care inspectorate

Inspection of adult social work and social care services: City of Edinburgh

March 2023

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1. About this inspection

Introduction

The Care Inspectorate's vision is for world-class social care and social work in Scotland, where everyone, in every community, experiences high-quality care, support and learning, tailored to their rights, needs and wishes. Our mission is to provide public assurance about the quality of social work and social care, promote innovation and drive continuous improvement.

Inspection focus

In October 2022, the Scottish Government's Minister for Mental Wellbeing and Social Care requested that the Care Inspectorate undertake an inspection of council services delegated to City of Edinburgh health and social care partnership. The focus of the inspection was to provide independent scrutiny and assurance of how the City of Edinburgh health and social care partnership ensured that:

- adults with incapacity were identified either at the referral stage or during the period when they were waiting for a social work assessment or support
- systems and processes were in place to review and prioritise referrals, including urgent referrals, and those awaiting further assessment or services
- professionals were involved in the oversight and monitoring arrangements in identifying deteriorating circumstances of those awaiting support
- social work leadership was visible
- social work staff had access to suitably qualified managers for supervision and support
- assurance mechanisms were in place to ensure statutory social work duties were being appropriately discharged

The inspection also considered strategic leadership and management activities, including supporting the planning for, commissioning, and delivery of services for people and carers. This was necessary to provide context to the assurances sought by Scottish Ministers.

The inspection team consisted of inspectors from the Care Inspectorate supported by professional staff from the Mental Welfare Commission. They were invited to

support the inspection given their focus, expertise and experience of social work practice with adults with incapacity.

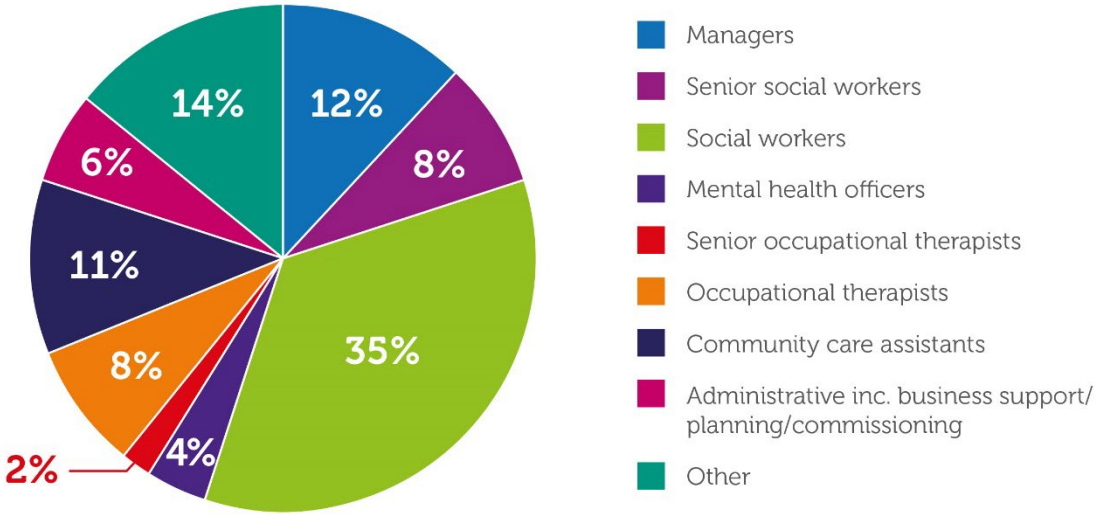
The focus of this report is social work and social care services planned, commissioned and delivered through the City of Edinburgh health and social care partnership. Our inspection findings and key messages are addressed to the wider partnership of which social work and social care services are key elements.

Inspection process and methodology

The inspection took place between November 2022 and March 2023. Our methodology included:

- reviewing publicly available data (for example from Public Health Scotland) and intelligence held by the Care Inspectorate
- undertaking a staff survey with 389 responses
- reading 104 sampled peoples' case files
- hosting 36 focus groups and interviews with a total of 181 frontline staff, managers and senior leaders
- observing practice, including with Social Care Direct, in 39 operational meetings
- reviewing documentary evidence submitted by the partnership
- holding three professional discussions with partnership senior leaders and managers
- participating in discussions with people and carers.

Figure 1: Staff survey respondents



Pandemic

The pandemic saw social care and social work services face unprecedented challenges. The impact of the pandemic on the delivery of social work and social care services in the City of Edinburgh was ongoing. This was evident in challenges in staff recruitment and retention, sickness absence levels and in the remobilisation of some services. This inspection made every effort to understand and account for its impact on the partnership, staff, service providers, people and carers.

Explanation of terms used in this report

When we refer to **people**, we mean adults aged over 18 years old who use social work and social care services. When we refer to **carers**, we mean the friends and family members who provide care for people and are not paid for providing that care.

When we refer to **cases** and **records,** we mean the records of the 104 sampled peoples' case files that we read.

When we refer to the **health and social care partnership**, or the partnership, we mean the City of Edinburgh health and social care partnership who are responsible for planning and delivering health and social care services to adults who live in the City of Edinburgh.

When we refer to **staff**, we mean the people who work in social work and social care services in the City of Edinburgh, as part of the partnership. This included:

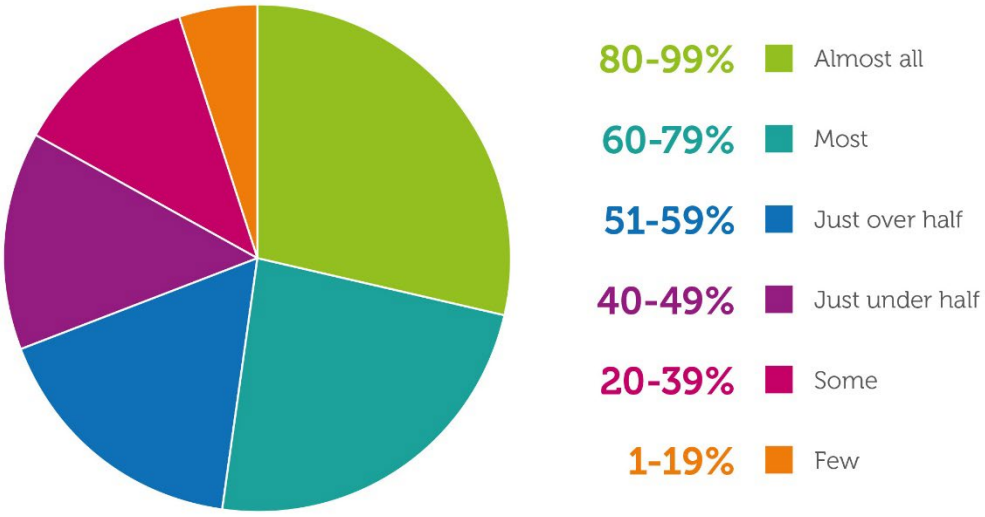
- managers
- senior social workers
- social workers
- mental health officers
- senior occupational therapists
- occupational therapists
- community care assistants
- administrative, including business support/planning/commissioning staff
- others such as care at home and day services staff.

When we refer to **leaders,** we mean the most senior managers who are ultimately responsible for the operation of the partnership's social work and social care services.

There is an explanation of other terms used in this report at **appendix one**.

Note: throughout this report we refer to the proportion of people, carers, staff, or service providers who reported on a particular issue. For example, “where cases that should have had a chronology it was absent in almost all instances”. How we describe these proportions is shown in figure two below.

