Policy and Sustainability Committee

10am, Tuesday 10 November 2020

Update on the Edinburgh Health and Social Care Older People Joint Inspection Improvement Plan

Executive/routine
Wards
Council Commitments

1. Recommendations

1.1 It is recommended that Policy and Sustainability Committee:

1.1.1 Note the significant progress to date in delivering agreed improvement actions as specified in the improvement plan, developed in response to the Joint Inspection of Older People's Services (appendix 1).

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Report

Update on the Edinburgh Health and Social Care Older People Joint Inspection Improvement Plan

2. Executive Summary

2.1 This report provides an update on the work undertaken to deliver against the agreed improvement plan, developed in response to the findings of the Joint Inspection of Older People's services. (appendix 1).

3. Background

3.1 The Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) (known as the Joint Inspectors) carried out a joint inspection of Older People's Services in health and social care across Edinburgh in 2016. The report was published in May 2017.

3.2 Given several findings were graded as 'weak', the Joint Inspectors returned to undertake a progress review against the initial report and the findings from this were published in December 2018. While some areas were noted to have made some slight improvement, overall the progress report found that progress of improvement had been slow and that the initial improvement plan had not made the impact expected. In response to this, the Partnership Executive Team developed a revised improvement plan which reflected the strategic direction of the Partnership, its transformation programme and a more strategic approach. The improvement actions plan was aligned to four areas to address the 17 recommendations set out in the initial report:

- 3.2.1 Conversation 1 - Listen and connect
- 3.2.2 Conversation 2 - Work with people in crisis
- 3.2.3 Conversation 3 - Build a good life
- 3.2.4 Conversation 4 - Infrastructure and enablers

3.3 The improvement plan is embedded as part of the Partnership's transformation and programme. The Executive Team also worked to ensure that both the CI and HIS were kept informed of the approach and development of the improvement plan, highlighted the move toward a more strategic approach to improvement and

operational delivery. A series of regular workshops with the Joint Inspectors has continued since the improvement plan was approved and these have continued over the course of the Covid-19 pandemic.

3.4 An initial report on the approach has been to Policy and Strategy in August 2019, and to the Edinburgh Integration Joint Board and NHS Lothian's Healthcare Governance Committee in December 2019.

4. Main report

4.1 The improvement plan addresses each recommendation by including a statement of aims and targets for year 1, year 2 and year 5. It also defines how this will be achieved and measures to indicate successful delivery. Each recommendation is led by a member of the Executive Team with regular scrutiny at the Partnership Executive Team, chaired by the Chief Officer. A monitoring tool has been developed to monitor progress against actions and is included as appendix 2.

4.2 From the 79 actions which were due for delivery in December 2019, 52 actions have been implemented and include:

- 4.2.1 The development of a transformation and change programme to support service redesign (agreed by the EIJB in February 2019)
- 4.2.2 The successful roll-out of Hospital at Home across the city
- 4.2.3 The closure of the Gylemuir interim care facility
- 4.2.4 Individuals diagnosed the dementia being offered a minimum of one-year post-diagnostic support
- 4.2.5 An improved falls pathway has been implemented
- 4.2.6 The set-up of a Quality Hub within the Partnership and the establishment of Clinical and Care Governance Committee and sub-committee structure underneath it with a focus on delivering quality services
- 4.2.7 Clear governance arrangements in place for the transformation programme, aligned to the Edinburgh Integration Joint Board (EIJB) governance arrangements
- 4.2.8 Savings and recovery programme is now in place with a regular review mechanism in place and regular reporting to the Performance and Delivery Committee and EIJB
- 4.2.9 Improvements made within the Inter-Agency Referral Discussions (IRDs) approach and adult support and protection training redesigned
- 4.2.10 Baseline workforce plan submitted and agreed by the EIJB, with second iteration due in March 2021.

4.3 There are 23 actions with a delivery date of December 2019. These relate to complex and interdependent areas of work which have been disrupted by the Covid-

19 pandemic and have not been completed in the initial timescale. However significant work has been done and these actions are being progressed through the relevant transformation programmes. The actions fall under the following areas of work:

4.3.1 The development of intermediate care facilities is being taken forward through the Partnership Bed Based Review, looking at the totality of the bed base and reconfiguring it to fit future needs of the population

4.3.2 A market facilitation strategy is being taking forward through the One Edinburgh Approach and options are developed to look at ways to contract care in a different way, by building relationship with providers

4.3.3 The promotion and uptake of Self-Directed Support (SDS) will be a fundamental pillar of the work within the Three Conversations model and the development of the Edinburgh Pact

4.3.4 Recognising that the Partnership need to futureproof the workforce, options being considered include, career paths for people, better promotion of health and care as a career choice, succession planning, scoping what the workforce of the future is and looking at options relating to volunteers.

4.4 Some of the actions in the monitoring plan remain at amber and will remain at amber until full implementation of transformation has been rolled out. This highlights the complex and far reaching nature of the change being implemented and reflects the strategic approach being taken. Members will however note that work is taking place to progress these aligned to the transformation programme.

4.5 Throughout 2019, there has also been significant engagement with the CI and HIS, sharing the strategic thinking in developing the Improvement Plan and demonstrating process with the actions identified.

5. Next Steps

5.1 There is an exercise ongoing to collate an evidence base to demonstrate to the Joint Inspectors that relevant actions have been achieved. The evidence gathered will be presented to the Joint Inspectors in November 2020 and discussions will be on going regarding what further actions, if any the Care Inspectorate require.

6. Financial impact

6.1 The delivery of the improvement plan is embedded in the Transformation and Change programme. The focus of the Transformation Programme is aimed at improving the experience of people seeking help and reduce demand for formal services by ensuring appropriate supports are available earlier for people.

7. Stakeholder/Community Impact

7.1 The inspection progress review report and the improvement plan highlight areas of unmet need and underdeveloped services across Edinburgh which are likely to impact on the health and wellbeing of services user and their unpaid carers

7.2 An impact assessment will be undertaken on each work stream within the transformation programme and associated change projects.

7.3 The development of the improvement plan and the subsequent transformation work streams has involved a range of stakeholders. Each work stream will include involvement from citizens and the public as well as partners from the voluntary and independent sector.

7.4 Each workstream will also include a range of internal stakeholders as well a lead officers from within the Partnership.

8. Background reading/external references

9. Appendices

Appendix 1: Older People Joint Inspection Improvement Plan

Appendix 2: Older People Joint Inspection Monitoring Plan

Appendix 1

Edinburgh Health and Social Care Partnership

Progress Review of Older People's Services

Framework for Improvement Based on the Three Conversations Approach

Agreed by the Executive Management Team: May 2019

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Introduction and Background

Joint Inspection

The Care Inspectorate and Healthcare Improvement Scotland (the Joint Inspectors) carried out an inspection of Older People's Services in Edinburgh in 2016 and reported their findings in a report published in 2017. The original report noted a number of areas of weakness across the partnership and set out 17 recommendations for improvement (fig 1 below).

It is normal practice, within joint inspections, that where a grade of 'weak' is applied, that the joint inspectors return within a year to assess progress. The progress review visit took place in June and July 2018 and the report published in December 2018. The review visit is not a further inspection and grades are not given, however levels of progress against the initial recommendations are provided.

The Partnership

This inspection was carried out on the wider partnership in Edinburgh – the Integration Joint Board (IJB) and the Health and Social Care Partnership (HSCP), and their partner organisations NHS Lothian (NHSL) and City of Edinburgh Council (CEC). Given the complex interrelationship between partners it's important that we address the remaining challenges set out in the report as a partnership and in a collaborative and collegiate way. However, given the number of recommendations, the issues they span and the requirement to make improvement at pace, it makes sense to have a single action plan, owned by all, but driven through the HSCP as the organisation responsible for operational delivery of Older People's Services in Edinburgh.

Actions, Improvement and Key Updates Since Review Visit

The review visit took place at a time of significant change in the EIJB and HSCP. A new Chief Officer took up post in May 2018 and a new Head of Operations took up post formally in July that same year. Much focus and activity had taken place since the initial inspection and action plans developed however since then there has been an opportunity to review and refresh the HSCP's approach to addressing improvement and its wider strategic and transformational change.

A significant focus has been placed on addressing some of our key challenges in performance. These are clearly identified in both the initial report and in this follow up report – Delayed Discharges, people waiting for an assessment of care and people waiting for care. We can demonstrate that by February 2019 improvements had been made in a number of areas including:

- We have set clear trajectories of improvement for Delayed Discharges over the winter and into 2019. These are monitored closely and we have reported a consistent improving trend since they were agreed;
- Linked to that, we have reduced the number of delays in NHS Lothian acute beds by 25% since September 2018;
- We have reduced the number of people waiting in hospital for an assessment for social care 40 to 16 during the same time period;

- There have been more significant improvements in relation to people waiting for a Package of Care on NHSL acute sites – WGH has 48% fewer Delayed Discharges and RIE 16% fewer;
- We would also report that waits for care in care homes remain under pressure.

