Report

Inspection of Older People's Services
Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. This paper outlines the response of the Edinburgh Health and Social Care Partnership to the Care Inspectorate's inspection of older people's services report. It summarises details of the report and sets out current and future actions of the Partnership in response to the improvement recommendations made.

Recommendations

The EIJB is asked to:

2. note the findings of the inspection (recommendations detailed in Appendix 2) and resource implications (detailed on page 9) required to take forward the improvements; and

3. note the progress made on the 17 recommendations made by the Care Inspectorate and in particular those that have been identified as a priority.

Background

4. From October to December 2016, The Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) carried out a joint inspection of older people's services in health and social work across Edinburgh.

5. The partnership was measured against 10 quality indicators which are detailed in Appendix 1 to establish if the health and social care services in Edinburgh worked together to provide good outcomes for older people and their unpaid carers. As part of the inspection process the partnership submitted a range of documented evidence against each of the quality indicators to help the inspection team to deliver an evaluation score. In addition, the inspection process also included a case file review of 100 service users, one to one meetings with service users, their carer's and the staff involved in the delivery of services to people over the age of 65.

6. The Partnership and the Integration Joint Board was formally established in April 2016. It was acknowledged that at the time of the inspection, the Partnership was going through a significant period of transition and restructuring.

7. The inspection report published the following judgements:

Evaluation Scores:

Key Performance Outcomes	Weak
Getting Help at the Right Time	Weak
Impact on Staff	Adequate
Impact on the community	Adequate
Delivery of key processes	Unsatisfactory
Strategic planning and plans to improve services	Weak
Management and support of staff	Adequate
Partnership working	Adequate
Leadership and direction	Weak

8. The key vision for the partnership is to provide care at the "right time, in the right place by the right person", streamlining service delivery and reducing unnecessary transitions in care, which disrupt continuity and result in poorer outcomes for citizens and their carers. The partnership recognises that providing safe, effective person centred care with good outcomes is reliant on good working relationships between organisations.

9. The new locality structure within the Edinburgh Health and Social Care Partnership has been designed to promote integrated working and management of multidisciplinary teams; maximise workforce potential and efficiencies; reduce unnecessary transitions in care in particular for our older and more vulnerable citizens.

10. The new management arrangements went live on 1 May 2017. The transition of staff to new managers is in progress along with finalisation of the financial ledgers and movement of staff and caseloads on our social care system, Swift to reflect the new locality model.

11. The context for the necessary changes within Edinburgh are similar to other partnerships across Scotland, those being:

- a more challenging fiscal climate;
- increasing numbers of citizens over 75 years of age living with one or more co-morbidities;
- increasing frailty;

- increasing numbers of people living with dementia and,

- a challenging and competitive market competing with retail industry to attract lower paid workers to choose a career in care.

12. The Scottish Government's 2020 Vision is that by the year 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a care system where:

    - We have integrated health and social care where there is a focus on prevention, anticipation and supported self-management;

    - where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm;

    - whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions; and

    - there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

13. The development of the integrated Health and Social Care teams within the Partnership has been designed to work to achieve the Scottish Government 2020 vision for Health and Social Care.

14. The partnership has already seen evidence of improvements in achieving this vision through the introduction of “multi-agency triage teams” and “hub teams”, which are now established within each locality. These teams provide a locality response to helping reduce avoidable admissions to hospital and facilitate a more co-ordinated early discharge from hospital ensuring the most appropriate person undertakes the initial review / assessment.

15. In addition, the localities operate a Mental Health and Substance Misuse team and two Cluster Teams, which are aligned to GP clusters. The clusters have a focus on building multiagency teams around GP’s ensuring our citizens and their carers are at the ‘centre’ of our care provision.

16. At the time of the inspection the partnership had only just appointed its senior management team, and all of the above arrangements were at the planning stage. Whilst the inspectors acknowledged the transition being undertaken their assessment was on current and previous practice.

Inspection outcomes and progress

17. The inspection report was published on 16 May 2017. Associated with the findings of the report were 17 recommendations for improvement as detailed in Appendix 2 of this report.

18. In response to those recommendations, the Partnership has produced an improvement plan which is detailed in Appendix 3. The Partnership views the inspection as a helpful process and its findings confirm the need to continue to drive forward the improvements identified by the IJB and the Health and Social Care Partnership following its inception in 2016.

19. The partnership has a robust transformation integration and performance improvement plan and through embedding the full inspection findings and recommendations, this joint improvement plan clearly lays out priorities and actions over 2017/18.

20. It became clear to the Partnership in 2016 that Edinburgh has a number of significant challenges to address. These include:

- a higher than expected use of residential and nursing home placements;
- under provision of and consequential difficulty in access to sufficient care at home support;
- under developed early intervention and preventative services and the development of local community support;
- a long-standing culture of delays in undertaking assessments, delivering services to meet assessed need and reviewing support plans; and
- an overreliance on internal and external scrutiny rather than an engagement of front line staff and leadership teams in quality improvement processes and measures.

21. The recent inspection has therefore rightly identified the above as significant weaknesses and our improvement plan builds on the work already underway to tackle resource gaps, unsatisfactory practice and the organisational cultural shift required to sustain ongoing improvement and embedding accountable practice cultures across all professions within the partnership.

22. The full leadership team is now in place and their emphasis is on strengthening locality operations. Fundamental to our success will be the role and competence of

front line managers. The development of this workforce is a major priority for the service.

23. The partnership has employed a general manager mode of operation to better secure the partnership functions and improve patient flow across the professions. The managers who are drawn from both the local authority and the NHS are key to effectively implementing this improvement plan and ensuring delivery of agreed performance standards. Support is in place to manage across the different disciplines and professions and to operate new reporting procedures, varying processes in finance, personnel, assessment, recording and reporting.

24. The Care Inspectorate have indicated that they will revisit and assess the partnership against the recommendations within 12 to18 months from receipt of the report. The key priorities have been agreed along with lead officers and timescales for delivery.

25. An improvement board was created whilst the inspection was underway and an improvement action plan has been agreed and implemented by senior managers. This action plan is fairly large covering all indicators and the 17 recommendations. Senior managers have been allocated as leads for the actions to be undertaken.

26. The improvement board has prioritised the required actions as follows:

    Actions in the improvement plan with priority status -

Priority 1	Completed within 3 month
Priority 2	Completed within 6 months
Priority 3	Completed within 12 months
Priority 4	Completed within 18 months
Priority 5	Completed within up to 2 years

27. Within the plan, 13 actions have been given a 'priority status1' – these are numbered below relating to the Quality Indicator standards to which they apply. Included within the following table are details as to the progress made to date:

Action	Action detail	Progress
1	Develop and implement a performance dashboard for the partnership to measure key performance indicators.	• Performance dashboard in place for the partnership. • Delayed discharge reporting through weekly star chamber • Delays down from 215 to 130. The target is 50 by December 2017 • MATTs now screening all packages of care

		• Social Work Practice framework revised and published on the Orb.
2	Monitor compliance against care at home and innovation contracts	• Key indicators in place for monitoring the Care at Home Contract, reporting to Performance Board.
11	Review of step down facilities providing intermediate care. (Liberton and Gylemuir)	• A presentation will be made to the June IJB detailing options for reprovision of Liberton and Gylemuir. Capital support from NHS Lothian and CEC will be required. .
19	Introduce workforce development programme for management teams	• There is a locality implementation steering group which has developed a clear induction programme around the six pillars of operational management for newly appointed integrated mangers.
22	Develop system to monitor compliance within agreed standards of social work practice	• Social Work standards revised and published on the CEC Orb. Further work has been commissioned to develop clear definitions against standards to reduce variation in interpretation and enable meaningful compliance reports to be produced.
24	Finalise implementation of new structure	• There is a steering group overseeing the implementation of the locality structure chaired by the Chief Performance and Strategy Officer. An operational lead has been seconded from NHS Lothian. Project support has been provided by CEC transformation team. There is a locality implementation risk register in place.
26	Improve staff communication strategy	• A Communications strategy is in place.
28	Revise and streamline the 'my steps' financial assessment on swift (AIS) to improve efficiency and performance of compliance	• Completed 1 May - financial assessments through senior social workers. Electronic FAS system aligned to Swift under review.
39	Review circumstances of all individuals currently on waiting lists for social work assessments and reviews	• Weekly Star Chamber for delays now covers reviews and assessment and unmet need on a locality basis.

46	Work with partner agencies to ensure delivery against care at home contract and build capacity in localities Work with partner agencies to ensure compliance with the care at home contract in a bit to build capacity	• Hospital to home contract agreed with two providers to increase over all capacity, delays reducing. Locality Managers meet regularly with providers within their localities. QA group for Care at Home has been reviewed and re-established and includes provider representation.
47	Develop a joint framework to effectively deliver shared approaches to ensure delivery of robust quality assurance systems across the partnership	• Partnership Quality and governance group operational and quality governance framework in place.
54	Develop and implement integrated induction programme for new managers	• Induction programme for new managers through the local implementation programme has been developed by the locality implementation steering group. Two leadership events for the senior management team have been arranged for 8 and 9 June 2017.
61	Communication strategy for staff and stakeholders around progress against improvement plan for older people's services	• Communications strategy.