Figure 2: Data descriptors for percentage scale



Source: Care Inspectorate

2. Our key messages

- There were significant weaknesses in the design, structure, implementation and oversight of key processes, including the assessment of people's needs and in their case management.
- Approaches to early intervention and prevention were uncoordinated and inconsistent.
- Steps had recently been taken to address issues and practice in relation to adults with incapacity.
- Long standing significant delays in discharging people from hospital, people waiting for assessment of their care needs, and meeting vulnerable peoples' unmet needs had recently begun to improve.
- Self-directed support had not been implemented effectively.
- There was insufficient support for unpaid carers.
- Staff were working hard to deliver services but were under considerable pressure and sometimes overwhelmed.
- Most staff experienced and valued positive, responsive and person-centred support from their immediate line manager.
- There had been insufficient strategic leadership and management oversight of key processes, meeting legislative requirements, policies, procedures and guidance and to ensure sufficient capacity and capability to deliver safe and effective services for vulnerable people. The pace of change was generally slow.
- Approaches to self-evaluation for improvement and quality assurance were not well-embedded.
- The partnership did not have effective social work governance arrangements in place. Strategic decisions were not always well informed by a social work perspective.

3. What we found during our inspection

3.1 Key processes

Initial point of referral: Social Care Direct

Referrals received for social work services were initially screened by Social Care Direct call handlers. Senior practitioner social workers supported this. Social Care Direct did not routinely provide advice and information or signpost people and carers to community services. An opportunity for early intervention and prevention was therefore missed. Information about a person's capacity was not gathered routinely at the initial point of contact. Almost all referrals were passed to social work locality teams for further action.

Social Care Direct was also the centralised entrance point for all mental health officer service referrals. These were appropriately passed to the mental health business support team. The mental health officer duty service usually had sufficient staff capacity.

Social Care Direct did not routinely provide information or advice about self-management or building on an individual's personal assets. Call handlers followed a needs deficit, or service led, approach. It was assumed that particular services would be provided and expected that social work locality staff would arrange such provision. A personal outcomes approach was not promoted.

The partnership aimed to improve practice and reduce the volume of referrals progressed to social work locality teams by investing in an initial response team to supplement Social Care Direct. This would be staffed by social workers, occupational therapists, community care assistants and senior practitioners, with an intended focus on early intervention and prevention. Successfully operationalising this team was seen as pivotal to reducing demand pressures on social work locality teams. The initial response team was in the process of being recruited to and was not yet in place.

Screening in social work localities

Senior social workers and senior occupational therapists screened referrals for localities. They spent a disproportionate amount of time on sifting referrals and allocating them to a range of professionals for further action. Just over half of referrals were screened on the same day as they were received. The standard was within 24 hours. Some cases waited longer than five days to be screened in localities.

The partnership had attempted to change its assessment culture and practice by introducing the three conversations (3Cs) approach. However, during locality screening there was mostly no direct contact with the person.

Therefore, these were missed opportunities for the first conversation of the 3Cs, approach, listen and connect, to take place. This might, if appropriate, have supported the person or carer to access community supports and avoid waiting for an assessment for formal services.

There was no clear set of policies and procedures underpinning early intervention and prevention. This led to an inconsistent and uncoordinated approach. Staff did not always view prevention and early intervention as integral to their role. As a result, people and carers had limited access to services when their situation first emerged. Early intervention approaches may have prevented some individuals' circumstances from worsening. Working in preventative ways with people and carers was not fully embedded. This extended to a lack of investment in preventative services such as telecare. The City of Edinburgh was delivering below Scottish average levels of telecare across all age groups.

Staff and managers were mostly unable to undertake early intervention and prevention work due to constantly managing crisis and urgent situations. The volume and complexity of referrals to locality teams was overwhelming for frontline staff and managers. This was compounded by significant amounts of referrals reaching locality teams which could have been dealt with at the initial point of contact with Social Care Direct.

The partnership had aspirations to work with people in the community to prevent hospital admission. Hospital discharge and prevention of hospital admission were afforded an equal formal priority. In reality, the prevention of hospital admission work was secondary due to the pressure to support people out of hospital. A lack of access to services, such as care at home, reablement and respite, hindered the ability of staff to assist people to avoid hospital admission.

Capacity to make decisions is not an all or nothing concept and should be assessed relative to any proposed intervention. The partnership worked to the presumption that the person had capacity. During screening if it was unclear if a capacity assessment had been undertaken, in most cases no further steps were taken to determine capacity. In the few cases where steps had been taken to determine capacity, a record of the outcome of the assessment was present in almost all records. These did not always establish the areas of decision-making which evidenced incapacity. Screening concluded with a decision about assessment priority. In almost all cases we found that risk was correctly and appropriately prioritised.

The social work electronic case recording system was a significant barrier to the efficient processing of referrals. Information about people was inconsistently recorded and difficult to find.

Waiting lists

The partnership had multiple waiting lists operating in each locality. These were for social workers, occupational therapists, community care assistants, mental health officers, reviews and adult support and protection duty to inquire activity. The numbers waiting for each service were high.

Senior social workers, and sometimes senior occupational therapists, were tasked with managing waiting lists. The clear organisational priorities were hospital discharge and adult support and protection. Other work was less of a priority. Demand was ineffectively managed. More than half of people waited longer than procedural timescales on a waiting list for assessment, including beyond statutory guidance timescales. Some people waited between six and 12 months and some waited more than 12 months.

Seniors met regularly to review the circumstances and risk of the people awaiting assessment. Workaround spreadsheet tools assisted seniors to manage waiting lists. Seniors prioritised allocations using a risk rating system. Considerable time and staff resources were invested in these meetings with often no or minimal positive outcomes for most of the people waiting. There were wide variations in the implementation of the process across the four localities.

It was challenging to allocate work as practitioners had full caseloads. Staff worked reactively to crisis and urgent situations, responding mostly to critical need. This was in line with the application of eligibility criteria. Urgent work was sometimes unallocated. The collective volume of risk that seniors had responsibility for was considerable. They constantly balanced assessment of risk to direct limited staff resources effectively. There was some evidence of management oversight and quality assurance of seniors' decision-making. There was limited evidence that this led to an effective management response. Placing these volumes of individual case risk management arrangements on seniors was in itself a substantial organisational risk.

Most people had no ongoing communication with the partnership about their waiting time for assessment. Contact with people while they were on the waiting list was inconsistent. People waiting for assessment, review or service provision were not routinely advised about their expected waiting times. When the person, carer or the referrer initiated further contact, risk was adequately reassessed in most instances. There was an over-reliance on people and carers getting in touch when something

changed, rather than a proactive approach from partnership teams. People were usually required to re-establish contact by going through Social Care Direct again.

This approach assumed people would recognise if their situation was deteriorating and had the ability to get in touch. In some records there was evidence of management oversight of senior workers' decision-making when there was further contact from the person or their carer. Some people on waiting lists were monitored for deteriorating circumstances. In almost all cases no changes in relation to a person's capacity were identified. When it occurred, risk to the person was adequately reassessed most of the time.

In 2020, the partnership committed more focus and resources to managing waiting lists and unmet need. During 2022 there was a notable reduction in the number of people on waiting lists. This was both because of the provision of packages of care and also for other reasons, such as people dying, going into care homes or people finding their own solutions. Teams experienced difficulty in maintaining this level of focus. Some seniors lacked specific training on how to effectively manage waiting lists.