The additional investment of funding toward community care capacity has begun to be applied and providers are reporting positively. We anticipate the additional capacity this will purchase to come on stream in January (the time lag relating to recruitment, PVG checks, mandatory training of new staff etc). This will create further capacity and will enable both a targeting of delays, as well as supporting older people in the community remain at home.

Other areas of leadership for change and transformation have been identified and we can highlight:

- Significant activity around strategic planning and the development of our Outline Strategic Commissioning Plans (including the Older People's OSCP) – and in relation to engagement and participation with this being recognised as good practice in the recent Audit Scotland Report – 750 people;
- Carers' Strategy – we have undertaken a test of change in relation to carers' assessments and access to self directed support and a new carers' strategy is in development. A lot of engagement with carers, carers' groups and other stakeholders has taken place and the strategy will come to the IJB in February;
- The HSCP's first Workforce Plan has been developed following the '6 step' methodology and the baseline document will come to the IJB in December. A cross system workforce planning group is in place to oversee this work and the next steps of its development;
- The Chief Officer commissioned an independent review of the IJB's Governance and the report and recommendations will come to the IJB in December. If agreed, the actions taken to implement the recommendations will support a strengthened strategic leadership and direction and support a new transformation programme in support of the longer term vision and longer term sustainability of the HSCP.

<u>Transformation and Change – Three Conversations Model</u>

A proposal setting out a recasting of our strategic transformation model and vision will come to the IJB in February 2019. This is not the place to go into detail however the proposal sets out a reshaping of our model in Edinburgh aligned to the '3 conversations' approach – summarised in Fig 2 below. The implementation of this programme, if successful, would support delivery of improvement against the inspection report and the follow up, and, beyond that, the longer term sustainability of good quality health and care services in Edinburgh which shift the balance of care, support independence and self direction, and which promote health and wellbeing.

The Approach to our Improvement Plan

Given our shift toward a new strategic transformation programme it makes sense that we align our inspection improvement work to that. In this way it will be embedded in our change programme and central to it. It is clear in the review follow up report itself that the joint inspectors believed we were too detailed in the initial response to the recommendations – the revised approach embeds this within longer term strategic change.

Fig 3 below sets out how we've mapped the recommendations against our three conversation approach. There are areas of overlap and our programme management approach will support us in ensuring both good governance of implementation and reducing duplication in delivery.

It should also be noted that we can demonstrate that we've closed off a number of recommendations since the visit in June.

Fig 1 Joint Inspection Recommendations

Noted below are an overview of all recommendations identified:

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
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
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
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
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 the carers strategy
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.
Recommendation: 7	The Partnership should streamline and improve the falls pathway to ensure that older people's needs are better met
Recommendation: 8	The Partnership should develop joint approaches to ensure robust quality assurance processes are embedded in practice.
Recommendation: 9	The Partnership should work with the local community and other stakeholders to develop and implement a cross market facilitation strategy. This should include risk assessment and contingency plans
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
Recommendation: 11	The Partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved for the Integrated Joint Board
Recommendation: 12	The Partnership should ensure that: **1.** there are clear pathways to accessing services **2.** eligibility criteria are developed and applied consistently **3.** pathways and criteria are clearly communicated to all stakeholders, and **4.** waiting lists are managed effectively to enable the timely allocation of services (refer to recommendation 13)
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
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.
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
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
Recommendation: 17	The Partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model

Fig 2

1 Conversation 1 : Listen & Connect

Listen hard. Understand what really matters. Connect to resources and supports that help someone get on with their chosen life, independently.

2 Conversation 2 : Work intensively with people in crisis

What needs to change urgently to help someone regain control of their life? Put these into an emergency plan and, with colleagues, stick like glue to help make the most important things happen.

3 Conversation 3 : Build a good life

For some people, support in building a good life will be required.

What does 'a good life' look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organized?

Fig 3

Conversation 1 – Listen and Connect (Access, Wellbeing and Prevention)

- Recommendation 1
- Recommendation 2
- Recommendation 5
- Recommendation 6
- Recommendation 7
- Recommendation 8
- Recommendation 9
- Recommendation 14
- Recommendation 15

Conversation 2 – Work Intensively with People in Crisis (Crisis intervention, Short Term and

- Recommendation 1
- Recommendation 4
- Recommendation 5
- Recommendation 6
- Recommendation 7
- Recommendation 8
- Recommendation 10

Conversation 3 – Build a Good Life (Long Term Care, Complex Care, Accommodation and Bed Based Care)

- Recommendation 1
- Recommendation 3
- Recommendation 5
- Recommendation 6
- Recommendation 7
- Recommendation 8
- Recommendation 10
- Recommendation 13
- Recommendation 15

Infrastructure and Enablers Programme

- Recommendation 1
- Recommendation 5
- Recommendation 6
- Recommendation 7
- Recommendation 8
- Recommendation 9
- Recommendation 10
- Recommendation 15
- Recommendation 16
- Recommendation 17

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**

Executive Lead:
Chief Officer

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We are committed to ensuring there is an appropriate level of engagement with staff and key stakeholders including 3rd, independent and voluntary sectors in the design and implementation of our transformation and change programmes

Aligned to Quality Indicators:
9 - Leadership and Direction the supports partnership
9.1 – Vision, values and culture across the partnership
9.2 - Leadership of strategy and development
9.4 – Leadership of change and improvement

Targets

1 year: By December 2019

- A Transformation and change programme agreed and resourced by IJB by Feb 2019
- The transformation plan and delivery structure will set out clear engagement with key stakeholders at every stage
- There will be clear stakeholder involvement in the review of the partnership's vision and values
- Development of a partnership communication plan and a range of platforms to improve communication with key stakeholders
- Staff involvement in the key stages of service redesign will be set out and evidenced

3 years: By December 2021

- The transformation programme will evidence stakeholder led change and delivery
- Staff will be involved in decision making around service redesign and transformation and this will be evidenced through annual staff surveys and evidence of participation

5 years: By December 2023

- There is clear and visible leadership and participation by our staff and partners embedded across all service redesign, transformation and change programmes
- Plans and developments are co-produced and there is clear evidence of community / communities of interest participation in decisions that affect them

How will we do it?

- Clear programme board membership and participation plan for the three conversations approach.
- Where appropriate, fund in kind, 3rd, independent and voluntary sector engagement in transformation and change programmes
- Develop a stakeholder satisfaction survey to assess progress
- Establish stakeholder focus groups
- Develop a partnership website and social media platforms to improve communication with staff and key stakeholders
-

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Key stakeholder membership at programme board meetings
- Stakeholders fully engaged in all transformation and change programmes and market facilitation strategies
- Evidence of a shift in investment towards community organisations and 3rd and independent sectors
- Fully established EHSCP website with regularly updated information to keep staff and key stakeholders up to date on partnership business and developments
- Good level of attendance from all staff groups across the partnership at staff engagement sessions
- Positive stakeholder satisfaction survey results
- Evidence of 3rd, independent and voluntary sector attendance and input at programme board meetings
- Agreed timetable for stakeholder focus / engagement sessions
- Positive staff and stakeholder feedback through staff survey

What evidence do we have to support this?

- Evidence of engagement and participation clear in terms of reference of all our groups and through notes and minutes
- Stakeholder surveys at regular points of our work to gauge experience of role and its impact
- Number of community engagement opportunities evidenced will increase over the course of the programme
- Evidence of partnership approach to commissioning and service design

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

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We are committed to building and reinforcing community capacity and support in order to avoid and reduce formal care and support. We are committed to the principles of a 'home first' model and our early intervention strategy and our prevention strategy will reflect that. We intend to invest in community capacity building and work collaboratively across all sectors. We are committed to the implementation of three conversations which will facilitate the transfer of resources to support early intervention and prevention services.

Aligned to Quality Indicators:

2 – Getting help and the right time
5 – Delivery of key processes
6 – Policy development and plans to support improvement in service

Targets

1 year: By December 2019

- Our conversation 1 programme board will be established and will have prioritised and agreed its key priorities to early intervention and prevention
- Explore and begin to develop sustainable expenditure
- Develop our current Be Able service

3 years: By December 2021

- We will have established a co-ordinated community capacity approach by developing a network of low level community connections to compliment the support available to support older people to remain in their own homes

5 years: By December 2023

- Early intervention and prevention will be the main focus in our approach to support older people to live independently in their own homes with improved outcomes.

How will we do it?

