ITEM 5.9

Report

Joint Inspection – Older People

IJB Board Meeting

16 September 2016

1. Executive Summary

1.1 The purpose of this report is to update the Edinburgh Integration Joint Board, on the forthcoming joint inspection on services for older people by the Care Inspectorate and Healthcare Improvement Scotland.

2. Recommendations

2.1 To accept the report as assurance that the Edinburgh Health & Social Care partnership (EHSCP), is taking a whole system approach to prepare for the inspection.

2.2 Support the EHSCP welcome of the inspection, which will provide a foundation for improvement moving forward.

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014, (the Act), gave the Care Inspectorate and Health Care Improvement Scotland the duty to undertake joint inspections, with the specific requirement for:

3.1.1. reviewing and evaluating the extent to which the independent health care service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes;

3.1.2. reviewing and evaluating the extent to which the planning, organisation or co-ordination of services provided by an independent health care service and social services is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes;

3.1.3. reviewing and evaluating the effectiveness of a strategic plan prepared under section 23 of the 2014 Act in complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes;

3.1.4. encouraging improvement in the extent to which implementation of a strategic plan prepared under section 23 of the 2014 Act complies with the integration

delivery principles and contributes to achieving the national health and wellbeing outcomes; and

3.1.5. enabling consideration as to the need for any recommendations to be prepared as to any such improvement to be included in the report .

3.2 The integration delivery principles of the Act are:

3.2.1 that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

3.2.2 that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—

3.2.3 is integrated from the point of view of service-users,

3.2.4 takes account of the particular needs of different service-users,

3.2.5 takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

3.2.6 takes account of the particular characteristics and circumstances of different service-users,

3.2.7 respects the rights of service-users,

3.2.8 takes account of the dignity of service-users,

3.2.9 takes account of the participation by service-users in the community in which service-users live,

3.2.10 protects and improves the safety of service-users,

3.2.11 improves the quality of the service,

3.2.12 is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),

3.2.13 best anticipates needs and prevents them arising, and

3.2.14 makes the best use of the available facilities, people and other resources.

3.3 The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are aiming to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. By working with individuals and local communities, the Act expects that Integration Authorities (IJBs), will support people to achieve the following outcomes:

No.	National Health and Wellbeing Outcome
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

4. Main report

The Approach

4.1 The approach for the Joint Inspection for Older People Services in Edinburgh has been clearly set out in recent correspondence, and includes:

4.1.1 Partnership Position Statements to be completed
4.1.2 Submission of an Evidence Log associated with the Position Statements
4.1.3 A Staff Survey to be undertaken
4.1.4 Submission of the Top 10 Commissioned Services
4.1.5 Case file reading by the Inspectors
4.1.6 Following up on particular points and cases
4.1.7 A Scrutiny Week
4.1.8 Professional Discussions

Partnership Position Statements

4.2 The Position Statements are based upon key elements that allow the Inspectors to determine our performance against the delivery principles and national health and wellbeing outcomes. The outline of the ten sections for position statements is indicated below, with the full document that includes examples of very good and weak illustrations, which is available on request.

Section 1 - Key Performance Outcomes	**Key Features** Evidence about the real difference and benefits that healthcare and social work services have made to the lives of individual families and communities
Indicator	**Main Areas**
1.1 Improvements in partnership performance in both healthcare and social care	Improvements in performance in health and social work services
1.2 Improvements in the health and wellbeing and outcomes for people, carers and families	Improvements in outcomes for individuals and carers in health, wellbeing and quality of life
Section 2 - Getting help at the right time	**Key Features** This area is about the experience and feelings of individuals, how they understand and appreciate the services provided to them. Individual's perceptions may differ from how the partnership evaluates itself
Indicator	**Main Areas**
2.1 Experience of individuals and carers of improved health, wellbeing, care and support	• Partner agencies have an integrated approach at the most appropriate time to promote and maintain individuals' health, safety, independence and wellbeing. • There is joint action to support individuals capacity for self-care and self-management • There is joint action to support managing long term conditions

	• Systems are in place to obtain feedback about individuals' experiences of using health and social work services. • Individuals receiving support are enabled and supported to make decisions throughout their care experience. • Individuals who are subject to the partnership's adult protection procedures, are safer as a result.
2.2 Improvements in the health and wellbeing and outcomes for people, carers and families	• The partnership has a clear strategy and services in place to support prevention and early and timely intervention. • Individuals are able to timeously access a range of preventative, rehabilitative and enabling services, which are suitable for their needs.
2.3 Access to information about support options including self-directed support	• Partners ensure that readily accessible information is available about supports and services, including self-directed support • Individuals are provided with full information about their needs/condition and any care or treatment they require and their right to Consent. At the point of diagnosis of a long term condition, partners provide early information on appropriate supports and services to individuals and their carers
Section 3 - Impact on staff	**Key Features** This area is about what employees think and feel about working in the partnership. This is about the staff view point rather than the initiatives or measures that managers have put in place.
Indicator	**Main Areas**
3.1 Staff motivation and support Main areas	Staff are motivated and committed to providing high quality support and services. Staff feel well supported and managed, and their workload is managed to enable them to deliver positive outcomes for individuals and their carers. Staff feel that teamwork is effective, including within joint teams.

	Staff understand and are supportive of organisational priorities. They have good opportunities for professional development and to contribute to change planning and change management.
Section 4 - Impact on the community	**Key Features** This area is about the activities used to promote positive community capacity and engagement. This will look at evidence that the characteristics of local communities are understood and there is evidence of community participation.
Indicator	**Main Areas**
4.1 Public confidence in community services and community engagement	The partnership is committed to engaging with and involving local communities in meeting the health and social care needs of the adult population. There are joint strategies to promote and develop community involvement and community capacity. The community is involved in a wide range of identification, early intervention, and support activities such as volunteering, befriending, independent advocacy and time banking. Individuals and community groups value the supports and services provided by the partnership and believe they are effective. Individuals and community groups are positive about how the partnership engages with the public.
Section 5 - Delivery of key processes	**Key Features** This indicator focuses on the extent to which all staff recognise that an individual is in need of care and support. It considers how well information is shared between partners and is used to make decisions. It looks at the timeliness and effectiveness of the help and support provided in preventing difficulties arising or increasing. This will include anticipatory care planning, re-enablement, rehabilitation and self-management
Indicator	**Main Areas**
5.1 Access to support	The partnership has clear procedures and pathways about how supports and services can be accessed that support achievable outcomes. This includes clearly articulated

	arrangements for referrals between partners. These procedures and pathways take account of the need for prevention, early identification and intervention at the right time. The partnership has criteria for accessing services in place, which are consistently and equitably applied. Charging policies are clear The partnership informs individuals and carers who do not meet its criteria for accessing services of possible alternative sources for advice and support and of what to do if their circumstances change
5.2 Assessing need, planning for individuals and delivering care and support	Effective systems are in place for the assessment of individuals' needs. These systems work effectively on a single and multiagency basis. Effective information sharing between partners underpins an approach to assessment, care planning and service delivery which is person centred and focused on individual outcomes. Individuals and carers are fully involved in their assessments and in planning and participate in the co-production of the supports and services they receive. The care and support which individuals and carers receive meets the desired outcomes and assessed needs. Partners jointly review the care and support which individuals and carers receive to ensure that this is achieving the desired outcomes.
5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks	Clear guidance processes and tools support all staff in assessing and managing risk. Competent risk assessments and associated risk management plans are prepared for all individuals subject to risks, and individuals who are subject to significant non-protection type risks that health and social work services have a responsibility to manage. Systems are in place to assess risk to individuals who are receiving self-directed support (direct payment recipients and personal budget holders).

	Adult protection partners effectively work together to robustly investigate adult protection concerns, and subsequently take action to keep individuals who are at risk of harm safe. Joined-up approach to managing risk, which includes systems to evaluate and learn from practice, even when things have gone wrong.
5.4 Involvement of individuals and carers in directing their own support	Listening to individuals and working with them to create personalised approaches to meet their needs. Evaluating individuals' experiences of services and adjusting services responses in the light of these. Support individuals using services to make decisions which allow them to co-produce their supports.
Section 6 - Policy development and plans to support improvement in services	**Key Features** This area is about organisational and strategic management across the partnership and evidence gathered will show the extent that strategies and plans reflect properly the vision of the service. This will show how purposefully you involve individuals and carers in service development. It also covers quality of services and how quality management drives improvement.
Indicator	**Main Areas**
6.1 Operational and strategic planning arrangements	There is a shared vision for services, which is informed by a whole-systems approach and is set out in comprehensive, joint strategic plans for services. These contain strategic objectives, measurable targets and timescales. There are processes and guidance to implement the joint vision, strategies and policies. There is a systematic approach between health and social work managers, which evidences effective management of services and resources across the whole system of care. Priorities set at partnership, team and unit levels reflect jointly agreed plans and priorities.
6.2 Partnership development of a range of early intervention and support services	All partners collaborate to promote and maintain individuals' health and independence. There is a range of integrated interventions and policies that can evidence the integrated approach to support individuals' capacity for self-care and self-

	management including mitigation of risk and the support for long-term conditions. Partners can evidence the effectiveness of their support for individuals to remain within their own communities
6.3 Quality assurance, self-evaluation and improvement	There are joint performance management and quality assurance systems in place. There are clear reporting arrangements for performance information. Joint information systems, which are effective in supporting service development. Key strategic partners involve voluntary and private sector partners, carers and users groups in monitoring the quality of services. Joint performance management and quality assurance drive continuous improvement systems and there are clear plans, which prioritise and implement improvements agreed by partners
6.4 Involving individuals who use services, carers and other stakeholders	There is systematic and comprehensive engagement with individuals who use services, carers, providers and other relevant stakeholders. Planning processes (operational and strategic) incorporate the views of individuals, carers, providers and other relevant stakeholders. Processes are in place to ensure the views of those who are considered hard to reach are gathered and reviewed Individuals who use services and carers are included in planning services, and consulted about changes in policies. Providers and other relevant stakeholders are involved in planning services.
6.5 Commissioning arrangements	Joint strategic commissioning strategies are in place, that identify partnership priorities and resource contribution. Commissioning by partners is able to deliver increasingly personalised services. The views and preferences of individuals and carers inform commissioning. Best value and best outcomes for individuals

	determines the balance between direct provision and purchased services. There are sound monitoring and review systems, including effective collaboration with regulators and scrutiny bodies.
Section 7 - Management and support of staff	Key Features This area is about how staff are supported and managed within the workforce. It also looks at how staff are supported to learn and develop in their roles and in a changing culture how the partnership approaches joint workforce planning and deployment.
Indicator	**Main Areas**
7.1 Recruitment and retention	A joint workforce strategy sets out priorities, identifies possible staffing shortfalls and outlines measure to address shortfalls. Partners evaluate measures to address areas of particular staff shortages and pressures. This is done on a single agency basis and a multi-agency basis. Partners apply safer recruitment practises in order to protect service users. Partners have clear and agreed objectives for shared posts and jointly monitor the posts to ensure that their objectives are fulfilled. Partners are aware of the need for succession planning and are jointly aware of its implications for partnership working. Partners have a culture of valuing, supporting and retaining staff and take appropriate opportunities to harmonise human resource arrangements.
7.2 Deployment, joint working and teamwork	Staff are deployed effectively within and across services to achieve priorities and objectives set out in strategic plans. There is an appropriate employee mix in teams within and across services with an appropriate breadth of skill and experience within and across services. Supervision and employee development systems link individual performance to service objectives.