28. The Chief Officer, Chief Performance and Strategy Officer, Chief Social Work Officer and Clinical Director are leading the work streams for these actions and positive progress has been reported to the core group overseeing the delivery of the improvement plan.

29. The full improvement plan with all actions is included as Appendix 3. Detail of the progress against each action is detailed in Appendix 4.

30. The report acknowledged the role of the Chief Social Work Officer (CSWO) as a key post, which should play a critical role in helping partnerships deliver on their statutory responsibilities. Processes have been put in place to support the CSWO role and the contribution the position should make to the Health and Social Care Partnership through including the position within the membership of the Senior Management team and the Partnership Quality Assurance and Improvement Group.

Key risks and challenges

Quality Assurance

31. There is recognition that in order to deliver on the improvement plan actions, there will need to be a significant investment in quality assurance and improvement support as well as support for Adult Support and Protection. This will include the agreement of the level of quality assurance and improvement support and contribution available from the NHS and CEC Quality Improvement teams.

32. NHS are providing support from their data analyst team and the partnership quality leads are working with the NHS Lothian Quality Academy to develop a branch Quality Academy for Health and Social Care within the Edinburgh partnership.

33. The quality assurance resource for Adult Health and Social Care currently sits within the direct governance of the Chief Social Work Officer (CSWO). Compliance measures against the revised standards for social work have been developed. The measures for assessments and reviews going forward will need to take into consideration the contribution of integrated teams (e.g. single shared assessment).

34. The general resource requirements to progress the change and improvements required within “Quality indicator 5 – Key Processes” are set out in section 47 below and these include the appointment of two Adult Support and Protection posts. Funding has been identified and appointments will be made in the next few weeks.

35. Additional support has been identified to improve standards within Adult Protection within the partnership to develop compliance reports for each locality against the recently issued practice framework for adult social work. The Chief Performance and Strategy Officer is working closely with the CSWO and the Strategy and Insight Team introducing new locality based performance reports for assessments, reviews and unmet need. Once compliance reports are developed they will be monitored as part of the performance framework on a locality basis similar to the delayed discharge model.

36. The weekly star chamber meeting for delayed discharges will now also include a weekly review of the progress in reducing assessment waiting lists and outstanding reviews. This group is chaired by the Chief Performance and Strategy Officer and has management representation from each locality team.

Care at Home

37. Achieving the target delivery for the care at home contract of 30,000 hours per week is a key priority. Referrals will need to be managed in a way which supports optimum use of in house reablement and home care services as part of the wider effort to improve flow and reduce delayed discharge and community waiting list numbers.

38. The reablement model was recently reviewed to increase efficiency and maximise reablement capacity. Further work needs undertaken to review the total care at home requirements and ensure that we achieve the capacity required. Ernst and Young (EY) are supporting the partnership taking forward a brokerage model and all teams are looking at how to reduce reliance on traditional packages of care.

39. Contract capacity as at 8 May 2017 was 26,290 hours per week, facilitating the support of 1,953 service users. Between 10 April 2017 and 8 May 2017 capacity increased by 1,723 hours (7%) enabling support to be provided to an additional 130 people. During the same period contracted providers increased delivery of hours and number of people supported from 47% of total to 52%. The council are proactively engaging with providers to establish the extent to which current shortfall in target capacity (3,710 hours) can be reduced between now and October 2017. The in house capacity is currently 12,164 hours/week. In addition, more self directed support and direct payments are being made to individuals. These amount to a further 2,838 hours/week. In total the number of hours of care provided equates to 43,015 hours/week.

40. Competition for scarce labour continues to intensify and numbers of new hotel, leisure retail and call centre developments threaten ability to recruit and retain care workers.

Technology Enabled Care

41. Ernst and Young are supporting the partnership to increase TEC solutions in care provision, with the intention of supporting people at home without the need for intrusive packages of care. We expect a significant increase in the numbers of packages that can now be provided through equipment.

Financial implications

42. The financial implications associated with the delivery of the key areas for improvement have been considered and a business case has been developed to support the need for key posts to be funded. Resources via Corporate Services within CEC and NHSL are supporting the improvement plan. There may be a need for further funding as systems and assessments improve which will identify further needs within the community. A further paper will be brought to the IJB should this be the case.

The following additional support will be utilised:

Strategy and Insight

43. The partnership is receiving further dedicated strategy and insight support to develop the performance measures required to manage improvements. This business support will support business processes in particular around assuring data cleansing and recouping of financial costs where appropriate.

Organisational Development

44. Dedicated support from Organisational Development is helping manage change and bring together cultural difference to ensure a streamlined integrated Health and Social Care service within the Partnership. Support from NHS and CEC is developing a Partnership forum for health and safety and business resilience that draws together both the NHS and CEC processes. This work is being led by the Chief Strategy and Performance Officer on behalf of the Partnership.

Contract support and managing purchasing budgets

45. There is an urgent need for CEC to review the current contract for care at home, and to develop an options appraisal as to alternative provision, should the current contact performance not improve. The recent Flow Programme Board has determined the scope of this appraisal.

Capital development support

46. The inspection report details the need for an exit strategy from the Partnership's interim step down functions in Liberton Hospital and Gylemuir Care Home. These strategies will require further bed based facilities. Support is provided across both CEC and NHSL capital teams on this work.

Delivery of key processes

47. In addition to the support from the two new Adult Support and Protection (ASP) posts, training and development work directly with staff on the quality of recording assessments and reviews is now in place to ensure common practice in applying thresholds and standards.

Assessment and reviews

48. Whilst work to improve productivity is underway across all assessors, if this fails there will be a need to import further resource from CEC to clear the backlog of assessments and reviews. A further paper will b brought to the IJB if this is the case.

Background reading/references

Appendix 1 – Older People's Inspection Quality Indicators
Appendix 2 – Inspection Report 17 Recommendations
Appendix 3 – EHSCP Improvement Plan in response to the recommendations
Appendix 4 – Summary of progress against recommendations

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Appendix 1 – Older Peoples Inspection Quality Indicators

What key outcomes have we achieved?	How well do we jointly meet the needs of our stakeholders through person centred approaches?	How good is our joint delivery of services?	How good is our organisational management in partnership?	How good is our leadership?
1. Key performance outcomes	**2. Getting help at the right time**	**5. Delivery of key processes**	**6. Policy development and plans to support improvement in service**	**9. Leadership and direction that promotes partnership**
1.1 Improvements in partnership performance in both healthcare and social care **1.2** Improvements in the health and well-being and outcomes for people, carers and families	**2.1** Experience of individuals and carers of improved health, wellbeing, care and support **2.2** Prevention, early identification and intervention at the right time **2.3** Access to information about support options including self directed support	**5.1** Access to support **5.2** Assessing need, planning for individuals and delivering care and support **5.3** Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks **5.4** Involvement of individuals and carers in directing their own support	**6.1** Operational and strategic planning arrangements **6.2** Partnership development of a range of early intervention and support services **6.3** Quality assurance, self evaluation and improvement **6.4** Involving individuals who use services, carers and other stakeholders **6.5** Commissioning arrangements	**9.1** Vision ,values and culture across the partnership **9.2** Leadership of strategy and direction **9.3** Leadership of people across the partnership **9.4** Leadership of change and improvement
	3. Impact on staff		**7. Management and support of staff**	**10. Capacity for improvement**
	3.1 Staff motivation and support		**7.1** Recruitment and retention **7.2** Deployment, joint working and team work **7.3** Training, development and support	**10.1** Judgement based on an evaluation of performance against the quality indicators
	4. Impact on the community		**8. Partnership working**	
	4.1 Public confidence in community services and community engagement		**8.1** Management of resources **8.2** Information systems **8.3** Partnership arrangements	
What is our capacity for improvement?				