- Establish conversation 1 programme board
- Identify key priorities and manage these with robust programme / project management support
- Use Ministerial Steering Group (MSG) measures to monitor activity and measure improvement

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Reduction in the number of delayed discharges in acute hospitals
- Reduction in the number of >75 admissions and readmissions
- Reduction in the number of unscheduled hospital bed days
- Reduction in A&E attendances
- Reduction in the % of last 6 months spent in an acute setting
- Balance of care; % of population in community of institutional care
- Reduction in waiting lists for assessments and reviews
- Improved outcomes for service users
-

What evidence do we have to support this?

- Measurements against MSG improvement objectives.

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

Executive Lead:
Chief Nurse

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
Deliver community based services to assist older people and carers to receive quality support at home or in a setting of their choice. Where it is identified that a person's needs can no longer be met at home and can only be met in a care home, we will ensure that there is a high quality, person centred interim and intermediate services, which can care for their needs while they are waiting for a permanent place in a care home of their choice. We have committed to the closure of our current interim facilities at Liberton Hospital and Gylemuir House Care Home as they no longer suitable.

Aligned to Quality Indicators:
2 – Getting help at the right time
6 – Policy development and plans to support improvement in service

Targets

1 year: By December 2019

- Interim care at current establishments will be closed at Liberton Hospital and Gylemuir House Care Home. An intermediate care facility for 40 people will open at the Jardine Clinic in late 2019
- We will have reviewed our interim care arrangements and will have a clear plan in place, in terms of our interim care services. This is intrinsically linked with our bed based resources and we will manage this under Recommendation 4.
- Our interim care services will be supported by the appropriate home based pathways so that people only stay in interim care beds when there is no alternative and when they are waiting on a place at an identified care home becoming available. This is intrinsically linked with our bed based resources and we will manage this under Recommendation 4.

3 years: By December 2021

- **No further action specific to this recommendation as linked to and will be managed under Recommendation 4**

5 years: By December 2023
Not applicable

How will we do it?

- Capture improved interim care directions within Strategic Plan.
- Continue to work with all stakeholders to continually improve our interim care model.
- Continue to be clear on our interim care model and ensure that people have clear plans for moving on prior to admission.
- Identify how improvements in the care at home position can support more people to be cared for intensively at home as an alternative interim solution and while they are being assessed.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- People in our interim care facilities will not exceed maximum length of stay and will be assessed timeously with the appropriate level package of care, back to their own home.

What evidence do we have to support this?

Recommendation: 4

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

Executive Lead:
Head of Strategy

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We will have clear pathways from home to hospital and then back to home which will provide the optimum level of care and rehabilitation for people so that they are supported to remain as independent as possible for as long as possible. This will be designed as part of the Strategic Plan and within it the transformation programme. Implementation will be further supported by the roll out of the Three Conversations approach.

Aligned to Quality Indicators:
2 – Getting help at the right time
5 – Delivery of key processes
6 – Policy development and plans to support improvement in service

Targets

1 year: By December 2019

- Further engage with stakeholders to firm up plans for future intermediate care facilities, including whether this involves new buildings or different utilisation of current facilities such as HBCCC.
- Analysis of current community intermediate care provision and understanding of how this could be improved to facilitate more intermediate care within people's own homes.
- Agree the exit strategy for Liberton hospital which includes opening the Jardine clinic and the transfer of people currently based in Liberton hospital.
- Agree closure plan for Gylemuir House and transfer residents and staff. **Afternote: this action has been completed.**
- We will have reviewed our interim care arrangements and will have a clear plan in place, in terms of our interim care services.
- Our interim care services will be supported by the appropriate home based pathways so that people only stay in interim care beds when there is no alternative and when they are waiting to return home or on a place at an identified care home becoming available.

3 years: By December 2021
Directly links to the outcomes of the transformation programme within the current 3 year strategic planning cycle. In particular output from the Hospital at Home review, the bed based review and the care at home review.

5 years: By December 2023

We will have well established intermediate care in the community and within bed based resources that is a short term assessment and rehabilitation and reablement service.

How will we do it?

- Conduct further engagement activities around bed based intermediate care proposals, particularly around how rehabilitation, HBCCC and internal care home facilities are utilised, to support the strategic 'home first' approach.
- Identify how community based intermediate care could impact on the bed numbers needed for bed based HBCCC, internal care home, rehabilitation and intermediate care.
- Further analysis of pathways to understand optimum rehabilitation journey for people and the services required.
- Gain feedback from the pilot of Discharge to Assess to understand if this could support the intermediate care model.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Fewer delayed discharges in RIE, WGH, Liberton hospital/the Jardine Clinic
- Service user feedback
- Increase number of frail elderly returning home rather than institutional care
- Increase number of frail elderly returning home with less intense Package of Care, therefore decreasing additional demand for care at home services
- Reduce the number of people delayed in hospital when fit to go home (Delayed Discharge)
- Reduce length of stay and bed days lost to delays
- Reduce unplanned admissions and re-admissions into acute hospitals
- Reduce number of people waiting for an assessment and the length of time people wait for an assessment
- Sustainable intermediate care and support

What evidence do we have to support this?

- Through the Older People Partnership Working Group, the redesign of Intermediate Care Models is underway including internal care homes, HBCCC, Respite, Interim and intermediate care underway, and rehabilitation pathways, with intended outcomes:
  - Improve the experience for people receiving care and services
  - Improve frail elderly discharge pathway
  - Enable appropriate care capacity to meet needs with timely reviews
  - Development of a highly engaged, motivated, and supported workforce, able to utilise the full extent of their professional training and skills

- The redesign and model review will be informed by work which is underway:
  - A review of the orthopaedic rehabilitation pathways (27.03.19)
  - A review of improving access and pathways, including Acute Care at Home Review (04.04.19)
  - A review of respite provision and HBCCC (25.04.19)
  - A review of community rehabilitation and intermediate care services is planned to
  - Application of a Test of Change for Discharge to Assess, and planned roll out
  - Engagement with key stakeholders and wider workforce in the redesign work, to understand the level of medical and rehabilitation needs presented within the pathway, and clearly seeking and challenging views about the environment in which care can be provided

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 the carers strategy

Executive Lead:
Head of Strategy

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We will collaborate with carers and partners on all aspects of the implementation of the carers act and update the Edinburgh Joint Carers Strategy to include the contribution from key stakeholders.

Aligned to Quality Indicators:
5.4 – Involvement of individuals and carers in directing their own support
6.4 – Involving individuals who use services, carers and other stakeholders

Targets

1 year: By December 2019

- By the end of January 2019, finalise the draft Edinburgh Joint Carers Strategy following consultation with adult and young carers and prepare the final version for ratification by the end of March 2019. This will include the statutory Short Breaks Services Statement (Unpaid Carers). **Completed**
- Consider new ways of working with paid and unpaid colleagues and adopt the learning from successful pilots in North West Edinburgh and Longstone.
- Develop an implementation plan to support the rollout of the Carers Strategy in Edinburgh for EIJB ratification in August 2019.
- In partnership with third, independent and voluntary sectors, and in consultation with carer representatives, the needs of carers will be considered across each of the Three Conversation approach within the transformation programme.

3 years: By December 2021

- Review the carers strategy in consultation with key stakeholders.
- Paid and unpaid carers will be prevalent across all EHSCP delivered services.
- Collaborative work with carers and carers organisations will be embedded as continuous improvement business as usual.

5 years: By December 2023

- The views of paid and unpaid carers will be prevalent across all EHSCP delivered services.

How will we do it?

- Fully consider paid and unpaid carer views in the development of the final revised Carer's Strategy for EHSCP, including the Short Breaks Services Statement.
- Develop a clear implementation programme for the roll out of the carers' strategy.
- Ensure carer representation for each of the work streams identified as part of the implementation programme.
- Invite carer representatives to join each of the Three Conversation transformational Programme Boards.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?

(Measures: process, outcome and balancing)

- Positive carer representative feedback.
- Performance data shows improvement against measurable indicators associated with the high level priorities and activities identified in the strategy, and recorded form April 2019.
- Number of Adult Carer Support Plans and Young Carer Statements Completed.
- Review of services and clear robust contract management.

What evidence do we have to support this?

- Redesigned paperwork to meet the new duties of the Carers (Scotland) Act 2016 – Adult Carer Support Plans, Eligibility Criteria.
- New business processes and supporting documentation produced and tested – SWIFT/AIS. This will allow performance to eb measured and reported against key indicators form April 2019 onwards.
- Carers census survey results.
- Consultation data and report to inform Strategy Development and implementation.
- Regular progress reports including minutes from various groups / committees.
- Feedback from carers/case studies from pilots.
- Draft carers Strategy and Short Breaks Services Statement to 29th March 2019 EIJB
- Final Carer's Strategy and Implementation Plan ratified by EIJB in August 2019.

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.