	Clear systems for line management and access to professional support. There are clear job descriptions.
7.3 Training, development and support	Employees across services receive appropriate management and professional training and development. Joint training is strategically developed and implemented and is open to all partners. There are effective employee development and supervision systems in place. Staff are involved in the strategic planning of training and development.
Section 8 - Partnership working	Key Features This area is about how finances and resources are managed across the partnership and whether there is a whole systems approach where areas such as business support and ICT support the delivery of the right outcomes for individuals and for the respective members of the partnership.
Indicator	**Main Areas**
8.1 Management of resources	There is an increasingly integrated approach between health and social work services which results in effective management and future planning of the range of services and resources across the whole system of health and care. Health and social work services work closely and effectively with other key partners to ensure the best use of the range of existing resources and to plan future resource use in line with agreed shared strategic priorities. Priorities set at partnership, team and unit levels reflect jointly agreed plans and priorities. There is joint financial reporting of all services by key strategic partners
8.2 Information systems	There is a joint ICT strategy with effective information sharing and shared assessment protocols. This includes a coherent strategy to gather and use data to improve outcomes.

	Health and social work services staff have arrangements and share appropriately, information on individuals who use services that is held on the health ICT system and the social work services ICT system. Practitioners and managers use information systems to record performance against a range of key outcomes. IT systems communicate with each other and share information at both an individual and strategic level. Information systems have permissions and security to protect sensitive data. Information systems provide accurate profiles of need and the range of care, treatment and support options.
8.3 Partnership arrangements	Partnerships are strategic and focus on delivering key strategies, plans, and initiatives including self-directed support and early and intervention. Partners regularly evaluate partnership working – and measure partnership benefits in outcomes attained for individuals. There is extensive, effective and well-supported involvement of individuals who use services and carers. There are joint systems for reporting on outcomes.
Section 9 - Leadership and direction that promotes partnership	**Key Features** This area is about the quality of leadership and the contribution of corporate leadership to drive the vision, culture and communicate this with the workforce and the wider population. Effective leadership of strategic and cultural change and improvement that is driven by effective practice and better outcomes for individuals
Indicator	**Main Areas**
9.1 Vision, values and culture across the partnership	There is a clear vision for adult and older people's services with a shared understanding of the priorities. The vision is reflective of national priorities and translates into locally determined outcomes. All are able to articulate local priorities, inclusive of Board & Elected members. There is a supportive and respectful culture with

	explicit shared values which all staff and managers are engaged. High standards of professionalism are promoted and supported by all professional leaders elected members and Board members. Partners can evidence clear links between the vision and the strategic plans.
9.2 Leadership of strategy and direction	Senior managers promote collaboration between social work services and health teams and external partners. There are good examples of partnership working, roles and responsibilities are clear and understood. Elected members and Board members promote partnership working. Leaders of health and social work services have a high level awareness of future trends and joint strategic commissioning. Social work services and health services are aligned with community planning priorities. There is effective clinical & professional leadership for the development and delivery of integrated services and improving outcomes for individuals. Preparedness for health and social care integration.
9.3 Leadership of people across the partnership	Senior managers and other leaders model and promote a positive and respectful engagement with the public and staff. Leadership which promotes high professional standards. Leadership which promotes the development and empowerment of staff at all levels. Other key agencies within the partnership or working on behalf of the partnership are supported in developing strong leadership.
9.4 Leadership of change and improvement	All partners secure improvement in services through rigorous self-evaluation and self-assessment that evidences improved outcomes for individuals Leading continuous improvement through effective change management

	Working with all partners and stakeholders e.g. individuals who user services, carers, voluntary and private sector to achieve effectiveness for the delivery of present and future services
Section - 10. Capacity for improvement	Judgement based on an evaluation of performance against the quality indicators
Judgement about the capacity for improvement hinges on the confidence in important levers for improvement. It is based firmly on the extent to which partners can reliably evidence the following: improvements to outcomes and the positive impact services have on the lives of individuals and carers; effective leadership and management; effective approaches to quality improvement and a track record of delivering improvement; preparedness for health and social care integration. This high-level question requires partners to come to a global judgement and overall statement about the capacity for continued improvement, which is based on evidence and evaluations across the quality indicators.	

4.3 As part of the ongoing improvement approach, the EHSCP has had a group looking at the approach to establish our position against each of the indicators, with the view that we would involve a wide range of stakeholders to develop the position statements and have an early view on our areas of strength and improvement.

4.4 The ratified Position Statements for EHSCP, will be available for circulation at the IJB Board Meeting

4.5 This approach has been overtaken by the notice that we are to be inspected, and the group are now bringing forward the development of the position statements with a workshop on the 15 August being held to ensure people can contribute to, and own the submitted statements. At this event, we will establish what people consider are our areas of strength, where the key evidence to support this is, and where the areas for improvement may be, against the sections above.

Timeline

4.6 There is a clear timetable of deadlines for submission of key documents and for elements to take place, which are highlighted below:

Element	Key Deadline	Full Process for Inspection
Staff Survey Sample - Job Titles of Senior Teams	19.08.16	Survey issued 29.08.16 Confirmed number of people survey sent to 02.09.16 Survey closes 23.09.16
Submission of Advanced Information Associated with the Position Statements	26.08.16	
Case File Sample	26.08.16	Health Record Tool Template 23.09.16
Partnership Position Statements	26.08.16	
H&SCP Organisational Chart	26.08.16	
Top 10 Commissioned Services	26.08.16	
File Reading Week	17. 10.16	Confirm Local File Readers x2 SW/X2 NHS 26.08.16 Database Training 14.10.16
Follow Up Week	07.11.16	Cases to be identified by 31.10.16
Scrutiny Week	21.11.16	Core Sessions and Daily Timetable to be complete by 14.11.16
Professional discussions	Ongoing	
Report Back	TBC	For discussion at initial meeting with Inspectors 12.08.16

4.7 There is an initial meeting with the Inspectors on the 12th August 2016, where there will be the opportunity to discuss the elements above in more detail.

5. Key risks

5.1 There is a sense of urgency associated with the preparatory work now, and there is a risk that if this is not sufficiently supported, key areas of good practise, evidence and identification of areas for improvement will be missed. This is being mitigated by the EHSCP Joint Inspection Group ensuring that there is appropriate support to arrange sessions in a timely manner.

5.2 There is a risk that staff don't feel informed or supported throughout the process. This is being mitigated by the inclusion in the workshop on the 15 August, and ongoing involvement sessions going forward, with the EHSCP Executive Group taking a responsibility to inform and support people at every opportunity. This will also allow the EHSCP to develop a continuous improvement programme moving forward, based on the initial position statements.

6. Financial implications

6.1 There is likely to be a requirement to enhance the administrative support for the next five months to ensure that the operational organisation of the process is well coordinated and cohesive. This is yet to be quantified.

6.2 There may be implications arising from the recommendations that have cost implications, and these will be worked up once the recommendations are made.

7. Involving people

7.1 As indicated above, there will be involvement of as many health and social care staff, third and independent partners, as possible, as well as engagement with carers and service users as part of the overall process, in preparation for the inspection, and as part of the ongoing continuous quality improvement process.

8. Impact on plans of other parties

8.1 Key learning will be applied to all care groups in the EHSCP going forward.

Background reading/references

Public Bodies(Joint working) (Scotland) Act 2014:
http://www.parliament.scot/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32bs4-aspassed.pdf

Edinburgh's Joint commissioning Plan for Older People 2012 -22 – Live Well in Later Life:
http://www.edinburgh.gov.uk/transformedinburgh/downloads/file/22/live_well_in_later_life_edinburghs_joint_commissioning_plan_for_older_people_2012-2022

Report Author

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Links to actions in the strategic plan

All actions in the strategic plan will be affected by recommendations from the inspection about how we can further improve our approach to meeting the strategic actions for older people, and more integrated working.

Links to priorities in strategic plan

All priorities in the strategic plan will be affected by recommendations from the inspection about how we can further improve our approach to meeting the strategic actions for older people

Edinburgh Health and Social Care Partnership

Joint Inspection for Older Peoples Services

August 2016

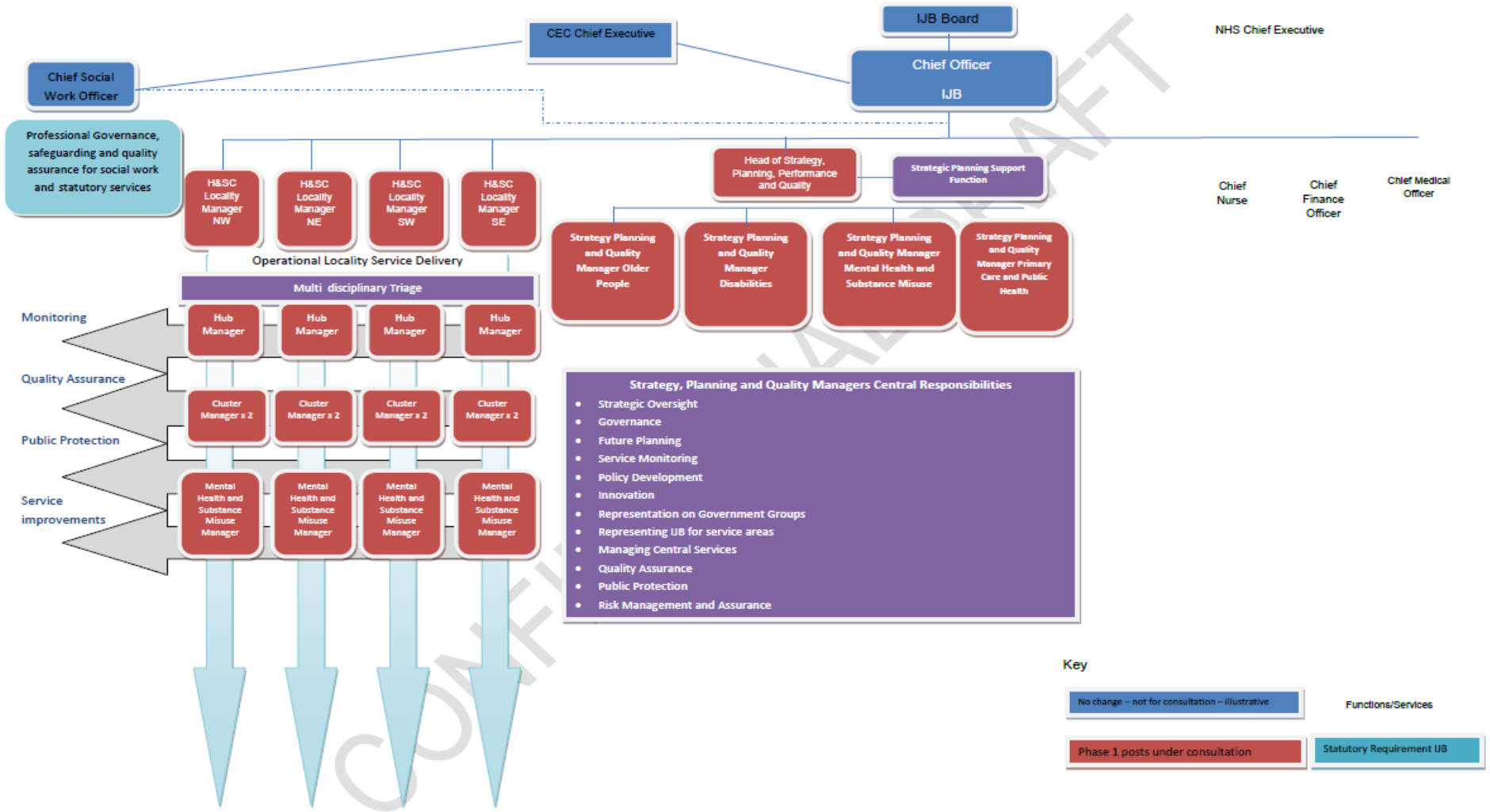
NHS Lothian · EDINBVRGH · THE CITY OF EDINBURGH COUNCIL

Working together for a caring, healthier, safer Edinburgh

Edinburgh is a diverse city with many different communities of both geography and interest that have varying levels and types of needs in terms of health, social care and wellbeing. Although the population of each of our four localities is similar in size, there are big differences in life expectancy, life chances and health and wellbeing both between and within localities. The total population of Edinburgh is estimated to be 487,500, and is predicted to grow by 11% between 2012 and 2022, faster than any other area of the country. Those aged 65 or over make up 15% of the population and the number of people aged 85 is projected more than double by 2037 rising from 10,100 to 21,300 (an increase of 110%). Whilst it is a cause for celebration that people are living longer, it presents challenges to Health and Social Care for the delivery of services for older people.

