Item 5.5

Report

Older People's Inspection Update Report

Edinburgh Integration Joint Board

2 March 2018

Executive Summary

1. This report updates the Integration Joint Board (IJB) on the Health and Social Care Partnership's (the Partnership) progress against the Older People's Inspection action plan. The report sets out progress made to date and the next steps required against each of the 17 Care Inspectorate recommendations.

Recommendations

2. The Integration Joint Board is asked to consider and comment on:

    - progress to date
    - the risks associated with the plan.

Background

3. In May 2017, the Care Inspectorate and Healthcare Improvement Scotland published their joint inspection findings on older people's services provided by the Partnership on behalf of the IJB.

4. The report made 17 recommendations. In October 2017, the Interim Chief Officer reviewed and recast the Partnership's improvement plan to ensure it focused more effectively on addressing the 17 recommendations and appointed a lead officer for each one.

Recommendation	Lead Officer
1. Engagement	Strategic Planning Group chair
2. Early intervention/Prevention	Strategic Lead for Older People and Locality Manager
3. Exiting interim arrangements	Strategic Lead for Older People
4. Interim care arrangements	Strategic Lead for Older People

5. Intermediate care arrangements	Planning and Commissioning Officer
6. Dementia diagnosis and support	Strategic Lead for Older People
7. Falls pathway	AHP Director and Locality Manager
8. Joint quality assurance framework	Quality Manager – Partnership and Council
9. Market facilitation	Strategic Planning Group chair
10. Joint strategic commissioning	Strategic Planning Group chair
11. Financial recovery	Interim Chief Finance Officer
12. Accessing services	Locality Manager
13. Key processes	Locality Manager
14. Risk assessments	Senior Manager Quality, Governance and Regulation (Council)
15. Self-directed support	Strategic Planning, Service Re-Design and Innovation Manager
16. Joint workforce development	Chief Nurse
17. Volunteers	Strategic Planning, Service Re-Design and Innovation Manager

5. The Quality Assurance and Compliance Manager (Council) was tasked with co-ordinating progress-reporting. A schedule of monthly meetings with recommendation leads was established.

6. Critical challenge meetings with senior Partnership managers and recommendation leads are being held over the course of February: to ensure that progress is well understood; to support additional problem-solving; and to ensure that collaborative opportunities across the recommendations are identified and acted on.

Main report

Recommendation 1

7. *The Partnership should improve its approach to engagement and consultation with stakeholders in relation to:*
   - *its vision*
   - *service redesign*
   - *key stages of its transformational programme, and*
   - *its objectives in respect of market facilitation.*

8. The Integration Joint Board approved the Partnership's Statement of Intent in November 2017. The content of this statement has been shared with staff and partners and is being used as a means of bringing together all improvement activity and informing stakeholders of progress.

9. The IJB has established a Reference Board to oversee the development of each of the strategic commissioning plans. Chairs have been identified and discussions are now taking place with the chairs to agree the membership of these Boards to ensure wide engagement.

10. The Community Engagement Sub-group of the Strategic Planning Group met for the second time in December 2017 and began mapping out the community engagement and participation landscape in Edinburgh, including the opportunities for linking with community planning. This group will meet regularly to oversee community engagement.

11. The first meeting of the Workforce Development Steering Group took place in January 2018. This was a scoping meeting and included identification of stakeholders who should be represented in the membership.

12. The market facilitation strategy will be produced in tandem with the detailed strategic commissioning plans by September 2018. These developments will begin to map out how the concepts of 'realistic care' will become a reality. These ideas require engagement with the public, staff, and all stakeholders.

13. Staff engagement sessions are scheduled regularly.

Recommendation 2

14. *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.*

15. The grant funding of voluntary organisations continues to provide for a level of prevention and early intervention across the Partnership. A range of initiatives across the localities complement this, however, in the short-term, the Partnership has had to prioritise the reduction of delays in people leaving hospital and this has detracted from significant progress in preventative services.

