Notice of Meeting and Agenda

Edinburgh Integration Joint Board

9.30 am Friday 11 March 2016

Meeting Room 7/8, Waverley Gate, 2-4 Waterloo Place, Edinburgh

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This is a public meeting and members of the public are welcome to attend.

1. Welcome and Apologies

1.1 Including the order of business and any additional items of business notified to the Chair in advance.

2. Declaration of interests

2.1. Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

3. Deputations

3.1. Edinburgh Health Forum (In relation to item 5.6 – Strategic Commissioning Plan)

4. Minutes

4.1. Note of the meeting of the Edinburgh Integration Joint Board meeting of 15 January 2016 (circulated).

4.2. Matters Arising

5. Reports

5.1. Appointment of Standards Officer- report by the IJB Chief Officer (circulated)

5.2. Financial Regulations - report by the IJB Chief Officer (circulated)

5.3. Update on Financial Assurance - report by the IJB Chief Officer (circulated)

5.4. Partnership Tripartite Agreement and Interface Group - report by the IJB Chief Officer (circulated)

5.5. Rolling Actions Log (circulated)

5.6. Strategic Commissioning Plan Final Draft - report by the IJB Chief Officer (circulated)

5.7. Workforce Strategy - update - report by the IJB Chief Officer (circulated)

5.8. Hub Test of Change - report by the IJB Chief Officer (circulated)

5.9. Delayed Discharges In Edinburgh - report by the IJB Chief Officer (circulated)

5.10. GameChanger - project update - report by the IJB Chief Officer (circulated)

5.11. Hospital Plans – Presentation

5.12. Inclusive Edinburgh: Complex Care Homelessness Service Review Update - report by the Chief Social Work Officer (circulated)

5.13. Health & Social Care Population and Premises - Presentation

5.14. Sub-group updates – verbal updates

5.14.1. Audit and Risk Committee

5.14.2. Professional Advisory Group

5.14.3. Performance Sub Group

5.14.4. Strategic Planning Group

6. Any Other Business

Item 4.1 - Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 15 January 2016

Waverley Gate, Edinburgh

Present:

Board Members: George Walker (Chair), Councillor Elaine Aitken, Shulah Allan, Carl Bickler, Kay Blair, Andrew Coull, Christine Farquhar, Councillor Joan Griffiths, Councillor Ricky Henderson, Kirsten Hey, Councillor Sandy Howat, Angus McCann, Moira Pringle, Gordon Scott, Ella Simpson, Richard Williams and Councillor Norman Work.

Officers: Nikki Conway, Wendy Dale, Carol Harris, Susanne Harrison, Ian McKay, Lesley McPherson, Gavin King, Michelle Miller and Katie McWilliam.

1. Previous Minutes

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board of 20 November 2015.

2. Matters Arising

2.1 Progress with Locality Hubs

Katie McWilliam provided an update on progress with the implementation of Locality Hubs across Edinburgh. A South East Locality Hub, including implementation of referral mechanisms and pathways, had been established as a pilot. Next steps were detailed, including a roll out to other localities.

Decision

1) To include as a standing item for future Joint Board meetings.

2) To note that information on the following would be included in the next update:

   a) Case studies.
   b) Confirmation of consultation arrangements with partners.

c) Information sharing.

2.2 NHS/Council Financial Proposals

Moira Pringle tabled an update report on the potential financial settlement for the Edinburgh Integration Joint Board. This took into account the December 2015 Scottish Government budget announcement on the resources available to both the City of Edinburgh Council (CEC) and NHS Lothian. Further work would be required to quantify the full impact on the financial settlement for the Joint Board; however, it was advised that from the information currently available, significant financial challenges were expected in 2016/17 and beyond.

Decision

To include as a standing agenda item for future Joint Board meetings.

(Reference – report by the Interim Chief Finance Officer, submitted.)

3. Rolling Actions Log

The Rolling Actions Log for 15 January 2016 was presented.

Decision

To note the Rolling Actions Log and to approve the closure of items 1, 4, 5, 7, 8, 9, 11, 14, 17.1 and 17.2.

(Reference – Rolling Actions Log – 15 January 2016, submitted.)

4. Standing Orders and Code of Conduct

The Joint Board was advised that an amendment had been made by Scottish Ministers in December 2015 to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. This amendment, which related to the determination if a member, who had declared an interest, should take part in a discussion, required the alteration of the Joint Board's Standing Orders and Code of Conduct. The amended governance documentation was presented for approval.

Decision

To repeal the existing Standing Orders and Code of Conduct of the Integration Joint Board and approve in their place appendices 1-2 of the report by the Chief Officer, such repeal and approval to take effect from 1 February 2016.

(References – minute of the Integration Joint Board 17 July 2015 (item 4); report by the IJB Chief Officer, submitted.)

5. Review of Edinburgh Professional Advisory Committee

As previously requested by the Joint Board the findings of a review of the Professional Advisory Committee (PAC) was submitted. The process had included wide consultation with key stakeholders and the outcome was a recommendation that the role of the PAC was enhanced, improving and formalising the relationship with the Strategic Planning Group, and ensuring adequate resourcing of the committee.

Decision

1) To note the review of the Professional Advisory Committee (PAC) and wide consultation with key stakeholders across Health and Local Authority.

2) To agree to provide professional advice and opinion to the Edinburgh Integration Joint Board via the PAC.

3) To note the membership of the PAC.

4) To agree that the PAC should be consulted upon before any significant service redesign was implemented.

5) To agree that there would be two co-chairs, one from each of the parent professional organisations (NHS Lothian and City of Edinburgh Council) and that they should serve their three-year terms in an overlapping manner, to allow for continuity.

6) To agree that the co-chairs should have a seat on the Strategic Planning Group.

7) To acknowledge that the PAC and its office bearers would require appropriate administrative and secretarial support.

8) That the PAC would be represented on the Joint Board's Performance Group.

9) That the general issue of Joint Board support be discussed at the next meeting of pan-Lothian IJB Chairs.

(References – minute of the Integration Joint Board 17 July 2015 (item 6); report by the IJB Chief Officer, submitted.)

6. Feedback from public consultation on the Draft Strategic Plan

Feedback following the three month public consultation process on the Edinburgh Integration Joint Board Draft Strategic Plan; including specific responses, overarching themes and actions that would be taken in response to feedback; was submitted.

A total of 67 responses had been received to the consultation, 47 of which were from groups or organisations and the remaining 20 from individual members of the public.

Decision

1) To note analysis of the feedback received through the consultation on the draft strategic plan and Joint Strategic Needs Assessment (JSNA) and the proposed responses to that feedback detailed in the report and Appendix B.

2) To approve the use of Appendix B as the basis for communicating the feedback received and the actions to be taken in response to that feedback.

3) To note that the next steps were:

   a) To present a draft to the Strategic Planning Group on 29 January 2016.
   b) To present a further draft to the Joint Board Development Session on 12 February 2016.
   c) To present to the Joint Board on 11 March 2016 for sign off.

(References – minute of the Edinburgh Integration Joint Board 17 July 2015 (item 13); report by the IJB Chief Officer, submitted.)

7. IJB Structure

Decision

To note that the item had been withdrawn from the agenda.

8. Communications Resource and Strategy for Edinburgh and Lothian's Integration Joint Board (IJB)

Key communications and engagement priorities were outlined, including the establishment of a dedicated communications team to support the work of the Joint Board in Edinburgh.

Decision

1) To agree the initial communications and engagement priorities outlined in the report and the draft communications plan set out in Appendix 1. These actions would be taken forward jointly by CEC and NHS Lothian in the interim. This would include the development of a communication and engagement strategy for the Joint Board and further programme of activity for 2016/17.

2) To agree to the development of a dedicated structure and resourcing budget for a new communications team to support the Edinburgh Integrated Joint Board.

3) To ensure that sufficient links with localities existed.

4) To request further development of staff communication including:

   a) Roles and Remits of the Joint Board and Executive Team.
   b) Scope for newsletters and staff events.

(References – minute of the Edinburgh Integration Joint Board 25 September 2015 (item 12); joint report by the Chief Communications Officer, CEC, and Head of Communications, NHS Lothian, submitted.)

9. Development Sessions 2016/17

As previously requested by the Joint Board a reworked programme of topics for discussion at development sessions during 2016/17, including suggestions made by Board Members, was submitted.

Decision

1) To note the schedule of Development Sessions for 2016/17.

2) To include updates on Joint Board Structure and the Leadership Group to the 12 February 2016 Development Session.

3) To add hospital capacity as an additional topic.

4) To invite board members to submit issues regarding ICT for consideration as part of the development session scheduled for 15 April 2016.

(References – minute of the Edinburgh Integration Joint Board 20 November 2015 (item 7); report by the IJB Chief Officer, submitted.)

10. Community Planning Arrangements

Community planning arrangements within Edinburgh, and the changing statutory landscape, including the Public Bodies (Joint Working) (Scotland) Act 2014 and the Community Empowerment Act 2015, were detailed. The Joint Board was presented with options regarding how to approach its role as a statutory community planning partner.

Decision

1) To note the role of the Joint Board as a statutory partner in community planning arrangements.

2) To agree to option 2, becoming a formal member of the Edinburgh Partnership, as the way forward for supporting community planning arrangements in the city.

3) To agree to the proposals for delivery of the Community Plan outcome 'improving health and tackling health inequalities in health' in line with Strategic Plan delivery/ implementation arrangements.

4) To note that many of the wider determinants of health and health inequalities were outwith the scope of its functions and would need to be supported by all partnerships and agencies within the city.

5) To note the linkages to the wider Edinburgh Partnership local community planning and governance arrangements.

6) To request that the management/ support role associated with this work was suitably addressed through the Professional/ Technical and Administrative work stream.

(Reference – report by the IJB Chief Officer, submitted.)

11. Delayed Discharge Update

Nikki Conway (Locality Manager, South East, CEC) provided an update on Delayed Discharge.

It was advised that the winter period was the most challenging time of year with regard to delayed discharges and capacity. A number of changes had been implemented to assist with the additional pressure; this included key links between locality managers and the Western General, adjustments to support team and line management arrangements, and the placement of Service Matching Unit personnel within acute facility discharge hubs.

Efforts had also focussed on the Gylemuir House Interim Care Facility. This had included; increased Social Care resource, the introduction of a residency agreement to clearly articulate charges and length of stay; and approximately 30 additional beds, due to come online by the end of January 2016. Discussions were ongoing with Bupa regarding the purchase of the building.

Recruitment of staff to the homecare and reablement teams was also ongoing. A tender had been put out for an additional 200-250 hours per week for hospital to home services. It was expected that this would release pressure to allow for capacity reviews in other service areas to be worked through.

Decision

1) To note the update.

2) To request regular updates on delayed discharge, including relevant statistics.

12. Edinburgh Integration Joint Board (EIJB) Directions - Policy

Details were provided on a policy for making 'directions' for the carrying out of the functions delegated to the Joint Board under the Public Bodies (Joint Working) (Scotland) Act. It was advised that the policy had been prepared in the absence of any detailed guidance on the form or content of a direction from the Scottish Government.

Decision

1) To approve the proposed policy for the making of directions for 2016/17.

2) To review the approach to making directions in light of Joint Board operations at the end of 16/17 and/or any guidance issued by Scottish Government.

(Reference – report by the Integration Programme Manager, CEC, submitted.)

13. Scotland's National Dementia Awards 2015 – Edinburgh Finalists

The recent success of several Edinburgh based initiatives recognised at Scotland's National Dementia Awards 2015 was outlined. There had been four finalists from Edinburgh, with two of these being selected as winners of their category.

Decision

1) To note the recent success of Edinburgh in Scotland's Dementia Awards 2015.

2) To note the excellent examples of partnership working and significant contribution to improving services for people with dementia and their circles of support.

3) To agree that to build on this success for Edinburgh citizens, further dementia related developments be considered through the Edinburgh Integration Joint Board.

4) To congratulate the finalists on their success.

(Reference – report by the IJB Chief Officer, submitted.)

14. Any Other Business

14.1 Joint Board Committee and Sub-Groups

The Chair advised that, in addition to the Professional Advisory and Strategic Planning groups, a Performance Sub-group would be established. Shulah Allan would chair this group and it would be operational from 1 April 2016. Two

workshops had been scheduled in advance of this date to progress meeting arrangements.

As previously agreed an Audit and Risk Committee would be established. This would be chaired by Angus McCann and the membership would consist of representatives from the Council, NHS Lothian and key stakeholders. This was also scheduled to be operational from 1 April 2016 onwards. Further information would be shared with Committee members in the coming weeks.

It was not envisaged that any additional groups would be formed and regular meetings between the four sub-group chairs would be organised.

Decision

1) To note the update and agree that regular updates would be provided to the Joint Board.

2) To note that further discussions would take place regarding the reporting of Quality Assurance.

(Reference – minute of the Edinburgh Integration Joint Board 20 November 2015 (item 9))

14.2 Standing items

Decision

To note that the following would be considered as standing items going forward:

a) Locality Hubs.
b) Delayed Discharge – including relevant statistics.
c) Finance update.
d) Sub-group/Committee updates.

Item No. 5.1

Report

Appointment of Standards Officer

Edinburgh Integration Joint Board

11 March 2016

Executive Summary

1. The Ethical Standards in Public Life (Scotland) Act 2000 (Register of Interests) Regulations 2003 requires the Integration Joint Board (IJB) to appoint a Standards Officer. This officer is responsible for advising and guiding members of the Board on issues of conduct and propriety. The Standards Officer will also act as the liaison officer between the IJB and the Standards Commission. The Standards Commission will also be required to endorse any appointment and guidance is awaited on the mechanism to do so.

Recommendations

2. To appoint Gavin King, Committee Services Manager, the City of Edinburgh Council as the Standards Officer for the Edinburgh Integration Joint Board.

Background

3. The Ethical Standards in Public Life (Scotland) Act 2000 (Register of Interests) Regulations 2003 requires the Integration Joint Board (IJB) to appoint a Standards Officer.

4. The Standards Commission is an independent body whose responsibility is to encourage high ethical standards in public life. It does this through the publication and enforcement of Codes of Conduct.

5. The Commissioner for Ethical Standards in Public Life in Scotland investigates complaints about the conduct of MSPs, local authority councillors and members of public bodies. The Commissioner also monitors how people are appointed to the boards of specified public bodies.

Main report

6. The Standards Commission has recently provided guidance on the role of a Standards Officer. The following was highlighted as a duty or responsibility:

6.1. Ensuring appropriate training is provided to Board members on the Ethical Standards Framework and the Code of Conduct.

6.2. Contribute to the promotion and maintenance of high standards of conduct by providing advice and support to members.

6.3. Ensuring the IJB keeps a Register of Interest and a Gifts and Hospitality Register.

6.4. Ensure there is a consistent approach to obtaining and recording declarations of interest.

6.5. An investigative role if local resolution is appropriate in respect of complaints or concerns made about a Member's conduct.

6.6. Report to the IJB when necessary on the Code of Conduct.

6.7. Act as the principal liaison officer with the Standards Commission.,

6.8. Act as the principal liaison officer with the Commissioner for Ethical Standards in Public Life in Scotland and assist where necessary in connection with the investigation of complaints against a Member.

7. The Standards Commission has confirmed that it will be required to endorse any appointment of a Standards Officer by the IJB and it is currently consulting with the Scottish Government on the mechanism to do so.

8. In the meantime The Standards Commission has indicated that an officer should be identified to fulfil for the IJB the functions described at paragraphs 6.1-6.8. It is therefore recommended that the IJB appoint a Standards Officer. The Standards Commission will consider and, subject to being content, ratify the appointment following confirmation of the process from the Scottish Government.

Key risks

9. Elements of the work of the Standards Officer are requirements of the Ethical Standards in Public Life (Scotland) Act 2000. The IJB and its members are required to comply with this legislation.

Financial implications

10. There are no financial implications as a result of this report.

Involving people

11. The Standards Commission recommends that Standards Officers develop relationships with other Standards Officers to share knowledge, experience and information.

Background reading/references

Ethical Standards in Public Life (Scotland) Act 2000
The Ethical Standards in Public Life (Scotland) Act 2000 (Register of Interests) Regulations 2003
Standards Commission for Scotland (website)

Report author

Rob McCulloch-Graham

Chief Officer

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Links to priorities in strategic plan

Item No. 5.2

Report

Financial Regulations

Edinburgh Integration Joint Board

11th March 2016

Executive Summary

1. The Integration Joint Board (IJB) is required to adopt a set of financial regulations; these define the financial roles and outline the financial governance for the IJB.

2. Draft regulations are attached at Appendix 1.

Recommendations

3. It is recommended that the Committee:

   - adopt the financial regulations as laid out in Appendix I: and
   - delegate the responsibility for preparing the directives and instruction (to support the regulations) to the Interim Chief Finance Officer.

Background

4. A key element of financial governance is a clear set of financial regulations.

5. Section 95 of the Local Government (Scotland) Act 1973, requires all Integration Joint Boards (IJB) in Scotland to have adequate systems and controls in place to ensure the "proper administration of their financial affairs", including the appointment of an officer with full responsibility for their governance. These financial regulations detail the responsibilities of the Chief Finance Officer who has been appointed as the "proper officer" along with the responsibilities of the Chief Officer and members of the IJB.

6. A proposed draft is attached as Appendix 1 to this report.

7. It should be noted that the IJB does not employ any staff nor does it have a bank account.

8. These regulations will be supported by a series of financial directives and instructions which are at a more operational level. It is proposed that the responsibility for producing the directives be delegated to the Interim Chief Finance Officer.

9. The IJB may revise the financial regulations at any time but any changes must be approved by the IJB.

Key risks

10. The key risk is that, without a clear set of financial regulations, there is a lack of clarity about roles and responsibilities.

11. A clear agreed approach as outlined in this paper will help mitigate this risk.

Financial implications

12. As set out in the main body of the report.

Involving people

13. The successful implementation of these recommendations will require the support and co-operation of both CEC and NHSL personnel.

Impact on plans of other parties

14. As above.

Background reading/references

15. None.

Report author

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Links to priorities in strategic plan

Managing our resources effectively

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Financial Regulations Summary

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1. DEFINITIONS AND INTERPRETATION

1.1. "**1973 Act**" means the Local Government (Scotland) Act 1973;

"**Act**" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"**Chief Finance Officer**" means the Chief Finance Officer of the Board appointed by the Board in terms of section 95 of the 1973 Act;

"**Chief Officer**" means the Chief Officer of the Board appointed by the Board in terms of s10 of the Act;

"**Council**" means City of Edinburgh Council;

"**IJB**" means the Integration Joint Board;

"**Integrated budget**" means the integrated budget of the IJB set in accordance with the provisions of the Integration Scheme;

"**Integration Scheme**" means the Integration Scheme between the parties approved by the Scottish Ministers;

"**NHS**" means Lothian Health Board;

"**Parties**" means the Council and the NHS (and "party" means either of them); and

"**Strategic plan**" means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services to adults and children in accordance with section 29 of the Act.

1.2. Words in these financial regulations that are also used in the IJB's other governing documents shall, where possible, have the same meanings as they have in those other governing documents.

2. SCOPE AND OBSERVANCE

2.1. The IJB is a legal entity in its own right created by Parliamentary Order 2015 No 88 The Public Bodies (Joint Working) (Board Establishment) (Scotland) Order 2015 which came into effect on 1 April 2015 following Ministerial approval of the Integration Scheme.

2.2. The IJB is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a function of management and, therefore, a responsibility is placed upon the appointed members and officers of the IJB. In particular:

(1) NHS (Financial Provisions) (Scotland) Regulations 1974 require NHS Directors of Finance to design, implement and supervise systems of financial control and NHS circular 1974 (GEN) 88 requires the Director of Finance to:

- approve the financial systems;
- approve the duties of officers operating these systems; and
- maintain a written description of such approved financial systems including a list of specific duties.

(2) Section 95 of the 1973 Act requires that every local authority shall make arrangements for the proper administration of its financial affairs and shall secure that the proper officer of the authority has responsibility for the administration of those affairs.

2.3. All members of the IJB (voting and non-voting) have a duty to abide by the highest standards of probity in dealing with financial issues. This is achieved by ensuring everybody is clear about the standards to which they are working and the controls in place to ensure these standards are met.

2.4. The key controls and control objectives for financial management standards are:

(1) the promotion of the highest standards of financial management by the IJB;

(2) a monitoring system to review compliance with the financial regulations;

(3) comparisons of actual and forward projection of financial performance with planned/budgeted performance that are reported to the IJB; and

(4) the IJB Audit and Risk Committee fulfilling its duties under its terms of reference.

2.5. Prior to any funding being passed by one of the parties to the IJB as part of the integrated budget, the financial regulations or standing financial instructions of the relevant party will apply. Similarly, once funding has been approved from the integrated budget by the IJB and directed by it to the Council or the NHS for the purposes of service delivery, the standing financial instructions or financial regulations of the relevant party will then apply to the directed sum, which will be utilised in accordance with the priorities determined by the IJB in its strategic plan.

2.6. The IJB has been delegated the responsibility for delivering a set of health and social care functions by the City of Edinburgh Council and NHS Lothian. These functions are laid out in the IJB's Integration Scheme. The City of Edinburgh Council and NHS Lothian will provide financial resources in respect of these functions to the IJB.

2.7. The IJB will issue directions to the Council and to the Health Board in relation to the delivery of the delegated functions. The Council and the Health Board in following these directions shall ensure that their own financial regulations are fully observed. This is explicit in the directions that are issued by the IJB.

2.8. The IJB will not deliver any of the delegated functions itself, all operational delivery for delegated functions will be provided by either the City of Edinburgh Council or NHS Lothian as directed by the IJB.

2.9. The IJB will ensure that only expenditure within the legal powers of the IJB is incurred or directed to be incurred. Where this is not clear, the IJB will consult the Chief Finance Officer prior to incurring such expenditure. Similarly, the legality of expenditure relating to new service developments, initial contributions to other organisations and responses to new emergency situations will also be clarified prior to any related expenditure being incurred.

3. FRAMEWORK FOR FINANCIAL ADMINISTRATION

3.1. The financial regulations detail the responsibilities of all members of the IJB. They may only be amended by the IJB.

3.2. The Chief Finance Officer as the 'proper officer' for the administration of the IJB's financial affairs will oversee the operation of the financial regulations within the IJB and will provide to the Chief Officer and the other members of the IJB a written framework which governs the IJB's financial affairs. The framework will consist of:

- **Financial directives** - These will cover all relevant aspects of financial administration and the Chief Finance Officer will have the delegated authority to alter the financial directives except for any matters which are covered by the financial regulations where IJB's approval will be required. Changes to the financial directives will be reported to the IJB's Audit and Risk Committee for their endorsement; and

- **Financial guidance notes** - These guidance notes will provide the IJB with detailed guidance and advice on specific procedures to be followed and any such guidance notes issued will require the prior approval of the Chief Finance Officer.

3.3. All financial directives and guidance notes issued in terms of these financial regulations are issued with the same status and authority as if they were contained within these financial regulations.

4. INTEGRATION JOINT BOARD RESPONSIBILITIES

4.1. The Integration Scheme sets out the detail of the integration arrangements agreed between the parties in accordance with the Act.

4.2. The IJB and its officers (Chief Officer and Chief Finance Officer) will continuously strive to secure best value and economy, efficiency, and effectiveness in their use of resources.

Responsibility of the IJB

4.3. The IJB is responsible for the production of the strategic plan, setting out the needs, priorities and services for its population over the medium term (3 years), including:

- the payment from the Council to the IJB for delegated social care services;
- the payment from the NHS to the IJB for delegated primary and community healthcare services; and
- the amount set aside by the NHS for delegated services.

Responsibility of the Chief Officer

4.4. The Chief Officer will provide a strategic leadership role as principal advisor to, and officer of, the IJB and will be a member of the senior management teams of the parties. The Chief Officer will lead the development and delivery of the strategic plan for the IJB and will be accountable to the IJB for the content of the directions issued to the parties by the IJB and for monitoring compliance by the parties with directions issued by the IJB.

4.5. The Chief Officer is the accountable officer of the Board in all matters except finance. The Chief Officer will discharge his/her duties in respect of the delegated resources by:

- ensuring that the strategic plan meets the requirement for economy, efficiency and effectiveness in the use of the IJB resources; and
- giving directions to the NHS and the Council that are designed to ensure resources are spent according to the strategic plan. It is the responsibility of the Chief Officer to ensure that the provisions of the directions enable the parties to discharge their responsibilities with regard to the provisions of the directions.

Responsibility of the Chief Finance Officer

4.6. Subject to the overarching responsibility of the IJB, the Chief Finance Officer will be responsible for overseeing the IJB's financial and budgetary arrangements.

4.7. The Chief Finance Officer will undertake the role as laid out in S95 of the 1973 Local Government (Scotland) Act and shall make arrangements for the proper administration of

the IJB's financial affairs and, as the proper officer of the IJB, have responsibility for the administration of those affairs. The Chief Finance officer will discharge this duty by:

- establishing financial governance systems for the proper use of delegated resources;
- ensuring that the strategic plan meets the requirement for best value in the use of the IJB's resources; and
- ensuring that the directions to the Council and NHS require that the financial resources are spent according to the allocations in the strategic plan.

4.8. The Chief Finance Officer, in consultation with the Chief Officer, will advise the IJB and all its committees on the financial implications of the IJB's activities.

5. FINANCIAL MANAGEMENT

5.1. The responsibilities of the IJB and its committees in relation to the conduct of the IJB's financial affairs are defined in the IJB's Standing Orders and Integration Scheme. In summary they are as follows.

IJB

5.2. The IJB, on recommendations of the Chief Officer and the Chief Finance officer will approve all revenue budgets.

Chief Officer and Chief Finance Officer

5.3. These officers will:

- develop and implement an operational policy within the IJB's approved budget and strategic policy framework;
- provide the IJB with appropriate financial assurance to allow the IJB to accept the opening and future years' budgets allocated by the Council and NHS;
- consider and recommend to the IJB for approval all revenue budgets and no expenditure can be authorised unless provided for in approved estimates. These estimates will be clearly detailed in the directions issued to the Council and the Health Board

and neither of these parties may expend more that the approved estimate without the specific approval of the IJB; and

- monitor the overall financial performance of the IJB's functions (as directed to either the Council or the Health Board) in relation to the approved revenue budgets. The Chief Finance Officer will provide to the IJB regular budget monitoring reports along with explanations for any significant variances from budget and the remedial action planned.

6. FINANCIAL PLANNING

Strategic Plan

6.1. The IJB is responsible for the production of the strategic plan, setting out the needs, priorities and services for its population over the medium term (3 years). This should include a financial plan for the resources within the scope of the strategic plan, incorporating:

- the integrated budget – aggregate of payments to the IJB; and

- the notional budget – the amount set aside by the NHS for delegated set aside services.

6.2. The NHS and the Council should provide indicative three year rolling funding allocations to the Board to support the strategic plan and the medium term financial planning process such indicative allocations would remain subject to annual approval by both parties.

6.3. It is the responsibility of the Chief Officer and the Chief Finance Officer to develop a draft integrated budget based on the strategic plan and to present this to the parties for consideration and agreement within each party's budget setting process.

Budgetary Control

6.4. It is the responsibility of the Chief Finance Officer to report regularly and timeously on all budgetary control matters, comparing projected outturn with the approved financial plan to the IJB and other bodies as designated by the NHS and the Council in the Integration Scheme.

6.5. The Director of Finance of the NHS and the Chief Financial Officer (section 95 officer) of the Council shall, along with the Chief Finance Officer put in place a system of the budgetary control which will provide the Chief Officer with management accounting information for both arms of the operational budget and for the IJB in aggregate.

6.6. It is the responsibility of the IJB Chief Finance Officer, in consultation with the Director of Finance of the NHS and the Chief Financial Officer (section 95 officer) of Council, to agree a consistent basis and timetable for the preparation and reporting of management accounting information.

Management of budget variances

6.7. The Integration Scheme lays out the arrangement for the management of variances within the IJB's operational budget, that is the resources that have been allocated by the Council and NHS to undertake the functions delegated. The Chief Officer and the Chief Finance Officer will prepare and present to the IJB arrangements for the financial management of these variances. This will be laid out in the financial directives.

Reports to the IJB

6.8. All reports to the IJB and any committees thereof must specifically identify the extent of any financial implications. These must have been discussed and agreed with the Chief Finance Officer prior to lodging of reports.

Legality of Expenditure

6.9. It is the duty of the Chief Officer to ensure that no expenditure is incurred, or included within the Strategic Plan, unless it is within the legal powers of the IJB. In cases of doubt the Chief Officer should consult the respective legal advisors of the NHS and the Council before incurring expenditure. Expenditure on new service developments, initial contributions to other organisations and responses to new emergency situations which require expenditure, must be clarified as to legality prior to being incurred.

Management of Reserves

6.10. Legislation empowers the IJB to hold reserves, which should be accounted for in the financial accounts and records of the IJB.

6.11. The Chief Finance Officer will prepare a policy to hold and manage any such reserves which will be presented to the IJB for approval..

Accounting Procedures and Records

6.12. The IJB's accounting policies are governed by the appropriate local government Acts as directed and amended by Scottish Ministers.

6.13. All accounting procedures and records of the Board shall be determined by the Chief Finance Officer in consultation with the Director of Finance or equivalent of the relevant party.

6.14. Legislation provides that the Board is subject to the audit and accounts provision of a body under section 106 of the 1973 Act. This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations - section 12 of the Local Government in Scotland Act 2003 and regulations under section 105 of the 1973 Act. These will be proportionate to the limited number of transactions of the Board whilst complying with the requirement for transparency and true and fair reporting in the public sector.

6.15. The accounting records of the IJB will be held by City of Edinburgh Council on behalf of the IJB.

7. INTERNAL AUDIT

7.1. A Chief Internal Auditor will be appointed by the IJB. The Council and NHS will support the Chief Internal Auditor as they require per the Integration Scheme:

- The Chief Internal Auditor will report to the IJB's Audit and Risk Committee;
- The internal audit service will undertake work in compliance with the Public Sector Internal Audit Standards;
- The Chief Internal Auditor will at the start of each financial year prepare an annual strategic risk based audit plan for the IJB and submit this for approval to the IJB's Audit and Risk Committee;
- The Chief Internal Auditor will submit an annual audit report summarising the work undertaken during the

year and provide an opinion on the adequacy of risk management, governance and internal controls. This will be presented to the Chief Officer and the IJB's Audit and Risk Committee;

- All internal audit reports for the IJB will be presented to the Chief Officer and the IJB's Audit and Risk Committee; and

- The Chief Internal Auditor, or their appointed representative (on production of identification), will have authority (as defined in the Audit Charter) to access any data held on any site by either the City of Edinburgh Council or NHS Lothian that relates to the functions delegated to the IJB through the Integration Scheme.

8. RISK MANAGEMENT AND INSURANCE

Audit and Risk Committee

8.1. The purpose of the Audit and Risk Committee is to provide assurance to the IJB of the adequacy of the risk management framework and the internal control environment. It provides independent review of the IJB's governance, risk management and control frameworks and oversees the financial reporting and annual governance processes. It oversees internal and external audit, helping to ensure efficient and effective assurance arrangements are in place:

- The Audit and Risk Committee will endorse the annual Internal Audit Plan, and receive regular reports on these in accordance with the Internal Audit Reporting Calendar;

- The committee will receive and review reports from the Chief Internal Auditor on audit activity and results of reviews;

- The committee will review the risk register on a regular basis;

- The committee will promote sound corporate governance, management of risk, and a robust internal control environment;

- The annual accounts of the IJB will be presented to the committee for review prior to the presentation to the IJB;

- The committee will consider reports by the IJB's external auditors, including reports on the audited annual accounts; and

- The committee will review and approve the Annual Governance Statement which will be presented for approval to the IJB.

Risk

8.2. The Chief Officer will be responsible for establishing the IJB's risk strategy and profile and developing the risk reporting arrangements, including a risk register. The risk management strategy will be approved by the IJB and reviewed by the IJB Audit and Risk Committee.

Insurance

8.3. The IJB will join the NHS CNORIS scheme which will provide the IJB with the appropriate insurance cover. This insurance scheme will only cover the IJB, its professional advisors and Council or NHS officers who have been requested by the IJB to provide specific advice or services to the IJB. NHS Lothian and City of Edinburgh Council in delivering functions as directed by the IJB will ensure that the appropriate clinical and liability insurance is in place.

9. STRATEGIC PLANNING GROUP

9.1. The IJB will set up a Strategic Planning Group which will prepare a strategic plan as directed by the 2014 Public Bodies (Joint Working) Act and subsequent regulations;

9.2. This Strategic Plan will include a financial plan (and any other financial information as directed by regulations). The Chief Finance Officer will support the production of this financial plan in line with these financial regulations; and

9.3. The IJB will approve the Strategic Plan and the resources committed by it to delivering the functions delegated to the IJB as laid out in the Integration Scheme.

Directions to the Council and to the Health Board

9.4. The Public Bodies (Joint Working) Act 2014 lays out in sections 27 to 28 that an IJB will give directions to a constituent authority to carry out the functions delegated to

that IJB. The provenance for these directions being the IJB's agreed strategic plan. Directions must specify the payment to be made (or the element of the set aside budget to be used as appropriate) and to regulate the manner in which the function is carried out:

- The IJB will agree a policy and a format for directions made as above;
- Directions will flow from the IJB's approved strategic plan;
- Directions will be authorised by the Chief Officer or, in the absence of the Chief Officer by the Chief Finance Officer; and
- All directions will be reported to the IJB at least annually.

10. DELEGATED AUTHORITY

10.1. Through its directions to the Council and the Health Board (as appropriate), the IJB will delegate financial resources for the delivery of the delegated functions. The Council and the Health Board will apply their own financial regulations as part of the undertaking of any direction issued by the IJB.

10.2. The Council and the Health Board may not, without the specific approval of the Chief Finance officer vire funds between individual directions unless there is a specific protocol for financial risk management agreed as part of the direction.

10.3. If a protocol for financial risk management is drawn up between the IJB and the Council or the Health Board (as appropriate) and/or between the IJB and other IJBs, then this will be agreed by the IJB prior to the direction being issued.

11. CORPORATE GOVERNANCE

11.1. The public sector has adopted corporate governance principles which, in the context of an IJB, are about how it conducts its business and relates to its community. Corporate governance is about openness, integrity and accountability.

11.2. The six principles of Corporate Governance are:

- Focusing on the purpose of the IJB and on outcomes for the community and creating and implementing a vision for the area;
- Members and officers of the IJB working together to achieve a common purpose with clearly defined functions and roles;
- Promoting values for the IJB and demonstrating the values of good governance through upholding high standards of conduct and behaviour;
- Taking informed and transparent decisions which are subject to effective scrutiny and managing risk;
- Developing the capacity and capability of members and officers to be effective; and
- Engaging with local people and other stakeholders to ensure robust public accountability.

11.3. The IJB is expected to demonstrate that its local Code of Corporate Governance is available to be viewed by all stakeholders, partners and members of the public. Audit Scotland expects the IJB to have robust corporate governance procedures in place. A code of corporate governance will be prepared and agreed by the IJB.

11.4. The Local Code of Corporate Governance is approved by the IJB and scrutinised by the Audit Committee. The IJB will receive an annual report from the Chief Officer on compliance with the Code and whenever the Code requires to be updated.

11.5. The annual report coincides with the publication of the annual accounts and performance information, which will include an annual governance statement, signed by the Chief Officer and the Chair of the of the IJB.

11.6. The basis of the annual governance statement will be an overview and opinion on the IJB's arrangements contained in the approved Local Code.

11.7. The IJB will submit an annual performance report every year as laid out in regulations. This will be prepared by the Chief Officer and presented to the IJB for approval prior to submission.

12. ECONOMY, EFFECIENCY AND EFFECTIVENESS (BEST VALUE)

12.1. The Chief Officer will ensure that arrangements are in place to maintain control and clear public accountability over the public funds delegated to the IJB. This will apply in respect of:

- the resources delegated to the IJB by the Council and the NHS; and
- the resources paid to the Council and the NHS by the IJB for use as directed and set out in the strategic plan.

12.2. The IJB has a duty to put in place proper arrangements for securing best value in the use of resources and delivery of services. There will be a process of strategic planning with full Board member involvement, in order to establish the systematic identification of priorities and realisation of best value in the delivery of services. It is the responsibility of the Chief Officer to deliver the arrangements put in place to secure best value and to co-ordinate policy in regard to ensuring that the IJB provides best value.

12.3. The IJB will follow best practice principles as set out in the Code of Guidance on Funding External Bodies and Following the Public Pound and this will be incorporated into the directions made by the Integration Joint Board.

13. OBSERVANCE OF FINANCIAL REGULATIONS

Responsibility of Chief Officer and Chief Finance Officer

13.1. It is the duty of the Chief Officer, assisted by the Chief Finance Officer, to ensure that these financial regulations are made known to the appropriate persons within the IJB and the partnership and to ensure that they are adhered to.

Breach of Regulations

13.2. A breach of these financial regulations must be reported immediately to the Chief Officer, who may then discuss the matter with the NHS's Chief Executive, the Council's Chief Executive or another nominated or authorised person as appropriate to decide what action to take.

Review of Financial Regulations

13.3. These financial regulations shall be the subject of regular review by the Chief Finance Officer, and where necessary, subsequent adjustments will be submitted to the IJB for approval.

Item No. 5.3

Report

Update on Financial Assurance

Edinburgh Integration Joint Board

11 March 2016

Executive Summary

1. Indicative budget propositions have been received from both the City of Edinburgh Council (CEC) and NHS Lothian (NHSL). Neither partner is yet in a position to make a final offer therefore it is not possible at this time to give the Edinburgh Integration Joint Board (IJB) comprehensive assurance about the opening budget for 2016/17.