Edinburgh Health and Social Care Partnership
Integrated Inspection for Older People

NEW INTEGRATED ORGANISATIONAL STRUCTURE



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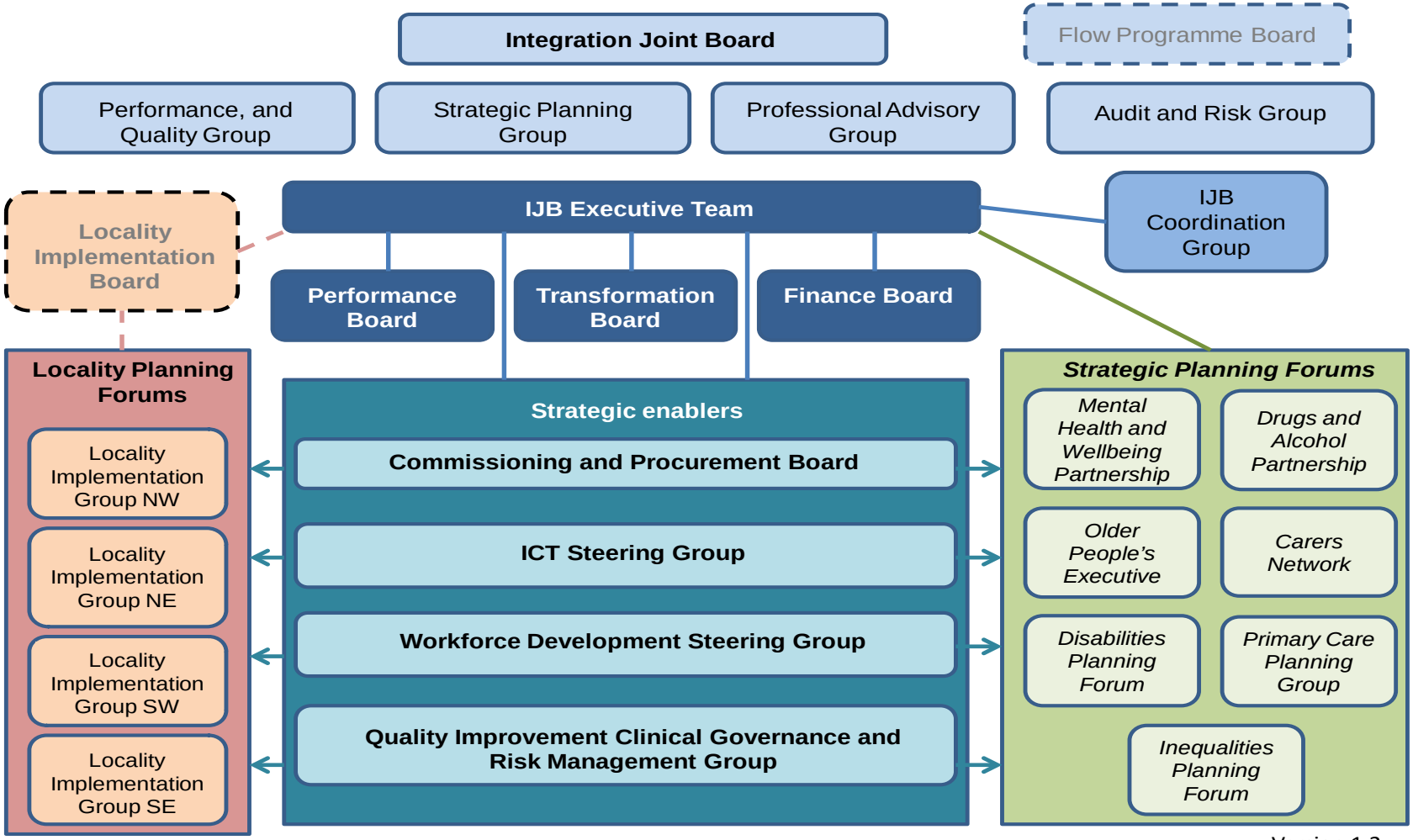
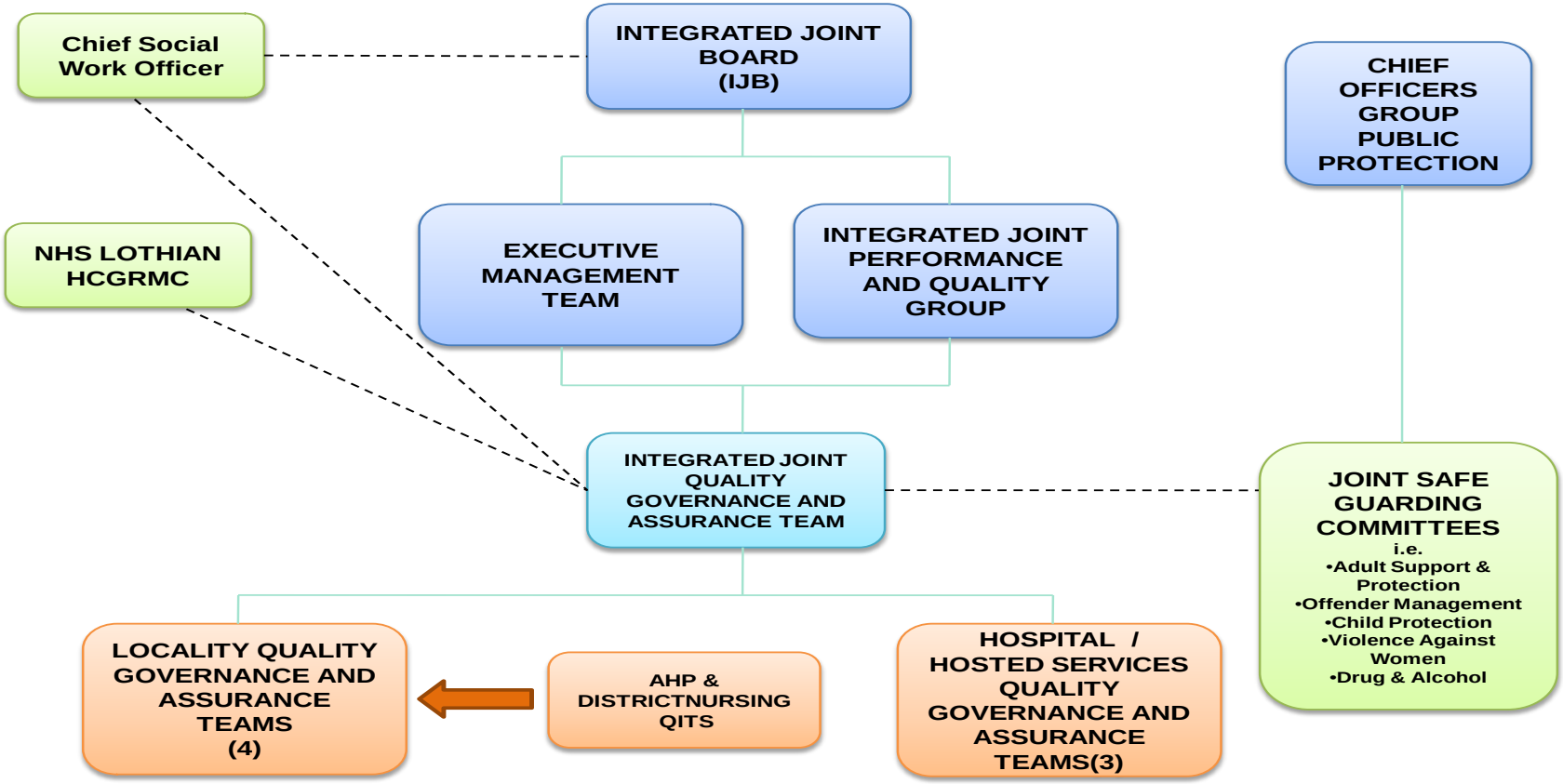
Integrated Inspection for Older People

GOVERNANCE AND PLANNING STRUCTURE



Version 1.2

CLINICAL, CARE AND RISK MANAGEMENT GOVERNANCE STRUCTURE



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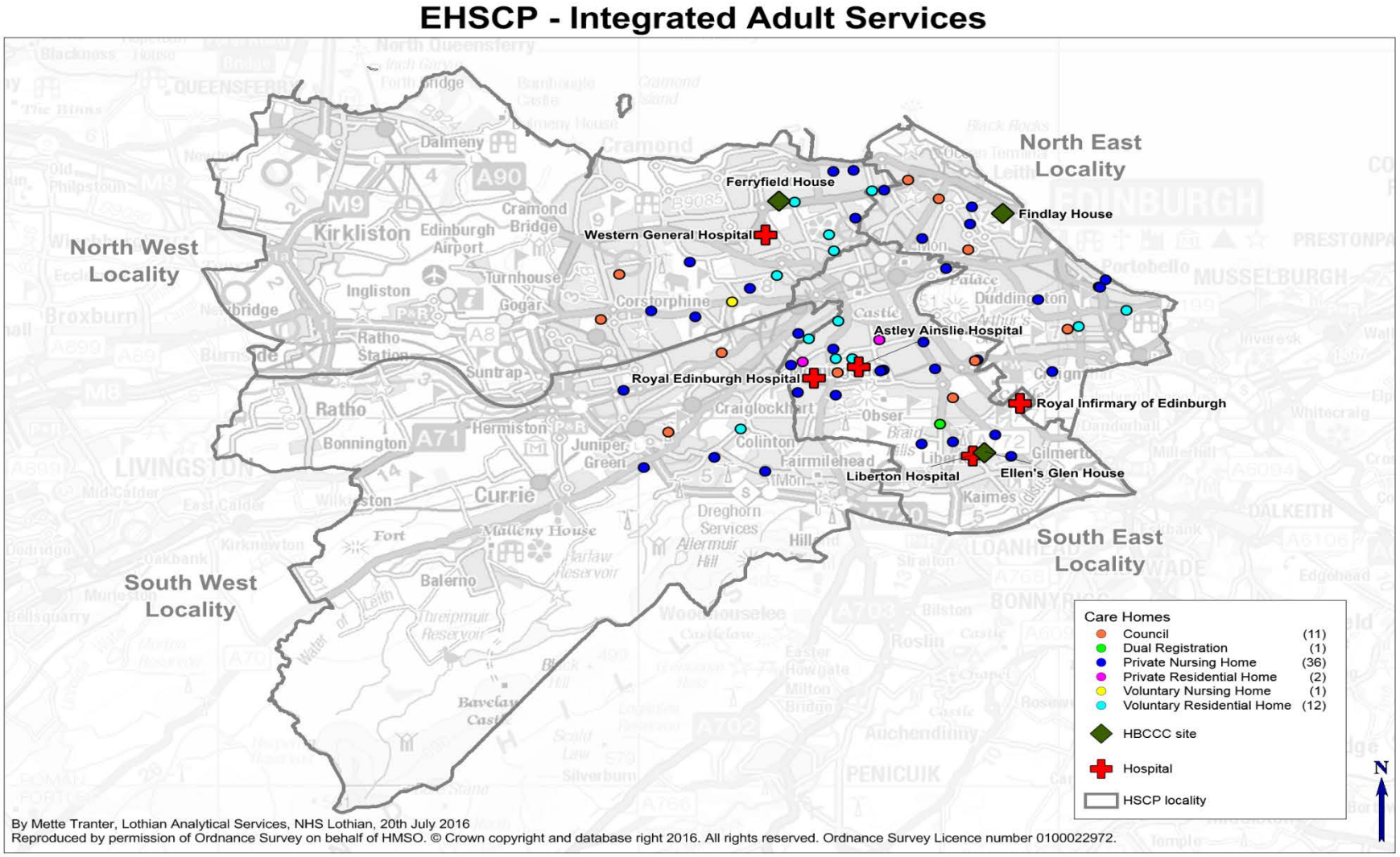
Integrated Inspection for Older People