Waiting list dashboards for all localities had been produced. This provided useful management information, comparative data across localities and progress tracking over time. Aside from mental health officers, there were marked inconsistencies across localities in the numbers of assessments waiting for specific staff role types. Across localities significant differences existed in the numbers of people waiting to be assessed, including those waiting for six months or more. The numbers of allocations differed widely too. While dashboards had been produced, the impact of these was limited. There was limited evidence of them being used to effectively manage demand across the city.

The period between first contact and having a completed assessment was lengthier, including those with critical needs, compared to the Scottish average. Average waiting times for an assessment and the hours of unmet need were higher compared to the Scottish average. Long assessment waiting times meant there was significant unmet need as people still had to be assessed. There had been improvements but there were very high numbers of care hours still to be delivered following an assessment.

Assessment

The approach to assessment was often task-centred and in response to crisis. We identified elements of outcomes-focused practice although this was often minimal. Some records did not evidence any focus on personal outcomes. Just over half considered a person's strengths and assets, to some extent.

Most files did not evidence if the assessment had been shared with the person or other relevant practitioners. Whilst some cases evidenced good practice, overall we evaluated the quality of assessment practice was adequate and therefore requiring improvement.

Some assessments presented evidence of concerns about the person's capacity. Just over half of these people had a formal capacity assessment, almost all of these were completed timeously.

Almost all staff indicated they could access policies and procedures relevant to their work. However many were out of date and in need of updating, including assessment and care management policies and procedures. An internal audit had identified more than fifty existing policies and procedures required to be reviewed and updated. Very little progress had been made.

Systems, processes, and procedures did not support social work and social care practitioners to deliver seamless services for people and carers. They did not underpin comprehensive social care assessments and the planning and delivery of care.

Three conversations approach (3Cs)

Staff understood the ethos and principles which underpinned the 3Cs approach. The introduction of the 3Cs intended to improve strength-based practice and reduce bureaucracy. The emphasis was on early intervention, affordability of service provision and improving practice consistency. Almost all staff were critical of the implementation of the approach. There was a lack of procedures and guidance. Supporting tools were reported as difficult to work with. Opportunities to provide feedback about the paperwork had been limited. Suggested changes made by staff had not been accepted. The 3Cs approach had not been rolled out to all teams.

Some social workers in hospitals, occupational therapists, mental health officers, and council officers engaged in adult support and protection did not consider the approach, and particularly the accompanying templates, to be suitable to their work. Most staff considered, that to some extent, they were already practicing in outcomes-focused ways.

Staff were unhappy with multiple approaches and recording options for assessments. Sometimes hybrid approaches developed when workers copied content from previous assessment forms into the 3Cs forms. Some staff thought there was a lack of vision for implementation and timelines had slipped.

Partnership working across sectors regarding the 3Cs had been limited. Service providers had little knowledge of the 3Cs approach and had not received many 3Cs assessments forms. Due to the inadequacy of information on 3C forms, some staff had to provide additional assessment documentation to enable service providers to support the person. This was both time-consuming and inefficient. More often than not the standard of information provided was poor with only minimal information on the assessed needs recorded.

Self-directed support

There had been limited implementation of self-directed support. There was an emphasis on needs and deficits rather than building on people's strengths and finding creative solutions. Implementation of self-directed support had retracted due to services constantly responding to critical situations. In many instances self-directed support was viewed by staff as separate from assessment and outcomes-focused practice. It was viewed as a task rather than an approach to working with people.

Just over half of records evidenced a good conversation which reflected what mattered to the person. Practitioners did not offer self-directed support in a meaningful way. Some occupational therapists believed that it was not part of their role to do so. They lacked confidence and had not had training. People and carers were not given every opportunity to co-produce their supports. They did not understand all the resources available to them, including any constraints to these. Externally commissioned service providers experienced social work staff as lacking in knowledge about self-directed support options.

The partnership had performed, in recent years, above the Scottish average on the proportion of social care funding allocated using direct payments/personalised managed budgets. However, this performance had declined during 2022/23. It could take a long time for direct payments to be put in place. Some people could pay for care and support until their direct payment came through. This created an inequality for people who could not afford to fund their own care in the interim. In some instances, following the direct payments route had become a way of moving responsibility for sourcing support from the partnership to the person or carer.

Risk assessment and management

Most records, where relevant, had evidence of some risk assessment activity. This was often minimal. Some had no evidence of any risk assessment at all. Where it was present the quality of risk assessment activity was good or adequate in broadly equal measures. Where cases should have had a chronology it was absent in almost all instances.

There was evidence of risk management activity in most of the records. In evaluating the quality of risk management activity, just under half were assessed as good with broadly the same proportion rated as adequate. A few were weak. It was difficult to locate where risk assessment and management plans were recorded. This limited managers' or out of hours staffs' oversight to make decisions.

3Cs forms had no dedicated section to record assessed risk or risk management. There was insufficient guidance on recording risk in the 3Cs forms. 3Cs leads positively promoted the 'Keeping Safe and Well' section in conversation three form as a solution.

This inspection overlapped with a joint inspection of Adult Support and Protection[1]. Reference should be made to that report for more detailed information of adult support and protection matters including relevant risk assessment and management.

Care and support planning and service delivery

Accessing community resources, supports and services was challenging for people. Less than half of people had a care and support plan which aligned with their most recent assessment. It could take a long time for a care package to be put in place due to service capacity. The delays increased stress on frontline staff as they managed relationships with people, carers and service providers during the wait. There were instances where urgent care and support packages were not progressed due to lack of service availability. This had increased the stress on people and pressure on carers.

Lack of choice and availability of supports and services limited opportunities for people and carers to make meaningful decisions about their care and support. Arranging services had become increasingly difficult for staff. An excessive amount of paperwork required to be completed to access service provision. Systems integral to delivering assessment, planning and service delivery were overly bureaucratic and

[1] https://www.careinspectorate.com/images/documents/6974/Edinburgh%20adult%20support%20and%20protection%20report.pdf

time-consuming. By the time a service was available the person's needs had often changed and they needed to be reassessed.

Most delays in service delivery were for care at home. The One Edinburgh Command Centre met daily to address the unmet need waiting list. There had been a considerable reduction in the 12-month period to January 2023.

Just under half of people waiting for services were being monitored in terms of risk. Some people waited more than six months to receive care and support. Such delays increased the stress on carers who were required to do more in the absence of formal support services.

Reviews

In just over half of cases there was evidence of review activity. When undertaken, most people contributed to reviews. There was a high volume of welfare guardianship reviews, undertaken by the review teams, involving private guardians that were out of date. In a few cases, individuals were placed at potential risk due to the lapse of legal safeguards. Partnerships have powers available to them to cease or vary frequency of guardianship[2]. Direct payment reviews were often well behind schedule.

Numbers of outstanding reviews had risen substantially over the past three years. The partnership had attempted to focus on reviews using a residential care review team. There was also a review team focused on community packages provided by external care at home service providers. However these teams were often carrying out adult support and protection work instead of their intended role.

Staff had developed workarounds to replace formal reviews. This led to inconsistency of approach. Staff were not able to undertake reviews properly due to workload pressures and staffing capacity issues. Recording reviews on IT systems was cumbersome and time-consuming. Teams had developed their own ways of navigating the system to try to rationalise the volume of recording. Service providers had mostly negative experiences of irregularly held reviews with social work staff.

Individual outcomes

Most people, as a result of the partnership's interventions, had seen changes to their personal circumstances that one would have reasonably expected to see. Just over half of people had achieved positive personal outcomes as a result of the partnership's interventions. For most, these benefits were focused in particular

[2] The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014 (legislation.gov.uk)

areas. These included being able to look after and improve their own health and wellbeing and to live in good health for longer. However, positive outcomes for people and carers were inconsistent. As a result, opportunities to improve the wellbeing for significant numbers of people and carers were missed.