Executive Lead:
Head of Strategy

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement

We are committed to delivering timely diagnosis and quality post-diagnostic support for people who have a dementia diagnosis and those who give support. We aim to deliver this within the EHSCP priority areas and in line with national policy, standards and local plans. This will link to other dementia related developments as outlined in the draft Strategic Plan's Older People' Commissioning Plan and draft IJB Directions.

Aligned to Quality Indicators:
2.2 – Prevention, early identification and intervention at the right time
5.1 – Access to support
5.2 – Assessing need, planning for individuals and delivering care and support

Targets

1 year: By December 2019

- Implement revised ISD data set for Scottish Government Local Delivery Plan (LDP) target on diagnosis and post-diagnostic support - "*To deliver expected rates of dementia diagnosis and all people newly diagnosed with dementia will have a minimum of a year's worth of post – diagnostic support coordinated by a Link Worker, including the building of a person-centred support plan.*"
- Through 2019 scoped and developed project plan for quality improvement work to streamline post-diagnostic support (PDS) referral pathways, including referral transitions and addressing any service provision gaps.
- Through 2019 support post-diagnostic support training as a test of change development.
- Implement revised service specification for the current Alzheimer Scotland PDS Service contract.
- Develop and progress implementation plan for PDS developments, in partnership, which includes implementing published Quality Improvement Framework for PDS, PDS training model for staff, national Homebased Memory Rehabilitation pilot site. This will take account of links to Carers' Act, technology enabled care and wider dementia pathways work.
- To support GP Practices in North East Edinburgh National Innovation Test Site to test relocation of post-diagnostic support to primary care and scope opportunities for further development, ensuring it links with wider post-diagnostic support provision and developments. This includes the testing of both PDS group work and post-diagnostic support in care homes.
- Improve the pathway for referral to diagnosis by working with locality MATs to find ways to streamline assessment and triage processes.

3 years: By December 2021

- Review current post-diagnostic support contract in place (1 April 2018 to 31 March 2021) by December 2020.
- From 2019 to 2021, support GP Practices in North East Edinburgh National Innovation Test Site to test relocation of post-diagnostic support to primary care.
- To share learning and continue to develop PDS delivery model as required in line with local and national influences.
- A clear pathway for referral to diagnosis of patients with symptoms of dementia.

5 years: By December 2023

- Continue to support dementia post-diagnostic support service developments, including service delivery, implementation of national Quality Improvement Framework, training, and data, taking account of local and national influences and Scottish Government Local Delivery Plan (LDP) target reporting requirements.

How will we do it?

- Multi-agency Edinburgh Dementia Post Diagnostic Support Reference Group in place. Terms of reference recently reviewed to take forward priority areas.
- Links to National Dementia Post Diagnostic Support Leads Group will help influence and shape Edinburgh developments taking account of developments, innovation and challenges experienced across Scotland.
- Dementia and Memory Support Steering Group in place for National PDS Innovation Test Site in Primary Care to take forward work.
- Continue to develop engagement opportunities with people living with a dementia diagnosis and their carers to ensure their views inform developments.
- Work with locality MATs to improve the pathway for referral to diagnosis by reviewing current pathways and streamlining the process for triage and assessment.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Increased numbers of people receiving timely post-diagnostic support through quantitative data from national reporting to ISD on Local Delivery Plan (LDP) target.
- PDS Contract – monthly and quarterly reporting.
- Report on the National Innovation Test Site in North East Edinburgh GP Cluster External evaluation, (through funding by Scottish Government contract for all national test sites evaluation) in which will further inform developments. Evaluation to begin in 2019.
- Engagement feedback from people living with dementia and their families on experiences of support, gaps and suggested areas for improvement.

- Test for change paper will be completed for improving the referral to diagnosis and onward signposting pathways.

What evidence do we have to support this?

- Review of contracted Alzheimer Scotland Dementia Post-Diagnostic Support Service completed April 2017. This included evidence gathered through 2 focus groups with people living with dementia and their carers, and a review of semi-structured questionnaires routinely sent to service users and their carers at 12 months post-diagnostic support.
- Monthly LDP Target reporting and ISD published performance report.
- Commitments 1 and 2 within Scotland's National Dementia Strategy 2017-2020 which specifically relate to further post-diagnostic support developments and testing relocation of PDS to Primary Care.
- A clear and timely pathway for referring patients for diagnostic tests and onward signposting for post diagnostic support.
- Remain engaged with the development of the Alzheimer Scotland 'Delivering Fair Dementia care for People with Advanced Dementia'.

Recommendation: 7

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

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We will broaden our approach to managing falls and focus on prevention and early intervention as part of our falls pathways

Aligned to Quality Indicators:
2.2 – Prevention, early identification and intervention at the right time
2.3 – Access to information about support options including self directed support
5.3 – Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks
6.2 – Partnership development of a range of a range of early intervention and support services

Targets

1 year: By December 2019 we will:

- have developed a process to proactively identify individuals at risk of falls and fractures at an early stage to ensure they are able access the right support at the right time.
- have successfully implemented "Prevention of Management of Falls in the Community: A framework for action for Scotland 2014/16"
- have tested the Care Inspectorates best practice tool 'Managing Falls and Fractures in Care Homes for Older People'
- review existing falls pathways
- provide targeted support to care homes
- engage with health promotion to develop public awareness campaign

- have completed a programme of training to locality hub and clusters

3 years: By December 2021
We will continue the work to improve our falls pathways and continue to test ways to reduce the number of falls in the community and our care homes through early intervention and prevention and it will be embedded in continuous improvement business as usual

5 years: By December 2023
We will continue to deliver a programme of improvement around access to falls services and falls prevention with good engagement with SAS, acute services, and 3rd, independent and voluntary sector organisations.

How will we do it?
Continue to deliver a range of initiatives with a focus on early prevention and intervention through a clearly developed programme of work.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)
Reduction in the number of falls resulting in injury and requiring hospital admission
Reduction in admission rates to A&E for people over the age of 65.
Reduction in the number of falls within care homes
Clear referral and care pathways

What evidence do we have to support this?

Recommendation: 8

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

Executive Lead:
Clinical Director / Chief Nurse

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We are committed to delivering high quality, safe care and support to all service users in the EHSCP by following the key principles of the Health and Social Care Standards: 'My support, my life.

Aligned to Quality Indicators:
6.3 – Quality Assurance, self evaluation and improvement
9.4 – Leadership of change and improvement

Targets

1 year: By December 2019 we will have completed the workstreams to:

- Review the current quality assurance and improvement resource for the partnership including the understanding of partner's roles and contributions to EHSCP quality agenda to ensure there is a joint approach across all services.
- Agree the partnerships approach to quality assurance and improvement and review governance arrangements to ensure there is a clear reporting line for the escalation of care and service delivery concerns.
- Build capacity and capability around quality improvement across the partnership through the development of a Quality Assurance Hub
- Develop a clear joint reporting framework to gather information across services to provide assurance that the care we deliver meets an expected standard and as a tool to benchmark against good practice.
- Developed a framework for managing risk with a clear escalation route from service level to corporate level
- Adopt a single IT platform for managing risk

3 years: By December 2021 we will:

- have a fully developed and implemented Quality Framework for the partnership
- have an agreed set of quality standards linked to national standards that we will use to measure the quality of the services we deliver
- have a fully developed programme to introduce a single IT platform for reporting adverse events across all services and a joint policy for the review and investigation of adverse events and significant occurrences
- be able to demonstrate that quality is recognised as a cross cutting enable across the 3 conversations model for transformation and change

5 years: By December 2023 we will:

- **b**e able to evidence that we deliver all our services to the highest possible standard by measuring against local and national standards.
- have a fully embedded culture of quality improvement across all our staff groups and our staff will be equipped with the knowledge and skills to allow them to influence improvement.

How will we do it?

1 year

- Review the current quality assurance and improvement resource in the partnership with a view to managing the resource centrally as part of the EHSCP Quality Hub. This will increase the skill mix across the partnership and allow the resource to be managed more effectively to support the delivery of the agreed quality and assurance workstreams.
- Consider the requirements of the QA support available through safer and stronger communities to ensure the level of quality assurance support available to the partnership is sufficient enough to deliver the level of assurance required to ensure the services we deliver are of the highest standard
- Identify the key drivers required to support the development of a EHSCP Quality Hub
- Consider quality and assurance as part of the wider EHSCP governance review
- Review the current 'quality dashboard' model to establish if it provides the level of scrutiny required
- Develop a EHSCP corporate level risk register with a clear process for managing risk across the partnership
- Support locality and hosted service teams to develop local risk registers and provide training to aid appropriate identification of risk and appropriate escalation
- Implement DATIX as single system for risk management

3 years

- Involve key stakeholders in the development of a quality framework with measurable standards linked to the Health and Social Care Standards: My support, my life
- Prepare a business care highlighting the benefits and cost implications to move to a single IT platform for incident management

5 years

- The quality hub will be the main driver in the delivery of a fully embedded culture of improvement and assurance in EHSCP. The Quality Hub will continually review and measure against agreed standards and support staff across all professions to continually improve the standard of care we deliver across our services.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

Year 1
Centralised quality resource
Coaching network
EHSCP Quality Website
Clear arrangement with Safer and Stronger Communities Directorate for QA support
Quality and assurance part of the EHSCP governance framework for EHSCP
Reporting framework used across all services with a clear reporting line
Fully developed local and corporate risk registers
Single IT platform for risk management and service user feedback

Year 3
Agreed EHSCP Quality Framework
Measurable standards
Plan to introduce a single reporting system for incident management
Quality input into the 3 programme boards for transformation and change

Year 5
Fully developed and functioning quality hub with a range of skill mix across all professions.
Measurable standards consistently applied to measure the quality of services we provide
A comprehensive programme of improvement initiatives

What evidence do we have to support this?