Appendix 2 – Inspection Report, 17 Recommendations for Improvement

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

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

Edinburgh Health and Social Care Partnership
Quality Improvement Programme for Older People and Improvement Plan in response to the recommendations from the Inspection of Older People's Services in Edinburgh

Partnership Evaluation and Inspection Scores

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

Quality Indicators

What key outcomes have we achieved?	How well do we jointly meet the needs of our stakeholders through person centred approaches?	How good is our joint delivery of services?	How good is our organisational management in partnership?	How good is our leadership?
1. Key performance outcomes	**2. Getting help at the right time**	**5. Delivery of key processes**	**6. Policy development and plans to support improvement in service**	**9. Leadership and direction that promotes partnership**
1.1 Improvements in partnership performance in both healthcare and social care **1.2** Improvements in the health and well-being and outcomes for people, carers and families	**2.1** Experience of individuals and carers of improved health, wellbeing, care and support **2.2** Prevention, early identification and intervention at the right time **2.3** Access to information about support options including self directed support	**5.1** Access to support **5.2** Assessing need, planning for individuals and delivering care and support **5.3** Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks **5.4** Involvement of individuals and carers in directing their own support	**6.1** Operational and strategic planning arrangements **6.2** Partnership development of a range of early intervention and support services **6.3** Quality assurance, self evaluation and improvement **6.4** Involving individuals who use services, carers and other stakeholders **6.5** Commissioning arrangements	**9.1** Vision ,values and culture across the partnership **9.2** Leadership of strategy and direction **9.3** Leadership of people across the partnership **9.4** Leadership of change and improvement
	3. Impact on staff		**7. Management and support of staff**	**10. Capacity for improvement**
	3.1 Staff motivation and support		**7.1** Recruitment and retention **7.2** Deployment, joint working and team work **7.3** Training, development and support	**10.1** Judgement based on an evaluation of performance against the quality indicators
	4. Impact on the community		**8. Partnership working**	
	4.1 Public confidence in community services and community engagement		**8.1** Management of resources **8.2** Information systems **8.3** Partnership arrangements	
What is our capacity for improvement?				

Background

This improvement plan follows the recent joint inspection of older peoples services in Edinburgh. This inspection was a helpful process and its findings confirm the need to continue drive forward improvements identified as urgently required by the IJB following its inception in 2016.The IJB has a robust transformation integration and performance improvement plan and through embedding the full inspection findings and recommendations, this joint improvement plan clearly lays out priorities and actions over 1017/18.

It became clear to the IJB in 2016 that Edinburgh has a number of significant challenges to address. These include:

- A higher than expected use of residential and nursing home placements
- Under provision of and consequential difficulty in access to sufficient care at home support
- Under developed early intervention and preventative services and the development of local community support.
- A long-standing culture of delays in undertaking assessments, delivering services to meet assessed need and reviewing support plans.

The recent inspection has therefore rightly identified the above as significant weaknesses and this improvement plan builds on the work already underway to tackle resource gaps, unsatisfactory practice and the organisational cultural shift required to sustain required ongoing improvement.

The senior leadership team is now in place and the emphasis is on strengthening locality management teams. Fundamental to our success will be the role and competence of front line managers. Therefore and workforce development focus must now be on growing competence of these managers within our integrated organisation. These managers who are drawn from both the local authority and the NHS and are key to effectively implementing this improvement plan and ensuring delivery of agreed performance standards.

Recommendations

1	The partnership should improve its approach to engagement and consultation with stakeholders in relation to: • its vision • service redesign • key stages of its transformational programme, and • its objectives in respect of market facilitation.
2	The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.
3	The partnership should develop exit strategies and plans from existing 'interim' care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice
4	The partnership should engage with stakeholders to further develop intermediate care services, including bed based provision, to help prevent hospital admission and to support timely discharge
5	The partnership should work in collaboration with carers and carer's organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating the Carer's Strategy.
6	The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.
7	The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.
8	The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.
9	The partnership should work the local community and with other stakeholders to develop and implement a cross sector market facilitation strategy. This should include a risk assessment and set out contingency plans.

10	The partnership should produce a revised and updated joint strategic commissioning plan with detail on: • how priorities are to be resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • fully costed action plans including plans for investment and disinvestment based on identified future needs • expected measurable outcomes.
11	The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.
12	The partnership should ensure that: • there are clear pathways to accessing services • eligibility criteria are developed and applied consistently • pathways and criteria are clearly communicated to all stakeholders, and • waiting lists are managed effectively to enable the timely allocation of services.
13	The partnership should ensure that: • people who use services have a comprehensive, up to date assessment and review of their needs which reflects their views and the views of the professionals involved • people who use services have a comprehensive care plan, which includes anticipatory planning where relevant • relevant records should contain a chronology, and • allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.
14	The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing maintained.
15	The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased in confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.

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

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Date: 26.05.17

	Priority 1 - Completed within 3 month
Open	**Priority 2 - Completed within 6 months**
Current	**Priority 3 - Completed within 12 months**
Complete	**Priority 4 - Completed within 2 years**
Overdue	**Priority 5 - within >2 years**

RMG - Rob McCulloch- Graham	**MG - Marna Green**
MMcI - Maria McIlgorm	**AS - Andy Shanks**
MM - Michelle Miller	**LMs - Locality Managers**
IM - Ian McKay	**KMcW - Katie McWilliam**
CB - Carl Bickler	**DW - David White**
MP - Moira Pringle	**PW - Pat Wynne**
WD - Wendy Dale	**JF - Jon Ferrer**
AL - Angela Lindsay	**KD - Keith Dyer**
NC - Nikki Conway	**LMcD - Lyn McDonald**

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 1: **The partnership should improve its approach to engagement and consultation with stakeholders in relation to:** **• its vision** **• service redesign** **• key stages of its transformational programme, and** **• its objectives in respect of market facilitation**								
Action 25	***Review role and influence of Professional Advisory Group when contributing to service redesign.***		Priority 2 - completed within 6 months	CB	Apr-17	Jul-17	Open	
Action 27	***Improve partnership and collaborative working with independent and third sector*** **Sub Action:** Locality teams will meet regularly with third sector organisation. Regular cycle of meetings with partners to be agreed.	Monthly meetings with partner providers in care at home contract. Third sector involvement in hubs and MATTs picking up appropriate referrals. Workshop planned for September. Third sector and independent representation on IJB Board and Sub Groups. Third and independent sector to contribute to the development of Locality plans. Re-commission grants and contracts with third sector. The health and wellbeing sub group in NW has a large membership comprising of third sector, independent reps and reps from the statutory agencies. Work is underway in developing the locality plan. Key priorities have been identified and short, medium and longer term action plans are being finalised. Joint work in NW and the third sector focussing on a social prescribing pilot in 5 GP practices as part of NC funding working in partnership with Health in mind. The brokerage model will enhance working with independent and third sector. The Quality Groups for Care at Home and Care Homes have been revised and involve local providers. Regular meetings with independent care home providers both city wide and on localities. ***AL: 6 weekly meetings established with Directors of contracted Care at Home Services*** ***North East Locality Manager sits on Edinburgh Affordable Housing Partnership***	Priority 3 - completed within 12 months	WD LMs	Apr-17	Sep-17	Current	
Action 44	***Develop and implement a cross sector market facilitation strategy with local communities and other stakeholders This should include contingency and identification of risk.***	Progress: Will be completed by July 17	Priority 3 - completed within 12 months	MP	Apr-17	Oct-17	Open	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 45	***Improve approach to engagement and consultation with staff and stakeholders in relation to:*** ***- its vision*** ***- service redesign*** ***- key stages of its transformational programme, and*** ***-its objectives in respect to market facilitation***	Progress: Road shows have been undertaken in each locality and specifically for stakeholders. Addressed in action 26	Priority 3 - completed within 12 months	WD	Apr-17	Oct-17	Current	
Action 46	***Work with partner agencies to ensure delivery against care at home contract and build capacity in localities*** ***Work with partner agencies to ensure compliance with the care at home contract in a bit to build capacity.***	Progress: Review of care at home contract underway.	Priority 1 - completed within 3 month	MMCI	Apr-17		Current	
Action 60	***Locality teams to meet regularly with third sector organisations.***	Development of a regular meeting cycle with 3rd sector partners and organisations. AL: ***There are regular engagement forums that include 3rd sector colleagues - Wellbeing PSP, Way finder, and MH accommodation group for example. 3rd sector are also well integrated within substance misuse and overseen by Edinburgh Alcohol & Drug Partnership which has shared representation.*** ***Third sector and housing organisations attend bi-monthly North East Locality Innovation Group meetings and H&SC LIP Sub Group has a representative from EVOC*** ***6 weekly meetings established with Directors of contracted Care at Home Services*** ***North East Locality Manager sits on Edinburgh Affordable Housing Partnership***	Priority 3 - completed within 12 months	AL MG NC AS	Apr-17	Jul-17	Current	
Action 61	***Communication strategy for staff and stakeholders around progress against improvement plan for older people's services*** **Sub Action (1):** Develop joint NHS and CEC communication strategy		Priority 1 - completed within 3 month	RMG	Apr-17	May-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 2: **The partnership should further develop and implement approaches to early intervention and prevention services to support older people to maintain in their own homes and help avoid hospital admissions**								
Action 1	***Develop and implement a performance dashboard for the partnership to measure key performance indicators*** **Sub Action (1):** Identify dedicated performance information analyst support to ensure the recommendations and partnership performance can be clearly monitored. **Sub Action (2):** Develop locality performance dashboards to measure key performance indicators (Action LMs) **Sub Action (3):** Identify key performance indicator suite.	Progress: Weekly delayed discharge meeting established to monitor delays. Performance Board established Mar 17 Locality performance dashboards to be finalised. A performance dashboard for the partnership has been developed. Key areas of focus are delayed discharges and access to care. A weekly delayed discharge Star Chamber has been set up and chaired by Chief Strategy and Performance Officer. Data provided on a locality basis and trajectories to achieve 50 delays by Dec have been added to performance targets. Assessment and review data reports have also been developed on a locality basis and will be used to manage down the outstanding assessment delays (1251) and reviews (6051). This will be closely monitored.	Priority 1 - completed within 3 month	MMcI	Apr-17	May-17	Current	
Action 3	***Agree and develop outcome measures for the delivery of care for service users and carers***	Agree outcome measures: National indicators Local indicators Progress: Outcome measures for the delivery of care for service users and carers Discussions have taken place with the inspectors to agree specific outcome measures relating to this target and await feedback on this matter.	Priority 3 - completed within 12 months	WD	Apr-17	Sep-17	Open	
Action 4	***Increase homecare capacity and review options for alternative models of care e.g locality brokerage and asset based approach models*** **Sub Action (1):** Designated project management support required to take this work forward. **Sub Action (2):** Develop capacity plan for homecare. **Sub Action (3):** Increase care provider choice and capacity across third and independent sectors. **Sub Action (4):** Strengthen management scrutiny through the development of new and revised performance and exception reporting using KPIs and data quality tools at a locality level. **Sub Action (5):** Review of service action unit.	Progress: Key priorities identified following the referral and access event on 28.03.17 Progress: Market facilitation strategy will be updated by July 17. Capacity for packages of care against contract I being closely monitored. Work with EY around brokerage model has been progressed. Implementation date to be confirmed.	Priority 3 - completed within 12 months	MMcI	Nov-16	May-17	Current	Ref:

