Policy and Sustainability Committee

10.00am, Tuesday, 30 November 2021

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

Executive/routine
Wards
Council Commitments

1. Recommendations

1.1 Note the content of this report, which summarises significant improvement progress made in relation to the recommendations of the Joint Inspection of Older People's Services in 2016.

1.2 Note that formal feedback has now been provided by the Joint Inspection Team, that progress has been assessed overall as positive and that no further review/scrutiny activity is planned in relation to this inspection.

Judith Proctor

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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 details of the improvement activity undertaken by the Edinburgh Health and Social Care Partnership (EHSCP) in response to the Joint Inspection of Older People's Services in 2016. The report sets out the approach taken to provide evidence of improvement, key improvements delivered and the formal feedback from the Joint Inspection Team on their assessment of progress.

2.2 The Joint Inspection Team has noted that overall progress has been positive. There are a limited number of areas where further work is required and plans are in place to deliver on these as part of the EHSCP transformation programme, or within business as usual. The Joint Inspection Team has confirmed that no further review/scrutiny action is planned and as such, this report concludes activity on the Joint Inspection Improvement Plan.

3. Background

3.1 The Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) (known as "the Joint Inspection Team") carried out a joint inspection of Older People's Services in health and social care across Edinburgh in 2016.

3.2 The initial inspection, reported in May 2017, identified 17 distinct areas where improvement action was required. The follow up progress review of December 2018, indicated that the Edinburgh Health and Social Care Partnership (EHSCP) had made limited improvement progress in relation to these recommendations and that the initial improvement plan had not made the impact expected.

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

3.4 A report was presented to the Policy and Sustainability Committee in November 2020, setting out the significant progress made to date in relation to the improvement action plan.

3.5 This report provides a final update, including evidence of improvement submitted to the Joint Inspection Team and their formal assessment of progress.

4. Main report

4.1 The EIJB Strategic Plan 2019 – 2022 sets out clearly the strategic ambitions to create a high-quality, sustainable health and social care system for the city. A wide-ranging and ambitious transformation programme has been established as the key mechanism to deliver on this strategic intent. The transformation programme is structured around the key pillars of our Edinburgh Wellbeing Pact, Home First ethos and 3 Conversations approach. We have a clear and stated focus on early intervention and prevention, shifting the balance of care from acute to community settings, supporting individuals to build better lives and developing and equipping our workforce to provide quality supports and services. Our transformation programme underpins the improvement activity that was required in response to the Joint Inspection of Older People's Services, and impacts all adult provision across the Health and Social Care Partnership.

4.2 In late 2020, in acknowledgement of the difficulties presented by the Covid-19 pandemic and the fact that the Joint Inspection Team was unable to carry out face-to-face visits to review evidence of progress, an alternative and more collaborative approach was agreed. A series of online meetings were held between January and April 2021, involving the Joint Inspection Team and officers responsible for improvement activity. These meetings allowed for in-depth discussion about improvement action against each of the recommendations and future plans for further improving or sustaining progress.

4.3 This approach built on the partnership working which has already been established within our strategic transformation programme, which has seen staff from the Care Inspectorate and Health Improvement Scotland assume roles as transformation board members, helping to inform, shape and deliver major change and improvement. The new approach has been welcomed by both the EHSCP and the Joint Inspection Team, with a move away from formal scrutiny and towards more supportive, partnership working. The Joint Inspection Team has described the process as "thoughtful, thorough and collaborative".

4.4 Following the series of meetings, written self-evaluation statements were developed for each of the 17 recommendations setting out the improvement journey to date, key successes and the future plans for maintaining and further improving performance. These statements, along with a significant volume of supporting evidence, were submitted to the Joint Inspection Team in late June 2021. The collated statements are attached as Appendix 1 and demonstrate the wide range of improvement achieved across older people's services and beyond. The EHSCP, and Joint Inspection Team, commend the commitment of teams involved in providing the significant evidence, demonstrating improvements and ongoing developments.

4.5 Between June and October 2021, the Joint Inspection Team reviewed the evidence provided to formalise their assessment of the progress made by the EHSCP since 2018. A report setting out their findings was published on 9 November 2021. This is attached as Appendix 2.

4.6 The Joint Inspection Team has noted that overall, positive progress has been made. The report acknowledges that, since the progress review of 2018, senior leaders in the partnership have driven forward the change agenda and invested resources to progress strategic planning, which had previously lacked vision, direction, and pace. A positive shift has been noted, from a reactionary to a more planned and structured approach.

4.7 The Joint Inspection Team has highlighted a number of specific areas where positive progress has been evidenced. These include:

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

4.8 The Joint Inspection Team has also highlighted areas, in line with EHSCP self-evaluation, where some additional work is still required to ensure that the original recommendations are satisfied. These include:

- Development of a market facilitation strategy.
- Ensuring adequate resource for ongoing transformation and improvement.
- Embedding of fully integrated quality assurance and improvement processes
- Effective management of social care review waiting lists.

4.9 Plans are in place to ensure that these outstanding actions are addressed, with most being included within the EHSCP transformation programme.

- The market facilitation strategy will form part of the new Strategic Plan, which is due for publication in March 2022.
- A report is due to be submitted to the EIJB in December 2021 setting out the case for the establishment of permanent project management resource to support major change and transformation.
- Further work is planned to embed integrated quality assurance processes and an action plan will be developed for this.
- Social care review waiting lists remain challenging, particularly in light of current system pressures. However, new approaches to managing this are being trialled as part of the 3 Conversations project.

5. Next Steps

5.1 The formal report from the Joint Inspection Team draws to a close the original inspection of Older People's Services and the follow up progress report of 2018. The Joint Inspection Team do not intend to revisit any further progress against the 17 original recommendations, however will continue to work with the EHSCP to support improvement through established contacts.

5.2 Remaining outstanding actions will be addressed either through the transformation programme or as part of business as usual, as described above.

5.3 Further and ongoing improvement will be delivered across health and social care services as part of the change and transformation programme. A refresh of the Strategic Plan is underway, with the final draft due for publication by March 2022. This will confirm the commitment to ongoing transformation, improvement, engagement, involvement and consultation, with the aim of creating a high-quality, sustainable health and social care system that is fit for the future.

6. Financial impact

6.1 There are no direct financial impacts arising from the content of this report.

7. Stakeholder/Community Impact

7.1 Extensive engagement with stakeholders and the community has been undertaken as part of the transformation programme and is being used to inform and shape change proposals.

7.2 The self-evaluative statements and supporting evidence gathered have a focus on the impacts and outcomes experienced by people who use health and social care services. Considerable engagement and involvement of EHSCP teams contributed to the quality of the evidence produced.

7.3 There has been valuable ongoing engagement with the Joint Inspection Team throughout this self-evaluation process, which has been collaborative and supportive in nature. A member of the Joint Inspection Team also sits on one of the transformation governance boards and is heavily involved in projects to redesign home-based and bed-based services.

7.4 There are no equalities impacts directly arising from the content of this report.

7.5 There are no carbon or climate change impacts directly arising from the contents of this report.

8. Background reading/external references

8.1 Update on the Edinburgh Health and Social care Partnership Older People Joint Inspection Improvement Plan: Report to Policy and Sustainability Committee, November 2020

9. Appendices

Appendix 1 – Self-Evaluation Report

Appendix 2 – Formal Feedback from Joint Inspection Team

Edinburgh Integration Joint Board

JOINT INSPECTION OF OLDER PEOPLE'S SERVICES

SELF-EVALUATION SUMMARY

JUNE 2021

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Foreword

The initial inspection of services for older people, reported in May 2017, identified 17 distinct areas where improvement action was required. The follow up progress review of December 2018, indicated that the Edinburgh Health and Social Care Partnership had made limited improvement progress in relation to these recommendations.

Since then, there has been a notable shift in our approach and we are developing a sustainable strengthened position of better relationships, systems, processes, leadership and governance. The Edinburgh Integration Joint Board and the Edinburgh Health and Social Care Partnership can demonstrate a clear unity of purpose, and shared ownership of the challenging agenda faced not only by Edinburgh, but also by other health and social care partnerships across Scotland.

Our Strategic Plan 2019 – 2022 sets out clearly the strategic ambitions of the Edinburgh Integration Joint Board to create a high-quality, sustainable health and social care system for the city. We have established a wide-ranging and ambitious transformation programme as the key mechanism to deliver on our strategic intent. Our transformation programme is structured around the key pillars of our Edinburgh Wellbeing Pact, Home First ethos and 3 Conversations approach. We have a clear and stated focus on early intervention and prevention, shifting the balance of care from acute to community settings, supporting individuals to build better lives and developing and equipping our workforce to provide quality supports and services.

This report allows us the opportunity to reflect on our improvement journey over recent years. There has seen significant change since the original inspection, with a new leadership team in place, improved governance and oversight, and a commitment to place people at the heart of the planning, commissioning and delivery of services and supports across a multitude of services in a complex, integrated environment. These developments have been possible through the dedication, commitment and leadership shown by our staff and a wide range of partners.

The Covid-19 pandemic has required us to work flexibly and adapt to changing circumstances. Due to the restrictions associated with lockdown, it was not possible for the Joint Inspection Team to visit and assess our improvement progress in the same way as previously. Instead, we worked with the Joint Inspectors to develop a supportive and collaborative approach, which gave the opportunity for reflection and self-evaluation, whilst also providing assurance about progress made. This took the form of a series of informative discussions between the Joint Inspection Team and key lead managers directly involved in the areas across the key recommendations, and was co-ordinated by two senior managers.

Although new to everyone involved, this approach was considered a valuable, flexible way to provide, through good conversations, a more open and supportive environment to explore the detail of developments and improvements. It also provided an opportunity to describe the more inclusive, transparent and strengthened relationships across the Edinburgh Health and Social Care Partnership, our community, voluntary and independent partners, City of Edinburgh Council and NHS Lothian, which has led to successes in developing our fundamental cohesive approach to the way we work.

This document describes our achievements associated with the 17 recommendations of the 2018 Progress Review, which are supported by our latest and best evidence. It is evident that the environment across the Edinburgh Health and Social care Partnership has changed considerably over the last few years, and this period of reflection has allowed us to describe progress and demonstrate that we have moved from planning change, to delivering improvements against the recommendations. We are realistic about the challenges we face, but have confidence that ongoing improvements are placed squarely into our strategic work programmes, effectively providing self-assurance that the recommendations can now be closed.

Moving forward, we are confident that our strategic ambitions are well aligned with the findings of the recent Independent Review of Adult Social Care and provide the foundation for ongoing change and transformation. We are grateful for the ongoing dedication, resilience and willingness for continuous improvement shown by all of those involved, across our communities, partners who provide valued care and support, and our own teams who place the needs of the Edinburgh population at the centre of everything we do.

Judith Proctor, Chief Officer

Edinburgh Integration Joint Board

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
1	The partnership should improve its approach to engagement and consultation with stakeholders in relation to: its vision; service redesign; key stages of its transformational programme; and its objective in respect of market facilitation.

Position Statement and Key Achievements	**Evidence reference**
Strategic Plan and Transformation Our Strategic Plan 2019 -2022, published in August 2019, sets out clearly the vision and values for the Edinburgh Integration Joint Board and Edinburgh Health and Social Care Partnership. The Plan was developed following extensive consultation and engagement with citizens, staff and partners. This included "town hall" events, focus groups, staff briefings and engagement sessions with our partners. We have continued to build our engagement approach and in November 2020, the EIJB held 2 public engagement sessions, focusing on our transformation plans and efforts to improve the experience and outcomes for those we support. Service redesign plans are being taken forward via our transformation programme, which was formally launched in February 2020 and has a clear focus on involvement, engagement and co-production. Projects have been scoped and developed with a wide range of multi-disciplinary stakeholders, with numerous workshop sessions held to gather expertise and help inform the shape of the change. New governance boards have been established to oversee the progress of the transformation programme, with board members drawn from across the EHSCP, our partners in City of Edinburgh Council and NHS Lothian, third and independent sectors, Care Inspectorate, Healthcare Improvement Scotland, further education institutes and unions. The transformation programme has helped to strengthen relationships with a wide range of stakeholders, offering our partners across a range of sectors and organisations, the opportunity to shape and influence the change. We are now in a new planning cycle with the intent to publish a refreshed strategic plan for 2022-25 by March 2022. A consultation programme began in February 2021 and will run throughout the year. The first phase was directed at staff groups and ran until late April. From May to July the focus is on the Third and Independent sectors. Further engagement will follow to consult on the initial draft which will be presented to the Strategic Planning Group in August 2021.	1.1 – Strategic Plan 2019-2022 (see link) 1.2 –1.5 Transformation programme definition documents
Communications and Engagement In April 2020, the EHSCP recruited to a new position of communications and engagement manager. This has provided additional capacity to strengthen our approach to engaging with public and stakeholders. Since the 2018 progress review, the EHSCP has developed its own branding and logo and a dedicated website has been created, independent of the City of Edinburgh Council and	1.6 – EIJB public

NHS Lothian. We have stepped up our use of social media to engage with partners and the public. We have held 2 successful public engagement sessions to give citizens and partners the opportunity to actively engage with EIJB members. Weekly newsletters (daily during the first wave of the pandemic) from the Chief Officer to all staff have provided opportunities to ensure widespread awareness and understanding of our strategic priorities and transformation projects. We have provided information and updates on our transformation programme to EVOC, our third sector interface, to allow them to engage more widely with their third sector partners. Thrive newsletters are issued on a monthly basis to a wide range of stakeholders, providing information, advice and support. A communications and engagement strategy for the EIJB was presented to the Strategic Planning Group, (SPG), in May 2021. A second EIJB public facing event will take place in November 2021.	engagement sessions output 1.7 – sample Chief Officer newsletters 1.8 – sample Thrive newsletters 1.9 Draft Communications strategy
Edinburgh Pact and Community Mobilisation Our work to develop the Edinburgh Pact has involved extensive engagement with a range of stakeholders and citizens. This has included a public survey, interviews with city leaders and focus groups with staff and partners. The feedback has been drawn together to inform the approach we will take to developing our Pact and the new relationship of co-production and partnership which we will embed. Our community mobilisation project is one of the key examples of the enactment of our Edinburgh Pact. A workshop session on 27 January 2021 (see 1.10) saw over 140 attendees come together to begin the process of shaping a new, radical approach to community support and investment. The approach will see the replacement of our traditional grants programme, with a more innovative and collaborative funding mechanism for local priorities and will explore approaches such as 20 Minute Neighbourhoods and anchor organisations and networks. A further event exploring possibilities for the establishment of anchor organisations took place on 24 March 2021(see 1.11). A formal report to the EIJB was approved in April 2021, setting out a clear plan for our community mobilisation work going forward. We are working in close partnership with our third sector colleagues to deliver on this.	1.10 – Edinburgh Pact engagement summary 1.11 – “Art of the Possible” event report 1.12 – “Anchoring our Thinking” event report 1.13 – EIJB report, April 2021, Community Mobilisation
Care at Home Contract A key element of our transformation programme is the development of a new relationship with care at home providers within Edinburgh, as part of the broader redesign of home-based care. We have begun a process of consultation to deliver a new, fit for the future contract for care at home services for over 65s, based on co-production and genuine collaboration. A series of co-production events took place throughout December 2020 and January 2021, setting out our vision for the future of care at home services and inviting providers to get involved. Nine providers have since volunteered to work with us to develop the “One Edinburgh” Charter. Engagement and consultation with people who use the service will be a key focus of the next stage of our work. The approach being taken to develop the new over 65s contract is a key element of our market facilitation plan. We have not yet developed a formal market facilitation strategy – currently our focus is on understanding the additional challenges that suppliers face as a result of Covid-19 and working to support them during these difficult times whilst looking ahead to a more innovative and collaborative relationship. The market facilitation strategy	1.14 – Home Based Care consultation summary

will be taken forward as part of the development of the new Strategic Plan, with a first draft targeted for August 2021.	

Self-Evaluation Summary and Recommendation
Significant progress has been made in relation to this recommendation. Robust plans are in place for our transformation programme and strategic planning process, involving a wide range of stakeholders. We have strengthened the identity of the EIJB and EHSCP, with recognisable branding and a new website. Transformation projects are being shaped with the input and expertise of our staff and partners. Plans are in place to engage widely in the production of a market facilitation strategy as part of the development of a refreshed Strategic Plan. Our focus going forward will be to increase and improve the collection and use of feedback from citizens and service users to inform further change. There is a high level of confidence that appropriate improvement progress has been made and that appropriate plans are in place going forward to allow this recommendation to be closed.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
2	The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.

Position Statement and Key Achievements	**Evidence reference**
Transformation Programme – Conversation 1: Listen and Connect The Transformation Programme was launched in February 2020 and is underpinned by our Edinburgh Integration Joint Board's Strategic Plan. The programme is working to revolutionise what we do, so that more people can access the support they need to live healthy and independent lives. Our Transformation Programme is focused on four key areas, and the first programme is 'Conversation 1: Listen and Connect'. Programme one is designed to explore people's needs and connect them to personal, family and community sources of support, this programme will therefore focus on prevention and early intervention at its broadest sense, looking to connect people back into their communities. We want to put people in control of their own health and wellbeing and empower them with the resources, tools and support needed to live well. Conversation 1 is delivering a number of projects which are aimed at improving the quality of our interactions with individuals and their families to limit the need for formal health and care services. We are making a sustained shift towards a preventative agenda, working with our partners to build community capacity and resilience, and supporting people to use their assets and strengths to remain independent for as long as possible. Some of the key programme workstreams are set out below and within the attached Programme Definition Document at 2.1.	2.1 – Conversation 1 Programme Definition Document
Three Conversations EHSCP are the first in Scotland to embrace and implement the Three Conversations (3Cs) model at scale, as a strategic and cultural framework. 3Cs has been chosen for Edinburgh because it underpins and supports our intent, strategic priorities, vision and values. It is based on working differently, to achieve improved outcomes for people and families, working in a more preventative and personal way. Rather than focusing on the function of care management and its processes, 3 C's focuses on having "three conversations" effectively. It supports staff to work collaboratively with people as the experts in their own lives. It recognises the power of connecting people to the strengths and assets of community networks, and the necessity to work dynamically with people in crisis. Staff are encouraged to think creatively about how to support people to deliver improved outcomes. The roll-out of 3 C's began in summer 2019. The impact of Covid in early 2020 caused an initial period of uncertainty and slowed progress between March 2019 and June 2020, as the Partnership adjusted to pandemic restrictions and some staff were redeployed. Despite this, the innovation sites rose to the challenge of providing services within the lockdown situation.	