2. Based on the information available the draft IJB budget will be £574.4m with a savings target of £32.4m.

Recommendations

3. It is recommended that the Board:

- note the contents of this report;
- agree to proceed based on the draft budget outlined in this paper; and
- receive the full due diligence report following receipt of final budget settlements from CEC and NHSL.

Background

4. On 1 April 2016 financial resources will be formally delegated to the IJB by the City of Edinburgh Council and NHS Lothian to support the implementation of the IJB's strategic plan. These resources are formally accepted by the IJB following a formal process of financial assurance.

5. Both CEC and NHSL have made interim or draft offers to the IJB and financial assurance work has been undertaken in parallel. However, at the time of writing, the IJB has received neither a formal offer from either party nor all the necessary information to complete the due diligence process.

6. Officers of the IJB, supported by the Chair, have been working closely with both parties and, whilst further work is required to complete the assurance process, no material issues have been identified to date.

7. It is therefore proposed that the IJB proceed on the basis of the draft budgets received to date. The full due diligence report will be presented to the Board when final offers have been received from CEC and NHSL.

Main report

Financial Models

8. The Integration Scheme lays out the functions that have been delegated to the IJB. There are 4 component parts to the resources that support these delegated functions (the IJB's 'budget'):

(i) The CEC budgets for adult health and social care;

(ii) The core NHS budgets for the community health partnership (including general medical services (GMS) and prescribing);

(iii) A share of the budgets of the NHS Lothian 'hosted services' (services delivered on a pan Lothian basis) that have been delegated to the IJB; and

(iv) A share of the acute services budgets for those functions that are delegated to the IJBs.

9. The proposed settlements for 2016/17 are summarised in table 1 below and discussed in paragraphs 10 to 20 below. The opening budget for the IJB would be £575m, comprising a "payment" of £485m with a further £89m set aside by NHSL.

	£k
City of Edinburgh Council	184,766
NHS Lothian core and hosted	280,231
Social Care Fund	20,180
Subtotal	**485,177**
NHS Lothian set aside	89,387
Total	**574,564**

Table 1: Indicative opening 2016/17 budget for Edinburgh IJB

City of Edinburgh Council

10. CEC agreed a 4 year budget framework on 21 January 2016. This required savings of £148m to be generated across all council departments and made limited provision for investments.

11. Following this a draft offer was made to the IJB, which is summarised in table 2 below and attached at Appendix 1.

	Income £k	Exp £k	Net £k
Brought forward from 15/16	**188,133**	**195,133**	**(7,000)**
Financial framework adjustment	7,000		7,000
Inflationary increases	4,651	4,651	
Increases in cost (demography)		5,853	(5,853)
Savings target	(15,018)		(15,018)
Net budget change	**(3,367)**	**10,504**	**(13,871)**
2016/17 forecast	**184,766**	**205,637**	**(20,871)**

Table 2: forecast implications of CEC financial settlement

12. Although the CEC proposal totalled £190.7m it should be noted that this assumed a contribution of £5.9m from the Social Care Fund, which is discussed in more detail in paragraphs 23 to 25 below. As this decision is within the remit of the IJB, this has been adjusted to give a total funding allocation from CEC of £184.8m.

13. Against this funding, the projected costs for 2016/17 have been modelled, giving a resultant funding gap of £20.9m. This in turn can be considered as having 2 component parts: £15.0m which represents the IJB share of the CEC wide savings target and a potential demography pressure of £5.9m.

14. Obtaining reassurance through the due diligence process that the £205.6m accurately represents the total forecast cost for 16/17 is key to being in a position to confirm that this budget should be accepted by the IJB. It is anticipated that this information will be available shortly.

NHS Lothian

15. The NHS Lothian financial planning process is not yet completed. Draft financial plans have been presented to the Finance and Resource Committees and the NHS Board but, a significant financial gap remains and a series of further financial risks yet to be quantified. The latest version shows an overall gap for 2016/17 of £108m against which uplifts totalling £35.7m are applied to give a net position of £87.0m. NHS Lothian is working with its management teams to prepare recovery plans to address this shortfall but do not currently have sufficient confidence that these plans will deliver the full required savings. This position was confirmed in a paper to the NHS Lothian Board meeting of 3 January 2016 which indicated that it would not have a balanced financial plan by 1April 2016 and therefore any allocations of resource to the IJB for 16/17 would therefore be indicative.

16. That said, NHS Lothian has written to the IJB proposing a model to set the IJB's budget. This letter is attached (Appendix 2) and the implications for the Edinburgh IJB are summarised in table 3 below:

	Income £k	Expenditure £k	Net £k
Brought forward from 15/16	**364,581**	**373,427**	0
Uplift from financial plan	5,037		5,037
Inflationary increases		13,607	(22,454)
Net budget change	**5,037**	**22,454**	**(17,417)**
2016/17 forecast	**369,618**	**387,035**	**(17,417)**

Table 3: forecast implications of NHSL financial settlement

17. The net impact for the IJB is a savings target of £17.4m, £12.1m of which relates to core and hosted services with the balance of £5.3m to be delivered against set aside.

18. In the proposition, NHS Lothian included: details of the model they are proposing to use to generate the IJB budgets; and a suggested methodology for applying their £35.7m uplift across business units. Of these, the allocation of uplift is the main issue which remains outstanding.

19. Another area of ongoing dialogue is between the 4 Lothian IJBs who are discussing a potential risk sharing arrangement for prescribing.

20. Finally, it should be noted that NHS Lothian is in the process of updating it's financial plan, as a consequence the numbers previously presented to IJBs will change, potentially materially.

Savings

21. Based on the numbers above, savings of £32.4m must be delivered against the delegated services, these are summarised in table 4 below:

	£k
CEC	(15,018)
NHS Lothian	
Core & hosted	(12,074)
Set aside	(5,341)
Total	**(32,433)**

Table 4: Savings target 2016/17

22. Initial assessments have been undertaken with the next stage being to work up detailed proposals. The IJB Executive team, supported by programme management resource, will drive delivery of the Health and Social Care Partnership's element of the savings programme. An early indication of the extent to which the savings are deliverable will be a key factor in determining the application of the social care fund discussed below.

Social Care Fund

23. The new social care fund is a crucial element of the IJB financial plan. A fund of £250m to enhance social care will be passed to the NHS for onward distribution to IJBs. The use of this fund is laid out in the formal offer letter to Scottish Local

Authorities dated 27th January from Mr John Swinney. The £250m is to be considered in two parts:

- *'£125 million is provided to support additional spend on expanding social care to support the objectives of integration, including through making progress on charging thresholds for all non-residential services to address poverty. This additionality reflects the need to expand capacity to accommodate growth in demand for services as a consequence of demographic change'*
- *'£125 million is provided to help meet a range of existing costs faced by local authorities in the delivery of effective and high quality health and social care services in the context of reducing budgets. This includes our joint aspiration to deliver the Living Wage for all social care workers as a key step in improving the quality of social care.'*

24. Edinburgh's share of the fund is £20.2m and further work is required to accurately quantify the commitments in line with the guidance but an indicative position is given in table 5 below:

	Growth £k	Pressures £k
Available funding	**10,090**	**10,090**
Demography	(5,853)	
Charging thresholds	(522)	
Living wage		(7,000)
Potential commitments	**(6,375)**	**(7,000)**
Balance	**3,715**	**3,090**

Table 5: Potential Application of the social care fund

25. As discussed previously, work is progressing to fully identify the required level of savings against the IJB budget. Until this exercise is concluded and the risk associated with delivery is clear, it would be prudent to not make any commitments against the balance of this funding. A proposal on utilisation of the social care fund will be presented to the IJB in due course.

Conclusions from financial assurance

26. Given that the proposed budget allocations from both partners have yet to be finalised it is not possible at this point to complete the financial assurance process. Further, as NHS Lothian are not yet in a position to agree a balanced budget for next financial year it is unlikely that the IJB will have a confirmed budget at 1st April. However it should be noted that dialogue to date with both parties has been positive.

Key risks

27. Until final budget propositions are received from both CEC and NHS Lothian there is a risk that the draft opening budget for the IJB will be subject to change.

28. Risks inherent in the settlements include prescribing and full delivery of savings.

Financial implications

29. As set out in the main body of the report.

Involving people

30. The successful implementation of these recommendations will require the support and co-operation of both CEC and NHSL personnel.

Impact on plans of other parties

31. As above.

Background reading/references

32. None.

Report author

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Links to priorities in strategic plan

Managing our resources effectively

IJB - Draft Financial Allocation from City of Edinburgh Council 2016/17 (Subject to Due Diligence)

	Delegated to IJB £000	Notes
Approved Budget 2015/16	**187,091**	Areas not delegated are Business and Support Services; Property; Criminal Justice
In-Year Budget Adjustments	1,042	Allocation of confirmed uplifts for pay awards, pensions, etc.
Revised Budget 2015/16	**188,133**	
Changes in Budget Framework 2016/17:		
Additional Funding Contribution to Address Budget Pressures	**7,000**	**Additional Council contribution to offset projected 15/16 financial deficit.**
Pay Award	843	1% assumed
Purchasing Inflation	853	Includes provision for New Living Wage (£8.25) in Care at Home Contract
Care Home Fees Inflation	1,355	Provision in line with national contracts negotiated through COSLA
Legislative Change - Loss of Existing National Insurance Rebate	1,600	Indicative allocation
Provision for Additional Costs of Health and Social Care in 2016/17	**4,651**	
Demographic Provision	5,900	CEC budget assumes contribution from additional £250m
Provision for Additional Capacity to Respond to Change and Demand	**5,900**	
Total Additional Funding assumed in CEC Budget	**17,551**	
Updated Budget Baseline 2016/17	**205,684**	
Approved Savings	-15,018	
Approved Budget 2016/17	**190,666**	Assumes £5.9m to be provided through £250m
Year-on-year increase in resource allocation	1.3%	Compares to reduction of 6.8% for other CEC services
Savings as a proportion of revised expenditure baseline	-7.3%	Compares to savings of 11.2% for other CEC services

Lothian NHS Board

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Dear Colleague

RESOURCE ALLOCATION TO THE INTEGRATED JOINT BOARD (IJB) IN RELATION TO FUNCTIONS DELEGATED BY NHS LOTHIAN

The Integration Scheme for each IJB lays out that financial resources to deliver the functions delegated (I have referred to these as 'budgets' below) will be allocated to the IJB. There have been a series of discussions and papers laying out the options for translating existing CHP budgets into IJB budgets and for determining the distribution of the set aside Acute budget. The purpose of this letter is to set out NHS Lothian's formal budget allocation proposal for IJB consideration. The letter also sets out a proposal for 16/17 uplift on these budgets following the Spending Review and current thinking on NRAC.

NHS Lothian are not able to make a final financial proposal at this time as further work is required to fully understand the impact of the Scottish Government's recent budget announcements on the resources available to the Board. For example, the Scottish Government has indicated a 7.5% reduction in the funding for the 'bundles' and we are still establishing how this will impact on your IJB. In addition this proposal is also subject to consideration of the proposals from all our Council partners.

To support this we have developed a set of underlying principles, key of which is the equitable distribution of the financial challenge across the full range of NHS services.

The resultant proposal for apportioning budgets and allocating uplift is summarised in sections 1 to 4 below:

1. Core Services (Specific IJB services and GMS budgets)

The budgets that are held for the services that represent functions delegated to the IJBs by NHS Lothian are held at cost centre level and a detailed model has been developed to allocate these budgets by cost centre to the IJBs. This model will be agreed by the Chief Officers on behalf of the IJB and will be distributed to the Chief Officers separately. These cost centres will be allocated to IJBs based on the historic core budgets held by the CHPs

2. GP Prescribing budgets

It is proposed to allocate the current prescribing budget for NHS Lothian across the 4 IJBs using the Prescribing Budget setting model. The PBSG model is specifically designed for GP Prescribing and is based at GP Practice level. I appreciate that the IJBs may wish to continue with the current risk sharing model but this will be a matter for IJBs.

3. Share of pan-Lothian Services (Hosted and Set Aside)

It is proposed to allocate budgets for services that represent functions delegated to the IJBs by NHS Lothian currently managed on a pan-Lothian basis on a PCNRAC basis with certain exceptions as appropriate. The detail associated with this is attached as an Appendix 1 to this letter.

A summary of the opening budget for 16/17 for each IJB, based on these proposals is attached as Appendix II. These budgets are prior to any uplift for 16/17.

Turning to the proposal for uplift there are 4 elements to this: pay and price uplift, NRAC, Social Care funding, and efficiency savings.

4. 2016/17

1. Pay and Prices - The general uplift of 1.7% available to NHS Lothian in 2016/17 is calculated on NHS Lothian's baseline funding of £1.2bn and therefore equates to circa 1. 4% when shared across all budget. It is proposed that this is distributed on a pro rata basis with the exception of GMS which receives a separate nationally determined uplift.

2. NRAC - There are currently 2 options being considered by NHS Lothian for the distribution of the NRAC allocation of £14m. The discussion at our meeting on the 8 January with Chairs, Chief Officers, and section 95 officers concluded that NRAC should be allocated across all Acute budgets. Since then further consideration has been given to the pressure across all drugs budgets and the use of NRAC to partially address this. Given that the NRAC allocation for NHS Lothian is still subject to the final approval of the Spending Review no formal proposal is being made to the IJBs at this stage.

3. Social Care Fund - It is proposed to distribute this Fund as directed by the Scottish Government. In addition the Delayed Discharge step up will be distributed to the IJBs on the same basis as the original allocation.

4. Efficiency Schemes - CHPs have been provided with a summary financial plan for 16/17 which identifies the forecast cost pressures within their services for 16/17. Chief Officers in their capacity as managers of NHS Lothian services have been asked to develop financial recovery plans to demonstrate how financial balance can be achieved for these services. For this reason each IJB has a specific savings target for their service. Once plans are agreed this may result in the reallocation of budgets to reflect the consequent service change. This will be agreed with IJBs.

The NHS Lothian Board will be considering the draft Financial Plan at its Board Meeting on 3 February and so a response to this proposal prior to then is required. Of course I am happy to meet and discuss this proposal.

I am copying this letter to my Council partners and would be grateful for details on their proposals to the IJB.

Yours sincerely

Susan Goldsmith
Director of Finance

Circulation :
To Chairs of East Lothian, Midlothian, Edinburgh and West Lothian Integration Joint Boards

Copies to Chief Officers and Chief Financial officers of East Lothian, Midlothian, Edinburgh and West Lothian Integration Joint Boards

IJB Allocation Table As agreed at F&R December 2015 **Appendix 1**

Area	Description	Allocation Split	East Lothian %	Edinburgh %	Mid Lothian %	West Lothian %	Acute Non Delegated %
Core Services							
The share of the core services is 100% to the specific IJB with the following exceptions:							
Exceptions:							
	Lothian Memory Treatment Clinic	PC NRAC (Traditional)	12.64	56.04	10.44	20.88	0.00
	E And M School Nurses/HPV Inoculation	East and Mid Split	50.00	0.00	50.00	0.00	0.00
	Community Equipment Store and Continence Service	Edinburgh, East and Mid	15.19	72.15	12.66	0.00	0.00
	Prescribing	PBSG	13.00	54.00	11.10	21.90	0.00
Hosted							
The share of the hosted services based on PCNRAC(Traditional) with the following exceptions							
Exceptions:							
	Edinburgh Mental Health and Psychology Services	All in Edinburgh	0.00	100.00	0.00	0.00	0.00
	West Lothian Mental Health and Psychology Services	All in West	0.00	0.00	0.00	100.00	0.00
	East & Mid Psychology Services	East and Mid Split	50.00	0.00	50.00	0.00	0.00
	Liberton Hospital	Liberton	4.40	71.20	22.40	2.00	0.00
	REH - Adult Psy beds	REH - Adult Psy beds	10.00	80.00	10.00	0.00	0.00
	VO - Children And young People	East and Mid Split	50.00	0.00	50.00	0.00	0.00
	Change Fund reserve	ICF	12.36	57.52	10.11	20.01	0.00
Acute - Set Aside			0.00	0.00	0.00	0.00	0.00
The share of the hosted services based on PCNRAC(Traditional) with the following exceptions							
Exceptions:							
	Cardiology and Respiratory	Cardiology (non Lothian)	8.00	37.80	6.60	13.90	33.70
	RIE Emergency Department	ED @ RIE	14.80	57.50	15.70	2.50	9.50
	St John's Emergency Department	ED @ St. John's	0.30	7.20	0.30	85.00	7.20
	Adult Therapy Service	Edinburgh, East and Mid	15.19	72.15	12.66	0.00	0.00
	RIE & WGH Metabolic Diseases	Endocrinology (non Lothian)	8.90	42.20	7.40	15.60	25.90
	WGH Infection Diseases	Infectious Diseases (non Lothian)	11.00	52.00	9.10	19.20	8.70
	Liberton Hospital	Liberton	4.40	71.20	22.40	2.00	0.00
	WGH ARAU	WGH ARAU	20.60	62.90	16.50	0.00	0.00
Note:		PC NRAC (Traditional)	12.64	56.04	10.44	20.88	0.00

NHS LOTHIAN DRAFT FINANCIAL PLAN 2016/17 based on Allocation Table **Appendix 2**

	Total	East Lothian IJB	Edinburgh IJB	Mid Lothian IJB	West Lothian IJB	Not Delegated	
						Acute Budget	Other Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Delegated							
Core	423,047	67,777	218,820	49,974	86,476		
Hosted	90,248	9,783	57,592	8,718	14,155		
Set Aside	153,773	19,011	88,169	17,738	28,855		
Total Delegated	**667,068**	**96,571**	**364,581**	**76,430**	**129,486**		
Non Delegated							
Hosted	5,030						5,030
CHP	36,057						36,057
Acute	463,042					463,042	
Corporate	299,303						299,303
Total Non Delegated	**803,432**					**463,042**	**340,390**
Total Potential Budget	**1,470,500**	**96,571**	**364,581**	**76,430**	**129,486**	**463,042**	**340,390**

Item No. 5.4

Report

Partnership Tripartite Agreement and Interface Group Edinburgh Integration Joint Board

11 March 2016

Executive Summary

1. This report outlines a proposed approach for the parties who comprise the Edinburgh Health and Social Care Partnership to work together to deliver operationally on the statutory requirements of integration.

2. It proposes:

    - some key principles for joint working at all levels in the Partnership in a Tripartite Agreement; and
    - an 'Interface Group' for the three parties to come together informally to discuss financial, operational and risk matters which impact on the Partnership.

Recommendations

3. It is recommended that the Edinburgh Integration Joint Board (EIJB):
    - agrees to the proposed Tripartite Agreement as a statement of principle and intention for joint working;
    - agrees to the purpose, remit and membership of the Interface Group; and
    - agrees that the Interface Group will be reviewed after one year.

Background

4. The Edinburgh Health and Social Care Partnership comprises of EIJB, NHS Lothian (NHSL) and the City of Edinburgh Council (the Council). The Integration Scheme, which is a legal document, sets out roles, responsibilities and expectations for the three parties under the new statutory arrangements.

5. In summary, the Council and NHSL will set the budget for the EIJB each year. The EIJB will direct the Council and NHSL to deliver services in line with its

Strategic Plan. NHSL and the Council will deliver on these directions and have already agreed to do so through an integrated management structure.

6. The effect of the legislation and the integrated management structure means that the three parties will now share responsibility and accountability for delivering the integration functions, with each party responsible for different but interwoven aspects of funding, governing, planning, directing, delivering and monitoring/reporting on performance.

7. Additional complexity comes in the form of; the 'set-aside' budget for functions which will be delivered through hospital sites; interim management arrangements for mental health functions pending the re-provision of The Royal Edinburgh Hospital; and high demand for services at a time of severe financial constraint.

8. This is a complex and demanding arrangement, across a very wide range of services that are being brought together in this way for the first time. The Chief Officer's role is to steer a course through this complexity, however, in reality this must be a coordinated approach from all three parties as expected by the policy aspirations of the legislation.

Main report

9. The establishment of the EIJB and all that this has entailed has been governed by a Joint Leadership Group of Council and NHSL leaders. From the 1 April, subject to approval of the EIJB Strategic Plan, the EIJB will be fully operational and have functions delegated to it. As agreed, the Joint Leadership Group will stand down at this point; its task completed.

10. The EIJB will take over responsibility for planning, directing, resourcing and overseeing the delivery of the functions. The Council and NHS Lothian will remain responsible for setting the EIJB budget and for the operational delivery in line with directions.

11. Given these demanding arrangements, the senior leaders across all three parties are clear that it will be helpful to establish and agree 'working principles' and to facilitate regular discussion of relevant financial and operational matters between all three parties so that the complexity can be well managed.

12. This is particularly so for the first year of Partnership when a number of major changes are being rolled out; for example the issuing of directions for the first time, managing the 'joint' budget and managing the risks of embedding an integrated management structure.

13. To that end, the Chair of the EIJB, the Chair of NHS Lothian and the Leader of the Council jointly propose the following:

Tripartite Agreement

14. A Tripartite Agreement: this sets out the working principles for behaviour across all three parties. This supports the description of roles and responsibilities within the Integration Scheme by describing expected behaviours and will help to continue to build trust and ensure safe and effective service delivery. The draft is provided in Appendix 1.

Interface Group

15. An informal 'Interface Group': this has a legitimate remit to discuss ongoing financial and operational matters which require senior leadership input, such as the impact of major demand pressures on future years' budgets, operational responses to directions and the management of risk across the three parties.

16. The group is intended to facilitate discussion to support the Chief Officer to steer a course through the complexity. It has no formal role. Formal roles are set out in statute and in the Integration Scheme. The group will be chaired by the Chair of the IJB.

17. The proposed purpose, remit and membership are outlined in Appendix 2 and will be reviewed after one year.

Key risks

18. The roles of the relevant parties within the partnership are clearly spelled out in the Integration Scheme. In reality, the effect of these roles and responsibilities is that all three parties now share responsibility and risk for the integration functions.

19. The national Audit Scotland report on integration authorities highlights that ''there is a risk that the complex interrelationship between IJBs, Councils and NHS Boards will get in the way of clear lines of accountability. The key to this is clear roles and responsibilities''.

20. While roles and responsibilities are clear in the Integration Scheme, it is likely that there will be a transition period during which the new arrangements are embedded and tested. The Interface Group will provide a regular opportunity for discussion to ensure a common understanding.

Financial implications

21. There are no financial implications arising from this report.

Involving people

22. This is an informal group to support open dialogue between the three parties. Relevant colleagues have been consulted.

Impact on plans of other parties

23. The Interface Group will be a regular informal mechanism whereby senior leaders across the three parties can discuss and understand the implications of proposed changes, directions and financial position and other matters to ensure impacts across the organisations are raised and examined.

24. It will be the role of the Chief Executives of NHS Lothian and Council to share, as appropriate through their normal mechanisms, any issues which require a specific response from the NHS Board or Council.

Background reading/ References/ Appendices

Appendix 1: Tripartite Agreement
Appendix 2: Partnership Interface Group: Draft Purpose, Remit and Membership

Report author

Rob McCulloch-Graham

Chief Officer

Edinburgh Integration Joint Board

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Links to priorities in Strategic Plan

Appendix 1:

Tripartite Agreement between Edinburgh Integration Joint Board (EIJB), NHS Lothian and City of Edinburgh Council

This tripartite agreement sets out the principles by which the above parties intend to operate for the safe, effective and efficient delivery of delegated health and social care functions for the people of Edinburgh to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

It is intended to:

- support the Integration Scheme, which sets out the arrangements for the establishment of the EIJB and roles and responsibilities with regards to the Public Bodies (Joint Working) (Scotland) Act 2014;
- describe a way of working between all parties which recognises that they now share duties, powers, responsibility and risks in relation to the delegated functions;
- ensure compliance with the statutory regulations and guidance (such as the National Outcomes and the Integration Planning Principles) in the spirit, as well as the letter, of the law; and
- ensure open lines of communication and dialogue.

The Edinburgh Integration Joint Board, City of Edinburgh Council and NHS Lothian will:

- Develop a unity of direction and purpose for the delegated services, led by the EIJB and delivered through Chief Officer.

- Be transparent in their operations - for example in relation to appropriate decision-making, financial management, resource deployment and performance/delivery of outcomes;

- Abide by the Integration Planning Principles and in particular, deliver services in an integrated way which maximises the benefit to people who use them, for example through co-location of staff, integrated management, virtual teams;

- Share sovereignty, according to statutory roles and responsibilities, in a way which maximises the benefits to people who use our services;

- Innovate and test alternative models of service delivery and be responsive to feedback and learning from a wide range of stakeholders, including staff and people who use our services;

- Raise risks and issues in a timely manner and manage risks in a way which is shared appropriately between the parties;

- Provide professional, technical and administrative support in a coordinated way which supports streamlined operation of the integrated arrangements;

- Escalate concerns or issues, where there is potential for dispute or negative impact on service, through the Interface Group in the first instance, prior to initiating the Dispute Resolution Process outlined in the Integration Scheme.

Signed by Chair of Edinburgh Integration Joint Board

Date:

Print: George Walker

Signed by Chief Officer of Edinburgh Integration Joint Board

Date:

Print: Rob McCulloch-Graham

Signed by Chief Executive of City of Edinburgh Council

Date:

Print: Andrew Kerr

Signed by Chief Executive of NHS Lothian

Date:

Print: Tim Davidson

Appendix 2:
Edinburgh Health and Social Care Partnership Interface Group
(Draft for Approval)

Context

The leadership arrangements set up to establish the Integration Joint Board will stand down from 1 April 2016 following delegation of functions.

The Council's Internal Audit report in August 2015 noted the need for a group to replace the Leadership Group which allowed for the parties to have open dialogue when necessary and for a clear remit to be developed.

Furthermore, the Audit Scotland report: Health and Social Care Integration , published in December 2015, recommends that parties set out clearly how governance arrangements will work in practice particularly when disagreements arise, to minimise the risk of confusing lines of accountability and to ensure constructive working relationships exist between all parties, Chief Officer and Chief Finance officer.

The remit is drafted on the basis of legitimate discussions that can take place between the 3 constituent parties within the new legislative framework which also acknowledges that all three parties now share powers, responsibility and risk for the delegated functions.

This group does not have a formal governance role and the legislative role of the EIJB is not affected.

Purpose of the Group

- To ensure open dialogue between the constituent parties of the Health and Social Care Partnership i.e. NHS Lothian, City of Edinburgh Council and the Edinburgh Integration Joint Board during the first year of the Integration Joint Board.

Remit

- To discuss financial matters in relation to future years' budget setting;
- To discuss and mitigate financial and other risks to the operation of the EIJB and associated Health and Social Care Partnership;
- To discuss and resolve any delivery issues in relation to EIJB directions; for example, where proposals exist to commission or decommission in new/different ways (overspends and under spends);
- To provide a first point of discussion on any operational matters in relation to directions which may need to be addressed jointly by the parties; and
- To provide the first point of discussion to avoid formal dispute mechanisms as outlined in the Integration Scheme.

Proposed membership
Chair of the Edinburgh IJB (Chair of Interface Group)
Vice Chair of Edinburgh IJB
Chief Executive of Council
Chief Executive of NHS Lothian

Chief Officer or Health and Social Care Partnership
Director of Finance, NHS Lothian
Council S95 Officer – Head of Finance
Integration Joint Board S95 Officer – Chief Finance Officer
Others as required

Frequency (during 16/17)

- This group would commence when the Integration Leadership Group stands down in April 2016.
- Quarterly, linked to financial reporting regimes, with a minimum one per year prior to budget setting in relation to mid year forecast (for example)
- It may be necessary to call at short notice if required to avoid any emerging disputes
- Purpose, remit and frequency to be reviewed in April 16/17.

Operation

The group will:

- ensure that the Edinburgh Integration Scheme is supported; and
- abide by the principles of the Integration Tripartite Agreement.

Item 5.5 – Rolling Actions Log – March 2016

11 March 2016

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	**Transition Funding**	17/07/15	Update on Scottish Government funding to be circulated.	Chief Officer	When available.	
2	**Visits to Establishments**	17/07/15 and 25/09/15	Further information on visit options – including visits to acute facilities.	Chief Officer	12 February 2016	A list is currently being finalised and will be presented to the next Development Session.
3	**Deputations**	20/11/15	1) To agree to pilot deputations at the Joint Board and its committees for twelve months using the procedure outlined in appendix one of the report. 2) To note that following the pilot period, a report reviewing the procedure would be submitted to the Joint Board. 3) To note that the scope for deputations would be made available as part of the forthcoming communications strategy	Chief Officer/Gavin King	November 2016	
4	**Finance**	17/07/15	1) Further report on outcome of Internal Audit Teams work on due diligence. 2) To report on a budget consultation strategy as part of the	Hugh Dunn / Susan Goldsmith	Not specified.	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			2016/17 budget process.			
5	**Performance Sub-Group**	20/11/15	To request that the Sub-Group provide regular updates to the Joint Board.	Shulah Allan	Ongoing	
6	**Governance Arrangements, Capacity and Infrastructure**	25/09/15	1) To request further information on activity within hospital teams to support effective patient discharge 2) To agree to receive further information on the ongoing review of Council Occupational Therapist services.	Chief Officer	Not specified	
7	**Gamechanger – Public Social Partnership** **Development Sessions 2016/17**	25/09/15 15/01/16	1) To consider future options at a development session, to include localities and inequalities issues, and links with the draft Strategic Plan. 2) To include updates on Joint Board Structure and the Leadership Group to the 12 February 2016 Development Session. 3) To add hospital capacity as an additional topic.	Chief Officer	Not specified 12 February 2016	
8	**Financial Assurance for the IJB**	25/09/15	1) That the 11 December 2015 development session would focus on the budgets being delegated to the EIJB. 2) To agree to consider Finance at the December 2015 development session, alongside the draft Strategic Plan. 3) To request further information on the decision making process regarding the £1.1m reduction in mental health nursing spend.	Interim Management Team/ Moira Pringle	December 2015	decisions (1) and (2) reported to Joint Board on 15/01/16
9	**Information, Communication and Digital**	25/09/15	1) To note the current position on information governance and that a further report would be provided in due course. 2) To invite the Council's ICT Solutions Team and NHS Lothian	Interim Programme Manager/ Angus McCann	Not specified	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
	Technology: Position Statement		e-Health services to review and comment jointly on the Draft Strategic Plan as part of the consultation. 3) To request that an appropriate approach be developed for ensuring that information governance and ICDT requirements could be considered for all major service/pathway re-design proposals to ensure improved information flows along the pathway. 4) To request that appropriate and affordable ICDT delivery/implementation plan(s) were developed in relation to these service/pathway re-design proposals 5) To use a future development session to address current issues, including shared protocols, and future development, and to ask Angus McCann to act as the Joint Board's member lead on this.			
10	**New Grant Programme for Prevention of Health Inequality from 2016/17**	25/09/15	To consider grants at the Joint Board meeting in February 2016 for grants starting in April 2016, with a phased approach aligned to partner funding cycles	Chief Officer	March 2016	Grants approved at the Health, Social Care and Housing Committee on 26 January, will be report to the IJB in due course.
11	**Progress with Locality Hubs**	15/01/16	To note that information on the following would be included in the next update: • Case studies. • Confirmation of consultation arrangements with partners	Chief Officer	March 2016	
12	**Review of Edinburgh Professional Advisory Committee**	15/01/16	That the general issue of Joint Board support be discussed at the next meeting of pan-Lothian IJB chairs.	IJB Chair	January 2016	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
13	**Communications Resource and Strategy for Edinburgh and Lothian's IJB**	15/01/16	1) To agree the initial communications and engagement priorities outlined in the report and draft communications plan. This would include the development of a communication and engagement strategy for the Joint Board and further programme of activity for 2016/17. 2) To agree to the development of a dedicated structure and resourcing budget for a new communications team to support the Edinburgh Integrated Joint Board. 3) To ensure that sufficient links with localities existed 4) To request further development of staff communication including: • Roles and Remits of the Joint Board and Executive Team. • Scope for newsletters and staff events.	Chief Officer/ Head of Communications (CEC and NHS)	Not specified	
14	**Community Planning Arrangements**	15/01/16	1) To agree to option 2, becoming a formal member of the Edinburgh Partnership, as the way forward for supporting community planning arrangements in the city. 2) To request that the management/ support role associated with this work was suitably addressed through the Professional/ Technical and Administrative work stream.	Chief Officer	Not specified	
15	**EIJB Directions Policy**	15/01/16	To review the approach to making directions in light of Joint Board operations at the end of 16/17 or any guidance issued by Scottish Government.	Chief Officer	April 2017	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
16	**Standing Items**	15/01/16	To establish the following as standing items: • Locality Hubs • Delayed Discharge • Finance • Sub-group/Committee updates	Chief Officer	March 2016	

Item No. 5.6

Report

Final draft of the Strategic Plan for Health and Social Care Integration Joint Board

11 March 2016

Executive Summary

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Edinburgh Integration Joint Board to produce a strategic plan setting out how the health and social care services, delegated by the City of Edinburgh Council and NHS Lothian, should be delivered, in order to achieve the National Health and Wellbeing Outcomes. The plan must be approved and published by the Board before services can be delegated from 1 April 2016.

1.2 This report seeks the approval of the Integration Joint Board for the final draft of the strategic plan attached as Appendix A.

Recommendations

2.1 The Integration Joint Board is asked to:

- Approve the final draft of the strategic plan attached as Appendix A for publication as the Strategic Plan for Health and Social Care in Edinburgh 2016 – 19.

Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on the Edinburgh Integration Joint Board, along with Integration Authorities elsewhere to:

- produce a strategic plan dividing the city into at least two localities and setting out how the health and social care services delegated by the City of Edinburgh Council and NHS Lothian should be delivered, in order to achieve the National Health and Wellbeing Outcomes
- establish a Strategic Planning Group to ensure the involvement of key stakeholders in the development of the plan

- invite the Council and NHS Lothian to comment on the plan following consultation with the Strategic Planning Group and prior to the final version of the plan being published

3.2 The plan must be approved by the Integration Joint Board before services can be delegated by the City of Edinburgh Council and NHS Lothian. Once approved the plan must be published.

3.3 The published strategic plan provides the basis for directions that may be issued on behalf of the Integration Joint Board to NHS Lothian and/or the City of Edinburgh Council setting out how services should be delivered.

Main report

4.1 The Edinburgh Shadow Health and Social Care Partnership established a Shadow Strategic Planning Group in February 2015 in order to allow work to commence on the strategic plan prior to the Integration Joint Board being formally established. Staff from the Council and NHS Lothian have worked in collaboration with the Strategic Planning Group to produce both the first draft of the strategic plan approved by the Integration Joint Board as the basis for consultation in July 2015 and the final draft of the plan attached as Appendix A.

4.2 The first draft of the strategic plan set out the vision and priorities of the Integration Joint Board together with details of high level actions to be taken to deliver both the priorities within the plan and the National Health and Wellbeing Outcomes. This version of the plan was subject to a period of three months public consultation between August and October 2015. The feedback received through this consultation and the proposed response was the subject of a report to the Integration Joint Board in January 2016.

4.3 A second draft of the strategic plan was produced and considered in detail by the Strategic Planning Group on 29 January 2016. Following this the City of Edinburgh Council and NHS Lothian were invited to comment on the second draft of the plan.

4.4 The Strategic Planning Committee of NHS Lothian considered the strategic plan on 11 March 2016 and provided a formal response attached as Appendix C. The Committee:

- welcomed the six priorities, twelve areas of focus and direction of travel set out in the plan
- gave positive feedback about specific actions such as the development of the locality hubs, the proposal to develop alternative models of care to support frail older people at home and in care homes and the aim of developing a single model for acute unscheduled care services across the city

- expressed disappointment that the commissioning of care at home on a locality basis will not take place until October 2016
- suggested that there should be further consideration within the plan to building capacity to support older people with learning disabilities and with profound and multiple needs
- expressed the desire to see more detail about: the future accommodation profile of Hospital based Complex Clinical Care; work to support phase 1 of the Royal Edinburgh Hospital reprovision and improved access to psychological therapies; financial recovery and savings plans and changes required to "set aside" acute services and mental health services hosted by NHS Lothian

4.5 The Corporate Policy and Strategy Committee of Edinburgh Council considered the strategic plan on 23 February 2016 and approved the response attached as Appendix D. The Committee:

- welcomed the six priorities, twelve areas of focus and direction of travel set out in the plan
- welcomed the move to locality working whilst seeking reassurance that the approach being taken should complement rather than duplicate that being taken by the Council
- gave positive feedback about the commitment to work with community planning partners to tackle inequalities and the approach to supporting people with long term conditions
- expressed the desire to see:
  - more reference to working with other parts of the Council such as community safety and children and families to provide reassurance that the integration of health and social care will not simply result in a different set of silos
  - more detailed plans for the implementation of the proposals to improve services for frail older people and those with dementia to give confidence that these will proceed at pace
  - the financial plan for the Integration Joint Board once this is available
  - more case studies demonstrating the impact that the Integration Joint Board expects their plan to have on citizens

4.6 Where possible the final version of the plan takes account of the comments received from the Council and NHS Lothian. Where more detailed information has been requested this will be shared with both organisations once it becomes available.