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 6	***Review the prevention and early intervention actions within the EHSCP Strategic Plan and agree priorities for the next 5 years.*** **Sub Action (1):** Implement new commissioning model for third sector grants and contracts and reallocate to providers including early intervention and prevention. **Sub Action (2):** Include prevention and early intervention for people with Long Term Conditions.	Progress: Review of strategic plan underway. Current grants and contracts aligned to end April 18. New tender to close Dec 17. Prevention and Early Intervention Review of strategic plan currently under way. This includes identifying key priorities around prevention for 2017-18	Priority 2 - completed within 6 months	WD	Apr-17	Jul-17	Current	
Action 7	***Improve service user / patient pathways and access to services.*** **Sub Action (1):** Reduce duplication and confusion about services availability and access. **Sub Action (2):** Review all unplanned admissions for patients over 65 to acute services. Progress: Project remit being developed by Clinical Lead for Long term Conditions **Sub Action (3):** Locality plans to include approaches to early intervention and prevention. **Sub Action (4):** Create referral pathway for MATTS	Progress: Development of MATT'S and HUBs to reduce duplication, streamline care, reduce admissions to hospital and manage delayed discharges within localities. Steering group overseeing the implementation of MATTs and Hubs. Accommodation identified in 3 localities. Most areas have identified and accommodation for their HUBS and equipment with exception of the SE locality MATTs and Hub structure to be fully operational May 17. Hub managers in post from April 2017 Protocols for access have been developed. Locality MATTs (Multi Agency Triage Teams) are now fully operational in each locality on a daily basis. Performance matrix around delayed discharge and prevention of admission are being measured related to decisions made by locality MATTs now linking with daily discharge hubs at acute hospitals.	Priority 2 - completed within 6 months	MMcI	Feb-16	May-17	Current	Ref:
Action 12	***Increase use and provision of telecare services.***	Progress: EY transformation project underway around telecare provision and access. Promote professional awareness. Transformation project underway around telecare provision, supported by Ernst & Young colleagues. Current activity includes adjusting the assessment documentation to consider TEC options as a foundation for care and support; identifying target population to increase TEC numbers; developing the investment plan; and developing promotional and awareness material for assessors. Work ongoing with EY to increase provision. Business case being prepared for IJB for additional funding.	Priority 3 - completed within 12 months	KMcW	Jan-17	Jun-17	Current	
Action 13	***Continue to increase Anticipatory Care Planning and develop reporting and quality management processes.***	*Cross Ref: Actions 1* Progress: ***AL :ACP work stream is part of FLOW Board programme of works.*** ***Performance will be reported through performance board.*** ***Work ongoing to increase ACP in care homes. This is being monitored through the FLOW Board.*** ***A city wide working group has been established in mental health to look at the delivery around ACPs*** ***Project team formed and key actions identified including focus on improving quality, quantity and access of KIS as part of FLOW programme board – quarterly performance report*** ***Integrated Care funded project supporting improved ACP process within 4 care homes and widespread KIS/ACP training to GP practice teams and community health teams in North Edinburgh*** ***Project set up to focus on maintaining KIS when person moves GP practice*** ***Number of KIS in Edinburgh increased by 27% since April 2016*** ***7.7% of Edinburgh population has Key Information Summary*** ***60% of high risk (SPARRA) with a Long Term Condition have a Key Information Summary (8% increase compared to July 2016)*** ***From July 2017 planned work is to extend ACP improvements in 6 further care homes, continue training and education and develop a training toolkit aimed at a range of clinical teams***	Priority 4 - completed within 2 years	AL	Apr-16	Apr-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 34	***Review GP referral and information sharing protocols for all social care assessment***		Priority 3 - completed within 12 months	DW	Apr-17	Oct-17	Open	
Action 60	***Locality teams to meet regularly with third sector organisations.***	Development of a regular meeting cycle with 3rd sector partners and organisations. AL: *There are regular engagement forums that include 3rd sector colleagues - Wellbeing PSP, Way finder, and MH accommodation group for example. 3rd sector are also well integrated within substance misuse and overseen by Edinburgh Alcohol & Drug Partnership which has shared representation.* *Third sector and housing organisations attend bi-monthly North East Locality Innovation Group meetings and H&SC LIP Sub Group has a representative from EVOC* *6 weekly meetings established with Directors of contracted Care at Home Services* *North East Locality Manager sits on Edinburgh Affordable Housing Partnership*	Priority 3 - completed within 12 months	AL MG NC AS	Apr-17	Jul-17	Current	
Action 43	***Develop and produce a revised joint strategic commissioning plan*** **Sub Action (1):** produce strategic plan update for 2017/18 **Sub Action (2):** produce detailed delivery plan for older people **Sub Action (3):** strategic plan delivery plans overseen by programme board	Progress: Work is progressing to provide an update of the joint strategic commissioning plan.	Priority 2 - completed within 6 months	WD	Mar-17	Jun-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 3: **The partnership should develop exit strategies and plans from existing 'interim' care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice**								
Action 11	***Review of step down facilities providing intermediate care.*** **Sub Action(1):** Review service exit / contingency plans for Liberton Hospital and Gylemuir.	Progress: Step Down facility in place through Liberton and Gylemuir Step- down (intermediate care facility) is being developed to replace Liberton Hospital - will form part of the options appraisal for capacity planning for a bed based model of care. Current activity includes developing the bed based model and standard operating procedures; securing General Practice cover; and building the case to enhance community rehabilitation capacity Cross Ref: Action 5 and 10 Cross Ref: Action 5 and 10 This is being progressed through the options appraisal for the bed based model of care as described above. This includes Liberton and Gylemuir.	Priority 2 - completed within 6 months	KMcW	Apr-17	Jul-17	Current	
Recommendation 4: **The partnership should engage with stakeholders to further develop intermediate care services, including bed based provision, to help prevent hospital admission and to support timely discharge.**								
Action 5	***Review of bed capacity for care homes, HBCCC, respite and rehabilitation*** **Sub Action:** Options paper to be prepared.	Progress: Workshop in Jan 16 reviewed HBCCC and care home capacity requirements. EY is supporting capacity plans for HBCCC, care homes, respite and rehabilitation. Bed Capacity. Outline work is almost concluded that will highlight current capacity, condition of facilities, outline costs and future demographic demand, with outline options for short and longer term requirements. HBCCC, Care homes and the closure of Liberton. Option appraisal being developed with paper to IJB in June 17. ***KMcW: Options paper to be prepared.Progress:Workshop in Jan 16 to review HBCCC and care home capacity requirements. Capacity & Demand for community bed based requirements underway, supported by Ernst & Young EY are supporting capacity plans for HBCCC, care homes, respite and rehabilitation.***	Priority 4 - completed within 2 years	KMcW	Jan-17	Jan-18	Current	Ref:
Action 10	***Review and identify respite requirements*** **Sub Action:** Separate work stream required to review day care respite.	Progress: Bed based respite requirements being addressed through capacity and demand modelling for bed based care. Cross Ref: 5 Bed based respite requirements have been included in the bed capacity plan	Priority 3 - completed within 12 months	KMcW	Apr-17	Sep-17	Open	
Recommendation 5: **The partnership should work in collaboration with carers and carer's organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating the Carer's Strategy.**								
Action 8	***Develop a EHSCP website and content*** **Sub Action (1):** Identify dedicated resource to take this work forward.	Progress: This work is progressed through the ICT steering group work programme. Dedicated support to be identified to progress.	Priority 4 - completed within 2 years	WD			Open	
Action 9	***Improve how carers needs are identified through collaborative working.*** **Sub Action (1):** To be incorporated into carers strategy.	Progress: Carers strategic partnership group forms part governance framework.	Priority 3 - completed within 12 months	WD	Apr-17	Sep-17	Open	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 6: **The partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.**								
Action 16	***Review timescales associated with and access to Dementia services and post diagnostic support***	Current target is in line with Scottish performance. Current activity includes review of post diagnostic support contract, including feedback from service users, staff providing service and wider stakeholders; activity analysis on response times and outcomes; appraising options for future delivery; and making a successful bid to be one of the three partnerships in Scotland to participate in a test of change, which will mean people newly diagnosed with dementia receive some of their support within their own communities and at their local surgery. (St Triduana's Medical Practice)	Priority 3 - completed within 12 months	KMcW	Apr-17	Oct-17	Open	
Recommendation 7: **The partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.**								
Action 17	***Streamline and improve the falls pathway to ensure older people's needs are better met.***	***Progress:*** ***LD: Systems review of Fallen Uninjured pathway and falls with injury pathway underway and comprehensive work programme in place. Progress reviewed under FLOW programme board. Links with national Falls work stream to improve SAS response to fallen uninjured in localities.***	Priority 3 - completed within 12 months	LD	Apr-17	Oct-17	Current	
Recommendation 8: **The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.**								
Action 47	***Develop a joint framework to effectively deliver shared approaches to ensure delivery of robust quality assurance systems across the partnership.***	Progress: A partnership Quality Assurance framework has been developed. The Quality Assurance and Improvement group will be the overarching quality and governance group for the partnership and all other partnership quality improvement groups will feed into this. All improvements plan and learning from significant adverse events will be overseen by this group.	Priority 1 - completed within 3 month	MMcI MM IM	Apr-17	Jul-17	Current	Ref:
Action 48	***Develop joint Infection Control framework***	Progress: Short life working group has been commissioned to progress this work with a view to developing a joint framework for processes and reporting.	Priority 4 - completed within 2 years	MMcI	Apr-17		Open	
Action 49	***Develop joint Health and Safety framework***	Progress: Short life working group has been commissioned to progress this work with a view to developing a joint framework for processes and reporting.	Priority 4 - completed within 2 years	MMcI	Apr-17		Open	
Action 50	***Develop joint Business Continuity and Resilience framework***	Progress: Short life working group has been commissioned to progress this work with a view to developing a joint framework for processes and reporting.	Priority 4 - completed within 2 years	MMcI	Apr-17	Apr-18	Current	
Action 59	***Review of ICT systems across the partnership*** **Sub Action (1):** work across NHS and CEC ICT systems to improve process and reduce duplication		Priority 4 - completed within 2 years	MMcI	Apr-17	Apr-18	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 9: **The partnership should work the local community and with other stakeholders to develop and implement a cross sector market facilitation strategy. This should include a risk assessment and set out contingency plans.**								
Action 27	**Improve partnership and collaborative working with independent and third sector** **Sub Action:** Locality teams will meet regularly with third sector organisation. Regular cycle of meetings with partners to be agreed.	Progress: Monthly meetings with partner providers in care at home contract. Third sector involvement in hubs and MATTs picking up appropriate referrals. Workshop planned for September. Third sector and independent representation on IJB Board and Sub Groups. Third and independent sector to contribute to the development of Locality plans. Re-commission grants and contracts with third sector. The health and wellbeing sub group in NW has a large membership comprising of third sector, independent reps and reps from the statutory agencies. Work is underway in developing the locality plan. Key priorities have been identified and short, medium and longer term action plans are being finalised. Joint work in NW and the third sector focussing on a social prescribing pilot in 5 GP practices as part of NC funding working in partnership with Health in mind. The brokerage model will enhance working with independent and third sector. The Quality Groups for Care at Home and Care Homes have been revised and involve local providers. Regular meetings with independent care home providers both city wide and on localities. ***AL: 6 weekly meetings established with Directors of contracted Care at Home Services*** ***North East Locality Manager sits on Edinburgh Affordable Housing Partnership***	Priority 3 - completed within 12 months	WD LMs	Apr-17	Sep-17	Current	
Action 58	***Commissioning role to be realigned with locality planning and third sector provision.***		Priority 3 - completed within 12 months	MMcI	Apr-17	Oct-17	Open	
Recommendation 10: **The partnership should produce a revised and updated joint strategic commissioning plan with detail on:** **• how priorities are to be resourced** **• how joint organisational development planning to support this is to be taken forward** **• how consultation, engagement and involvement are to be maintained** **• fully costed action plans including plans for investment and disinvestment based on identified future needs** **• expected measurable outcomes.**								
Action 2	***Monitor compliance against care at home and innovation contracts***		Priority 1 - completed within 3 month	MMcI	Mar-17	Apr-17	Current	
Action 56	***Review financial recovery plan*** **Sub Action (1):** Detailed financial recovery plans to ensure a sustainable financial position, including investment and disinvestment based on identified needs.	Progress: Direction for review agreed by IJB	Priority 3 - completed within 12 months	MP	Apr-17	Oct-17	Current	
Action 58	***Commissioning role to be realigned with locality planning and third sector provision.***		Priority 3 - completed within 12 months	MMcI	Apr-17	Oct-17	Open	
Recommendation 11: **The partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.**								