OLDER PEOPLE SERVICES IN EHSCP



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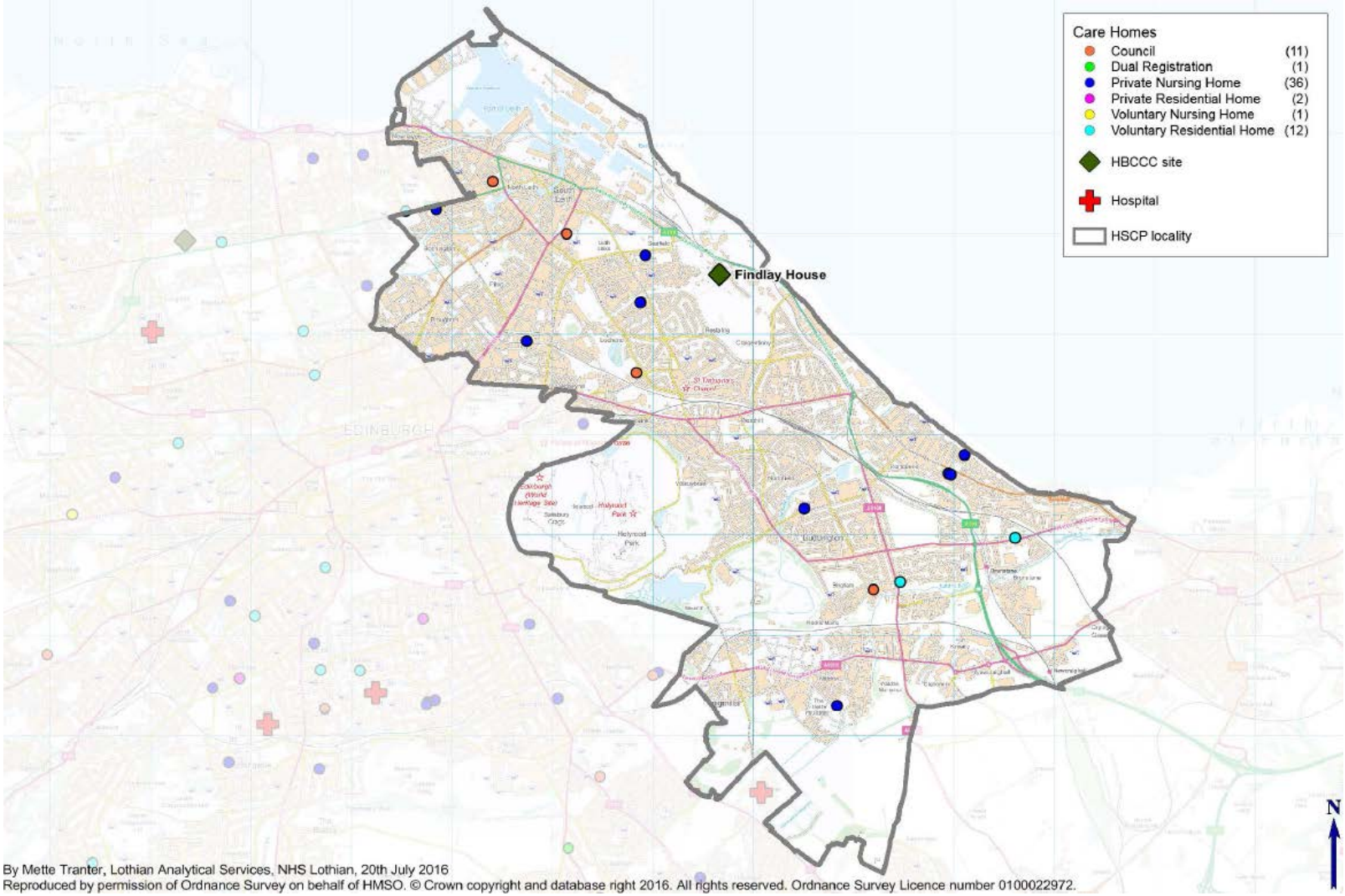
OLDER PEOPLE SERVICES IN NORTH EAST



By Mette Tranter, Lothian Analytical Services, NHS Lothian, 20th July 2016

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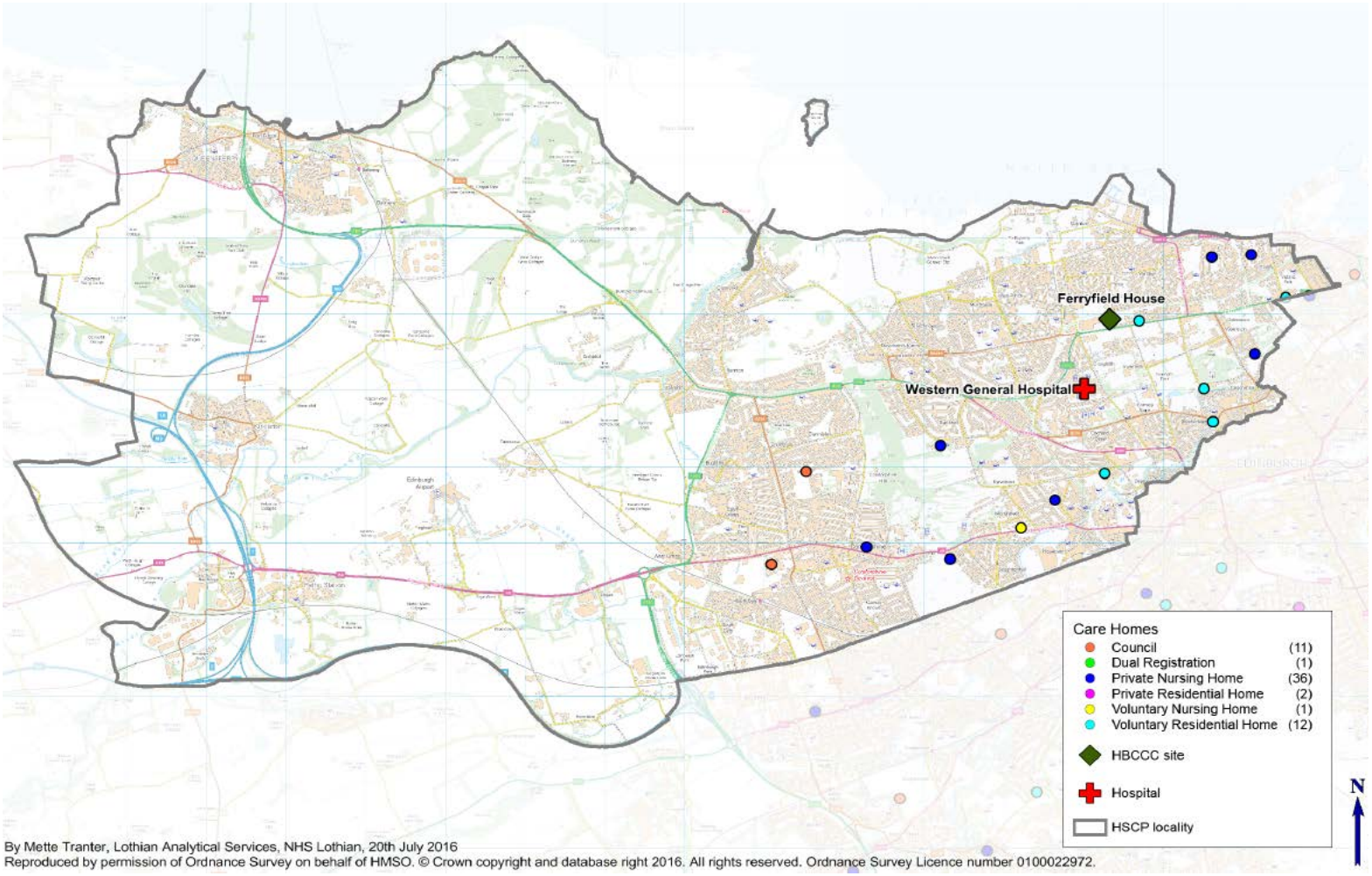
Integrated Inspection for Older People

OLDER PEOPLES SERVICES IN NORTH WEST



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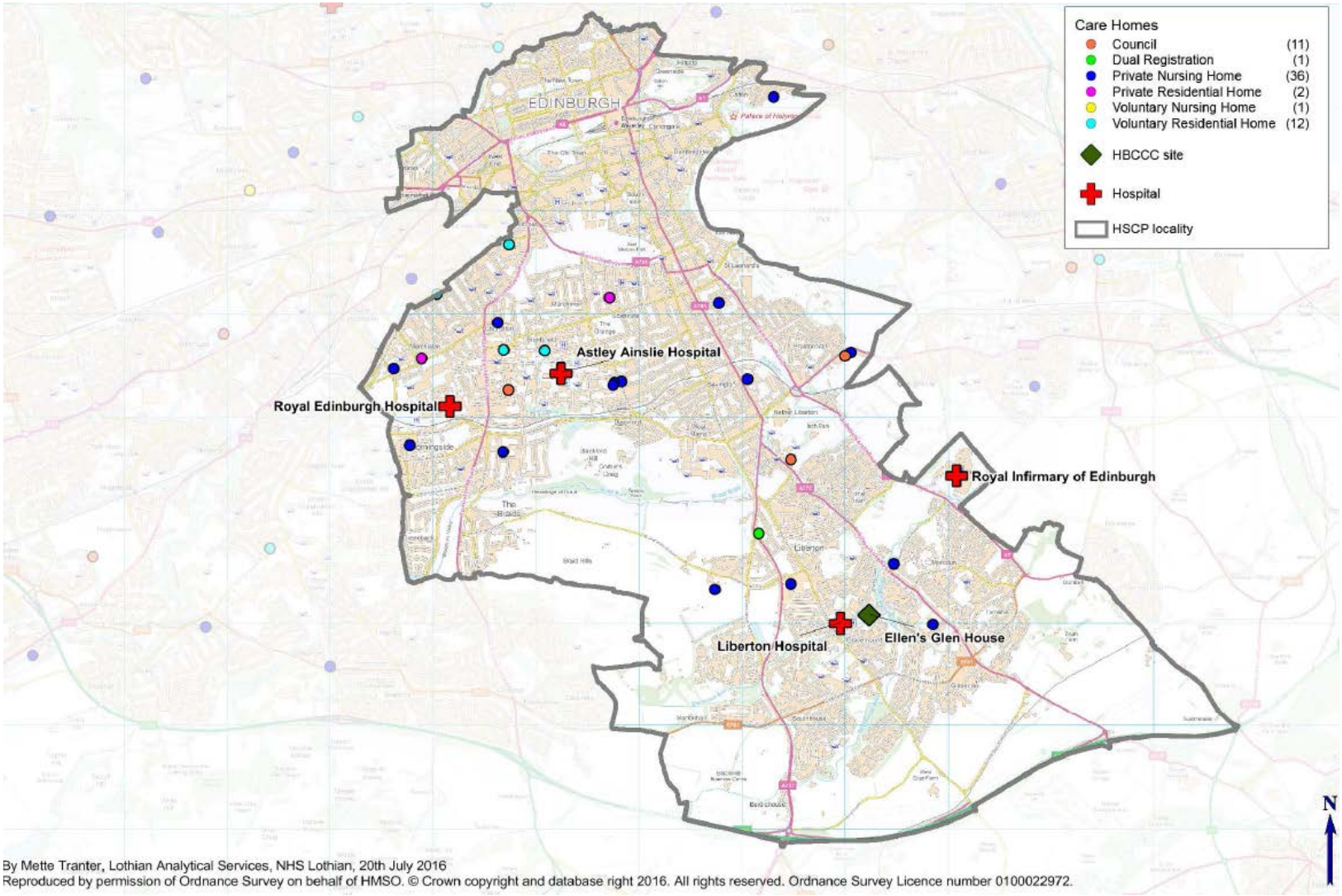
OLDER PEOPLES SERVICES IN SOUTH EAST