4.7 An Integrated Impact Assessment has been undertaken in respect of the plan and the following recommendations made:

- Greater emphasis should be placed on understanding the issues for minority ethnic communities, including refugees and asylum seekers through the development of the Joint Strategic Needs Assessment.
- Equitable access to information should be ensured by taking account of literacy, disability and language barriers in the design of material to support people and through the provision of interpreting and translation services
- The impact of redesigned services on vulnerable groups should be monitored through the integrated performance framework
- The Integrated workforce strategy and plan should include cultural competency around all aspects of equality and diversity and the use of tools such as “Teach Back” to support staff in the delivery of high quality person centred care and enable the “good conversations” that will underpin this. Raising awareness of issues such as Fuel poverty and welfare reform and enabling access to existing training on health promotion should be encouraged (e.g. Alcohol Brief Interventions) to equip staff with the knowledge and approaches to support individuals appropriately
- Links between the Health and Social Care Partnership and other sections of the Council such as Criminal Justice, Homelessness and Children and Families should be maintained and strengthened
- At locality level, links with Neighbourhood Partnerships should be strengthened to address the wider influences on health including community safety, transport and housing

4.8 Following approval of the final version of the strategic plan by the Integration Joint Board the Chief Officer will determine those aspects of the plan that will require the development of directions.

Key risks

If the strategic plan is not approved by the Integration Joint Board prior to 1 April 2016 the timescales set out within the legislation will not be met and functions and services cannot be delegated to the Board.

The challenging financial position detailed in the strategic plan may make it difficult to implement some proposed actions. Actions will therefore need to be reviewed once the financial plan is completed and prioritised to make most effective use of resources.

Financial implications

The strategic plan sets out the current assumptions in relation to the overall size of the budget to be delegated to the Integration Joint Board and the anticipated level of efficiencies required.

Involving people

The strategic plan has been produced in collaboration with the Strategic Planning Group, membership of which includes citizens with lived experience of using health and social care services and unpaid carers. The first draft of the plan was subject to a period of three months public consultation.

Impact on plans of other parties

The draft strategic plan has been shared with the other Health and Social Care Partnerships in Lothian and both NHS Lothian and the Council have been invited to comment on the second draft of the plan prior to it being finalised for consideration by the Integration Joint Board.

Background reading/references

Public Bodies (Joint Working) (Scotland) Act 2014

National Health and Wellbeing Outcomes

First draft of the strategic plan report to the IJB July 2015

Feedback from consultation on the strategic plan report to IJB January 2016

Appendices

Appendix A – final draft strategic plan

Appendix B – appendices to the strategic plan

Appendix C – formal response from NHS Lothian

Appendix D – formal response from the City of Edinburgh Council

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Links to priorities in strategic plan

Edinburgh Health and Social Care

Strategic Plan

2016 – 19

Final draft

for approval by Edinburgh Integration Joint Board

March 2016

Contents

1. Foreword by the Chair and Vice-chair of the Integration Joint Board

We are delighted to introduce this first Strategic Plan for Health and Social Care, setting out the priorities and actions we need to pursue to achieve our shared vision for a caring, healthier, safer Edinburgh. We are embarking on an exciting journey to ensure we make best use of our joint resources through reshaping services with and around people and communities. The plan introduces four new locality hubs for Edinburgh. We believe this will bring services closer to people in their homes and local communities where possible. It will allow us to deliver more joined up care and support, use resources more effectively and achieve better outcomes for people.

Edinburgh's population of almost half a million, accounts for 9% of the total population of Scotland and is projected to increase faster than any other area of the country; with a higher rate of growth in some age groups than others. Whilst this growth has many social and economic advantages, it also presents challenges. Although a relatively affluent city, Edinburgh has areas of significant inequality and 'deprivation' and one of our key priorities will be to lead, where possible, on tackling health and social inequalities.

A great opportunity now exists to plan and deliver joined up services both at a local level and city-wide. More integrated working through four aligned geographical localities has been agreed across the public sector in Edinburgh, including the Council, NHS, Police and Fire and Rescue services and by the third sector. Locality working will be able to take account of variations in need, foster improved relationships and understanding and build on the existing strengths and opportunities in local communities.

At the heart of our plan is the development of a new relationship between citizens and communities, our services and staff and the many organisations who contribute to encouraging, supporting and maintaining the health and wellbeing of the people of Edinburgh. We want to ensure that people are at the centre of our plans, are supported to live independently by being enabled to look after themselves at home, but can also access the right care and support when needed.

The financial environment is challenging for local authorities and health boards, so we have to do better with limited funds. Over the next five years, the City Council must reduce its operating costs by £148 million, while Lothian Health Board needs to make efficiency savings of circa £40m year-on-year to re-invest in services to meet changing needs. The Partnership itself has to identify efficiencies of £26 million in 2016/17. This makes the current way of doing things unsustainable and requires a fundamental re-think of how we work together. We need to use public money, our skilled staff teams, the capacity and capability of the third, independent and housing sectors and of people and communities, to support better health and social care outcomes across the City.

The first draft of our strategic plan was consulted on during 2015. It was high level, focusing on the key priorities and seeking views on the actions and approach we should take to reshaping services. in developing our plan for the next 3 years we have listened to the views expressed through the consultation events and to the feedback of those who use our services, our staff and others who provide care, including unpaid carers and community groups.

This final plan builds on our vision and the six priorities which were endorsed through the consultation. It sets out the actions we plan to take to transform the health and care landscape in Edinburgh for all our benefit. Many of the changes we propose will take time to fully deliver, but some improvements will be seen quickly. We are keen to make progress and have already put in place devolved management arrangements to enable staff and citizens to work together more effectively in the four localities.

As Chair and Vice Chair of the Board overseeing the Edinburgh Health and Social Care Partnership, we look forward to working with all those who use services, those who provide services and local communities to take the vital steps needed to redesign and reshape your services to deliver the caring, healthier, safer Edinburgh we all want to see.

George Walker

Chair of the
Edinburgh Integration
Joint Board

Ricky Henderson

Vice Chair of the
Edinburgh Integration
Joint Board

2. Executive summary

In line with Scottish Government legislation the Edinburgh Integration Joint Board was formally established in July 2015, with responsibility for planning the future direction and overseeing the integration of health and social care services for the citizens of Edinburgh through the Edinburgh Health and Social Care Partnership.

The Board is responsible for a health and social care budget of £575 million from April 2016, delegated from NHS Lothian and the City of Edinburgh Council, which funds community health and social care services, including GP practices and also some elements of acute hospital services. This Strategic Plan sets out how services will be developed and changed over the three years from April 2016 using the resources available to meet the changing needs of the population and achieve better outcomes for people.

The Integration Joint Board intends to deliver its vision for a Caring, Healthier, Safer Edinburgh through taking actions to transform how Council and NHS services and staff teams work together, with other partners, those who use services and communities. The diagram on page 17 summarises the changes we want to make and where we want to be by 2020.

The partnership faces a number of challenges including the growing population, more people living with long term and complex conditions and a very difficult financial climate for the foreseeable future. The six key priorities identified in the plan are linked and equally important, focusing on: identifying those at risk; preventing avoidable ill-health; providing timely and appropriate interventions which promote recovery; using resources and the capacity of all partners effectively. This plan sets out the 12 areas where we intend to focus efforts to deliver change and the actions planned in each, to help achieve these priorities. The Housing Contribution Statement attached as Appendix G sets out the significant role of housing partners across the city in supporting Strategic Plan priorities. This includes the commitment by the Council and its housing association partners to build 16,000 affordable and low cost homes over the next ten years. The Council's housing strategy will aim to commit up to £300 million of this investment to delivering around 3,000 affordable homes and integrated health, care and support services which opens up significant opportunities to take forward collaborative and innovative approaches to delivering services.

Achieving Integration at Locality Level

An immediate action is to shift planning and delivery of services to as local a level as possible, adopting four common geographic boundaries across the city with Community Planning partners and taking account of the 12 existing neighbourhood partnerships.

Locality management is being put in place for the majority of Health and Social Care services and collaborative working arrangements will be established with the third and independent sectors, housing providers, local communities, unpaid carer and service user representatives. Locality hubs and GP practice clusters will manage the transition of patients between communities and hospital and integrate longer term care around individual needs.

Tackling Inequalities

Taking action to identify those experiencing poorer health outcomes and address the barriers they face will in turn help us manage the increasing demand for health and social care services. We will review with community planning partners and local communities our current plans and determine our future approach. Specific actions will be set out in the locality plans we will develop during 2016/17.

Consolidating our approach to prevention and early intervention

The Christie Commission suggested that at least 40% of public service spend in Scotland was on issues that could have been prevented by taking action earlier. Our locality focus will include establishing links with community resources and assets to ensure people have the opportunity to access preventative opportunities which will help them keep themselves as fit and healthy as possible. Helping people build and maintain social networks, preventing falls, increasing physical activity, supporting unpaid carers and intervening early when long term conditions develop are key components of our approach.

Ensuring a sustainable model of primary care

Maintaining a robust primary care system of GP practices and other community staff providing universal first line healthcare is crucial to ensure everyone can access the health services they need. However, there are both workload and workforce challenges to be addressed. We will plan further development of core GP practice capacity, including buildings, to meet the needs of the growing population of the city. The partnership will work with GP practices and other staff groups like nurses and pharmacists to explore newer ways of working. Our locality hub and clusters model will provide alternatives to hospital admission and better care transitions to support the shift in the balance of care we want to see from hospitals to community.

Improving care and support for frail older people and those with dementia

We want to shift the balance of care so that more frail older people can be supported to live as independently as possible at home

or in a community setting. We know that early intervention and specialist advice can address concerns quickly and return people to more independent living. Our starting point will be to review both the need for different bed-based and community care services and capacity across the system. We also aim to improve the pathway for people with dementia by working with hospital teams and our locality hubs to support more personalised care and support in all settings.

Transforming services for people with disabilities

The Partnership will continue to develop models that help people with learning disabilities, autism, physical disabilities and sensory impairments live more independent lives. Working with NHS Lothian we will modernise learning disability hospital facilities and develop support services in the community which prevent admission to hospital. Services for people with physical disabilities and care pathways for progressive neurological conditions will be redesigned through a joint strategy focused on rehabilitation and greater community support. Accessible housing options for people with disabilities will be explored through the process of the city housing strategy. A business case to re-provide specialist and complex rehabilitation services from the Astley Ainslie Hospital to the Royal Edinburgh Hospital campus will be developed,

Living with long term and multiple conditions

The existing long term conditions programme in Edinburgh will form the basis of our response to the care and support needs of people living with multiple conditions (multimorbidity) who account for 78% of consultations in GP practices. A risk assessment approach adopted at locality level will allow multi-disciplinary care planning for those at higher risk and supported self-management to avoid deterioration for those at lower risk. While continuing the successful integrated care model for Chronic Obstructive Pulmonary Disease, we will work with NHS Lothian to ensure consistent pathways for the increasing number of people living with diabetes.

Redesigning Mental Health and Substance Misuse services

Our strategic approach to improving mental health and addressing substance misuse recognises the importance of prevention and the benefits of access to personalised services which support people to recover and keep safe and well. A mental health locality model will be taken forward initially in North East Edinburgh with a range of partners. With the redevelopment of the Royal Edinburgh Hospital we have an opportunity to redesign the service model across community and hospital services, including an

improved rehabilitation pathway. Actions to redesign pathways for substance misuse will also be progressed in collaboration with Edinburgh Alcohol and Drug Partnership.

Maximising the use of technology to support independent living

Greater use of technology enabled care within care pathways offers opportunities to support people to live as independently and safely as possible and make better use of available resources. To integrate our services and embrace joined up working our joint ICT teams have produced a roadmap which sets out the key assumptions and areas we will progress to provide our staff with effective and reliable systems which allow them to access and share information securely, including mobile technology where staff work on the move. Our commissioning of care services will also consider technology support for customers, including through our approved providers.

Improving our understanding of the strengths and needs of the local population

The partnership has developed a Joint Strategic Needs Assessment (JSNA) to help us understand the current and future needs of our population, including the high level characteristics of our four localities and the health inequalities across the city. We will further develop our needs assessment and embed this with broader work underway on profiling localities as part of the Council's Transformation Programme.

Integrated workforce planning and development

We believe that achieving the vision and priorities in our plan will require significant culture change for the partner organisations and their workforce. During 2016/17 we will develop an overarching workforce strategy and action plan to support this, with input from the statutory, third, independent sectors and people who use services.

Living within our means

The key financial challenge for the Partnership will be how we use our money wisely to support cost-effective redesign at the same time as maintaining good outcomes for people. The Board will continue to work with the Council and the NHS to develop sustainable plans to achieve financial balance, including delivery of savings plans to be implemented from April 2016. A robust decision making framework will be developed to support decisions going forward.

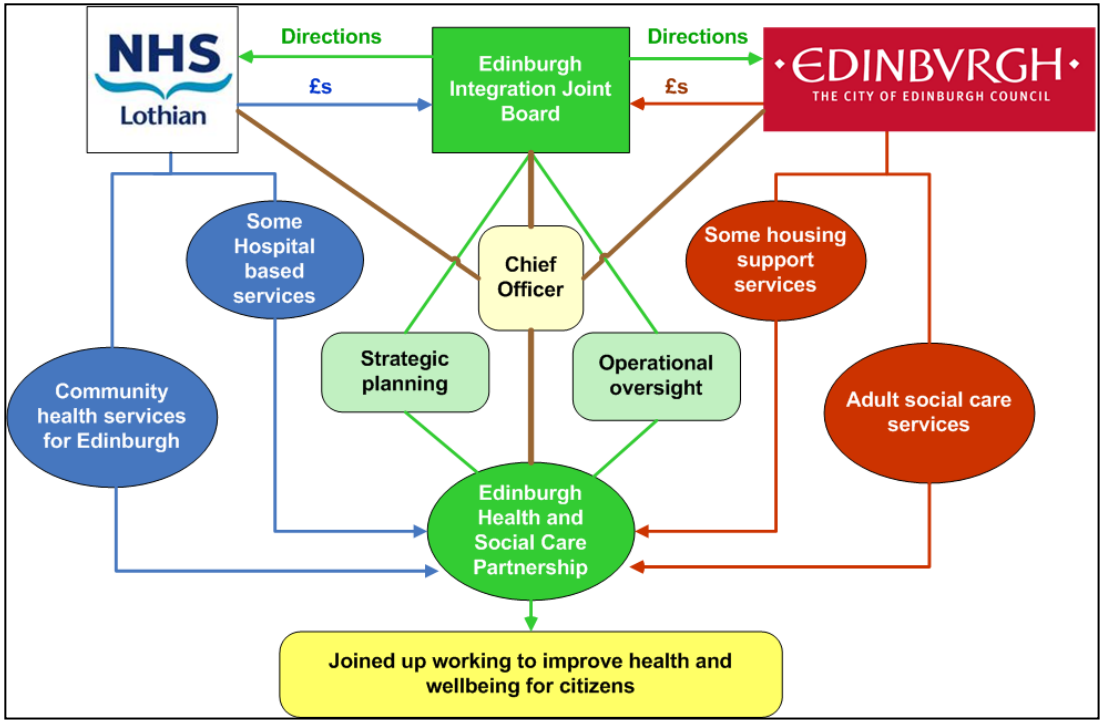
3. Integrating health and social care services

In 2014 the Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act bringing together the planning and operational oversight for a range of NHS and local authority services for adults in each local authority area under a single body. The purpose of the legislation is to improve the overall health and wellbeing of the population of Scotland by delivering efficient and effective joined up health and social care services. In Edinburgh, the Integration Joint Board is the body responsible for the *strategic planning* of the services delegated by the legislation. The majority of these services are *managed* on a day to day basis by the Edinburgh Health and Social Care Partnership, led by the Chief Officer. The Integration Joint Board will issue directions to the Council and NHS Lothian setting out how services should be delivered. The diagram below illustrates the relationship between the Integration Joint Board, the Health and Social Care Partnership, NHS Lothian and the City of Edinburgh Council.

Details of the members of the Integration Joint Board are given in Appendix A.

In order to have a positive impact on health and wellbeing in the city, the Health and Social Care Partnership will need to work closely with its partners including other statutory, voluntary and independent sector organisations and with citizens and communities.

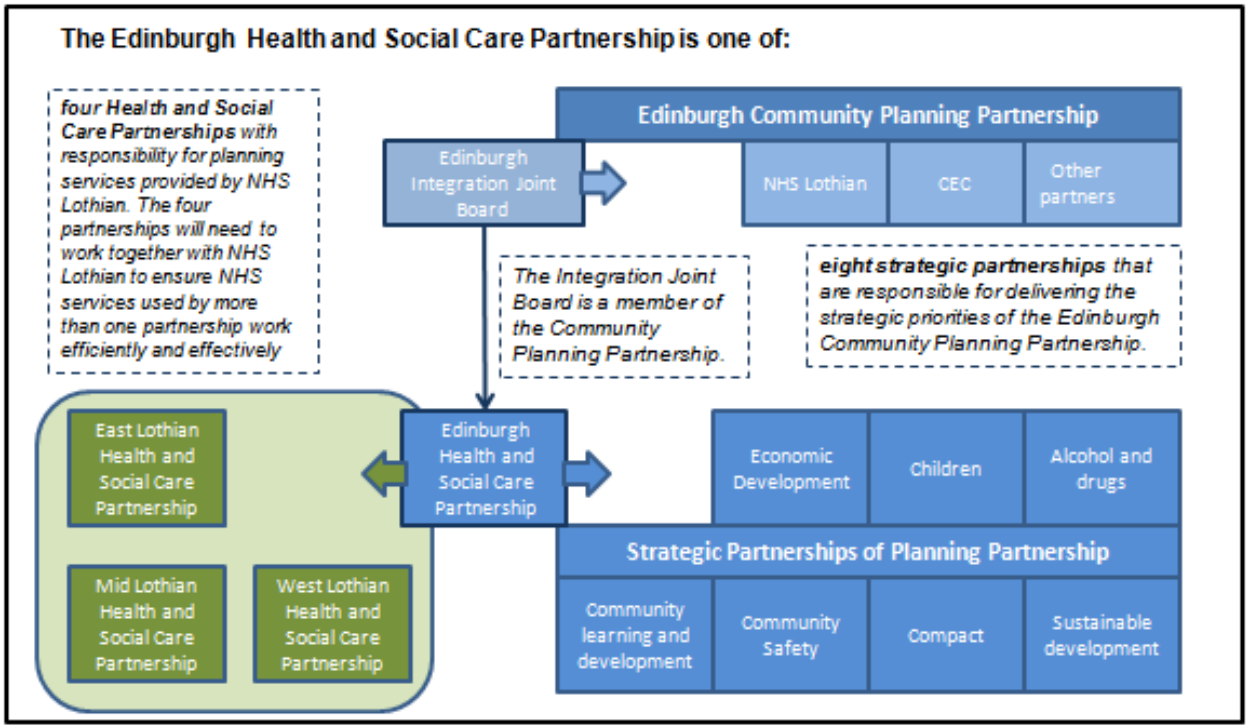
The role of the Edinburgh Community Planning Partnership is to ensure that there is a coordinated approach to planning public services through the development of a community plan for the city. The Integration Joint Board is a member of the Edinburgh Community Planning Partnership and the Health and Social Care Partnership is one of the eight strategic partnerships that support the



delivery of the community plan.

It is important that the strategic plan for the Health and Social Care Partnership takes account of the Edinburgh Community Plan and the local community plans produced by the 12 neighbourhood partnerships; and contributes to the achievement of the aims and objectives set out within those plans.

The diagram opposite sets out the relationships between the Integration Joint Board and Health and Social Care Partnership, the Edinburgh Community Planning Partnership and the other Lothian Health and Social Care Partnerships.



Scope of the Edinburgh Health and Social Care Partnership

Edinburgh is one of four Health and Social Care Partnerships that have responsibility for services previously planned for and still delivered by NHS Lothian, some of which operate on a Lothian wide basis. The other partnerships are East, Mid and West Lothian Health and Social Care Partnerships. Whilst it has been relatively straightforward to transfer resources for some services to individual partnerships, in other cases it is much more complicated. Agreement has therefore been reached between the four partnerships and NHS Lothian as to how these services should be managed to ensure they operate as effectively and efficiently as possible. As a result, the services that the Edinburgh Integration Joint Board is responsible for planning fall into three groups:

- services that are managed through the Edinburgh Health and Social Care Partnership

- services that are managed by East, Mid or West Lothian or NHS Lothian on behalf of all five organisations – these are referred to as “hosted” services
- services that are managed by NHS Lothian but used by one or more of the Health and Social Care Partnerships where it is not sensible to split the resources available between them without destabilising the services, these are referred to as “set aside” services

The table below summarises the main services for which the Edinburgh Integration Joint Board has a strategic planning responsibility. Information about hosted and set aside services is contained in Appendix C.

Adult Social Care Services	Community Health Services	Hospital Based Services
• Assessment and Care Management-including Occupational Therapy services • Residential Care • Extra Care Housing and Sheltered Housing (Housing Support provided) • Intermediate Care • Supported Housing-Learning Disability • Rehabilitation-Mental Health • Day Services • Local Area Coordination • Care at home services • Reablement • Rapid Response • Telecare • Respite services • Quality assurance and Contracts • Sensory impairment services • Drugs and alcohol services	• District Nursing • Services relating to an addiction or dependence on any substance. • Services provided by Allied Health Professionals (AHPs) • Community dental service • Primary medical services (GP)* • General dental services* • Ophthalmic services* • Pharmaceutical services* • Out-of-Hours primary medical services • Community geriatric medicine • Palliative care • Mental health services • Continence services • Kidney dialysis • Prison health care service • Services to promote public health *Includes responsibility for those aged under 18	• A&E • General medicine • Geriatric medicine • Rehabilitation medicine • Respiratory medicine • Psychiatry of learning disability • Palliative care • Hospital services provided by GPs • Mental health services provided in a hospital with exception of forensic mental health services • Services relating to an addiction or dependence on any substance

Our Strategic Plan

It is a legal requirement that the Integration Joint Board publish a strategic plan every three years setting out how the services and budget it is responsible for will be used to deliver a set of national health and wellbeing outcomes detailed in Appendix D and summarised in the diagram on page 21. This first plan has been produced through collaboration between officers of NHS Lothian and the Council and the Strategic Planning Group set up by the Integration Joint Board. Members of the Strategic Planning Group include representatives of those who deliver and receive health and social care services and other key stakeholders; a list of members is given in Appendix B.

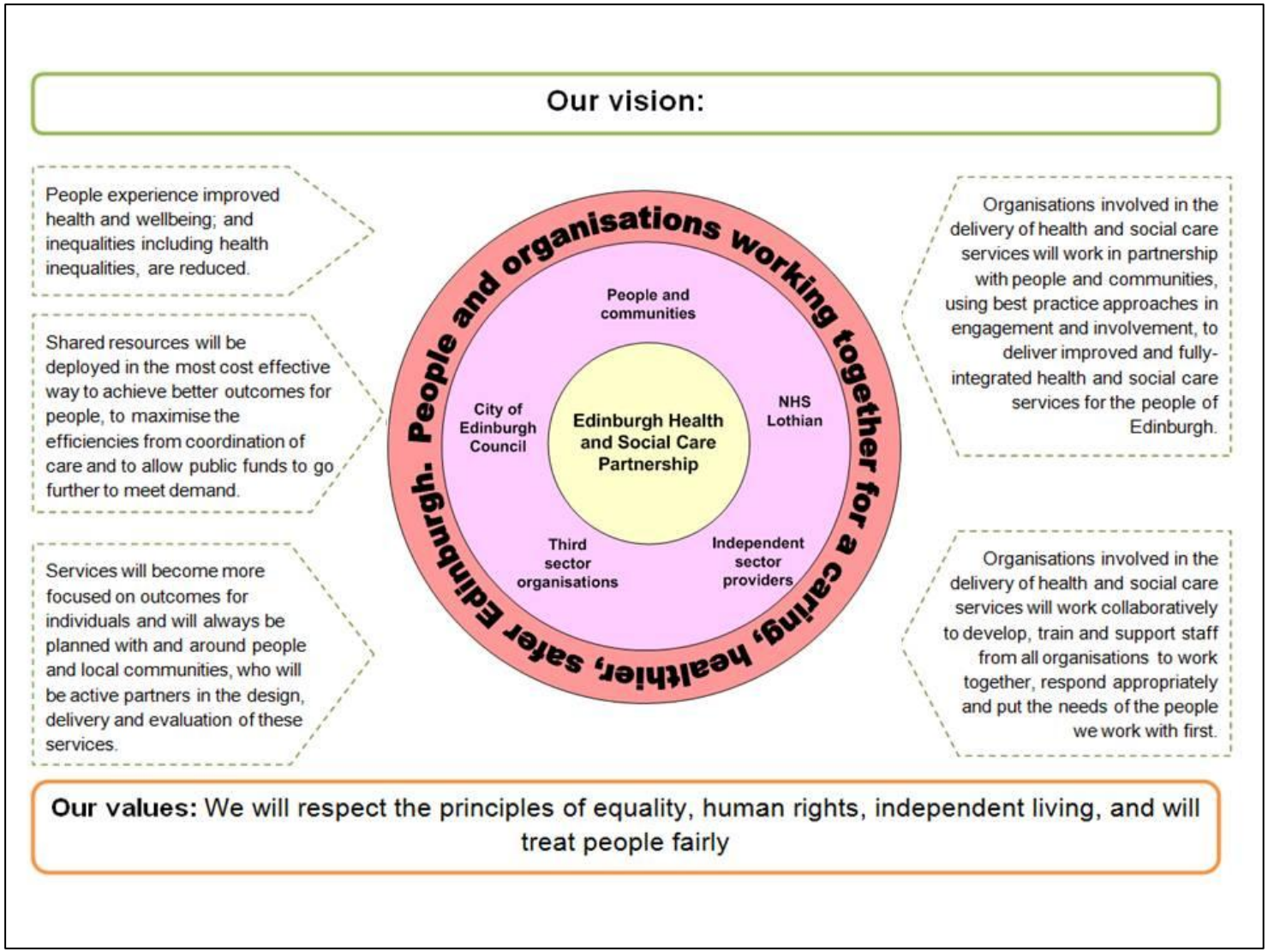
During the autumn of 2015 we asked our partners and the public to provide feedback on an earlier version of this plan. The key things that we learned from the feedback are that:

- people understand the financial pressures that the Health and Social Care Partnership is facing and are concerned about how this will impact on the amount and quality of care available to meet people's needs
- we need to better explain the relationships between NHS Lothian and the four Health and Social Care Partnerships in Lothian and between the Edinburgh Health and Social Care Partnership and the community planning arrangements in Edinburgh
- people are generally supportive of the proposed move to locality working but have some concerns that this could lead to a postcode lottery and that the needs and interests of communities of interest such as minority ethnic and LGBT communities and people with disabilities could get overlooked
- there is strong recognition of the importance of the Health and Social Care Partnership working in equal partnership with the third or voluntary sector, including social housing providers, if we are to deliver the priorities set out in our strategic plan
- primary care services including GPs have an important role to play in helping us achieve our priorities at a local level and need support to undertake this role
- there is an urgent need to ensure our ICT systems are reliable, support staff to work more efficiently and address the need to share data within and across organisations to facilitate effective joined up working

- there is widespread support for our proposed priorities set out on page 19, although there is also concern that these may not be achievable in the current economic climate

We also received suggestions about the actions we need to take to achieve our key priorities. We have taken the feedback we received into account in producing this version of the strategic plan and will ensure that it is also used to inform the development of more detailed future plans and our ongoing engagement with our partners including citizens and communities. More detail about the feedback we received through the consultation and the way in which it will be used is contained in a report considered by the Integration Joint Board in January 2016.

4. Our vision and values

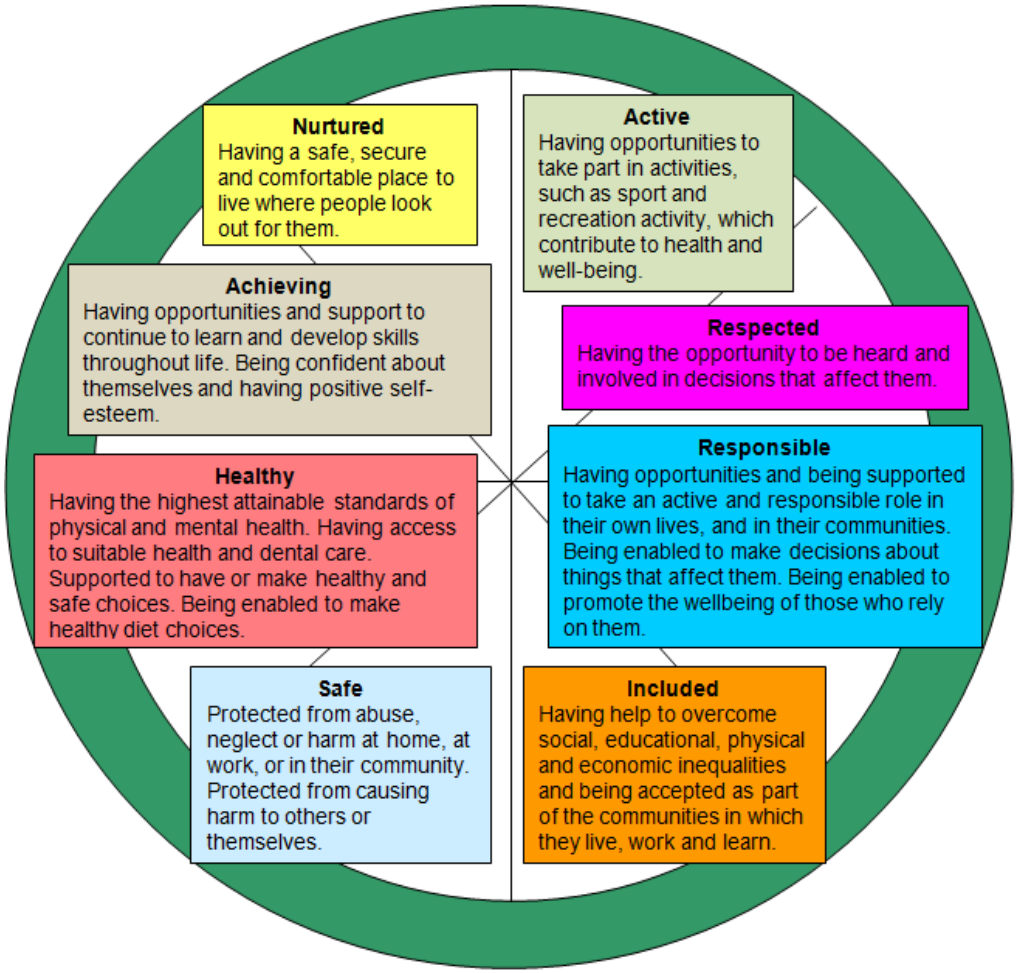


The vision and values of the Edinburgh Integration Joint Board for the Health and Social Care Partnership set out the positive impact we believe the integration of health and social care will make on:

- the way organisations work together and work with people and communities
- the way services are planned and delivered; and most importantly,
- on the lives of those living in the city

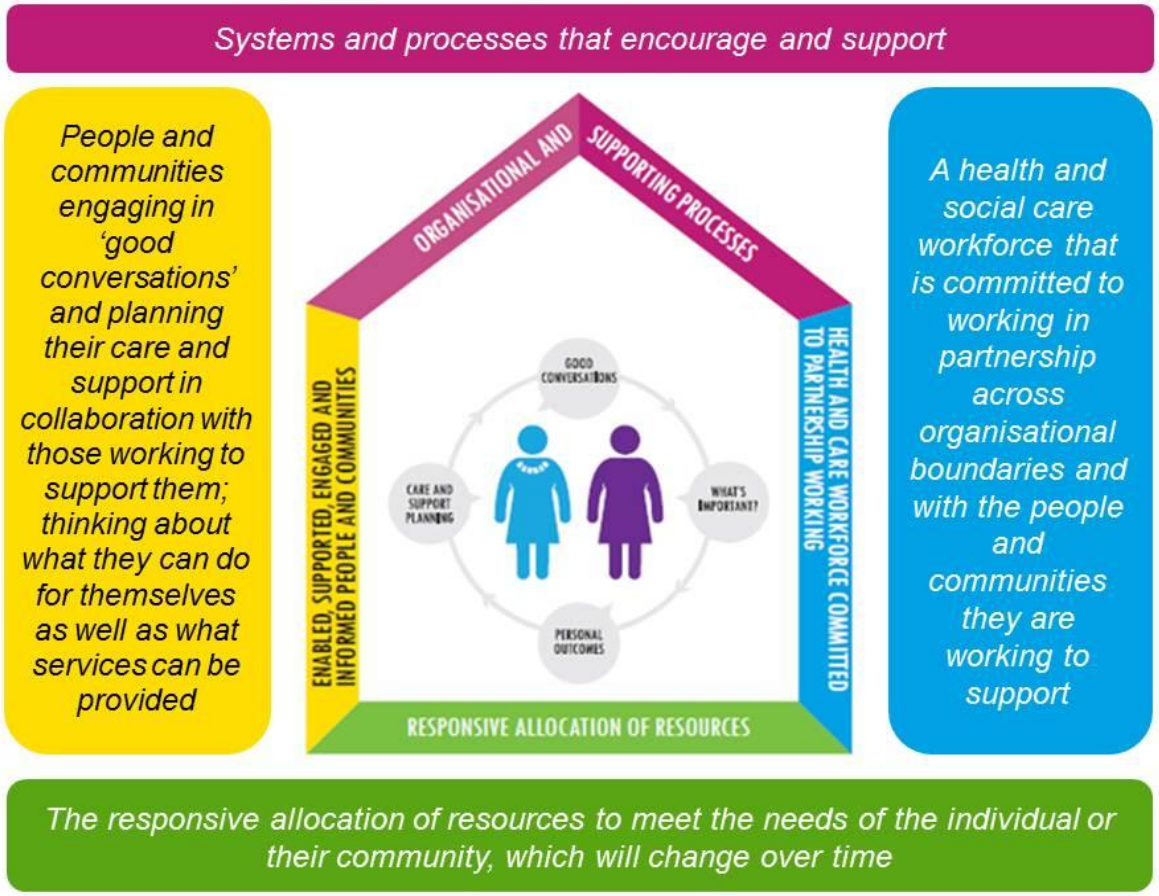
Changing the relationship between the people responsible for the planning and delivery of health and social care services, the people who receive them and the communities in which they live is at the heart of our strategic plan. We are committed to working in person centred ways with citizens to support them retain and regain their independence and take more control over their lives.

The Wellbeing Wheel opposite sets out the person centred outcomes that the Edinburgh Health and Social Care Partnership seeks to achieve for all citizens in order to improve their health and wellbeing; whilst recognising that the way to achieve them will vary from person to person.



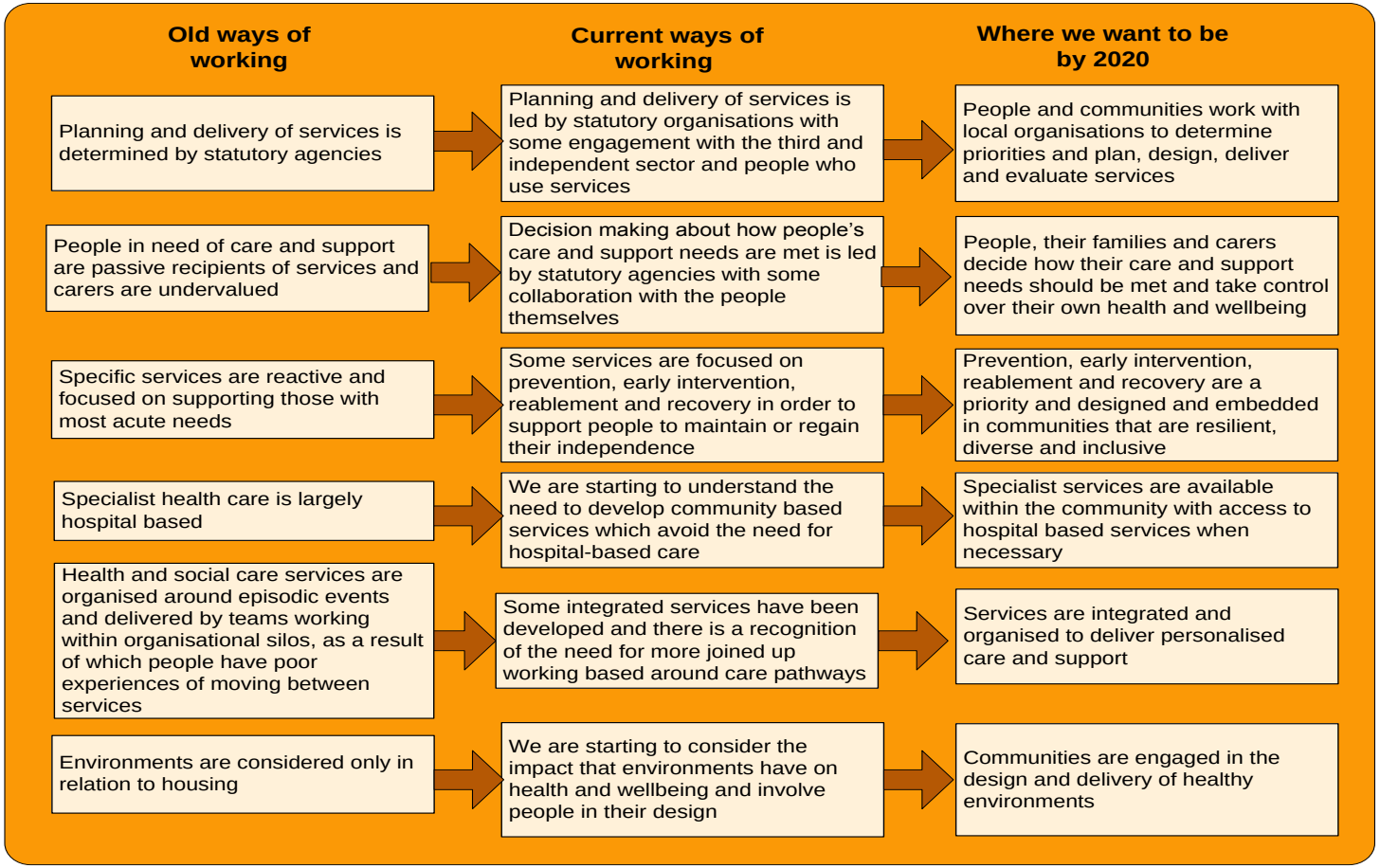
The House of Care model being developed in partnership between NHS Lothian, third sector organisations, the Health and Social Care Partnerships in Lothian and people who use health and social care services offers a good metaphor for the whole systems change we hope to achieve through integration; with relationships and the ability to have 'good conversations' that focus on what is important to the individual at the centre of how we work.