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 56	***Review financial recovery plan*** **Sub Action (1):** Detailed financial recovery plans to ensure a sustainable financial position, including investment and disinvestment based on identified needs.	Progress: Direction for review agreed by IJB	Priority 3 - completed within 12 months	MP	Apr-17	Oct-17	Current	
Recommendation 12: **The partnership should ensure that:** **• there are clear pathways to accessing services** **• eligibility criteria are developed and applied consistently** **• pathways and criteria are clearly communicated to all stakeholders, and** **• waiting lists are managed effectively to enable the timely allocation of services.**								
Action 32	***Review FAS process for indicative budget and processes for funding allocation to ensure they are robust and transparent and easy to use with staff.***	Progress: EY supporting the review of financial allocation systems. Will be part of swift (AIS) replacement programme. FAS options are currently being explored to help improve systems for financial approval.	Priority 4 - completed within 2 years	WD			Current	
Action 33	***Review OT hospital and community nursing assessment and referral process to build consistency of thresholds.***	Progress: MATT and Hub work stream is developing a single referral pathway.	Priority 2 - completed within 6 months	MMCI	Mar-17	Jun-17	Current	
Action 35	***Partnership will review its eligibility criteria where relevant across services to ensure they are applied consistently and that pathways are clearly communicated to stakeholders and staff.*** **Sub Action (1):** Relevant eligibility criteria are clearly communicated and available through internal and external websites. **Sub Action (2):** Review eligibility criteria across the partnership to ensure consistency of application. **Sub Action (3):** Creation of an evaluation panel to review eligibility criteria across the partnership. **Sub Action (4):** Timescales for carers and service users receiving support after they have been assessed as meeting substantial or critical need are reviewed. A target or standard to be agreed and measured as part of wider performance framework.		Priority 3 - completed within 12 months	MMcI	Apr-17	Oct-17	Open	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 41	***Quality assure service user experience of contact with Social Care Direct*** **Sub Action (1):** Undertake a variety of mechanisms which may include mystery shopper / spot check audit and quality of recording	Progress: QAO exploring methodology, practicalities and background work behind approach prior to rolling out 'mystery shopper' calls. QA checks will also be undertaken using sample of recorded calls made to SCD. Approval and authorisation to access recorded calls being progressed ***17 May – scoping meeting with Fiona Benzies and Heather Smith.*** ***Further scoping needed with Corporate side of SCD to ensure clarity of work and acknowledging that only TL & SP are EHSCP staff – call handlers are CEC staff.*** ***Planned methodology is to use existing recordings of calls to measure performance and quality against set protocols in place.***	Priority 2 - completed within 6 months	MM	Apr-17	Jul-17	Open	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 13: **The partnership should ensure that:** **• people who use services have a comprehensive, up to date assessment and review of their needs which reflects their views and the views of the professionals involved** **• people who use services have a comprehensive care plan, which includes anticipatory planning where relevant** **• relevant records should contain a chronology, and** **• allocation of work following referral, assessment, care planning and review are all completed within agreed timescales.**								
Action 1	Develop and implement a performance dashboard for the partnership to measure key performance indicators **Sub Action (1):** Identify dedicated performance information analyst support to ensure the recommendations and partnership performance can be clearly monitored. **Sub Action (2):** Develop locality performance dashboards to measure key performance indicators (Action LMs) **Sub Action (3):** Identify key performance indicator suite.	Progress: Weekly delayed discharge meeting established to monitor delays. Performance Board established Mar 17 Locality performance dashboards to be finalised. A performance dashboard for the partnership has been developed. Key areas of focus are delayed discharges and access to care. A weekly delayed discharge Star Chamber has been set up and chaired by Chief Strategy and Performance Officer. Data provided on a locality basis and trajectories to achieve 50 delays by Dec have been added to performance targets. Assessment and review data reports have also been developed on a locality basis and will be used to manage down the outstanding assessment delays (1251) and reviews (6051). This will be closely monitored.	Priority 1 - completed within 3 month	MMcI	Apr-17	May-17	Current	
Action 13	***Continue to increase Anticipatory Care Planning and develop reporting and quality management processes.***	*Cross Ref: Actions 1* Progress: ***AL :ACP work stream is part of FLOW Board programme of works.*** ***Performance will be reported through performance board.*** ***Work ongoing to increase ACP in care homes. This is being monitored through the FLOW Board.*** ***A city wide working group has been established in mental health to look at the delivery around ACPs*** ***Project team formed and key actions identified including focus on improving quality, quantity and access of KIS as part of FLOW programme board – quarterly performance report*** ***Integrated Care funded project supporting improved ACP process within 4 care homes and widespread KIS/ACP training to GP practice teams and community health teams in North Edinburgh*** ***Project set up to focus on maintaining KIS when person moves GP practice*** ***Number of KIS in Edinburgh increased by 27% since April 2016*** ***7.7% of Edinburgh population has Key Information Summary*** ***60% of high risk (SPARRA) with a Long Term Condition have a Key Information Summary (8% increase compared to July 2016)*** ***From July 2017 planned work is to extend ACP improvements in 6 further care homes, continue training and education and develop a training toolkit aimed at a range of clinical teams***	Priority 4 - completed within 2 years	AL	Apr-16	Apr-17	Current	
Action 14	***Increase support for end of life care in community settings.*** **Sub Action (1):** Review impact of DN staffing levels. Strategic support to be identified. **Sub Action (2):** Review in-house home care provision to enable increased support for people to remain at home in the last 6 months of life. (Scottish Government target)	Progress: Funding has been identified from the MCN to recruit a palliative care lead for 1 year secondment. Palliative and end of life care services will be hosted in Edinburgh from April 2017 (following a review of current palliative and end of life care within Lothian). A Lothian wide Palliative and End of Life Care event across all four IJBs and acute sites planned for end June 17. This will identify key priorities to shift the balance of care in line with Scottish Government recommendations and new targets for IJBs.	Priority 3 - completed within 12 months	PW	Apr-17	Oct-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 22	***Develop system to monitor compliance within agreed standards of social work practice.*** **Sub Action (1):** Clarify standards and expectations for assessment completion **Sub Action (2):** Improve completion rate of assessment (better data management of time taken and compliance reporting as a KPI) **Sub Action (3)** Audits will be used to improve on care planning **Sub Action (4)** Clarify review schedule for cases **Sub Action (5)** Review swift (AIS) / AIS recording of reviews. Create a review KPI to ensure reviews are taking place and are being recorded as complete.	Sub action 2&5 updates - Keith Dyer meeting with Strategy & Insight with view to producing KPI reporting against Social Work standards for key processes. Next meeting 16/5/17 which will agree report format and date to begin - ASAP Cross Ref : Action 1 Progress as above in Sub Action (2) Progress: Practice standards published on Orb. Standards to be incorporated into performance framework Locality case file audit complete and report and findings shared with locality managers. Locality improvement plans being developed and will be monitored through thee Quality Assurance group. Post identified to develop compliance reports. (BS) Funding is being progressed. Funding identified for 2 adult support and protection posts to improve standards and processes within localities. Adult support assessment tool has been revised and shortened to help improve staff compliance and completion to standards expected. KPIs and compliance will be monitored through Performance Board and Quality Assurance Group. ***9 May – Keith meets Eleanor Cunningham & Catherine Stewart – Strategy Insight to discuss compliance reporting based on Practice Standards for Adult Social Work.*** ***12 May – Maria invites Keith to meeting with Eleanor Cunningham, Sally Heaton, Mary McIntosh and Maria. Meeting reviews the 9 May meeting and the definitions of tasks underlying the practice Standards – allocation, contact, etc. Quick solution not preferred option – preference to get definitions well understood and embedded prior to reporting Keith emails locality managers to provide locality based managers to meet and agree consistent definitions to base standards on.*** ***16 May – Keith meets with Catherine Stewart to advise of above. As of this date 3 of 15 standards reportable on. Catherine and Keith to meet 30 May where most likely 10 of 15 standards will be reportable on.*** ***19 May – desktop review of main policies/procedures to elicit existing definitions of practice to base standards definitions upon.*** ***23 May – Marna and Andy have provided staff names regarding above meeting to agree definitions.*** ***30 May – next meeting with Catherine Stewart to look at reporting data – most likely 10 of 15 standards.***	Priority 1 - completed within 3 month	MM	Apr-17	May-17	Current	