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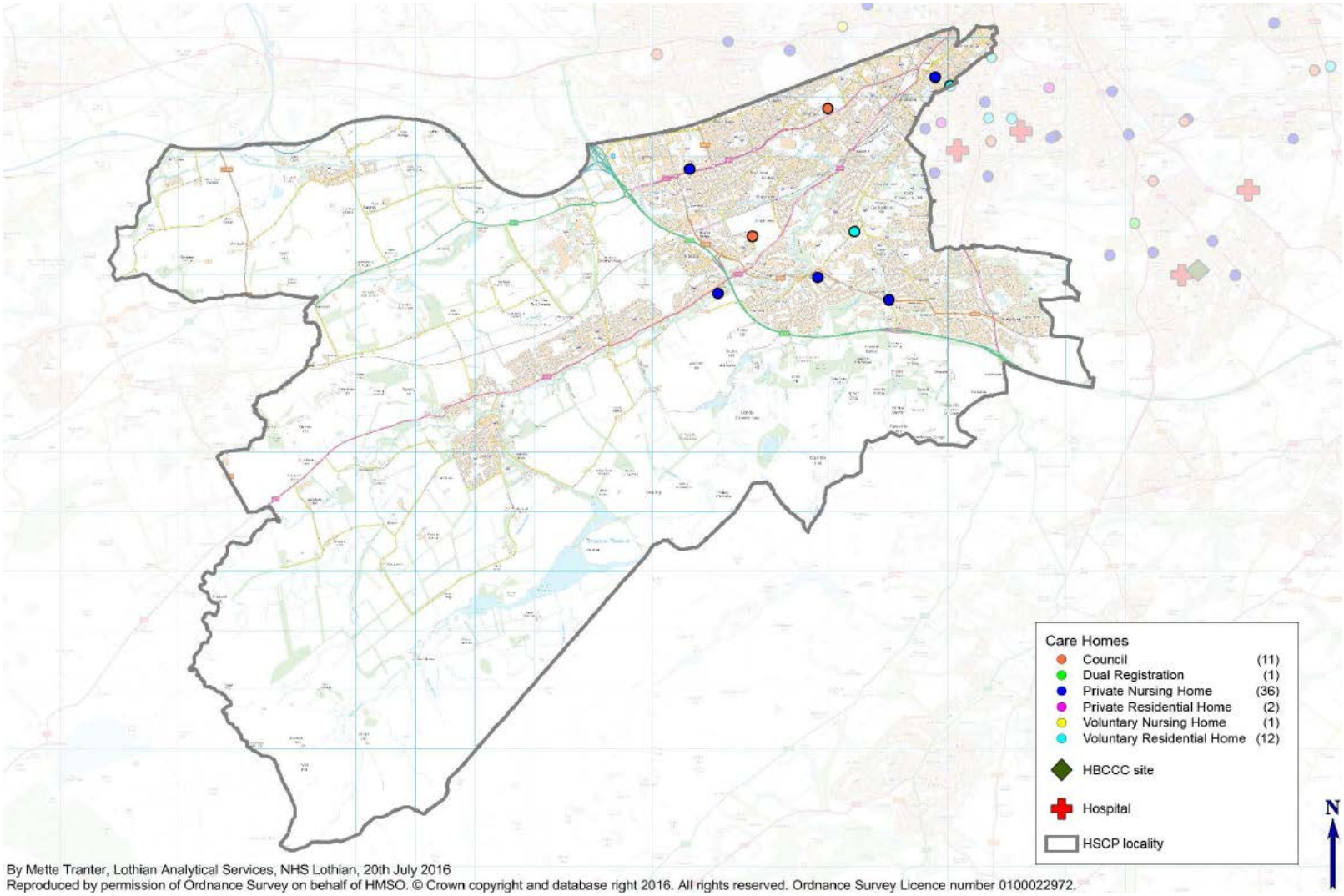
OLDER PEOPLES SERVICES IN SOUTH WEST



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Edinburgh Health and Social Care Partnership
Integrated Inspection for Older People

MANAGEMENT TEAM

NAME	TITLE / POSITION / POST
Rob McCulloch – Graham	Chief Officer EHSCP
Michelle Miller	Chief Social Work Officer
Maria Wilson	Chief Nurse
Ian McKay	Clinical Director
Moira Pringle	Chief Finance Officer
Mike Houghton-Evans	Health and Social Care Consultant
Angela Lindsay	Locality Manager – North East
Marna Green	Locality Manager – North West
Nikki Conway	Locality Manager – South East
TBC	Locality Manager – South West
Katie McWilliam	Strategic Planning and Quality Lead – Older People
Colin Beck	Strategic Planning and Quality Lead – Mental Health / Substance Misuse
Wendy Dale	Strategic Planning, Service Re-Design and Innovation Manager
David White	Strategic Planning and Quality Lead – Primary Care
TBC	Strategic Planning and Quality Lead – Learning Disabilities
Sheena Muir	Hospital and Hosted Services Manager
Wanda Fairgrieve	Partnership (NHS)
Kirsten Hay	Partnership (CEC)
Jon Ferrer	Quality Assurance Team Lead (CEC)
Jennifer Evans	Quality Assurance Lead (NHS)

Outcome 1: Key performance outcomes

What do we do well?

We routinely benchmark our performance over a range of indicators against other partnerships in Scotland. We perform well in respect of emergency admission rates, associated bed days and unscheduled care costs, all of which are ahead of the Scottish average and improving.[1.1]

To better understand the underlying causes for delays within the whole system, the Flow Board, chaired by the IJB Chair, has hosted two successful workshops bringing together partners from community and acute services. Following these, a number of key work streams have been established and a self assessment against the NICE best practice guidance has been commissioned.[1.2]

Despite being the top rated partnership for falls management in Scotland, our falls rate remains relatively high. To address this we have: a multi agency pathway for falls and bone health; falls risk assessments within clinical areas; and we employ a falls coordinator.[1.3]

The recent Health Improvement Scotland review of Hospital Based Complex Clinical Care service (2015) in Edinburgh commended the Partnerships capacity for self evaluation and reported evidence of good practice in relation to patient centred care. There were six recommendations for service improvement which were incorporated into the existing service improvement plan. Implementation of the recommendations and improvement plan is being monitored through our quality structure.[1.3a]

We have over 45,000 key information summaries (KIS) for people with complex health and social care needs. A Lothian Anticipatory Care Planning (ACP) forum has been established alongside an interface group, which shares research and best practice. Care homes are piloting the use of a structured ACP questionnaire for residents. This has led to positive outcomes on unscheduled care contacts and patient/carer experience. A multi agency training programme helps staff to engage in person centred conversations with people who have deteriorating health needs to ascertain what matters most to them and their family in order to support informed care choices.[1.4]

There are several services across the partnership for reablement, rehabilitation, prevention, admission avoidance and management of Long Term Conditions. Following evaluation, we have refocused our reablement services to target those people who are likely to benefit most. There are early signs that this recent change is leading to improved outcomes and performance. In addition we operate a jointly funded and managed integrated intermediate care service accessed via a single point of contact offering urgent community based assessment 7 days per week. This service helps avoid hospital admission; supports early discharge; and provides evidence based functional rehabilitation. Other actions that we are taking to avoid hospital admissions are detailed in Outcome 2.[1.5]

The majority of GP practices participated in the Quality Outcome Framework and had a high point's attainment. The Partnership is working with practices in preparation for the quality arrangements that will be embedded in the new GMS contract, which is due in 2017.[1.6]

We have a joint carers' strategy, coproduced with unpaid carers and carers' organisations. The related action plan seeks to address a number of priority areas including identifying unpaid carers, the provision of information and advice, improving carer health and wellbeing; personalised support including respite care. We have well established contracts in place for independent advocacy services for carers.[1.7]

The results from a series of surveys of people receiving support and their carers showed that at least 85% of carers felt that the service helps them maintain their own health and wellbeing to some extent; and over 90% of people receiving a service felt that it helped them maintain their own health and wellbeing.[1.8]

In our Strategic Plan (Appendix E) we set out the range of local and national policies and strategies that we are seeking to deliver for example; prevention, self-directed support, long term conditions strategy, quality strategy. Our approach to the implementation of these is addressed through-out our submission.[1.9]

Where do we need to improve?

- Ensure that delays across the system are reduced and people receive the right care, in the right place at the right time.
- Ensure proactive and consistent application of self directed support
- Compliance with the falls frailty pathway.
- Increase the number, quality and access to Anticipatory Care Plans.
- Improve pathways for older people and reduce unnecessary transitions in care.

What action are we taking?

- In order to reduce delays across the whole system we are monitoring the impact of the workstreams set up by the Flow Board and adapting our approach to recognise those actions which are delivering the most improved outcomes. We will also identify actions from the self assessment against the NICE best practice guidance.
- Embedding the multi-agency falls pathway for falls and bone health.
- Rolling out ACP training to the wider primary care team and monitor compliance with quality and access.
- We are identifying GP quality leads within each locality Cluster and will engage further with GPs around the proposed new integrated Clinical Governance and Risk Management structures.[1.10]
- We have implemented a performance board that is reviewing the performance measures and targets within each of the parent bodies and are working to develop an integrated performance framework.
- Exploring the opportunities for integrating our complaints, incident reporting, health and safety, business continuity and litigation processes within the partnership. [1.11]
- An integrated project board has been established to take forward implementation of the requirements of the carers act.
- Edinburgh Partnership has recently been given the responsibility for hosting Palliative Care Services across Lothian working closely with the Edinburgh hospices. There is a well established Lothian Palliative Care Clinical network.[1.7(a)] We are currently setting up a pan Lothian steering group.
- We are using individual stories and feedback to inform the IJB and care teams about the impact disjointed pathways have on the experiences of citizens, their carers and families.

The Partnership have assessed performance against this indicator 1 as overall Grade 3

However specifically to delayed discharge and access targets we recognise that we have significant weakness, and consequently this is the main focus of our improvement activity

Evidence to include:

Evidence Ref No;

1.1 Performance Measures
1.2 Flow Board
1.3 Falls
1.3a HBCCC HIS Inspection Report
1.4 Anticipatory Care Plans and Key Information Summaries
1.5 Services for Re ablement, Intermediate Care, Rehabilitation, Prevention, Admission Avoidance and Management of Long Term Conditions
1.6 Quality Outcomes Framework
1.7 Carers Information
1.7a Lothian Palliative Care Clinical Network
1.8 Citizens Feedback
1.9 Strategic Plan
1.10 Clinical Governance and Risk Management Structures
1.11 Integration of Quality Assurance

Outcome 2: Getting help at the right time

What do we do well?