This model will underpin how we work with people, unpaid carers with communities and with our staff and partners to achieve our vision for a caring, healthier, safer Edinburgh.



The changes we need to make

If we are to achieve our vision, there are a number of changes we need to make. Some progress has already been made that will help us get to where we want to be. What we need to do now is escalate the pace so that we see real change in the life span of this strategic plan.



5. Our priorities

Along with other public sector organisations in Scotland and the wider United Kingdom, the Edinburgh Integration Joint Board faces three major challenges:

1. An increase in demand for health and social care services that is expected to continue due to a combination of factors including:
    - growth in the number of people living in the city
    - increased life expectancy in the overall population which means that people are living longer but not necessarily healthier lives
    - increased life expectancy amongst people with complex health conditions as a result of advances in medical science
    - an increase in the prevalence of long term conditions in the population overall

2. Changes in social policy and public expectations about the health and social care services that local authorities and the NHS should provide

3. The financial climate which has resulted in the need for both the NHS and local authorities to meet the increased demand for services with less resources in real terms

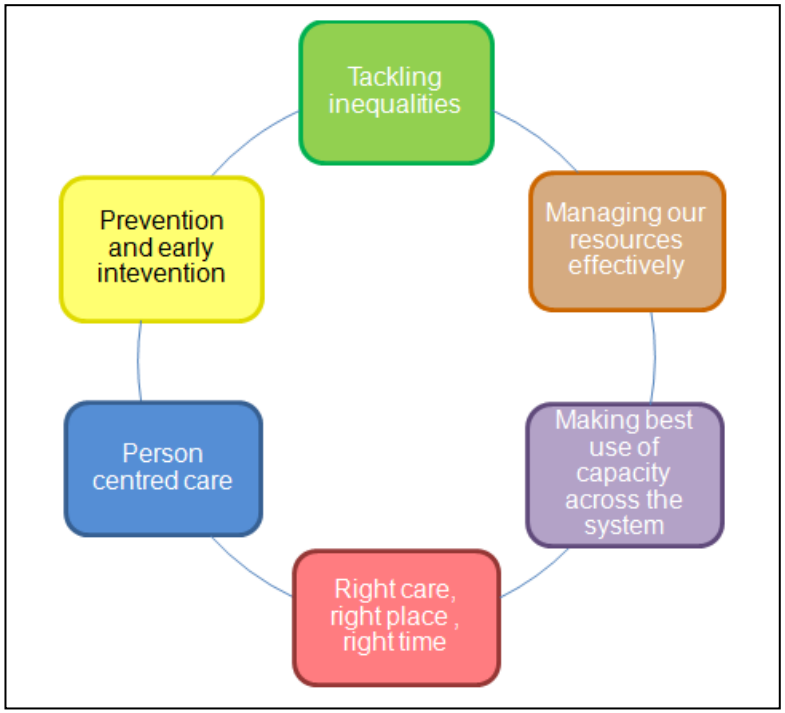
The challenges that are more specific to Edinburgh are set out in our Joint Strategic Needs Assessment which is attached as Appendix I.

The Edinburgh Integration Joint Board is very aware of the challenges we face but also recognises that they present an exciting opportunity to do things differently, as it is clear that continuing to deliver the same services in the same way is not an option. We have developed a set of linked priorities that underpin our strategic plan, reflect the wider context within which we operate, link to the national health and wellbeing outcomes and are aligned to the strategic priorities of the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian as set out in the diagram on page 21. The range of national and local plans and strategies that impact on or are affected by the strategic plan are set out in the diagram in Appendix E.

Our key priorities are set out below.

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality:

- supporting individuals to maximise their capabilities and have control over their lives
- creating healthy and sustainable communities that can resist the effects of inequality on health and wellbeing
- ensuring that core health and social care services are delivered in such a way as to reduce and not exacerbate health inequality
- recognising that some sections of the population need targeted support in order to address the cause and effect of inequalities



Preventing poor health and wellbeing outcomes by supporting and encouraging people to:

- achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing;
- make choices that increase their chances of staying healthy for as long as possible
- utilising recovery and self-management approaches if they do experience ill health

Practicing **person centred care by** placing 'good conversations' at the centre of our engagement with citizens so that they are actively involved in decisions about how their health and social care needs should be addressed.

Delivering the **right care in the right place at the right time** for each individual, so that people:

- are assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary

- are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community
- experience smooth transitions between services, including from children's to adult services
- have their care and support reviewed regularly to ensure these remain appropriate
- are safe and protected

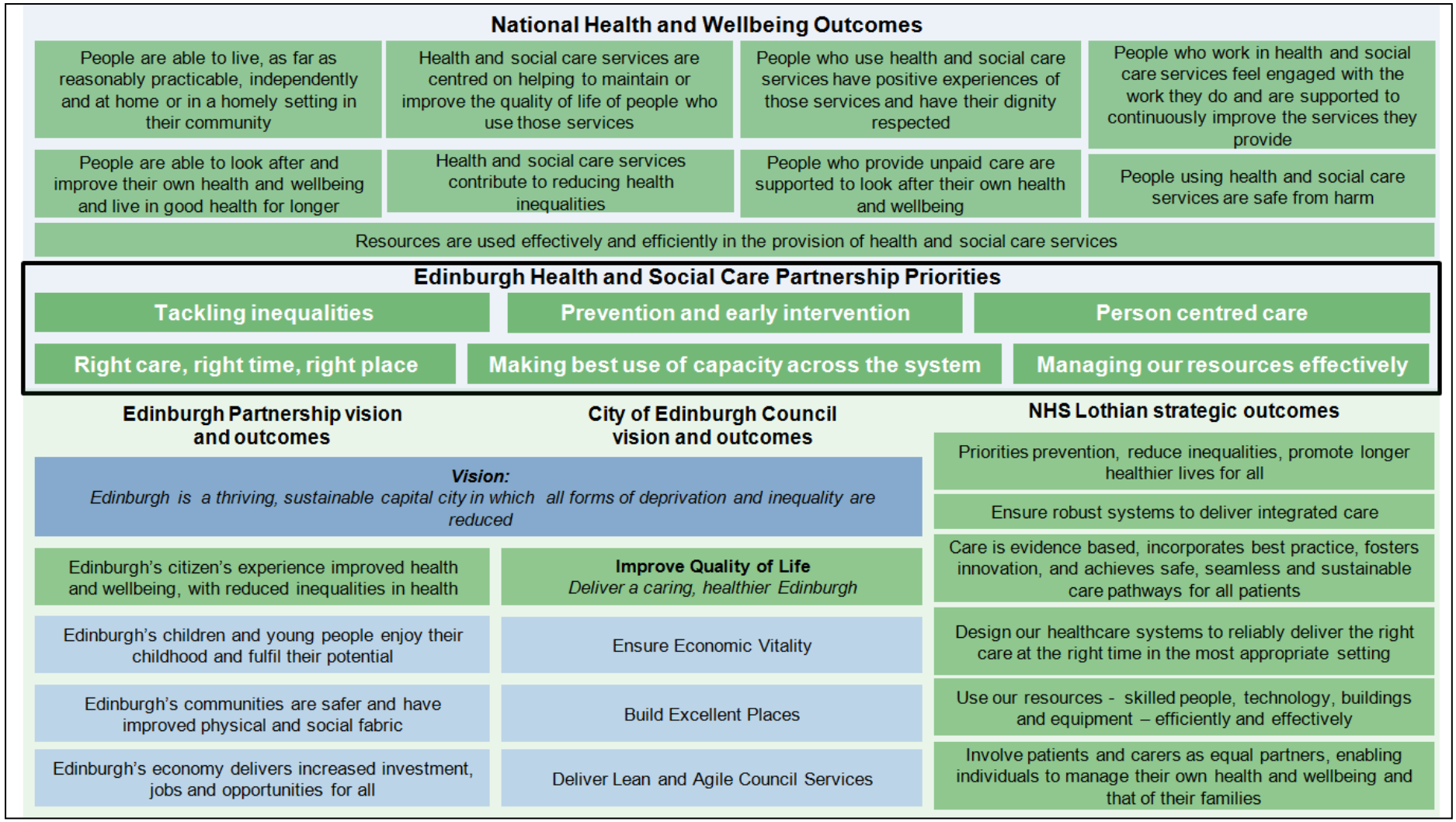
Developing and **making best use of the capacity available within the city** by working collaboratively with individual citizens, unpaid carers, communities, the statutory third, independent and housing sectors to deliver timely and appropriate care and support to people with health and social care needs, including frail older people, those with long-term conditions and people with complex needs.

Making the best use of our shared resources (e.g. people, buildings, technology, information and procurement approaches) to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge.

Why these are our priorities

The role of the Edinburgh Integration Joint Board is to plan for the delivery of services that improve the health and wellbeing of the population of Edinburgh. Given the challenges of increased demand and limited resources it is vital that we not only focus our attention on those people in greatest need of health and social care support today but also work to manage future demand. Taking action to tackle the wider causes of poor health and wellbeing and investing in preventative approaches that support people to take more control over their own lives is an integral part of our strategy. Whilst the provision of care, support and medical services are a key function of the NHS and social care, other partners are better placed to address some of the underlying causes of poor health and wellbeing through the provision of good quality housing, green spaces, social activities, education, good working conditions, accessible information and advice, informal care, support and friendship.

The diagram below illustrates the linkages between the key priorities of the Integration Joint Board, the national health and wellbeing outcomes and the strategic priorities of the Edinburgh Community Planning Partnership, the City of Edinburgh Council and NHS Lothian.

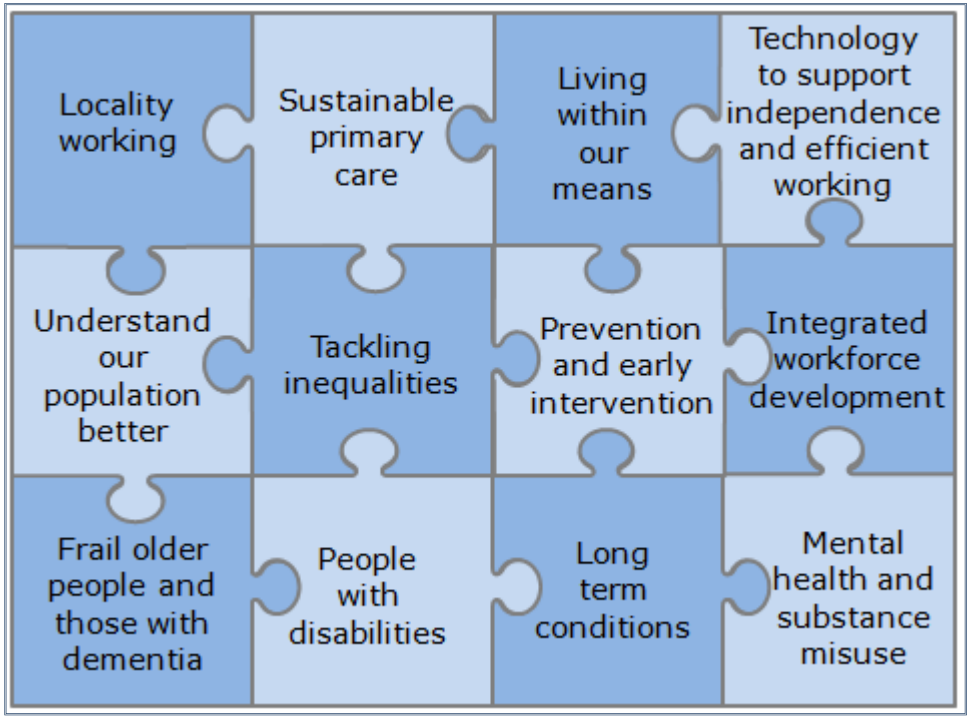

National Health and Wellbeing Outcomes
People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
People who use health and social care services have positive experiences of those services and have their dignity respected
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the services they provide
People are able to look after and improve their own health and wellbeing and live in good health for longer
Health and social care services contribute to reducing health inequalities
People who provide unpaid care are supported to look after their own health and wellbeing
People using health and social care services are safe from harm
Resources are used effectively and efficiently in the provision of health and social care services
Edinburgh Health and Social Care Partnership Priorities
Tackling inequalities
Prevention and early intervention
Person centred care
Right care, right time, right place
Making best use of capacity across the system
Managing our resources effectively
Edinburgh Partnership vision and outcomes
City of Edinburgh Council vision and outcomes
NHS Lothian strategic outcomes
Vision:
Edinburgh is a thriving, sustainable capital city in which all forms of deprivation and inequality are reduced
Edinburgh's citizen's experience improved health and wellbeing, with reduced inequalities in health
Improve Quality of Life
Deliver a caring, healthier Edinburgh
Edinburgh's children and young people enjoy their childhood and fulfil their potential
Ensure Economic Vitality
Edinburgh's communities are safer and have improved physical and social fabric
Build Excellent Places
Edinburgh's economy delivers increased investment, jobs and opportunities for all
Deliver Lean and Agile Council Services
Priorities prevention, reduce inequalities, promote longer healthier lives for all
Ensure robust systems to deliver integrated care
Care is evidence based, incorporates best practice, fosters innovation, and achieves safe, seamless and sustainable care pathways for all patients
Design our healthcare systems to reliably deliver the right care at the right time in the most appropriate setting
Use our resources - skilled people, technology, buildings and equipment – efficiently and effectively
Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families

Delivering our priorities

To achieve the vision and priorities set out above we have identified 12 areas where we believe we need to focus our attention during the life of this strategic plan, in order to deliver real change. In the same way that there are linkages across and between our six key priorities these 12 areas are interconnected so that actions taken in one area will also impact on others.

The areas on the top row are those where we believe we can and must deliver change quickly. The middle row contains a number of areas that we feel should be golden threads throughout our plan. The bottom row sets out the groups of people that we believe can most benefit from the transformation of services we want to see.

Throughout the plan the actions that we will take to progress our vision and priorities over the next three years are denoted by the italicised text in boxes.



6. Our plans to achieve integration at locality level

The case for change

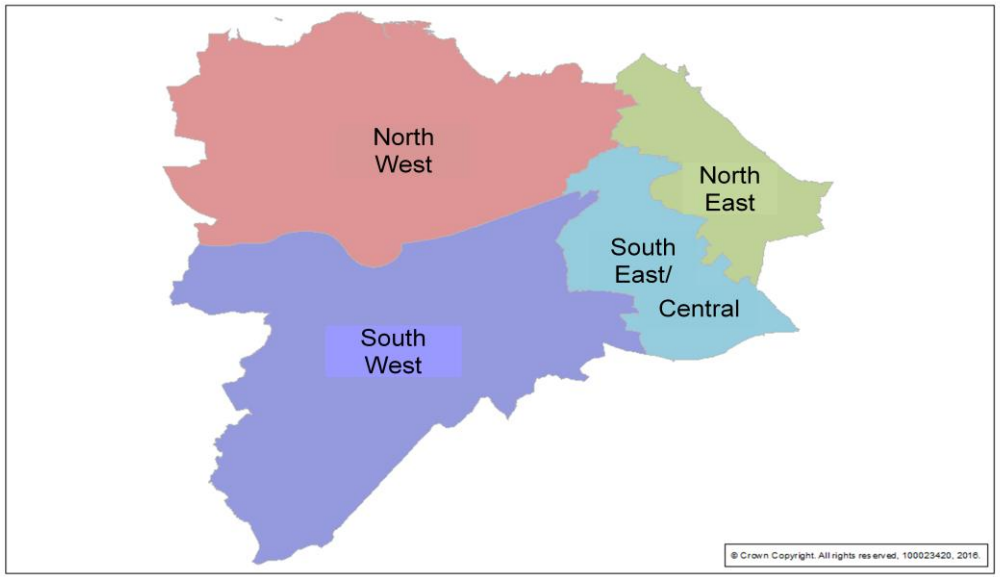
There is general recognition at both a national and local level that communities are the engine house for delivering transformation in public services. If we are to achieve the changes we need to make in order to realise our vision, the planning and delivery of services must take place as locally as possible.

Edinburgh is a diverse city with many different communities of both geography and interest that have varying levels and types of needs in terms of health, social care and wellbeing. In many cases, these are needs that can best be addressed by a range of services, not simply those that are the responsibility of the statutory health and social care agencies. Indeed the most effective way of meeting some needs, loneliness for example, may lie with communities themselves. It is for these reasons that the Edinburgh Health and Social Care Partnership, along with the City of Edinburgh Council, NHS Lothian and their partners in the Edinburgh Community Planning Partnership, believes that it is right to shift the focus of our service planning and delivery to localities. This will involve working in partnership with and empowering local people and communities, improving the co-location and integration of services and devolving budgets and decision making closer to the point of service delivery.

To achieve this, the organisations that belong to the Edinburgh Community Planning Partnership have agreed that all partners will adopt the same four geographic locality boundaries as the basis for service planning and delivery in the city. The four localities are based around the existing twelve Neighbourhood Partnerships as detailed in the table below and shown on the map on the following page:

Locality	Neighbourhood Partnerships	Population
North West	Almond, Forth, Inverleith and Western Edinburgh	138,995
North East	Leith, Craigentinny/Duddingston and Portobello/Craigmillar	110,550
South West	Pentlands and South West	111,807
South East/ Central	City Centre, South Central and Liberton/Gilmerton	126,148
	Total	487,500

An initial profile of each locality is contained in the Draft Joint Strategic Needs Assessment contained in Appendix I.



What we plan to do

Bringing health and social care service providers together to work as integrated teams to better meet the needs of people and communities is the core purpose of the Health and Social Care Partnership. To achieve this we have put in place a locality management structure to lead the delivery of most front line services to citizens within the four localities.

The use of common boundaries across partners provides excellent opportunities to integrate service planning and provision not only across health and social care, but across all agencies. A Transformation Programme is currently underway within the Council, aiming to integrate services such as housing, services for communities, children and families etc at a locality level and similar changes are being considered by Police and Fire and Rescue Services. Edinburgh Health and Social Care Partnership staff will be core participants in the new multi-agency Locality Leadership Teams being established by the Council. Effective joint working with council services and other partners will be vital to help deliver our priorities, in particular greater focus on prevention, early intervention and tackling inequalities.

The move to managing services at locality level and indeed working below this at neighbourhood level, will enable all partners to build on local knowledge and connections to foster the healthy neighbourhoods and resilient communities that respondents to our strategic plan consultation told us they want to see. The focus on localities will help health and social care teams to work more effectively with the existing community groups which support those whose needs are for social networking and healthy living opportunities e.g. lunch clubs, walking groups etc.

Action 1
From April 2016 the four Health and Social Care Locality Managers will ensure that local health, social care, third, independent and housing sector providers, along with unpaid carer and service user representatives and other local organisations, are able to work effectively together by establishing collaborative working arrangements in each locality.

Bringing existing staff teams together and providing them with the opportunity for more local engagement is also anticipated to support the culture change in our services which many people have identified is needed.

We will ensure that while aspects of service delivery may vary according to local circumstances and needs, outcomes will be monitored to ensure that unwarranted variation in support does not develop in different parts of the city and resources are allocated fairly. There will of course continue to be a need to plan and deliver services at a citywide level where they are focused on meeting the needs of communities of interest or there is limited demand or a reliance on limited specialist facilities.

Action 2
Locality managers will establish integrated teams that empower staff to work more flexibly across professional boundaries and to seek solutions and avoid unnecessary referrals on to another team or service, with the aim of providing more seamless and responsive care and support when needed.

The development of locality hubs and clusters is a key part of our approach. The first hub was piloted in South East/ Central locality during the winter of 2015/16 and the learning from this has been shared across the city. Close working with hospital based staff has been established and existing staff teams are being supported to work more flexibly to develop timely plans to meet people's increased needs at home where possible. When individuals are admitted to hospital, information on their care needs is being shared at daily reviews and joint plans developed to allow people to return home with support as soon as their acute care needs have been met.

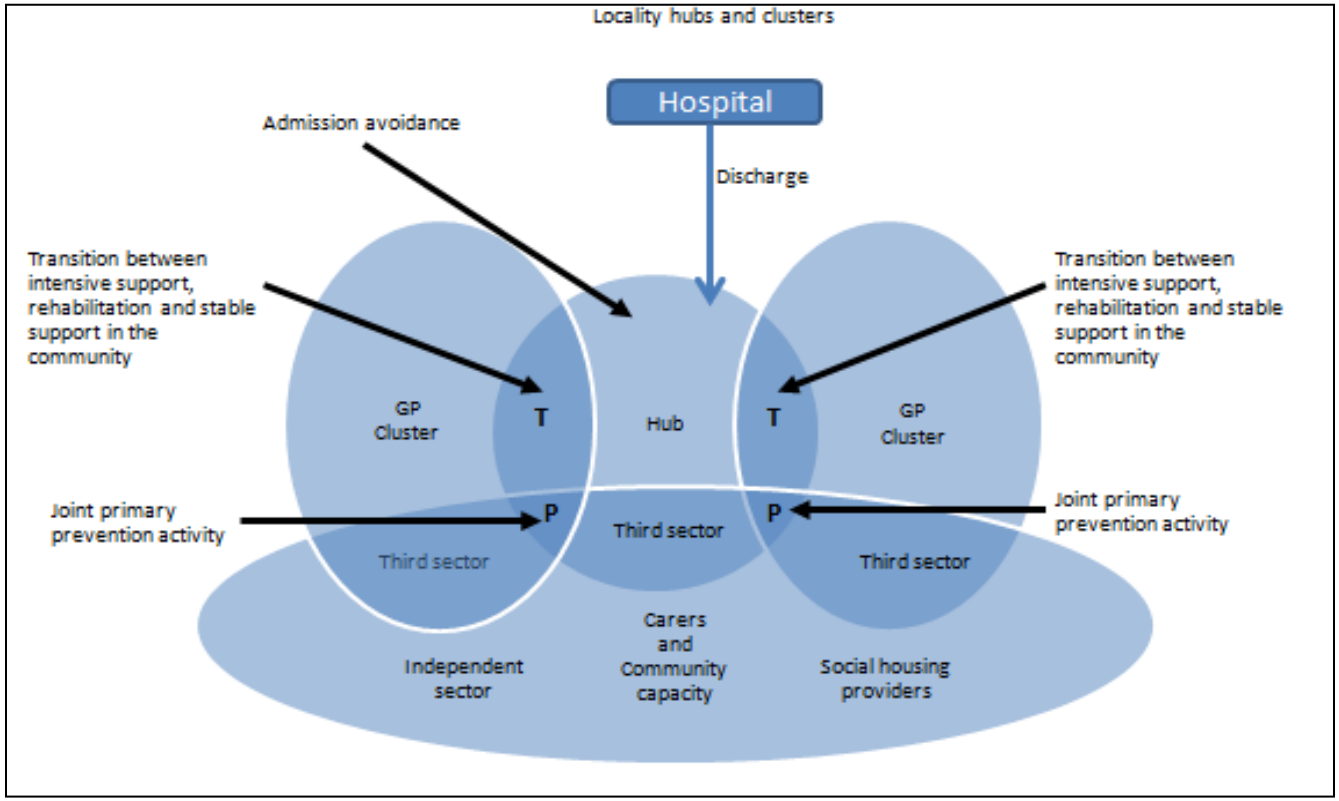
Action 3
A priority action for the Partnership is to develop hubs within each locality coordinating community resources more effectively in order to:

- *maximise support for independent living*
- *provide a community response to urgent need and care crises*

- *reduce the need for admission to hospital*
- *support timely discharge from hospital*

All four localities will adopt the same team structure: a single hub to manage the transition of patients between hospital and community and two clusters based on GP practices responding to immediate care need and providing longer term community care support.

The diagram opposite illustrates the planned interaction between the locality hubs, GP clusters, acute hospitals and community resources.



The vital role Primary Care plays in providing and co-ordinating care at a local level and the increasing needs and demands which are managed by GP practice teams means they are the foundations of the Clusters and the teams closest to the local communities we serve.

A "Total Place" approach to the co-ordination of all public sector and community assets has been adopted in two economically disadvantaged areas of the City. The two areas are coterminous with two of the eight Clusters and the Headroom Initiative ensures Primary Care and in particular GPs are able to play an active role in developing this approach. In one

of the areas House of Care is also being widely utilised as an approach to person-centred care for people living with long term conditions.

Action 4
We will support the development of eight integrated health and social care Clusters based on geographical groupings of GP practices within the four localities to support more flexible ways of working in teams with a focus on prevention, early intervention, anticipating and planning for care needs and long term support.

Improving the responsiveness of services when individuals with complex needs require an escalation in care and support, their health deteriorates, or their normal care arrangements temporarily break down is a priority. We know these factors lead to people being admitted to hospital when there may be alternatives which could allow them to be cared for safely at home. Even when admission to an acute hospital is appropriate, too many people are unable to get home again in a timely way because community based services such as care at home, are not easily restarted.

Action 5
We will work with colleagues across all sectors to identify people with significant needs who are high users of services and improve anticipatory care planning with the aim of reducing emergency admissions.

Action 6
During 2016/17 we will develop locality plans for each of the four localities that complement the locality improvement plans that are a requirement of the Community Empowerment Act

7. Tackling inequalities

The case for change

We know that people living in poverty and those who are part of specific social groups experience poorer life chances, reduced health and wellbeing and shorter life expectancy. Tackling the root causes of current levels of inequality as well as reducing the health and social impacts will help us to address the increasing demand for health and social care services.

Although life expectancy has increased steadily in the last ten years in Edinburgh, there are significant inequalities in the health experiences of different groups of people. Poorer health and earlier deaths affect those who face social and economic barriers such as poor housing, lack of employment, low pay or discrimination. At the most extreme, this can mean a difference in life expectancy of more than 25 years between the least and most affluent areas of the city. People living in the least affluent areas are more likely to develop long term conditions and to develop them at least ten years earlier than their fellow citizens living in the most affluent parts of town; they are also at greater risk of emergency admission to hospital.

- Many unpaid carers who are unable to work due to their caring role are living on low incomes and experience poor physical and mental health as a result of the strain of their caring responsibilities.
- 12% of residents in Edinburgh aged between 16 and 74 who are not in work are unable to participate in the labour market due to a limiting long term illness. This is a significant barrier to increasing incomes above the poverty threshold.
- Fuel poverty is a major issue which affects the lives and health of some of the poorest and most vulnerable households in the city. Health benefits can be achieved through investing in energy efficiency and providing support to help people manage their energy consumption.

Health inequalities are not restricted to areas classified as experiencing multiple deprivation as defined by the Scottish Index of Multiple Deprivation (SIMD). There are significant pockets of poverty within each of the four localities, while up to 50% of people experiencing poor health do not live in the most deprived areas of the city. There is evidence that being part of a specific group, including those with “protected characteristics” under equalities legislation, for example people with disabilities, minority ethnic groups and the LGBT community can increase the likelihood of poor life chances:

- poor mental health with depression affects one in five older people living in the community and two in five living in care homes
- older members of the LGBT community are 2.5 times more likely to live alone and 10 times more likely to indicate they have no-one to call on in times of crisis
- difficulties in communication can be a significant barrier to accessing services for many people from minority ethnic groups and people with disabilities

Our strategic approach

The challenge is to adopt a strategic approach that is focused on meeting current need by providing the right care in the right place at the right time whilst also seeking to reduce future demand by investing in approaches that seek to prevent ill health, tackle inequalities and promote independence. Health inequalities can be influenced to some extent by the way in which services are delivered. However, many of the factors that lead to inequalities in health outcomes are outside the control of the Partnership. It is vital that we work with our colleagues in the Edinburgh Community Planning Partnership to develop and implement a coordinated approach to tackling inequalities across the City. We will have a key role to play in making this happen as the Health and Social Care Partnership is responsible for delivering the following community planning outcome Edinburgh Community Plan 2015-18:

> *"Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health"*
> *focusing particularly on shifting the balance of care, reducing alcohol and drug misuse and reducing health inequalities*

Work to coordinate the approach to health inequalities has been undertaken by the Health Inequalities Standing Group, membership of which is drawn from the Council, NHS Lothian and the third sector. This Group has developed a Health Inequalities Framework and Action Plan and also administers the health inequalities grant fund, on behalf of NHS Lothian and the Council.

Action 7
During 2016/17 we will work with our community planning partners to:

a) *determine the most effective way of developing and implementing a coordinated approach to tackling inequalities, including health inequalities, across the City*
b) *deliver the health inequalities grants programme in line with funding decisions made by the Council and NHS Lothian*

c) assess the impact of the current grants programme on tackling inequalities in order to inform future funding arrangements

The development of our Joint Strategic Needs Assessment has brought together data and information held by a number of partners and helped us to start to develop a picture of health and social care needs across the city. We have begun to develop a joined up picture of those geographic areas and social groups whose health and wellbeing is most likely to be impacted by the social and economic factors that lead to inequalities. We will continue to work with our partners at locality level, including Neighbourhood Partnerships, to develop the Joint Strategic Needs Assessment in a way that helps increase our understanding of the strengths and needs of the local population and informs ongoing service planning and delivery at both a local and citywide level.

Action 8

As an Integration Joint Board working at a strategic level we will:

- *a) improve our understanding of the range and effectiveness of current actions and funding that impact on tackling inequalities in order to inform our future strategic direction*
- *b) embed tackling inequalities within our strategic and service planning, operational delivery and performance management framework*
- *c) develop improved intelligence about the distribution of Edinburgh Health and Social Care Partnership services and their uptake by people with protected characteristics and where possible, by people living in poverty*
- *d) develop a set of 'equalities outcomes' in line with the Equality Act*

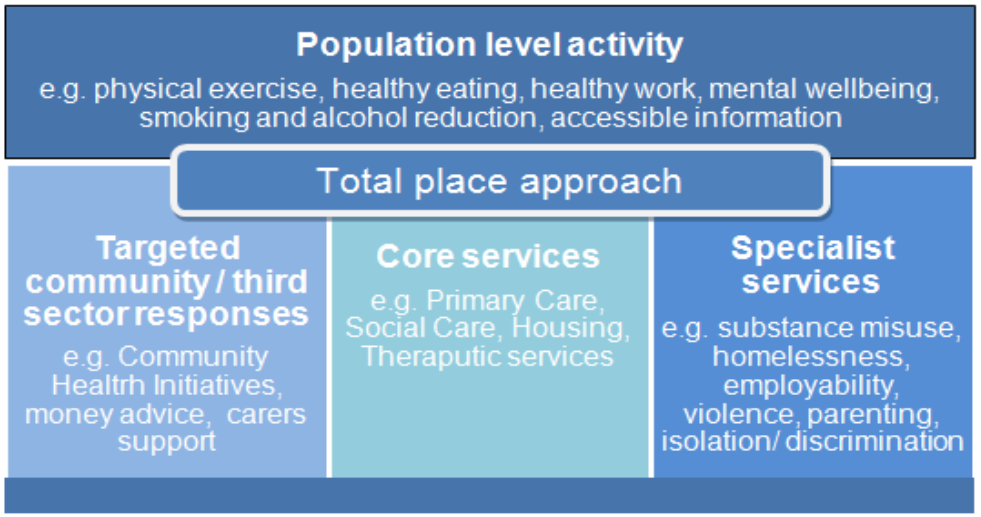
What we plan to do

Activity to tackle inequalities and make a positive impact on people's health and wellbeing takes place at a number of levels. Health promotion activity supports everyone to adopt healthy lifestyles whilst specialist services and initiatives target specific sections of the population, geographic areas or issues where health inequalities are evident. The diagram below illustrates how we categorise the range of activities involved in taking a joined up partnership approach to tackling inequalities.

The move to locality working will allow us to gain a better understanding of the specific issues that lead to poor health and wellbeing within each locality and help us and our partners work with citizens and communities to develop plans to address these. We will set out our approach to tackling inequalities in the We will set out our approach to tackling inequalities in the plans we develop for each

of the four localities during 2016/17 (see Action 6).

The third sector and social housing providers have a major role to play in tackling inequalities across the city through the provision of a wide range of services at a local and citywide level. We will fund a number of these through the Health Inequalities Grants programme in 2016/17 with a particular emphasis on increasing social capital, promoting healthy eating, physical activity and the use of green spaces, maximising incomes, supporting newcomers including refugees and asylum seekers and tackling stigma.



The core services delivered through the Health and Social Care Partnership operate across localities and work with the range of communities of interest in the city by supporting the population as a whole to remain as independent and healthy as possible. We also provide a number of specialist services targeting some of the groups that are most disenfranchised. Inclusive Edinburgh is a major initiative started in 2014 to engage all service providers to improve access to services, to provide psychologically informed services and to maintain an integrated response to people no matter the level of need, risk or complexity they present.
A number of initiatives have also been developed with a focus on supporting those who are most economically or socially disadvantaged.

A working group is in place to address health inequalities for people with learning disabilities. Membership of the group includes people with learning disabilities and staff from the Council, NHS Lothian and third sector organisations. The group is focusing its efforts on five specific areas: eating healthily, being active, health checks and screening, good mental health and access to health care

In primary care, 17 GP practices have become part of the Headroom initiative which aims to improve outcomes for people in areas with concentrated economic disadvantage. These practices cover 25% of the city's population and 50% of people living in areas of economic disadvantage. Working in partnership with the Council, third sector and other community organisations the Headroom

practices are using a range of interventions to test the effectiveness of new approaches. One example is social prescribing which involves supporting people to access community based activities as an alternative or in addition to prescribing medication or other mainstream services.

Action 9
We will build on the experience of the Headroom practices and other initiatives to develop the benefits and applications of social prescribing in order to determine where this approach is most effective and how to encourage wider take up as an alternative to traditional health and social care services.

The Patient experience and Anticipatory Care planning Team (PACT) works within the acute hospital setting using data on service usage to identify people who are frequently admitted to hospital and most at risk of emergency admission. The team seek out these individuals and work with them and the clinicians treating them to develop a shared management plan to reduce the likelihood of future admissions to hospital. This approach has proved effective to date. A significant proportion of the people the team works with are from groups most likely to be affected by social, economic and health inequalities.

Action 10
We will support initiatives such as Inclusive Edinburgh, Headroom, the Patient experience and Anticipatory Care Team (PACT), and the Health Inequalities and Learning Disability Group as part of our approach to gaining a better understanding of the most effective means of addressing health inequalities in the city.

Inequalities are deep seated within our society and whilst actions taken to address them will deliver some positive results in the short and medium term the real impact of much of the work in this area will take decades to be realised. The Health and Social Care Partnership will engage in targeted activities to address specific health inequalities and work with our partners to support activities intended to address the broader issues of social and economic inequality.

Action 11
During the life of this plan we will:

a) be an active partner in the locality based multi-agency Leadership Teams designed to tackle inequalities
b) work closely with NHS Lothian's Public Health service to ensure our approaches to tackling health inequalities are well founded and supported with appropriate evaluations

c) *engage with a wide range of community based organisations at the locality level in a preventative approach which recognises and works alongside community assets*

People with protected characteristics

It is imperative that all health and social care services are accessible, appropriate and inclusive of and sensitive to the needs of all and that consideration is given to barriers that can limit access for particular groups. There is detail throughout this plan about how we will support some of these groups, people with disabilities and older people for example; however, our intentions in terms of supporting LGBT people and people from minority ethnic groups may be less clear.

Action 12

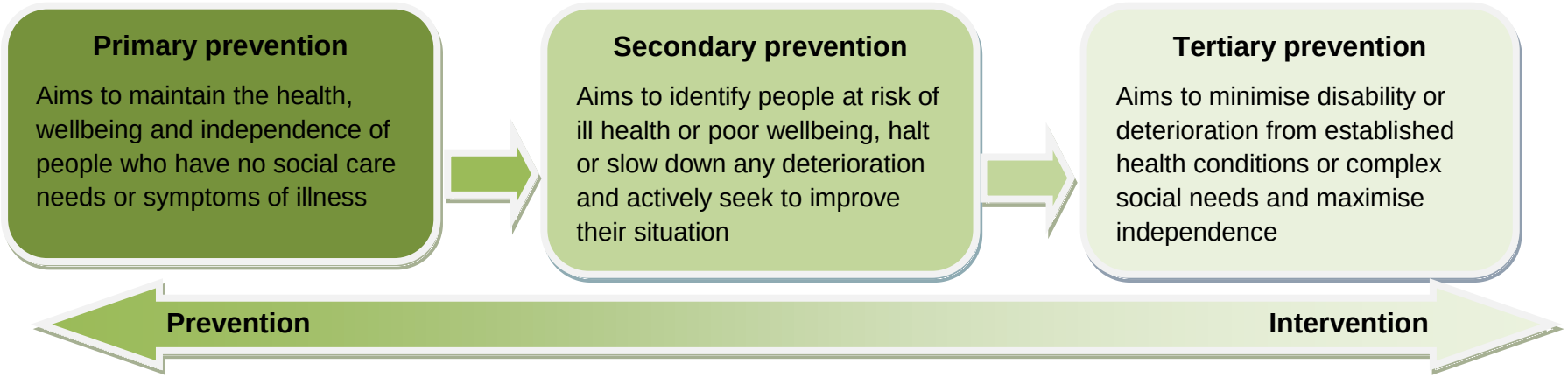
a) *We will continue to raise awareness and understanding of the challenges that LGBT people can face when accessing health and social care services, using the tools developed by projects such as Edinburgh LGBT Age.*
b) *We will work with people with protected characteristics to understand their needs better, provide specialist services where appropriate and improve access to mainstream services.*

8. Consolidating our approach to prevention and early intervention

There is a strong link between prevention and early intervention and tackling inequalities, so that action taken to address one of these issues is likely to have a positive impact on the other.