Action 28	Revise and streamline the 'my steps' financial assessment on swift (AIS) to improve efficiency and performance of compliance. Sub Action (1): Measure the improvements made from the changes. Sub Action (2): Improve completion rates of assessments in line with KPI measures. Sub Action (3): Further sub action created due to lack of clarity and inconsistent practice related to operational definition of 'assessment' within social work. Review of current practice has been completed, minimum standards expectations paper for formal assessments pending (KD)	Progress: Assessments have been reviewed and updated on swift (AIS). Launch date 1st May 2017 Communication plan and price guide being drafted. Sub Action 1 Complete - Revised assessment now operational Sub Action 2 Subject to KPI's developed under action 22 Update included in action 22 ***2 May - Discussion paper on Assessment created, yet not distributed for wider discussion. Preference to keep clear standard of assessment report completion. Case note assessment for <£400 anomaly exists.***	Priority 1 - completed within 3 month	MM	Apr-17	May-17	**complete**	
Action 31	***Develop single shared assessments for Health and Social Care Partnership***	Progress: Short life working group has been set up to progress this work	Priority 4 - completed within 2 years	MMCI	Apr-17	Apr-18	Current	
Action 33	***Review OT hospital and community nursing assessment and referral process to build consistency of thresholds.***	Progress: MATT and Hub work stream is developing a single referral pathway.	Priority 2 - completed within 6 months	MMCI	Mar-17	Jun-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 36	***Promote the use of advocacy when undertaking assessments to ensure service users are appropriately represented.*** **Sub Action (1):** Assessment format to include advocacy and record of requirement.		Priority 3 - completed within 12 months	WD	Apr-17	Oct-17	Open	
Action 38	***Review the use and necessity of case file chronologies*** **Sub Action (1):** Set an expectation of when chronologies should be included / needed **Sub Action (2):** Clarify with staff the use of chronologies, their importance to capture patterns of concerns, behaviours and focus actions required. **Sub Action (3):** Amend SWIFT (AIS) system to ensure that a chronology is repeated on any report completed **Sub Action (4):** Use SSSC chronology guidance as standard **Sub Action (5):** Cross reference with children's services to ensure consistency of application	Progress: Care Inspectorate Chronology guidance to be reissued to all staff along with new minimum standard practice development document reinforcing expectations around required use of chronology (APC - KF) Minimum standards guidance paper under development ***Prelaunch of CI Chronology guidance will be issued wk. ban 5 June*** ***Chronologies to feature in training programme for level's 2 and 3***	Priority 3 - completed within 12 months	MM	Apr-17	Oct-17	Current	
Action 39	***Review circumstances of all individuals currently on waiting lists for social work assessments and reviews.*** **Sub Action (1):** Review eligibility for unallocated cases. **Sub Action (2):** Promote better signposting / use of paraprofessional staff can boost this area of work. **Sub Action (3):** Improve productivity of existing teams and scope the requirement for additional capacity (cross ref: Action 1).	Progress: Sub Action 1: North West - Waiting lists are currently being reviewed along with individual workers case loads to prioritise and close off as many cases as possible. South West - working groups in SW Locality systematically working through waiting lists for assessment and review to identify priority cases, as well as ensuring data is of good integrity. Sub action 2: Revised assessment tool has been introduced alongside a streamlined authorisation process. Sub Action 3: Third sector rep is part of the hub and cluster daily MATT focusing on over 65s who are socially isolated. All incoming work is allocated across the professional and Para professionals (CCA) staff according to the level of complexity- This is decided at daily screening meetings and through seniors reviewing waiting lists. Currently progressing centralised monitoring of the review team to increase productivity and support with reducing the number of outstanding reviews within adult HSC. AL:***Caseloads require to be determined for each staff group. Have met to discuss process to agree this with Lyn McDonald and Maria McILgorm*** ***Targets against each unmet waiting time target need to be determined. Have met with Eleanor Cunningham to progress this*** ***MHSM get regular updates – currently have 4 Ax waiting allocation – mainly older people at REH. The Implementation Project Team will discuss the timeline of transfer of over 65s to either hub, matt, cluster at their meeting on 18/05/17*** ***Agreement to be sought across localities around prioritisation and process, including a review of the Review Procedure*** ***Seniors have started work on current caseloads to identify which cases will move to another locality, and those cases that will require essential long term reallocation.*** ***Seniors have looked at waiting lists for SE to identify which individuals may come over to NE*** ***Senior Social Workers in NE have recently examined the social work waiting list to identify which cluster each individual belongs to and included a comment indicating whether the hub should be involved. Senior Occupational Therapist will undertake a similar exercise wk/beg 22/05.*** ***Senior Social Workers & Occupational Therapist have met to begin work on the CCA waiting list*** ***System data cleanse to be undertaken - it has been recognised that there are cases on the system which have not been updated/closed***	Priority 1 - completed within 3 month	AL MG NC AS	Apr-17	May-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 14: **The partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing maintained.**								
Action 29	***Strengthen Adult Protection processes ensuring staff compliance across the partnership and increase expert adult protection support for practitioners.*** **Sub Action (1):** Improve consistency in approaches to Adult Support and Protection in particular identifying which cases should have an IRD **Sub Action (2) :** Development of stand alone LSI procedure (action held on APC improvement plan 2017-18)	Progress: Additional funding agreed to add expert social work practitioner role to each locality. Process to be aligned with child protection and mental health. Staff communication plan under development. Criteria for IRD published and hosted on CEC website IRD guidance available on ORB will undergo refresh (pending - KF). Funding for 2FTE (grade 8) Senior Prac posts to be created. Main functions of post to include; training & Professional development, local and national practice standards, QA activity, chairing APCC, supporting the role of the e-IRD Review Group, professional support and consultation. ***Person spec and remit extended to reflect key functions and tasks. Recruitment subject to delay. Cost centre identified 22/05/17***	Priority 1 - completed within 3 month	MM	Apr-17	May-17	Current	