Recommendation: 9

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

Executive Lead:
Head of Strategy

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement

Building on the work conducted with local community and stakeholders to date; work in partnership to develop a cohesive approach to market facilitation which includes risk assessment and contingency plans for key market segments.

Aligned to Quality Indicators:

6.1 – Operational and strategic planning arrangements

6.5 – Commissioning arrangements

Targets

1 year: By December 2019

- Have established principles for market facilitation through the Strategic Plan.
- Develop and agree a plan to address each market segment based on a combination of priority, risk and opportunity.
- Have clear processes for engaging with key providers and other stakeholders to plan for the future**.**

3 years: By December 2021

- Co-produce with relevant stakeholders, the Edinburgh market shaping strategy, which includes risk assessment and contingency plans.
- Continue to improve engagement and relationships with all stakeholders
- New approach to the grants programme agreed with the 3rd sector through the Community Engagement Strategy.

5 years: By December 2023

- Evidence that the impact of the well established relationships with stakeholders has improved the outcomes for the users of our services.

How will we do it?

- Identify and agree key market segments.
- Identify the best approach to engaging with each segment (building on networks that already exist).
- Work together to agree principles for working together.
- Work together to identify upcoming challenges in key market segments and work together to address these.
- Establish a regular forum for engagement with the 3rd sector.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- There will be clearly identified mechanisms for engaging with market segments.
- Market facilitation principles will be produced and agreed**.**
- Marked improvement in engagement across all provider groupings.

What evidence do we have to support this?

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**

Executive Lead:
Head of Strategy

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement

The EIJB draft Strategic Plan for 2019-2022 will contain a full range of steps to be taken to improve older people's care in accordance with the care Inspectorate report and recommendations. Most of this effort will be focussed within the transformation programme.

Targets

1 year: By December 2019
- Review the strategy for older people as part of the development and production of the new EIJB Strategic Plan taking full account of the Inspection report and work conducted within the Older Peoples Reference Group.
- Develop action plans which flow from the transformation programme that include anticipated cost implications, active monitoring cost implications and develop costed business cases at key decision making points.
- Develop engagement and communications plan.

3 years: By December 2021
- Review Older People care within the EIJB Strategic Plan against action plans and the Inspection report.
- Review progress on action plans and business cases.
- Monitor progress including benefits from the roll out of the Three Conversations approach.

5 years: By December 2023
- Continuous review and improvement based on lessons learned from the transformation programme outputs. This is particularly in relation to Hospital@Home, the bed base review and the care at home review.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- EIJB Strategic Plan 2019-2022 will be published and ongoing monitoring of the actions and implementation plans.
- Analysis of the performance management framework.
- Analysis of EIJB Directions directly linked to older people.
- Engagement plan actions have been achieved.
- Action plans have been achieved.

What evidence do we have to support this?

- Feedback from the Older People Reference Group**.**
- Feedback on the draft Strategic Plan consultation.

Recommendation: 11

The Partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved for the Integrated Joint Board

Executive Lead:
Chief Finance Officer

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We will produce a comprehensive 3 year financial plan setting out the quantum of the financial challenge facing the IJB and reflecting the aims and ambitions set out in the strategic plan.

Aligned to Quality Indicators:
8.1 – Management of resources

Targets

1 year: By December 2019 we will have:

- An IJB financial plan for 2019/20 developed reflecting the budgets delegated by NHS Lothian and CEC and agreed by IJB
- An approved savings and recovery programme for 2019/20 which is reviewed regularly and progress updates given to the IJB
- A 3 year financial framework developed in line with the strategic plan

- Started work with the IJB to consider its risk appetite, in particular how it views the balance of financial and service risks

3 years: By December 2021:

- We will have processes in place to refresh and update the financial plan on a routine basis
- We will have developed a financial strategy aligned to the strategic plan
- The IJB will have agreed its risk appetite

5 years: By December 2023 we will have:

- A financial framework which allows us to plan and deliver high quality services improving overall outcomes for the citizens of Edinburgh
- A level of financial intelligence to model, predict, plan and evaluate the impact of service change including the transfer of resource from acute services to community services.

How will we do it?

- Through a series of workshops with the IJB, develop and deliver a savings programme for 2019/20
- Agree the budgets delegated by our partners In line with our budget protocol
- Produce a financial plan for agreement by the IJB
- Work closely with the heads of finance in NHS Lothian and CEC to ensure the appropriate level of financial support is available to support the development of our strategies.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Agree a financial plan based on delegated budget
- Have a credible savings plan which is on target for delivery

What evidence do we have to support this?

- Evidence (through papers, minutes etc) of IJB agreement of financial plan with associated savings programme
- Projected delivery of a balanced financial position for 2019/20 evidenced by through the annual accounts for the year

Recommendation: 12

The Partnership should ensure that:

1. **there are clear pathways to accessing services**
2. **eligibility criteria are developed and applied consistently**
3. **pathways and criteria are clearly communicated to all stakeholders, and**
4. **waiting lists are managed effectively to enable the timely allocation of services (refer to recommendation 13)**

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We aim to provide clarity and consistency to our pathways for accessing services. We aim understand how we engage with people. We aim to introduce Three Conversations

Aligned to Quality Indicators:
5 – Delivery of key processes

Targets

1 year: By December 2019
Under the umbrella of Three Conversations we will:

- Develop a new protocol and processes to improve the quality and efficiency of screening and allocation
- Improve the standard for responding to referrals and initial conversations
- Improve the waiting time for assessments
- Review ICT and business processes to support new ways of working
- Identify mechanisms to clear the backlog of assessments and reduce waiting lists
- Develop, agree and implement the Edinburgh Offer

3 years: By December 2021
Access to services will be integrated into the Three Conversations approach

5 years: By December 2023
There will be clear pathways for stakeholders to access our services in a timely manner and be signposted to services within agreed timescales.

How will we do it?

- Implement Three Conversations with the first principle of a providing and immediate response to someone contacting us
- Simplify review processes
- Introduce a performance framework to continually measure improvement
- Work closely with data and compliance team to review and cleanse the list of overdue reviews

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Our pathways will be clear and easy to navigate
- Reduction in front end waiting lists
- Eliminate waiting lists for assessments

What evidence do we have to support this?

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

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
In line with our implementation of Three Conversations, we will provide a clear and comprehensive process and engagement strategy for the assessments and review of people's needs that is proportionate to need and complexity.

Aligned to Quality Indicators:
1 – Key performance outcomes
5 – Delivery of key processes

Targets

1 year: By December 2019 we will:
Under the umbrella of Three Conversations we will

- Review and streamline the assessment process and documentation
- Review the process of engagement with stakeholders
- Ensure chronologies are determined by the complexity of individual care plans

3 years: By December 2021
Assessments and care planning will be part of the Three Conversations approach

5 years: By December 2023
All people that use our services will have access to a level of resource and support proportionate to their needs, with a good standard of assessment, care planning and review.

How will we do it?
Review as part of recommendation 12
Use the principles of building on individual assessments
Develop a new protocol to streamline the process for assessment, review and care planning under the 3 conversations model.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?

(Measures: process, outcome and balancing)

Our pathways will be clear and easy to navigate
Reduction in front end waiting lists
Chronologies proportionate to the level of complexity

What evidence do we have to support this?

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.

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement

Our processes for managing risk are effective to ensure the safety of our service users

Aligned to Quality Indicators:
5.3 - Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks

Targets

1 year: By December 2019 we will:

- streamline the process for tracking and monitoring IRDs
- continue the development of a programme of ASP training at level 1,2,3 and 4
- progress with health participation in IRDs
- ensure health participation in all IRDs (conversations and recording) standard by end 2019
- ensure all APCC plans are SMART
- recognise the 'Duty to Inquire' stage as a formal assessment
- move the Complex Risk Assessment to a more person centred asset based Safety Assessment
- ensure all staff who take lead in adult protection investigations are offered appropriate level of support

3 years: By December 2021

We will be confident that our systems and processes are robust enough to provide assurance that the users are services are safe and where risk is a concern, people are assessed appropriately.