In 2001, the Christie Commission on the 'Future Delivery of Public Services' suggested that around 40 – 45% of expenditure on public services in Scotland was spent on addressing issues that could have been prevented if action had been taken earlier. Shifting the balance of investment in favour of services and approaches that prevent problems occurring or stop them from getting worse can improve outcomes for citizens, reduce future demand for services and make more effective use of available resources.

The Edinburgh Community Planning Partnership has produced a Prevention Strategic Plan, which recognises a continuum of prevention:



- It is estimated that the projected increase in the population of Edinburgh will lead to an increase in demand for health and social care services of 1.4% per year.
- 23% of the Edinburgh population have at least one long term condition, which increases their risk of emergency admission to hospital. Although the individual cost to the NHS of people in this group is relatively low, the size of the group means they

account for a significant level of expenditure. Consequently early interventions to prevent people's conditions progressing could have a significant impact on resources.

- Currently 27% of the adult Scottish population is obese; this is predicted to increase to 40% by 2020. Diabetes currently affects around 3% of the population in Edinburgh. If the prevalence obesity continues to increase, the prevalence of type 2 diabetes will also rise, which has significant implications for health and social care resources.
- Loneliness has been shown to be as harmful to long-term health as smoking 15 cigarettes a day. It can also put people at risk of developing dementia, high blood pressure and depression.

Throughout this plan we set out our intentions to develop and provide services that fit with the definitions of primary, secondary and tertiary prevention in the diagram above. However, there are a range of other services and initiatives, not mentioned elsewhere, that play a crucial role in helping people to improve or maintain their health and wellbeing and retain their independence.

Health screening programmes such as regular dental and eye check ups along with targeted national screening programmes e.g. bowel cancer, play an important role in identifying and treating problems at an early stage. The importance of ensuring that all citizens are able to access these services has already been discussed in the section on tackling inequalities.

Developing a preventative approach is a key theme within 'Live Well in Later Life', Edinburgh's Joint Commissioning Plan for Older People 2012-22. While demonstrating the impact of preventative services can be challenging due to the longer term nature of the changes made, significant evidence of impact is available. Some practical examples which show how preventative services are helping people and reducing the demand on health and social care services are:

- *"I go to the hairdressers every week by myself now. The Doctor is taking me off anti-depressants as they weren't helping me"* (Community Connecting)
- *"There was a consensus around the table that, over the period we had been working with Rita, she had presented at the surgery less. Previously she had frequently visited the surgery, often as a means of social contact, to talk about her low mood."* (Community Connecting)
- *"If the service had not been put in place David would be in a care home and not looking forward to a new sense of freedom"* (Community Alarms Service)

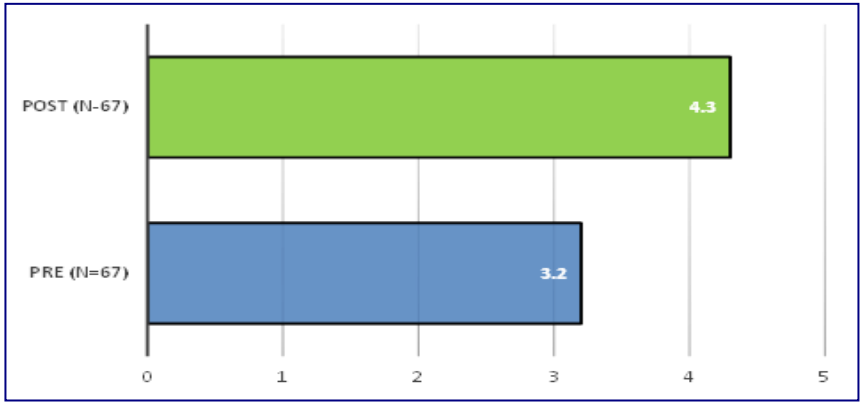
Additional investment from the Reshaping Care for Older People Change Fund (2011-15) and now the Integrated Care Fund has supported a range of initiatives across primary, secondary and tertiary prevention. We want to ensure sustainable funding if possible for successful initiatives following the end of this fund in 2018.

Regular physical activity helps prevent over 40 chronic diseases; evidence shows that just 150 minutes of moderate exercise a week reduces the chance of:

- Type 2 Diabetes by 40%
- Cardiovascular Disease by 35%
- Falls, Depression and Dementia by 30%
- Joint and Back pain by 25%
- Colon and Breast Cancer by 20%

There is evidence to suggest regular physical activity can also: improve mental health and well-being, reduce blood pressure and contribute to healthy weight maintenance.

Fit for Health is a physical activity programme designed to improve the health and well-being of people with one or more long term condition including cardiovascular disease, heart failure, respiratory disease, diabetes and peripheral artery disease. Fit for Health is currently delivered in partnership with Edinburgh Leisure at five leisure centres in Edinburgh.



Data collected since April 2014 demonstrates that people who have participated in the Fit for Health programme are now exercising more frequently. The graph above shows the number of days per week participants reported exercising for 30 minutes or more before (3.2) and after (4.3) taking part in the programme.

The risk of falling increases with age (30% risk for those over 65 years, 50% risk over 80 years) and with this comes increased risk of fractured bones. It is estimated that *40,000* older people in Edinburgh are at risk of at least one fall per year. in 2014 the Scottish Ambulance Service responded to *3,626* call outs to people over 65 years who had fallen, with 77% of these being taken to hospital. There were *6,853* falls related presentations to the hospital emergency departments.

Edinburgh's falls prevention strategy follows the National Framework for Community Falls Prevention in Scotland. The Falls Service also works in partnership with the Community Alarm Tele-care Service (CATS) who respond to approximately 9,000 calls per year to provide assistance to people who have fallen and carry a personal care alarm.

Following a fall, people can be referred for assessment to either Intermediate Care or Day Hospital Assessment Units. Some may be referred to community exercise programmes such as Steady Steps (run in partnership with Edinburgh Leisure) or the Be Able and Fit for Life programmes which use a reablement approach to improve personal resilience.

Action 13

We will:

- *a)* work with partners to map local services, assets and resources that could be used to improve people's health and wellbeing (Action 1)
- *b)* use locality level forums to assist organisations to come together, build relationships, share ideas and develop collaborative working and ensure the right people offer the right support (Action 1)
- *c) build on the development of the LOOPS (Local Opportunities for Older People) initiative to enhance the opportunities for older people to retain socially connected and independent lives within the localities where they live and continue to raise awareness across the public, staff and volunteers of opportunities locally*
- *d) identify local needs, gaps in services and develop co-produced and innovative solutions which build community capacity Priority areas include:*
    - *reducing social isolation*
    - *promoting healthy lifestyles including physical activity*
    - *falls prevention strategy*
    - *supported self management of long term conditions*
    - *support for unpaid carers*
    - *technology enabled care and supporting older people to use technology*
    - *transport options*

Support for unpaid carers

Unpaid carers play a vital role in supporting friends and family members with health and social care needs to live as independently as possible. We recognise the importance of supporting unpaid carers to both continue in their caring role and look after their own

health and wellbeing. The Edinburgh Joint Carers Strategy, co-produced in 2014 between the City of Edinburgh Council, NHS Lothian, unpaid carers and carers organisations has a vision that *adult carers are able to live healthy, fulfilling lives and that they will be valued as equal partners in the provision of care and inform decisions about carer support. Carers will be able to sustain their caring role, if appropriate and if they choose it'.* The Health and Social Care Partnership shares this vision and will support the delivery of the action plan to address the following six priority areas set out within the Carers Strategy:

- identifying unpaid carers
- information and advice
- carer health and wellbeing
- short breaks / respite
- young adult carers
- personalising support for unpaid carers

The Carers (Scotland) Bill is currently being considered by the Scottish Parliament. Once enacted the Bill will place additional duties on public bodies to provide support to young and adult unpaid carers and put them at the centre of decision making on how services are designed, delivered and evaluated. Two individuals with experience of providing unpaid care currently sit on both the integration Joint Board and the Strategic Planning Group. The Board will continue to work in partnership with unpaid carers during the implementation of this plan and the development of related plans and strategies.

Action 14

During the life of this plan we will:

a) *continue to implement the action plan associated with the Edinburgh Joint Carers Strategy 2014-17*
b) *develop a new Edinburgh Integrated Carers' Strategy and establish our new priorities in line with National Carers Policy, new carers legislation and the Integration Joint Board's priorities on prevention and early intervention*

9. Ensuring a sustainable model of primary care

Why we need to change

The term 'Primary Care' covers the wide range of health professions and support staff providing universal first line healthcare advice, diagnosis and treatment in the community and referring to secondary (usually hospital based) health services when needed. These staff include GPs, district nurses, physiotherapists, dieticians, podiatrists (chiropody), pharmacists, dentists and optometrists. The importance of engaging GPs in particular and primary care teams generally in health and social care integration is emphasised in the policy guidance which established health and social care partnerships.

A robust primary care system of GP practices, working well within communities and in partnership with other staff and services, such as wider community teams, social care and the third sector, is crucial to delivering the priorities in the strategic plan. We need to ensure everyone has access to the services of a GP practice in a timely way since GPs are the first point of contact for most people about health and care issues.

It is clear that the GP services in Edinburgh are under substantial pressure. This is due both to increasing workloads and the significant challenges facing GP practices in recruiting and retaining sufficient skilled staff. Workload pressures in primary care arise from a range of factors including population increase, an increasingly older population and the overall strategic direction to shift the balance of care from hospital to the community.

There are common workforce challenges which affect many of the different professional groups who work in primary care. These include an ageing workforce, more staff choosing to work part-time, staff numbers not increasing in line with increased population numbers and the more complex needs of people living at home, in care homes and in other community settings.

The ratio of GPs per head of population in Edinburgh has decreased overall since 2008, while workload has increased. This is not unique to Edinburgh and there is an ongoing national challenge in recruiting and retaining GPs including in out of hours services.

Integration offers an opportunity to look at community services holistically, including both social care services such as home care and health services such as district nurses, GPs, physiotherapists etc. It allows us to redesign how we work and to develop new models of care, which better connect health, social care and community services and resources around the needs of particular

individuals and groups, rather than around professional specialisms. We need to look at different workforce models for delivering primary care services in the future including better ways of using the medical expertise of GPs, advanced practice roles for nurses and a strengthening of the pharmacist role.

Integration also offers the potential to simplify the health and social care landscape to make it easier for staff and citizens to access the right care and support in a co-ordinated way. Making it easier for GP practices to access wider resources for prevention of admission and to provide "hospital at home" services is a key objective of the locality hubs. Primary care teams currently negotiate complex local networks to provide support for patients and we need make this simpler.

National discussions are underway on a new contract for GPs in Scotland to be implemented in 2017. We expect that this change will see a greater focus on using the skills of GPs as "Expert Medical Generalists" who assess health and care needs, develop and coordinate plans with patients and unpaid carers and work with extended teams to put these plans in place. This direction of travel fits well with our vision of integrated services. A national review of Out of Hours GP services has recently reported and we will work with East Lothian Health and Care Partnership which hosts this service in Lothian to consider the implications for the Lothian Unscheduled Care Service (LUCS).

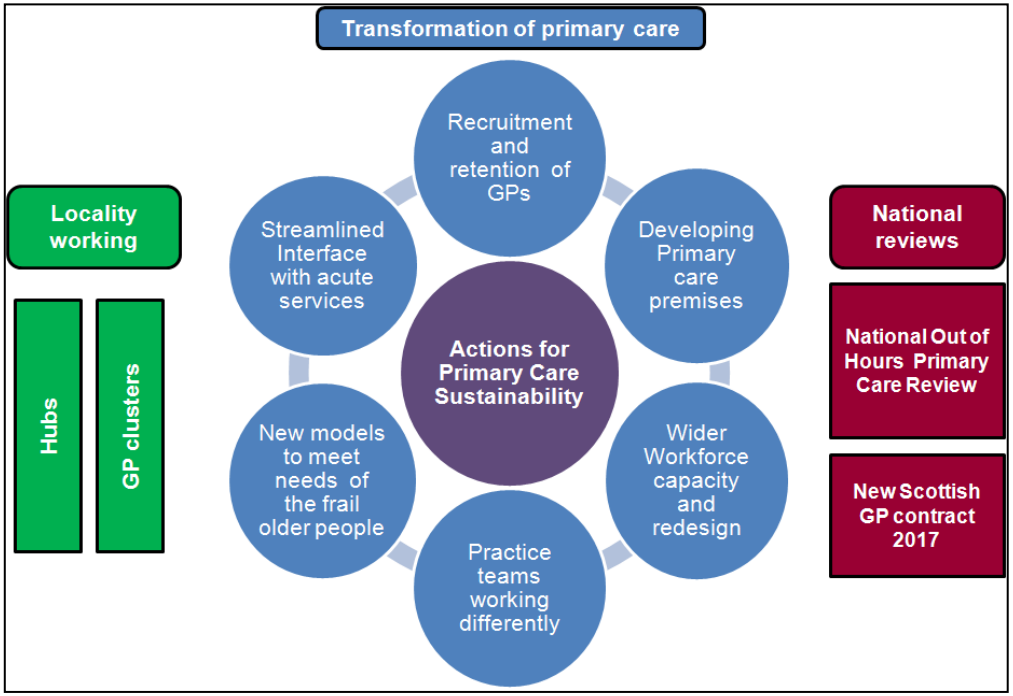
Primary Care Prescribing (by both GPs and others) for patients in Edinburgh costs around £70m each year. This equates to approx £143per person in Edinburgh, which is lower than other parts of Lothian and the rest of Scotland, reflecting existing good quality cost effective prescribing practice. Primary care teams will continue to work with the public to improve their understanding of the medicines they are prescribed, with the aim of increasing the health benefits and reducing the risk of harm and avoidable waste from poor compliance with treatments. While in many cases prescription medicines offer the best treatment for illnesses and long term conditions, for some people and problems other approaches, including "social prescribing", can offer alternative non-medical sources of support alongside or in place of medication.

What we plan to do

Our key aims are to support the transformation of primary care through 6 workstreams as set out in the diagram below.

i. Work with GPs to improve the resilience of practices

It is vital that we support practices in Edinburgh to remain viable and able to care for their registered population. We are already working with practices to identify difficulties and risks and find ways to resolve these. We are also committed to implementing measures to make general practice an attractive career and are implementing a range of measures to improve recruitment and retention of GPs in Edinburgh. This includes offering flexible roles which give GPs the opportunity for combination posts, looking at ways to encourage retired GPs back into part-time work and the national "GP returner scheme" to encourage those who have left general practice to return.



Action 15

We will continue to gather information from all practices to develop a better understanding of the workforce and to engage with GP practices on their 'resilience' in order to offer support at an earlier stage where a practice is experiencing staffing or other difficulties.

i. Supporting practices to work differently

Continuing to work in the same way is not an option. Through the development of localities and in particular the formation of eight GP practice based clusters across the City, we will support general practice and wider primary care to be at the centre of discussions on redesigning the system. GP leads from each of the Clusters will be invited to be part of the Locality

Management arrangements, ensuring Primary Care is able to influence the Partnership's operational planning and decisions. This will help us to develop more person centred ways of working and to be more integrated, efficient and productive.

We are already working with GP practices and other community staff groups to develop new and creative ways to work. This includes looking at new ways of accessing GP services, e.g. telephone follow up appointments; exploring the use of time saving technologies, e.g. self monitoring of blood pressure by patients; new ways to manage the needs of frail older people; developing the skill mix of staff in GP practices; employing pharmacists to manage pharmacy workload and medication reviews; opportunities for shared management and administration resources across practices.

Action 16
We will

a) *encourage and support general practice to examine new ways of working, to review their own workload and pressures, to look at new ways of working to support practice specific demands and to encourage redesign of general practice to meet these new demands*
b) *continue to support the 17 Headroom practices to explore new ways of working with economically disadvantaged communities and to test arrangements which can inform the 2017 GP contract*

ii. Building the wider primary care team capacity and capability

New ways of working are needed not just for GPs and their staff but for the whole primary care workforce so that they are better able to meet future demands. We will review the operation of all our clinical managed services, such as community nursing, pharmacy and allied health professions e.g. physiotherapists and redesign and develop these to meet the challenges we are facing. We will work with children's services to ensure effective transitions for children too.

A key priority in developing the primary care workforce will be to take steps to support all professional staff groups to be better integrated around the needs of the people they support. Through collaboration and innovative approaches, we want to ensure a sustainable and affordable staffing model for primary care and community services and work with acute services to share opportunities for skills development and shared learning.

Many services can be accessed directly without the need for a GP referral. We will work with national services like NHS Inform to make people aware that they should contact an NHS optometrist, dentist, pharmacist, podiatrist or physiotherapist directly for relevant problems, rather than their GP. This would save time for the patient and reduce the workload of GPs.

Action 17
We will do this by:

a) *identifying ways to maximise the contribution of community nurses who support those with healthcare needs, including frail older people living at home and in care homes, as part of developing a sustainable model of care for this group of people*
b) *continuing and extending medicines reviews for people taking a large number of medicines (polypharmacy) in care homes and in the community, focused on the high risk groups, linked to "Prescription for Excellence" funding*
c) *expanding the primary care pharmacy workforce, salaried and sessional, to work alongside and support GP practices*
d) *testing and rolling out models of "teach and treat" polypharmacy clinics to assist patients to better manage their own medicines*
e) *increasing opportunities for social prescribing for anxiety and depression, for example, as an alternative to prescription medication*
f) *considering better ways to inform the public of how to access directly health services which do not require a GP referral*

iii. Developing premises to meet population growth

The population of Edinburgh is growing by around 5,000 each year, so having GP practice premises in the right locations for people to access is important. The Edinburgh Primary Care Premises Strategy has been developed to identify practices and neighbourhoods where expanded or additional GP premises and/ or practices are needed, largely as a result of housing developments, or to replace older buildings which do not meet current standards. Finding sites for new practices to be built in the city will require joint working with Council planners and private developers, to ensure the need for land and resources for new or expanded GP practices is considered alongside the impacts on schools, roads and other amenities. We will continue to explore opportunities to re-use land and premises no longer required by NHS and City of Edinburgh Council for development to meet future needs.

Action 18

We will work with NHS Lothian to build and expand GP premises to increase capacity, including:

a) starting construction of 2 new partnership centres in 2016, incorporating GP practices and community services at Firrhill and establishing a new practice in North West Edinburgh

b) building new premises for Leith Walk and Ratho GP practices in 2016/17

c) relocating the Edinburgh Access practice (due to tenancy expiring) in 2016

d) exploring opportunities at up to 4 other practices to extend/refurbish practices to increase capacity

e) supporting a number of practices to create additional consulting space

f) exploring potential development opportunities for incorporating practice reprovision in wider healthy living initiatives

iv. New models to better meet the needs of the frail older people at home and in care homes.

The number of frail older people living in the city is growing and we need to ensure that primary care is able to meet their requirements. GPs have a key role in assessing and managing the healthcare needs of the very elderly living at home or in care homes, who are likely to be living with long term conditions and to need access to care and support on a more frequent basis. Our plans to develop alternative models to support frail older people to remain at or close to home are set out in the next chapter. These need to be designed to make best use of the skills of GPs and the wider primary care workforce, in particular community nurses and pharmacists and with easy access where required to more specialist expertise, including Medicine of the Elderly and Old Age Psychiatry. The Hospital at Home model aims to bring services and staff skills to the patient where possible, rather than transporting a frail older person unnecessarily to an acute hospital. Integrated community health and social care teams and locality hubs will be designed to enable a more joined up approach, making it easier for GPs to access the range of services and supports needed for their patients (Actions 3 and 4).

Action 19

We will:

a) take account of the learning from the Behaviour Support Service and Care Home Liaison pilots, to develop alternative models of support to care homes and ensure primary care and specialist teams engage effectively to allow older people and those with dementia to avoid unnecessary hospital admissions

b) deliver the recommendations of the "Promoting Continence in Lothian" report to improve community based support

for individuals

v. Improving the interface between primary and secondary care

We need to ensure that primary and secondary care work well together, so that people can have as streamlined a healthcare journey as possible, with information easily shared about medical history, current medicines and care arrangements to ensure patient safety and so that people do not need to repeat their story again and again.

When people do need the services of acute hospitals, especially in an urgent (unscheduled) situation, the process of referral and assessment at the hospital front door should be as simple to navigate for primary care as possible. The acute hospital should be able to develop plans for treatment and aftercare with input from the patients and their unpaid carers and the support of community health and social care teams, which avoid delays in discharge.

We want to shift the balance of care so that more care and support is provided at or close to home and GPs and the wider primary care team have a key role in co-ordinating care and providing the continuity of care people value. We say more about our approach to this is relation to older people and those with long term conditions elsewhere in this plan.

Providing good quality palliative care which supports people as they near the end of life is important too and the recent National Strategic Framework for Action for Palliative and End of Life Care will influence our plans in this area, along with the local redesign programme developed in partnership with Marie Curie.

Action 20

To help achieve integration of care pathways at a locality level we will work with:

- *a) other Lothian Integration Joint Boards and the acute hospital division of NHS Lothian to develop a single model for acute unscheduled care services across the city, including early assessment at hospital front doors and approaches which provide alternatives to admission and which work effectively with local community services in Edinburgh*
- *b) primary and secondary care colleagues to improve the efficiency and safety of processes for care across the interface between primary and secondary care to improve transitionms between the two, e.g. medication reconciliation and discharge planning*
- *c) support the implementation of the palliative care redesign programme in partnership across Lothian*

10. Improving care and support for frail older people and those with dementia

Why we need to change

Improving the care pathways for older people and people with dementia is one of the most urgent areas for attention if we are to provide the right care in the right place at the right time. 25% of the total health and social care budget relates to spend on older people's services.

Most people want to live healthy independent lives for as long as possible. People in Edinburgh are generally living longer which is a cause for celebration and older people make a very significant contribution to our communities as unpaid carers of both young and old, as volunteers and community leaders and by continuing as part of the paid workforce beyond traditional retirement ages.

However our ageing population also presents challenges for health and social care services, as the rate of growth in people aged over 85 is predicted to be greater than for any other age group and people are increasingly likely to develop more complex long term health conditions, including dementia, as they get older. Fundamental changes are required in how our services operate to make them more responsive and focused on maximising independence, early intervention to prevent deterioration, promoting rehabilitation and supporting people at the end of life with dignity and respect.

While this section focuses on older people, we know that living with frailty and long term conditions can also affect younger people and people with disabilities. We recognise that the care and support needs of individuals should take account of their unique circumstances and therefore services need to work across traditional service and professional boundaries.

Our key aims are to:

i. Shift the balance of care from hospitals to community based settings
ii. Develop whole system capacity plans to provide the right mix of services
iii. Improve support for people with dementia through integrated services which the provide the right support at the right time
iv. Embed rehabilitation, reablement and recovery approaches to maximise independence and support self-management
v. Develop services and activities that improve health and wellbeing and prevent or delay the need for more intensive support

i. Shifting the balance of care

There has already been a significant shift in the balance of care from hospitals to community.

- the percentage of older people with high level needs (10+ hours of care per week) who are cared for at home has increased
- the total number of hours of care at home provided has increased from 34,000 in 2012 to 40,000 in 2015
- the average size of individual care at home packages has risen by almost 2 hours per week
- the dependency level of people living in care homes has increased

In order to sustain the current balance of care and shift this further, a redirection of resources and new ways of working are required to enable community services to meet increasing demand and provide quality care for people living in the community with increasingly complex conditions.

We know that hospitals are not a good environment for providing longer term care for people whose needs could be met at home. In October 2015 there were 149 people delayed in hospital in Edinburgh. Reasons for delays can be complex but in the majority of cases it is because the level of care needed to allow the person to leave hospital is not in place. While the number of older people waiting in hospital for a care home place remained relatively stable during 2015, the number of older people waiting in hospital for a package of care at home increased. In November 2015, demand for care at home exceeded the capacity available by between 4,500 and 5,000 hours a week. This results in people remaining in hospital longer than necessary or waiting in the community, increasing stress on unpaid carers and increasing the risk of an unplanned admission to respite care or hospital. Workforce availability is a key factor limiting the available capacity.

We have established the Older People Service Redesign Executive to bring together those responsible for delivering assessment, treatment, care and support along the frail older people and people with dementia pathways to plan and deliver change. We are working with support from Healthcare Improvement Scotland to increase our understanding of demand, identify how we can better use our current capacity and develop plans to rebalance the system and address key gaps and barriers.

Action 21

a) From October 2016 we will commission care at home on a locality basis through new contracts with the

independent and third sector, ensuring that local care providers can work closely with local homecare organisers and engage with the locality hubs to maximise flexibility and capacity to meet care needs.

b) We will also support the development of alternative delivery models across market sectors to deliver cost effective and good quality care at home, through a potential third sector collaborative for example

c) We will work with housing providers and housing colleagues in the council to identify future needs and support the development of more accessible and affordable housing to meet the needs of frail older people and those with dementia

ii. Developing whole system capacity plans to provide the right mix of services

The partnership recognises the importance of developing our plans to ensure we can provide the right mix of service capacity if we are to provide the right care in the right place at the right time. We will continue to develop whole system mapping of capacity and demand, with support from Healthcare Improvement Scotland, to help achieve the optimum patient pathways and determine the resources we need to ensure seamless transitions for individuals from home to hospital when required and back to home or homely settings whenever possible.

Building sufficient capacity in primary and community care core services to support growing numbers of older people with increased levels of need in the community, including people living in care homes, is vital. A focus on prevention and anticipatory care is required across all services. Our plans to develop a sustainable model in primary care, set out in section 9 above, are key to improving care and support to help people live at home as long as possible.

Resources currently spent keeping people in hospital beds could be better spent providing the right kind of care and support to people at home. We will be working with the other Partnerships in Lothian and the acute hospital division to deliver alternative care models which will allow the resources currently tied up in Liberton Hospital and the Royal Victoria Hospital site to be redirected. Work is already underway to identify the longer term need for Hospital Based Complex Clinical Care in the city, taking account of recent Scottish Government guidance and consider options to ensure that patient facilities and staffing profiles meet these needs. This will incorporate learning from the Healthcare Improvement Scotland review of Hospital Based Complex Clinical Care in Edinburgh which is expected to report in April 2016.

Action 22

We will:

a) *consider the longer term needs for interim care beds currently being provided at Gylemuir House and determine the future model of delivery for this service during 2016*
b) *update our capacity plans for long stay nursing and residential care home places, including those which care for older people with behaviours that challenge and provide specialist dementia care, alongside our capacity planning for those whose needs cannot be met anywhere but a hospital during 2016.*
c) *explore the opportunities to use the resources and assets associated with the Royal Victoria and Royal Edinburgh Hospital sites*
d) *evaluate the need for the development of an Integrated Care Facility model to meet our capacity requirements for the care and support of older people as part of the Hospital Based Complex Clinical Care review and work with the council housing team to deliver homes for older people with higher needs*
e) *work with neighbouring Integration Joint Boards and the Acute Division of NHS Lothian to allow the closure of Liberton Hospital and release resources for reinvestment in community based services*

iii. Improving support for people with dementia

In Edinburgh, it is estimated that 7,823 people have dementia, over 95% of whom are aged over 65. People living with dementia are very likely to require high levels of health and social care support as their illness progresses. It is estimated that the average cost of dementia care and support per person is £27,647 per annum. A Scottish Government performance target introduced in 2013 requires that all people newly diagnosed with dementia have a minimum of one year's post-diagnostic support coordinated by a link worker. The partnership has provided a Post Diagnostic Support service since 2014, funded through the Integrated Care Fund. The service is coordinated by six Link Workers employed by Alzheimer Scotland, who deliver support to 300 people recently diagnosed with dementia.

Action 23

We will:

a) *develop an improved pathway for people with dementia from assessment, diagnosis and post- diagnostic support, including effective engagement between Medicine for the Elderly and Old Age Psychiatry Services, to ensure individuals get the specialist support they require in a timely way*

b) *develop a plan in response to the intended reduction in old age psychiatry inpatient beds at the Royal Edinburgh Hospital to ensure adequate capacity to provide appropriate discharge planning and personalised care and support in the community for people with mental health problems including dementia*
c) *provide training for staff in all sectors working with people with dementia*
d) *continue to develop the award winning Dementia Friendly Edinburgh programme*
e) *work with housing providers to support the development of more dementia friendly housing*

iv. Embedding rehabilitation, reablement and recovery approaches

There are many examples of services for older people that have been designed around the principles of rehabilitation, reablement and recovery which have been shown to deliver better outcomes for individuals whilst also making best use of resources. These services aim to provide intensive short term support to maximise the independence of people, supporting rather than doing things for them and focus on what is important to the individual. We want to ensure that everyone who can benefit has access to this opportunity and that this approach is embedded in all care pathways. Examples of such services supporting older people are: Reablement, Intermediate Care, Be-able, falls prevention and mental health recovery.

We know that a significant number of people have been unable to access reablement in the last two years due to blockages in our system and we are already taking urgent action to address this. Our overall capacity planning work will help us understand the reablement and rehabilitation capacity we need to deliver timely and appropriate care in the longer term.

Action 24

a) *We are temporarily increasing the level of care at home capacity to be able to offer timely access to reablement to match needs and ensure that people can move on from reablement with their longer term needs met, so that the reablement capacity is released to support others who can benefit from this service.*
b) *We will plan for the right balance of reablement and rehabilitation within our overall capacity planning work and ensure this is a core accessible support service within the locality Hub model going forward.*

Jenny's Story – how the locality hubs can make a difference

Jenny is 86 years old and lives alone.
She:
- copes okay with good support from her family who call in everyday.
- Receives 5 hours care at home a week to help her get up and dressed
- Attends a local lunch club run by a third sector organisation

In January 2015 Jenny's son, Bob, calls on her and find her in a very confused state, she has fallen and hit her head which is bleeding.

Bob calls Jenny's GP who comes out to visit her. The GP diagnoses that Jenny has a urinary tract infection, is dehydrated and has a very high temperature.

In the past the GP would probably have arranged for Jenny to be admitted to hospital. However, now he contacts the new Locality Hub.

Staff at the Hub decide that a community nurse is the best person to visit and coordinate support for Jenny.

The community nurse talks to Jenny and her family and decides that she can be cared for safely at home. To enable this to happen he arranges:
- a visit to the Day Assessment Unit so that Jenny can be re-hydrated; and
- additional care at home hours and additional support from the family to make sure that Jenny is eating, drinking, taking her medication and generally keep an eye on her to get her back on her feet

Jenny's family agree to call twice a day.
A volunteer from the lunch club also pops round to see Jenny and keep her up to date with what is happening at the club

After 10 days Jenny's condition is back to normal. The additional care hours are no longer needed and she can get back to the lunch club .

The introduction of Locality Hubs will increase the chances of Jenny and others like her being cared for in their own homes rather than admitted to hospital. This is better for her as she is able to maintain her independence and is happier. It is also a much better use of scarce resources to support Jenny at home and means that hospital beds are available when needed for those who cannot be cared for at home.

11. Transforming services for people with disabilities

There has been a welcome increase in the life expectancy of people living with a range of physical, complex and learning disabilities. In part, this is due to the greater survival rate of children with disabilities and improved support and rehabilitation for people with progressive conditions. At the same time, there has also been a change in social attitudes that recognises people with disabilities as friends, relatives and colleagues who have a valuable contribution to make to the life of their communities. In terms of health and social care this has led to a drive to support and enable people with disabilities to live as independently as possible, taking as much control over their lives as they wish and ensuring that they have access to services available to other sectors of the community.

Learning disabilities, autism, many physical disabilities, complex conditions and sensory impairments are life long conditions. However, responsibility for the provision of care and support for people with disabilities from both the NHS and social care changes at the point of transition to adulthood, with different services and budget regimes coming into play. This transition can cause significant difficulties for the young person, their families and unpaid carers. Detailed planning with families for their sons and daughters to live independently from them has been successful in significantly reducing the need for crisis placements. Early intervention in childhood with families of children with behaviours that challenge and recognition of the strengths of the person and the contribution they can make would improve transition to adult services. Planning for additional accessible homes through the City Housing Strategy will be an important action over the plan period.

The Health and Social Care Partnership will continue to develop models that help people with disabilities live more independent lives; reduce dependence on services by improving the response to families with children with disabilities; minimise breakdowns in service at points of transition; reduce dependency on night time services and reduce hospital admissions by enhancing community based services.

It is also important to recognise that some people may be living with a number of different disabilities, be aged over 65 and have experience of mental health problems. The Health and Social Care Partnership recognises the need to move away from approaces based around services or conditions and develop a way of working that is person-centred and focuses on the strengths, needs and aspirations of the individual. We believe that the move to locality working will help us make this shift.

Services for people with learning disabilities

The Scottish Government strategy the 'Same as You' indicated that 2% of the population have a learning disability with the vast majority being unknown to health and social care services. The City of Edinburgh Council knows of 3,405 people with learning disabilities in the city, 480 of whom are aged over 60. It is anticipated that the number of older people with learning disabilities will increase threefold over the next decade.

The main thrust of the Scottish Government's strategy for improving the quality of life for people with learning disabilities 'The Keys to Life', is about improving access to health care and support to achieve outcomes related to healthy life choices so that people's human rights are respected and upheld. We have already made reference in section 7 to the fact that people with learning disabilities are more likely to experience health inequalities than the majority of the population. Supporting people with learning disabilities to live as independently as possible in the community is central to delivering on both the Government's ambitions and the vision and priorities set out in the strategic plan.

40% of people with a learning disability have communication difficulties and within this group 80% with severe learning disabilities do not acquire effective communication. The provision of information and advice in easily understandable formats such as 'easy read' can greatly enhance people's ability to engage in ordinary activities. Supporting people with learning disabilities to take part in regular health checks enables them to be more involved and, take more control over their own health and wellbeing.

People with mild learning disabilities need support to navigate health and social care services and are particularly vulnerable to issues of adult or child protection and falling into debt, yet they struggle to access any support services. Welfare reform has dramatically affected people with disabilities, who need assistance to make claims and support to argue for basic benefit entitlements when they are reviewed.

Approaches that focus on building confidence, skills and friendships and the ability to travel independently are crucial to changing the service dependency culture in learning disability services.

The number of people with learning disabilities living into old age has increased significantly in recent years this section of the population also exhibits signs of aging earlier than their fellow citizens, an older adult with learning disabilities is considered to be someone aged over 50. The care and support needs of older people with learning disabilities also differ from those of other older people. However, the overall approach to supporting this group is to support people to continue to live as independently as

possible in the community. The Health and Social Care Partnership will take forward the work already taking place with partners in Edinburgh to develop and implement a strategy in respect of older people with learning disabilities.

The modernisation and redesign of hospital based learning disability services is dependent upon the development of integrated community services leading to a reduction in the need for inpatient learning disability beds. This fits well with the Health and Social Care Partnership strategy to transform services for people with disabilities by shifting investment from hospital to community based support. As many of these services are provided on a Lothian-wide basis and not just for Edinburgh, this will involve working in partnership with NHS Lothian and the Integration Joint Boards for East, Mid and West Lothian via the Lothian Learning Disability Collaboration, to agree both the allocation of funding released through the redesign of hospital services and to co-ordinate detailed plans for this to take effect.

Action 25

During the life of this plan we will:

- *a) work with partners to establish options for developing a cradle to grave service for people with learning disabilities in Edinburgh to improve support for the transition to adulthood*
- *b) work with NHS Lothian to modernise the learning disability inpatient facilities and develop forensic and positive behaviour support services in the community focused on prevention of admission to hospital*
- *c) reach agreement with Lothian partners on the allocation of NHS resources as hospital services are redesigned*
- *d) realign internal day support services for people with learning disabilities into complex care and community based support*
- *e) work with all providers of day support to develop a framework agreement for these services*
- *f) evaluate a model of working collaboratively across the NHS, social care, third sector and families to prevent admission to hospital, from either supported accommodation or the family home*

Services for people living with autism who do not have a learning disability

It is estimated that around 4,850 people in Edinburgh are living with autism, approximately 2,400 of whom do not have a learning disability. Whilst the diagnosis of autism in children is now more accessible, many adults have gone through childhood without their condition being diagnosed.

The Edinburgh Autism Plan for people with autism who do not have a learning disability was developed in 2013, in partnership between the City of Edinburgh Council, NHS Lothian, third sector organisations and people living with autism. The plan sets out six priority areas for action:

- development of a care pathway to ensure that people get the right service at the right time
- ensuring the wellbeing of children with autism
- providing better support on housing matters and the right kind of housing
- increased support in finding and keeping employment
- improving people's quality of life
- better training to increase awareness of autism in services and amongst unpaid carers

The Health and Social Care Partnership is committed to the ongoing delivery of the Autism Plan.

