase in the number of people self-directing their care and support.

To conclude, this report provides an overview and assessment of the work undertaken by the EHSCP to meet each of the recommendations. Progress overall is positive. No further review activity is planned, and as such we will continue to work with the partnership to support improvement and monitor progress through our normal contacts.

care inspectorate

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