5 years: By December 2023
Good quality and appropriate risk assessments and robust risk management plans, informed by relevant partners will be evidenced in continuous improvement business as usual to ensure older people are protected from harm

How will we do it?
The Senior Manager for Regulation and Compliance (Safer and Stronger Communities) will lead on a programme of improvement work to address the identified priorities

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

What evidence do we have to support this?

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

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
We are committed to enabling citizens of Edinburgh to live their own chosen life independently with the right resources and support. We aim to implement Three Conversations which will promote greater choice for people and will ensure staff in all settings are confident about discussing self-directed support.

Aligned to Quality Indicators:
2 – Getting help at the right time
7.3 – Training, development and support

Targets

1 year: By December 2019

- Introduction of clear guidance for staff, articulating the intent and core principles of self-directed support, as well as revised step by step processes.
- Re-introduction of Resource Allocation System (RAS) to enable assessors to discuss the indicative budget with citizens to support the co-production of support plans to meet identified outcomes.
- Staff and multi-agency training workshops developed, including the introduction of Three Conversations approach through several innovation sites and the roll out of Good Conversations skills based training to all staff who will be involved in assessing.
- Improvement targets set to increase use of Options 1 and 2, and performance measures established.
- Continued roll out of access to SDS for carers

3 years: By December 2021

- A catalogue of "stories of difference" to support workers to be more creative in their approach to support planning
- Demonstrated qualitative improvements in practice which will be supported by the roll out of the 3 conversation model, to be introduced in 2019
- Demonstrate senior management support through creative solutions decision making

5 years: By December 2023

- Have a fully embedded culture which meets our Aim Statement.

How will we do it?

- Working with Partners for Change to introduce the 3 Conversation Approach.
- Introducing workers handbook providing clear guidance for SDS practice, which will increase worker confidence.
- Roll out training workshops to support SDS quality practice.

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

- Increased proportion of people in receipt of support services using Options 1 and 2.
- Implementation of RAS and working with individuals to use their budgets creatively.
- Variety of "stories of difference"..
- Staff satisfaction surveys.

What evidence do we have to support this?

- Tools introduced with 3 Conversation Model will measure and evidence success, as demonstrated in other authorities with whom they have worked.

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.

Executive Lead:
Chief Nurse

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
Develop a flexible and sustainable workforce across EHSCP by improving staff development opportunities and by investing in staff health and well being

Aligned to Quality Indicators:
6.4 – Involving individuals who use services, carers and other stakeholders
7 – Management and support of staff
9.3 - Leadership of people across the partnership

Targets

1 year: By December 2019

- Develop a baseline workforce development plan using a six step methodology
- Develop an integrated framework for education and training
- Engage with national apprenticeship scheme for caring roles
- Improve engagement with all stakeholder (staff, partnership and 3rd, independent and voluntary sector organisations) in the development of workforce model
- Work in partnership with the newly established Quality Assurance Hub (recommendation 8)

3 years: By December 2021

- We will continue to use the workforce development pan to further strengthen our workforce
- We will have a well established partnership employee health and wellbeing strategy

5 years: By December 2023

- We will have a fully developed workforce to deliver a high standard of care across all services in EHSCP

How will we do it?

Workforce plan to be overseen by EHSCP workforce development group
Recruit 17 modern apprentices to work in caring roles across EHSCP
Promote the health and wellbeing of staff to help stabilise the current workforce
Succession planning
Transform role – identify skill mix across all professions
Review processes for recruitment
Proactively manage sickness absence across all services
Move to a single framework (imatters) to measure staff satisfaction

How will we know that change has led to an improvement / how will we know we have achieved what we set out to do?
(Measures: process, outcome and balancing)

Reduction in absence rates
Measure against a standard that all posts will be filled within 10 weeks
Reduction in vacancy rate to <5% across all sectors
Staff surveys will indicate staff are more confident and competent
Our workforce remains with us and more people want to work in the Partnership

What evidence do we have to support this?

Recommendation: 17

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

Executive Lead:
Head of Operations

Last Update:	**Update Frequency:**	**Target Stage:**
Jan 2019	3 monthly	**1 Year** 3 Years 5 Years

Aim Statement
Support organisations to develop volunteering networks and thereby building community capacity that supports early intervention and links with Recommendation 2. Our aim is to support community capacity and sustainable communities that support people through the implementation of Three Conversations

Aligned to Quality Indicators:
8 – Partnership working

Targets

1 year: By December 2019

- Review existing city wide volunteering structures and networks
- Build a robust relationship with our 3rd Sector partners that supports community capacity building
- Agree the approach to produce a revised community group set up to align with Edinburgh volunteering strategy and maximise volunteer participation and retention

3 years: By December 2021

- Implement the EHSCP elements to the Edinburgh Volunteer Strategy

5 years: By December 2023

- Well established volunteer network across all services in EHSCP that supports our strategic aims

How will we do it? • Engage through the delivery group set up by volunteer Edinburgh • Start work on reviewing the existing structures
How will we know that change has led to an improvement / how will we know we have achieved what we set out to do? **(Measures: process, outcome and balancing)** • Increase in the number of volunteers, their satisfaction and retention.
What evidence do we have to support this?

Appendix 2 Older People Joint Improvement Monitoring Action Plan

KEY	Blue	Green	Amber	Red
	Completed	On track to complete by agreed date	On track to be complete within 3 months of agreed date	Work not started or might have started but issues/barriers identified

Reference	Recommendation	Executive Lead	Year 1 Target / actions by December 2019	Progress	Indicator
1	**The partnership should improve its approach to engagement and consultaion with stakeholders in relation to:** **Its vision** **Service redesign** **Key stages of its transformational programme** **Its objective in respect of market facilitation**	Chief Officer	A Transformation and change programme agreed and resourced by the EIJB by February 2019	Paper to EIJB in Februuary 2019, approved and resources secured	Blue
			The transformation plan and delivery structure will set out clear engagement with key stakeholders at every stage	Paper to IJB begins this and further work completed by revision of the strategic plan and the Interim Transformation Programme. Workshops held to explore priorities	Blue
			There will be clear stakeholder involvement in the review of the partnership's vision and values	Strategic Plan consultation with stakeholders, feedback influenced content and report to IJB	Blue
			Development of a partnership communication plan and a range of platforms to improve communication with key stakeholders	Development of EHSCP web page and communication plan on going. Strategic Plan engagement sessions held with a wide variety of stakeholders. Work being done on engagement with people who use services	Blue
			Staff involvement in the key stages of service redesign will be set out and evidenced	Programme for transformational change underway and programme/project staff recruited. Specific topic workshops held with key stakeholders and business cases developed. Programme boards established. iMatters survey completed and action plans in development. Employees Partnership Forum continues and Employee Partnership embedded in partnership governance. Making it Happen meetings established and innovation site feedback influences service redesign	Green

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**	Head of Operations	Our conversation 1 programme board will be established and will have prioritised and agreed its key priorities to early intervention and prevention	Programme boards established. Three Conversations is implemented (7 innovation sites). Early intervention and prevention transformational workshops held and agreed as priority to support change and 3Cs. Feedback from innovation sites will influence programme board 1	Green
			Explore and begin to develop sustainable expenditure	As above. Previous grants process has been reviewed and new grants process focused on ensuring sustainable community activity, community investment activity and partnership working with Third Sector	Green
			Develop our current Be Able Service	Be Able review underway alongside review of partnership day centres and Steady Steps programme. Focus to re-align support based on person's need and support to maintain level of ability	Green

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**	Chief Nurse	Interim care at current establishments will be closed at Liberton Hospital and Gylemuir House Care Home. Intermediate care facilities for 40 people will be estanblished	GMH closed on 28th June 2019, all residents supported and transferred to appropriate long term care facility. . Model on intermediate care agreed and resources secured.	Blue
			We will have reviewed our interim care arrangements and will have a clear plan in place, in terms of our interim care services. This is intrinsically linked with our bed based resources and we will manage this under Recommendation 4.	Agreed "interim care" is a model we no longer want to pursue. Focus will be on intermediate care, Home First and Discharge to Assess	Blue
			Our interim care services will be supported by the appropriate home based pathways so that people only stay in interim care beds when there is no alternative and when they are waiting on a place at an identified care home becoming available. This is intrinsically linked with our bed based resources and we will manage this under Recommendation 4.	As above	Blue
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**	Head of Strategic Planning	Further engage with stakeholders to frim up plans for future Intermediate care facilities, including whether new buildings or different utilisation of current facilities such as HBCCC	Multi agency, multi professional workshops held regarding HBCCC, review of partnership bed capacity underway, discussions about care home based intermediate care underway	Amber
			Analysis of current community intermediate care provision and understanding of how this could be improved to facilitate more intermediate care within people's own homes	Discharge to Assess under the banner of Home First in development and likely to start in November 2019 – recruitment underway.	Blue
			Agree the exit strategy for Liberton hospital which includes opening the Jardine clinic and transfer people from Liberton hospital	Agreed and action plan in place. Delay in moving date is a building issue rather than a service issue. Bed capacity already reduced to 40 and team in place to move as quickly as building works allows	Blue
			Agree closure plans for Gylemuir House and transfer residents and staff	Gylemuir House closed on 28th June 2019	Blue