Action 26

During the life of this plan we will:

a) take action to raise awareness of autism amongst front line workers, unpaid carers and the public

b) develop a care pathway to improve access to diagnosis and post diagnostic support in the first year for adults with autism who do not have a learning disability

Services for people with physical disabilities

In 2007, there were estimated to be 30,735 people aged between 16 and 64 living with moderate to severe physical disabilities in Edinburgh, this figure is predicted to increase by 1.4% a year based purely on assumptions about increases in the size of the overall population. There is a higher prevalence of disability amongst those aged over 65 which is largely explained by the fact that the likelihood of developing a disability increases with age.

The Scottish Government have recently entered into public consultation on their Draft Delivery Plan 2016-2020 for implementing the United Nations Convention on the Rights of Persons with Disabilities intended to remove barriers and enable people with a disability to enjoy equal citizenship throughout Scotland. The four main outcomes of the draft national delivery plan are that disabled people, including disabled children, have equal and inclusive access to:

- the physical and cultural environment, transport and suitable affordable housing
- health care provision and support for independent living
- education, paid employment and an appropriate income and support whether in or out of work
- the justice system without fear of being unfairly judged or punished and with protection of personal and private rights

Whilst the Health and Social Care Partnership, as part of the Edinburgh Community Planning Partnership, will have a role to play in ensuring that all of these objectives are delivered, it is clearly the requirement in relation to access to health care and support for independent living that is of the most direct relevance. Our strategic approach is to assist people to build on their abilities to be as independent as possible. We will work in partnership with people maximising support to promote and enable self management of their conditions. Integration offers significant opportunities for collaboration to enhance further the delivery and provision of community support for and with people with physical disabilities, within the four localities and across the city.

The provision of accessible homes for people with disabilities is essential to promote independence and self-management and the housing sector are key partners in delivery of this. The Housing Contribution Statement in Appendix G sets out how housing agencies and Edinburgh Council Housing Team will work with the partnership to develop, allocate and adapt homes to meet needs.

The Health and Social Care Partnership is keen to foster more joint working across rehabilitation services and supports for people with disabilities, with the ultimate aim of shifting the balance of care to local community based services wherever appropriate. The re-provisioning of the Royal Edinburgh Hospital involves the redevelopment of MacKinnon House to provide outpatient and administrative services, plus the transfer of a range of Lothian-wide services currently provided at the Astley Ainslie Hospital to the new Royal Edinburgh Hospital campus. The services that will be relocated include:

- cardiac and stroke rehabilitation
- rehabilitation for traumatic and acquired brain injury
- rehabilitative and clinical care for people with progressive neurological conditions
- services for people who have experienced amputation
- services for younger trauma patients requiring a period of orthopaedic rehabilitation

NHS Lothian's Neurological Care Improvement Plan 2014 – 2020 sets out the case for change across tertiary, secondary and

primary care with the aim of developing universal pathways of healthcare across Lothian and across a range of conditions. Having a neurological condition is the most likely reason for people aged under 65 experiencing complex and physical disabilities. The NHS ambition is to ensure people receive effective healthcare, appropriate to their presenting condition from the most appropriate clinical area and are supported to be as well and as self managing as possible. Key stakeholders in the delivery of this ambition include third sector organisations and people with neurological conditions themselves. The initial clinical areas being prioritised to lead this service transformation are services for people with Parkinson's disease, headache and epilepsy.

Action 27

During the life of this strategic plan we will:

- *continue to shift the focus of day and home care services for people with physical disabilities from long term support to rehabilitation and life style management, building confidence, independence, local connections and support for unpaid carers*
- *re-align existing day support for people with physical disabilities to move from two sites to a single physical disability hub that will focus on rehabilitation, prevention and condition specific intervention and accommodate Edinburgh Community Stroke Service*
- *set up a new contract for the delivery of independent living services in the city that includes information and advice about self-directed support including Direct Payments*
- *work with housing colleagues to establish a programme for suitable accessible homes for people with physical disabilities and complex needs within the City's new build housing programme*
- *work with people with physical disabilities to develop a joint strategy, informed by the review of Hospital Based Clinical Complex Care, with a clear focus on supporting people to manage their conditions, build confidence and increase their independence*
- *develop the business case for the re-provision of specialist and complex rehabilitation services (hosted for Lothian at the Astley Ainslie Hospital) within phase 2 of the Royal Edinburgh Hospital Campus development*
- *work with primary care and the acute hospital sector to implement the Neurological Care Improvement Plan to support early intervention, self-management and planned access to specialist services when required in a timely way*
- *within the framework of the Neurological Care Improvement Plan, continue to progress the redesign of services for people with progressive neurological conditions such as Multiple Sclerosis and Huntington's Chorea, provided through the Lanfine*

Unit, to include a smaller in-patient provision, a Lothian wide community outreach team and options for flexible breaks from caring

- *implement the redesign of the amputee rehabilitation service with the support of the housing sector*
- *further develop the stroke rehabilitation service to improve outcomes for those post-stroke to engage in a range of activities including returning to work*
- *work with other Lothian Integration Joint Boards and the acute hospital division to reconfigure stroke services to improve patient outcomes including discharge support*

Services for people with sensory impairments

Around 20% of Edinburgh's population are living with a hearing or sight loss. These conditions are most prevalent amongst people aged over 60, whilst sight and hearing loss often goes unnoticed amongst people with learning disabilities, people with dementia and minority ethnic communities.

The Government's See Hear strategy published in 2014 sets out a framework for improving awareness, access and treatment for people with a sensory impairment. The British Sign Language (BSL) (Scotland) Act 2015 places a duty on public bodies to produce plans to increase the profile of BSL and its use in the delivery of services. The Scottish Government has committed to producing a national plan by 2017 with the expectation that other public bodies, including local authorities and the NHS, will produce local plans within the following 12 months.

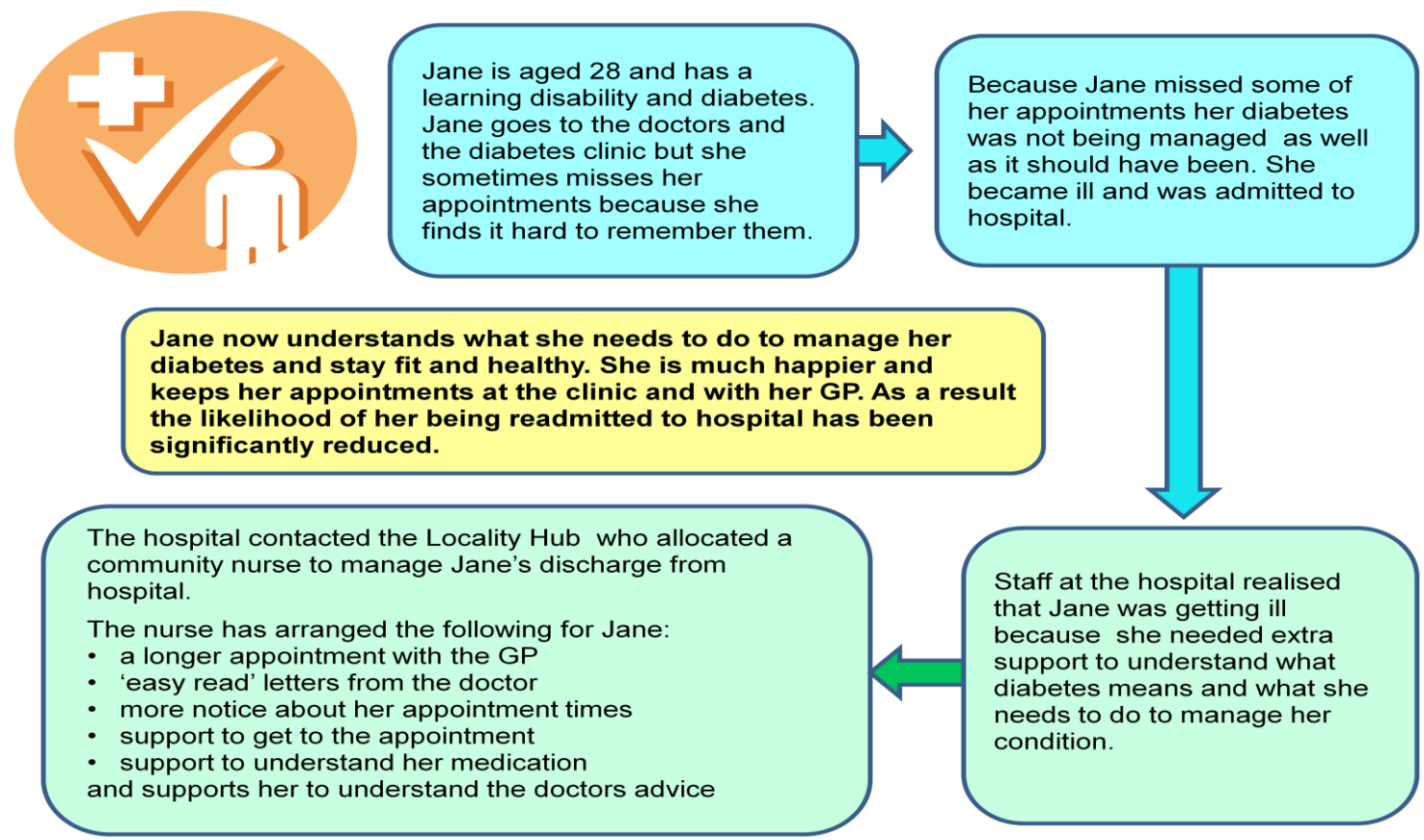
Action 28

During the life of this strategic plan we will:

- *implement a new contract for the provision of social work care management and assessment services, specialist equipment and rehabilitation for people with a sensory impairment (including an assessment of those people with sensory impairment at risk of fire and in need of particular fire alarms)*
- *work jointly to improve the pathway for audiology services focusing particularly on improving access for those people with hidden hearing loss and co-ordination of social support to people at diagnosis*
- *determine how early identification of and intervention with people with sight and hearing loss can improve the pathway for eye care services, paying particular attention to those groups whose sensory impairments often go unnoticed*

- *establish how the Scottish Government's sensory awareness training tools can best be rolled out in the city to improve quality of life*
- *respond to the requirements of the British Sign Language (BSL) Scotland Act 2015 building on the work of the sensory champions*

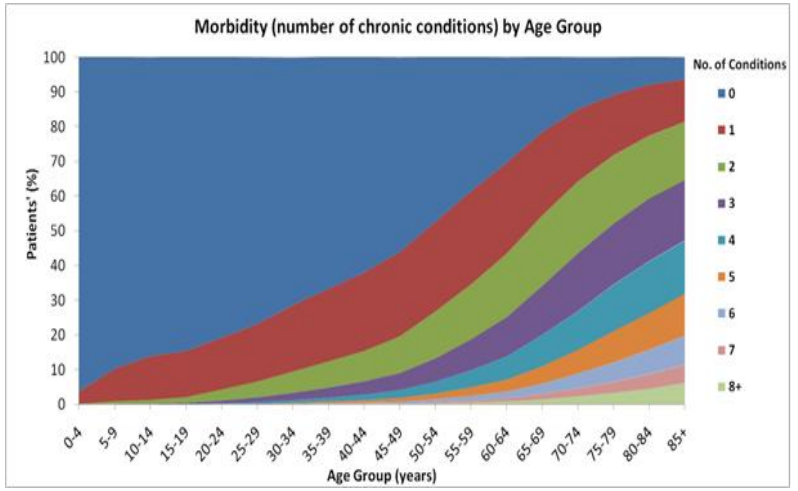
Jane's Story – how taking account of specific needs can improve health and wellbeing

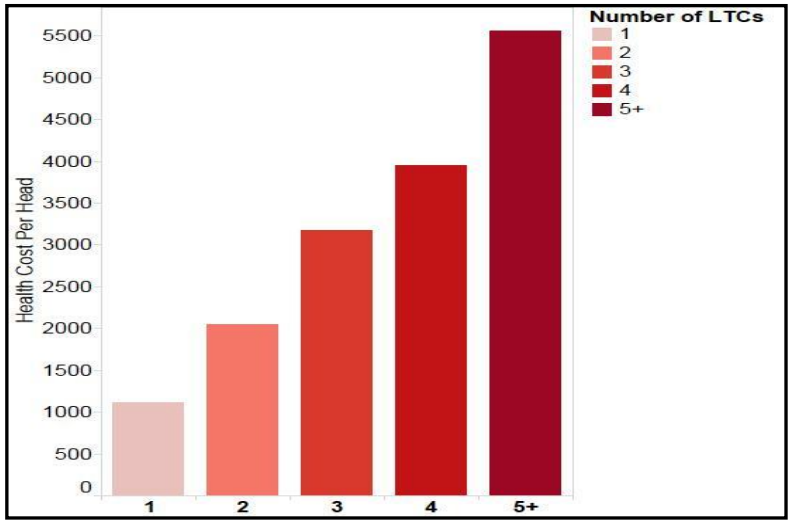


12. Supporting People living with Long Term Conditions

The case for change

People in Scotland are living longer and long term conditions are increasingly common. Many more people are living with more than one long term condition than ever before. (Common long term conditions include epilepsy, diabetes, heart disease, arthritis, chronic pain, asthma and chronic obstructive pulmonary disease (COPD)). In Edinburgh we estimate that 23% of people have at least one long term condition and 38% of these people have two or more long term conditions, known as multimorbidity. Much of the health service is designed to care for each condition in isolation. People with multiple long term conditions often experience disjointed services and have a high 'burden of treatment' from the various professionals who support them to manage their conditions.





We know that as people get older they develop more long-term conditions and their use of health and social care services increases and becomes more expensive. The top graph [1]opposite illustrates the increased prevalence of long term conditions with advancing age. People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer and account for over 60 per cent of hospital bed days used. People with multimorbidity account for 78% of consultations in primary care**.** The bottom graph

[1] Barnett, K., et al., *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* Lancet, 2012. **380**(9836): p. 37-43.

opposite shows the health costs per person for people with one or more long-term condition.

Many people with multiple long term conditions will require support from services other than health including from the voluntary sector, social housing, social care and employability services. Far greater integration and signposting is needed between these and health services.

'Many Conditions, One Life - Living Well with Multiple Conditions', is the national action plan to improve care and support for people living with multiple conditions in Scotland by adopting a Whole Person, Whole Team and Whole System approach:

- Whole Person: changing the conversations and shifting the relationship between the person and the professional in every consultation;
- Whole Team: new ways for health and care professionals to work together and with volunteers and community supports, around the GP practice;
- Whole System: improving the way that care and support is planned and co-ordinated across the whole pathway between home and hospital

The vision of Edinburgh's Health and Social Care Partnership is to deliver integrated services using the House of Care model detailed on page 16, which offers many benefits to people with multiple long term conditions, allowing them to have 'good conversations' focused on what is important to them and have their care planned in a collaborative way.

Edinburgh's Long Term and Multiple Conditions Programme has focused on improving care for people with long term conditions by developing integrated care service models that use technology, prevention, anticipatory care and supported self-management approaches to provide people with more information about and have better control over their condition. We have identified those people who are most likely to be admitted to hospital because of their long term condition(s) and created five specialist community based health teams to support them by providing more complex care in the community, preventing avoidable hospital admissions, embedding anticipatory care and self-management approaches and avoid inconsistencies.

To date, the programme has primarily focused on people with a single long term condition and our challenge is to capitalise on the opportunities that an integrated health and social care partnership present to better support people with multiple conditions to self-manage their condition and to reduce health inequalities.

What we plan to do

The Long Term and Multiple Conditions Programme aims to deliver the key components of the 'Many Conditions, One Life' Action Plan to not only improve the care of people with long term/multiple conditions but also to transform their use of health and care services and enhance personal resilience and community capacity.

Identification and Risk Stratification

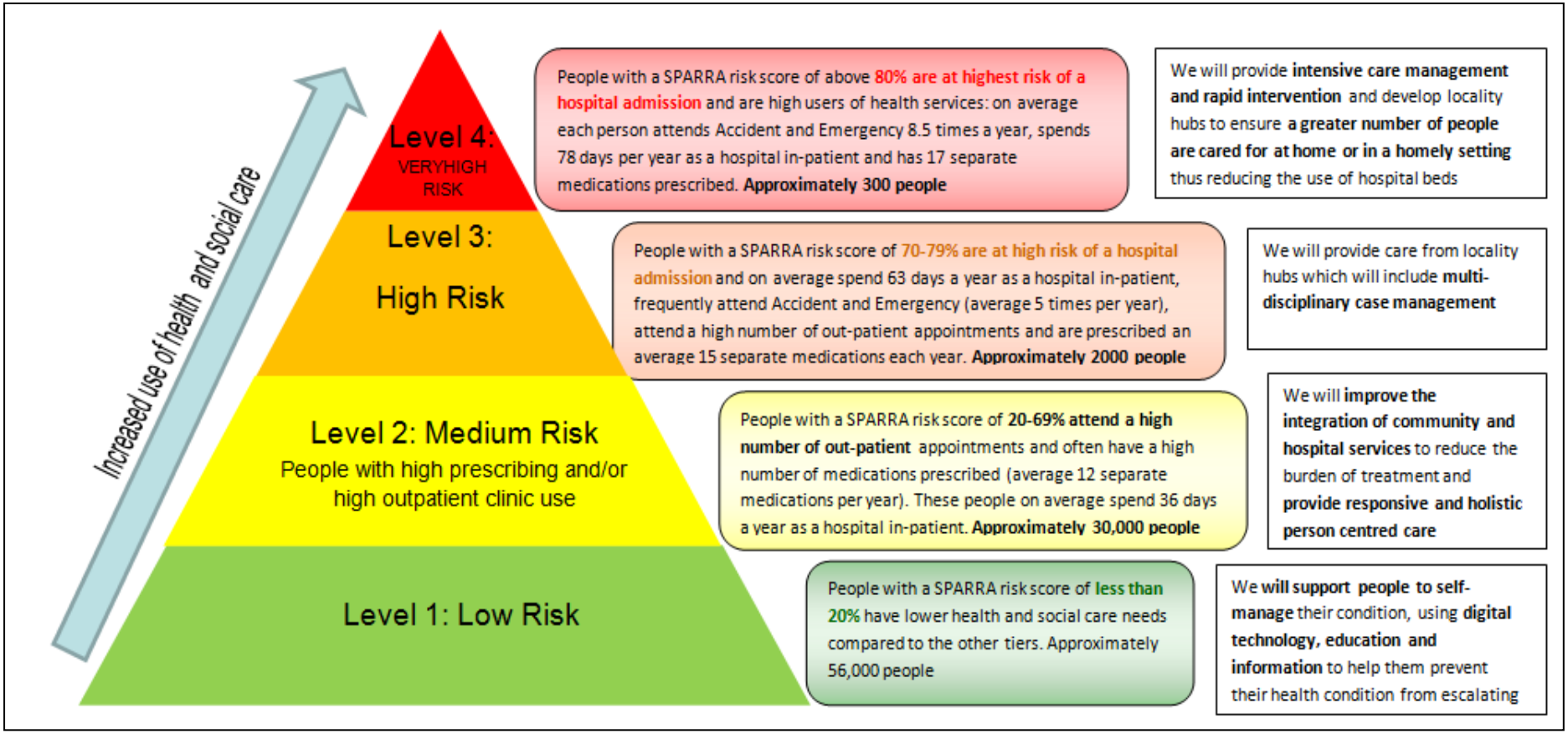
The Scottish Patients at Risk of Readmission and Admission (SPARRA) database predicts the risk of emergency admission to hospital in the following year for patients in Scotland. By analysing activity such as the number of drugs prescribed by GPs, Emergency Department attendances, hospital admissions and out-patient appointments, patients are allocated a risk score of between 1% and 100%, which predicts the likelihood of an emergency hospital admission within the next year.

The Long Term and Multiple Conditions Programme will continue to use SPARRA data and data produced by GP practices, hospitals and community health teams to identify people who are most at risk and would benefit from support. We have identified three overlapping groups of people with long term conditions/multi-morbidities for whom we will design a tiered approach to improve their care:

1. People with long term conditions/multimorbidities who are high users of hospital in-patient beds
2. People who require improved condition specific management (e.g. COPD, Diabetes, Heart Failure) to reduce their risk of becoming high users of hospital beds as well as improving their resilience and capacity to self-manage and reduce their reliance on statutory services
3. People with long term conditions /multimorbidities who will benefit from supported self-management and use of technology to improve their ability to use services efficiently and prevent early progression of their condition.

The diagram on the following page illustrates the tiered care approach using SPARRA data for 2014/15.

Health and Social Care services within the programme will work together in an integrated way to develop locality based services that provide targeted support for people within each tier.



The tiered approach requires the development of a range of services which include, for those most at risk, intensive case management, to the provision of information, anticipatory care and self-management plans and increased use of technology for those at the lower end of risk. We will continue to scale up the use of home monitoring and digital platforms like *Living it Up,* so that people with long term conditions can benefit from online support to help them stay well and contribute to the community. We will work in partnership with the third sector to develop support for people to understand and self-manage their conditions to improve

their health and resilience and reduce their reliance on statutory services.

Action 29

We will:

a) *continue to use SPARRA and other health and social care data to identify high risk individuals and work with them their families and unpaid carers to agree how best to reduce the risks to their health and wellbeing*
b) *work with locality based hubs to deliver holistic, person-centred care for people with complex multiple conditions to effect reductions in hospital bed days, improved anticipatory care planning, self-management and medicines management.*
c) *carry out multi-disciplinary reviews led by advanced practitioners providing expert clinical advice, including pharmacy input to rationalise medicine regimes by using medication prompting for example to reduce the need for visits*
d) *work in partnership with the third sector and NHS Lothian's House of Care Collaborative to deliver an integrated model of self-management, social prescribing and peer support for people with long term conditions*
e) *signpost people to digital platforms like Living It Up to benefit from online support to help them stay well and contribute to the community*
f) *work with housing options and Edindex at a local level to ensure the right long term solutions are planned with people to enable them to remain living independently*

We recognise there is an overlap between people with long term and multiple conditions and other care groups including frail older people and people with complex needs. We plan to work with these groups to co-ordinate the care of those people at highest risk of a hospital admission through the locality hubs.

Integrated care for people with Chronic Obstructive Pulmonary Disease (COPD)

Building on the success of our Chronic Obstructive Pulmonary Disease (COPD) model, we will continue to develop integrated care models and adopt a Whole Team approach with our internal and external partners including the Scottish Ambulance Service, Managed Clinical Networks, Lothian Unscheduled Care Service and the third sector. We have created a virtual community based Respiratory Hub which brings together specialists from nursing, physiotherapy, occupational therapy, pharmacy, psychology and respiratory medicine to work together with our partners to support people.

By working in an integrated way, the multi-agency Community Respiratory Hub delivers consistency in the way people with COPD are cared for during the day and at night. The service has been recognised nationally through a number of awards for innovation, team working and person-centred care. The Hub creates an environment for choosing well, ensuring patients have access to the right service at the right time in the right place in line with the Partnership's vision.

Action 30
We will continue to develop the multidisciplinary/multi-agency COPD integrated care model to target patients most at risk of hospital admission/readmission, to extend the reduction in hospital bed days and to use transferable learning in the development of services for complex patients with multimorbidity in locality based hubs.

Managing the increasing number of people living with diabetes

A growing concern for the health of our population is the increasing number of people living with diabetes. 16,430 people in Edinburgh have been diagnosed with diabetes (3.32% of the population). While lower than the Scottish rate of 4.6%, we know that the numbers are expected to rise dramatically. It is estimated that the treatment and care of patients with diabetes accounts for 10% of total NHS costs,[2] while in Edinburgh more than 8% of the primary care prescribing budget is spent on medication and monitoring of diabetes.

Section 8 above emphasises the opportunities for the prevention of diabetes, through encouraging people to take more exercise and support for weight management. GP practices are already being encouraged, through an Enhanced Service Fund, to put in place care plans for newly diagnosed type 2 patients whose care can be managed in primary care and diabetes specialist nurse posts have been piloted in North and South Edinburgh.

Action 31
Over the life of this plan we will work with the Lothian Diabetes Managed Clinical Network to implement the national Diabetes Action Plan which aims to put in place improved and consistent pathways for people with both type 1 and type 2 diabetes and to increase public awareness of the risks and consequences of this condition.

[2] Scotland. Scottish Government Health Department. Diabetes Action Plan 2010 – A Summary. Scottish Diabetes Group. August 2010. Diabetes UK.

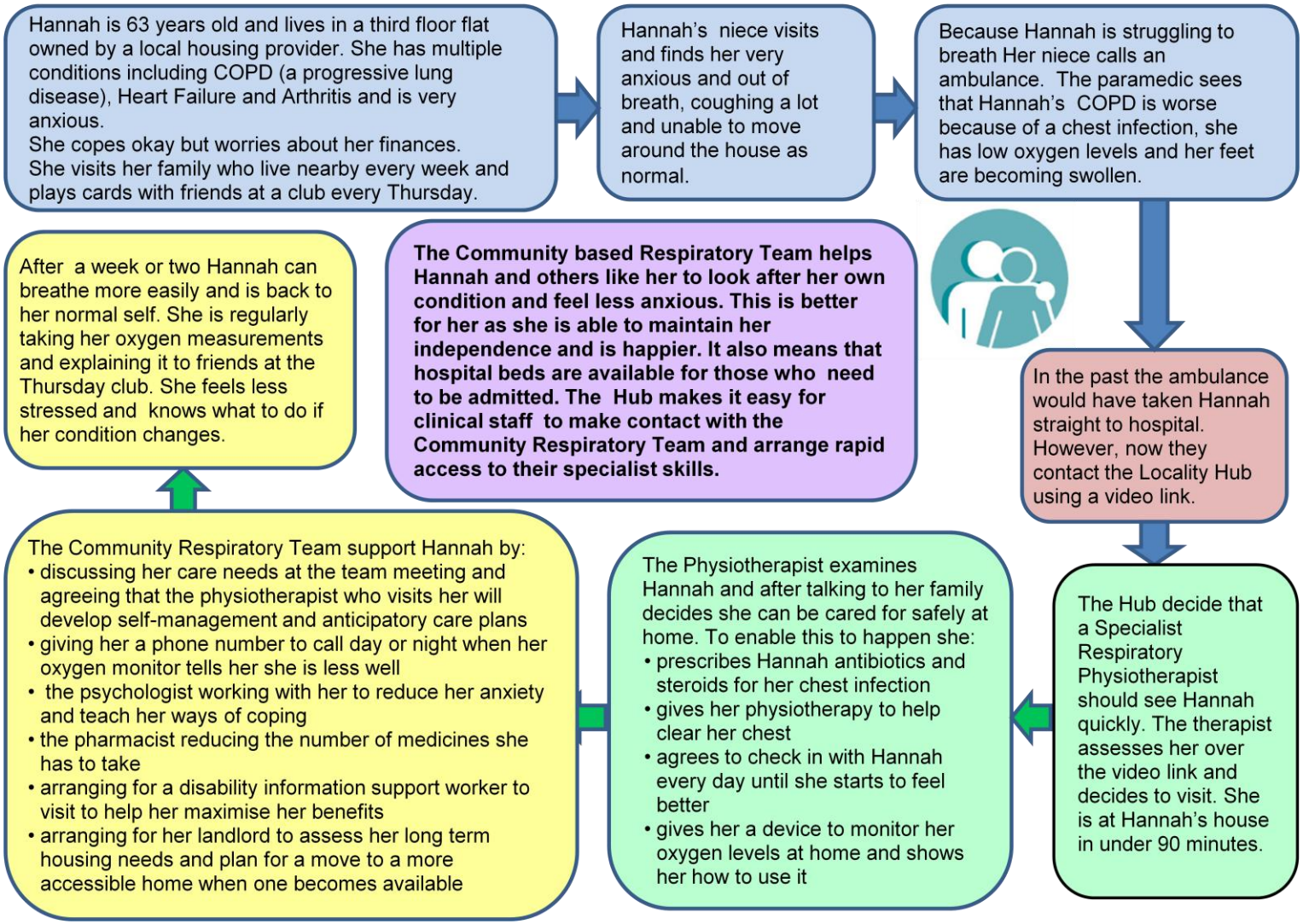
Anticipatory Care Planning - use of Key Information Summaries (KIS)

Anticipatory care plans allow people to have greater choice and control over their care and support by recording their wishes in the event of future deterioration in their health. They also contain vital health and social information that will help healthcare professionals to make decisions on the most appropriate care for that person based on their wishes. Anticipatory Care Planning will be further developed in each locality. We will continue to work with hospitals, general practices and community based teams to increase the number of staff who routinely create and access electronic Key Information Summaries (KIS) so that they make decisions based on the person's wishes and preferences.

Action 32

We will increase the quantity and quality of new and existing anticipatory care plans, ensuring these are created and shared using electronic Key Information Summaries (KIS) and contain information based on the person's wishes, including preferred place of care. We will achieve this through integrated working and by providing training to health and social care professionals.

Hannah's Story – how the Community Respiratory Team can make a difference



13. Redesigning Mental Health and Substance Misuse Services

Mental Health Services

The case for change

Our mental health is just as important as our physical health to our overall health and wellbeing. We know that over 25% of the population of Edinburgh, more than 120,000 people, will experience a mental health problem at some point in their lives. Anxiety and depression are the most common conditions; others include schizophrenia, personality disorders, eating disorders and dementia.

Mental ill health is not evenly distributed across society and is more common in socio-economically disadvantaged areas[3][4]. Old age is also a risk factor for poor mental health with depression affecting one in five older people living in the community and two in five living in care homes[5].

There are also clear links between mental health problems and substance misuse problems; some people will experience both of these and may require complex and coordinated responses from treatment and support services. Some of the determinants for poor mental health and substance misuse are similar with both problems more prevalent in less affluent areas. The key components of recovery are also similar and involve reducing isolation, helping people to connect with their communities, reducing stigma and supporting people into employment and to take part in meaningful activities.

The four key priorities in the Joint Lothian Mental Health Strategy A Sense of Belonging 2011-2016, still represent the aims we need to pursue to improve the health of our population. These are closely aligned with the key priorities on which this Strategic Plan is based:

- tackling health inequalities
- embedding recovery and living well
- building social capital and wellbeing

[3] SPICe briefing, Mental Health in Scotland, May 2014
[4] Scotland's Mental Health, October 2012, NHS Health Scotland
[5] Adults In Later Life with Mental Health Problems, Mental Health Foundation quoting Psychiatry in the Elderly, 3rd edition, Oxford University Press, 2002

- improving services for people

Much has happened to progress these priorities, with a well established Recovery Network, shifts in the balance of care as a result of investment in community services and resources and a focus on building personal resilience through enabling people to engage with their local community. In recent years specialist services have been put in place for people suffering from post-traumatic stress, for new mothers with mental health problems and for those with eating disorders. Alongside this the number of acute hospital beds has been reduced, with intensive home treatment and crisis care and support providing alternatives to hospital.

However, we know that more needs to be done to improve mental health and wellbeing. The integration of health and social care provides the opportunity to further develop local, integrated services that are easy to access and provide early intervention, prevent hospital admission where possible and support early discharge from hospital.

The first phase of development of the Royal Edinburgh Hospital, which opens in December 2016, will reduce the provision of bed based hospital care for people with mental health problems. At present too many people are unable to move on from a stay in acute mental health wards because the care and accommodation they need is not available; this has to be a major priority to address. Currently 25% of hospital inpatients aged under-65 are either waiting for supported accommodation or waiting for an alternative NHS resource such as the inpatient rehabilitation service. The problem of delayed discharge is caused in part by historically lower levels of investment in community mental health services in Edinburgh than the Scottish average. More community services including supported community places therefore need to be developed.

The recent review of progress in the implementation of A Sense of Belonging and consultation on Edinburgh's mental health and wellbeing commissioning plan identified the following priorities which we are developing plans to address:

- improved access to services
- prevention and early intervention
- delivery of personalised services to support recovery
- support to keep people safe and well
- improved health and wellbeing

Improving Access to Services

We want to move to a new locality based way of developing services which make better use of local assets to improve access to community support for individuals and prevent the need for hospital admission. This will include exploring how we can join up

physical and mental health care so that people can access support via a single point. We will learn from and build on the initial work of the locality hubs described in section 6 and work closely with third sector partners and service users to design more integrated and personalised responses to meet people's needs.

We need to work together with our partners to transform the delivery of operational mental health services, integrate health and social care staff into more effective teams, provide care and support closer to home and make use of innovative technology.

Action 33

We will:

a) *implement the agreed mental health locality partnership model beginning in North East Edinburgh with a focus on the communities of Craigmillar, connecting with Total East and Leith and maximising the opportunities of the "GameChanger" Public Social Partnership being developed with a range of partners focused on the population of this locality which we know has the highest percentage of people with long term health problems*

b) *review the current service model with inpatient service teams to ensure that there is a coherent and effective model of care across community and hospital services in place prior to the opening of the new acute facilities in the phase one redevelopment of the Royal Edinburgh Hospital in December 2016*

c) *continue to work with colleagues across Lothian to reduce the waiting times for people who require specialist psychological therapies to meet the Government standard of 18 weeks, including identifying opportunities to work more effectively with third sector partners who can offer a wider range of support*

d) *through our locality partnership model, seek to maximise the opportunities for shared premises accommodating health and social care, other public sector agencies and the third sector in each of the localities to make it easier for people to access a range of supports in one place*

Prevention and early intervention

We know that there is opportunity for much greater use of peer support and peer working, which can be very valuable to people on their recovery journey. We have evidence that this approach works from models in place in mental health, substance misuse and other services and we want to ensure it is part of our holistic support and service model.

There is capacity for much greater joint working across third sector organisations and consultation on the health and social care commissioning plan in 2014 has resulted in a decision to take forward future commissioning through a co-production process. This will allow joint planning and delivery of a more responsive and appropriate range of services and support which will include exploring the opportunities for greater self-directed support enabling individuals to have more control over their lives and take more personal responsibility where possible. We do need to take actions to live within our means and we believe that the co-production approach will allow us to maximise benefits from spend through third sector partners which will achieve better outcomes overall.

We will continue to work with partners to reduce the number of suicides in Edinburgh with a particular focus on those groups who are at most risk: younger men and men aged between 40 and 55. This will include training for partner agencies and specific initiatives.

Action 34
During 2016 we will redesign wellbeing and preventive services by using approaches that engage citizens, service user and unpaid carer groups and other partners to focus on co-designing services that meet identified needs. A range of commissioning options will be considered for co-produced and delivered services to be in place by April 2017.

Delivery of personalised services to support recovery

As part of the overall service model we will work with NHS Lothian to ensure improvement in the therapeutic environment, culture and rehabilitative focus of inpatient services at the Royal Edinburgh Hospital campus as the hospital is redeveloped. This will include acceleration of the “green space; art space” Public Social Partnership which will create volunteering and employment opportunities for service users.

Health and social care community teams will be integrated to focus on reablement, recovery and personalised approaches, providing early intervention to prevent hospital admission and to support and facilitate timely discharge from hospital if admission is necessary

We will support NHS Lothian to develop business cases to:

- put in place provision for those who require relational, procedural and environmental security, to comply with legislation and ensure that people are not cared for in conditions of excessive security

- commission and deliver a service for women with multiple and complex needs to enable more women to receive appropriate care and support closer to home

Action 35

The partnership will:

a) *significantly improve the rehabilitation pathway for those who have longer term needs for care and support, including the urgent production of a business case to commission and deliver up to 15 community places with 24/7 support, in time for the completion of phase 1 of the Royal Edinburgh Hospital. This builds on the Firrhill development recently commissioned which provides 6 places as part of the Wayfinder Programme.*
b) *explore other opportunities for community provision for those with 24/7 community support needs*
c) *deliver the new Rivers Centre Public Social Partnership which will provide a new centre for the treatment of people of all ages whose lives are adversely affected by the impact of trauma by Spring 2016*

Support to keep people safe and well

We know that recovery from mental health problems requires ongoing access to care and support for many people and that avoiding social isolation and having a warm and secure place to live is essential to keep people safe and well.

Action 36

We will work with partners from the Edinburgh Affordable Housing Partnership, housing colleagues in the council and third, independent and statutory sector partners to ensure we maximise the potential for people to live well in community settings with timely access to inpatient care when required.