During the response to COVID-19, we have received feedback from staff that the 3C model has provided a strong foundation for continuing to engage with and support individuals and their families. To date, the 3C project has delivered 11 innovation sites including approximately 100 staff, we have additional sites going live in quarter 1 of 2021/22, and our first NHS sites are being scoped. Initial findings from the progress report commissioned in March 2020 revealed that: • we are responding very quickly, the average wait to see a health and social care worker reduced from 40 days to 3.8 days • we no longer start with a presumption that paid for support is the only or best response, and as a result significantly fewer people require paid for or formal long-term services, yet still have needs met • we are more effective and working in a more person-centred way by connecting people to wider support; We supported 71% of new people at Conversation 1 level of prevention and early intervention, without the need to progress to formal service provision. Only 14% of new people required paid-for services, compared to 24% previously. Most teams managed to operate without a waiting list through the period under evaluation, and staff reported enjoying working in a more collaborative way, by eradicating formal referrals within teams, and through the use of team huddles and reflective practice sessions. As we continue to move into Phase 2 we are finding early results that are consistent with our initial Phase 1 results, and will continue to improve our data quality and monitoring. The project will be extended into NHS areas of the Partnership throughout 2021/22, with the aim of proving the effectiveness of the approach across both health and social care services. Work is underway to embed, and sustain the 3Cs approach into the way we do business, including the appointment of a 3Cs Operations Manager post. Implementing the 3C's approach is leading to a fundamental change in practice, enabling staff to respond more quickly, provide support that is needed on a personal basis, rather than being systems led, and is leading towards a fundamental change in our organisational culture and a focus on the strengths and resilience of individual, families and communities. The "stories of difference" included at 2.4, show some of the impacts of the approach on individuals we have supported. We have also recently commenced simple satisfaction surveys for the people we work with and, over time, this will give a better indication of the outcomes and experience of the people we support. Fortnightly governance and engagement meetings have been established to oversee the implementation of the model. Representatives from frontline teams attend along with members of the Executive Management Team and a representative from our third sector interface, the Edinburgh Voluntary Organisations Council (EVOC). Through close working with EVOC we recently held a joint event where innovation sites and 3rd sector organisations were brought together to identify opportunities to better make better connections, and support sites to find suitable community resources for people they are supporting.	2.2 and 2.3 – 3 C's Phase 1 Evaluation Report and Phase 2 Progress report 2.4 – 3 C's "Stories of Difference" 2.5 – 3C Citizen survey responses 2.6 – EVOC event summary – see link
Community Mobilisation The Edinburgh Wellbeing Pact will be an informal agreement between the Partnership and everyone who lives and works in Edinburgh. It will help to support our ambition to create healthy communities, empowered by local services and organisations. We want to reshape how we think about health and social care, how we support one another and work together to	

deliver support and care across the city in a sustainable and joined up way. We want to build thriving communities in Edinburgh and embrace the opportunity to create a different type of relationship with residents, communities and organisations across the city. In June 2020 we began a dialogue with citizens, staff from the Partnership, staff from partner agencies, communities of interest, community planning partners and interested stakeholders. We used different approaches including public survey, photovoice, facilitated meetings, in depth interviews and focus groups to ensure our reach was wide. From all the conversations to date we identified 6 emerging themes: Shared Purpose; Relationships; Community Mobilisation; Agility; Radical Transformation; Measuring and Evidencing change. The Pact is underpinned by a shared common purpose: to achieve and maximise the wellbeing of our citizens. We are now moving to enactment of the Wellbeing Pact through a 3-year Community Mobilisation and commissioning plan, looking at whole system investment in an area, stimulating activities across local organisations and working collaboratively to support and fund local need in a sustainable way. We will take a place-based approach to understand need and will look to define the role of anchor organisations and networks, the 20-minute neighbourhood, and community wealth building to support this. In order to shape what Community Mobilisation might look like for Edinburgh, we have held a number of events. On 27 January "The Art of the Possible" stakeholder event took place online. This was set up to enable deeper conversations around a number of the radical ideas about community wealth building, 20-minute neighbourhoods and community anchor organisations. We **had 162 attendees at this event**, representing an incredible range and diversity of organisations across the city. Building on the conversations from the Art of the Possible event, a further stakeholder event was held on 24 March in partnership with EVOC focusing on what people wanted community anchor organisations to be and importantly what they didn't want them to be. This event signalled the beginning of the coproduction of community anchor organisations in Edinburgh. We had **140 people attend**. *3-year plan* The Community Mobilisation Plan has a number of key milestones whilst recognising that as we continue with an active engagement and participation programme more actions may be identified. Some example high-level milestones within the 3-year plan include: - Extending the current grants programme for a further year - Co-produce specification for Community Anchor Organisations and Networks - Embed Community Navigator roles in localities so support 3Cs and Home First - Establish research community of practice - Review community projects and programmes - Detail specifications of what needs to be delivered in communities against our outcome's framework - Embed Anchor Organisations and Networks and see them leading community commissioning - Research initiatives and additional income generated As we continue to develop our Community Mobilisation plan, there is a clear and compelling case for person and community centred approaches to health and wellbeing, and we will continue to work with people across Edinburgh to empower individuals and communities to take more control.	2.7 Outputs from Pact Engagement 2.8 – Write up of Art of the Possible Event 2.9 – "Anchoring our Thinking" event write up 2.10 – Edinburgh Pact EIJB Report – April 2021

Digital project in development The Transformation Programme recognises the huge opportunities presented by digital technologies and services to support people to remain independent for longer. Our overall objective is to increase and improve our use of digital solutions to deliver services, technology, and equipment in a more coherent, joined up, and person-centred way, providing citizens and staff with the necessary tools, products, processes, devices and infrastructure to support people to remain at home for longer and put them in control of their health and wellbeing. The programme had initially scoped two separate projects – one with a focus on digital technology to support citizens and one with a focus on digital technology to support our staff and improve business capabilities. In recent weeks, we have identified risks with alignment and overlap between these two pieces of work. As such, we are working to coordinate the activities across both and combine into one overarching project with clear and consistent leadership. We will also work to align our priorities and activities with the Scottish Government Digital Health and Care Strategy, which makes it clear that we should be providing staff and citizens with the necessary tools, products, devices and infrastructure to provide digital capability to access, update and meaningfully use HSC information. The digital projects are at an early stage and will be a key focus of the transformation programme in the coming months.	
ATEC 24 Prevention Support In addition to the Digital Transformation work, we continue to make improvements and develop innovative service models through the delivery of our existing digital and telecare services. Throughout the pandemic, our Assistive Technology and Enabling Care (ATEC 24) service, with community equipment, community alarm and response, and internal sheltered housing functions, undertook pro-active, outbound wellbeing calls to those in receipt of telecare services. We worked with the Vulnerable and Shielded Persons initiative and our own ATEC24 home-working Sheltered Housing Support Workers and Call Handlers to carry out proactive calls. Between April 2020 and June 2020, 15 advisors/ staff carried out 18,281 wellbeing calls to 7,000 citizens, with an average call duration of 30-40 minutes. As Lockdown continued, the duration of the calls increased. We were able to identify people who would like regular telephone contact and referred them on to different community services. As part of the calls, we asked the person about their general wellbeing, how they were coping with isolation, if they had any immediate practical needs, if they were able to maintain physical health. We offered hints and tips to reduce the risk of falls and encouraged the person to active their alarm should they need assistance, or even just to chat. ATEC 24 staff have continued to make regular wellbeing calls to residents in sheltered housing, with approximately 38,000 calls logged as at April 2021. These calls have provided a vital link for vulnerable or isolated individuals and allowed staff to identify where a further referral was required to provide additional support, or where people needed assistance with shopping or collection of prescriptions. The calls are focused on using a 3 Conversations approach. In addition, pro-active work was undertaken by the ATEC 24 team, through May and June 2020, to ensure people with dementia, living at home, and who were not already in receipt of formal care and support, were contacted, and connected with appropriate onward supports where necessary. A briefing document highlighting a summary and impact on outcomes was	2.11 – ATEC wellbeing call stats 2.12 – ATEC Covid wellbeing call script 2.13 – Assistive Living – pre-screening call script

presented to Executive Management Team in August 2020, with the calls very much being welcomed by families. The ATEC 24 service has recently made a successful bid to the Scottish Government for funding for a small test of change to further build on this experience, with a view to ensuring it is built into the service going forward. The test of change involves ATEC24 working in partnership with Care and Repair Edinburgh and is focused on making wellbeing calls to people in the following situations: • Those identified as at risk of a fall; • Those who make frequent contact with the telecare/alarm service but have no formal package of care in place; and • Those who are new to the telecare/alarm service and have no formal package of care in place. In addition to this, ATEC has also successfully received Scottish Government funding for a test of change pilot to support citizens to use their own smart devices to improve their safety and independence at home. The service is currently working with Perth & Kinross and Falkirk HSCPs to test this service is sheltered housing situations, with a view to rolling it out more widely in the future.	2.14 and 2.15 – "Bring Your Own Device" business case and funding bid
GP frailty In Programme 1 of our Transformation Programme, our GP Frailty project is looking to improve the early identification of frailty syndromes, initially by working with GP practices in the Leith Cluster to more accurately identify frailty syndromes, to inform the application of appropriate preventative measures and interventions for improved outcomes. Identification of frailty in the primary care setting within time and resource limitations is a major challenge, not only in the identification of frailty, but having access to resources to provide early intervention, develop anticipatory care plans, prevent crisis and unnecessary admission to hospital, or long-term care. Based on learning from the wider NHS and Midlothian, in May 2020, EHSCP established a GP-led Frailty Collaborative within a 9 GP practice cluster in Leith in Edinburgh to support the delivery of: • Clear identification of frail practice populations with increased confidence to use the data for improvement • Reduction in unscheduled hospital admissions by people with frailty • Proactive tiered frailty system of care across Health & Social Care • Process measures across the care system to improve reliability of care and reduction in unwanted variation • Data to inform strategic and service planning There is good engagement with the Edinburgh clinical leads and frailty has been agreed as a priority both strategically, through the older people strategic programme, gaining support more recently through the Transformation Programme, and at practice level, and across the Primary Care Improvement Network. This approach seeks to provide a system that flags changes to those living with frailty (No, Mild, Moderate, Severe Frailty), to enhance communication across key services and design care to meet population needs. Initial piloting and early indication data from the Leith cluster is positive, with key learning about the importance of applying clinical judgement for people who may be 'flagged' as being frail, to provide a holistic perspective for people. The Transformation team are now supporting looking at how to roll that data collection out further, make connections between our	2.16 – Community Frailty Project Brief

Community Mobilisation work and GPs, and identifying early interventions that can be tested and piloted based on what the frailty data tells us, with impact on outcomes being considered along the way.	
Home First The overall objective for the Home First project is to support people to maintain as much independence as possible at home or in a homely setting through a new model of assessment, rehabilitation and recovery led by Home First Edinburgh. Five workstreams have been identified with one specifically focused on prevention of admission and the redesign of urgent care. The objective of this workstream is to support the delivery of the Home First project by identifying areas of focus that can prevent unnecessary attendance/admission to hospital from community and primary care settings. Through early identification of people at risk of admission via primary care and hub teams, interventions can be initiated earlier to avoid people ending up in crisis situations. The redesign of urgent care is a national incentive directed by the Scottish Government. It is known that approximately 20% of those who present to the front door of hospitals, could have their care and treatment provided elsewhere, either in a community setting or at home. From December 2020, a new triage service has been implemented through NHS24 where people can access a single point of contact and be directed to the service most suited to meet their needs. Through this work the Partnership has implemented a new urgent therapy and social care pathway that allows people to access rapid therapy and social care interventions. This pathway has been in place since January 2021 and will be evaluated at set points to understand what is working well and what could be improved. Currently, this service is available 5 days a week however, if proven to be successful would be enhanced to offer a 7 day service. In addition to the introduction of the new pathway, a Home First navigator has also been recruited to sit within the Flow Centre (NHS 24 triage) to provide expert advice on the best options available to people to meet their needs. This post has been in place for 2 months and will be reviewed regularly to assess the impact it is having. Home First navigators have been working in acute sites alongside multidisciplinary teams to support discharge planning. Through validation and assessment of referrals for bed based services, they are able to influence the patient pathway to ensure people receive the right care in the right place at the right time. These roles support proactive discharge planning meaning patients are discharged quicker, where it is appropriate to do so (on average approx. 2 bed days saved per person). In addition to the navigators and following a test of change held throughout winter, Home First Social Workers have also been introduced to acute sites to enable multidisciplinary discharge planning, these roles will be in place in both the Royal Infirmary and Western General Hospital, within Hospital Based Complex Clinical Care and within Intermediate care. The test of change evidenced that these roles have an impact on delayed discharges and length of stay through proactive discharge planning and management, they will focus on reducing Health delays initially and will support the MDT with complex discharge planning. The introduction of Planned Date of Discharge (PDD) should support a reduction in length of stay for patients and should help towards a reduction in delayed discharges. By proactively planning for discharge earlier in the process, actions required to allow people to leave hospital (packages of care, assessments, on-going home based reablement) will be completed in advance of them being ready for transfer. This should reduce delays as care and support will be arranged in line with the PDD and will reduce length of stay as patients will be able to leave hospital on the planned date as agreed. This is being trialled initially in ward 51 in the WGH and discussions are underway to introduce PDD into Intermediate Care Facilities. More wards will implement this in a phased roll out across acute and hospital based services.	2.17 – Home First project brief 2.18 – EIJB Strategy Update report April 2021 (Benefits appendix)

Hospital at Home The EHSCP Hospital at Home service has been expanded to increase capacity. This service aims to prevent admission and offers personal care that can be met in a community environment. The service now operates 7 days per week and offers 3 levels of response: Urgent (within 4 hours); Same day (within same day of referral); Next day (the day following referral). The service accepts referrals via the Flow Centre usually from Primary Care, this is being expanded to allow the Scottish Ambulance Service to refer directly to hospital at home to further support prevention of admission.	
Medical Day Hospitals In March 2020, the Edinburgh Integrated Joint Board (EIJB) gave authority to progress to options appraisal to more clearly understand the function of the Medical Day Hospital, the relationship with other wider community supports, and how this can best be delivered across the city. This represented a deliberate shift to more integrated community early intervention and prevention, building independence and resilience at individual and community level. The COVID-19 pandemic impacted on all community care provision. During the pandemic all medical day hospitals were suspended, and the Royal Victoria Building Assessment and Rehabilitation Centre was re-purposed as the COVID Assessment Centre. Since then, a phased route map of guidance has been provided to transition out of lockdown. Guidance has been provided for all NHS staff on how patient care can be provided within the COVID-19 Framework for Decision-Making. These restrictions – likely to be in place for some time – impact on vulnerable people gathering in groups to reduce the likelihood of contracting the virus. The Medical Day Hospital Review will inform how services continue to adapt to meet patient needs and how interventions can be delivered in the long term, through a more integrated community approach. The changes from a Medical Day Hospital perspective, through pandemic has already seen a wider impact on community care provision: • Physio@Home (P@H) and the Hubs are providing essential services, to greater capacity • Community nursing continues to operate to full capacity, with nil to note specifically about those who used to attend day hospitals, with key priority being regular interventions and end of life care • Hospital@Home has had a positive and accelerated expansion city-wide • Home first has also accelerated, with presence in hospital sites, with the key aim of enabling timely and safe discharge, and prevention of admission Options for the future were developed by a multi-disciplinary group of colleagues, followed by those options being appraised, with the preferred option to be explored further being an integrated community model of service delivery. This model will offer routine and urgent assessment functions in communities, with only very specialist requirements being delivered from a building base. Staff engagement and involvement has been underway since August 2020, informing options for future consideration, highlighting good practice that has emerged throughout the pandemic, and shaping the future integrated community model, and, local managers will subsequently lead implementation of any agreed changes. Development of a framework to highlight impact on outcomes for people and a cost benefit analysis is also underway and will contribute to the final business case in 2021.	2.19 – Medical day Hospitals project brief 2.20 – Medical day Hospitals Options Appraisal 2.21 – Medical Day Hospitals Staff Engagement

Anticipatory Care Planning

The EHSCP continues to implement initiatives to improve outcomes for older people through Anticipatory Care Planning. In August 2019, 20 Care Homes and their aligned GP practices were able to demonstrate a 56% reduction in avoidable admissions to hospital, enabling residents to receive the right care in their homely setting. Taking account of continuous learning the ACP model was adapted to be Covid-19 relevant. At the end of March 2020 the partnership provided all care homes for older people and GP practices with: 7 steps to ACP – creating covid-19 relevant ACPs in Care Homes, implementation guidance and resources. The *7 steps to ACP* supports care homes to put residents and their families at the centre of shared decision-making. The partnership summarised it's experience of supporting care homes residents and their families through ACP during Covid-19 in a poster which won the best innovation award at the RCGPs national event in February 2021.

Feedback from Care Home Manager on the Covid-19 revised 7 steps to ACP for Care Homes

"From our point of view the ACP tools are a great foundation for us to build a more person centred anticipatory care plan for our residents, it's a really good sensitive prompt of topic. They are simple and straight to the point in a professional caring way. When we have used them with the GPs during this pandemic they allowed us to gather the information we needed quickly and allowed us to prepare for the inevitable. Families who have used them directly have said they were an easy guide to follow but still allowed them to get their relatives wishes down. Having the ACP-Key Information Summaries in place with the up to date relevant information has been a god send!"

The EHSCP has also developed an ACP bundle for health & social care teams to implement approaches to early intervention and prevention. The community ACP model provides practitioners with guidance, educational resources, and a process for sharing ACP quality criteria across the integrated system. This ACP approach supports older people to remain in their own home and helps avoid hospital admissions. The ACP bundle was made available to all healthcare community teams at the beginning of the pandemic together with training and implementation support. Social care teams, such as homecare teams, are currently testing the ACP model.

Feedback from a social worker on the ACP community bundle

"I think this is excellent, the 1 page format is what we need and you've thought of everything, any one of these points (quality criteria) could lead to a non-medical admission of someone being delayed coming home. It also gives a clear structure for the conversation, this will really help get the right information shared with those who need it".

Additionally, through the GP Frailty work, there is a keenness to develop appropriate ACP bundles.

Self-Evaluation Summary and Recommendation

Since the 2018 progress review, the EHSP has made a sustained shift towards a strategic approach to early intervention and prevention activity. The Strategic Plan and transformation programme recognise the importance of supporting citizens to remain healthy and independent at home for as long as possible and our Home First ethos underpins our policy and practice. We have clear plans in place to continue to build on the progress made to date and our refreshed Strategic Plan will confirm our commitment to this going forward.