Action 30	***Increase access to adult protection training programme for all staff groups and monitor compliance and build partnership and locality compliance reports.*** **Sub Action (1):** General monitoring through Adult Support and Protection Committee (ASPC) Monitor uptake across partnership through performance framework (ASPC) Monitor compliance through locality performance frameworks	Progress: Action ratified by APC 08/05/17. Action incorporated into APC improvement plan 2017-18, tasked to the APC L&D Sub Group. Meeting with JF and KF to agree parameters of work on 16-05-17 ***16 May – following actions agreed;*** ***Comprehensive evaluation of level 2 and 3 ASP training commissioned supported by Occupational Development, APC L&D Sub and QA Service.*** ***Refresh of training frequency and content at level 1 (PP), 2 (ASP) and 3 (ASP – Council Officer) with view to mandatory refresh for all council officers.*** ***Steps being taken to increase trainer pool (including ASP snr prac and QAO) new trainer's and contributors also being proposed from Health and Police Scotland*** ***ASP performance report revised to reflect expectations around standards of practice and compliance with ASP procedures. Revised performance and compliance report will be presented at next APC for comment*** ***X5 ASP workshops being undertake in each locality (+hospital) with TL's and Managers, facilitated by JF/KF – first session confirmed 7 June 2017***	Priority 1 - completed within 3 month	JF	Apr-17	Oct-17	Current	
Recommendation 15: **The partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased in confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.**								
Action 37	***The partnership ensures that Self Direct Support is used to promote greater choice and control for older*** *people.* **Sub Action (1):** Build on existing multi agency training and increase capacity to support staff in all settings. **Sub Action (2):** Guidance is provided to all staff to ensure SDS options are clearly explained to service users and that their views and decisions are recorded. **Sub Action (3):** Social Care Direct staff are provided with input on the principles of SDS options and how service users **and carers can access support.** **Sub Action (4):** Reinstate SDS champion initiative across the partnership		Priority 3 - completed within 12 months	WD	Apr-17	Oct-17	Open	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Recommendation 16: **The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skills mix that delivers high quality services for older people and their carers.**								
Action 15	***Review workforce requirements across the partnership to reduce use of agency staff.***	Progress: Review of HBCCC and District Nursing completed - recommendations being progressed for both. Gylemuir workforce review underway Care Home workforce review underway. Social Work, Reablement and Care Homes workforce reviews pending. Workforce review underway for gylemuir and due to commence for Care Homes to identify ways to reduce agency spend. This will include ensuring establishments include numbers for planned and unplanned leave to enable better management for reasons for use of agency against funded establishments.	Priority 4 - completed within 2 years	MMcI	Nov-16	Oct-17	Current	Ref:
Action 18	***Undertake staff survey using I -matters for each of the locality teams***	Progress: I matters is currently only used in HBCCC. EMT to agree for survey to commence Sept 17. Discussions underway with plans to undertake this	Priority 3 - completed within 12 months	MMcI	Sep-17	Mar-18	Current	
Action 19	***Introduce workforce development programme for management teams.*** **Sub Action (1):** Cascade leadership training and development to Tier 2 managers and locality teams. Develop and implement integrated induction programme. Progress the development of a Quality Academy for HSCP staff.	Progress: HR support and external consultants appointed. Workshop days planned and regular monthly sessions discussed. ***RMG: Dates agreed and event taking place June 8th & 9th. Invitees include the senior management team.***	Priority 1 - completed within 3 month	RMG	Apr-17	May-17	Current	
Action 20	***Primary Care Sustainability - develop primary care workforce plan***	Plans are being progressed and are monitored through the Primary Care Board chaired by medical director for NHS Lothian	Priority 3 - completed within 12 months	DW	Apr-17	Oct-17	Current	
Action 21	***Review completion rate of staff appraisal across the partnership through performance framework.*** **Sub Action (1):** Measure eKSF compliance across NHS services	*Cross Ref: Action 1* Progress: New employee performance framework launched for CEC staff Apr 17.	Priority 3 - completed within 12 months	MMcI	Apr-17	Oct-17	Open	
Action 23	***Monitor and reduce sickness absence levels and over reliance on agency staff.***	*Cross Ref: Action 1* Progress: Included in performance framework dashboards	Priority 4 - completed within 2 years	MMcI	Apr-17	Apr-18	Current	
Action 24	***Finalise implementation of new structure***	Progress: Locality Implementation Group overseeing. Phase 3 to commence Apr 17 ***AL: Third sector and housing organisations attend bi-monthly North East Locality Innovation Group meetings and H&SC LIP Sub Group has a representative from EVOC***	Priority 1 - completed within 3 month	RMG	Apr-17	May-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 26	***Improve staff communication strategy.*** **Sub Action(1):** Rolling programme to be developed over next 12 months Initial communication to be launched by end May 17.	2 day leadership for senior managers in the partnership has been planned for 8th and 9th June. This group will agree a staff communication strategy. ***Staff bulletin to be released first week in June 2017.***	Priority 1 - completed within 3 month	RMG	Apr-17	May-17	Current	
Action 40	***Establish a model of Family Group Decision Making to support the principles of GIRFE to enable early and preventative family based problem solving.*** **Sub Action (1):** Develop compliance reports for localities and individual teams for regular monitoring.	Progress: Initial discussions taken place to agree compliance reporting Coordination group established April 2017, pilot for adult cases progressing in SW Locality. HSC rep Marna Green. Focus of adult sample includes prevention of hospital admission, accelerating hospital discharge, mental health and Drug and Alcohol	Priority 4 - completed within 2 years	MM	Apr-17	Apr-18	Open	
Action 42	***Build a culture of learning and improvement through practice teaching and collaboration with academic institutions.*** **Sub Action (1):** Duplicate model across other professional groups within the partnership.	Progress: Kathryn Mackay (Stirling University), Viv Cree (Edinburgh University) planned meetings with Keith Dyer & John Kerr. Meetings set up with 4 H&Sc practice teachers ***17 May meeting with Keith, John Kerr (Learning Development) Social Work faculty at Edinburgh University to begin discussions of replicating Practice Café work completed in C&F from 2011 onwards.*** ***23 May meeting with Kathryn Mackay (Stirling University) and John Kerr to explore connections between core adult social work processes and academia.*** ***24 May – Keith Dyer and John Kerr meeting with 4 existing practice teachers to explore barriers and levers to successful practice teaching in adult based social work.*** ***26 May – Keith Dyer meeting with 4 social work managers from previous patch model to explore what led to reduction in student placements, what we have learned from this and what a brighter future for practice teaching in adult social work will require?***	Priority 3 - completed within 12 months	KD	Apr-17	Oct-17	Current	
Action 51	***Scope potential for new recruits for a career in care to build workforce capacity.*** **Sub Action (1):** Explore and report on alternatives to attracting care providers including co-location and training.	Progress: Research team has been commissioned Workforce strategy group established. Focus on careers in care across the partnership. Integrated induction programme developed for managers. ***Awaiting report from research team.***	Priority 2 - completed within 6 months	RMG	Apr-17		Open	
Action 52	***Identify, develop and implement a joint comprehensive workforce strategy, involving the third and independent sectors to support sustainable recruitment and retention of staff.*** **Sub Action (1):** Introduce a joint workforce development framework **Sub Action (2):** Build a culture of learning and improvement through practice teaching and collaboration with academic institutions.	Progress: Leadership coaching programme Focus on top tier management team in May 17 and locality and second tier teams in June 17 ***Date for first session set for June 2017. Appointment of 2 Senior Practitioners Social Work to support learning and improved practice.***	Priority 3 - completed within 12 months	RMG	Apr-17	Oct-17	Open	
Action 53	***Develop and embed operational system pathways and processes within new integrated locality team*** s **Sub Action (1):** Finalise locality budget allocation.		Priority 2 - completed within 6 months	LMcD			Open	
Action 54	***Develop and implement integrated induction programme for new managers***	Progress: Work to progress in line with restructuring plans.	Priority 1 - completed within 3 month	LMcD	Apr-17	Jul-17	Current	