16. The Care Inspectorate recommended that a greater 'strategic' approach to prevention and early-intervention. By the end of March 2018, the Partnership will produce a plan to reduce need and demand through transformation. This will have a strong preventative emphasis, including:
   - adoption of strength-based assessments

- family group decision-making
- reablement (including the expectation that reablement will characterise commissioned services)
- the promotion of realistic care
- the roll-out to all staff 'good conversations' training, currently being piloted in North East
- developing a robust review processes to promote individual independence and resilience

17. The plan will be presented to the IJB in May 2018.

18. In September 2017, the IJB approved a business case for the expansion of telecare as a preventative service. Telecare is the use of technology to support an individual's independence. Fall detectors, bed sensors, motion sensors and GPS sensors can all be used to support an individual's independence and provide discrete assurances of his/her wellbeing. This work has its own project manager, as well as communication and implementation plans. The impact of Telecare expansion will be reviewed in March 2018.

19. Third sector partner EVOC is scoping the preventative services operating in Edinburgh for older people. This will provide valuable information on availability and identify gaps.

Recommendation 3

20. *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.*

21. Liberton Hospital will close this year. A manager has been identified to coordinate the transfer and service redesign. The Jardine Clinic at the Royal Edinburgh Hospital is the site identified for this purpose.

22. Oaklands care home will close by December 2018, and work is underway to ensure the safe and effective transfer of residents to alternative placements. Residents and their relatives will be kept fully informed of developments and involved in decisions regarding their care.

23. Work is ongoing to develop an intermediate/rehabilitative care model to replace Gylemuir care home. The Partnership is in discussion with the Care Inspectorate regarding the possible extension of the registration of Gylemuir beyond the current end date of June 2018, to allow for longer term plans to be agreed and implemented. This will also require the negotiation of an extension to the current lease of the building. has been provided an extension of its interim registration by the Care Inspectorate until June 2018.

Recommendation 4

24. *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.*

25. Intermediate care is needed when an individual requires further assessment, yet they are medically well and able to leave hospital.

26. In addition to the work outlined under Recommendation 3, discussions are underway with representatives from Edinburgh's universities, voluntary sector providers, NHS Lothian, the City of Edinburgh Council and the Scottish Government regarding the possible development of a research-based care development. This work is at an early stage.

Recommendation 5

27. *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.*

28. The Partnership is preparing for new statutory obligations that will come into effect on 1 April 2018. This work is at an advanced stage, with four work streams established. All work streams are on target, except for the finance group, as there is no data yet from the Scottish Government regarding the financial support to be attached to this new legislation.

29. A 3-week pilot is underway in the North West locality. This will assess the impact of the legislation – testing new processes, paperwork and measurement tools, prior to the 1 April 2018. A monitoring group, with representation from the Partnership, the third sector, the Council, NHS Lothian and unpaid carers, meets monthly to oversee progress.

30. The young carers' statement, the adult carer support plan and the assessment tools have all been co-produced with carers. The Partnership is considering ways of adapting these tools for general assessments, given their simplicity and popularity.

31. Financial modelling of the system is still to be finalised from the pilot results. The intention is to develop a more streamlined payment for services, to ensure that carers receive support as near to the completion of the assessment as possible.

32. The testing of the processes and guidance is scheduled for March 2018, a month ahead of the legislation going 'live'.

Recommendation 6

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

34. The Partnership has developed a new service specification to meet the needs of people requiring post-diagnostic dementia support.

35. Alzheimer Scotland – Action on Dementia has been approved to provide a Post Diagnostic Support Service on behalf of the Partnership for people newly diagnosed with dementia for an initial 3-year period, with the option to extend for a further 2 years.

36. This is an exciting new development. The service provides support for people newly diagnosed at an early stage of dementia. This is based on Alzheimer Scotland's 5 Pillars Model of Support. The service is locality-based and provides one-to-one support for up to 1 year for around 300 people.

37. A national test site has been identified in the North-East Locality (East GP Cluster). This will involve a Dementia Support facilitator based in the GP surgery. The test will last until April 2019.

38. The Partnership is developing Post Diagnosis Support training using NHS Education for Scotland's Promoting Excellence resource. This training is being piloted in Liberton Hospital.