Services for Older People – Joint Inspection Progress Evaluation 2021

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

Position Statement and Key Achievements	**Evidence reference**
Development of the Bed Based Care Strategy The Bed Based Care (BBC), project is part of Programme 3 of Transformation and its objectives are to transform and redesign a broad range of bed-based services across the Partnership, taking into consideration demand and capacity, and to design and implement the optimum model for the provision of sustainable bed-based care services. The overall vision of the bed-based care strategy is to help achieve the shift of the balance of care from hospital inpatient services to community services, as described in the EIJB Strategy. We will do this by designing a bed base model that is sustainable and based on a whole system approach and that places people's needs and preferences at the heart of the decision-making process. Our future bed-based services will provide: • A right sized bed base that meets known and projected demand • A bed base that enables recovery, rehabilitation and reablement • A bed base that supports the principles of Home First • A bed base that is outcomes focused and person centred • A bed base with a motivated, skilled and valued workforce • A bed base that works in collaboration with the voluntary, independent and third sectors • A bed base that supports continuous improvement • This project is looking at 8 main bed-based care services: • Intermediate Care beds; Hospital Based Complex Clinical Care (HBCCC) beds; Care Homes; Mental Health Rehabilitation beds; Supported Housing; Palliative care & End of Life beds; Specialist Inpatient Rehabilitation beds; and Beds for breaks from caring. Due to the size, scale and complexity of the bed-based project, it is necessary to implement it on a phased basis. The following areas have been prioritised due to a number of strategic drivers: • **Intermediate Care:** Our intermediate care provision is currently provided across two sites in the north and south of the city. There are 40 beds within Liberton Hospital and 24 beds within Findlay House. For a number of years, NHS Lothian's strategic intent has been to close Liberton hospital, particularly as this has become less fit for purpose. To enable the decommissioning of the site, the Edinburgh Health and Social Care Partnership must find alternative accommodation for the services	3.1 Bed-based care project brief

provided at Liberton Hospital. A commitment was made in quarter 3 of 2020/21 by the EHSCP to vacate the site by December 2021 therefore, intermediate care is a priority area for the bed based care project. • **HBCCC:** In order for the EHSCP to relocate the Intermediate Care service from Liberton Hospital, a redesign of the HBCCC estate is required. Edinburgh has the highest number of HBCCC beds per head of population and has more than double the suggested number of beds identified through a benchmarking exercise completed in 2017. We also know that around 40% of patients currently occupying an HBCCC bed could have their care needs met elsewhere. The Bed Based Strategy has recommended reducing the overall number of HBCCC beds in line with the benchmarking estimations. Through the redesign of the HBCCC estate, the EHSCP plan to reduce the overall number of HBCCC beds in line with the benchmarking projections and instead accommodate intermediate care services within these sites. • **Care Homes:** The EHSCP manages eight care homes across the city. These care homes offer residential level care to those who are most vulnerable in our society and have been assessed as no longer capable of living at home. A full redesign of our model of care is required in the longer term to focus more fully on complex and high levels of need, complementing that which is available readily elsewhere. The work of the care home transformation programme has started to address this by focusing on quality of care, workforce development and standards within our internal care homes. These priority areas are being considered together as any changes made in one part of the system will directly impact on another. Proposals need to be undertaken sequentially to ensure sufficient capacity across the system to absorb the changes and continue to meet demand. We have gathered data about our current bed base and engaged with the staff involved in the delivery of care and/or management of these services through 8 workshops between November 2020 and January 2021. The strategy has been further informed with the expertise and input of both the programme and project boards, which have multi-disciplinary and stakeholder representation. Phase 1 of the strategy, along with a high level implementation plan, will be presented to the EIJB in June 2021. Our bed-based care project is well aligned with the recommendations set out in the recent Independent Review of Adult Social Care, and seeks to improve choice, flexibility and quality of life for those who use the services. Redesigned models of care for bed-based services will also start to inform our wider market shaping and facilitation approach, setting out more clearly what we expect our business needs to be in the future and helping providers to understand our preferred service models and likely demand.	3.2 – Bed based care engagement outputs
Closure of Gylemuir House At the time of the original inspection and during the 2018 progress review, concerns had been raised about “interim” care models such as that provided at Gylemuir House. The EHSCP recognised that the model of care provided at Gylemuir House did not align well with our strategic ambitions for quality, bed-based services. The lease for Gylemuir House did not permit the physical upgrades and improvements which were necessary to meet the terms of Care Inspectorate registration. Gylemuir could therefore not continue to provide a service	3.3 – EIJB Financial

going forward and in March 2019, a report to the EIJB was approved which set out plans for its closure. Gylemuir House closed in June 2019, with there being sufficient capacity across the rest of the care home estate to manage the demand, pending a wider review and redesign of bed base services and the creation of a bed base strategy.	Plan report March 2019
Intermediate Care NHS Lothian and the Partnership have agreed to decommission the site of Liberton Hospital which is no longer of the standards we want to provide longer term. The original plan had been to move the intermediate care beds within Liberton Hospital to the Jardine Clinic, at the Royal Edinburgh Hospital, and a refurbishment project commended for the Jardine Clinic. The estimated completion date was initially June 2019 however, due to delays this slipped to November 2019. Further issues were uncovered during the refurbishment which delayed work until March 2020, then COVID-19 hit pausing all building work. In November 2020, it was agreed that the intermediate care beds within Liberton Hospital will not move to the Jardine Clinic as originally planned. This decision was taken on the basis that moving the wards from Liberton Hospital to the Jardine Clinic is no longer aligned to the EIJB's strategic direction and transformation ambitions. A move from one hospital base to another doesn't allow the EHSCP to continue to shift the balance of care from hospital services to the community. Any move of these beds needs to align with the strategic direction of providing community based services and supports and therefore, it was agreed that the wards currently based at Liberton Hospital would not move to the Jardine Clinic and that the Bed Based Care project would coproduce the future service model for these beds with staff and key stakeholders. The objective remains to close Liberton Hospital by the end of 2021 and to move the intermediate care beds to a more suitable community based location. To ensure that this operational decision aligns with our wider bed-based care strategy, we incorporated it within our modelling and our long-term planning. We invited a group of colleagues involved in both the delivery/management of intermediate care services and the design of the wider bed-based care strategy via the bed-based care project board to meet with the project team on 25 February 2021 to start planning the move from Liberton Hospital and the redesign of the model of intermediate care. This will ensure that the future plan to vacate Liberton Hospital will closely align with the wider bed-based care strategy and its vision to help shifting the balance of care from inpatient hospital services to community services. Our vision for redesigned intermediate care services is focused on ensuring people receive the right care, in the right place, at the right time. The service will be established with a clear pathway to discharge home, realistic rehabilitation goals will be set following assessment on admission and monitored throughout the person's stay. The delivery of intermediate care is provided by multidisciplinary teams made up multiple professions including therapy staff, focusing on rehabilitation and reablement; nursing staff, supporting the medical needs of patients; geriatricians who specialise in providing care to our older citizens, as well as community teams who continue to provide ongoing care and support at home following discharge. Through the successful introduction of the Home First principles and adoption of Home First practice, the intermediate care teams are experiencing a growing trend of patients with more complex needs. Historically, intermediate care was provided to those with low medical / high rehabilitation needs however recently, there has been a shift in the complexity of patient's needs. More patients now have medium to complex medical needs and high rehabilitation	3.4- SBAR to NHS Lothian CMT 3.5 – letter to Liberton staff

needs. This has been attributed directly to the success of Home First, with patients who can have their rehabilitation needs met at home no longer requiring a bed based service. Following a successful trial during the winter period, a Home First social worker will be onsite to support the intermediate care teams with complex discharge planning, reducing delays in planned discharges, and promote proactive discharge planning to ensure patients can go home when they are ready. Home First will use our Intermediate care service to introduce planned date of discharge (PDD). This will support a reduction in delayed discharges and a reduction in the patient's length of stay. By working closely with the multidisciplinary team, putting the needs of people at the heart of decision making and, by being involved in discharge planning earlier in the process, our aim is to ensure that the actions required to allow the patient to be discharged are completed in advance of the discharge date, allowing a seamless transfer from intermediate care to home. Planned date of discharge will also assist with achieving better outcomes for patients. The date will be set and agreed by the multidisciplinary team (MDT), following assessment of the patient. All MDT members will be involved in the decision making and the discharge date will be collectively agreed. Unless there is a further acute episode, the PDD should remain on TRAK as agreed by the MDT. Patient's, and families, will have the opportunity to consider realistic outcomes, and will be advised of their planned date of discharge. Weekly targets will be set to encourage rehabilitation and recovery and patients will be kept informed of their progress. By focusing on a person centred approach with realistic goals, expectations are managed and timescales are more achievable. By introducing PDD and being involved in discharge planning sooner, there should be no delay to discharge due to service requests for packages of care or capacity issues with community teams, which improves outcomes for patients and their families. This change should ensure there is flow through the system as discharge dates will be known and capacity can be more accurately forecast.	3.6 Planned date of discharge slides
Drumbrae Care Home reablement unit The Joint Inspection Team will be aware, from previous discussions, that we had been investigating the viability of establishing a reablement unit within the Dunblane unit of Drumbrae Care Home. This proof of concept was developed by a project team involving the bed-based care project manager and programme manager to ensure it was strongly linked with the development of the bed-based care strategy and the future model for intermediate care and care homes. The proposal considered whether existing capacity within Drumbrae could be used to provide reablement to people over 65 who have no acute medical needs and low level rehabilitation requirements. We have since completed further scoping and due diligence, including discussions with other HSCPs who have similar models. Our development of the bed based strategy has confirmed that our preferred model is to offer reablement support at home. Where this is not possible, because of more complex needs, the existing, now more established intermediate care services can already provide bed-based support. On blanace, our assessment is that this proposal would duplicate services already in place or planned and would not be in line with our stated strategic objectives. As such, the decision has now been taken not to progress with this model.	

Step up model in Intermediate Care The intermediate care service within Liberton Hospital has a flexible resource of one bed which can be used as a step-up bed for people who may experience deterioration and can still be managed safely outside of an acute hospital. This step-up model is managed by Hospital at Home. This resource was discussed during the intermediate care workshop that took place in December 2020 and the feedback was very positive. Stakeholders involved in the workshop thought that intermediate care was the ideal place for a step-up model and that this model could be further developed to help prevent avoidable hospital admissions. The bed based care project team will further explore the step-up model currently in place in Liberton Hospital, to assess if this should be taken forward in the long term intermediate care model as it will be described via the BBC strategy.	

Self-Evaluation Summary and Recommendation
Since the original inspection and the 2018 progress review, significant progress has been made in establishing a strategic approach to the development of sustainable bed -based services in Edinburgh, including the provision of a high-quality intermediate care model. The previous interim care model at Gylemuir House has been decommissioned. The bed-based care project is taking a whole system approach to the development of bed-based services for those who require them, whilst also linking closely with the Home First and home-based care projects to ensure that people can be looked after at home, or in a homely setting and remain as independent as possible, for as long as possible. The Bed-Based Care strategy sets out our vision for a phased approach to delivery and will be presented to the EIJB for approval in June 2021. There is a high level of confidence that appropriate improvement progress has been made and that the Bed Based Care strategy will provide the framework to deliver on these recommendations once approved.

Services for Older People – Joint Inspection Progress Evaluation 2021

	Recommendations for improvement
5	The partnership should work in collaboration with carers and carers organisations to improve how carers' needs are identified, assessed and met. This should be done as part of updating the carers strategy

Position Statement and Key Achievements	Evidence reference
Carers Strategy developed in collaboration Edinburgh's Joint Carers Strategy 2019-22 https://www.edinburghhsc.scot/wp-content/uploads/2020/06/Edinburgh-Joint-Carers-Strategy-2019-2022-FINAL.pdf was ratified by the EIJB August 2019, and included the Implementation Plan (5.1). The Strategy update, implementation plan and associated outcomes were informed through engagement, consultation and feedback from adult and young carers, tests of change, carer organisations and professionals, which, in turn informed the 6 priority areas for investment. The new strategy was further informed by the independent review of the implementation of the previous strategy by Edinburgh Voluntary Organisations Council, (EVOC), which is the council for Voluntary services for the city of Edinburgh, and a partner in the Edinburgh network of third sector interfaces, which provided clear considerations to inform the new strategy and development of the 6 priority areas: 1. Identifying Carers 2. Information and Advice 3. Carer Health and Wellbeing 4. Short Breaks 5. Young carers 6. Personalising Support for Carers The statutory Short Breaks Services Statement (Unpaid Carers), (5.2), https://www.edinburgh.gov.uk/downloads/file/26356/short-break-services-statement was agreed in March 2019, and is incorporated in the Carers Strategy. This Statement is required by the Carers (Scotland) Act 2016, and gives information about the short breaks services available locally and across Scotland for unpaid carers and the person or people they care for. A variety of short break options for carers have been available through the Edinburgh Health and Social Care Partnership (EHSCP) and Third Sector Organisations prior to the implementation of the Carers (Scotland) Act 2016, and, these opportunities will continue to be available, and further developed during 2021-22. One successful example of this is the short residential break for carers called 'Stepping Out', and a variety of information can be found on the Carers page on the EHSCP website, (5.3), https://www.edinburghhsc.scot/coronavirus-information/carers/ The EHSCP Carer Strategic Planning Group was re-established in 2019, and has been instrumental in informing the priorities, developing the strategy and overarching spending plan and ongoing developments. This group have also shaped the performance and evaluation framework associated with measuring impact of the strategy from both quantitative and qualitative perspectives, with a focus on impact on outcomes Membership includes carers	5.1 Link to Edinburgh's Joint Carers Strategy 2019-22, August 2019 5.2 Link to the Short Breaks Services Statement (Unpaid Carers) March 2019 5.3 EHSCP website link to Stepping Out

organisations, EIJB Carer representative, operational practitioners and strategic leadership. Over the next year, they will play a key role in shaping the review of the joint Carer Strategy.	
Joint Carer Strategy Implementation Plan and improving capacity to meet carer needs The Implementation Plan was ratified in August 2019 by EIJB, as part of the Strategy. As indicated above, ongoing work will be undertaken to refine the Performance and Evaluation Framework, which was ratified by the Performance and Development Committee, December 2020, and will be monitored by the Carer Strategic Planning Group. The Carer Strategic Planning Group members have also contributed to the thinking of how the performance and evaluation framework can be further refined, and this is indicated in the recent discussion paper being presented to the clinical and Care Governance Committee, (5.4). Significant investment of £17.37million, has been supported against the 6 priority areas, through enhanced contract awards, live from January 2021. Specifications were coproduced with providers, and the commissioning process encouraged a collaborative approach with smaller and larger carer organisations coming together in Carewell Partnerships, to deliver supports for carers across communities. As well as the contract award, the wider spend plan was ratified EIJB Feb 2021, (5.5), and includes additional areas of focus for 2021 and beyond, informed by what carers indicated where further investment should be made, and included: • Contribution of funding to further develop short breaks which will be shaped by the outcome of the Bed Based Review work stream on Short Breaks. • Development of Adult Carer Support Plans, along with production of a practitioners guide • Enhanced Carer Support Team provision, offering advice, information and support on; rights as a carer; connection with local services; medical conditions and medication; looking after yourself as a carer; becoming more confident as a carer; and setting goals and priorities for your own life, as a carer. Other supports for carers are highlighted in the EHSCP website(5.6), https://www.edinburghhsc.scot/carers/ourcommitmenttocarers/ • Contribution of funds for purchasing replacement care where a need has been identified through the person's own assessment and/or the Adult Carer Support Plans. This may be in the form of traditional support at home, day support or residential respite, but may also be used creatively via other self-directed support options and aligned to the personalising support for carers. • Commitment to support community led carer supports through the community investment transformation work stream. • Contribution towards commissioning of independent advocacy for carers and BME carer support. In April 2021, the Carer Strategic Planning Group identified the need for a business case to be developed to support a dedicated Carer Planning and Commissioning officer to take forward the implementation plan, performance and evaluation framework, and refreshment of the Strategy. This is being progressed now, with the intention of having a post holder in place by summer 2021.	5.4 –CCG May 2021 Paper with developing Performance and Evaluation Framework update 5.5 Carer spend plan EIJB February 2021 5.6 EHSCP website – Carer Support

Impact of the Independent Review of Health and Social Care for unpaid carers The enhanced contract award, and additional focus areas being progressed places EHSCP well to respond to the key recommendations associated with improved information and advice for carers, local person centred assessments, involving the person themselves in planning support, and the development of a range of quality short breaks, breaks from caring and respite. The Carer Strategic Planning Group will play a key role in formulating response to any additional developments required. The Edinburgh IJB has also recently appointed a second carer representative alongside two citizen representatives.	

Self-Evaluation Summary and Recommendation
Significant progress has been made in relation to this recommendation. The Carer strategy has been developed. A robust implementation plan has been developed which supports the implementation of the key priority areas, with a thorough commissioning and procurement process undertaken with enhanced contract awards made, to provide additional support for carers against our six agreed priority areas, and ongoing carer engagement. Additional areas for development and improvement have been identified to be progressed 2021 and beyond, and co-production will continue to refine the performance and evaluation framework. The established Carer Strategic Planning Group will continue to monitor progress and inform further developments. There is a high level of confidence that appropriate improvement progress has been made. This recommendation should be closed.

Services for Older People – Joint Inspection Progress Evaluation 2021

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

Position Statement and Key Achievements	Evidence reference
Improving timely diagnosis, and pathway improvements AT 2021 there are an estimated 8,295 people living with dementia in Edinburgh, (including 293 diagnosed under 65 years). In 10 years this is expected to rise to 10,228 people and in 20 years to 12,907 people. This will put additional pressures on services that diagnose, provide post-diagnostic support and provide ongoing assessment, care and support. Many of these services are already under significant pressures to meet demand. The COVID pandemic has exacerbated this even more, putting increasing pressures on informal carers. It is anticipated that enhance carer support will be provided, through the work underway indicated in recommendation 5 above. Edinburgh remains motivated to demonstrate continuous improvement of the experience of people and their carers, and have driven change, and continue to learn from various developments underway, including: **Post Diagnostic Support in Primary Care** In March 2018, EHSCP were successful in bidding to become one of 3 national innovation sites to test the relocation of post-diagnostic support to primary care as outlined in commitment 2 of Scotland's National Dementia Strategy[1]. Work has been ongoing since 2018, to develop this service in the 8 GP practices North East Edinburgh, East GP Cluster with the service now firmly established and delivered by one full time Dementia Support Facilitator. This work has is funded by Scottish Government and supported by the Focus on Dementia portfolio based at Healthcare Improvement Scotland I-hub. Scottish Government have extended funding to March 2022 with external evaluation of all 3 national sites expected to be concluded in summer 2021. Learning from this will inform dementia pathway improvements. In addition, to further enhance primary care ability to respond to people living with dementia and those who provide informal care, a test of change has been developed with Dementia UK to provide 2 Admiral Nurses (based at Stockbridge and Pentlands GP Practices) with focus on carer support. These posts are currently funded by Standard Life. **Improving processes** Improvements have been made with a simpler process in places for referrals to Memory Assessment and Treatment Service from Acute hospitals, with their being a Dementia Bridging, Stressed and Distressed support team being present in acute hospitals, to provide resource for assessment, intervention and care plan developments, as well as raising	

[1] COMMITMENT 2: We will test and independently evaluate the relocation of post-diagnostic dementia services in primary care hubs as part of the modernisation of primary care.

awareness, and providing training, as well as ensuring key connections with community supports on discharge. **Support for Care Homes** Similarly, the psychology led provision to support care homes for people who may become stressed or distressed, continues, with an established training and awareness programme. The EHSCP Scottish Care partnership lead, has played a key role in ensuring parity for people in care homes, to receive an appropriate dementia diagnosis, and associated support. Support has also been secured for the wider training and awareness programme across care home, hospital and community services. All of these developments will inform an overarching review of the transformation work underway to improve the pathway and experience for dementia diagnosis and post diagnostic support, for both people with dementia and their carers. **Transformation Programme - Dementia Pathway Review** In March 2019, EHSCP and the Royal Edinburgh and Associated Services submitted an application to Healthcare Improvement Scotland to become a national Dementia Care Coordination Implementation site. The main aim of this call for applications, was to take a whole systems approach to dementia pathway improvements with work towards a more integrated, co-ordinated approach to supporting people with a diagnosis of dementia. This linked to Scotland's National Dementia Strategy 2017-2020. It was hoped if successful this would support Edinburgh dementia pathway improvements with funding available for quality improvement support. Edinburgh was unsuccessful but a close second with Inverclyde being successful. The learning shared so far from the Inverclyde work has potential to support future Edinburgh dementia pathways improvements. Following this application, and learning since, EHSCP agreed that Older People's Mental Health Pathways be included within the Transformation Programme to take this work forward as part of the dementia pathway review, in Phase 2 of the programme, commencing January 2021. The focus of this will consider the experience of people with dementia, and their carers, from staying well, prevention and early intervention, through assessment, treatment and post diagnostic support. Work is currently underway, to include more detailed scoping of the whole system approach to timely diagnosis and post diagnostics support, which will include updating the baseline information from significant stakeholder engagement in 2018, with the learning from developments since then, and, learning from responses during the pandemic, across community, hospital and care home environments, and will encompass the Memory Treatment Assessment, Community Mental Health Team, and wider hospital, community and voluntary supports, to develop an improved, more co-ordinated experience, see 6.1. **Commissioned post diagnostic support** The Alzheimer Scotland contract, for post diagnostic support (PDS), has been awarded to 31 March 2023. Specifications have been co-produced and updated to reflect the current Scottish Government COVID -19 restrictions and delivering a blended approach which has enabled an increase in service volume from 300 people to 330 people receiving PDS at any one time. This extension will provide an opportunity for future proof post- diagnostic support delivery and specifications to be further informed by the pathway review work.	6.1 Dementia Pathway Improvements – Draft Scoping Document

For rates of people being diagnosed with dementia, and supported thereafter, Edinburgh has historically been seen to perform below Scottish average, both in volume and lengths of time waiting for post diagnostic support. A deep dive to determine where the issues lie, has indicated that there is room for improvement through the overall pathway, as indicated above, as well as improvements in the mechanism in place for monitoring and recording of people having a diagnosis and post diagnostic support, against the national local delivery plan target, (LDP), to more accurately reflect the ongoing caseload for the twelve month period post diagnosis. Improving the mechanism for monitoring and recording has included working with Scottish Government, local practitioners, and data analyst colleagues, to clarify the parameters for monitoring and recording. This has also resulted in error reports reducing, and being responded to more timeously, through building a shared understanding of the data set. Through the practitioner led short life working group, early improvements have been noted in reducing the time that people have to wait for Post Diagnostic Support (PDS), with the north community mental health team including Alzheimer Scotland in their clinical team meetings, and discussing who is best to take on the support, at the earliest opportunity; building relationships, and trust, as well as providing a mechanism to quickly escalate and manage any concerns about people being supported. Interestingly, moving the clinical team meeting to Teams has enabled this more consistent involvement! In the south, as there are five consultants involved in the Memory Assessment and Treatment service, with there being multiple clinical sessions, adopting a liaison nurse approach regularly connecting with Alzheimer Scotland, has also shown improvements, with people being supported as quickly as possible after diagnosis. Impact will be monitored during 2021. Overall the improved system of record keeping, will more accurately indicate how many people are being supported, and prove crucial to seeing our LDP performance improve. Ongoing work associated with the LDP improvement going forward in 2021 includes completion of the Data Protection Impact Assessment, and to progress the PDS key workers gaining access to appropriate information, through application for them to have TRAK access, to provide information about the experience of people receiving support, and real time, accurate records.	
<u>Additional Developments</u> **Herbert Protocol:** The Herbert Protocol is an information gathering tool to assist the police to find a person living with dementia who has been reported missing as quickly as possible. Care Homes and families use the protocol, and it is being considered an integral element of the Anticipatory Care Planning conversation. EHSCP in partnership with Police Scotland, Missing Persons Unit colleagues, Scottish Care and Alzheimer Scotland have spear headed, and been an early implementer of the Herbert Protocol, the aim of which is to increase awareness and promote use of the Herbert Protocol in Edinburgh, embedding into systems and processes, (e.g. Vulnerable Person reports sent to Social Care Direct following someone going missing, which are then sent on to Locality Screening Team to follow up on use of the Herbert Protocol if one has not been in place). This has continued throughout 2020 with regular open MS Teams information sessions being jointly run by EHSCP and with Police Scotland. It has also had the added value of enhancing joint working in other areas related to dementia on a case to case basis across Police Scotland as these arise.	