Robust and established adult protection procedures are in place to safeguard and protect the safety of our citizens. Tools to assist practitioners and managers when undertaking adult protection enquiries have been developed to support and assist decision making and the management and identification of risk factors. Current methods include performance reporting, data quality analysis, case file audits, reflective practice evaluations and compliance against agreed multi-agency protocol, policy and procedure. Further work is required to ensure we promote and raise awareness of performance targets and developments in practice, generated from the learning and recommendations of recent Significant Case Reviews and Large Scale Enquiries. (cross reference Indicator 5)

Providing the right care in the right place at the right time for each individual is a key priority for the partnership. Our aim is to assess, treat and support people at home and in the community wherever possible; so that they are only admitted to hospital when clinically necessary and are discharged timeously with support to recover and regain their independence at home.[2.1] The early implementer Multi Agency Triage Teams (MATTs), have been designed to deliver on this ambition and maximise the use of community assets.[2.2]

We recognise the importance of supporting individuals to exercise greater choice and control through the use of self directed support and the self management of long term conditions. The number of older people choosing to use direct payments is slowly increasing and we are encouraging the use of Individual Service Funds through Option 2.[2.3] Supporting people to self manage long term conditions is a key part of the work we are doing with statutory and third sector partners to implement the Scottish Government's Many Conditions, One Life Action Plan.[2.4]

The Partnership has a focus on prevention, co-production and community capacity building are clearly articulated in Edinburgh's Joint Commissioning plan for Older People 2012-2022[2.5]. We fund a number of third sector organisations to deliver low level preventative services for older people, ranging from lunch clubs to Community Connecting. The effectiveness of these services is regularly evaluated[2.6]. The Partnership also invests in services such as reablement, intermediate care, COMPASS, IMPACT Team, domiciliary physiotherapy and the Community Alarm and Telecare Service that support people with more intensive needs to regain their independence and prevent further deterioration.[2.7]

Early diagnosis of dementia by Old Age Psychiatry varies across the city. Post diagnostic support is provided by the Memory Clinic or the Post Diagnostic Support Link Workers using the Alzheimer's Scotland five and eight pillar models of dementia support. More recently the Partnership has identified funding for the development of Older Peoples Mental Health Rapid Response Team.[2.8]

The Local Opportunities for Older People Networks (LOOPs) in each locality, funded by the Partnership and coordinated by the third sector, provide information for older people about activities and services available locally.[2.10] There are a number of online directories[2.11] that provide information about services available within the city. We also publish a range of leaflets about care and support services for older people and how to access them.

Social Care Direct (SCD) provides a single point of contact for people seeking advice and support in relation to health and social care services and is the starting point for social care referrals.[2.12] We commission a direct payments support service from a third sector agency[2.13] providing advice on using direct payments, assistance with the recruitment of Personal Assistants and a payroll service. We also have contracts in place for the provision of independent advocacy services.[2.14]

Staff are required to undertake training, be familiar with legislation in relation to adults with incapacity and carry out documented assessments.[2.15] (referenced in Outcome 7) Proxies are involved in decision making and we are working to ensure that Anticipatory Care Plans are in place for all those who require them.[2.16]

Where do we need to improve?

- Access to timely diagnosis of dementia.
- Develop a single shared outcome focused assessment tool and reduce waiting times for assessments, which are a major barrier to people accessing support at the right time supported by a single assessment process.
- Our implementation of Self Directed Support is not consistent. We need to build on best practice examples, expand our use of technology enabled care and support people to live more independently and reduce pressures on other services.
- Review all existing information for citizens and staff to reflect the new integrated organisational arrangements.
- We do not currently have a single shared assessment for older people. Each professional group involved in delivering care undertake their own assessment and where appropriate, seek contributions from the wider team. The assessment used within social care has been developed to encourage a conversational and outcome focused approach.[2.9]

What action are we taking?

- Improvements for dementia are being taken forward through the recently established mental health group, which is a sub group of the Older People Executive Group.
- We are in the process of implementing Multi-Agency Triage Teams (MATTs) across the city with a focus on early intervention, earlier hospital discharge and prevention of admission of older adults.
- Reviewing our current arrangements for assessment, support planning, brokerage and resource allocation to ensure compliance with the principles of self-directed support, as part of the Demand Management workstream within our Transformation Programme.[2.17]
- Working in partnership with a social housing provider to pilot the use of technology as an alternative to onsite staff providing night time support.[2.18]
- New care at home contracts supported by a realigned in-house home care service will increase capacity, responsiveness and flexibility within our domiciliary care offer.
- As part of establishing the locality arrangements we will review the communication strategy for staff and the information directories for citizens.

The Partnership has assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

2.1 Prevention of Admission/LTCs - Cross Reference to Indicator 1 - Reference Documents: 1.1, 1.2,1.4 and 1.5
2.2 Locality MATTS - Cross Reference to Indicator 1
Reference Document: 1.5
2.3 Self Directed Support – Cross Reference to Indicator 1 – Document Reference 1.1
2.4 Work with Voluntary Sectors
2.5 Living Well in Later Life Strategic Commissioning Plan for Older People
2.6 Community Connecting with 3rd Sector Low Level Preventative Services
2.7 Community Services - Cross Reference to Indicator 1 –
Reference Documents: 1.3, 1.4 and 1.5
2.8 Dementia
2.9 Care Assessment Documentation
2.10 LOOPs Information – Cross Reference to Indicator 2 – Document Reference 2.4
2.11 Online Directories
2.12 Social Care Direct
2.13 Commissioned Third Sector Direct Payments Support Services and Payroll
2.14 Adults with Incapacity Assessment Information
2.16 Anticipatory Care Planning - Cross Reference to Indicator 1 –
Reference Document 1.4
2.17 Demand Management and Transformation Programme Information
2.18 Social Housing Pilot – Use of Technology

Outcome 3: Impact on staff

What do we do well?

Our NHS staff survey and Council pulse trackers tell us that staff are committed to providing high quality, safe, effective person centred care for older people and support to their carers.[3.1] These surveys also demonstrate that the vast majority of staff understand their role and the need for change and are prepared to go the extra mile.

There are good interdisciplinary relationships across the partnership and staff are committed to continually evaluating the quality of care and services provided. Examples of innovative practice and positive service user feedback demonstrate we put the needs of older people and carers first.[3.2]

The evaluation of some of our patient pathways and stories for older people demonstrates that professional groups and agencies work well to promote the best care for older people. However, we need to improve integrated working between teams to reduce unnecessary transitions.

Many teams and services are co-located within localities and we are actively looking for opportunities to develop this model. The newly formed hub and cluster structures have been set up with the intention of promoting better integrated working amongst teams caring for older people and are aligned to GP practice clusters and other locality services. We have received feedback that the early test of change around the introduction of locality based Multi Agency Triage Teams (MATTs)[3.3] support staff to gain a better understanding of each other's roles and contributions.

We have consulted staff on the development of the full range of strategic plans, the joint strategic needs assessment and we have involved staff in events on service change[3.4]. There are excellent opportunities across the partnership for staff development and established single agency processes for staff appraisal and personal development, as set out in Outcome 7.

There is a well established partnership arrangement with staff trade unions within the NHS which has now been fully adopted with council service and this has facilitated the development of the new staffing structure.

Where do we need to improve?

- More effective communication with all staff working within the partnership as well the third and independent sectors to gain commitment to embrace the changes required to fully integrate services and maintain staff morale.
- Continue to build on the test of change in relation to the establishment of the locality MATTs to embed a culture of integrated working throughout the Partnership. [3.5]
- Exploit the opportunities offered by integration to develop workforce Partnership policies and procedures.
- We need to recognise staff morale is low during these times of change.

What action are we taking?

- Providing clear communication through visible leadership at a time of change and uncertainty.
- Implementing the new structure[3.6].

- Developing new roles and ways of working to support improved outcomes for older people.
- Implementing the use of shared workforce and caseload management tools across the partnership.
- Continue to involve staff in service redesign and planning.[3.7]
- Capacity planning on both a locality and city wide basis.

The Partnership has assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

3.1 Staff Surveys
3.2 Examples of Service Innovation and Service User Feedback – Cross Reference to Indicator 1 – Document Reference 1.7
3.3 Locality MATTS – Cross Reference to Indicator 1 – Document Reference 1.5
3.4 Strategic Plan Consultation Feedback
3.5 Locality MATTS – Cross Reference to Indicator 1 – Document Reference 1.5
3.6 Organisational Structure
3.7 Staff Involvement in Service Redesign and Planning

Outcome 4: Impact on the Community

What do we do well?

The strategic plan has secured support across the full partnership and community of service users. It is explicit in its determination that by 2020 "people and communities work with local organisations to determine priorities and plan, design, deliver and evaluate services" this is explicit in our Strategic Plan.[4.1] Citizens, communities and other partners have been actively engaged in the checkpoint group, established to oversee consultation on the current commissioning strategy for older people[4.2] and in the Strategic Planning Group[4.3] that produced our Strategic Plan.

The Joint Strategic Needs Assessment (JSNA) which underpins the Strategic Plan was produced directly with the engagement of key stakeholders including patients and service users and contains profiles of our four localities and specific groups within the community. Priorities within the local community plans produced by the 12 Neighbourhood Partnerships have informed both the JSNA and the Strategic Plan itself. The final version of the plan was influenced by feedback from public consultation.[4.4]

We have worked in partnership with the third sector to establish Local Opportunities for Older People (LOOPs) Networks[4.5] in each locality. The Networks aim to increase the capacity within communities to support vulnerable older people, increase the take up of local community services by older people and strengthen the voice of local older people so they are able to influence services available locally. We also support local community organisations to provide preventative services for older people through our mainstream grant programme[4.6] and a 'Third Sector Preventative Fund' using the Integrated Care Fund[4.7].

We regularly carry out surveys to obtain feedback from citizens about their experience of using services. We have service user membership in some strategic groups and have a number of forums for service users, their carers and family members in relation to specific services such as home care.[4.8]

Establishing strong links with communities is one of the strengths of the locality model that we are implementing. Our aim is to build on assets within local communities providing opportunities for older people to offer and access support. We have introduced models of social prescribing as an alternative to traditional intervention and as a means of relieving pressure on GP practices.[4.9]

The partnership across CEC and NHS has secured the inclusion of health within the local development plan ensuring that health infrastructure is considered within future developments.[4.10]

Where do we need to improve?

- Embed a systematic approach to engaging citizens and communities in a collaborative way at both a strategic and operational level across all service areas.
- Improve the way in which we use the feedback we routinely receive from citizens through surveys and complaints as a tool for service improvement and planning.
- Develop a sustainable model of funding for LOOPs and other community based preventative approaches.
- Expand the locality based social prescribing model, building on the experience of others.

What action are we taking?

- Developing a new planning framework that will involve citizens and communities in planning services for both localities and communities of interest.
- Developing an over arching engagement strategy through a sub group of the Strategic Planning Group based around the principle of increased collaboration and building upon the experience of the Personalisation Core Group and SDS Evaluation Group[4.11].
- Continuing to develop the JSNA with a wider group of stakeholders to ensure it is both comprehensive and of use to the whole community.

The Partnership has assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

4.1. Strategic Plan – Cross Reference to Indicator 1 - Document Reference 1.9
4.2. Live Well in Later Life – Edinburgh's Joint Commissioning Plan for Older People 2012-22 – Cross Reference to Indicator 2 – Document Reference 2.5
4.3. Terms of Reference and Membership of Strategic Planning Group
4.4 Edinburgh's Joint Strategic Needs Assessment 2015
4.5 LOOPs - Cross Reference to Indicator 2 – Document Reference 2.10
4.6 Mainstream Grants Programme
4.7 Integrated Care Fund
4.8 Citizen Feedback – Cross Reference to Indicator 1 – Document Reference 1.8
4.9 Social Prescribing
4.10 HSC Infrastructure Developments
4.11 Engagement Strategy

Outcome 5: Delivery of key processes

What do we do well?

An interagency information exchange portal has been developed as a means of sharing information between professional groups.[5.1] Each partner agency has well established referral and access procedures and processes[5.2]. Social Care Direct (SCD) operates a triage function for social care and intermediate care referrals, where appropriate individuals will be referred to the relevant service for assessment, otherwise advice is offered about alternative sources of support for those not requiring council services.[5.3]

Within the Partnership all social care and health professional groupings currently have their own assessment and care planning tools.[5.4] Those that are IT based are shared through the IIE portal.