Recommendation 7

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

40. The Partnership has employed two falls co-ordinators to focus on prevention and early intervention – addressing the vicious cycle of minor falls impacting upon an individual's confidence leading to a gradual withdrawal from an active lifestyle.

41. As part of the improvement activity, the falls co-ordinators have engaged in a host of events aimed at raising awareness of the falls pathway, which includes:
    - fracture clinic trauma practitioners and acute falls coordinators to explore opportunities to signpost people to falls prevention and management resources at their first contact with a health professional
    - training sessions with musculoskeletal physiotherapists
    - better use of capacity to identify and engage earlier to prevent falls and inactivity created from minor falls
    - localities: identified falls training needs and training sessions delivered
    - localities: developed links with voluntary sector– explored ideas for assessment, provided training to LOOPS community navigators
    - collaborating with Steady Steps programme (Edinburgh Leisure)
    - collaborating with pharmacists to improve pathway awareness and knowledge of falls service
    - engagement with partners and public for the 'Move and Improve' campaign
    - exploring the development of a 'hotspot' falls map – using locality boundaries – to prioritise training and assessments
    - planning of an extensive series of further publicity events.

Recommendation 8

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

43. Much work has been done to establish joint quality assurance systems across the Partnership. Quality Improvement Teams, with Lead Officers have been established and charged with improving the quality of service delivery. A quality dashboard has been introduced to assist the locality Quality Improvement Teams to identify possible areas for additional focus across the Partnership's services, and to report to the Quality Assurance Improvement Group, a new governance group established, which in turn will report to the Partnership's senior management team.

44. Hosted services deliver quality improvement through agreed programmes of work connected to annual Quality Improvement Plans. As part of the expansion of joint quality assurance systems, a trial is underway using Datix (NHS database) to report Significant Adverse Events, with a view to rolling this out across all Partnership care homes.

45. The Partnership now has an integrated complaints process – Datix hosted – measuring weekly performance against agreed targets. The next stage is to establish a system of learning and improvements from complaints and feedback, and to introduce a requirement that all upheld complaints have an improvement plan, which is monitored locally, with outcomes reported to the Quality Assurance Improvement Group to share learning across all services.

46. A Partnership Risk Register is under development.13 key 'joint' risks identified have been identified. Datix will be used to record and manage the Risk Register. A programme of training in the identification and management of risk is to be rolled out to locality teams. A business continuity group has been established.

47. The Partnership's Clinical Director is leading on an extensive programme of improvement across primary care. A Quality Improvement Officer has been appointed to support the cluster quality leads (GPs) in this work.

48. With the support of the NHS Lothian's Quality Academy, key Partnership staff are being trained in quality improvement. This will provide the foundation of the Partnership's 'joint' quality assurance services. The longer term intention is that a Partnership-led quality academy will be established. A programme steering group has been established to take forward the development of a partnership Quality Hub.

49. A quality improvement programme, focusing on key processes is underway in localities. This work complements the existing multi-agency quality assurance meetings for care at home and care homes.

50. The Partnership has established a Health and Safety group to monitor awareness and compliance.

51. Further work is required in this area to:
    - improve the level of self-evaluation across the Partnership
    - improve line management scrutiny of case files
    - embed a consistent mechanism for the monitoring of all quality improvement activity by the Quality Assurance and Improvement Group
    - develop a Partnership quality assurance framework

Recommendation 9

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

53. Work on updating the market-shaping strategy has yet to begin. This will be done in tandem with the development of the comprehensive strategic commissioning plans for older people, mental health, learning and physical disabilities and primary care. The strategy will reflect the transformation plan to be presented to the IJB in May 2018.

Recommendation 10

54. *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.*

55. Outline strategic commissioning plans for older people, learning disabilities, mental health and primary care have been completed, consistent with the Statement of Intent produced by

the Partnership in October 2017. These will be developed into comprehensive commissioning plans during 2018. A member of the IJB will chair the Reference Board, established to oversee this work.