Plans are now underway for Herbert Protocol to be implemented at a national level later in 2021 with EHSCP being involved in proactively supporting work by enabling networking with national and local colleagues and sharing the learning from Edinburgh Implementation. This includes engaging the support of Health and Social Care Scotland Chief Officers' Group; scoping/gap analysis work; support in developing/getting feedback for development of a single Herbert Protocol form for use across all of Scotland, as well as communications and engagement planning. *6.2 Link to the Edinburgh Herbert Protocol information* *https://www.edinburghhsc.scot/the-herbert-protocol/* **Unpaid Carers:** As indicated in Recommendation 5, significant investment has been made for unpaid carers, with it being expected that unpaid carers, caring for people with dementia, will benefit from locality based commissioned provision, as well as the short breaks, and breaks from caring programme, through the adult carer support plan being widely applied. Additionally, the Carer strategy investment plan includes the purchasing budget being enhanced, in particular to respond to the choice of unpaid carers, who find it more appropriate to have replacement care in their own home, to provide a short break from caring, as opposed to the person being cared for leaving their home and potentially becoming more distressed. Work is underway to determine best method of evaluating impact and performance. **John's Campaign:** Currently within Edinburgh Health and Social Care Partnership 65 care homes, Community Hospitals and Care of the Elderly wards in hospitals, promote and support the Johns Campaign. John's Campaign recognises the important role of those family members who care for people who are living with dementia. Behind its simple statement of purpose lies the belief that carers should not just be allowed, but should be actively welcomed, and that a collaboration between the person living with dementia and all connected with them is crucial to their health and their well-being. The EHSCP Scottish Care Partnership lead has played an instrumental role in developing the approach in Edinburgh throughout 2018-19, with this being formally recognised in October 2019, at EIJB,(6.3), EIJB report 29 09 2019 Johns Campaign V.01.pdf (edinburgh.gov.uk). Continuous development about how John's Campaign has taken place since implementation, with key learning from feedback from carers and workers in care homes further shaping ongoing improvements, (6.4). Applying this ethos to provide well-being support, will be all the more important as covid restrictions ease, and families and carers once again, can be encouraged to safely visit, and take part in the lives of their loved ones.	6.2 Link to the Edinburgh Herbert Protocol information 6.3 Link to EIJB John's Campaign Report Oct 2019 6.4 John's Campaign feedback following implementation
Impact of Independent Review of Adult Social Care in Scotland Progress and plans indicated above, places Edinburgh well to continue to achieve an ethical, human rights based approach, where choice and control are at the centre of meeting needs of people with dementia and their carers, through improved models of care and experience.	

Self-Evaluation Summary and Recommendation
Reasonable progress has been made in relation to this recommendation, and to address the key points from the 2018 report, through primary care and wider developments, with ongoing improvements now sitting squarely in the Transformation Team Phase 2 Programme. The local drive to improve experience to have timely diagnosis and support thereafter, as well as improving monitoring and recording, has resulted in improvements already evident in people accessing post diagnostic support as quickly as possible, much closer relationships across the statutory and voluntary sector, with overall Local Delivery Plan target performance being closely monitored to highlight further progress during 2021 reporting cycle. There is a good level of confidence that further model of care and pathway improvement progress is planned as part of the Transformation Programme will be made. This recommendation should be closed as there is clear direction of how the key points are being progressed.

Services for Older People – Joint Inspection Progress Evaluation 2021

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

Position Statement and Key Achievements	Ref
The Long-Term Conditions Programme provides support to health and social care teams to improve care for people living with long-term health conditions and those who are at risk of falls. Care is improved through supporting practitioners to translate the principles defined in the national *Quality Strategy* into practice, by: • seeing the whole person rather than each individual condition. • engaging the whole team involved in the person's care, including third sector partners; and • improving the way that care and support is planned across the whole system. Building on the 'good progress' reported by the Care Inspectorate in the inspection review report dated 2018, The Long Term Conditions Programme has continued to adopt a continuous improvement approach to embedding falls pathway improvements across Edinburgh Health & Social Care partnership, led by two dedicated (part-time), locality aligned Falls Co-ordinators. Key areas of work where significant improvements have been made, in a sustainable way, include: 1. Care Homes support to improve the prevention and management of falls 2. Falls Pathway review and improvements 3. Improved integrated multi-disciplinary/cross sector working to support falls prevention and management 4. Measuring and planning continuous Improvement	
1. Care Homes support to improve the prevention and management of falls Key achievements include: • **Walking Aid Safety project (7.1);** ○ 7 care homes participated in a short improvement project ○ 164 walking aids were assessed by trained Physiotherapy Assistants to check for safety ○ 11% were repaired and 15% were replaced ○ Plans are underway to adopt this practice as business as usual, as a preventative measure. • **Targeted falls training and support to embed the Care Inspectorate's *Managing Falls and Fractures in Care Homes for Older People – good practice resource (7.2 and 7.3)*** Both partnership and independent care homes were selected following discussions with community colleagues, and identifying area with high incidence of falls. Phase 1 ○ tailored falls training and support to 4 Care Homes ○ an average 62% reduction in falls related A&E attendances ○ an average 70% reduction in falls related unplanned admissions compared to the pre-intervention period Phase2 ○ a further 7 care homes participated	7.1 Evaluation of Walking Aid Safety in care homes 7.2 Phase 1 Care Home – Falls Management Improvement 7.3 Written Summary of Phase 1 7.4 Outline proposition to

○ 82 staff completed training and providing 98% positive feedback setting out a 'better understanding' of falls prevention and management ○ As a result of Covid-19, the programme was paused, and will resume, once restrictions ease • ***Steady Steps in Care Homes:*** a *16 week* Strength and Balance exercise programme delivered by Edinburgh Leisure in 4 care homes, supported by care home staff. Very successful and good feedback; paused as a result of Covid-19 pandemic. Will recommence and obtain evaluation once restrictions lift. The original proposal and benefits, from our partners Edinburgh Leisure, can be seen in 7.5. • Development of ***Managing Falls in a Care Home*** **poster (7.6) –** Training tool developed in partnership with falls leads in Perth & Kinross HSCP, consultation has taken place online, and has had very positive feedback.	move to phase 2 – SBAR format 7.5 Steady Steps 7.6 Managing Falls poster – a guide
2. **Improved integrated multi-disciplinary/cross sector working and sharing of resources to support falls prevention and management**: As well as the websites and staff intranet, additional work has contributed to this area, including: • Established bi-monthly multi-disciplinary pan-Lothian **Care Home Falls and Frailty Forum** (7.7), with an aim of being a community of practice sharing best practice, optimising links with services to reduce falls and frailty. All the information shared is shared as a valuable resource on the new care home portal, and will include learning form hosting a variety of multi-agency/disciplinary speakers covering topics including: ○ Anticipatory Care Planning ○ RNIB in care homes ○ MacMillian Cancer and Palliative care training ○ 'Online' Supportive Conversations and Reflective Sessions (OSCaRS) in care homes ○ Continence Care, Medication reviews ○ Footcare/health and Nutrition ○ Adult Support and Protection training ○ Behavioral Support Service ○ Infection Prevention and Control ○ Physical Activity, Oral Health ○ Care for severe symptoms of COVID-19 ○ Role of Care Home Manager in a Pandemic • **Care Homes Near Me Project:** multi-disciplinary falls support to care homes testing the use of 'Near Me' video consultation platform that resulted in 61% reduction in falls through supporting 9 care homes over a five month period during Covid-19 pandemic restrictions when care homes were closed for visitors and were coping with high instances of Covid-19 infection. General information and advice was also provided by way of support for care home teams. This will continue to be built upon going forward, (7.8). • **Targeted falls prevention communication/information** during winter for public, staff, care homes and GP practice teams. **Webpages** internally for practitioners, as well as the updated information on the Edinburgh Health & Social Care Partnership webpages – aimed at public audience link (7.9): https://www.edinburghhsc.scot/longtermconditions/falls-support/ • **Big Slipper event** – North east locality, Hibs Public social Partnership, and Cyrenians partnership, hosted by Cyrenians, this event brought together a wide range of voluntary	7.7 Falls and Frailty Forum, Terms of Reference 7.8 Care home Near Me – Evaluation 7.9 EHSCP web pages for falls support – public.

sector partners, and statutory services to host a social event where 70 local older people who attended were fitted and supplied with a pair of new slippers free of charge to help reduce the risk of falls. This work has received very positive feedback and it is likely that this will be repeated going forward, (7.10). • **Digital support** – Expansion of **Scale Up BP project** targeted to reduce hypertension, a known risk factor of falls. The successful Scale Up BP project already had 1,004 people registered from Edinburgh GP practices, measuring their own blood pressure at home in March 2018. By January 2021 this has increased to 2,666 people, through the Florence digital recruitment mechanism, (7.12). • **Staying Active packs/leaflets** – working in partnership with the British Redcross, 250 'Staying Active' packs have been provided to people who were shielding, and at risk of falls during Covid-19 pandemic. These were widely distributed, through key frontline colleagues, and included crosswords, and suggested exercises to do at home. A further 600 Staying Active leaflets distributed via Edinburgh Council, through the dedicated local assistance/shielding line during lockdown 2020, and the information was also passed onto both internal and external housing support teams, (7.13 and 7.14) • **Falls Peer Support Group** established for Assistant Practitioners carrying out Falls Assessments within the locality hubs, led by Falls Co-ordinator to improve falls prevention and management, (7.15)	7.10 Big Slipper Report 7.11 Big Slipper Feedback 7.12 Florence BP digital Recruitment 7.13 and 7.14 Staying Active leaflets 7.15 Falls Peer Support outline purpose
3. Measuring and planning continuous Improvement • Measuring impact of the falls improvement programme is broadly acknowledged as challenging, and taking a quality improvement approach allows a comparison with falls pre and post intervention, however, formal data availability is limited to A&E attendances and admissions. This has prompted the development of an Outcomes Framework across the Long Term Conditions programme that that will enable the ability to assess and measure the impact of the falls programme, using local data, experience and impact on outcomes, which in turn will support planning for continuous improvement. A key source of local data, to demonstrate experience and impact on the system, is our community alarm and response activity. From April 2020, to March 2021, the team responded to just over 14,700 emergency call outs, with 377 citizens conveyed to hospital. A yearly average conveyance of 2.58%. This activity is regularly reported to EMT, as part of the performance scorecard, (7.17). The outcomes framework is aligned to Edinburgh IJB key priorities, and National Health and Wellbeing Outcomes. The framework will also be used to review and plan for activities together with our partners- cross sector, and will inform the EHSCP, as the overarching performance and evaluation framework further develops. The outline can be seen at 7.16.	7.16 LTC Outcomes Development Framework – Falls 7.17 Community Alarm and Response Scorecard April 2020-March 2021
Impact of Independent Review of Adult Social Care in Scotland Improvements made in prevention and managing falls, makes significant contribution to ongoing development of models of care, with the aim of ensuring people are assisted to stay in their own communities, and enabled to be as independent, for as long as possible.	

Self-Evaluation Summary and Recommendation
Despite the pandemic, significant progress has been made in relation to this recommendation, with an ongoing continuous improvement programme being embedded as *'business as usual'* within the Long Term Conditions Programme led by dedicated Falls Co-ordinators. A robust Outcomes Framework is currently being developed to enable the Long Term Conditions programme to assess and then demonstrate impact for people and the system. The outcomes framework will support planning and alignment to key strategic plan priorities. There is a high level of confidence that appropriate improvement progress has been made, with it being evident that the continuous improvement programme clearly demonstrates ongoing future approach. This recommendation should be closed.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
8	The partnership should develop joint approaches to ensure robust quality assurance systems are embedded in practice

Position Statement and Key Achievements	**Evidence reference**

Since the 2018 Report, much has been developed and implemented to provide evidence of being proactive to assuring a robust approach to quality, including:
• Establishing the EIJB Clinical and Care Governance Group
• Development of, and implementation of the new joint quality assurance framework
  ○ Development of the Professional quality improvement teams
  ○ The development of NHSL quality academy training and coaching network, and Social Work Quality Assurance groups
  ○ Progressing the quality dashboard
  ○ Establishment of Joint complaints system and associated improvement plans for complaints upheld/partially upheld
 	
Clinical and Care Governance Committee
 	
• The Good Governance Institute has supported EIJB to strengthen its governance arrangements and as a result the EIJB Clinical Care Governance Committee (CCG) was established at the end of 2019, which seeks assurance from the Clinical & Care Governance Teams. The Clinical and Care Governance Group replaces the former Quality Improvement and Assurance Group discussed in previous reports. The Committee was suspended during 2020, and is in the process of being re –e stablished. Reports and presentations will be forthcoming, and discussions are underway about the best way to more widely share these.
 	
• There is a shared vision that the Clinical & Care Governance structure in the partnership takes an integrated approach across both health and social care services. The Clinical & Care Governance Committee (CCG), is co – chaired by the Chief Social Work officer, and EHSCP Clinical Director, and its membership includes representatives from health and social work services, and there is confidence that there is a robust reporting framework and associated structure. The purpose of the CCG is to review and report to the Board on the quality of care to the local population, specifically in relation to safety, quality of access and clinical effectiveness and experience, see the Terms of Reference, 8.1.
 	
• Recent public report packs, 8.2, and 8.3, demonstrate a wide range of agenda items, with a key focus on clinical and care governance, including vaccinations, both flu and covid; a deep dive on primary care; chief social work report; care home improvement actions; corporate governance and assurance in the NHs, and the whistleblowing framework for partner organisations
 	
• Key people involved in Clinical and Care Governance from EHSCP attended a Scottish Government event at the end of 2019 where we were asked to share our CCG approach, this was commended as good practice and we were asked to work closely with colleagues
	8.1 EIJB CCG Terms of Reference
	
	8.2 EIJB CCG Public Report Pack March 2021
	
	8.3 EIJB CCG Public Report Pack Feb 2021

in Scottish Government, to contribute towards the roll out of a national Clinical and Care Governance framework. Unfortunately, this work has not progressed due to the pandemic.

- The quality dashboard that was previously developed as a test of change improvement exercise, to enable us to establish the availability and reliability of data has been reviewed, and has informed the new reporting template, developed for Clinical and Care Governance teams to start using from April 2021 onwards. The template Reporting will be focussed on service delivery and its direct impact on quality of clinical and care governance and the care of residents, patients and people using our services. There are five reporting mechanisms now established, see 8.4, and being embedded, in line with recommendations of the 2018 Report. The recent CCG presentation, also indicates CCG agenda prioritisation (8.5) :

  1. **Exception reporting** will be used to describe instances, data, activity, practice or performance which has deviated significantly from expectations, usually in a negative direction. The intention of this section is to focus attention on just those areas requiring immediate action.
  2. **Escalation reporting** will be used as a vehicle for CCG Teams to draw attention to issues, themes or problems where resolutions have not been found, or are hampered by barriers or blockers.
  3. **SBAR reporting** will be used when developing / expanding commentary supporting *exception* and *escalation* topics, setting out the **S**ituation, **B**ackground, **A**ctions, and **R**ecommendations, and is widely used across EHSCP in other business.
  4. **The Dashboard** will be used by each CCG Team to provide standardised recording across a number of 'fixed' categories. (complaints / service user feedback, adverse events/ significant occurrences / Large Scale Inquiries, Infection Prevention and Control, and registered services inspection activity. The dashboard will also be used to consolidate improvement when compiling evidence for an annual report which will be submitted to the Clinical & Care Governance Committee
  5. **The Three Questions** will be used to offer insight into 3 distinct subjects, topics or cases whether planned/unplanned events or where the learning was drawn from intended/unintended consequences that have impacted directly on Clinical and Care Governance and/or safe care. Indicate the 3 Qs

8.4 EHSCP QMS Reporting mechanisms

8.5 EIJB CCG Presentation – Agenda and Reporting Priorities

Development of the joint quality assurance framework, its application, and support from the locality quality improvement teams

- We recognise that, traditionally, the local authority's focus is more around assurance and control, and health more around improvement.
- To provide a single, joint approach for a joint quality assurance framework, (8.5), , the partnership has adopted the use of a Quality Management System (QMS) which is based on Juran's Trilogy System and HIS Quality Management System. Key examples from the framework are indicated in the next section, and provides a new, structured single approach to planning, assurance and control, and improvement, all of which will influence our strategic planning approach and inform areas for transformation. The QMS the outline includes:

  Planning:
  - Understanding our systems
  - Reporting
  - Feedback
  - Measures

8.6 EHSCP Quality Management System

Assurance and Control:

- Risk Management Systems
- Systems for early identification of concern
- Observation of Care
- Measures against standards

Improvement:

- QI knowledge and Expertise
- Training
- Coaching
- Shared Learning

- The QMS approach is currently being used in Royston Court Care Home, and is a helpful example to demonstrating impact to support the team to make improvements in order to meet the seven Care Inspectorate requirements and associated areas for improvement, (8.7), as well as colleagues in Royston identifying other areas for improvements. The partnership Quality Lead and the Professional Lead for Quality and Standards have been based in Royston for 6 months from October 2020.