Adults with incapacity

In May 2021 the Mental Welfare Commission published Authority to discharge: Report into decision making for people in hospital who lack capacity[3]. In response, the partnership carried out an internal audit of the legal authority for discharges from hospital to care homes. It identified that between March 2020 and early August 2021, 31% of moves from hospital to care homes in the City of Edinburgh had been unlawful. As a result, the partnership had put in place an improvement plan.

Improvement actions included training for staff in aspects of working with adults who lack or might lack capacity. In addition there was increased management oversight in signing off moves under section 13ZA of the Social Work (Scotland) Act 1968. Most social workers were aware of access to training. Supported by legal services, this offered increased awareness and understanding of relevant legislation. These were the Adults with Incapacity Act (Scotland) 2000, Adult Support and Protection (Scotland) Act 2007 and Mental Health (Care and Treatment) (Scotland) Act 2003.

Managers viewed the training as a positive development although not all relevant staff had accessed it yet. When required, most staff sought advice from, and had good links with, mental health officers in relation to adults with incapacity. Advice was most commonly sought in relation to capacity issues and how to proceed with individual cases. Most staff had access to relevant specialist advice for their work.

Most relevant staff were aware of the Mental Welfare Commission's report and the partnership's internal audit. There had been a shift in awareness of adults with incapacity legislation. Social workers indicated they were more cautious and considered in the use of section 13ZA. There had been training offered and structured conversations about moving people lawfully from hospital.

A hospital-based adults with incapacity team consisting of social workers and mental health officers was a valued resource which assisted with progressing welfare guardianship orders when people were in hospital. Staff reported that this small team provided effective advice to social workers on the appropriate use of 13ZA, restriction of liberty, limitations of section 47 (Adults with Incapacity Act, Scotland 2000) and use of restraint.

[3] https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf

Service demand combined with a lack of service capacity adversely impacted on mental health officers' abilities to fulfil their statutory duties. There was a one-year waiting list of people, across Edinburgh, waiting for private guardianship suitability reports. Based in mental health/substance misuse teams in each locality, the dedicated mental health officer team focused solely on statutory work. Vacancies and sickness absences placed pressure on this service.

There were additionally 20 'satellite' mental health officers. Their contribution to specific mental health officer work was limited as these were in addition to their main social work duties.

The partnership had a similar rate of numbers of mental health officers compared to the Scottish average. However, the level of delivered hours on mental health officers' work was much lower. The partnership had not been fully able to utilise the funding available for training mental health officers due to staff shortages. There was insufficient staff capacity to meet increasing demand. Mental health officers were routinely working over capacity in an attempt to manage basic statutory roles and responsibilities.

Some occupational therapy and care at home staff did not have well developed knowledge or skills in relation to adults with incapacity. They had not accessed formal training on adults with incapacity legislation. They relied heavily on input from social workers. Social workers noted a lack of understanding in the hospital system regarding the centrality of mental health and human rights legislation.

There were difficulties recording or finding information related to a person's capacity. It was recorded on systems in a range of locations. Guidance was also difficult to access. Sharing of information was challenging. It was not possible for staff in locality teams to see information on the NHS Lothian TRAK system. This sometimes included vital information about a person's capacity. Mental health officers with access to TRAK, and with working relationships with psychiatrists and GPs, found it easier to obtain information about capacity.

Social workers were aware of the need to ask whether there was a proxy decision maker in place and, if so, to see copies of legal documents and check the powers. Some locality workers noted difficulties obtaining statutory documents such as power of attorney documents.

When adults with incapacity required support with decision-making, mental health officers were confident about their role in promoting the involvement of independent advocacy. Mental health officers experienced mostly a good response from independent advocacy services who prioritised cases where legal measures were being considered. There was an inconsistent approach to referral and access to

supported decision-making across and within localities. It was dependent on the knowledge, skills and practice of individual workers.

Independent advocacy was more accessible for some care groups than others. Carers' organisations reported highly variable involvement of carers in adults with incapacity processes. In these instances, access to independent advocacy was dependent upon the actions of the individual social worker. In the records few people required individual advocacy support. Most were not referred for independent advocacy. Of those that were, most did not receive it.

Carers

There was inconsistent recording of the preferred outcomes of carers. It was not clear where these were to be recorded. Where there was a carer, more than half had not been offered an adult carer support plan. Being offered an adult carer support plan is a statutory requirement of the Carers (Scotland) Act 2016. For the carers who had been offered an adult carer support plan it was difficult to determine if it had been completed, if support had been provided, or whether it had resulted in positive outcomes.

Staff were unclear about their duties and responsibilities in relation to the Carers Act. Staff had a vague awareness of the carer support team. They did not know about their role and remit or how to refer to them. Locality staff were often involved reactively with carers when care broke down due to carer stress. The lack of support for carers in the community sometimes led to hospital admissions. Carers' organisations noted a large backlog in carrying out adult carer support planning in carer centres due to a lack of training.

Respite could only be accessed, generally, in private care homes. Emergency respite was mostly unavailable. Opportunities for respite and day services had been reduced during the pandemic. Some had been remodelled, some had not restarted, and some had changed their availability. Recovery of services had been partial. These changes to delivery levels were a major source of stress for people and carers. Some carers had experienced the partnership taking back budgets if the provider withdrew or no services were available.

3.2 Impact on staffing

Staff motivation, supervision and support

The lack of available suitably skilled and qualified staff was an ongoing and considerable challenge for the partnership. Staff vacancies, turnover and absences impacted on staff's capacity to undertake their roles and responsibilities as fully and to the quality required and which they desired. Available capacity of appropriately qualified staff to deliver the intended assessment, care planning, service delivery and review outcomes was insufficient.

Staff were mainly clear and confident about undertaking their roles and responsibilities competently. They were committed to their roles and motivated to delivering and improving care and support for people and carers.

Most staff experienced positive, supportive and responsive person-centred management from their immediate line manager. First line managers and the supervision and support they provided were highly regarded by staff. At times, demands on staff and manager capacity reduced the amount of available time for reflection and development discussions within supervision.

Supervision enabled staff to reflect on their practice and to receive appropriate challenge to develop their skills and experience. Almost all staff received regular operational management, support and professional supervision in line with policy timescales and from a senior person in the same profession. Social workers received this from senior social workers. All mental health officers received support and supervision for their work from the mental health officer service manager.

Senior social workers and senior occupational therapists were highly motivated to support staff. Staff appreciated support from senior social workers and senior occupational therapists who they recognised were under pressure. Supervision was routinely provided in line with the minimum standards for the frequency of supervision. When specific cases were discussed in supervision, it was uncommon practice to record this in the social work information system. This adversely impacted the accuracy of potential data reporting around supervision of cases.

A review of the supervision policy and procedure (2018) was overdue. Not all staff were aware of the supervision procedure or policy and there was variable use of the templates. Recording practice was also variable. Some staff had knowledge and experience of the partnership's performance review system but this approach was not consistently used.

The partnership undertook an annual survey of staffs' experience of supervision. Response rates to the most recent survey (2021) were low. The analysis made it difficult to identify issues for particular staff cohorts. There was no specific quality assurance activity around compliance with the supervision policy and procedure. Nor were there mechanisms in place to ascertain the quality of supervision provided to staff and managers. The most recent supervision survey highlighted the need for audits of supervision records and some activity to explore good practice in supervision. There was also a need to create tools to support supervisors' focus on reflection and wellbeing. This had yet to progress. Senior leaders were aware of the need for improved data and oversight of the quantity and quality of supervision. Work to progress this had only recently commenced.