Recommendation 11

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

57. The Partnership faces a very challenging financial situation, which has been reported extensively to the IJB. Many initiatives and controls have been established to ensure efficiencies and realise savings. Budget holder training has taken place in two localities and is planned for the remaining two. Financial self-assessment checklists have been sent to all Partnership senior and middle managers. The self-assessments are broken down by key activity and graded using the traffic light system. Each area is expected to be 'green' by April 2018.

58. A Savings Governance Board has been established, chaired by the Chief Finance Officer for the IJB.

Recommendation 12

59. *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.*

60. Guidance on eligibility criteria for social work and hospital-based occupational therapists has been re-issued to all staff. Locality hubs have new standard operating procedures, which are intended to improve screening and allocation. The hubs are refining their multi-disciplinary screening/triaging of individuals in need of care and support.

61. A review of access to all Partnership services is underway, which will include consideration of whether a single point for the whole city is both effective and consistent with the move to localities. Options to explore include localities acting as the gateway to all services in their area.

62. A 6-month test of change began in February, which involves alternative matching arrangements for people assessed as requiring care at home or residential/nursing care. For the test period, this will be limited to people assessed as medically fit for discharge from the Royal Infirmary of Edinburgh. If successful, the model could be rolled out across the city for everyone waiting for support.

63. Information on available services and access to these is being updated, as is communication regarding 'realistic care' to begin a conversation with stakeholders on how the impact of public services can be maximised and complemented by private, family and community contributions.

64. An assessment and review project has been established to deal with the waiting list issues affecting social work services. A senior Partnership officer is managing the project, which will operate to a 7-month timescale for reducing the wait for assessment to agreed standards.

Recommendation 13

65. *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.*

66. The assessment and review project, together with the revision of associated tools to reflect self-directed support and personalisation, and the planned roll-out of training for all assessing staff will address the backlog of assessments and reduce the risk of waits increasing again, post intervention.

67. The intention is to create a hierarchy of assessment both to speed up response times and to protect professional assessment time for complex, higher risk cases. A simplified and streamlined assessment, proportionate to the level of need being assessed is required to support the capacity of assessment teams and meet the needs of those requiring varied levels of support.

68. The Partnership is developing the use of an Indicator of Relative Need (IoRN). This is a streamlined and easy-to-use tool for assessors, which provides a summary of a person's functional needs and/or the degree of their dependence/independence. It delivers key information for frontline practice and allows effective and accurate targeting of limited resources.

Recommendation 14

69. *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.*

70. Much work has been done to improve the decision making around adult protection. Multi-agency Inter-agency Referral Discussions (IRDs) are now recorded via a digital document, known as an 'e-IRD', which allows partners to share and access information effectively. Decisions are scrutinised by a multi-agency review group to ensure vulnerable people are safe from harm, and that there is a consistency of practice across the city.

71. The review group has been tested and its remit and membership revised. It is chaired by a non-Partnership senior manager and co-chaired by a Police Scotland representative. A formal evaluation of the changes is underway. The e-IRD system has been amended to simplify recording of abuse type and client category, and all IRD reporting is now based on information extracted from the e-IRD.

72. As well as scrutinising adult protection decision-making and risk management, training and information events have been held. 5 locality-based adult support and protection workshops have been run for managers and senior social workers, focusing on practice standards, barriers to improved performance, support and expectations, thresholds, screening decisions and the need for accurate record-keeping. Direct support and input have been offered to colleagues from previous NHS Lothian roles who are now involved in overseeing adult support and protection work and participating in IRDs.

73. Monthly adult support and protection performance reports have been made available to HUB/Cluster managers and senior social workers since December 2017. This reporting will foster a closer correlation between individual practice and areas of performance. Adult protection data is now reported at the monthly locality performance board, which examines both city-wide and locality figures.

74. Two adult protection senior practitioners have been appointed and are leading the recast and re-design of the adult support and protection officer programme, to be delivered in localities. The stage 2 training will prioritise senior social workers new to the Partnership, new in post, or who need refresher training.

75. Staff responsible for adult support and protection work have all been referred to the minimum standards paper, internal guidance, and the Care Inspectorates (2016) revised guidance on chronologies. An extensive plan of continued training for all Partnership staff is being planned and will be rolled out throughout 2018.