- A supportive and co-productive approach has been encouraged, with the Royston Team gaining an understanding of where the problems were, taking ownership of ideas for improvement, and being supported to apply them in a sustainable way. We are able to evidence that this approach has led to significant improvements and an overall improvement in grades. The home was recently inspected and have been advised all outstanding requirements have now been met. Part of this work included staff sessions on leadership, coaching, improvement methodology for sustainable improvement. The quality leads have worked with the Royston Team, to develop a sustainability plan, with the care home manager, for the team to use to reaffirm the improvements made. The Royston Team have indicated that they:
  - are more skilled and have more awareness, of the improvement approach
  - have improved consistency and continuity of care
  - have greater ownership within the team delivering the care
  - have accepted the quality leads as a valuable resource

- The Quality Leads plan to support the remaining EHSCP care homes, following the same methods with a view to standardising the approach to quality and assurance, with the Royston Team contributing with their learning.

- Additionally:
  - Work is underway to provide assurance of social work and care, through case reviews, with teams sharing learning from this with operational and strategic teams to ensure focussed improvements
  - Across localities the Quality improvement Hub has been established in a virtual way, to comply with pandemic restrictions, with an overview of the quality improvement expertise being gathered, to build on, and optimise existing locality capacity to own and affect sustainable change
  - Reports by exception will be presented to the CCG, with growing confidence of transparency and reports being publicly available as 2021 progresses.

8.7 EHSCP Royston Care Home Team Improvement Plan

How our new EHSCP Quality Framework is operating, and benefiting people
As well as the key examples above, the new quality framework continues to be applied, to provide various feedback opportunities to inform improvements and strategic directions, through various mechanisms, including:

Development of professional quality improvement teams; Allied Health Professionals, Social Work, Community Nursing, hospital and hosted services teams:

- When fully implemented the quality framework will have Clinical & Care Governance Teams established in each locality, and hospital and hosted service area which will report into the Clinical and Care Governance Group - as described previously. These team will be multidisciplinary rather than singular professional groups, drawing on shared knowledge, experience and expertise, and further emphasising the cross sector approach.
- On-going developments will take into account the new responsibilities

The development of NHSL quality academy training and coaching network, and Social Work Quality Assurance groups

- The partnership has good relationships and close links with NHS Lothian quality academy – a small number of social care staff have undertaken this training. Covid has had an adverse impact on the delivery of this training, and associated QI work, with applications now open again for staff to apply.
- As well as the partnership quality hub gathering information about who has what QI skills, EHSCP is planning a quality network to optimise the capacity, and plan to set up a coaching network to support staff undertaking improvement work.

Single complaints system and associated improvement plans for complaints upheld/partially upheld

- As part of the new quality framework, health and social work complaints are now managed centrally, with all complaints recorded and managed through a single system - Datix. Complaints sits within the quality hub, as complaints are one of the key sources of feedback to inform planning. The complaints team meets weekly to review all new complaints with an emphasis of identifying complaints that involve more than one service in the partnership, and has close links with the NHSL patient experience team. The 2018 Brief highlighting this approach, in place since then (8.8).
- At a meeting with the Scottish Public Services Ombudsman (SPSO), our joint approach was identified as a best practice example.
- Looking ahead, we will do further work to determine the best mechanism to ensure that improvement plans are fully implemented, to provide assurance that improvements have been made, learning is shared, and actions closed off.
- When the complaints team was devolved, the existing remaining Council complaints roles were reviewed and social care quality assurance officer posts were developed, and assigned to each locality, making a valued contribution to the locality quality hubs.
- Plans are underway to identify a lead complaints officer to support each of the EHSCP care homes, to encourage ownership of the approach to managing complaints, to make responses more person-centred, and in line with duty of candour principles. Taking this approach has seen improvement in the way the quality hub now works alongside the locality teams, with quality of investigations and responses having improved considerably. The new approach to local resolution has been welcomed, where we make direct contact with those who have complained to explain process, and see whether immediate action can be taken to improve the situation, pending a full

8.8 EHSCP 2018 Complaints Brief

investigation, if appropriate. This has often resulted in early, satisfied conclusion for the complainant, with teams reporting that this is a helpful, more satisfying way forwar **Locality manager led quality assurance meetings for care homes and care at home** • These established multiagency fora, continue to provide oversight across both internal and external provision, ensuring support and continuous improvement of standards. The Care home group terms of reference have recently been updated, (8.9). And the care at home terms of reference can be seen at 8.1.	8.9 EHSCP MAQA Care at Home TOR
Impact of the Independent Review of Adult Social Care in Scotland • The enhanced Professional and Clinical Oversight structures for care homes, as established in May 2020, contributes to the recommendation in the independent review of the safety and quality of care provided in care homes being improved to guarantee consistent, appropriate standards of care. • The full implementation of the EHSCP quality framework will also contribute, and places Edinburgh well, to achieve a balance across all vulnerable communities, providing professional and clinical oversight, balancing: o protection, welfare and holistic interests of residents o clinical and care interests with ongoing commitment to individuals' human rights, and ethical principles, including engagement, choice and control • Additionally, the application of a single system complaints process, and local resolution contributes to having rapid recourse to an effective complaints system and to redress, when things do not work out for people, or where their rights may not have been upheld	

Self-Evaluation Summary and Recommendation

Our aspiration remains to have an integrated quality improvement hub which will allow us to influence the assurance, improvement and transformation work needed in the partnership. We plan to identify quality champions or experts that can help spread this kind of methodology across the partnership, and draw upon the learning from the full implementation of the quality framework, allowing a shared language, understanding and vision for continuous improvement across the partnership.

Although we are not yet where we want to be, there has been significant progress made over the last few years, through starting to implement the quality framework, and establishment of a robust clinical and care governance infrastructure. We recognise a significant culture change, moving from different historical systems to a single, and shared vision will take time to embed.

Our focus on the strategic approach to roll out quality methodologies will make a difference to embed sustainability of quality assurance and a continuous improvement mind set, impacting positively on peoples' experience and the capacity and confidence of our multi agency workforce. This in turn, add confidence to our ability to demonstrate robust quality assurance systems are embedded in practice.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
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

Position Statement and Key Achievements	**Evidence reference**
A market facilitation strategy and accompanying risk assessment and contingency plans, aligned to our commissioning plans	
Plans for the production of a market facilitation strategy were originally set out by the EHSCP in the "Statement of Intent" in 2018. There has been significant change since that time, with a new leadership team now in place and a wide-ranging strategic transformation programme underway. The production of a formal market facilitation strategy is now being built into our approach to the development of a refreshed EIJB Strategic Plan. Agreement has been reached with the Strategic Planning Group of the EIJB that the strategy will form part of the overall Strategic Plan, due to be published by March 2022.	9.1 April EIJB report – Strategic Plan Update
To support the EIJB strategic objectives, a Market Facilitation Strategy will be developed in collaboration with our partners and other stakeholders. The intent is to create a market facilitation project within Programme 3 of the Transformation Programme, which will sweep up the Care@Home (external) services, Home Care (internal) services and the further development of the One Edinburgh concept. The transformation programme seeks to be innovative and to challenge traditional care models. Our approach to market shaping and facilitation will be informed by the current planning cycle, stakeholder engagement and ultimately production of the next Strategic Plan for 2022-25. Over the past 12 months, during the Covid-19 pandemic, the market within Edinburgh has faced considerable challenges and our focus has been on supporting and working with providers to ensure the continuity of vital services. Furthermore, the implications of the recent Independent Review of Adult Social care Services are not yet fully understood. As such, a decision has been made to take some additional time to fully develop our market facilitation approach and ensure it is informed by the ongoing work to refresh the Joint Strategic Needs Assessment (JSNA) and well aligned with our financial planning and commissioning planning. Whilst we do not yet have a formalised market facilitation strategy, the principles which will underpin this document are clear and are based on a new collaborative relationships with our providers, aligned to the principles of the Edinburgh Pact and in line with the approach being taken as part of the "One Edinburgh" model of redesigning care at home services. We recognise the importance of a dynamic and ongoing conversation with providers to shape a new relationship. Our market facilitation strategy will take account of the unique nature of the Edinburgh market and the additional risks that brings. Our focus will be on building the resilience of the market, being very clear about our strategic plans and what we need from our commissioned services going forward.	9.2 – SPG Market Facilitation report, May 2021

Engaging effectively with key market sectors and investing in relationship building in a planned and strategic way In the last 12 months, we have embarked on a new and innovative approach to our commissioning and procurement of essential services, rooted in the principle of collaboration and co-production with our providers. Within our transformation programme, extensive engagement has been undertaken in relation to our "One Edinburgh" approach and as part of the process of commissioning a new contract to provide care at home support for over 65s in the city. We are seeking to move away from competitive based procurement processes and towards the creation of robust and innovative partnership models. A number of visioning workshops took place with providers throughout May and June 2020 to set out our vision for change and invite providers to engage with us in the redesign of care at home services (see 9.3 and 9.4). Following this, a series of co-production sessions were then held in December 2020 and January 2021 (see 9.5). The PIN (Prior Information Notice) for the care at home contract, issued in October 2020, was clearly positioned not as a call for competition, but as a call to providers to work with us in partnership to develop a redesigned, sustainable and outcome-focused model of service delivery. Similarly, the commissioning and procurement process for the recent enhanced carer contract awards has seen a Carerwell Partnership emerge, with key providers working together to deliver community carer support. Our transformation governance structure ensures representation from colleagues from the third and independent sectors and allows an opportunity for stakeholders to shape our change plans, both at project and at programme level. The programme structure also allows for close alignment between the development of transformation of home based care services, and the emerging principles and themes of the Edinburgh Wellbeing Pact and Community Mobilisation work. Significant work has also been done at an operational level to improve and strengthen relationships with our commissioned providers on an ongoing basis. Weekly meetings with provider representative colleagues from Scottish Care, covering both care homes and care at home services, have been in place since May 2020, to provide support during the Covid-19 pandemic. Learning from this engagement will help to inform the new market facilitation approach.	9.3 – one Edinburgh design and engagement slides 9.4 – Visioning Feedback Summary 9.5 – Co-production summary 9.6 – Home Based Care project brief
Issues of choice, quality, contract rates and capacity in the care home market Over the last 12 months we have seen significant changes to the profile of care home usage in the city, due to the impacts of Covid-19. At present, we have greater care home available capacity than when the original inspection and progress review were carried out. We are mindful of the unusual circumstances and are taking full account of likely future demand and capacity of care home beds through our Bed Based Care project, within the transformation programme. Aligned to the Bed Base Care project, we have also initiated a care home transformation programme, led by Chief Nurse. This is focused on improving quality and outcomes and has identified a number of key work streams including: workforce; standards; governance; health and wellbeing, person-centred planning, participation and engagement; communication; improvement, innovation and research. The care home managers are playing a key role in	9.7 – Care Home Transformation work streams

identifying key areas for improvement, and are being supported to affect sustainable change. We have invested significant time and effort over recent years in building and strengthening relationships with new providers, working to influence the provision of social care beds at any new builds. At the time of the progress review, inspectors noted that additional beds had been purchased at a higher rate to deal with short term capacity issues. These beds have not been recommissioned, and although, like many partnerships, some short term beds were commissioned as part of the initial response to Covid-19 to support hospital discharge. Instead, any capacity challenges are being addressed in a planned and strategic way as part of our transformation programme. Regular engagement approaches are in place to ensure both the sustainability of providers and the quality and capacity of services remain post-pandemic. Regular meetings are taking place with the Care Inspectorate. Our "Scottish Government Route Map Board", jointly chaired by the Head of Strategic Planning and Head of Operations, considers any viability issues and there is ongoing support from our Locality, Commissioning and Contracts teams, with the latter, along with finance colleagues, managing any covid related financial claims from the sector.	9.8 – Route Map ToR
Challenges with the care at home framework in relation to quality and capacity Since the original inspection and the 2018 progress review, there has been a marked improvement in the overall stability of our care at home services. The Sustainable Community Support programme was established to drive improvements in capacity and quality of services under the current care at home contract. Moreover, the programme has facilitated relationship building between locality teams and provider organisations. We have seen a sustained increase in care at home capacity over the last 2 years. As at February 2019, we commissioned 31,587 hours of care per week to support 1970 older people. By February 2021, this has risen to 44,387 hours of support per week for 2217 people. This is an increase of 12,800 hours per week and an additional 747 people supported. During the same period, our internally delivered home care reduced by 3295 hours per week, but this still represents a net increase of 9505 hours per week over the 2 year period. We have also seen an increased stability in existing provision. Despite the pressures of Covid, no providers have withdrawn from the market, which is a testament to the stronger relationships and increased support that EHSCP has provided (5 providers had withdrawn in the previous 2 years). Suspension of providers due to quality concerns has also reduced. There are currently only 3 providers suspended, and we are supporting 2 providers to improve failures in their service delivery. We have strengthened and improved the terms and conditions of service specification, to promote stability and ensure continuity of care for service users. This has included: • Removing the option of providers handing back POCs with only 48 hours' notice; • Removing the risk of service users terminating their care with 12 hours' notice; • Ensuring continuity of care where people go into hospital for up to 7 days.	9.9 – Care at Home capacity data report 9.10 – Care at Home service specification

We have established a new tiered approach to managing providers, which has enabled additional due diligence and a sustainable approach to supporting small providers in the sector. Moving forward, our One Edinburgh approach will transform the way in which we commission and provide care at home services, with a focus on building collaborative relationships to drive improvements in quality, capacity and sustainability of services and supports. We will ensure that regular feedback from service users forms a key part of our approach under the new contract and use this learning to inform further improvements.	
Quality and capacity in relation to day care and respite Since the 2018 progress review, day opportunity provision has been reviewed, with business need incorporating a consistent approach for all mainstream registered day opportunities being delivered through third sector. This is seen as a valuable component of support for unpaid carers and breaks from caring. Providers were engaged and involved in providing feedback from their expertise and the lived experience of people who use day opportunities, and their families. This has informed the co-production of the specification, with encouragement to provide a variety of provision, beyond the traditional centre base, to enhance choice and control, initial reluctance, however adaptability during pandemic has seen a shift to more flexible delivery. Thorough procurement process has been undertaken, with recent discussions taking into account the adjustments associated with flexible delivery through increased outreach and one to one support. Fourteen providers have been awarded £4.93m worth of contracts on a Framework Agreement, over two years, following approval at Finance and Resource Committee March 2021. Evaluation of tenders through this process indicated 70% associated with quality, and 30% against finance criteria. Sustainability considerations were also taken into account. Ongoing market facilitation through involvement, responding to market intelligence and impact on outcomes and performance will influence the longer term market position and ongoing developments. The Edinburgh Joint Carer Strategy has indicated short breaks from caring as a key priority area, increasing investment by almost 60%. Application will see the range, choice and control enhanced, responding to what matters to unpaid carers. In response to feedback from carers and providers and the independent review of the previous carer strategy, the strategy also sees additional investment to support replacement care for unpaid carers, to enhance opportunity for short breaks from caring. Through the Performance and Delivery Committee, a robust performance and evaluation framework has been ratified, with a balance between measuring performance outputs and outcomes for people clearly indicated. There will be a consistent approach for measuring outcomes, and this will be secured through the appropriate commissioning processes. First annual performance and evaluation report will be presented to performance and delivery committee after one year of the delivery of new, enhanced contracts, after Jan 2022. It should be noted that bed based respite care is being reviewed as part of the Bed Based Care Strategy, with the guiding principle that this should be provided in as homely a setting as possible, in wider community settings.	9.11 F&R report March 2021 – Day Opportunities Framework 9.12 – Joint Carer Strategy 9.13 – Carers Performance and Evaluation report to CCG

Self-Evaluation Summary and Recommendation

Since the 2018 progress review, the EHSCP has invested significant time and effort in fostering new, collaborative partnerships with colleagues in the third and independent sectors. Despite a formal market facilitation strategy not yet being in place, the principles by which we intend to work with our partners are clearly laid out within the Strategic Plan and the Edinburgh Pact.

We have already strengthened our approach to engaging and involving partners, both in our transformation programme and within our operational, business as usual services. Significant improvements have been seen in capacity of care at home services and plans are well underway to commission new, innovative, redesigned care at home services in partnership with the third and independent sectors, in line with our “One Edinburgh” vision.

We are confident in the direction of travel for our future commissioning plans and market facilitation approach, which is closely aligned with the principles set out in the recent Independent Review of Adult Social Care.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
10	The Partnership should produce a revised and updated joint strategic commissioning plan with detail on: - how priorities are to be resourced - how joint organisational development planning to support this is to be taken forward - how consultation, engagement and involvement are to be maintained - fully costed action plans including plans for investment and disinvestment based on identified future needs - expected measurable outcomes

Position Statement and Key Achievements	**Evidence reference**
Previous Outline Strategic Commissioning Plans Prior to the publication of the current Strategic Plan 2019 – 2022, significant work had been carried out to produce five outline strategic commissioning plans for: older people, physical disabilities, learning disabilities, mental health and primary care. Although these five outline plans were produced following extensive engagement and consultation with a wide range of stakeholders, the five plans were produced in isolation, raising risk of duplication and lack of alignment. On appointment of the new Head of Strategic Planning, a decision was taken to align the outputs from the five plans into the transformation programme and the new overarching Strategic Plan. A mapping exercise was carried out of the five plans and all of their stated deliverables, with a significant amount of activity subsumed into emerging transformation projects. Where activity did not directly align with transformation priorities, this was taken on as business as usual, to ensure that none of the vital work developed was lost. A formal report (10.1) was taken to the EIJB to evidence this and to ensure that stakeholders could see that their work had been captured and would be taken forward.	10.1 – EIJB Strategic Plan report August 2019
Development of the Current Strategic Plan/ Review and Refresh of the Plan The current Strategic Plan was approved by the EIJB in August 2019. The plan captured key elements from the outline commissioning plans and set out the direction of travel, including our transformation ambitions. The plan was structured around 4 “pillars” – 3 Conversations, Home First, the Edinburgh Pact and Transformation. Extensive engagement and consultation was carried out to finalise the plan and further details of this are provided in the statement for recommendation 1. A review of the existing strategic plan was carried out in September/October 2020. Good progress has been made, including the recruitment of the transformation team and the establishment of our transformation programme. The focus has now shifted towards the review and refresh of our Strategic Plan, to identify any gaps and ensure that it fully reflects our current strategic priorities and ambitions. The intention is to produce 2 plans – one which sets out a higher level and longer term strategic direction, and a second which sets out 3-year commissioning plans for the period 2022 –	10.1 – EIJB report (see above) 10.2 – SPG report – review of Strategic Plan 2019-2022