While staff were motivated to deliver quality care and support, protect people and support carers, staff morale was generally low. Existing structures and processes, including length of waiting lists, budgetary restrictions and dealing mostly with critical issues impacted the overall effectiveness of social work staff. It moved them away from their ability to deliver comprehensive assessment and care management. This combined with high vacancy rates adversely impacted on staff wellbeing with both staff and managers feeling tired and overwhelmed. The volume of work was perceived as relentless. Staff were routinely working over capacity and in addition to their contracted hours without additional remuneration. Levels and complexity of staff caseloads varied substantially.

The volume of work was intensifying. Staff did not feel that they were equipped with the essential resources to deliver their job roles satisfactorily, or that their workload was manageable. There was pressure on more experienced staff to manage new and ongoing pieces of adult support and protection work in addition to their existing caseload. This was partly the result of vacancy levels, delays in recruiting staff, employment of agency staff with little or no adult support and protection experience, and limitations on work undertaken by newly qualified social workers. This in turn impacted adversely on staff's capacity to deal with their non-adult support and protection caseloads.

Existing electronic social work information systems impacted adversely on staff's effectiveness, efficiency and ability to timeously record and retrieve information. Recording and inputting work had to be fitted to the requirements of the system rather than supporting the tools and processes utilised by staff. Reduction of business support, particularly for minuting adult support and protection case conferences and adults with incapacity case conferences, was a challenge for social work staff as they were expected to participate in, and minute, meetings.

Staff had been supported to work from home during the pandemic and hybrid working continued. Staff continued to be mostly based at home and undertook visits to people's homes to assess them for care and support. Some staff found hybrid working beneficial from a work/life balance perspective. There were also some disadvantages to this approach. These included a sense of isolation and lone working, particularly when staff were dealing with difficult or distressing calls or home visits. Hybrid working reduced the opportunity for informal peer support and discussion. Teams experienced less cohesion and there were challenges for new staff understanding processes and building relationships with colleagues.

Recruitment, deployment and workforce development

The partnership had produced its Working Together joint workforce strategy 2022-2025. It was in the early stages of implementing this. Working groups had yet to develop detailed timescales and resourced implementation plans to progress the strategic priorities. The pace of progress was slow.

Recruitment and retention were highlighted as key strategic challenges in the workforce strategy. There was consensus among staff and leaders of the challenges in delivering services and caseload management with fewer staff. Building workforce capacity was a key focus of the workforce strategy delivery groups. A series of initiatives had commenced to assist with this. These had not yet had a significant impact.

Robust workforce planning systems that minimised the risks associated with staff's ill health, retirement or staff vacancies were not in place. The workforce strategy did not fully include the third and independent sectors. It was limited in how it took account of existing and future staffing, succession, and absence planning and career structures. Absence rates were generally high and above targets. The partnership had identified specific absence challenges in homecare and reablement, and invested in human resources which focused on those services. The support provided in these services had seen a reduction in sickness absences.

Managers with responsibility for social work and social care staff undertook human resources functions, including the full range of recruitment processes. These were reported to be onerous, complex and time-consuming tasks. While corporate support was available through the partnership's intranet portal, online guidance resources and human resources consultants, managers strongly felt that the corporate support offered was insufficient. Centralisation and rationalisation of corporate human resources support had resulted in unintended consequences for social work

managers and staff. The partnership had recently moved to appoint additional staff to support recruitment activity.

Undertaking recruitment processes significantly adversely impacted on managers' availability for operational matters and supporting staff, further increasing managers' workload pressures. Frontline social work staff experienced higher workloads due to the length of time it took to recruit staff into posts.

A number of factors influenced the potential to successfully recruit new social work and social care staff. These included lower salary scales for new employees compared to neighbouring local authority areas, insufficient volume and quality of applicants, and a higher cost of living in Edinburgh. The partnership had used agency staff extensively as a stop gap between filling vacancies. Some agency staff were inexperienced or newly qualified and therefore were less able to work with complex cases or adult support and protection. They also required additional support from frontline managers.

Leaders recognised that a more strategic approach was required to progress more timely recruitment. Recruitment problems in specific areas had been identified but were slow to be addressed. Scoping was underway to develop a recruitment strategy, which would consider partnership recruitment timescales. Staffing levels were monitored but had not been reviewed in line with changing needs over time. The four locality teams varied in how they deployed workers within teams. The same was the case for mental health officer teams. Staff were unclear about staffing levels and how some services were deployed within the localities in which they were based.

Managers' workloads caused stress as demand was greater than capacity. Senior social workers experienced significant pressure balancing demand, service capacity, risk and overseeing staff, including newly qualified social workers.

Front line managers' roles had expanded beyond operational and human resources tasks, to include more corporate functions such as facilities management and securing IT facilities for staff. Front line managers did not readily have the knowledge or skills to undertake these tasks and required support to do so. These responsibilities were time-consuming and reduced valuable time for operational work and supporting staff.

Training

Prior to the pandemic there was good access to training. Subsequently most training had moved online. Access to training had become more limited. Just over half of staff reported they could access training and development required to deliver their role. Staff capacity to take up learning and development opportunities was often limited to undertaking mandatory courses.

Staff were generally unable to pursue development opportunities as their capacity to undertake training was significantly impacted by the volume and intensity of work.

This limited ongoing development of staffs' knowledge, skills and expertise. This was a source of frustration and dissatisfaction for staff. Almost all staff could access training and development opportunities in relation to adult support and protection. Most staff could access training in relation to adults with incapacity legislation and wider mental health legislation. The ability to share such training with third and independent sector service providers was very limited.

The partnership did not have a learning and development strategy, informed by a training needs analysis to meet strategic priorities, in place. Available learning and development data was not collated. Staff training needs were not routinely audited. Support for learning and development was provided by a small learning and development team within the council which offered consultancy, signposting and developed training in partnership with social work staff. The team did not undertake formal skills gap analysis but reviewed role specific training requirements. There was a mixed approach to consultancy. Learning and development consultants gave advice on accessing training or supported the development of role mandatory training. They worked with subject matter experts to develop or source training.

Adults with incapacity training, developed following the Mental Welfare Commission's Authority to Discharge Report, was a successful example of this mixed consultancy approach. A specific adults with incapacity training needs analysis was undertaken using a mixed approach of focus groups, questionnaires and individual meetings to gain staff feedback. Work was then undertaken with subject matter experts to design and deliver a suitable training programme.

This was delivered using a mixed model of learning, in person and online. The adults with incapacity training needs analysis identified the need for training regarding interplay of protection legislation. 'Working across the acts' training was developed and was being delivered digitally. The partnership did not provide data around numbers of staff that had undertaken the adults with incapacity or working across the acts training. There were no impact analyses provided. Therefore it was not

possible to determine the benefits to practice for staff that had completed the training. There were examples of social work staff taking the initiative to source and develop training. For example, mental health officers proactively sought opportunities for training based on their own training needs analysis. The mental health officers forum also identified specific training to share experience across their workforce. Course evaluations were routinely requested following partnership provided training. There was no formal process for periodic evaluation to routinely generate impact and measure the difference the learning had made to improving staff's practice.

3.3 Strategic management

Strategic and locality planning

The Integration Joint Board's existing strategic plan (2019-22) was intended to be delivered by a transformation programme including the flagship projects of 3Cs, Home First and the Wellbeing Pact. Although Transformation Oversight Meetings continued, the programme's progress was significantly impacted due to the pandemic.