			We will have reviewed our interim care arrangements and will have a clear plan in place, in terms of our interim care services	EHSC Partnership no longer exploring interim care as a service, focus is on intermediate care and Home First	Blue
			Our interim care services will be supported by the appropriate home based pathways so that people only stay in interim care beds when there is no alternative and when they are waiting on a place at an identified care home becoming available	EHSC Partnership no longer exploring interim care as a service, focus is on intermediate care and Home First	Blue

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 the carers strategy**	Head of Strategic Planning	By the end of January 2019, finalise the draft Edinburgh Joint Carers Strategy following consultation with adult and young carers and prepare the final version for ratification by the end of March 2019. This will include the statutory Short Breaks Services Statement (Unpaid Carers)	Draft joint carers strategy presented in March 2019 and ratified by EIJB in August 2019. The Short Breaks Service Statement (unpaid carers) was agreed in March and is published and available on the web	Blue
			Consider new ways of working with paid and unpaid carers and adopt the learning from successful pilots in North West Edinburgh and Longstone.	Learning from pilots is under review and hopes to be concluded in November 2019. Plan to adopt the learning form pilots, as well as learning from 3Cs, will be developed following the review	Green
			Develop an implementation plan to support the rollout of the Carers Strategy in Edinburgh for EIJB ratification in August 2019	Implementation plan developed and ratified by the IJB in August 2019	Blue
			In partnership with third, independent and voluntary sectors, and in consultation with carer representatives, the needs of carers will be considered across each of the 3 conversation approach within the transformation programme	Stakeholder sessions undertaken as part of the consultation for the strategic plan which included carers and care support organisations	Blue
			Implement revised ISD data set for Scottish Government Local Delivery Plan (LDP) target on diagnosis and post-diagnostic support - "To deliver expected rates of dementia diagnosis and all people newly diagnosed with dementia will have a minimum of a year's worth of post – diagnostic support coordinated by a Link Worker, including the building of a person-centred support plan"	Implemented revised ISD and people newly diagnosed with dementia will be offered a minimum of one year's post-diagnostic support, coordinated by a named link worker	Blue
			Through 2019 scoped and developed project plan for quality improvement work to streamline post-diagnostic support (PDS) referral pathways, including referral transitions and addressing any service provision gaps	In progress but slight delay to expected start because of staff capacity and availability. Post Diagnostic Support (PDS) Reference Group to take forward	Amber
			Through 2019 support post-diagnostic support training as a test of change development	Completed tests of change at Liberton Day Hospital and selected care homes in North East Edinburgh. As above, included in PDS Reference Group	Blue

6	**The Partnership should ensure that people with dementia receive a timely diagnosis and that diagnostic support for them and their carers is available.**	Head of Strategic Planning	Implement revised service specification for the current Alzheimer Scotland PDS Service contract	Completed and subject to ongoing development through regular contract monitoring	Blue
			Develop and progress implementation plan for PDS developments, in partnership, which includes implementing published Quality Improvement Framework for PDS, PDS training model for staff, national Homebased Memory Rehabilitation pilot site. This will take account of links to Carers' Act, technology enabled care and wider dementia pathways work	The work from this has been folded in to the project plan and the planned work of the PDS Reference Group. Work has been reviewed and revised and is now focused on improvement	Blue

			To support GP Practices in North East Edinburgh National Innovation Test Site to test relocation of post-diagnostic support to primary care and scope opportunities for further development, ensuring it links with wider post-diagnostic support provision and developments. This includes the testing of both PDS group work and post-diagnostic support in care homes	As above – folded into PDS Reference Group	Blue
			Improve the pathway for referral to diagnosis by working with locality Memory Assessment and Treatment services to find ways to streamline assessment and triage processes	Steering group in place to progress improvement work. Work identified and test of change in South West locality planned Spring 2020 to streamline diagnosis and improve access to support following diagnosis	Amber
			Develop a process to proactively identify individuals at risk of falls and fractures at an early stage to ensure they are able access the right support at the right time	Enhancing Be Able to increase capacity Training has been carried out with staff across the partnership on level 1 assessments to proactively identify people at risk of falls or fractures. This is in line with NICE guidelines. Work is ongoing to improve the referral process within ATEC24	Blue

7	**The Partnership should streamline and improve the falls pathway to ensure that older people's needs are better met**	Head of Operations	Implemented "Prevention of Management of Falls in the Community: A framework for action for Scotland 2014/16"	Long Term Conditions team lead on this and other developments with dedicated Community Falls Co-ordinator. The four stages of the framework have been implemented across the partnership. Training has been carried out across the partnership to meet Stage 1 and Stage 2 requirements and there are Assistant Practitioners in each hub who carry out level 2 multifactorial assessments Stage 3 - there is an established Fallen Uninjured Person pathway and a Scottish Ambulance Service (SAS) Pathway. GP's, NHS 24, ATEC24 and SAS have been involved in the embedding of the pathways and their review. Stage 4 specialist assessments are carried out in one of the three day hospitals in the city or by specialist AHP's embedded in local teams	Blue
			Test the Care Inspectorates best practice tool 'Managing Falls and Fractures in Care Homes for Older People'	A test of change has been carried out to trial the impact of embedding the care inspectorate best practice tool 'Managing falls and Fractures in Care Homes for Older People' . The aim was to reduce falls related A+E admissions by 20% in a six month period. Four care homes were in the initial phase, Jewel House, Laverock House, Ashley Court and Fords Road. Evaluation data showed an average 62% reduction in falls related A+E attendances. A further 2 phases are currently being carried out in 8 care homes	Blue
			Review existing fall pathways	The existing Lothian Falls and Bone Health Pathway was reviewed in January 2018	Blue

			Provide targeted support to care homes	Long Term Conditions team links with care homes as above. The care homes targeted have been spread across the four localities and were identified as those that had the highest rates of A+E attendances for falls. A Care Homes Falls Panel has developed organically from this process and brings together professionals from across the city who work in Care Homes to share their experiences and professional knowledge	Blue
			Engage with health promotion to develop public awareness campaign	Some involvement with health promotion around physical activity and increasing falls awareness but there has been no specific campaign.	Red (Action needs to be allocated)
			Have completed a programme of training to locality hub and clusters	An ongoing programme of training is carried out with practitioners across the Partnership. The focus is on the early identification of people who might be at risk of falling and onward referral for further more detailed assessments as required. Information on where to signpost individuals to following a falls has been widely circulated	Blue
			Review the current quality assurance and improvement resource for the partnership including the understanding of partner's roles and contributions to EHSCP quality agenda to ensure there is a joint approach across all services	Review undertaken and new model identified that is a joint approach to improvement in the Partnership	Blue
			Agree the partnerships approach to quality assurance and improvement and review governance arrangements to ensure there is a clear reporting line for the escalation of care and service delivery concerns.	Clinical and Care Governance Committee established by the EIJB following the Good Governance Institute report and action plan. Scorecard performance reporting framework developed.	Blue