2025. The 3-year commissioning plans will continue to be very much linked to our transformation plans, and, over time we intend to transition the work into a "core programme" of activity, ensuring that changes are well embedded, and sustained through our business as usual activity. As part of this process, locality operational plans will also be developed. Further details of this proves are set out in an update report to the EIJB in April 2021. Draft commissioning plans will be ready by August 2021 and then further shaped by consultation. Both plans will be published by March 2022.	10.3 – EIJB report, April 2021, Strategic Plan Update
Transformation Programme The Transformation Programme is one of the key mechanisms for delivery of the ambitions set out in the Strategic Plan. The programme was partly suspended during the initial stages of the COVID-19 pandemic, and a report subsequently brought to the EIJB setting out a proposed phased approach to delivery. The transformation programme is taking forward a number of key strategic priorities, including 3 Conversations, Home First, Edinburgh Pact, Bed Based Care review. The programme follows national direction of travel in shifting balance of care. These projects will deliver against many of the issues raised in the original inspection. Outputs from projects will enable the delivery of key strategic changes. All aspects of the programme are led by locality, strategic planning and commissioning, senior managers, as senior responsible officers, with executive team members leading the programme boards. Work is underway to determine project and programme level benefits for the programme, which will evidence impact and contribute towards defining overall measures of effectiveness for the Strategic Plan. There will be a balance between qualitative and quantitative measures, seeking to evidence performance improvements as well as improvements in the outcomes and experience of the people we support. The key elements and approach associated with Transformation Programme will, in time, become business as usual and be considered as a key part of the implementation of the Strategic Plan. Consideration is underway of resource and organisational requirements to ensure that key projects are adequately resourced beyond the current 2-year lifespan of the programme team.	10.4 EIJB transformation report, July 2020 (10.3 – EIJB Strategic Plan update, April 2021- see above)
Measuring Performance and Outcomes The performance framework and surrounding governance has been significantly improved since the 2018 progress review. In February 2021, a new Performance and Evaluation Manager was recruited and is working on establishing and embedding improved measures of effectiveness as a matter of urgency. This will ensure we can effectively track and assess the impacts of delivery of the Strategic Plan. This post works closely with performance and analytics staff in our partner organisations, NHS Lothian and City of Edinburgh Council. More robust monitoring and governance arrangements are now in place to review performance. A report is presented to the Performance and Delivery Committee every 2 months on progress against the national indicators and key performance indicators. This has been instrumental in showing some improvement, and understanding of trends and analysis of information. Extensive work has been undertaken in recent months to refresh the Joint Strategic Needs Assessment and this will help to inform the new plans and strategic priorities. The first set	10.5 – P&D performance reports 10.6 – P&D Committee ToR 10.7 – 10.9 – JSNA topic papers: Dementia,

of JSNA papers have been produced, focusing on: population and demographics; poverty in Edinburgh; and dementia. The project team continues to work on additional topic papers. A robust process is in place for the development of the annual performance report. The transformation programme is working on identification of benefits measures to evidence success.	Poverty & Population 10.10 – EIJB Annual Performance Report 2019/20
Consultation, Engagement and Involvement In early 2020, a dedicated Communications and Engagement Manager joined the EHSCP and has since been supported by a small communications team to provide additional support. An overall communications strategy is being created for the EHSCP/EIJB and will be ready by June 2021. A DRAFT version is included at 10.10 for information. Communications and engagement plans are underway for the refresh of the strategic plan and a series of staff focus groups have commenced. Ongoing development of the plan will include engagement with all stakeholders, including public, staff, partners etc. Extensive communications and engagement have taken place, as part of the 3 Conversations, Home First and Home Based Care programmes, and more recently through the Edinburgh Pact and Community Mobilisation project. A very successful session took place in January with wide range of third sector and community based organisations, beginning the process of developing new, collaborative and partnership based community commissioning and investment models. A report was taken to the EIJB in April 2021 setting out the plans for delivery of the Community Mobilisation work. Overall EIJB communications and engagement has improved. Since the 2018 progress review, a dedicated website has been developed for the EIJB/EHSCP, along with recognised branding and logos. EIJB public engagement sessions were held in late 2020, giving members of the public an opportunity to hear and ask questions about the EIJB's strategic priorities. In addition to this, we have recruited 3 new citizens' representatives to join the EIJB and provide the board with the benefit of their lived experience and the Head of Strategic Planning is also providing 6-monthly engagement sessions with community councils.	10.11 – draft communications strategy 10.12 – focus group slides 10.13 – EIJB report on Edinburgh Pact & Community Mobilisation, April 2021
Financial planning, investment and disinvestment Since 2018, significant improvements have been made in relation to our financial planning process and savings and recovery planning. More detailed evidence of this is set out in the evaluative statement for Recommendation 11. As detailed strategies and plans are developed, they will take account of the financial implications and identify areas of required investment and disinvestment, to ensure sustainability in the longer term.	

Self-Evaluation Summary and Recommendation
Over the last 2 years, it is evident that there has been a fundamental shift in approach, moving from a reactionary approach to a long-term planned approach. Strategic planning and commissioning frameworks and approaches have been strengthened. Communications and engagement are more robust and inclusive. The establishment of the transformation team and programme has provided the additional capacity needed to turn strategic intent into delivery. There is a high level of confidence that the necessary improvements have been made to facilitate a more structured and effective approach to the development and implementation of strategy going forward.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
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

Position Statement and Key Achievements	**Evidence reference**
Development and implementation of Savings Governance Framework: *Strengthened governance processes and monitoring* Management and oversight of financial planning has been strengthened considerably since the 2018 progress review. The Savings and Recovery Programme is now managed utilising the Savings Governance Framework that was put in place during Spring 2020, following an internal audit review of the governance of the programme (11.1). The framework considers not only the requirement for immediate savings in year to ensure financial balance, but provides a clear and structured approach for future years, that aligns with our partners financial planning processes. As appropriate, we have also recognised within the framework, links to the IJBs transformation programme to ensure that proposal development, delivery and benefits realisation (including savings) are monitored collaboratively to ensure consistency in approach, avoid duplication and ensure learning is shared. The Savings Governance Framework was developed in close dialogue with audit colleagues and following its production, the associated audit actions have been closed. Delivery of the Savings and Recovery Programme is overseen by the Savings Governance Board (SGB), chaired by the Chief Officer. This group meets monthly with all senior responsible officers submitting progress reports which inform the overall dashboard prepared by the Programme Manager. As part of this process all reports are signed off, and supported by finance colleagues to ensure accurate and appropriate reporting. SGB Monthly dashboards are used as the basis for quarterly reports to the EIJBs Performance and Delivery Committee provide. These reports provide assurance that appropriate checks and balances are in place, to both monitor and scrutinise the Savings and Recovery Programme projects and manage associated risks and impacts.	11.1: Savings Governance Framework 11.2: SGB dashboard Dec 2020 11.3 SGB action/ decision tracker 11.4 – P&D savings report
Recent successes: Delivery of savings and financial balance achieved • EIJB reached financial balance in 2019/20 without additional support from partners and fully delivered against the savings and recovery programme for the year • Comprehensive Savings Programme developed and approved as part of EIJBs financial plan for 2020/21 • The development of our financial plan takes account of demographics and the particular considerations for older people's services. • Reached financial balance in 2020/21 (11.6 and 11.7) - Progress has been made across all projects within the programme - Despite the challenges posed by COVID-19 highlighted above, overall, financial balance reached across the 2020/21 Savings and Recovery Programme. In some cases this will be achieved through under spends or slippage in other budget areas	11.5: EIJB report: Savings Prog 20/21 11.6: EIJB Finance Update 02/02/21 11.7: EIJB Financial Plan 21/22

and through Scottish Government (SG) funding for unachieved savings via mobilisation plans • Despite ongoing financial challenge and the fact that the 2021/22 financial plan is not yet in balance, we will continue to work with our partners to reach balance during the financial year. As well as the EIJB itself, this position is supported by our partners in the City of Edinburgh Council and NHS Lothian.	
Integration and Sustainability: developing a way forward longer term (11.6) In recent years our approach to financial planning has focused firstly on identifying the key priorities for the overall budget, then on quantifying the in-year shortfall between projected income and expenditure. Subsequently we identify, and then deliver, savings and recovery schemes to address the gap. Each year, developing savings proposals which will have limited impact on performance, quality and outcomes becomes more difficult. The existing and agreed Transformation Programme sets out ambitious and clear actions that aim to develop and deliver tailored solutions to make sure that people get the services that are right for them. However, even optimising this programme alongside the innovations seen more broadly within the organisation, will not realise efficiencies sufficient to address the financial challenges that will be faced in the next 3-5 years. The Transformation and modernisation approach will become our standardised approach to ensuring sustainability going forward, ensuring the right people are involved in the decisions, ensuring key alignment with strategic plan, transformation programme, savings and governance programme, and development of locality plans, to realise both transformation and efficiency aspirations. Examples of this alignment and fluidity is evident in various examples, such as the review of Medical Day Hospitals starting as a Saving and Governance proposal, and as scoping progressed understanding the transformational potential and better alignment with the Transformation approach, as part of the community frailty work stream. In this context an alternative approach has been adopted – an Integration and Sustainability Framework, aligned to/ underpinned by the EIJBs Strategic Plan, which looks at how we work with our staff and the people of Edinburgh to shape and reimagine, the delivery of services within communities, and, within the funding available to us. To help us look towards the future, it is important to understand exactly what the health and social care service currently looks like in Edinburgh. The first phase underway, is building a clear baseline understanding of the current system, services and how they are provided now. It is important to recognise that this is a long term approach, and that we still have a requirement to deliver savings in the short term. Therefore a savings and recovery programme will be required to bridge the transition to integration and sustainability in the longer term.	11.6: EIJB Finance Update 02/02/21
Independent Review of Health & Social Care: The recent Independent Review of Adult Social Care, commissioned by the Scottish Government, recognises that the key issue affecting social care is lack of funding and that social care is not currently funded in a way that is sustainable or supports the transformation of services. It is too early to know the timescales or funding implications for the implementation of recommendations set out in the Independent Review. It is clear however, that the EIJB's strategic direction and transformation ambitions are well aligned with the	

findings of the Independent Review and in the short term, the delivery of our transformation ambitions will proceed as planned.	
Ongoing financial pressures**:** *challenges with presenting a 3 year balanced plan* Despite the significant efforts that have been made to ensure financial balance in recent years, each year the task becomes more difficult, as is the case for many IJBs across the country. Even with the commitments of the financial framework around redesign and transformation of EIJB services the outlook remains extremely challenging, making it difficult to guarantee a sustainable financial position and present a 3-year balanced plan.	11.7 – March EIJB Finance report

Self-Evaluation Summary and Recommendation
Since the 2018 progress review, significant action has been taken to strengthen the governance and approach to financial planning. There has been a sustained shift from short term disinvestments and reinvestments towards a planned and methodical longer-term approach to ensuring financial sustainability. The links between strategic planning and financial planning have been strengthened and the improved Savings Governance approach has provided better transparency, rigor and control. Like all IJBs, financial challenges remain, however the EIJB has a clear unity of purpose and robust relationships, systems and processes are in place to deliver against our strategic intent.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
12	The Partnership should ensure that: - there are clear pathways to accessing services - eligibility criteria are developed and applied consistently - pathways and criteria are clearly communicated to all stakeholders, and - waiting lists are managed effectively to enable the timely allocation of services
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
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

NOTE THAT, GIVEN HOW CLOSELY INTER-CONNECTED THESE RECOMMENDATIONS ARE, A SINGLE STATEMENT HAS BEEN PROVIDED COVERING EVIDENCE FOR ALL THREE RECOMMENDATIONS

Position Statement and Key Achievements	Evidence reference
3 Conversations The 3 Conversations (3C's) approach is an asset-based approach that supports choice and flexibility, it is a more person-centred approach for individuals and their families across Edinburgh. It is based on the principle that the EHSCP should focus not on the function of care management and its processes, but rather on organising its resources around having "three conversations" effectively. 3C's focuses on what matters to people, working collaboratively with them as the experts in their own lives. It recognises the power of connecting people to the strengths and assets of community networks, and the necessity to work dynamically with people in crisis. Staff are encouraged to think creatively about how to support people to deliver improved outcomes. Our 3C's approach has allowed us to deliver improved outcomes for people through improvements to pathways and access to services, and by ensure that those pathways are communicated to all stakeholders. Fortnightly governance and engagement meetings have been established to oversee the implementation of the model. Representatives from frontline teams attend along with members of the Executive Management Team and a representative from our third sector interface, the Edinburgh Voluntary Organisations Council (EVOC). The	

meetings give frontline teams the opportunity to share and develop their learning regarding the new ways of working. Our innovation sites have reduced bureaucracy in the pathway to ensure that people get what they need as quickly as possible. Within innovation sites, we have introduced new simplified templates and processes to free up valuable staff time whilst still ensuring robust recording and reporting. 3C's focuses on staff taking ownership and avoiding hand-offs and referrals which can lead to increased waiting times and poor outcomes. The staff member who has the first conversation takes responsibility for supporting the individual, pulling in other support or expertise as needed. The 3C's project has so far delivered 11 innovation sites including approximately 100 staff, with two more ready to go live shortly and more in the pipeline. Innovation sites provide a supportive environment where staff can learn to practice the new approach, with added support from their peers, the transformation project team and Partners 4 Change. Initial findings from the Phase 1 Evaluation (see 12.3) have been very positive. 71% of new people have been supported at Conversation 1 without the need to progress to formal service provision. Only 14% of new people required paid-for services, compared to 24% previously. Staff were able to respond very quickly, with the average wait to see a worker reduced from 40 days to 3.8 days. Most teams managed to operate without a waiting list through the period under evaluation. Feedback from staff involved in innovation sites in Phase 1 was very positive, with staff reporting a high level of satisfaction, feeling that the approach resonates with their social work values and principles and allows them to better utilise their skills and experience in supporting people. Staff reported enjoying working in a more collaborative way, by eradicating formal referrals within teams, and through the use of huddles and reflective practice sessions. "Stories of Difference" (see 12.5) recorded by the innovation sites also give a sense of the kind of innovative approaches used to provide support and how these differ from what might have been done prior to the introduction of 3C's. Moving forward, there will be a focus on gathering more extensive and meaningful feedback from individuals that we support, to understand the impact of the 3C approach on personal outcomes and experience. A simple survey is currently being trialled to gather feedback from those we have worked with. Whilst this is in early stages and returns are still low, the feedback gathered has been very positive (see 12.6). The project will be extended into NHS areas of the Partnership throughout 2021/22, with the aim of proving the effectiveness of the approach across both health and social care services. Whilst not all services will adopt the approach fully (including paperwork and processes), it is still our ambition that all staff within the EHSCP will embrace the ethos and principles. Work is underway to embed the 3C's approach into the way we do business, including the appointment of a 3C's Operations Manager post.	12.1 and 12.2 – 3C conversation record and support plan 12.3 and 12.4 – Phase 1 Evaluation Report and progress update 12.5 – stories of difference 12.6 – People survey returns
Purchasing Improvement Programme A significant programme of work is underway, led by 2 of the locality managers, to improve our policies, procedures, systems, approaches and practice in relation to assessment and care management. Whilst this work was initially finance-driven and seeking to improve sustainability within the purchasing budget, the programme has now broadened to effect positive culture change and support staff to strengthen their practice. The programme is focused on providing the necessary infrastructure and support to enable this. As part of this work, a "Good Practice Forum" has been established. This forum gives staff an opportunity to engage with senior management, seek feedback, engage with subject matter experts (for example, from Finance, Quality Assurance, Learning Disability) and better	12.7 – Good Practice Forum ToR

understand good practice and good decision making. The forum seeks to support the reduction in bureaucracy, share knowledge and learning and support staff to make difficult decisions. Through the Good Practice Forum, we are now getting a better sense of the level of staff understanding about the decisions they make and associated impact, and we are able to identify where additional support is required and develop plans to address gaps in workers competence, knowledge and confidence in their decision making. This is leading to a shared language and greater understanding, with eligibility criteria being more consistently applied across staff groups. At the same time, staff are supported – via the 3C's model – to ensure that where people may not be eligible for formal statutory services, that we still work to connect them with community assets. The work underway in the transformation programme as part of the Community Mobilisation project, will help to strengthen and increase the range and capacity of community supports available. Although in the early stage, we have been developing a Learning and Development (L&D) Programme to help workers who need more support, as identified via the Good Practice Forum. We are identifying gaps and knowledge across our staff groups and are using that evidence to inform the content of the programme. We are currently planning the required resource and timescales to provide staff with the tools, training and support they need. This programme will ensure that staff fully understand eligibility criteria and how to apply it and will also help build decision making skills and resilience, empowering workers. A further workstream within the Purchasing Improvement Programme is focused on the re-introduction of a Resource Allocation System (RAS), to support workers to have effective conversations with individuals needing support, whilst also ensuring that we can meet the requirements of Self Directed Support legislation by providing an indicative budget for support needs. A RAS aligned to the 3C's model is currently being piloted within the South East locality, with a view to rolling this out more widely if successful. The requirement for a separate piece of work to review and update all relevant policies and procedures has recently been identified. We recognise that additional resource will be required to support this and the Executive Management Team is currently considering this.	12.8 – 3C's resource allocation model
Improvements within "Business as Usual" <u>Leadership and Governance</u> Since the original inspection and the 2018 progress review, leadership and management within the locality teams has been strengthened and improved. The locality model had only recently been implemented when the original inspection was carried out, with a number of managers taking on new roles and responsibilities outwith their area of professional expertise. The size and scale of the localities within Edinburgh is challenging, with localities covering areas the size of some entire HSCPs elsewhere. A new Head of Operations was recruited in 2018 to provide additional leadership, and stronger governance has been established to ensure consistency of practice and approach across localities. Plans are underway for further strengthening of clinical and care governance, including the recruitment of dedicated Lead Social Worker and Lead AHP roles to support general managers. <u>Waiting Lists</u> At the time of the 2018 progress review, concerns were raised about the length of time people were waiting for assessment and review. Within our 3C innovation sites, waiting lists have been significantly reduced or eliminated, with people waiting an average of just 3.8 days to see a worker. Within areas which are not yet part of the 3C approach however, we have also seen	12.9 and 12.10 – performance reports

sustained improvement in waiting lists since that time. A combination of the 3C approach and concerted efforts within locality business as usual teams have seen assessment waiting lists fall from a peak of 1, 790 in August 2018, to a current position of 697 in April 2021. Challenges remain with waiting lists for reviews, due to capacity. However, the 3C project is now working with review teams as an innovation site, in order to develop a consistent 3C approach to tackling this.	March 2019 and March 2021
<u>Home First</u> The 2018 review also noted concerns with pathways for people being discharged from hospital. Since that time, significant work has been undertaken as part of our transformation programme to make improvements in this area. The Home First team has been established, focused on avoiding admission to hospital and supporting people home as quickly as possible once it is safe to do so. The Home First project is redesigning some of the complex pathways from acute to community services. We have seen significant improvements in the destinations for those who have been referred for intermediate care services. Between March and December 2020, 605 intermediate care referrals have been screened by the Home First team, with 281 people being admitted. Of the 324 people not admitted, 189 (58%) were supported to instead go directly home. The team has now started work on developing a "planned date of discharge" approach, rather than an estimated date of discharge. There is good evidence from elsewhere that this can help to reduce unnecessary time spent in hospital and support people to return home at the right time. The scaling up and rolling out of our Hospital at Home service has also assisted greatly, supporting people within the community to avoid admission.	2.11 – EIJB Strategy Paper – appendix
<u>Quality Assurance</u> We continue to engage with, and benefit from the expertise of the Council's Quality Assurance team. Members of the team are involved in transformation projects and also attend the Good Practice Forum. The Quality Assurance Team supported the EHSCP in the completion of practice evaluation in 2018 and 2019 (see 12.6 and 12.7), with findings noting positive impacts in terms of strong person-centred practice, partnership working and positive interventions and outcomes for individuals. The 2019 report noted the impact of the 3 Conversations approach in supporting better conversations with individuals. Quality Assurance officers have also assisted the EHSCP with the creation of "People's Stories" – real life cases (with names changed) showing case studies of their interaction with health & social care services and staff (see 12.8 and 12.9).	12.12 – Practice Evaluation Report 2018 12.13 - Practice Evaluation Report 2019 12.14 and 12.15 - People's Stories
<u>Anticipatory care planning</u> The EHSCP continues to implement initiatives to improve outcomes for older people through Anticipatory Care Planning. In August 2019, 20 Care Homes and their aligned GP practices were able to demonstrate a 56% reduction in avoidable admissions to hospital, enabling residents to receive the right care in their homely setting. Taking account of continuous learning the ACP model was adapted to be Covid-19 relevant. At the end of March 2020 the partnership provided all care homes for older people and GP practices with: 7 steps to ACP – creating covid-19 relevant ACPs in Care Homes, implementation guidance and resources. The *7 steps to ACP* supports care homes to put residents and their families at the centre of shared decision-making. The partnership summarised its experience of supporting care homes residents and their families through ACP during Covid-19 in a poster which won the best innovation award at the RCGPs national event in February 2021.	