Action Ref:	Action / Sub Action	Progress	Priority Status	Lead	Start Date	Target Completion	Status	Evidence Ref:
Action 57	***Develop induction process required for new IJB members***	Progress: Meeting dates set	Priority 2 - completed within 6 months	WD	May-17	Aug-17	Current	
Recommendation 17: **The partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model.**								

Appendix 4

Briefing Note

Edinburgh Health and Social Care Partnership

Progress in addressing recommendations contained in the report on the Joint Inspection of Services for Older People

Recommendation 1 The Partnership should improve its approach to engagement and consultation with stakeholders in relation to: • its vision • service redesign • key stages of its transformational programme • its objectives in respect of market facilitation • appointment of management level for contract and SMU delivery • regular meetings in place with point of contract providers
Progress • Quality groups for care at home and care homes have been revised and involve local providers. • Fortnightly meetings held with professional representatives and trade unions. • A communications plan is in place and operational both internally and with stake holders.

Recommendation 2 The Partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.
Progress • IJB has agreed ongoing funding for a number of projects previously funded through the Integrated Care Fund which aim to support people to manage long term conditions, provide assessment and treatment in the community for people with COPD or distressed behaviour due to dementia, increase the number and quality of Anticipatory Care Plans and use technology to provide overnight support. • Assessors are being supported to actively consider the use of telecare to support people to remain at home. • A lead manager has been appointed to expand the use of Technology Enabled Care.

Recommendation 3
The Partnership should develop exit strategies and plans from existing interim care arrangements to help support the delivery of community based services that help older people and their carers to receive quality support within their own homes or a setting of their choice.

Progress

- The IJB will receive a capacity plan.

Recommendation 4
The Partnership should engage with stakeholders to further develop intermediate care services, including bed-based provision, to help prevent hospital admission and to support timely discharge.

Progress

- Work is nearing completion on this model and a report will be presented to a future IJB and Strategic Planning Group.

Recommendation 5
The Partnership should work in collaboration with carers and carers' organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating its carers' strategy.

Progress

- A Carers Act project board has been established, with representation from carers and carers organisations, to take forward the work necessary to implement the requirements of the legislation. A small number of task groups are also in place reporting into the Project Board.
- A single post has been created to lead the work on the implementation of the Carers Act and the development of the new Carers Strategy for both adult and young carers.
- The implementation of the Carers Act and the development of the new strategy will be overseen by the Strategic Carers Group membership of which includes carers and carers organisations.

Recommendation 6
The Partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.

Progress

- It has been agreed that the existing dementia post diagnostic support service will be continued.
- Eight GP practices in North East Edinburgh have been successful in their bid to become one of three sites testing the relocation of dementia post diagnostic support services to a primary care setting.

Recommendation 7
The Partnership should streamline and improve the falls pathway to ensure that older people's needs are better met.

- The Flow Programme Board work stream of Aids Pathways is rationalising the number of pathways operating across Edinburgh.

Recommendation 8
The Partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice.

Progress

- A Partnership Quality Assurance framework has been developed. The Quality Assurance and Improvement group will be the overarching quality and governance group for the partnership and all other partnership quality improvement groups will feed into this. All improvements plan and learning from significant adverse events will be overseen by this group.

Recommendation 9
The Partnership should work with the local community and other stakeholders to develop and implement a cross-sector market facilitation strategy. This should include a risk assessment and set out contingency plans.

- A lead manager has been appointed following repositioning work undertaken by an external consultant. This work will assist in the transfer of the service matching unit to the locality Multi-Agency Triage Teams. (MATTS)

Recommendation 10
The Partnership should produce a revised and updated joint strategic commissioning plan with detail on:

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

Progress

- Financial plan agreed by the IJB on 10/3/17.
- Review of the Strategic Plan based discussion by the May IJB development session.
- Directions being developed for discussion with CEC and NHSL to be presented to the IJB for approval in July.
- Workforce and Organisational Development Steering Group has been established with membership from CEC, NHSL and HSCP.

Recommendation 11
The Partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved by the Integration Joint Board.

- Plans are in place to deliver savings in 17/18, these include:
  - Implementing the new structure
  - Reducing purchasing costs
  - Reducing agency costs

Recommendation 12
The Partnership should ensure that:

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

Progress

- Weekly delayed discharge meeting established bringing together managers from the Health and Social Care Partnership and NHSL Acute Services to monitor and proactively manage current delays. The number of people whose discharge from hospital is delayed has reduced from 215 to 158.
- MATTS are taking place daily in each locality to focus on delivering timely discharges from hospital
- Whole system dashboard has been developed and is now been used to allow monitoring and analysis of performance trends through the weekly delayed discharge meetings and the Flow Programme Board.

Recommendation 13
The Partnership should ensure that:

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

Progress

- Adult support assessment tool has been revised and shortened to help improve staff compliance and completion to standards expected. KPIs and compliance will be monitored through the Performance Board and Quality Assurance Group.
- A number actions have been taken to improve the quality of practice including:

- The publication of practice standards for social work on Orb which are being incorporated into the performance framework
- Locality case file audits have been completed and findings shared with locality managers. Locality improvement plans being developed and will be monitored through Quality Assurance Group.
- Identified of funding for 2 Adult Safeguarding Practitioner posts to improve standards and processes within localities.
- Centralised monitoring of the review team is currently being progressed to increase productivity and support with reducing the number of outstanding reviews within adult HSC.

- A suite of performance reports has been developed to allow reporting and scrutiny of flow through the health and social care system within the community on a citywide and locality level. These are considered by the Performance Board established in March that meets monthly to monitor and scrutinise performance against a range of indicators across the Partnership.

Recommendation 14
The Partnership should ensure that risk assessments and management plans are recorded appropriately and are informed by relevant agencies. This will help ensure that older people are protected from harm and their health and wellbeing is maintained.

Progress

- New inter-agency Referral Discussion (IRD) guidance available on ORB will be refreshed.
- Main functions of the two additional Adult Safeguarding Practitioners will include: training and professional development, local and national practice standards, quality assurance activity, chairing Adult Protection Case Conferences, supporting the role of the e-IRD Review Group, professional support and consultation.

Recommendation 15
The Partnership should ensure that self-directed support is used to promote greater choice and control for older people. Staff and multi-agency training should be undertaken to support increased confidence in staff in all settings so that they can discuss the options of self-directed support with people using care services.

Progress

- A guide to price has been finalised and published on the Orb.
- Dates have been set for the CSWO to meet with staff teams.

Recommendation 16
The Partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity

and ensure a suitable skill mix that delivers high-quality services for older people and their carers.

Progress

- Workforce and Organisational Development Steering Group has been established with membership from CEC, NHSL and HSCP. This group will develop the workforce and organisational development plan for the Partnership taking account of the Workforce Plan being produced by the Scottish Government linked to the National Health and Social Care Delivery Plan.
- Management development training and coaching is in place supported by CEC Human Resources.

Recommendation 17

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

Progress

- Volunteer Net has been retained as part of the restructure.
- Responsibility for volunteers has been passed to localities and services.