Recommendation 15

76. *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.*

77. Despite intensive work to develop self-directed support when the Scottish Government launched its strategy, the Partnership did not promote its use during 2016 and 2017, nor finalise the necessary processes to allow it to grow as intended. This work is now being refreshed. The Thistle Foundation has been commissioned to provide staff training as part of a test of change in the North East locality; assessment tools are being redesigned to ensure they reflect the required strength-based approach and the engaging conversations needed for people to take full advantage of personalisation. In addition, the Partnership is considering ways to transform traditional models of service to free resources to provide people with the means to make genuine choices regarding how their support is designed and provided. This work will be reflected in the Partnership's development of strategic commissioning plans and in its market shaping strategy.

78. The North East locality test of change is being monitored by an implementation board. Three work streams are underway. These will develop an operating model for brokerage; design a revised budget allocation system; create a quality assurance framework; and develop the required assessment tools.

79. The opportunity to deliver more choice and control through reviews is being taken forward through a dedicated review team and by engaging service providers in the development of provider-led reviews.

80. Opportunities for early adoption and roll-out of the Thistle Foundation training are being explored to accelerate the Partnership's move to a more comprehensive implementation of self-directed support.

Recommendation 16

81. *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.*

82. The Partnership has established a strategic workforce planning group, led by the Chief Nurse. This work of the group is being tackled through 4 work streams, focused on ensuring the Partnership has the skilled workforce it needs to deliver its services; that there is sufficient succession planning; and that there is an emphasis on how the Partnership's workforce adapts to future demands. The first part of this work is focused on gathering baseline data on the Partnership's workforce (positions, skills, qualifications, etc.).

83. A short-life Agency Control Group was set up in June 2017 to address the immediate spend on agency staffing in the Partnership's care homes. The group has established checks and controls on the requirement, authorisation, and use of agency staff to supplement care home staffing. The group is tasked with considering additional mechanisms for reducing the use of agency staff and proposing alternatives to address the challenge of recruitment and absence management.

Recommendation 17

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

85. The Chief Executive of Volunteer Edinburgh is leading the work to address this recommendation. This work will be taken forward through the development of a revised volunteering strategy for the city, focused on volunteering and active citizenship.
86. Expansion of the use of the Volunteernet software (currently used to provide support for carers) has been identified as an opportunity to be explored to link volunteers and citizens requiring assistance quickly and easily.

87. A delivery group has been established to take forward the development and implementation of the Volunteering and Active Citizenship Strategy. The group first met in December 2017. The group is developing a project plan, with timescales, for consideration by the Partnership, to produce the revised strategy, and to explore existing contractual arrangements for Volunteernet software.

Key risks

89. There are risks attached to all 17 recommendations. The inspection report highlights the challenges ahead for the Partnership in its development of a financially viable, responsive range of services for Edinburgh's citizens. The overarching risk is in the scale of improvement activity required against a backdrop of significant financial pressure and high levels of unmet need.

Financial implications

90. There are significant financial implications across the 17 recommendations. Existing improvement activity is being contained within existing budgets.

Implications for Directions

91. There are no implications for Directions arising from this report.

Equalities implications

92. There are no equalities implications arising from this report. However, Integrated Impact Assessments will be undertaken in the work streams, where appropriate.

Sustainability implications

93. There are no sustainability implications arising from this report. However, Integrated Impact Assessments will be undertaken in the work streams, where appropriate.

Involving people

94. Stakeholders are involved in the development of the inspection improvement plan. Further engagement and collaboration with stakeholders, staff, and partners, including people who use health and social care services and unpaid carers will continue to be central to ensuring that the recommendations are met in full.

Impact on plans of other parties

95. There is no direct impact on the plans of other parties arising from this report. Any implications arising from the Improvement Plan for Older People will be discussed with the relevant partner organisations

Report author

Michelle Miller

Interim Chief Officer, Edinburgh Health and Social Care Partnership

Contact: Keith Dyer, Quality Assurance and Compliance Manager, Safe and Stronger Communities

E-mail: | Tel: 0131 529 6566