Self-Directed Support

The progress review in 2018 noted that insufficient progress had been made in relation to upskilling staff and simplifying assessment processes and templates to support people to better self-direct their own support. Since that time, we have initiated a project to roll-out and embed the 3 Conversation approach across our teams. 3C's is well aligned with SDS legislation, supporting the use of better conversations with individuals to help them direct and control their support and build better and more independent lives. The 3C's project has developed new simplified templates and processes to support this way of working.

Since the original inspection and progress review, the EHSCP continues to show good uptake of Options 1 and 2, with Edinburgh having a greater uptake of these options than is the case nationally. The table below shows the uptake of Options 1 and 2 for the years 2017/18, 2018/19 and 2019/20, compared with the rates for Scotland in 2017/18 and 2018/19 (published figures). It should be noted that figures for 2019/20* are local figures which have been submitted to Public Health Scotland but not yet verified and published.

Edinburgh

	Option 1 %	Option 2 %	Option 3 %	Option 4 %
2017/18	26.0%	8.5%	72.8%	7.0%
2018/19	25.9%	8.2%	73.3%	7.1%
*2019/20**	*25.9%*	*7.8%*	*73.0%*	*6.5%*

Scotland

	Option 1 %	Option 2 %	Option 3 %	Option 4 %
2017/18	9.5%	8.3%	86.9%	4.6%
2018/19	8.9%	7.1%	88.9%	4.7%

We recognise that there is more that can be done to encourage and support individuals to self-direct their support. Our current Direct Payment policy requires updating – we have recognised this as a gap and have plans in place to address it. Our Good Practice Forum and Learning & Development programme help to support staff to better understand and apply SDS legislation and the Purchasing Improvement programme is working on improvements to the processes and systems which will help support staff in this.

Self-Evaluation Summary and Recommendation

Since the 2018 progress review, significant progress has been made in relation to the roll-out and embedding of the 3 Conversations approach within Edinburgh. We have plans to continue to upscale this approach and embed it into our business as usual practice. We have made considerable improvements in the length of time that people wait for an assessment of their need and have maintained good performance in relation to the uptake of SDS options. Wide ranging programmes of work are underway to improve practice, systems, processes and infrastructure, to better support staff and citizens to access quality services when needed. There is a high level of confidence that this work will be sustained going forward.

Services for Older People – Joint Inspection Progress Evaluation 2021

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

Position Statement and Key Achievements	**Evidence reference**
Delivering consistent improvements across risk assessment and public protection outcomes Work has been underway to provide confidence that risk management policies and procedures were being consistently applied, and in the partnership's ability to deliver consistent positive public protection outcomes. This has been achieved through: • Improved involvement of people who use services, with there being a working group to determine how to continue to support and involve people with lived experience with advocacy and third sector organisations. There is also a test underway, with an Outcomes questionnaire being worked through with people who use our services, following a case conference, to gain further understanding of their experience of adult support and protection(ASP) • Improved focus on awareness training for the third, independent and housing sectors • The development of a replacement tool for assessing risk in adult support and protection, that was easy to use for all staff Safety Assessment is now used for all APCCs. (14.1) • There is ongoing improvement in chronologies in adult support and protection (ASP), case record, as chronologies are now included on the Safety Risk Assessment. There is also a Pan-Lothian Chronology that has been developed and is due to be rolled out across all four Lothian partnerships later in 2021 • Improved consistency across localities for adult protection case conferences; with plans monitored by Senior Practitioners who chair the majority of case conferences, and monitor plans by Senior Social Workers, who chair the remainder. Everyone who chair APCCs benefit from ASP Level 4 training, delivered in 2019 and 2020, on 'Being More Impactful at APCCs'. The Safety Plan is developed following APCC (14.2). • Evidence of better identification, assessment, and recording of non-adult protection risks, such as slips and trips. This complements the significant progress associated with improvements in Recommendation 7, associated with falls prevention and management. Additionally person centred, asset based Safety Assessment work is underway as part of the 3 Conversations work. • Improved professional supervision for adult support and protection work, as well as encouraging through the 3 Conversation approach, of the application of a more robust reflective practice individually, in one to one supervision, and, collectively as groups of staff	14.1 Safety Risk Assessment 14.2 Safety Plan

• Exploring the issues behind the number of large scale investigations, significant case reviews and inter agency referral discussions in care homes, to learn system wide lessons, taking appropriate remedial action, and contributing on ton going improvements • Improved understanding from EIJB members of adult support and protection through appropriate briefings and additional information, when required • Review of ASP courses: Level 1 is now e-learning, level 2 &3 revised and level 4 had new topics added. All courses now routinely evaluated, with a focus on the participants level of confidence following completion New Adult Protection Senior Practitioners in post beginning May 2021, and will review all levels of ASP training, in conjunction with learning and development colleagues, and feedback from the courses. Evaluation of training courses, indicate a consistent improvement of understanding and confidence post training, indicated in 14.3. All of the courses are fully booked, and more recently adapting to Teams delivery. A wide range of practitioners attend, including social work, health and care workers; housing; residential care; occupational therapists; family and household support; criminal justice and many more colleagues. • Progress with health participation in Initial Referral Discussions (IRDs), through the NHS Lothian Director for Public Protection having connected with each of the Edinburgh Cluster Managers, and Social Work colleagues, who are all involved in identifying professionals to participate in IRDs. As a result, it has been identified that some additional Level 3 training/ IRD demonstration will further improve capacity and confidence, and this is being planned to be implemented across Edinburgh in 2021. Terms of reference have been issued for the Edinburgh Initial Referral Discussion Group, (EIRD), 14.4, and is currently under review. This group monitors and tracks IRDs as well as provides quality assurance and feedback for the work undertaken. .	14.3 – 14.6 Evaluation of ASP courses and attendee records 14.7, EIRD Terms of Reference
Impact of the Independent Review of Adult Social Care in Scotland The progress made, indicates the value of involving people who use services in public protection case conferences, supports a rights based approach, as well as choice and control. Additionally the key focus on training, awareness, supervision, and reflection, in Edinburgh adds confidence in workforce capacity, capability and their confidence. Further work will taken forward, to determine how best to apply learning from significant case reviews.	

Self-Evaluation Summary and Recommendation
Reasonable progress has been made, with EHSCP currently undertaking further self-assessment to public protection approaches to further improve experience for people, training, awareness, on a multi- agency basis, and provide confidence that further areas identified for improvement will be progressed, with the view that this recommendation should be closed.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
16	**The Partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors.** This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skills mix that delivers high quality services for older people and their carers

Position Statement and Key Achievements	**Evidence reference**
Development of *EHSCP Workforce Strategy* Through our transformation programme, we are currently developing a new workforce strategy, to help us ensure that we have a skilled and capable workforce that can deliver on our strategic priorities. ***'Working Together'*** is the Edinburgh Health and Social Care Partnerships inaugural workforce strategy and describes how we will create the workforce we need to deliver our vision of '*a caring, healthier and safer Edinburgh'.* It will set out our vision and priorities for the workforce and how we will get to where we need to be together. The strategy will deliver against an overarching vision and aspirations, and our 4 strategic workforce priorities of Health & Wellbeing; Culture & Identity; Workforce Capacity & Transformation; and Leadership & Development. This draft workforce strategy is attached as item 16.1. This strategy sits within our Transformation Programme, as part of Programme 4: Cross-cutting Enablers. It focuses on both the workforce of the Partnership (CEC and NHSL), but also the implications of change on our non-direct workforce such as 3rd and Independent Sectors, Volunteers, as well as the role of carers. A programme board has been established as part of the Transformation Programme governance, membership reflects a partnership approach with key stakeholders/ service leads and heads of professions included along with representatives from Scottish Care, EVOC, and Higher/Further education. The strategy will be developed along with a route map of short (0-3 years), medium (3-5 years) and longer term (5-10 years) planning timelines. This is in recognition of that fact that not all of our ambitions for the workforce will be within the control of the EHSCP to deliver. Some will require partnership working with Scottish Government and other HSCPs, may be impacted by changes in national policy and direction, and as such, may take longer to implement. We have already started to develop the early action plan for the short term, which focuses on specific delivery actions against our early commitments. The workforce strategy will link and support other strategic developments, in particular the review of our Strategic Plan. The strategy is due to be presented to the EIJB in August 2021, with implementation beginning immediately thereafter.	16.1 – Summary of strategy

Communications and Engagement plan As we continue to develop the workforce strategy, and associated action plans, we are now planning communication and engagement across our workforce to input into the strategy. We will take a multi-agency approach to ensure all areas and services are accounted for and have the opportunity to input, and we are working with our communication partners within EHSCP to do this. **Short- and medium-term engagement plan – next 3 years** To receive feedback on the high-level strategy and the early action plan, which focusses primarily on the short-term goals (0-3 years) that we believe would see more immediate improvements, we will engage with our internal workforce (CEC & NHSL). Our engagement approach will be via a few different routes, including: - **EHSCP newsletter** as an early indicator of the workforce strategy and upcoming engagement - **One-page summary** including a link to draft strategy and focus group dates, to be cascaded widely and shared via email, website, link on text messages, Wellbeing Wednesday, WLT - **Online survey and focus groups** with staff asking for feedback on our strategy and the first phase of implementation The overall aim of our engagement sessions is for staff to feel involved, listened to, supported, and reassured that any changes made will reflect both the values of the EHSCP *and* the workforce's views shared with us throughout the development of the strategy document. **Medium-long-term engagement plan** Our longer-term engagement plan is still to be developed but will focus on actions which require further collaboration and external partnership to achieve and will take on learning from our early engagement with staff. We want communication with staff and stakeholders to be ongoing and consistent, through the development and future implementation of the strategy and its priorities.	16.2 – focus group slides
Operational Improvements At the time of the 2018 progress review, the EHSCP faced some workforce-related challenges. The progress report noted that we had recently implemented a locality model which had not yet fully embedded and there were concerns regarding the alignment of operations with strategy. The report also highlighted concerns regarding recruitment and retention and gaps in relation to professional governance. Since then, significant improvements have been made in a number of areas. **Alignment of Strategy and Operations** The establishment of our transformation programme, and the additional resource of our transformation team, has allowed us to focus more effectively on developing and implementing change and improvement whilst also dealing with operational pressures. The links between operations and strategy staff have been considerably strengthened. Senior managers from both areas have assumed leadership roles within the transformation programme and are supporting the implementation of our strategic aims. A Strategy and Operations Forum meeting has been established, jointly chaired by the Head of Operations and Head of Strategic Planning, giving an opportunity for joint decision making. The transformation programme team has delivered a number of workshops sessions to locality	

teams providing details of the programme and opportunities for staff to get involved in shaping and delivering change, and have ongoing contact across the localities as a result. Transformation projects teams have a good range of representatives from across locality and strategic teams. Work is underway to initiate an organisational change process to stabilise and strengthen existing management arrangements within locality teams, including a review of the roles and remits of our locality managers, hub managers and cluster managers. **iMatter Staff Survey** The iMatter survey was introduced to all EHSCP staff across health and social care services as a more effective way to measure and take action on staff experience. All health boards and HSCPs have chosen to participate and implement the iMatter survey. The response rate for the 2018 return was 65% and the directorate's Employee Engagement Index (EEI) score was 77. Overall, 24 of the 28 questions fall within the highest 'strive and celebrate' category: the remaining four need monitoring to 'further improve'. All teams have been asked to discuss individual report findings, identify areas for improvement and develop an action plan. In 2020 the survey was slightly adapted to meet the changing environment and work experienced during the pandemic, with added questions on changed job role and work environment. The response rate was significantly lower than previous years (35%), but results demonstrate that the majority of staff still report high personal wellbeing scores, despite the ongoing pandemic and impact on our workforce. Staff also reported that their overall experience of work, while slightly lower than previous years, remained positive. It is encouraging that staff have remained resilient and optimistic while faced with significant organisation disruption and changes to their working lives." **Professional Governance** At the time of the progress review, concerns had been raised regarding professional governance, which had primarily been provided via the locality model, with hub/cluster managers also assuming a lead professional role. Recent discussions have recognised that this could be improved and strengthened, and a decision has been taken to establish and recruit to dedicated professional leadership roles, including a Lead Social Worker and Lead Allied Health Professional, to provide additional support to the workforce. Job descriptions are in development. In addition to this, strong links have been made between the transformation programme team and the Professional Advisory Group, and transformation programme boards ensure a wide range of clinical and professional representation. **Staff Involvement** The establishment of the Partnership Forum has considerably improved the transparency and involvement of staff and staff representatives in any decision-making which has an impact on workforce. The forum meets on a monthly basis and considers a range of issues, including sickness absence, staff wellbeing, proposals for staffing changes and organisational review, and creation of new posts. The following documents are attached for information: • minutes of recent meeting at 16.5 • sickness absence reports at 16.6 The EHSCP has a strong working relationship with its staff side representatives from both NHS Lothian and the City of Edinburgh Council, with representatives included within the membership of transformation programme boards. **Care Home Transformation Group**	16.3 iMatter survey 2018 16.4 iMatter survey 2020 16.5 - Minutes 16.6 – Sickness dashboard

Care homes have faced a challenging year dealing with the impacts of the Covid-19 pandemic. Extensive work has been done in recent months to support and develop our internal care home quality and performance, with a key focus on upskilling and supporting care home staff. The group has identified a number of key workstreams, attached at 16.7. The workforce workstream is focusing on recruitment, education and training and skill mix. The project team is developing actions to stabilise and support the workforce, improve succession planning and reduce the use of agency staffing. There are also linked workstreams looking at wellbeing (for both staff and residents) and communication. **Recruitment** The EHSCP organisations (NHSL and CEC) have both been working to improve the recruitment of staff so we can build sufficient capacity across our services. With workforce planning key to supporting the delivery of services within EHSCP, the workforce planning group was set up in June 2018, and recruitment and retention was one of the key workstreams identified. <u>The City of Edinburgh Council Modern Apprenticeship Programme</u> Within the recruitment and retention workstream, the CEC Modern Apprenticeship Programme was created (in-line with NHS Modern Apprenticeship programme), which offers young people aged 16 and over employment with the Council, combined with workplace training and support from a training provider, to help them gain new skills and an industry recognised qualification. A Council wide initiative, the Modern Apprenticeship Programme forms part of the Edinburgh Guarantee, which is a vision that all sectors of the city will work together to ensure every young person in Edinburgh will leave school with the choice of a job, training or further education opportunity available to them. With the introduction of the Edinburgh Guarantee, the Council made the following commitments: • Increase Modern Apprenticeship numbers to at least 1% of our workforce • Establish a team to make it easy for employers to support the Edinburgh Guarantee • Champion the Edinburgh Guarantee to our peers and help them become involved Apprenticeships usually last for 2 years and training is offered at SVQ Level 3. As of 10th February 2021, we have 117 apprentices in health and social care, and aim to start another 50 people onto the qualification this year. <u>NHS Lothian Modern Apprenticeship Programme</u> The NHS also provides a Modern Apprenticeship programme which provide work experience and on the job training, and the opportunity to work towards gaining a qualification. The NHS programme is substantial and sits across a range of their services, with some modern apprenticeship roles aligned to the Edinburgh Health and Social Care Partnership. Six NHS modern apprenticeships have been completed within the EHSCP, with 80% of those completing having sustained employment. 50% of those who have completed are progressing to senior roles or higher level Nursing Training. There are currently 10 modern apprenticeships ongoing – 2 nearing completion with an additional 8 starting having started in post on the 12th April 2021. In addition, 10 Kickstart positions have been offered within HSC starting in March 2021. Kickstart is a partnership across a range or organisations, it is the main activity within the Young Persons Guarantee, which was created in November to support and develop youth employment opportunities. It is a DWP led programme and referrals come directly from DWP. NHSL is one of 4 national trailblazer employers supporting the young person's	16.7 – Care Home Transformation workstreams

guarantee. We are the only board in Scotland currently offering Kickstart, and the positions are linked to MA opportunities as progression.	
Supporting the Wider Health and Social Care Workforce The EHSCP recognises the vital role of the wider health and social care workforce, provided through third and independent sector organisations and unpaid carers. Our new workforce strategy will make a commitment to supporting the wider workforce. In order to provide additional advice, guidance and support for our colleagues in independent sector care homes, particularly during the Covid-19 response, a dedicated care home website has been established. The website provides details of latest news and policy, support on staff wellbeing, issues relating to testing and vaccination and support with training and education. The website has been very well received by our partners, with 3,000 hits in a single week in relation to vaccination information. https://services.nhslothian.scot/CareHomes/Pages/default.aspx Our Home Based Care transformation is already developing plans for a "One Edinburgh" approach, taking a responsible and supportive approach to commissioning and procurement. We are engaging with independent providers in a new, collaborative partnership approach to develop a modern contract for care at home services which recognises the skills and expertise of the wider health and social care workforce and is focused on quality outcomes for staff and the individuals we support. The approach taken in developing this contract will be a key part of our market facilitation strategy going forward. **Edinburgh Wellbeing Pact and Community Mobilisation** We are working towards an ambition to create healthy communities, empowered by local services and organisations. We want to reshape how we think about health and social care, how we support one another and work together to deliver support and care across the city in a sustainable and joined up way. In order to achieve this we have been developing the Edinburgh Wellbeing Pact, which is an informal agreement between EHSCP and the people of Edinburgh. The Pact will provide the framework to deliver a refined relationship with the public which will include consideration not just of services provided by the Edinburgh Health and Social Care Partnership (EHSCP) but also the wider health and social care workforce and how third sector and independent sector services are commissioned, accessed and provided. We are now enacting the Pact through our Community Mobilisation approach, which includes whole system investment in an area, stimulating activities across local organisations and working collaboratively to support and fund local need in a sustainable way. The approach is being developed and delivered in collaboration with a wide range of key stakeholders, including the third and independent sector, faith-based organisations, other partners and staff. Both of these projects are governed within the transformation programme.	16.8 – Care home portal (see link) 16.9 – Community Mobilisation – EIJB report April 2021
Development of *Strategic Workforce Plan* for Scottish Government Aligned to the Workforce strategy, we also continue to develop a 3-year workforce plan as per Scottish Government requirements. • Development of *Interim Workforce Plan* for Scottish Government (BAU work taken forward by Partnership colleagues) (April 2021)	

• Development of full 3-year Strategic Workforce Plan for Scottish Government (April 2022) Whilst documents will have distinct purposes, each will adopt the same principles of how to achieve a skilled, supported and sustainable workforce, along with additional immediate priorities to support our existing workforce. Extensive work has already been completed in analysing the baseline position of our current workforce. We now have a much greater understanding of the breakdown of our Council and NHS workforce in relation to issues such as age, gender and skill mix. We have been able to use this baseline data to identify some of the key workforce risks and challenges – for example an ageing workforce in some areas – and feed this into the development of our workforce strategy. The baseline data report is attached at 16.10. The Scottish Government has released guidance for the development of the workforce plan and confirmed that 3-year plans are due for submission by April 2022.	16.10 – Baseline Workforce report

Self-Evaluation Summary and Recommendation
Since the 2018 progress review, our approach to workforce planning and support to our existing workforce has been significantly strengthened. We have made operational improvement in a number of areas and are making clear progress in developing a workforce strategy that includes all relevant partners, to ensure we have a skilled, supported and sustainable workforce that meets the health and social care needs of the citizens of Edinburgh. The strategy and first phase of implementation will be presented to IJB in August 2021 for sign-off and implementation will begin thereafter. We are confident that we have appropriate arrangements in place to build on progress made to date and support and enable both the current and the future workforce.