8	**The Partnership should develop joint approaches to ensure robust quality assurance processes are embedded in practice.**	Chief Nurse / Clinical Lead	Build capacity and capability around quality improvement across the partnership through the development of a Quality Assurance Hub	Review of all staff with a role of improvement, either directly or indirectly, and those trained or qualified in this field to better understand the resources we have and make decisions about how to best deploy them	Amber
			Develop a clear joint reporting framework to gather information across services to provide assurance that the care we deliver meets an expected standard and as a tool to benchmark against good practice	Review data gathering. Currently use a balance scorecard (version 9) and need to agree if data gives us the information we need to improve and develop practice and services	Green
			Developed a framework for managing risk with a clear escalation route from service level to corporate level	Re-establish steering group. This is a complex and multi-faceted issue and work has begun on EIJB risk register and EHSCP risk register	Amber
			Adopt a single IT platform for managing risk	Agreed risk register should be on Datix but only as a holding register rather than how EHSCP manages risk. On-going discussions with partner agencies about how to achieve the use of a single platform. Recent decision to implement the current NHS Lothian H&S Assurance Framework across EHSCP so partnership managers are following one framework. Chief Officer to take a paper to CLT to raise issues and seek solutions/support	Red
9	**The Partnership should work with the local community and other stakeholders to develop and implement a cross market facilitation strategy. This should**	Contracts Manager	Have established principles for market facilitation through the Strategic Plan.	Principles developed in line with Strategic Plan and specific plan will be developed and implemented by June 2020 focused on building a collaborative relationship and sustainable community support across all different sectors with the external market	Green
			Develop and agree a plan to address each market segment based on a combination of priority, risk and opportunity.	As above	Green

	include risk assessment and contingency plans		Have clear processes for engaging with key providers and other stakeholders to plan for the future.	Specific plan will include communication and engagement strategy to develop a sustainable longer term framework for cross market facilitation	Amber
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 measureable outcomes**	Head of Strategic Planning	Review the strategy for older people as part of the development and production of the new EIJB Strategic Plan taking full account of the Inspection report and work conducted within the Older People's Reference Group	Previous reference group now disbanded, new working groups will be formed through the establishment of the Three Conversations Programme Board or as a need for business as usual improvement activity. New EIJB Strategic Plan agreed and approved in August 2019	Blue
			Develop action plans which include anticipated cost implications, active monitoring cost implications and develop costed business cases at key decision making points.	Transformation Programme being established which will drive transformational change. Programme/project staff are being recruited and business cases developed following stakeholder workshops. Savings and recovery programme established	Green
			Develop engagement and communications plan.	Inclusive engagement plan for al services, people and staff under development. Interim plan in place to ensure communication and engagement progresses	Green
			An IJB financial plan for 2019/20 developed reflecting the budgets delegated by NHS Lothian and CEC and agreed by IJB	Papers presented to EIJB in October 2019. Workshops held with EIJB and others to explore issues and options and recovery plan agreed.	Green

11	**The Partnership should develop and implement detailed financial recovery plans to ensure that a sustainable financial position is achieved for the Integrated Joint Board**	Chief Finance Officer	An approved savings and recovery programme for 2019/20 which is reviewed regularly and progress updates given to the IJB	Savings and recovery plan in place and monitored monthly through Savings Governance Board through to the EIJB Performance and Delivery Committee	Blue
			A 3 year financial framework developed in line with the strategic plan	Two sessions held with EIJB and final report will be presented to EIJB in January 2020	Green
			Started work with the IJB to consider its risk appetite and, in particular how it views the balance of financial and service risks	In development through GGI work which has begun to explore EIJB risk appetite. Workshop planned for early 2020 with EIJB	Green
	The Partnership should ensure that: **- there are clear pathways to accessing services** **- eligibility criteria are developed and applied consistently**		Develop a new protocol and processes to improve the quality and efficiency of screening and allocation	Implementation of Three Conversations ensures screening and allocation process will change or will be withdrawn. In the meantime current business as usual pathways remain in place and during 3Cs development learning will allow changes to current processes and pathways in preparation of full 3Cs implementation. Interim changes will be made to keep flow. New recording tools have been developed through 3Cs and a new procedure will be developed as 3Cs becomes more widely established	Amber - will remain amber until 3c's fully implemented
			Improve the standard for responding to referrals and initial conversations	As above. 7 innovation sites now running across a variety of teams bringing a wealth of information about how we respond quickly, appropriately and in a person centred, strength based way. Grip and control of processes to ensure consistency and rigour during our transformation	Amber - will remain amber until 3c's fully implemented

12	**- pathways and criteria are clearly communicated to all stakeholders, and** **- waiting lists are managed effectively to enable the timely allocation of services (refer to recommendation 13)** **<u>Recommendation now under the umbrella of Three Conversations</u>**	Head of Operations	Improve the waiting time for assessments	As above. Discharge to Assess under the banner of Home First and linked with Good Conversations (skills enhancement) will improve hospital assessments	Amber - will remain amber until 3c's fully implemented
			Review ICT and business processes to support new ways of working	As above. Learning from 3Cs will influence ICT requirements going forward as front line practice changes and develops. Engaged with support services to ensure service needs fully understood and they are part of Making It Happen.	Amber - will remain amber until 3c's fully implemented
			Identify mechanisms to clear the backlog of assessments and reduce waiting lists. Develop, agree and implement the Edinburgh Offer	As above. Two 3C innovation sites focused on waiting lists which will help us develop new operational delivery methods that are responsive and flexible. Edinburgh Pact (Edinburgh Offer renamed) is still in development and will be influenced by the outcomes from the 3Cs innovation sites	Amber - will remain amber until 3c's fully implemented
	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**		Review and streamline the assessment process and documentation	As above in Recommendation 12	Amber - will remain amber until 3c's fully implemented
			Review the process of engagement with stakeholders	As result of the new Strategic Plan and the development of a wider engagement and communication plan will ensure robust engagement with stakeholders	Amber

13	**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** **<u>Recommendation now under the umbrealla of Three Conversations</u>**	Head of Operations	Ensure chronologies are determined by the complexity of individual care plans	Training will be developed following the ASAP audit which is underway and chronologies will be addressed within new 3Cs recording and ASAP work	Amber
	The Partnership should ensure		Streamline the process for tracking and monitoring IRDs	New terms of reference have been issued for EIRD Group. This group monitors and tracks IRDs as well as provides quality assurance and feedback for the work undertaken.	Blue
			Continue the development of a programme of ASP training at level 1,2,3 and 4	All courses have been reviewed. Level 1 is now elearning, level 2 &3 revised and level 4 had new topics added. All course now routinely evaluated with a focus on the participants level of confidence following completion	Blue
			Progress with health participation in IRDs	Agreed principle of rota for Health colleagues	Blue

14	**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.**	Head of Operations	Ensure health participation in all IRDs (conversations and recording) standard by end 2019	Test of change undertaken in NW that agreed a rota for Health colleagues who can interrogate health care systems for information for the purposes of IRD. Will be rolled out to NE by December 2019. Senior Social Workers will have one point of contact on any particular day and will record discussion/information etc on EIRD	Green
			Ensure all APCC plans are SMART	APCC Plan monitored by Senior Practitioners who chair all APCCs and audit of ASAP and APCC underway. The will ensure consistency across all localities	Green
			Recognise the 'Duty to Inquire' stage as a formal assessment	Work on going through 3Cs that will address recording	Amber
			Move the Complex Risk Assessment to a more person centred asset based Safety Assessment	Work on going through 3Cs that will address recording	Amber
			Ensure all staff who take lead in adult protection investigations are offered appropriate level of support	3Cs includes robust reflective practice individually, in 1-1 and collectively as groups of staff	Amber
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**	Head of Operations	Introduction of clear guidance for staff, articulating the intent and core principles of self-directed support, as well as revised step by step processes.	In development and will be influenced by 3Cs. Edinburgh Pact still in development. Focus on choice and control for the person	Amber
			Re-introduction of Resource Allocation System (RAS) to enable assessors to discuss the indicative budget with citizens to support the co-production of support plans to meet identified outcomes.	Resource Allocation System (RAS) being reviewed	Amber
			Staff and multi-agency training workshops developed, including the introduction of Three Conversations approach through several innovation sites and the roll out of Good Conversations skills based training to all staff who will be involved in assessing.	On-going, see recommendation 12, 13 and 14	Amber

			Improvement targets set to increase use of Options 1 and 2, and performance measures established.	On-going, see recommendation 12, 13 and 14	Amber
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**	Head of Strategic Planning / Chief Nurse	Develop a baseline workforce development plan using a six step methodology	Baseline plan completed in 2018 and signed off by EIJB in December 2018	Blue
			Develop an integrated framework for education and training	Workforce Steering Group had been established under Converstaion 4 Enablers. Plan to develop a new Core Workforce Group which will report to EMT through the soon to be established Programme Board. National Guidance due in November 2019 with a likely recommendation of the Partnership must have 3 year integrated plan by March 2021	Amber
			Engage with national apprenticeship scheme for caring roles	In place and making progressp	Amber
			Improve engagement with all stakeholder (staff, partnership and 3rd, independent and voluntary sector organisations) in the development of workforce model	As above - integrated framework	Red
			Work in partnership with the newly established Quality Assurance Hub (recommendation 8)	See recommendation 8	Amber
17	**The Partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model**	Head of Operations	Review existing city wide volunteering structures and networks	This folds into recommendation 2 and 3Cs and will be address in Programme Board Conversation 1 and links with the overarching community investment programme supporting prevention and early intervention	Red
			Build a robust relationship with our 3rd Sector partners that supports community capacity building	As above. Relaytionship and frmawork developed in Partnership with EVOC	Red

			Agree the approach to produce a revised community group set up to align with Edinburgh volunteering strategy and maximise volunteer participation and retention	As above	Red