There are clear eligibility criteria in place for social care. Those assessed as having critical or substantial needs are eligible for support. People assessed as having moderate or low level needs are being signposted towards preventative services within the community. There are also eligibility criteria in place for Hospital Based Continuing Complex Care and our interim care facility. Individual services have their own access criteria.[5.5]

The Partnership promotes collaboration and choice by involving service users and carers, in planning and directing their own support. Those eligible for social care support are offered the four options of self directed support. Uptake of each option is monitored through our performance framework.[5.6] Our clinical strategy[5.7] encourages clinicians to discuss care choices with individuals and supports them to make informed choices around treatment, which is recorded in Anticipatory Care Plans including Do Not Attempt Resuscitation (DNAR).[5.8]

Reviews provide an opportunity to jointly evaluate with the service user whether current interventions are delivering the anticipated outcomes and, if necessary, make changes to care and support plans.

Edinburgh has a multi agency Adult Support and Protection Committee.[5.9] The Partnership has a comprehensive multi-agency professional training strategy[5.10] to provide office holders and employees with up-to-date and evidence-informed knowledge and skills to fulfil their duties to support and protect adults. A proactive approach is taken to responding to poor standards of care and adult protection concerns within the care sector.[5.11] We also have a range of processes which support the early identification of risk.[5.12] Our Speak up Speak out protection communication strategy[5.13] aims to encourage more people to engage with adult services around adult protection.

Operational and strategic oversight is the responsibility of the multi agency Adult Protection Committee, with additional scrutiny and support being provided by relevant sub groups focussed around Publicity (Public Protection Publicity Campaign), multi-agency training, professional development, quality assurance and self evaluation.

Where do we need to improve?

- Streamline and rationalise existing access and referral procedures across the Partnership, including the establishment of a single point of contact, improved interagency referrals and the development of a single shared assessment.
- Reduce waiting times for assessment, access to services and review.

- Strengthen the relationships between the developing integrated Multi Agency Triage Teams (MATTs) and the acute hospital discharge hubs.
- Ensure that all staff are familiar with eligibility and access criteria for all services and the principles of self-directed support.
- Improve adherence to procedures and processes in response to practice evidence and performance information.
- Strive to improve consistency of screening and practice in relation to thresholds that trigger inquiry and intervention in relation to adult support and protection duty to inquire which varies across the Partnership.

What action are we taking?

- Our aim is that all referrals between services are undertaken through the Interagency Information Exchange portal (IIE) which is governed by appropriate information sharing protocols and permissions. Where services are co located referrals are undertaken through direct contact.
- Development of integrated policies, procedures and pathways wherever possible. Once these are in place compliance will be monitored through line management, supervision and performance frameworks.
- Using a whole system approach to analyse delays and identify key priorities to be addressed in order to improve performance.
- Taking forward work to develop single shared assessments and support plans based on assets and outcomes through the Demand Management workstream of our Transformation Programme.
- Undertaking a programme of quality improvement actions from self evaluation activity which seeks to ensure that adult protection investigations adhere to agreed protocol.
- Developing joint practice guidance for adult protection care service investigations.

The Partnership have assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

5.1 Interagency Exchange Information
5.2 Service Referral and Access Processes and Procedures
5.3 Social Care Direct – Cross Reference to Indicator 2 – Document Reference 2.12
5.4 Assessment and Care Planning Tools – Cross Reference to Indicator 2 – Document Reference 2.9
5.5 Service Eligibility Criteria
5.6 Self Directed Support – Cross Reference to Indicator 2 – Document Reference 2.3
5.7 Clinical Strategy
5.8 DNAR Documentation – Cross Reference to Indicator 1 – Document Reference 1.4
5.9 Adult Support and Protection Committee
5.10 Adult Protection Training Strategy
5.11 Quality Assurance – Cross Reference to Indicator 1 – Document Reference 1.11
5.12 Adult Protection Risk Assessment Tools
5.13 Speak up Speak out protection communication strategy

Outcome 6: Policy development and plans to support improvement in service
What do we do well?

Our Strategic Plan[6.1] sets out the priorities for older people and builds on Edinburgh's Joint Commissioning Plan for Older People 2012-22 (LWILL).[6.2] The associated delivery plan[6.3] overseen by the Older People Executive Group (OPEG)[6.4] sets out key milestones and timelines. The post of Strategy and Quality Manager for Older People will take forward the implementation of these plans, including the development of processes and guidance, supported by OPEG.

The Capacity and Demand work stream[6.5] provides the opportunity to benchmark our current position against the priorities set out in LWIL and determine future requirements and delivery models to meet increasing demand within limited resources.

The Edinburgh Community Planning Partnership Prevention Strategic Plan 2015-18[6.6], clearly demonstrates strategic collaboration and vision to support citizens with their health, wellbeing and independence. This is echoed within our strategic plan which emphasises the need for assessment, treatment and support to take place as close to home as possible e.g. COMPASS[6.7]. Other examples include falls prevention, promoting healthy life styles, self management of long term conditions, technology enabled care, support for unpaid carers and the promotion of dementia friendly communities. The Partnership has invested in a range of prevention and early intervention initiatives delivered by the third sector and coordinated and evaluated by Edinburgh Voluntary Organisations Council (EVOC), using the Reshaping Care for Older People Fund/Integrated Care Fund.[6.8]

Policies, procedures and guidance compliant with statutory principles, clinical governance, regulations, guidance and codes of professional practice are available on the intranets of both parent bodies.[6.9] Staff are expected to be familiar and comply with organisations processes, polices and procedures.

The Partnership has developed integrated performance management[6.10] and clinical and care governance arrangements to monitor performance, quality assure services and drive service improvement. The quality improvement/assurance teams within the parent agencies undertake assessments against the Older People's Acute care in Hospital (OPAH) and Care Inspectorate standards. Findings and recommendations are fed back to managers and teams to action. The Performance and Quality Sub Group[6.11] of the IJB, provides assurance to the Board that the whole system is operating effectively to deliver the strategic plan.

Several service inspections have been carried out by the Care Inspectorate, Health Improvement Scotland and the Mental Health Commission. Implementation of the resultant actions and recommendations are overseen by senior management and quality improvement/assurance teams. The inspection of Hospital Based Complex Clinical Care highlighted the capacity of the Partnership for recognising gaps, and continuous quality improvement.[6.12]

Edinburgh's Market Shaping Strategy 2015-18[6.13] jointly developed by Edinburgh Council and NHS Lothian, reflects the principles of personalisation, integration, and best value set out in LWILL and our Strategic Plan. The Strategy and Quality Manager for Older People will lead our approach to commissioning in collaboration with partners, supported by our Contracts Team. Robust monitoring systems are in place, including effective collaboration with regulators and scrutiny bodies. The new Care at Home Contract[6.14] is outcomes focused with providers being held to account for failure to deliver.

Where do we need to improve?

- Develop a better understanding of current and future capacity and demand for services for older people and identify new delivery models.
- Developing integrated (rather than single agency) policies and procedures is a high priority.
- Review the current position for the provision of palliative and end of life care against the new Scottish Government commitments 2015.
- Develop Locality Plans setting out how we will deliver services at a local level.

What action are we taking?

- The Capacity and Demand work for older people will provide detailed financial and workforce resource information, and will inform the development of new models of service delivery.
- Reviewing our approach to the implementation of SDS and personalisation through the Demand Management workstream of the Transformation Programme, to ensure that it reflects the principles and strategic intentions set out in the legislation and, local and national strategies.
- Producing an engagement strategy for the Partnership through a sub group of the Strategic Planning Group. Locality Implementation Groups will provide the basis for better engagement with citizens and communities in each locality.
- Implementing an integrated clinical governance and risk management structure[6.19] for the Partnership. We are also looking to have a single recording system within the Partnership for complaints, incidents, health and safety, risk registers and litigation.
- Implementing a strategic planning framework that is more aligned with both the Locality and Strategic infrastructures.

The Partnership has assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

6.1 Strategic Plan – Cross Reference to Indicator 1 – Document Reference 1.9

6.2 Live Well in Later Life – Cross Reference to Indicator 2 – Document Reference 2.5

6.3 Older People's Delivery Plan – Cross Reference to Indicator 2 – Document Reference 2.5

6.4 OPEG Terms of Reference and Minutes

6.5 Capacity and Demand Workstreams – Cross Reference to Indicator 2 - Document Reference 2.17

6.6 The Edinburgh Community Planning Partnership Prevention Strategic Plan 2015-18

6.7 COMPASS Information – Cross Reference to Indicator 1 – Document Reference 1.5

6.8 Integrated Care Fund

6.9 Links to Policies, Procedures and Guidance on Intranets

6.10 Performance Management Framework / Clinical Governance Structure – Cross Reference to Indicator 1 – Document References 1.1 and 1.10

6.11 Quality Assurance – Cross Reference to Indicator 1 – Document Reference 1.11
6.12 External Service Reviews and Inspections
6.13 Edinburgh's Market Shaping Strategy 2015-18
6.14 Care at Home Contract
6.15 Strategic Planning Framework

Outcome 7: Management and support of staff

What do we do well?

The Partnership has completed phase 1 of our single integrated structure[7.1] designed to achieve our objectives and priorities as set out in the strategic plan. Phase 2 will be completed in December 2016. It ensures integration is embedded at all levels in the organisation whilst maintaining an appropriate mix of skills and experience. Generic job descriptions set out both operational and professional responsibilities[7.2] and appointees have the option to work under the terms and conditions of either parent body. The structure clearly articulates line management and professional supervision arrangements across the Partnership and in localities. Whilst the Council and NHS Lothian have their own recruitment policies a joint appointment policy has been developed to meet the needs of the Partnership.[7.3]

We have a Workforce and Organisational Development strategy group to support the development of the Partnership and the implementation of new integrated structures. Outputs from this group include: the "Playing to your strengths" leadership programme, coproduction of an integrated team development toolkit and; the mapping of existing joint learning and development opportunities for further integration.[7.4]

In response to ongoing recruitment challenges, the joint Workforce Strategy Group for Older People's Services[7.5] has implemented a range of measures to address staff shortages. Monitoring of staffing levels and workload pressures is currently undertaken through professional and operational reporting lines, primarily on a single agency basis. The performance measures in place include sickness absence and vacancy levels and use of agency staffing. Various workforce tools are used across the Partnership to inform safe staffing levels. As both parent bodies use different HR management systems opportunities to harmonise in this area are limited.[7.6]

The appraisal and personal development planning processes for staff are linked to organisational and personal development objectives. Compliance with appraisal processes is monitored across the Partnership. There are established supervision standards and processes across social care and clinical supervision and revalidation within health[7.7].

Staff have access to a range of learning and development opportunities across the partner bodies and other sectors. As part of the development of the Partnership the HR/OD Development group has facilitated integrated leadership and development workshops for management staff working across the Partnership as well as third sector colleagues. Staff in the Independent sector are able to access NHS training opportunities. Going forward we will build on examples of good practice and seek opportunities to integrate joint training further.[7.8]

Senior managers from the Partnership are active participants in the Council wider leadership development cohort.[7.9]

Both parent bodies within the Partnership have clear organisational values which are reflected in the IJB values and encompassed in the strategic plan.[7.10]

Where do we need to improve?

- Develop a comprehensive joint workforce strategy for the Partnership, building on the existing single agency strategies[7.11] harmonising policies and procedures wherever possible.

- Develop a succession plan for service sustainability following implementation of the new structure.
- Continue to reduce reliance in bank and agency and improve recruitment to older people's service.
- Continue to progress recommendations and inputs from District Nurse review.
- Continue to take forward workforce recommendations for HBCCC.
- Continue to seek opportunities for joint learning to reduce duplication.

What actions are we taking?