The partnership's planning processes were complex and not sufficiently SMART (specific, measurable, achievable, realistic and time-limited). There was often a lack of detailed implementation plans to inform future investment and disinvestment. Some actions were not fully costed. Delivery timescales were not always clearly identified. It was difficult for the partnership to track how it delivered on its strategic intentions. Opportunities were not always taken to report on the progress or incompletion of actions, or to implement lessons learned from previous actions and plans.

A new draft strategic plan was in preparation and due for publication in April 2023. It helpfully set out the partnership's shared vision, priorities and high-level intentions. It included a summary of the local strategic context, proposed financial planning and market facilitation approaches. Priorities aligned well with other relevant strategies such as the council's local outcome improvement plans and the NHS Lothian Board's Strategic Development Framework.

Many of the existing plan's actions had not been achieved. Much of the new plan's actions were transitioned from the previous version to an innovation and sustainability programme. Project management resources to take this forward were secured. The plan's functional and care group actions included formal care group strategies for mental health and carers. These were not replicated for some other care groups.

Some major service redesign processes had taken substantially longer than intended. This had led to uncertainty among service providers and staff, and people and carers about the future direction of these services.

The partnership was at an early stage of locality planning and commissioning and did not have comprehensive locality plans. It had produced locality profiles. Locality and team level priorities did not always correspond clearly with strategic plans. Service and team level improvement activity in support of the strategic plan could have been better recorded and reported. Service plans that linked to strategic planning priorities were not fully developed.

Strategic planning engagement with a range of stakeholders

The partnership was committed to involving and enabling the participation of a wide range of stakeholders. It had a formal communications and engagement strategy. This set out a range of communication and engagement activities undertaken with a range of stakeholders as part of its strategic planning. A small number of people and carers were meaningfully involved in relevant planning and governance groups. However, the partnership was not routinely collecting and analysing feedback from people and carers receiving services to inform service review and future service delivery.

The majority of service providers informed us that they were broadly content with their engagement. However some service providers' experiences could be substantially improved. Where service providers' forums existed, these were welcomed but, in some instances, these had taken place intermittently.

Third sector service providers generally enjoyed, though not without some reservations, a positive relationship with the partnership. It had representatives in prominent roles on the Integration Joint Board and its supporting bodies. The interface acted as a conduit to the third sector on consultation and provided feedback. The partnership's intention was for third sector service providers to have a greater focus on prevention and early intervention.

The independent sector had a more mixed relationship with the partnership. There were improving relationships with the independent sector service providers. Representatives were actively engaged with the health and social care partnership and its supporting bodies. There were fewer opportunities for independent sector service providers' involvement in planning for commissioning.

Strategic commissioning

There were significant challenges in ensuring local supply, capacity, quality and choice across social care services. The partnership's directly provided services had a minority share in key care markets. Constructive relationships with third and independent sector service providers were therefore essential.

The partnership's understanding of local care markets was improving. It had set out individual procurement strategies for particular commissioning exercises such as those for care at home frameworks. These strategies contained elements of market facilitation. The partnership had yet to produce formal market facilitation statements with accompanying plans.

Bed-Based Care

The partnership's bed-based care strategy focussed on its own direct provision. This fitted in with its strategic intentions for other elements of the care system. There were increasing demands for care placements for people with very complex needs. Bed numbers and provision types were not meeting current and anticipated future needs. This was a sizeable factor in, particularly older, people being unable to access the services they needed, when they needed them, leading to unnecessary hospital admissions. It contributed to delays for people whilst in hospital or bed-based care services and inappropriate admissions to care homes. There was a shortage of intermediate care where rehabilitation or reablement could take place.

The detailed strategy included forecasted numbers of service type beds and location. The proposed balance between intermediate care, health-based complex clinical care and residential care was outlined. The associated broad staffing, revenue and capital requirements were set out. This included increasing intermediate care provision, and replacing some residential care beds with services targeted at delivering complex nursing and dementia care. The strategy was at a very early stage of implementation. It did not fully account for interim care or respite care provision, its access and availability. The partnership had a comparatively very low level of this provision type compared to the national average.

There had been difficulties in delivering the strategy. These included matching needs and demand to sustainable resources. There were substantial numbers of people whose needs or choices were unable to be met within the City of Edinburgh. They were receiving care elsewhere. This was not always as a result of the person's choice. A range of stakeholders were concerned that some placement decisions lacked the full consideration of peoples' and carers' needs.

Care at Home

The interface between hospital, bed-based care and care at home settings was at the fulcrum of the health and social care system. The rate of numbers of people receiving care at home was lower than the Scottish average. The percentage of adults with intensive care needs receiving care at home was lower. The average numbers of care hours received, per person, was higher.

Care at home was a major focus for the partnership, attempting to shift the balance of care towards community settings. There were significant difficulties associated with the ongoing implementation of the existing care at home framework agreement. A procurement strategy intended to improve upon the current framework. Some progress had been made. However, the estimated service commencement date was postponed until early 2024.

The partnership's One Edinburgh approach for directly provided care at home services intended to better deploy underused capacity. This aimed to enable a greater focus on quality assurance, more efficient discharge from hospital and increasing capacity to provide additional reablement. Access to home based reablement was limited. There were some signs that this was beginning to have the intended positive impact. Increasing proportions of new care packages from the directly provided care at home service were receiving reablement. This demonstrated a positive shift to supporting independence through short term intervention. There were continued significant ongoing risks for the partnership for the delivery of care at home services. These included issues such as lack of staffing capacity, unit costs, assessment and care delivery.

Day services

Within the day care market there were major challenges with capacity, choice and service models. The partnership recognised it needed to change the way it delivered day care services, moving on from centre-based models in some instances. It aspired to focus on offering individual day opportunities, with a greater choice of more flexible options for people and carers. During the pandemic, the volume of day services, particularly building-based services, was significantly reduced. Subsequently, some had been remodelled, some had not restarted, and some had changed their availability. Recovery of services was partial. These changes to delivery levels were a major source of stress for people and carers. The partnership had not fully set out the future role of these services or their replacement. Greater clarity was needed on how the partnership would take forward any service reviews and redesigns.

Building capacity in communities

The partnership wished to develop the role local communities played by encouraging third sector involvement in the delivery of preventative services. The partnership had cooperated with the third sector to develop several valuable initiatives. These included, in the previous two years, the Edinburgh Wellbeing Pact. This aimed to create more resilient communities and a sustainable health and social care system. The Pact focused on improving population health and tackling inequalities with a particular emphasis on preventative and proactive care. This work had been assisted by providing extended periods for grant funding and dedicated grant allocations to relevant programmes.

Commissioning, contract compliance and monitoring

Relationships between the partnership's contracts and procurement services teams were productive. Contract management framework and risk assessment tools were used to monitor and report on contract performance. There were gaps in the delivery of the contract management function. This was mainly due to not having sufficient resources to support the effective oversight of the volume of contracts. This constrained contract monitoring activities. The contract management team's capacity to support service providers was also limited. Some service providers were generally not content with the level of contact they had or the support the partnership provided to them. Where support was offered, service providers were very appreciative of the partnership's interest and input. The partnership acknowledged that having market intelligence from externally commissioned services would help make for better informed commissioning decisions.

Financial planning

The partnership faced significant financial challenges. These included maintaining the current service levels into the future. Budget monitoring reported to the Integration Joint Board provided good quality information to assist scrutiny by board members. These reports were detailed, showed projected outturns against partners' budgets, an analysis of key variances, and proposals for dealing with potential funding gaps.