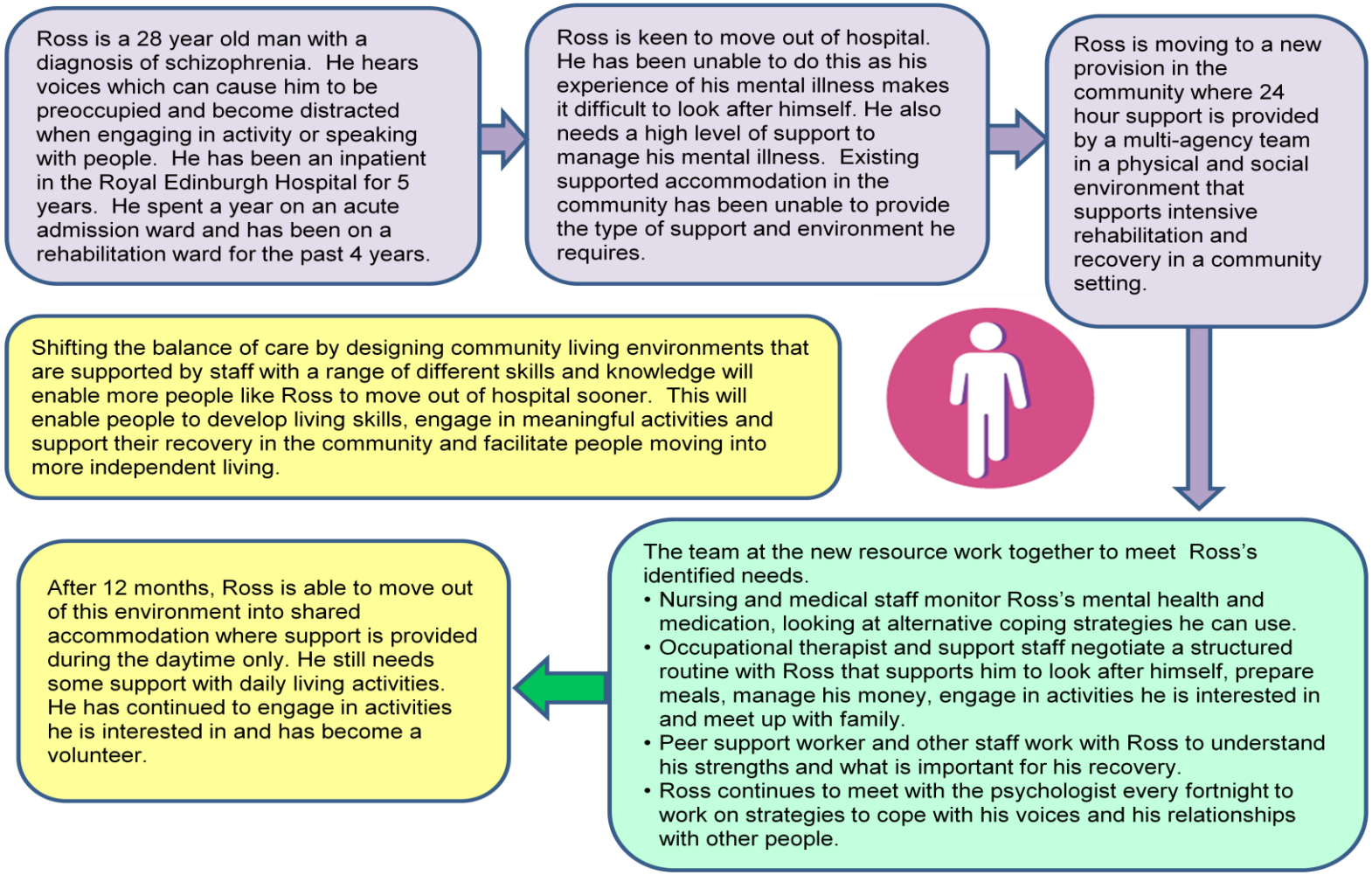
Improved health and wellbeing

We will continue to commission and support independent and collective advocacy provision to meet statutory requirements and to mitigate the impact of compulsory (legal) measures on those individuals with mental health problems and mental illness. A review of current provision is planned commencing March 2016 which will take account of the updated Mental Health (Scotland) Act 2015.

We will continue to engage with and use the learning from the Wayfinder Project Knowledge Transfer Partnership between NHS

Lothian, the City of Edinburgh Council and Queen Margaret University to develop the evidence base for the pathway redesign of adult mental health services, learning from best practice examples nationally and internationally.

Ross's story: How highly supported living environments can enable independent living



Substance Misuse Services

The case for change

It is estimated that there are 22,400 people in Edinburgh with dependent drinking. Alongside this there are 6,600 people with problem drug use (using heroin and/or benzodiazepines only). More than half of those who access substance misuse services are thought to have mental health problems of varying degrees of severity.

In Edinburgh, the estimated number of young people between the ages 15 and 24 with problem drug use rose from 520 in 2009/10 to 730 in 2012/13, an increase of 40.4%. Over the same period in Scotland as a whole the numbers in this age group decreased from 7,900 to 6,600, a reduction of 16.5%.

The reported rate of drug-related births in Edinburgh is almost twice the national average and a third of drug and alcohol users in contact with services in Edinburgh have at least one dependent child.

Edinburgh Alcohol and Drug Partnership (EADP) is one of the eight Strategic Partnerships within the Community Planning Partnership, leading on the planning of responses to substance misuse, alongside and on behalf of the Integration Joint Board. Adult treatment and recovery services, health and social care services and the third sector are key members of the EADP alongside, Police Scotland, Criminal Justice Social Work, HMP Edinburgh and people with lived experience of substance misuse. The EADP's current priorities span new service developments and improvements to the organisation, co-ordination and delivery of services and reflect a national and local policy shift towards helping people through recovery journeys as well as reducing harm.

The development of a recovery community has already started in Edinburgh, creating a social focal point for people who have achieved abstinence. The peer support component within treatment and support services is being developed to encompass all areas of delivery. Peer support workers will be well trained and supervised to ensure they sustain their own recovery whilst supporting others. Consideration is also being given to how people who continue to use methadone (and are therefore in treatment) can be seen as a part of the recovery community.

The impact of parental alcohol and drug use on children remains a challenge, including the impact during pregnancy. The EADP commissions a specialist service (Prepare) that brings together maternity, health visiting and alcohol and drug treatment services to support pregnant women who do not effectively engage in mainstream services. Alongside this, there are specialist family support

services for children and their families affected by these issues. There is recognition that adult treatment and recovery services need to develop to meet the needs of family members (particularly adult unpaid carers) through a focus on family recovery.

New psychoactive substances, also known as legal highs, are a recent challenge and responses are being developed in collaboration with acute hospital services.

The EADP has developed a locality based model through Recovery Hubs. This brings together social work, nursing and the third sector to provide an integrated response to people with alcohol and drug problems. Recovery Hubs are located in the most disadvantaged areas of the city where drug/alcohol problems have a greater impact. Alongside this many people receive their drug treatment through their GP, enabling them to access treatment alongside general healthcare.

The partnership is actively working to improve links between the Recovery Hubs, services for children and families, and mental health services and to improve arrangements for care co-ordination. In addition, the potential to combine data sources from the City of Edinburgh Council, NHS Lothian and the third sector is being examined to seek a more holistic overview of the way people move in and out of services.

The key priorities identified by the EADP are to:

- develop a coherent approach to preventing problem substance misuse, starting with a framework for investing in prevention
- develop more trauma informed services and focus on relationships to maximise effective engagement and minimise relapse
- develop a clear role for counselling and other psychological therapies to address underlying issues which may cause relapse
- invest in a broader range of aftercare services that focus on preventing relapse
- develop a “stepped care” approach to prescribing opiate replacement therapy (methadone and other opiate replacements) in primary and secondary care to ensure people receive an intervention which meets their recovery needs
- redesign services to increase the availability of detox in the community
- clarify and shift roles and responsibilities between practitioner groups to create greater efficiency
- integrate with mental health and other services to make joint plans around a shared service user group

The integration of health and social care provides the opportunity for greater coherence between the planning of substance misuse services and wider approaches to improving health and wellbeing. As locality working is developed, a more joined up approach to prevention, early identification and engagement with those at risk and greater local access to services is envisaged.

Substance misuse pathways include specialist treatment and recovery services such as the pilot service for those with Alcohol Related Brain Damage; we will work with Lothian partners to review the outcome of this pilot. The community services that the Health and Social Care Partnership directly manage and the hospital based services managed by NHS Lothian, will work together with other EADP partners to design and deliver integrated pathways that achieve the priorities of prevention and recovery, using resources as effectively as possible.

Action 37

We will:

- *a) review the treatment and recovery pathway for people with substance misuse issues including inpatient and community programmes (Ritson Clinic, Lothian and Edinburgh Abstinence Project (LEAP)) in line with Royal Edinburgh Hospital campus re-development*
- *b) consider the recommendations arising from the business case associated with the pilot Alcohol Related Brain Damage unit by June 2016*
- *c) implement a model of care within the Recovery Hubs including the concepts of key working, lived experience peer supporters and effective group work programmes*
- *d) explore new harm reduction and recovery approaches based on evidence and experience elsewhere to better engage those who receive drug treatment through their GP*
- *e) develop a stepped care approach to residential and community based rehabilitation programmes to ensure that people receive the right service to support their recovery*
- *f) develop and implement a stepped care approach to psychosocial and therapeutic interventions across recovery services, to ensure that services are able to support underlying trauma issues as part of the recovery journey when needed*
- *g) support the development of the recovery community by creating networking opportunities for people in recovery*
- *h) work with other Alcohol and Drug Partnerships in Lothian to manage and mitigate the impact of new psychoactive substances on health*
- *i) work with community planning partners to reassess the availability of alcohol and the link with alcohol related harm within*

Derek's Story – how the Recovery Hub can make a difference

Derek is 38 years old and lives with his partner.
He is prescribed antipsychotic drugs by his GP and he and his partner drink heavily on almost a daily basis.
He has visited the local Recovery Hub in the past to talk about his drinking but never previously engaged in a treatment programme.

In January 2015 Derek presented to the Recovery Hub in a highly distressed state, his partner had left him and he faced eviction from his flat.

The Recovery Hub assessed Derek and identified that he had stopped taking his prescribed medication and this was contributing to his distress

The work of the Recovery Hub enabled Derek to maintain his tenancy and stay in his own home and community. The drop-in assessment at the Hub meant he received help and support when he needed it. Maintaining his antipsychotic prescription with his GP meant he did not need to be referred to the Community Mental Health to resolve his mental health problems.

Derek's Key Worker at the Recovery Hub liaised with the GP to inform her of the situation. The GP agreed to set up an appointment with Derek to reinstate his prescription. Derek was accompanied to these appointments by a peer worker.

The Key Worker also liaised with the social housing landlord to resolve the issues around Derek's flat. This included the non payment of rent; there were also concerns about the cleanliness and safety of the flat . The Key Worker was able to help Derek resolve his benefit payments and help Derek to keep his flat in a cleaner state.

Derek continues to work with his Key Worker to reduce his drinking . He has been introduced to others in recovery as has shown interest in joining the local recovery social group.

14. Using technology to support independent living and efficient and effective ways of working

Increased use of technology offers significant opportunities to support citizens to live more independently and enable our workforce to work more efficiently and effectively. It should not be seen simply as a way of automating current practice but as a driver for developing different ways of providing care and support and as a facilitator of improved quality and safety.

The term Technology Enabled Care refers to the range of technological solutions that allow us to deliver care and support in new ways in combination with or without more traditional services, in order to enable people to live more independently. These solutions are sometimes referred to as Telecare and Telehealth and include the following:

- online advice and information, through Living it Up for example
- community alarms which provides a 24/7 alarm receiving and response service to support people in an emergency
- enhanced monitoring systems such as fall detectors, or motion detectors that raise alerts if there has been no movement in a person's home within a given time period
- home automation that includes sensors to detect floods and gas leaks, automated night time lighting and environmental control systems that allow people with severe disabilities and life limiting degenerative conditions such as Multiple Sclerosis and Motor Neuron Disease to control their heating, close their curtains or simply change the station on their TV
- clinical monitoring systems that allow blood pressure and diabetes blood sugar readings, for example, to be transferred directly from a meter, via a smart phone to a database. This provides doctors with much more usable data and supports the self management of long term conditions
- working with housing providers to establish technology solutions where this supports locality planning for specific groups of people
- remote consultations using video conferencing technology which can remove the need for people to attend their GPs surgery or hospital outpatients clinics

Effective use of Technology Enabled Care has the potential to:

- reduce social isolation by enabling people to stay connected via technology to family and friends
- help people to feel more safe and secure living at home

- improve people's confidence in self managing their health and wellbeing
- increase access to specialist hospital appointments and professional advice and support by using videoconferencing facilities, thus reducing unnecessary travel time
- reduce the need for GP appointments, visits to hospital and emergency admissions

Some use is currently made of technology to meet health and social care needs through the Community Alarm Telecare Service, the Occupational Therapist led Assistive Technology Service and the environmental controls provided by the Bio Engineers at the SMART Centre. However, services are not joined up, usage is small scale and the full potential of technology to increase independence and meet needs more effectively has not been realised.

Action 38

In 2016/17 we will:

a) improve our understanding of the extent to which Technology Enabled Care is currently utilised within the Health and Social Care Partnership and by our other partners, including housing providers

b) explore further options for increasing the use of Technology Enabled Care linked to the development of care pathways

c) undertake horizon scanning to support service delivery across all service areas

d) explore the options for improved coordination of the staffing and financial resources available to deliver Technology Enabled Care

e) work with our partners to develop a strategy for the delivery of Technology Enabled Care in Edinburgh

f) produce business cases in respect of developments to be implemented in each of the three years from 2016/17 onward; opportunities include:

- *an increase in the use of pendant alarms*
- *the use of technology for overnight support*
- *automated medication prompting and daily wellbeing checks*
- *video conferencing within care homes*
- *scaling up the use of home monitoring for people with long term conditions*
- *exploring the potential of MyGov technology to support person held records*

g) make applications through the Scottish Government Technology Enabled Care Programme and other available funding

sources to support the increased use of technology to both increase independence and support effective and efficient ways of working

If we are to integrate our services fully and embrace joined up working we need to provide our workforce with effective and reliable ICT systems that allow them to:

- access all relevant information to support the person they are working with as effectively as possible at the time and in the place it is needed – 'right information, right place, right time'
- share information about citizens quickly and securely, with appropriate regard to privacy, to aid decision making and ensure that citizens need only tell their story once
- share and access information across different partner organisations regardless of location
- work on the move using technology that makes it easy for staff such as nurses and home care assistants working in people's homes to remain in contact with their base without the need to go into the office
- produce the data and information to meet the performance management reporting requirements of all stakeholders as a by-product of operational record keeping

We will also make it a fundamental principle that any change to ICT systems needs to be an integrated part of changes to care pathways.

In addition to these general requirements many of the developments and change programmes detailed within this plan will have specific ICT implications. ICT systems will also underpin the performance management framework that will allow the Integration Joint Board to monitor the impact of this strategic plan.

ICT support for the Health and Social Care Partnership will be provided through NHS Lothian and the City of Edinburgh Council. ICT Teams within the two organisations have been working together for a number of years to develop solutions to support joint working. This has allowed staff from different agencies to be co-located within the same building and access their own systems, share email address books and view a subset of data from each others systems about people receiving services through the interagency portal. Building upon this experience and following engagement with managers and frontline staff involved in delivering health and social care services, the ICT Teams have produced a joint road map focused on six key areas and underpinned by six overarching assumptions for joint working.

Areas of focus	Assumptions for joint working
• A more streamlined approach to **Information governance** with the integration of services and improved outcomes for people at its heart; underpinned by improved information governance training and clarity for staff; a better model for patient/service user 'consent' and joint training to make best use of technology that is currently available; • Improved **connectivity** to networks and wifi to enable mobile and co-located working; • Responsive **mobile technology** for staff to help improve productivity in the field and cope with increasing demand; • **A 'pathways' approach** to information and systems access: so that relevant patient/service users data is accessible to appropriate people at the right time in their pathway through the care system. (Including the person being cared for); • Access to **real-time patient/service user information** wherever possible to ensure accuracy of decision-making for patients/service users and for responsive service operations; • A **joined up approach to electronic communication** between NHS Lothian and the Council for staff, such as contact and emails information, intranets, shared workspace and policies and procedures.	• Business information requirements (e.g. operational delivery, performance/management information) are supported by ICT **not** ICT driven • A whole system approach is required looking at: Primary Care, Community Health, Social Care and Secondary Care • There will be more integrated teams and more co-located teams as we move forward • There is a requirement for more sharing of personal data along people's pathway of care • We must work with and maximise the benefit from existing ICT systems – rather than create new ICT systems for the Health and Social Care Partnership • ICT support services need to work together at the highest level to support the integrated functions

In addition to the need for ICT systems to support joint working across the Council and NHS Lothian it is also important to consider the need to integrate and align with the systems used by other partners, including service providers in the third and independent sectors, if we are to make best use of capacity across the whole system.

The Integration Joint Board will give clear directions in relation to its ICT requirements to both the Council and NHS Lothian and will welcome guidance on the best technological solutions.

In recognition of the importance of technology in helping the Health and Social Care Partnership address current challenges and transform the way services are planned and delivered, the Integration Joint Board has nominated one of its members to act as an ICT champion. They will work with the managers of ICT services in the Council and NHS Lothian to develop a shared understanding of and approach to meeting the needs of the Partnership.

Action 39

During 2016/17 we will work with the ICT services in NHS Lothian and the Council to:

a) *understand the implications of the strategic plan in relation to ICT and wider technology which will allow us to develop an ICT Strategy and implementation plan for the Health and Social Care Partnership*
b) *develop a delivery plan in respect of the roadmap based on the areas of focus and assumptions for joint working set out above*
c) *ensure that any business cases developed in relation to the strategic plan clearly set out any ICT implications*

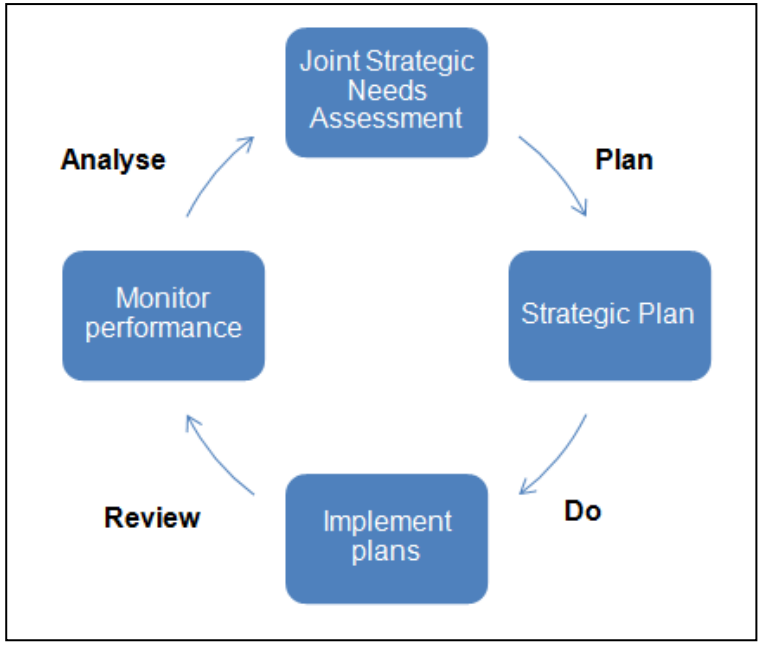
Whilst increased use of technology undoubtedly offers significant opportunities to increase independence for citizens and to support our staff to work more efficiently and effectively, the benefits will only be fully realised if we recognise that many citizens and staff do not have the skills and knowledge to make best use of the systems available to them. A key plank of our strategy around increased use of technology must therefore include steps to increase skills, knowledge, understanding and access to technology across both our workforce and the population as a whole.

15. Improving our understanding of the strengths and needs of the local population

A good understanding of the strengths and needs of the local population is essential to support effective strategic planning by helping us to identify:

- current and future needs
- what is working well and what could work better
- the major health inequalities and what can be done about them
- needs that are not being met, including those of seldom-heard populations and vulnerable groups

The production of a Joint Strategic Needs Assessment (JSNA) is part of a cycle of analyse-plan-do-review that both informs and helps monitor the impact of the strategic plan over time. It therefore needs to be developed and updated on an ongoing basis to ensure that emerging issues or patterns of need can be identified.



The Joint Strategic Needs Assessment is intended to provide a sound basis for decision making about the deployment of resources. To do this, it needs to be comprehensive, up to date, accessible and easy to use.

Edinburgh's first Joint Strategic Needs Assessment of health and wellbeing in the city (attached as Appendix I) was developed by people from across the Council, the NHS, the voluntary and independent sector, neighbourhood groups and citizens. It provides an overview of Edinburgh's population profile; patterns of resource use in relation to health and social care, pressures and unmet need. Information at locality level is available for a range of topics. The JSNA will also provide a baseline against which we can measure local changes in relation to health and social care and inform future iterations of our strategic plan.

The development of the Assessment revealed a number of gaps in our current knowledge and further gaps were identified through consultation with our partners and the public which will be addressed in future iterations.

Ongoing development of the Joint Strategic Needs Assessment will allow us to:

- develop more detailed locality profiles in order to support the move to locality working, recognising that there is as much variation within localities as there is between them
- enable the identification, monitoring and assessment of emerging issues, for example, the use of legal highs and the health and support needs of people who are obese
- support the identification of trends and shifts in resource use and unmet needs
- understand the needs of people from minority ethnic groups who have mental health problems, disabilities, frailty etc
- further investigate methods of forecasting needs among specific groups. At present, forecasts are based largely on population growth
- consider alternative indicators in areas such are inequalities and identify indicators for mental health

Action 40

We will continue to develop the Joint Strategic Needs Assessment to support the Edinburgh Health and Social Care Partnership and wider Community Planning Partnership to improve their understanding of the needs and strengths of the population at both locality and citywide levels. In doing so we will take the following actions during the financial year 2016/17:

a) review the membership of the Joint Strategic Needs Assessment Sub-group to ensure that we benefit from the knowledge, experience and information held by our partners, including local people
b) take account of feedback obtained through consultation on the first iteration of the Assessment
c) identify and incorporate areas for further or more detailed assessment to support the delivery of other actions within the strategic plan
d) embed the Joint Strategic Needs Assessment within the broader needs assessment and profiling of localities within Edinburgh as part of the Council's Transformation Programme
e) move the Joint Strategic Needs Assessment from the current paper format to become a web based tool that supports access to data at a number of levels

16. Integrated workforce development

Achieving the vision and priorities set out in our strategic plan will require significant culture change for the Council, NHS Lothian and our other partners, for the workforce delivering health and social care services across the city, for the people who use those services and the wider population.

Effective workforce development is central to helping us deliver the shift in culture required and can provide a model for the integrated working between partners, each of whom have their own skills, knowledge, experience and ideas to bring to the table; we hope to harness these to develop a truly integrated approach to workforce development making best use of capacity across the whole system.

We already have some good examples to build on, such as the Dementia Training Partnership through which the Council, Scottish Care, NHS Lothian and Edinburgh Voluntary Organisations Council (EVOC) are working together to roll out the Promoting Excellence in Dementia Care framework across all providers. The Council and NHS Lothian have previously involved people with experience of using health and social care services in the delivery of training activities. These are examples we hope to see developed further through the Health and Social Care Partnership.

We have already made a start on embedding an integrated and collaborative approach to workforce development through our participation in the 'Playing to your strengths' leadership training programme which has brought together senior leaders from across health and social care and the third sector in the four Lothian Health and Social Care Partnerships. The outcome from this Programme is the creation of personal development plans that will support successful leaders use their strengths and develop complementary competencies to enhance their leadership. The collaboration with the other Health and Social Care Partnerships in Lothian is intended to support the development of networks and relationships which will foster further joined up working in the future.

Action 41

During 2016/17 we will:

a) *bring together the specific actions within this plan that are related to or have implications for our workforce in order to inform the development of an overarching workforce strategy and plan. This will set out the future staffing models required to deliver sustainable and affordable high quality health and social care services that keep people safe*

b) *establish an Integrated Workforce Development Planning Group with membership drawn from key partners including, as a minimum the NHS, the Council, housing, third and independent sectors and people who use health and social care services in order to develop and oversee the implementation of an integrated workforce development strategy and action plan*

Staff need to feel empowered to:

- contribute to the development of a new culture and understand their role within it, which may involve opportunities to change the way in which they work
- broaden their understanding of the people we work with and the issues they face as well as the range of services available to them
- develop new working relationships
- take on new roles and responsibilities
- look after their own health and wellbeing

In addition to helping our workforce to embrace the new culture, more specific training needs are identified throughout this plan ranging from increasing awareness across the workforce of specific conditions, such as autism or dementia, to developing skills to increase the number of staff able to undertake particular roles.

17. Living within our means

Financial context

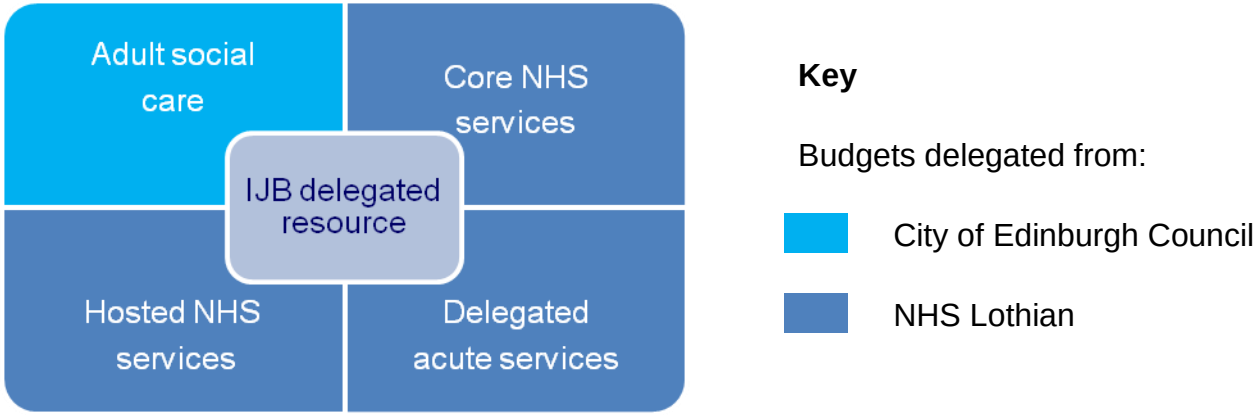
In an environment of increasing demographic pressures and a growing financial challenge, the ability to redesign services in ways that make the best use of scarce resource will be critical. Aligned with this is the rising expectation from the general public that health and social care services should be able to deliver the increased capacity required to fully meet changing needs.

Earlier in the plan (page 51) we gave the example of Jenny and how changing the way she accesses services and aligning these to best meet her needs resulted in a better outcome for Jenny at lower cost. This is the key to the financial challenge for all Integration Joint Boards, how we use our money wisely to support redesign at the same time as maintaining good outcomes for people.

How we get our money

Functions are delegated to the Edinburgh Integration Joint Board from the City of Edinburgh Council and NHS Lothian and the resources associated with these functions form the budgets for the Integration Joint Board. It then becomes the responsibility of the Board to deploy these resources in support of the strategic plan. As such the Board can choose to spend the money differently. One example of this would be the Integration Joint Board's ability to disinvest in hospital services, using the money released to invest in services designed to maintain people in their own homes and wider communities.

There are 4 component parts to the resources delegated to the Integration Joint Board as shown in the diagram below:



An explanation of each of these component parts is included in section 3 above along with a list of the services in each category. During 2015/16 we have been working closely with NHS Lothian and the City of Edinburgh Council to agree which elements of budget will transfer to the partnership. For hosted and delegated acute services this has required the agreement of a mechanism to share budgets currently held on a Lothian wide basis equitably between the four Lothian Integration Joint Boards.

These discussions have helped the Edinburgh Integration Joint Board shape a financial plan which shows the level of resource available as well as the savings which will require to be delivered.

Action 42
Whilst hosted and delegated acute services will be operationally delivered by other parties (e.g. NHS Lothian or one of the other three Health and Social Care Partnerships), the Edinburgh Integration Joint Board will have the responsibility for planning these services. We therefore require any material changes to these services, either investment or disinvestment, to be discussed and agreed in partnership. This will be reflected in Directions.

Our financial plan

As the resources available to the Integration Joint Board flow through the City of Edinburgh Council and NHS Lothian, the financial constraints facing these organisations are equally relevant for the Board. There is no doubt, given the financial constraints the City of Edinburgh Council and NHS Lothian face, both now and in the medium term, that the Board will have a significant financial challenge to address. In this environment achieving financial balance will require a focus on service redesign within the overall financial envelope.

The City of Edinburgh Council formally agreed a three year budget on 21st January 2016. NHS Lothian are not yet in a position to finalise their financial plans as further work is required to fully understand the impact of the Scottish Government's recent budget announcements on the resources available. The draft financial plan for the Integration Joint Board is therefore based on the best information currently available.

The initial assessment of the financial plan for 2016/17 identified a budget for the Integration Joint Board of £554 million with an associated savings target of £32 million, or 6%. This level of efficiency, set against a background of increasing pressure on services, is clearly a challenge for the Integration Joint Board. The figure below summarises the position:

	CEC £k	NHSL £k	Total £k
Projected 15/16 expenditure	**195,133**	**364,581**	**559,714**
Changes in 16/17			
Increases in costs	4,651	22,454	27,105
Savings	(15,018)	(17,417)	(32,435)
Net budget change	**(10,367)**	**5,037**	**(5,330)**
Projected 16/17 settlement from partners	**184,766**	**369,618**	**554,384**
Social care fund			20,180
Projected total 16/17 budget			**574,564**

Action 43
We will continue to work with City of Edinburgh Council and NHS Lothian to develop sustainable plans to achieve financial balance, including delivery of savings plans to be implemented from April 2016.

The scale of this challenge will require us to use our money wisely and to make sure we make the most of any funds available for investment as well as target any disinvestment appropriately. This includes the new Social Care Fund referred to above as well as any time limited or specific sources of funding such as the Integrated Care Fund. To support this we will need clear criteria and a methodology to assess and prioritise proposals.

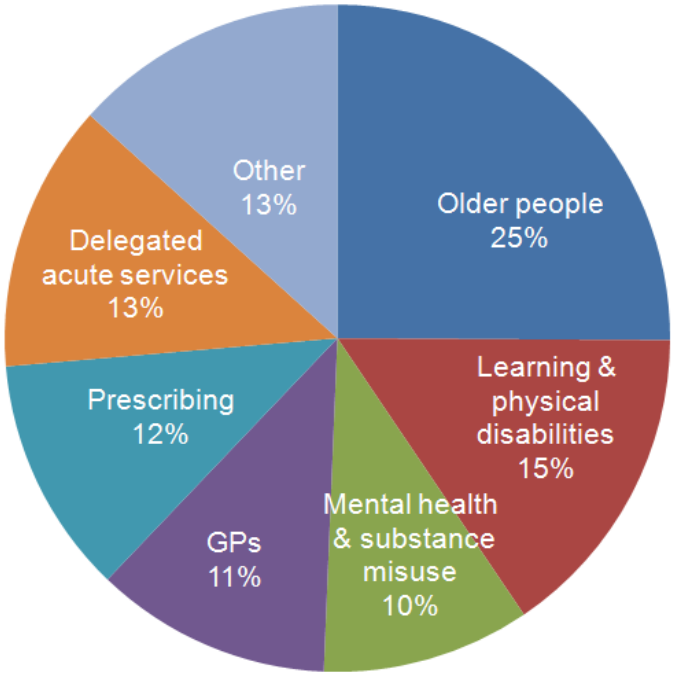
Action 44
We will develop a robust decision making framework which captures and assesses risk and supports both investment and disinvestment decisions.

How do we spend our money?

The diagram opposite shows how much of our money is spent on each of the different functions delegated the Integration Joint Board.

The opportunities

In this challenging financial environment integrating services brings opportunities to deliver efficiencies by making better use of our resources. Examples include: avoiding duplication; reducing management costs; avoiding admissions to hospital and unnecessarily long stays which don't provide the best outcomes for people; using our resources wisely by commissioning services which keep people well and independent; making better use of the skills and networks of the third and independent sectors.



18. Performance – its role in the Strategic Planning Cycle

Progress against the priorities and actions outlined in the Strategic Plan will be monitored through the Edinburgh Partnership's integrated performance framework.

The scope of the performance framework includes:

- Performance against targets e.g. NHS Local Delivery Plan (LDP) (formerly the NHS HEAT targets)
- Quality
- Finance
- Stakeholder experience (e.g. staff and the people who receive support)

The framework will support:

- **Operational oversight** – through a small group of measures which will be reported and considered relatively frequently e.g. monthly
- **Strategic planning and commissioning**

It will help us to assess whether:

- we are doing what we set out to do
    - *By monitoring progress against the priorities and actions within the strategic plan*
- We are moving towards our local and national priorities
    - *By using the suite of national indicators as well as local indicators and by getting feedback from key stakeholders*
- we are delivering the support we intended to at the right place and at the right time. Is it safe, timely, effective, efficient, equitable and person-centred?
    - *By using measures, performance indicators, assessing costs and processes and by using feedback from staff and the people we support*
- we are changing the way we use resources over time
    - *By comparing spend on hospital based and community provision, for example*

- the profiles of localities have changed over time
    - *Ongoing work to develop needs profiles will provide this information. We are particularly interested in looking at changes in measures of health and wellbeing*

The diagram on the following page provides a summary of our performance framework.

The Lothian Integration Dataset group, membership of which is drawn from NHS Lothian and the four Health and Social Care Partnerships within Lothian, has been working to identify a range of measures of interest to the four Integration Joint Boards. The aim is to provide a dataset for shared use by the four partnerships, which can be augmented by each with local measures. The proposed shared indicator set is shown in Appendix F.

The Performance and Quality Subgroup of the IJB will agree a set of performance, activity and progress measures in relation to the Strategic Plan, which will include measures of quality and service user experience.

Integrated Performance Reporting

Reporting progress:

1. Indicators and measures
2. Action plans
3. Feedback and experience
4. Finance

Project plan content:

1. The case for change
2. Current performance and challenges*
3. What we plan to do
4. Resource implications
5. What will success look like?*
6. We will collaborate with partners in this programme by …
7. We will collaborate with citizens and communities on this programme by …
8. Delivering our key priorities
9. Key milestones

*Performance indicators

Our key priorities:

1. Tackling inequalities and helping people to stay healthy
2. Prevention and early intervention
3. Person-centred care
4. Right care, right place, right time
5. Making best use of capacity across the whole system
6. Managing our resources effectively

Appendix C

Appendices A to H

to the Strategic Plan for Health and Social Care

Appendices to the strategic plan

Appendix A

Members of the Edinburgh Integration Joint Board

The Public Bodies (Joint Working) (Act) 2014 sets out who should be a member of the Board and which members should have a vote.

Responsibility for chairing the Board rotates between the Council and NHS Lothian every two years.

Voting Members	
George Walker (Chair)	NHS Lothian non-executive board member
Ricky Henderson (Vice Chair)	City of Edinburgh Council elected member
Elaine Aitken	City of Edinburgh Council elected member
Shulah Allan	NHS Lothian non-executive board member
Kay Blair	NHS Lothian non-executive board member
Joan Griffiths	City of Edinburgh Council elected member
Sandy Howat	City of Edinburgh Council elected member
Alex Joyce	NHS Lothian non-executive board member
Dr Richard Williams	NHS Lothian non-executive board member
Norman Work	City of Edinburgh Council elected member
Non-voting members	
Rob McCulloch-Graeme	Chief Officer Health and Social Care Partnership
Ian McKay	Clinical Director
Michelle Miller	Chief Social Work Officer
Maria Wilson	Chief Nurse
Moira Pringle	Interim Chief Finance Officer
Dr Andrew Coull	Clinical Director Acute Medicine
Wanda Fairgrave	NHS Staff representative
Kirsten Hey	Council Trade Union Representative
Sandra Blake	Citizen member

Christine Farquhar	Citizen member
Angus McCann	Citizen member
Beverley Marshall	Citizen member
Ella Simpson	Third Sector Representative
Dr Carl Bickler	Chair Professional Advisory Committee
Dr Gordon Scott	Vice-chair Professional Advisory Committee

Appendix B

Strategic Planning Group – remit and membership

Remit

The legal requirement to review and refresh the strategic plan every three years means that the planning process will be ongoing throughout the life of the plan. The Strategic Planning Group will have an ongoing role once the first plan for Edinburgh has been produced. The remit of the Strategic Planning Group will be to:

- collaborate in the preparation of the strategic plan, including:
  - developing recommendations about the content
  - developing the plan itself, including being part of sub-groups working on aspects of the plan
  - consultation on the plan within the groups they represent and through wider public consultation
- act as a critical friend to the Integration Joint Board when consulted on any decisions that need to be made outside the strategic planning framework or when consulted on any other matter

Membership

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Councillor Ricky Henderson (Chair)	Vice Chair of Edinburgh Integration Joint Board	City of Edinburgh Council	
George Walker (Vice chair)	Chair of Edinburgh Integration Joint Board	NHS Lothian	
Alex McMahon	Director of Strategic Planning, Performance Reporting & Information	NHS Lothian	Nominated by NHS Lothian
Angus McCann	Non voting member of Edinburgh Integration Joint Board (Citizen representative - users of health and social care services)	Users of health and social care services	Non voting members of Edinburgh Integration Joint Board

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Beverley Marshall	Non voting member of Edinburgh Integration Joint Board (Citizen representative - users of health and social care services)	Users of health and social care services	
Christine Farqhar	Non voting member of Edinburgh Integration Joint Board (Citizen representative - carer)	Carers of users of health and social care services	
Sandra Blake	Non voting member of Edinburgh Integration Joint Board (Citizen representative - carer)	Carers of users of health and social care services	
Colin Beck	Senior Manager Mental Health, Criminal Justice and Substance Misuse	Social care professionals	Nominated by the Professional Advisory Committee
Angela Lindsay	Allied Health Professionals Manager	Health professionals	
Rene Rigby	Independent Sector Development Officer, Scottish Care	Commercial providers of social care	Nominated by Scottish Care
Graeme Henderson	Director of Services and Development, Penumbra	Non-commercial providers of social care	Nominated by Edinburgh Voluntary Organisations Council (EVOC)/ Coalition of Care and Support Providers in Scotland (CCPS)
Blackmore, Lesley	Strategic Development Manager. Lothian Community Health Initiatives Forum	Non-commercial providers of health care	
Fanchea Kelly	Chief Executive, Blackwood Housing Association	Non-commercial providers of social housing	Nominated by Edinburgh Affordable Housing Partnership
Ella Simpson	Non voting members of Shadow Health and Social Care Partnership/IJB representing the Third Sector	Third sector organisations carrying out activities related to health or social care	Non voting members of Edinburgh Integration Joint Board
Michele Mulvaney	Community Engagement Manager	Localities	Nominated pending establishment of representation
Henry Coyle	Neighbourhood Manager	Localities	

SPG Member	Role	Group to be represented	Arrangements for appointment of representative
Anna Herriman	Participation and Information Manager	Localities	for proposed four localities

Appendix C

Hosted and set aside services

Hosted Services

Edinburgh
- Rehabilitation
- Sexual health
- Substance misuse

East Lothian
- Complex care
- Unscheduled care

Mid Lothian
- Art therapy
- Dietetics

West Lothian
- Clinical psychology
- Community dentistry
- Podiatry

NHS Lothian
- Hospital based learning disability services
- Hospital based mental health

Set aside Services

NHS Lothian
- Accident and Emergency
- Cardiology
- Diabetes
- Endocrinology
- Gastroenterology
- General medicine
- Geriatric medicine
- Infectious diseases
- Rehabilitation medicine
- Respiratory medicine
- Therapies

Appendix D

National health and wellbeing outcomes

as set out in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014

Outcome 1: improve health and wellbeing

People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: support to live in the community

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3: positive experiences and treated with dignity

People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4: quality of life

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5: reduce health inequalities

Health and social care services contribute to reducing health inequalities.