- Implementing the new integrated structure, including finalising job descriptions for all posts.
- Developing a comprehensive workforce strategy for the Partnership.
- Creating an overarching engagement strategy with staff based on the experience of the collaborative enquiry group for self directed support.
- Investigating opportunities for joint training and development with all partners.

The Partnership have assessed performance against this indicator as Grade 3

Evidence

Evidence Ref No;

7.1 New Structure Chart – Cross Reference to Indicator 3 – Document Reference 3.6
7.2 Sample Generic Job Description
7.3 Recruitment Policies – Single Agency and Joint Policies
7.4 Workforce Organisational Development Strategy Group and Outputs
7.5 Workforce Strategy Group for Older People Services
7.6 Staffing Levels and Workforce Planning
7.7 Appraisal, Personal Development Plans and Clinical Supervision
7.8 Training Opportunities and Compliance Reports
7.9 Leadership Development
7.10 Organisational Values
7.11 Single Agency Workforce Strategies

Outcome 8: Partnership working

What we do well?

Partnership governance is robust and has been in place for over a year. The IJB has full access to committee support, sub groups are fully active on audit and risk, quality and performance planning and we have full representation across all professions within the professional advisory committee.[8.1]

An interim integrated senior management team[8.2] has been in place since November 2015. Phase 1 of the restructure and the appointment to management and strategic posts is now complete. The full permanent management team will be complete by the end of September 2016 and the full restructure across 5000 staff complete by December 2016. The senior management team has been working together to operationalise key priorities set out in the strategic plan including: locality working; progressing the new structure; and managing budget pressures.

We recognise the difficult financial positions of both the Council and NHS Lothian and are working in partnership with them to finalise a financial settlement.[8.3] Indicative budgets reflect the priorities set out within our strategic plan[8.4] and we are in the process of aligning these budgets to the new integrated structure. In parallel, we will develop a financial framework for services for older people. This will identify the baseline position and demonstrate how resources move as the balance of care shifts. A delivery plan[8.5] with clear milestones, timescales and responsibilities has been produced in respect of improving care and support for frail older people and those with dementia.

We work closely with a range of partner agencies to make best use of capacity and resources across the whole system. This encompasses statutory, third and independent sectors including social housing providers, who have committed to a significant investment in accessible and affordable homes for those with disabilities and complex needs (including older people).[8.6] We are well aware of the potential for actions taken to relieve budget pressures to destabilise the third and independent sectors and are working closely with them to ensure we are all in a position to deliver sustainable services.

We have a number of premises from which we deliver collocated health, social care, third sector and other services and are conscious of the need to develop an asset management strategy which informs those of the parent bodies. Construction is underway on two partnership centre's which will provide further opportunities for collocation.[8.7]

The strategic plan sets out our ambitions for fully integrated ICT systems that allow staff to share information appropriately across agencies. This builds on existing portal arrangements that allow a subset of case record data to be shared. We have established an ICT steering group[8.8] to lead the development of a joint ICT strategy to support integrated working, including the implementation of specific transformation projects such as locality hubs.[8.9] Despite the current challenges of working with different systems, staff have sought practical solutions which have allowed the establishment of daily huddles to take place in each locality.

There are strong partnership arrangements in place within and between the Council, NHS Lothian, the IJB and the senior management team of the Partnership. The Flow Board[8.10] provides one example of robust inter agency working. We are very committed to working with other partners, building on existing positive relationships to improve outcomes for citizens and communities.

Where do we need to improve?

- The integrated financial management information currently available is limited and a priority for improvement.
- Stronger links between the strategic plan priorities and objectives and those in service and team plans and objectives for individual members of staff.
- Align our asset management ambitions with the plans of the Council, NHS Lothian and other partners.
- Urgently improve the extent to which ICT systems support integrated working.

What action are we taking?

- Establishing a permanent senior management team which recognises and builds on the strength of the interim arrangements.
- Developing a financial framework to support the delivery plan for older people.
- Devolving the management of budgets closer to the frontline to support the new integrated management structure underpinned by integrated financial reporting.
- Implementing a strategic planning framework and governance structure which sets out relationships between localities and areas of strategic focus.
- Ensuring there is a golden thread linking the priorities within the strategic plan through to individual and team objectives.
- Actively exploring further opportunities for bringing services together in shared premises e.g. Gamechanger, Tramway and integrated care facilities on the Royal Victoria and Royal Edinburgh Hospital sites.
- Developing an asset management strategy with the support of the Council and NHS Lothian.
- The ICT Steering Group will oversee the development of an ICT strategy to support integrated working.

The Partnership has assessed performance against this indicator as Grade 4

Evidence

Evidence Ref No;

8.1 IJB and Partnership Governance Framework
8.2 Organisational Chart – Cross Reference to Indicator 3 – Document Reference 3.6
8.3 Financial Settlement
8.4 Strategic Plan – Cross Reference to Indicator 1 – Document Reference 1.9
8.5 Dementia Delivery Plan – Cross Reference to Indicator 2 – Document Reference 2.8
8.6 Accessible Housing Investment Information
8.7 HSC Infrastructure Developments – Cross Reference to Indicator 4 – Document Reference 4.10
8.9 ICT Information – Cross Ref:
8.10 Flow Board – Cross Reference to Indicator 1 – Document Reference 1.2

Outcome 9: Leadership and direction that promotes partnership

What do we do well?

The Partnership vision and values for adult and older people's services were developed in collaboration with the Strategic Planning Group. These are clearly articulated within the Strategic Plan[9.1] as are the links to the strategic priorities of the Council, NHS Lothian and the Community Planning Partnership. The strategic plan has been subject to an equalities impact assessment and the IJB has published an equalities mainstreaming report[9.2].

Our approach to the development of the strategic plan included a 3 month period of public consultation using a number of accessible formats[9.3] to maximise engagement.

A leadership group with senior representatives from the Council, NHS Lothian and the IJB was established to oversee the implementation of integration. At the suggestion of the IJB chair this has been subsequently replaced by the informal Interface Group[9.4], the purpose of which is to ensure ongoing dialogue and act as a forum to broker challenging decisions informally. To cement partnership working the 3 parties have formally signed up to a tripartite agreement[9.5] which governs how they will work together.

Our new Partnership structure[9.6] has been designed to integrate management and embed integrated working at all levels of the Partnership in order to deliver a more seamless service for citizens. Great care has been taken to ensure both clinical and professional governance of professions is actively evident and exercised within the new structure; this has been agreed by all professional groups.

The new structure also incorporates a quality triangulation to both monitor and promote good practice. This is evidenced through the relationships with locality managers, strategic leads and professional leaders.

Professional and clinical leadership is provided by the Chief Nurse, Clinical Director and Chief Social Work Officer all of whom sit on the IJB. Other roles in the new structure (for example the Hub and Cluster Managers) have explicit professional and operational responsibilities. The IJB also has a professional advisory group.[9.7]

As members of the IJB, elected members of the Council and NHS Board members actively promote partnership working through leading specific pieces of work related to performance and transformation of services.[9.8] We also have representation from clinical leads in both primary care and acute services.[9.9]

Through our partnership with Ernst & Young we have developed a 5 stage approach[9.10] to service change which incorporates the production of business cases and associated benefit realisation.

Our senior management team, led by the Chief Officer, embodies our commitment to effective collaborative working as a means of improving outcomes for individual citizens and communities. This provides a sound basis from which to develop an organisational culture for the Partnership that promotes integrated working and builds on shared values thereby creating a seamless service for older people with fewer transitions. Our new integrated clinical and care governance and risk management processes have been designed to ensure we learn from best practice and will oversee the implementation of recommendations from incident investigations and scrutiny reports as discussed in Outcome 1.

We have a variety of means to engage with staff including: regular team meetings; Chief Officer road shows and newsletters[9.12]; consultation meetings on the strategic plan[9.13]; and multi disciplinary workshops[9.14] to address service change and improvement.

Where do we need to improve?

- Establish strong governance arrangements for planned service changes.
- Recognise progress to date, continue to endorse partnership working, systems leadership and integrate services.

What action are we taking?

- Implementing the new structure, promoting integrated working as the norm and establishing a partnership culture.
- Embedding the 5 stage approach in decision making.
- Improve systematic engagement.

The Partnership has assessed performance against this indicator as Grade 4

Evidence

Evidence Ref No;

9.1 Strategic Plan – Cross Reference to Indicator 1 – Document Reference 1.9
9.2 Strategic Plan Equalities Impact Assessment
9.3 Strategic Plan Consultation - Cross Reference to Indicator 3 – Document Reference 3.4
9.4 Informal Interface Group
9.5 Tripartite Agreement
9.6 New Structures – Cross Reference to Indicator 3 – Document Reference 3.4
9.7 Professional Advisory Group
9.8 IJB Quality Performance Group Membership
9.9 Clinical Leads Primary Care and Older Peoples Acute Medicine
9.10 Ernst & Young Transformation Programme of Works
9.11 Integrate Clinical Governance and Risk Management Structure – Cross Reference to Indicator 1 – Document Reference 1.10

Outcome 10: Capacity for Improvement

The capacity for improvement is reliant on the strength of the partnership. Our partnership draws its strength from moral commitment, transparency of operation, clear risk management with an appetite for change, all of which manifests within the governance arrangements for the partnership, the development and implementation of the strategic plan and now the real willingness for collaboration across previously divided factions who are now building strong partnership relationships to ensure effective leadership of integration at senior management level.

Based on a detailed understanding of our service and strengths and gaps and on our shared commitment to address these we assess our capacity for improvement to be strong. The IJB provides effective collaborative leadership. We therefore have clear partnership vision and ambition as we take the process of delivering the locality model to its next stage. Permanent appointments have now been made to key senior strategic and operational posts.

The operating model is being developed to support locality delivery of service with a streamlined process through the MATTs, Hubs and clusters. The principle being to provide a responsive service within clear timescales and with the minimum of hand-offs. Assessment processes will be proportionate, with a focus on improving outcomes for older people through maximising community assets, technology enabled care and flexible home support.

A key part of delivering these changes will be devolved and integrated budgets for support planning facilitated by a single assessment process. We recognise the importance of taking a structured approach to this development and the IT Steering Group will play a critical part in ensuring that 'business process redesign' sits alongside the design and development of IT solutions to support single assessment, integration and mobile working.

As well as ensuring an appropriate management structure with managers who operate as effective system leaders, we recognise the need for ongoing investment in the wider workforce. Integration will provide opportunities for revaluating the required skill mix and team make up as we support greater numbers of people at home and outside of the more traditional hospital and care home settings.

We know there are some significant challenges in meeting current demand and there are delays in assessment and providing support, in particular this is due to the historical levels of capacity in Home Care. New care-at-home contracts are being introduced over the second half of this year and these contracts have been specifically designed to increase both capacity and innovation into these services. These providers will accommodate and facilitate the use of direct payments and Individual Service Funds.

Partnership working is growing in strength and is helped where we have been able to achieve co-location of the workforce and this includes co-location with GP practices and some key voluntary sector services. We recognise the challenges around demand and capacity for GP practices and the need to look at new models of care involving the wider primary care team.

We recognise that we need to ensure the market is fit for purpose as models of support change and the emphasis on achieving outcomes for people becomes core to our way of working. To this end we are taking a market shaping approach as evidenced in our work on capacity planning. Our approach to performance management through the IJB Performance

Board will enable the evidence to be derived to support our spending in the market and a rebalancing of budgets for core services through the application of informed investment and disinvestment decisions.

The partnership have progressed the following elements, providing a strong leadership foundation:

- Clear governance in place.
- Budget control, and controls on agency spend, with delegated resource allocation, so those who spend are accountable for that spend.
- Staff development.
- Communication strategy.
- Training programmes.
- New structure focused on localities and quality triangulation.
- Improved rostering leading to reduced absence and better attendance.

The Partnership has assessed performance against this indicator as Grade 4