Services for Older People – Joint Inspection Progress Evaluation 2021

Recommendations for improvement	
17	**The Partnership should work with community groups to support a sustainable volunteer recruitment, retention and training model**

Position Statement and Key Achievements	**Evidence reference**
In the 2018 Report, key areas for development included progressing volunteering and active citizen engagement. The EHSCP, acknowledges that volunteer participation and retention is a corporate function, across both CEC and NHSLothian. With NHSL having an active Volunteering cohort, involved in many aspects across NHS areas, and who have been more recently been a key component in delivering the vast testing and vaccination programmes. For CEC, volunteer training, recruitment, retention have a contract with Volunteer Edinburgh which supports the following objectives: • Take a strategic leadership role in promoting and developing volunteering and active citizenship within community planning. • Carry out a range of research and activities on volunteering to inform strategic policy, planning and decision making in the city. • Deliver the Lord Provost's Inspiring Volunteering Awards. • Provide and develop capacity building activities to strengthen volunteering in the city The development of the Edinburgh volunteer strategy is being led by Volunteer Edinburgh, which was due to be launched in March 2019 however due to the pandemic, this was delayed. It is now anticipated that the strategy will be launched in summer 2021. Volunteer Edinburgh has been supported through the public sector, to fulfil their mission, particularly in the last year, *to inspire more people to volunteer so they can enhance their lives, the lives of others and build resilient communities.* Further recognising the value and expertise of our community and voluntary partners, the EHSCP has commissioned Volunteer Edinburgh (through Edinburgh Council), to provide volunteer support to older people, people with long term conditions, disabilities & other support needs to secure and sustain volunteering opportunities, this has been done through focussed work to contribute to improved outcomes for people, including: • reduced social isolation • enhanced connections • improved self-worth • improved health and wellbeing. These outcomes are central to the implementation of the EIJB's Strategic Plan and to the Equality Outcomes and Mainstreaming 2019-23. The benefits which the contract brings to both individuals and communities are fully documented both from qualitative and quantitative perspective, in the annual monitoring and evaluation which Volunteer Edinburgh publishes, and in their report back to commissioners, 17.1, https://www.volunteeredinburgh.org.uk/	17.1 Outcomes Volunteer Edinburgh

The key activities undertaken across Edinburgh communities, supported by Volunteer Edinburgh, include: • Volunteer Brokerage - recruitment and placement, and maintaining an accessible database of volunteering opportunities in the third and public sectors. • Volunteering for Personal development , helping people stay connected and participating, particularly through the delivery of services to support older people, reducing isolation and building social capital, as well as supporting and developing volunteering at the Royal Edinburgh Hospital and supporting people living in housing with support, who have a mental health diagnosis. • Building stronger community and challenging inequalities, championing equalities and rights through our coordination of the Equalities and Rights Network. • Helping organisations work better with volunteers, through providing advice, information and consultancy on volunteer's management to organisations who involve volunteers. Delivering training on all aspects of volunteer recruitment and management, and through promotion and delivery of National Quality Standards in Volunteers Management. • Influencing and informing public policy on volunteering, being a key partner in Community Planning, and through progression of the Community Planning Partnerships Volunteering Strategy. This approach has been in addition to the funded support provided by Volunteer Edinburgh, to support communities to build resilience and offer even more support of a remote wellbeing and befriending nature throughout the not only the humanitarian phase of the initial response to the pandemic, but on an ongoing basis, to people required to shield. The response to volunteer recruitment was tremendous, with it being clear that people who were experiencing extended periods of furlough, or had lost employment in early 2020, were a key component of applications. The partnership has secured agreement to extend this contract for a further 3 years until the end of March 2024. This extension will allow the service to be maintained and allow time for alignment with the Community Engagement Programme, through the Edinburgh Pact, and Community Mobilisation, where extensive work is underway to actively engage citizens, and to hear from them about how they support resilient communities by being active citizens in their local communities. This work is described in more detail within recommendation 1, above. **Enhancing Volunteer support for carers** Other valuable work undertaken through VolunteerNet, includes flexible support for unpaid carers. Carers can make arrangements safely and directly online with registered and vetted volunteers which enable them to stay in full control over the support they receive. VolunteerNet approach is designed around the person and their need, and is part of the EHSCP Carer Support Team. Carers can access support seven days a week throughout the day, evenings and weekends. Carers and the person they care for can choose type of support they need and the volunteer by whom they will be supported. Various types of support can be accessed through VolunteerNet, 17.2VolNet Flier Carers.pdf (nhslothian.scot) . These include: • Spending time with the cared for person which gives the carer a few hours of respite (volunteer can stay at home with the person or go out for a walk, to the cinema, gallery, cafe etc.) • Help with activities requiring extra pair of extra hands (i.e. when going somewhere by bus, attending appointments, or doing shopping)	17.2 VolunteerNet

• Spending time with the carer (providing them with companionship or practical help) • Practical support (i.e. help with gardening, going with the person to the shops, etc.) • All matches are community based and/or house visits. The service aims to support carers in their caring role so they can sustain their caring role if appropriate and they choose to do so. • The service also helps to tackle social isolation, increasing people's positive mental wellbeing and supporting people to stay independent in the community **Evidence** 17.1 Volunteer Edinburgh https://www.volunteeredinburgh.org.uk/ 17.2 VolunteerNet Edinburgh VolNet Flier Carers.pdf (nhslothian.scot)	
Working with other community groups to support sustainable communities An extensive review of various grant programmes funded by the partnership was carried out in collaboration with the third sector in 2019. The new grant programme, now in its second year of a 3 year programme, and brings together the various grant streams including health inequality, older people, mental well-being, advice and income maximisation. The programme provides a holistic programme which places a greater emphasis on tackling inequalities, prevention and early intervention and building on community assets. Priorities are: • reducing social isolation • promoting healthy lifestyles, including physical activity and healthy eating • mental wellbeing • supported self-management of long-term conditions • income maximisation • reducing digital exclusion • building strong, inclusive and resilient communities. Through these priorities, the grant programme helps promote community resilience, encourage volunteering, self-help, and complements the wider spending on volunteering, health and well-being and reducing inequalities. The Health and Social Care Partnership Grant Programme, Monitoring and Evaluation 2019-20 Report which reported on the first year of the programme, noted: "*Many of the organisations depend on volunteers to help deliver their programmes. Volunteer hours added a further 33% of hours worked by paid staff and without their involvement, the wide range of service provision would just not be possible. Volunteering also adds a financial value and it is estimated that the resultant financial value which volunteering brings is over £2.5m. Equally important are the many benefits which volunteering brings to the individuals themselves such as improved confidence and well-being, increased skills and increased social connections*" **Promoting resilient communities and building capacity** A recent example of the approach to engagement and involvement, inclusive of third sector partners, is **Thrive Edinburgh**, the new mental health strategy for Edinburgh, was produced collaboratively with all stakeholders. The strategy recognises the wider social determinants of inequalities and the strong link to mental health. The strategy aims to address health inequalities at a structural, community and individual level and has four objectives: 1. identify and address root causes 2. focus on those who are at highest risk 3. provide treatment that is easy to access and makes difference 4. building resilience and enhancing support for people to live well and meet their potential	

The Thrive Strategy will be implemented through 6 commissioning work streams: • building resilient communities • a place to live • get help when needed • closing the inequalities gap • rights in mind • meeting treatment gaps. In addition, recommendation 1 also provides further detail on involvement and engagement across Edinburgh, which also contributes to promoting resilient communities and building capacity.	

Independent review of Adult Social Care in Scotland

ongoing support for the organisations commissioned by the public sector, along with the transformation programme to enhance citizen engagement, clearly supports recommendations aligned with ensuring people are supported at home for as long as possible, and are able to have choice and control to access lower intensity supports, through wider community supports, whilst contributing to the encouragement of resilient communities.

Self-Evaluation Summary and Recommendation

There is a well established cross sector approach to actively engage citizens, and public sector support for ensuring our aspirations to enhance the function of volunteers, through Volunteer Edinburgh, VolunteerNet, and wider community supports through our grants programme.

There is a high level of confidence that this recommendation has been fully met, with ongoing work sustaining our approach to the value of volunteers and building resilient communities. This recommendation should be closed.

SUPPLEMENTARY EVIDENCE CATALOGUE

Ref Number	Title
1.1	Strategic Plan 2019 – 2022
1.2	Conversation 1 Programme Definition Document
1.3	Conversation 2 Programme Definition Document
1.4	Conversation 3 Programme Definition Document
1.5	Programme 4 Programme Definition Document
1.6	EIJB Public Engagement Event
1.7	Colleague News sample
1.8	Thrive newsletter sample
1.9	DRAFT communications and engagement strategy
1.10	Edinburgh Pact engagement summary
1.11	Art of the Possible stakeholder event
1.12	Anchoring our Thinking report
1.13	The Edinburgh Pact – Formulation to Enactment – EIJB report
1.14	Home Based Care consultation summary
2.1	Conversation 1 Programme Definition Document
2.2	3 Conversations Phase 1 Evaluation
2.3	3 Conversations Phase 2 Progress Report
2.4	3 Conversations stories of difference
2.5	3 Conversations – People Survey Responses
2.6	3 Conversations – EVOC innovation event
2.7	Edinburgh Pact engagement summary
2.8	Art of the Possible stakeholder event
2.9	Anchoring our Thinking report
2.10	The Edinburgh Pact – Formulation to Enactment – EIJB report
2.11	ATEC24 wellbeing call stats
2.12	ATEC24 wellbeing call script
2.13	Assistive Living script
2.14	“Bring your own device” business case
2.15	“Bring your own device” funding bid
2.16	GP Frailty Collaborative – project brief
2.17	Home first project brief
2.18	Strategy Progress Report – EIJB April 2021
2.19	Medical Day Hospitals – project brief
2.20	Medical day Hospitals options appraisal
2.21	Medical Day Hospitals – staff consultation
2.22	Medical Day Hospitals – engagement session
3.1	Bed Based Review – project brief
3.2	Bed Based Care workshops outputs
3.3	EIJB Financial Plan report March 2019
3.4	SBAR – Liberton hospital Proposal
3.5	Letter to Liberton staff
3.6	Planned Date of Discharge slides
5.1	Link to Joint Carers Strategy https://www.edinburghhsc.scot/wp-content/uploads/2020/06/Edinburgh-Joint-Carers-Strategy-2019-2022-FINAL.pdf

5.2	Link to short breaks services statement https://www.edinburgh.gov.uk/downloads/file/26356/short-break-services-statement
5.3	EHSCP weblink https://www.edinburghhsc.scot/coronavirus-information/carers/
5.4	Clinical and care Governance report – carers performance and evaluation framework
5.5	Carers Spend Plan – EIJB report February 2021
5.6	EHSCP weblink https://www.edinburghhsc.scot/carers/ourcommitmenttocarers/
6.1	Dementia Pathway Improvement – scoping
6.2	Link to Herbert Protocol *https://www.edinburghhsc.scot/the-herbert-protocol/*
6.3	EIJB Report, October 2019: John's Campaign EIJB report 29 09 2019 Johns Campaign V.01.pdf (edinburgh.gov.uk)
6.4	John's Campaign feedback
7.1	Evaluation of walking aid safety in care homes
7.2	Phase 1 care homes falls management
7.3	Phase 1 falls improvement written summary
7.4	Phase 2 falls improvement SBAR
7.5	Steady steps proposal
7.6	Guide to managing falls
7.7	Falls and Frailty Forum ToR
7.8	Care home Near Me evaluation
7.9	EHSCP weblink – falls support https://www.edinburghhsc.scot/longtermconditions/falls-support/
7.10	Big Slipper report
7.11	Bed Slipper feedback
7.12	Digital Support BP recruitment
7.13	Staying Active leaflet
7.14	Staying Active leaflet 2
7.15	Falls peer support
7.16	LTC falls outcomes development
7.17	Community Alarm scorecard
8.1	Clinical and Care Governance ToR
8.2	EIJB reports March 2021
8.3	EIJB report Feb 2021
8.4	EHSCP QMS reporting mechanisms
8.5	Clinical & Care Governance presentation – reporting mechanism
8.6	EHSCP Quality Management System
8.7	Royston Care Home Improvement Plan
8.8	2018 complaints brief
8.9	ToR - Care at Home Multi agency quality assurance
9.1	EIJB report – Strategy Progress Update April 2021
9.2	SPG report, May 2021 – Market Facilitation
9.3	One Edinburgh design and Engagement
9.4	Visioning Provider Feedback
9.5	Consultation Summary
9.6	Home Based Care project brief

9.7	Care home transformation workstreams
9.8	Route Map board – ToR
9.9	Care at Home capacity statistics
9.10	Care at Home service specification
9.11	Contract award for day opportunities
9.12	Edinburgh Joint Carers Strategy
9.13	Carers Performance and evaluation
10.1	EIJB report August 2019 – Strategic Plan
10.2	IJB strategic planning group papers September 2020
10.3	EIJB report – Strategy Progress April 2021
10.4	EIJB report – Return to Transformation, July 2020
10.5	Performance report – April 2021
10.6	Performance and Delivery committee – ToR
10.7	JSNA topic paper – Dementia
10.8	JSNA topic paper – Poverty
10.9	JSNA topic paper – Population and demographics
10.10	Annual Performance Report
10.11	Draft communications strategy
10.12	Strategic Plan Roadshow
10.13	EIJB report – Edinburgh Pact, Formulation to Enactment
11.1	Savings Governance Framework
11.2	Savings Programme Dashboard December 2020
11.3	Savings Programme Action Tracker
11.4	Performance & Delivery Committee Savings Report
11.5	Savings and Recovery Programme
11.6	EIJB Finance Update Feb 2021
11.7	Financial Plan 2021-2022
12.1	3C's conversation record template
12.2	3C's support plan template
12.3	3 C's Phase 1 Evaluation
12.4	3 C's Phase 2 Progress
12.5	3 C's Stories of Difference
12.6	3 C's People Survey
12.7	Good Practice Forum Terms of Reference
12.8	3 C's cost estimate
12.9	Performance report March 2019
12.10	Performance report March 2021
12.11	Strategy Progress Report April 2021
12.12	Practice Evaluation 2018
12.13	Practice Evaluation 2019
12.14	"People's Story" 1
12.15	"People's Story" 2
14.1	Safety Risk Assessment
14.2	Safety Plan
14.3	ASP course evaluation
14.4	ASP course evaluation
14.5	ASP course evaluation
14.6	ASP training records
14.7	Edinburgh Initial Referral Discussion Group ToR

16.1	Working Together summary
16.2	Working Together slides
16.3	iMatter report 2018
16.4	iMatter pulse survey 2020
16.5	Partnership Forum sample minute
16.6	Absence Dashboard November 2020
16.7	Care home transformation workstreams
16.8	Lothian care Home Website
16.9	EIJB report, Edinburgh Pact: Formulation to Enactment
16.10	Baseline Workforce Report
17.1	Outcomes Volunteer Edinburgh link https://www.volunteeredinburgh.org.uk/
17.2	Volunteer Net link VolNet Flier Carers.pdf (nhslothian.scot) .

care inspectorate

Healthcare Improvement Scotland

Services for older people in the city of Edinburgh

November 2021

Progress review following a joint inspection

HAPPY TO TRANSLATE

Contents

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

1. Background

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

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

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

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

2. Approach

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

Our approach included:

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

3. Overview of progress made

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

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

4. Progress on recommendations for improvement

Recommendation for improvement 1

The partnership should improve its approach to engagement and consultation with stakeholders in relation to:

- **its vision**
- **service redesign**
- **key stages of its transformational programme**
- **its objectives in respect of market facilitation**

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

What the partnership has done:

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

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

Assessment of progress

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

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

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

Recommendation for improvement 2

The partnership should further develop and implement approaches to early intervention and prevention services to support older people to remain in their own homes and help avoid hospital admissions.

We made this recommendation as the partnership's approaches to early intervention and prevention were under-developed. This was not helping older people to remain in their own homes where appropriate and was a contributory factor to hospital admissions.

What the partnership has done:

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

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

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

Assessment of progress

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

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

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

[1] The Three Conversations® – Partners4Change home

Recommendation for improvement 3

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

Recommendation for improvement 4

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

We made these recommendations because:

- interim care arrangements were not assisting older people and their carers to experience choice and a high quality of care and support within their own homes or a setting of their choice
- there were gaps in the delivery of intermediate care that had adversely contributed to higher levels of hospital admissions and subsequent delayed discharges.

What the partnership has done:

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

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

Assessment of progress

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

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

Recommendation for improvement 5

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

We made this recommendation because there was an insufficient understanding of the needs of carers and the delivery of related services to help them maintain their caring role.

What the partnership has done:

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

Assessment of progress

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

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

Recommendation for improvement 6

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

We made this recommendation because people with dementia did not always receive a timely diagnosis and that post-diagnostic support was not always readily available.

What the partnership has done:

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

Assessment of progress

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

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

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

Recommendation for improvement 7

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

We made this recommendation because there was a need to streamline referral and care pathways to improve outcomes for older people at risk of falling or who had experienced a fall. The falls strategy needed to be updated with a greater level of involvement from supporting agencies.

What the partnership has done:

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

Assessment of progress

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

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

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

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

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

Good practice example

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

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

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

Recommendation for improvement 8

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

We made this recommendation because the partnership did not have strong joint approaches to quality assurance that led to service improvements.

What the partnership has done:

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

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

Assessment of progress

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

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

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

Recommendation for improvement 9

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

We made this recommendation because there were underdeveloped approaches to market facilitation and the risk assessment and contingency plans to accompany these.

What the partnership has done:

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

Assessment of progress

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

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

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

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

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

Recommendation for improvement 10

The partnership should produce a revised and updated joint strategic commissioning plan with detail on:

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

We made this recommendation because the partnership's strategic planning, commissioning, consultation, and involvement needed to improve.

What the partnership has done:

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

Assessment of progress

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

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

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

Recommendation for improvement 11

The partnership should develop and implement a detailed financial recovery plan to ensure that a sustainable financial position is achieved by the integration joint board.

We made this recommendation because there were insufficient detailed financial recovery plans to ensure a sustainable financial position for the IJB.

What the partnership has done:

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

Assessment of progress

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

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

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

Recommendation for improvement 12

The partnership should ensure that:

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

Recommendation for improvement 13

The partnership should ensure that:

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

Recommendation for improvement 15

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

We made these recommendations because:

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

What the partnership has done:

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

Assessment of progress

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

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

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

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

Recommendation for improvement 14

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

We made this recommendation because we lacked confidence that risk management policies and procedures were being consistently applied and in the partnership's ability to deliver consistent positive public protection outcomes.

What the partnership has done:

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

Assessment of progress

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

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

Recommendation for improvement 16

The partnership should develop and implement a joint comprehensive workforce development strategy, involving the third and independent sectors. This will help to support sustainable recruitment and retention of staff, build sufficient capacity and ensure a suitable skill mix that delivers high-quality services for older people and their carers.

We made this recommendation because the partnership lacked a shared approach to workforce development that included the third and independent sectors.

What the partnership has done:

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

Assessment of progress

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

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

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

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

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

Recommendation for improvement 17

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

We made this recommendation because the partnership needed to better influence the improvements required in the co-ordination of volunteer recruitment, retention, and training.

What the partnership has done:

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

Assessment of progress

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

5. Conclusion

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

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

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

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

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

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

care inspectorate

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