There was an annual financial planning cycle. The financial year started with projected deficits. The means to address budget gaps were identified as the year progressed. At the year-end, an intended balanced budget would be achieved. In 2022/23 the council was forecasting an overspend mainly due to capacity issues in externally commissioned care at home and directly provided care at home, residential and day care services. This was notwithstanding a reduction in over 100 full time posts despite ongoing efforts to recruit. The previous year's budget shortfalls were met in part by underspend, vacancies, Scottish Government recurring and non-recurring funding spend slippage, winter monies and reserves.

The partnership had not yet developed a formal medium-term financial plan, although was working towards developing one. Detailed financial planning did not expressly link to the main priorities in the draft strategic plan.

The partnership had programmes in place to try to ensure a balanced budget for 2022-23. The identification and achievement of recurring savings was essential to the long-term sustainability of the partnership's financial position. The delivery of its innovation and sustainability programme in good time would be essential to meet its savings targets.

IT systems

The council's assessment and care management IT systems were out of date and not fit for purpose. It had created several workarounds to try to address these problems. The council was preparing a business case proposal to develop a new core IT system. However, it could be several years before an improved system could be deployed. The council had invested in the Total Mobile IT system to help improve directly provided care at home services to help deliver improvements.

There was not a coherent strategy to gather and use data to measure outcomes. Partnership staff did not routinely share relevant information where appropriate. IT systems did not provide accurate profiles of need and the range of care and support options. They did not assist with the delivery of seamless, person-centred care.

Performance

Public Health Scotland published an annual suite of integration performance indicators for partnerships across Scotland. The most recent published figures (March 2022) reported that the City of Edinburgh had broadly average levels of performance. For almost all indicators, its performance was in either the second or third quarter, compared to other partnerships in Scotland. There were a few exceptions. It had better performance in the rate of emergency hospital admissions for people aged over 18 years.

The partnership performed less well on the number of days people aged over 75 years spent in hospital when they were ready to be discharged. This was improving during 2022/23. It also performed marginally less well on the proportion of last six months of life people spent at home or in a community setting. Its performance on falls of people aged over 65 years admitted to hospital was also poorer.

Overall, the Care Inspectorate, through inspection of regulated care services, evaluated the partnership's externally commissioned services mostly as good. There were a small number of exceptions in the care home and care at home sectors. Most directly provided regulated care services were generally performing well.

The partnership published an annual performance report. The report set out the performance information across national indicators. There was a coherent structure in place for performance governance, with reporting to the Integration Joint Board through its supporting Performance and Delivery Committee.

Performance management information was improving. However it mostly responded to service-led demands. A draft first structured performance management framework was in development and due for implementation by spring 2023. It proposed information to be reported to the Integration Joint Board, senior management team

and operational managers. It aimed to link performance information and data to the strategic plan, national health and wellbeing outcomes, and the Scottish Government core suite of integration indicators. Links to the national health and social care standards were yet to be developed. It was too early to assess the framework's effectiveness in supporting the measurement and improvement of the partnership's performance.

There was less evidence of a systematic use of national and local performance data to drive identified improvements. Reports that could be used to review the performance of a single team, service or locality were not routinely available.

Performance management reporting did not gather, in the main, qualitative or outcome-focused data. Individual outcomes could sometimes be measured through a review of care and support plans. These were not aggregated or analysed and did not influence service delivery. It would strengthen the partnership's approach to improvement if the emergent performance management framework included personal outcomes as well as more qualitative information. The partnership was not always using its performance management information to identify priority areas for self-evaluation. It had difficulties demonstrating how action plans arising from performance management activities resulted in real improvements.

Quality assurance, self-evaluation and improvement

The partnership's evaluation and continuous improvement activity to better the quality of services delivered, and the experiences and outcomes for people and carers, was not systematic or routine. The partnership had an inconsistent approach to self-evaluation for continuous improvement. It had developed a wide-ranging and well organised social work quality assurance framework. This brought together elements from established quality assurance models rather than following a single method approach.

However much of its implementation had been paused. Therefore quality assurance and self-evaluation approaches were not fully embedded to improve the experiences and outcomes for people and carers across social work and social care services.

The framework was articulated in a service level agreement between the partnership and the council's quality, governance and regulation service, which reported to the Chief Social Work Officer. The agreement had not been signed off. This had led to missed opportunities to review, develop and improve services.

There had been some purposeful self-evaluation activities. There were good examples of audits with recommendations for follow-up actions. These included case audits of Adults with Incapacity subject to hospital discharges and welfare guardianships. Cross sector multi-agency quality assurance groups met regularly to

review the performance of care homes and care at home services. These were useful in highlighting areas of concern and taking forward improvements.

There were robust examples of how the partnership had evaluated the impact of its investment through expenditure in mental health services, services for carers and projects delivered by the third sector. However, this approach, whilst welcome, had not been applied across all major areas of investment. Overall, the partnership, did not have a systematic approach to self-evaluation and subsequent improvement planning at organisational and team level.

Frontline staff's perceptions of the partnership's quality assurance activities, where undertaken, were broadly positive. They were much less confident that improvement activities were monitored and evaluated, or that the quality of services were improving. The partnership did not demonstrate how it identified priority areas for self-evaluation. Much of the activity was reactive. It did not have a strategic and co-ordinated approach to ensure that intelligence gained from quality assurance mechanisms would better influence improvement. The partnership had yet to link self-evaluation activity directly to the strategic plan's priorities to support beneficial performance delivery.

Leadership and direction

The council's work with its main strategic partner, NHS Lothian, was characterised by shared understanding and inter-connected priorities. Leaders promoted a collaborative culture with shared values. Relationships between partners were positive, respectful and supportive.

The Integration Joint Board had been reconstituted following council elections in May 2022. Board members had been appropriately inducted and had received training and briefings in several key areas.

The partnership had commissioned a detailed audit following the publication of the Mental Welfare Commission's Authority to Discharge report. The audit reported in late 2022. Leaders had been fully informed of the outcome of the audit.

The board and its supporting working groups had appropriate memberships. There were reporting links to the council's Policy and Sustainability Committee. Third sector partners valued their input to the collaborative working. Integration Joint Board carers' and citizens' representatives had opportunities to express their views.

The partnership and the Integration Joint Board had strategic risk registers with indicative controls. Leaders had identified that a major risk facing the partnership in progressing operational improvements was its workforce capacity and capabilities. A

detailed joint workforce strategy was in place. More detailed plans, showing how the strategy would be implemented and when, were not in place.

Leaders were aware of some of the other key service areas that were in need of improvement. A weekly Whole System Oversight Group, established in 2022, with senior leader representation focused on service pressures such as delayed discharge and addressing unmet need. There was recent evidence of progress in reducing the numbers of delayed discharges, levels of unmet need and waiting lists. Rates of readmission to hospital within 28 days remained high. There was less evidence of a focus on outcomes for people and carers that could be supported by information on people's experiences.

There was a disconnect between leaders', middle managers' and frontline staffs' views on how well strategic priorities were being implemented. Leaders stated their commitment to shared long-term objectives. The practicalities were that managing shorter term pressures often took precedence over implementing longer-term strategic priorities.

Leaders were not always ensuring that change was effectively managed. Main strategic priorities such as the 3Cs, Home First and Bed-Based Care, or implementing an effective workforce strategy across the statutory, third and independent sectors were not being delivered at a sufficient pace to bring significant dividends across the whole health and social care system.

For most staff, leaders were not visible in driving priorities for change and improvement. Around a third of staff were of the view that leaders had a clear shared vision to improve wellbeing outcomes for people using services. A similar proportion agreed that leaders were visible to, and communicated well with, frontline staff. They would have liked to have seen a clearer link between the strategic vision, service redesign and day-to-day priorities and service delivery.

The partnership had a range of approaches for engagement with its staff. Many staff, at practitioner and team level, whilst aware of the general direction of travel, were not familiar with the detail of key strategic change agendas. Some staff expressed negative views about the level of influence they felt they had in the design of services. Middle managers did not feel involved in most development and improvement activity. There was a need for improvement in the communication between leaders and frontline staff.

Social work governance

The partnership did not have fully effective social work governance arrangements in place. A social work governance group aimed to improve the quality of services, safeguard standards of care, and foster an environment where good practice could grow across the service. This group had suitable representation from a wide range of service areas. It did not have a meaningful influence in strategic decisions that affected social work practice. The Chief Social Work Officer did not attend this body and therefore opportunities to inform and escalate priorities to senior managers were not always readily available. The interface between this group and the partnership's wider clinical and care governance arrangements was limited.

The partnership's clinical and care governance group's remit was to lead in quality improvement and assurance. The group's purpose was to ensure health and social care services were safe, effective and person-centred. The links between this group and social work governance, quality assurance and improvement were underdeveloped. The group recognised that and had taken some steps to develop a more integrated agenda.

The partnership was in the process of recruiting a new post of principal social work officer. It was intended that this post would have responsibilities including improving the oversight of the quality of social work practice in adult services. The post would complement work undertaken by, and be reportable to, the Chief Social Work Officer. The intention was that the post holder would be very visible to social work staff in adult services and provide clarity about professional standards. An updated approach to improving social work governance and developing social work quality assurance initiatives would be beneficial.

4. Conclusions

In the City of Edinburgh there were structural weaknesses in the planning and delivery of services in the health, social work and social care system. This led to areas of service gaps which in turn resulted in too many people and carers not receiving services at the right time or place.

Key processes did not support the delivery of high-quality assessment, care management and reviews. Outcomes - focused practice and self-directed support were not embedded as mainstream ways of working. Frontline staff and their seniors were under considerable pressure working within ineffective systems. They were overwhelmed with the high level of demand.

Strategies to manage demand needed to be better implemented. This needed to include a focus on community assets and self-management. Early intervention and preventative approaches would help support reductions in demand. These might include enhanced access to telecare, information, advice and community resources.

Staff vacancies, turnover and absences impacted on staff's capacity to undertake their roles and responsibilities as fully and to the quality they desired. There was not a sufficiently available capacity of appropriately qualified staff to deliver the intended assessment, care planning, service delivery and review outcomes.

Awareness of, and practice in relation to, adults with incapacity was being addressed. Most social workers were more confident in their understanding of the legislation. Mental health officers were an accessible and knowledgeable resource for staff. Other professionals needed support and training.

Strategic management activities were not always helping to deliver the aspirations that senior leaders wish to see realised. Matching strategic planning ambitions with the actual delivery of high-profile projects had been problematic.

The pandemic had exacerbated the already significant challenges that existed in the planning and delivery of care and support for people and carers. These challenges had negatively impacted on the services and support available for many people and carers. There was a need to develop resilience across the system to meet the further challenges ahead.

Next steps

The City of Edinburgh partnership should prepare an improvement plan. Prioritised actions will be required to ensure that people's and carer's needs are met and their wellbeing improved more consistently. The Care Inspectorate, through its link inspector, will monitor progress. We will discuss with the partnership 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.

Appendix 1: Explanation of terms

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act, every carer has a right to a personal plan that identifies what is important to them and how they can be supported to continue caring and look after their own health. This is called an adult carer support plan.
Adults with incapacity	The Adults with Incapacity (Scotland) Act 2000 defines Adults with Incapacity (AWI) as those adults (people aged 16 or over) who lack capacity to take some or all decisions for themselves because of a mental disorder or an inability to communicate.
Capacity	Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide.
Carer	An unpaid carer of an adult person.
Commissioning	Commissioning is the process by which health and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to.
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.
Contract Management	Contract management is the process that local councils and the NHS use to ensure that services they purchase from other organisations are of a good standard and are delivering at the expected level.
Core Suite of integration indicators	These are indicators, published by Public Health Scotland to measure what health and social care integration is delivering.
Day services	Care and support services offered within a building such as a care home or day centre or in the community. They help people who need care and support, company or friendship. They can also offer the opportunity to participate in a range of activities.
Early intervention	Early intervention is about doing something that aims to stop the development of a problem or difficulty that is beginning to emerge before it gets worse.
Good conversations	Conversations that take place between people, carers and staff. These conversations allow an understanding to develop of what is important to, and for, people and carers on their terms. This allows the identification of desired personal outcomes for the carer.

Term	Meaning
Incapacity	An adult with incapacity is someone who is unable to decide to grant powers to manage their own affairs and is unable to make informed decisions.
Independent sector	Non statutory organisations providing services that may or may not be for profit.
Integrated services	Services that work together in a joined-up way, resulting in a seamless experience for people who use them.
Integration Joint Board	A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities.
Outcomes	The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life.
Pandemic	The Covid-19 pandemic.
Person-centred	This means putting the person at the centre of a situation so that their circumstances and wishes are what determines how they are helped.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse.
Public Health Scotland	A national organisation with responsibility for protecting and improving the health of the people of Scotland.
Rehabilitation	The process of helping a person to return to good health, or to the best health that they can achieve.
Residential care	Care homes – places where people live and receive 24-hour care.
Respite care	Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting but can also be provided via short breaks for the person and/or their unpaid carers.
Scrutiny	The process of carefully examining something (for example a process, policy, or service) to gather information about it.
Self-directed support	A way of providing support that means people are given choice and control over what kind of support they get. It starts with a

Term	Meaning
	good conversation with social work and social care staff about what personal outcomes an individual wants to achieve. There are four options available for arranging support. 1. Option one: a direct payment where the person purchases their own support. 2. Option two: person chooses the service and the provider, and the health and social care partnership organises the support for them. 3. Option three: health and social care partnership identifies and arranges the support. 4. Option four: a combination of the options.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
Social care	Social care means all forms of personal and practical support for adults who need extra support. It describes services and other types of help, such as care and support at home, day services, respite care and residential care.
Social work	Social work provides a wide range of services. These include care services for adults, services for children and families and criminal justice services, including the supervision and rehabilitation of offenders. The statutory framework for social work services covers many different pieces of legislation. The Social Work (Scotland) Act 1968 is the key legislation and places the responsibility for these services with local authorities. For example social work service practice includes social workers' and occupational therapists' involvement in assessment, care planning and management functions.
Third sector	Organisations providing services that are not private or statutory. The term is often used to refer to voluntary organisations but can also refer to community organisations or social enterprise organisations.
Three conversations® (3Cs)	This is a health and social care approach to having open and engaged conversations with people and their carers about the support that they need and working jointly with partners to deliver this. • Conversation 1 is about really listening to understand what was important to people and carers and working with them to make connections and building relationships to help them live independently.

Term	Meaning
	• Conversation 2 involves working intensively with people in a crisis to help them regain stability and control. This requires an understanding of the causes of the crisis, creating an emergency plan, and working with the person to ensure rapid change and a successful plan. • Conversation 3 requires an understanding about what a good life looks like to carers and people needing longer term care and helping them organise support to enable the best quality of life.
Workforce plan	A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met.

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