Outcome 6: support for carers

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Outcome 7: safety

People using health and social care services are safe from harm.

Outcome 8: engaged and supported workforce

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9: use of resources

Resources are used effectively and efficiently in the provision of health and social care services.

Appendix E - National strategic policy drivers

Healthcare Quality Strategy for NHS Scotland

Community Empowerment (Scotland) Bill

Public Bodies (Joint Working) (Scotland) Act 2014

Commission on the Future Delivery of Public Services

Self-directed Support: A National Strategy for Scotland

The Keys to Life

Reshaping Care for Older People

Scotland's National Dementia Strategy

National Telehealth and Telecare Delivery Plan for Scotland

Improving Health and Wellbeing of people with long term conditions in Scotland: A national action plan

Mental health Strategy for Scotland

Caring Together

Changing Scotland's Relationship with Alcohol

The Road to Recovery

See Hear – Strategic Framework for people with a sensory impairment in Scotland

Strategies/plans outside the scope of but relevant to the Health and Social Care Partnership Strategic Plan for Edinburgh

C. NHS Lothian Strategic Plan

A. Edinburgh Partnership Community Plan

B. City of Edinburgh Council Strategic Plan

D. NHS Lothian Strategic Clinical Framework

E. Plan for Hospital-based Services not delegated to IJB

F. Edinburgh Anti Social Behaviour Strategy

G. Health Inequalities Framework and Action Plan

H. Reducing Re-offending Strategy

I. Volunteering Strategy

J. Sustainability Framework

K. Edinburgh Compact Strategy

L. Social Enterprise Strategy

M. Public Protection Strategy

N. Lothian Mental Health and Wellbeing Strategy

O. Integrated Plan for Children and Young People

P. City Housing Strategy

Q. Neighbourhood Partnership Community Plans

Strategies/plans within the scope of the Health and Social Care Partnership Strategic Plan for Edinburgh

1. Learning Disability Commissioning Plan
2. Older People's Commissioning Strategy
3. Mental Health Commissioning Plan
4. Alcohol and Drugs P'ship Commissioning Plan
5. Carers Commissioning Plan
6. Physical Disability Strategy
7. NHS Lothian Palliative and End of Life Care Strategy
8. Lothian Sexual Health and HIV Strategy
9. Plan for Hospital-based Services
10. Primary and Community Care Strategy
11. Multiple/Long-term Conditions Strategy
12. Technology enabled care Strategy
13. Prevention Strategy
14. *Inclusive Edinburgh Strategy*

Edinburgh Integrated Joint Board Strategic Plan

Key: Plan in place for Edinburgh | Lothian wide plan in place | No plan currently in place

Version: 7 20/4/2015

Proposed indicator set

National Health and Wellbeing Indicators

Ref	Indicator
	Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, it is expected that **Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.**
NI.1	Percentage of adults able to look after their health very well or quite well.
NI.2	Percentage of adults supported at home who agree that they are supported to live as independently as possible.
NI.3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
NI.4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
NI.5	Percentage of adults receiving any care or support who rate it as excellent or good
NI.6	Percentage of people with positive experience of care at their GP practice.
NI.7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
NI.8	Percentage of carers who feel supported to continue in their caring role.
NI.9	Percentage of adults supported at home who agree they felt safe
NI.10	Percentage of staff who say they would recommend their workplace as a good place to work.*
	Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.
NI.11	Premature mortality rate.
NI.12a	Rate of emergency admissions for adults - SMR01
NI.12b	Rate of emergency admissions for adults - SMR04
NI.13	Rate of emergency bed days for adults.*
NI.14	Readmissions to hospital within 28 days of discharge
NI.15	Proportion of last 6 months of life spent at home or in community setting.
NI.16	Falls rate per 1,000 populations in over 65s
NI.17	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
NI.18	Percentage of adults with intensive needs receiving care at home
NI.19	Number of days people spend in hospital when they are ready to be discharged
NI.20	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency
NI.21	Percentage of people admitted from home to hospital during the year, who are discharged to a care home
NI.22	Percentage of people who are discharged from hospital within 72 hours of being ready
NI.23	Expenditure on end of life care.*

Local Delivery Plan Indicators

Ref	Indicator
LDP.1	People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
LDP.2	31 days from decision to treat (95%)
LDP.3	62 days from urgent referral with suspicion of cancer (95%)
LDP.4	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support
LDP.5	12 weeks Treatment Time Guarantee (TTG 100%)
LDP.6	18 weeks Referral to Treatment (RTT 90%)
LDP.7	12 weeks for first outpatient appointment (95% with stretch 100%)
LDP.8	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
LDP.9	Eligible patients commence IVF treatment within 12 months (90%)
LDP.10	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
LDP.11	18 weeks referral to treatment for Psychological Therapies (90%)
LDP.12	Clostridium difficile infections per 1,000 occupied bed days (0.32)
LDP.13	SAB infections per 1,000 acute occupied bed days (0.24)
LDP.14	Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
LDP.15	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings
LDP.16	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
LDP.17	48 hour access or advance booking to an appropriate member of the GP team (90%)
LDP.18	Sickness absence 4%
LDP.19	4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
LDP.1	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

Additional Hospital Indicators

Ref	Indicator
AHI.1	No. patients age over 75 in hospital with unscheduled admission
AHI.2	No. patients (adults) in hospital with unscheduled admission
AHI.3	Occupied bed days (OBD) in week for patients aged over 75 with unscheduled admission
AHI.4	Occupied bed days (OBD) in week for patients (all adults) with unscheduled admission
AHI.5	A&E four hour waiting time (Lothian, Hospital Site)
AHI.6	Unplanned admissions as % of all admissions
AHI.7	Hospital admission rate over 75 (replication of 12. for National Indicators, but for aged 75+)
AHI.8	Over 75 LOS –median/average/90th percentile for patients discharged in month
AHI.9	Adults LOS – median/average/90th percentile for patients discharged in month
AHI.10	Rate of emergency bed days for adults
AHI.11a	Delayed Discharge a. No. patients waiting over 3 days on census
AHI.11b	Delayed Discharge b. No. occupied beds days lost from delayed discharge over two days
AHI.11b	Delayed Discharge c. No. patients waiting over 2 weeks on census
AHI.12	No. admissions from a care home
AHI.13a	Time of admission: a. No. Unscheduled Admissions to hospital within hours (all adults)
AHI.13b	Time of admission: b. No. Unscheduled Admissions to hospital within hours (75+)
AHI.13c	Time of admission: c. No. Unscheduled Admissions to hospital OOH (all adults)
AHI.13d	Time of admission: d. No. Unscheduled Admissions to hospital OOH 75+)
AHI.14e	Medical Readmission rate within 7 days
AHI.15	Medical Readmission rate within 28 days
AHI.16	A&E activity – number and rate per 100,000
AHI.17	Beds closed by infection
AHI.18a	A&E attendances converted to admission: a. (all adults)
AHI.18b	A&E attendances converted to admission: b. (75+)
AHI.19a	Alternatives to hospital admission: a. Hospital@Home prevention of admission i. No. referrals in month
AHI.19b	Alternatives to hospital admission: b. Redirection at hospital front door i. No. referrals to SPOC by bed bureau to urgent clinic, H@H, day of medicine, day hospital
AHI.20	Adverse events in hospital with serious harm
AHI.21	Patient falls with harm
AHI.22	No. grade 2 or above pressure ulcers

AHI.23	Potentially preventable admissions (ISD indicator available through Discovery)

Social Care Indicators

Ref	Indicator
SC.1	Number of domiciliary care hours provided in the snapshot week for people aged 65+
SC.2a	Total number of people 65+ who are supported in a care home
SC.2b	Number and % of people supported in a care home who are receiving FPNC (free personal and nursing care payments) only
	Number of people waiting for a domiciliary care package who are waiting:
SC.3a	- in hospital
SC.3b	- at home in the community – with no domiciliary care service in place
SC.3c	- at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
	For people waiting for domiciliary care in the following locations, number of hours of support needed:
SC.4a	- in hospital
SC.4b	- at home in the community – with no domiciliary care service in place
SC.4c	- at home in the community – where the person is already receiving a domiciliary care service but needs additional hours
SC.5	Number of people aged 65+ who are waiting in hospital for a care home place

Appendix G

Housing Contribution Statement

Strategic Enabler for Edinburgh Health and Social Care Partnership Strategic Plan (2016-19)

March 2016

Contents

Introduction

The Housing Contribution Statement is an integral part of Edinburgh Health and Social Care Partnership's Strategic Plan (2016-19). It sets out how the housing sector in Edinburgh contributes to Strategic Plan priorities. It has been informed by discussions between housing providers, health and social care partners, third sector partners and tenant representatives as part of the Strategic Plan consultation process and through housing representation on the Strategic Planning Group.

The Council has ambitious plans to expand the current Council-led house building programme to build 8,000 new affordable and low cost homes over the next ten years, a commitment which has been matched by our housing association partners. The Council and its partners will aim to fund the delivery of 16,000 affordable homes over the next 10 years through a total investment of £2 billion. The Council's housing strategy will aim to commit up to £300 million of this investment to integrate the provision of health and social care services with new affordable and low cost homes for people with complex physical and health needs.

Having a warm, dry, safe and affordable home has a significant impact on people's wellbeing. The Council has a strategic role in planning to meet housing needs but it is through strong partnership working that the City's housing issues and priorities are addressed. Edinburgh is a pressured housing market, with a high need and demand for affordable housing.

The Edinburgh Health and Social Care Partnership recognises that the housing sector in Edinburgh carries out a wide range of activities which have a significant impact on the health and wellbeing of citizens. These range from new house building, upgrading and adapting existing homes, supporting vulnerable people, making sure that Edinburgh's housing stock caters for the needs of the workforce and integrating housing and care in local neighbourhood settings.

To reflect the different ways in which housing contributes to improving health and well-being the Housing Contribution Statement has been structured under three themes:

- **More homes**: Increasing the supply of new energy efficient homes and investing in existing homes to meet people's health needs.
- **Integrated services**: Providing a wide range of services to help people live independently in their own home or homely setting
- **Caring community**: Housing organisations providing services at local level, building strong relationships with customers, communities and partners and helping to tackle inequalities.

The housing sector in Edinburgh demonstrates strong partnership working and has a key role to play in engaging with other services and professionals at a local level to strengthen partnerships and help improve health outcomes for individuals. Integration offers a real opportunity for housing to help meet health and social care objectives around shifting the balance of care from expensive clinical and institutional settings to helping people live independently at home or in a homely or community setting as far as possible

1. Governance and Partnership Working

1.1. As a local housing authority, the Council has a statutory duty and strategic responsibility to produce, and keep under review, a Local Housing Strategy, referred to as the City Housing Strategy in Edinburgh. The City Housing Strategy (CHS) is a five year plan, reviewed each year with updates reported to the Council's Health, Social Care and Housing Committee. It covers all housing tenures and it is developed, reviewed and delivered through partnership working and engagement with key stakeholders. These include:

- Edinburgh Affordable Housing Partnership (Registered Social Landlords and the Council)
- Edinburgh Homelessness Forum and Homelessness Planning Group
- Edinburgh Housing and Energy Forum
- EdIndex Partnership
- Private Rented Sector Forum
- Edinburgh Tenants Federation

1.2. The Council's Health, Social Care and Housing Convenor is one of ten voting members on Edinburgh's Integration Joint Board (IJB) and Vice Chair of the IJB. The IJB oversees the Health and Social Care Partnership in Edinburgh. Further information on Governance can be found in the Strategic Plan.

1.3. The Strategic Plan outlines the need to plan and deliver services at a local level if the vision and priorities in the Strategic Plan are to be achieved. There will be four localities within Edinburgh. The work to determine the localities has been taken forward through the Edinburgh Community Planning Partnership, with all members of the Partnership agreeing to use the same four localities as the basis for planning and delivering services. These are the same four localities that are being used as the basis for reorganising council services through the Transformation Programme which provides opportunities for integrating not only social care and NHS services but also other services provided by the Council at a locality level.

1.4. The Edinburgh Affordable Housing Partnership has established a health and social care sub-group, which Council officers from both housing and health and social care attend. The Chair of this sub group is the non-commercial housing representative on the Strategic Planning Group. The housing sector will continue to be represented on the Strategic Planning Group going forward. As well as these formal structures, regular Health and Social Care Overview Group meetings are taking place around housing's contribution to health and social care priorities involving housing association representatives and Council staff from housing, health and social care and locality teams.

1.5. Housing's contribution to health and social care integration was discussed as part of the formal consultation on the Strategic Plan. Edinburgh Affordable Housing Partnership, Edinburgh Homelessness Forum and Edinburgh Tenants Federation submitted written responses on the draft Strategic Plan following discussions led by housing sector representatives and health and social care colleagues from the Council. A workshop, hosted by Blackwood Housing and Care, brought health, social care and housing professionals together, including the IJB Chief Officer and Vice Chair, with the aim of increasing awareness of housing's contribution to integration among health and social care colleagues and discussing opportunities for better joint working. This approach to integrated workforce development, a Strategic Plan priority, can be built on as locality based working takes shape. A short film on Housing's Contribution to health and social care was shown at the workshop and was well received. The film is available for individuals or groups interested in finding out more about the housing contribution.

1.6. In January 2016 housing representatives (Council and housing association) and a Locality Manager for health and social care were invited to an Edinburgh Tenants Federation meeting to talk to them about integration. Discussions took place on the role local communities and Registered Tenant Organisations can play in engaging on integration at locality level.

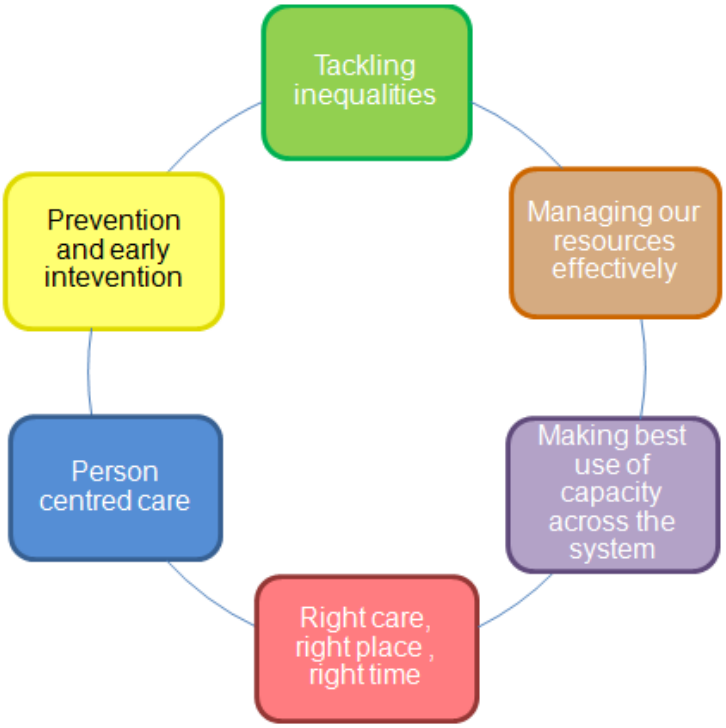
1.7. The Edinburgh Affordable Housing Partnership Health and Social Care Sub Group will be one of the main forums in which joint housing and health and social care priorities are discussed and taken forward. In developing the new City Housing Strategy for 2017-22, lead officers from housing within the Council will work with health and social care colleagues and the IJB to ensure joint priorities are agreed and progressed. Housing is programmed for discussion at an IJB Development Session in October 2016.

2. Shared Outcomes and Priorities

Strategic Plan Priorities

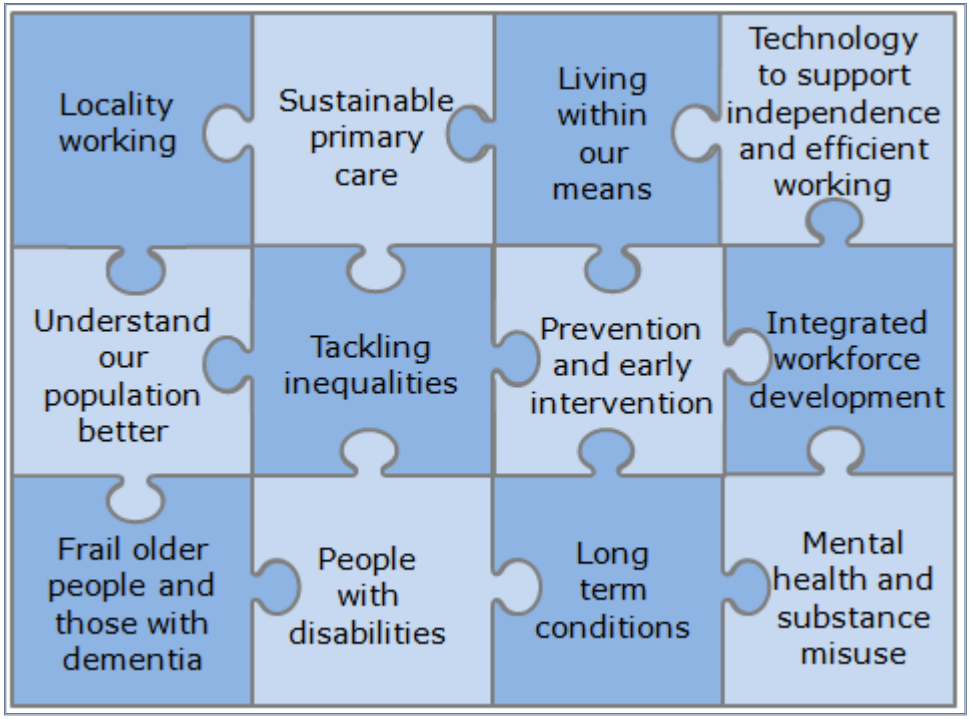
2.1. The IJB must publish a Strategic Plan every three years setting out how the services and budget that it is responsible for will be used to deliver a set of national health and wellbeing outcomes (Appendix 1). This Housing Contribution Statement forms part of the Strategic Plan but is provided as a stand-alone publication to provide a focus on housing, health and social care links.

2.2. The Strategic Plan 2016-19 has **six priorities**. These priorities describe the change that the Edinburgh Health and Social Care Partnership wants to see, with demand for formal care services being managed through investment in tackling inequalities and preventative services and encouraging and supporting people to take responsibility for their own health and wellbeing where possible. Where formal services are required it is essential that people get the right support in the right place at the right time – housing plays a key role here.



2.3. Housing activity supports the six Strategic Plan priorities and the nine national health and wellbeing outcomes, particularly outcome two: 'People, including those with disabilities or long term conditions, or who are frail ,are able to live, as far as reasonably practicable, independently at home or in a homely setting'. Outcome 7, 'Keeping people safe from harm' is also supported by services provided by housing organisations. This contribution is highlighted throughout the Housing Contribution Statement and housing's contribution is acknowledged in the Strategic Plan.

2.4. Twelve areas are identified in the Strategic Plan as a focus for delivering real change. As with the six priorities, the twelve areas, outlined in the diagram below, are interconnected so actions taken in one area will also impact on others.



2.5. The areas on the top row are where the Health and Social Care Partnership believes it can and must deliver change quickly. The middle row contains a number of areas that the Partnership sees as 'golden threads' throughout the Strategic Plan. The bottom row sets out the groups of people the Partnership believe can most benefit from the transformation of services as set out in the Strategic Plan.

City Housing Strategy

2.6. The Local Housing Strategy (City Housing Strategy in Edinburgh) is a Local Authority's strategic document for housing and housing services, as set out in the Housing (Scotland) Act 2001. It covers all housing tenures and must include the strategic direction on preventing and alleviating homelessness, provision of housing support and a fuel poverty strategy. The City Housing Strategy (CHS) 2012-17 has three outcomes:

- People live in a home they can afford.
- People live in a warm, safe home in a well-managed neighbourhood
- People can move home if they need to

2.7. These outcomes, described below, support the Strategic Plan priorities in a number of ways, not least through a shared focus on prevention, in relation to homelessness and housing support services and provision of adaptations for example, and tackling inequalities, through investing in new affordable homes and improving existing homes.

People live in a home they can afford

This outcome is about increasing the supply of homes, including affordable and private rented homes, making best use of existing homes and increasing the choice of housing options available in the city. The supply of rented homes is being increased through stepping up the affordable homes programme. This will make a significant contribution to investment in housing for people with complex physical and health needs and, more generally, meet the housing and care needs of the city's growing older population.

People live in a warm, safe home in a well-managed neighbourhood

The focus of the second outcome is on improving the quality of homes and neighbourhoods, which includes improving the energy efficiency of homes. Improving quality and management within mixed tenure areas is also important in helping deliver this outcome. Addressing fuel poverty is a priority and is being addressed through investing in existing homes, building new energy efficient homes and providing advice as part of the Homes and Energy Strategy.

People can move home if they need to

The third outcome is about helping people to live independently and stay in their own home where appropriate, and helping people to move home if they need to. The strategy of focusing on preventative services, including homelessness services, will continue as this provides better outcomes for individuals as well as preventing the need for more costly interventions such as providing temporary accommodation or a stay in hospital.

2.8. The 2015 CHS annual review identified housing's contribution to health and social care outcomes as one of the main priorities going forward. The new CHS for 2017-22 will be developed throughout 2016 in consultation with partners. This Housing Contribution Statement acts as a 'bridge' between the Strategic Plan and the CHS. The next CHS will identify further opportunities for health, social care and housing to address shared priorities and discussion with the IJB will be an important part of the consultation process. Revised Scottish Government Local Housing Strategy guidance (2014) also highlights the importance of addressing health and social care integration in local housing strategies.

The City Housing Strategy for 2017-22 will be developed in consultation with health and social care partners and will set out housing's contribution to Strategic Plan priorities, with a focus on the groups who can benefit most from the transformation of services as set out in the Strategic Plan.

3. Housing and Health Information

Health and Care Needs

3.1. The Strategic Plan highlights that there is an increase in demand for health and social care services that is expected to continue due to a combination of factors including:

- growth in the number of people living in the city;
- increased life expectancy in the overall population which means that people are living longer but not necessarily healthier lives;
- increased life expectancy amongst people with complex health conditions as a result of advances in medical science; and
- an increase in the prevalence of long term conditions in the population overall.

3.2. The Joint Strategic Needs Assessment (JSNA) to inform the Strategic Plan provides the evidence base for the underlying demographics and health and care needs of the adult population in Edinburgh. The JSNA has a housing chapter and housing topic paper (housing staff within the Council were represented on the JSNA planning group). Some of the main points from the JSNA which inform future need are:

- In both numerical and percentage terms, Edinburgh is projected to be home to a faster growing population than anywhere else in Scotland. Edinburgh's population is projected to continue its recent rapid growth, rising from 482,600 in 2012 to 537,000 in 2022 – an increase of 54,400 or 11.3% over the next 10 years.
- The number of people aged over 85 is expected to double by 2032.
- Population growth itself will bring about an increase in demand for services.
- Within 20 years the number of people living with **dementia** could rise by 61.7 % to 11,548 people.
- Assuming underlying prevalence rates remain the same the Strategic Plan estimate is that the number of people with **mental health** issues and **addictions** will increase by an average of 1.4% per year in line with the annual increase in the adult population. Additional factors such as living in areas of socio-economical deprivation and economic factors such as recession, low growth and insecurity can also contribute to an increase in demand for mental health services.
- If rates of alcohol consumption continue to rise, there will be an ongoing demand from service users with **alcohol related brain damage** (ARBD). As ARBD is often undiagnosed, and prevalence difficult to ascertain, it is not possible to provide estimates of future levels with any confidence.
- The overall prevalence of people with **learning disabilities** is expected to increase through improved neonatal care and increased life expectancy including for people with profound and multiple learning disabilities.

- There is evidence that the number of adults with a **physical disability** is increasing, again through improved medical intervention leading to increased survival at birth and in the early years, and for improved survival from trauma. The conservative assumption in the JSNA is that numbers will increase by an average of 1.4% per year, in line with the annual increase in the adult population.
- The number of **young people with disabilities** leaving school and needing support has been increasing gradually over recent years, and is expected to continue to increase, again, through population growth and also as a result of improved neonatal care, leading to increases in survival rates.
- **Sensory impairment** in particular is more prevalent amongst people aged over 60 and so the numbers of people affected will increase in line with changes in the population size.
- Assuming the prevalence rate remains the same, the number of people with **Autism** will change along with the size of the population. However, increasing awareness of the condition is likely to lead to increases in diagnosis rates, and potentially the level of demand for support.
- There are estimated to be 65,084 **carers** in Edinburgh, or 13.7% of the population. It is expected that the numbers of carers will rise in response to the rising population, but social factors such as changes in family composition make numbers hard to predict.
- It is difficult to estimate future levels of demand for **people with complex needs**, because there are different definitions of the group, reflected in the range of estimates of the size of the current group in Edinburgh being from 150-5,000 individuals.
- People in Scotland are living longer and **long term conditions** are increasingly common**.** In Edinburgh 23% of people have at least one long term condition and 38% of these people have multiple (two or more) long term conditions.

3.3. Areas which traditionally had a high concentration of social rented housing are often found to correlate with higher levels of poor health. Whilst the tenure in these areas has changed in some cases, with an increase of owner occupation and private rented housing, the prevalence of health-related issues still remains.

3.4. The Scottish House Condition Survey (SHCS) estimates that 24% of all households in Edinburgh were said to have at least one member who is long term sick or disabled (LTSD) in 2011/13, compared to the Scottish average of 36%. 56% of the households living in social housing were said to have a member who is LTSD, compared to 22% in owner occupied housing and 8% in private rented housing. Pensioner households are more likely to have a member with LTSD than other types of households at 44%. People living in the most ‘deprived’ areas of the city are more likely to develop long term conditions and to develop them at least ten years earlier than people living in the least ‘deprived’ areas. They are also at greater risk of emergency admission to hospital.

3.5. The SHCS also provides information on fuel poverty, showing that 26% of Edinburgh’s households are in fuel poverty, defined as needing to spend more than 10% of the household income to maintain a satisfactory heating regime at home.

3.6. The Joint Strategic Needs Assessment will be developed and updated on an ongoing basis to ensure that emerging issues or patterns of need can be identified.

The Council's housing service, and housing partners, will continue to be involved in monitoring and developing the JSNA to identify specific housing needs of priority groups identified in the Strategic Plan.

Housing Need and Demand

3.7. The projected population growth will increase demand for housing across all tenures in the city. As outlined above, the increasing population also brings an increasing demand for services to meet particular needs and the housing sector has a key role in helping to meet these needs. The second Housing Need and Demand Assessment (HNDA2) for the SESplan area estimates that around 4,000 new homes of all tenures are required in Edinburgh each year for ten years to meet current and future demand. The greatest need is for affordable homes.

3.8. The HNDA2 acknowledges that limited data is available to quantify the level and type of housing required to meet specific housing needs. However, the impact of an ageing population on housing and housing related services is set out in the HNDA2. It is recognised that a proportion of older people will live their lives without a requirement for specialist housing or housing support services, but some older people, and people with complex physical needs for example, may require more accessible or specialist housing, coupled with support services to help them live as independently as possible.

Housing Challenges

3.9. The shortage of homes is pushing up house prices and private sector rents. Edinburgh has the highest average house prices, when compared to other Scottish cities, and is 29% higher than the Scottish average. Private sector rents have risen by 25% since 2009. While housing costs are increasing, independent research shows that income growth has been strongest for high earners, while incomes have fallen for those already on lower incomes. Since 2008 low income households have seen their incomes decline in real terms by between 10% and 30%. The provision of more affordable housing can help tackle inequalities in the city and contribute towards providing homes for people on lower incomes, including those who work in the health and social care sector.

3.10. The EdIndex Partnership is an excellent example of joint working. It provides a single gateway to access social housing throughout the city of Edinburgh. The partnership consists of the City of Edinburgh Council and 20 Registered Social Landlords. Over time, the partner landlords have agreed priority groups for allocations of housing, to ensure that those in the greatest housing need are able to access homes more quickly.

3.11. Demand for social rented homes is high in Edinburgh. There are approximately 26,000 applicants registered with EdIndex, Edinburgh's common housing register, at any one time and almost 150 households bid for every Council and housing association home available to let through the Choice based system in Edinburgh.

3.12. As at the end of September 2015, around one fifth (5,400) of social housing applicants were from households who considered someone in their household as disabled. Of these 5,400 applicants, around 400 were awarded with Gold or (Urgent) Gold re-housing priority because their homes cannot be adapted to meet their needs. This highlights the importance of adaptations and other support in helping people to live independently in their homes.

3.13. The older, flatted profile of homes in Edinburgh means that not all homes can be easily adapted. 66% of homes in the city are flats (compared to 37% across Scotland) and 50% of homes were built before 1945. In some cases it is possible to adapt the flat but not the stair where the flat is situated or where lift access is required. Encouraging people to plan for their future housing needs before crises happen and ensuring housing options information is widely available is an area that can be strengthened through joint working.

3.14. While social housing landlords have an important role to play repairing and maintaining their homes and supporting tenants, there is also a need to address the housing and health issues of people in private sector homes. Home ownership is the largest tenure in Edinburgh, accounting for 56% of households. Private renting is the second largest tenure, accounting for 29% of households. 13% of households rent from the Council or a registered social landlord (RSL) (Scottish House Condition Survey (SHCS) 2013).

4. Housing Contribution to Strategic Plan Priorities

Housing Supply

More Homes

4.1. There is a commitment to expand the Council-led house building programme to build 8,000 homes over the next 10 years. These affordable Council homes for social and mid-market rent can be funded through the Housing Revenue Account (HRA) Business Plan within the next 10 years, through investing £1 billion.

4.2. The Council's not-for-profit housing (housing association) partners have committed to match the Council led programme by delivering the same number of new affordable homes. Through partnership working, the Council and its partners could potentially fund the delivery of **16,000 affordable homes over the next 10 years** through a total investment of **£2 billion**. This investment will make a significant strategic contribution to meeting housing need in the city, helping to tackle the inequality and affordability issues outlined earlier. Increasing the supply of affordable homes also helps meet the housing needs of the health and social care workforce.

4.3. The Council's housing strategy will aim to commit up to **£300 million** of this investment to delivering **around 3,000** affordable homes and **integrated** health, care and support services. It provides a significant opportunity to take forward collaborative and innovative approaches to delivering services, integrating the provision of health and social care services with new affordable and low cost homes for people with complex physical and health needs.

4.4. The investment strategy faces significant challenges which require the support and collaboration of many of the partners to overcome. They include land availability, construction capacity, planning, funding models and integrated decision making.

4.5. The delivery of the Affordable Housing Supply Programme (AHSP) is managed by the Council's Housing and Regulatory Service. Forward planning of this programme is done formally through the production of a bi-annual Strategic Housing Investment Programme (SHIP). Health and social care partners will be involved in the SHIP planning process.

The Council and housing association partners will invest up to £300 million to deliver around 3,000 affordable homes and integrated health, care and support services as part of an ambitious programme to build 16,000 affordable homes over the next 10 years.

4.6. The Strategic Plan outlines specific commitments to work jointly with housing on identifying and meeting future needs for frail older people and those with dementia, one of the groups of people the Edinburgh Health and Social Care Partnership believe can most benefit from the transformation of services.

4.7. The biggest challenge to delivering new affordable homes is securing sites for development. At present, affordable housing developers do not have control of many sites that could be developed. The housing sector will work to strengthen partnerships with other public sector agencies (including the NHS), and private sector landowners to help secure and acquire land to deliver more homes, quickly, at a cost that is affordable.

4.8. Private sector house-builders will be encouraged to build homes for competitive market rents. The Affordable Housing Policy will ensure that a 25% affordable housing contribution continues to be secured when house builders develop housing for market sale or market rent.

4.9. This collaborative approach supports the Strategic Plan priorities on **making best use of shared resources** and **making best use of capacity across the whole system.**

4.10. Work is ongoing with NHS Lothian regarding the potential for Council-led developments, which could provide around 500 homes alongside integrated Health and Social Care facilities. This would add to the current Council-led 21st Century Homes Programme to build around 80 accessible homes and two care homes. The Strategic Plan has a specific action on joint working on the Royal Victoria Hospital site. The Council will undertake an evaluation of extra care housing to inform future provision of this type of housing, including site specific evaluations.

4.11. In recent years, the combination of the Affordable Housing Supply Programme (AHSP) funding, Council land supply and housing association private finance has been used to jointly deliver high quality housing for older people. For example, using land transferred from Council ownership as part of the regeneration of Moredun Park and Hyvots, Dunedin Canmore Housing Association developed The Quarries. The 58 flats are all wheelchair adaptable. The quality of the environment and amenity provision, which includes a courtyard area, outdoor gym area, communal and community spaces, helps to support improvements in health.

4.12. Using the same combination of Council land, funding through the AHSP and housing association finance, Castle Rock Edinvar Housing Association developed social housing for older people in nearby Fortune Place, Moredun. The flats are designed to cater for different and changing needs to enable people to live at home contently for as long as possible. They are a mix of one and two-bed flats, with lift access to the wheelchair adapted properties. Eight of the homes are allocated through a nominations arrangement with the Council to older people with specific support needs, including those who may be discharged from hospital and need a care and support package as part of their tenancy. The focus on helping to keep residents physically and socially active is an important element of the development.

4.13. In 2011 the Council approved the sale of a former care home at Little Road, to Dunedin Canmore Housing Association. This sale was approved as part of the accommodation strategy for the Joint Capacity Plan Phase 2 (2008-18) for older people. The 48 homes provided on this site are a mixture of one and two bedroom flats and were built using a combination of funding, including a charitable donation levered in from the Merchant Company of Edinburgh.

4.14. Elizabeth Maginnis Court in the Granton area provides a model of care that consists of accessible homes suitable for people with a range of support needs, which can be adapted over time as needs change. Some of the flats are allocated to older people with more complex care needs, offering an alternative to care home placement when deciding where their accommodation and care needs can best be met. The provision of communal facilities and a day care centre on site helps to address social isolation.

Investing in and making best use of existing homes

4.15. As well as building new homes there needs to be investment in existing homes to make them more energy efficient and to adapt them where possible to make them more accessible. Health benefits can be achieved through investing in energy efficiency and providing support to help people manage their energy consumption.

4.16. Social housing providers have been investing heavily in improving the quality of their properties to achieve the Scottish Housing Quality Standard in recent years. Despite having some of the most energy efficient homes, around 26% of households in the social rented sector are still in fuel poverty. Social housing providers will continue to invest in improving their homes to achieve the Energy Efficiency Standards for Social Housing (EESSH) by 2020. Around £8 million in energy efficiency measures to Council homes is included within the 2015/16 Capital investment programme.

4.17. Generally, the private rented sector has a poorer state of repair and energy efficiency than the social rented or owner occupied sector. Home Energy Efficiency Programmes for Scotland: Area Based Schemes (HEEPS:ABS) is the Scottish Government's programme to specifically target areas of fuel poverty by funding owners' contributions to energy efficiency works to their homes. HEEPS:ABS funding not only helps individual home owners to improve the energy efficiency of their homes, but supports Council or housing association led mixed tenure projects by funding (or part funding) owners' contributions to these works. The Council was allocated £3.3 million from the 2014/15 HEEPS: ABS funding pot.

4.18. The EdIndex Partnership Board has been closely involved in the changes that are being introduced through the integration of Health and Social Care. A new joint approach has been developed between the Council, Registered Social Landlords (RSLs), and NHS Lothian, which matches social rented homes available to let to people with (Urgent) Gold Priority for re-housing. This priority is the highest possible priority for re-housing and is usually only awarded in exceptional circumstances, for example to enable a hospital discharge. It is also awarded to prevent

long term hospital and care home admissions and forms part of a wider support and care package. Between June and October 2015, the pilot matched 10 people to suitable homes, reducing the time they spent in hospital. The approach has now been extended to other EdIndex partners and will continue to be monitored and developed through the Housing Matching Group.

4.19. The demand for social housing in Edinburgh currently exceeds the supply. A revised housing options approach, which puts an emphasis on alternative tenures and other options for people in housing need, is being implemented. It is proposed that a review of the allocations policy will be undertaken by the EdIndex partners in 2016. This will provide an opportunity to review priority housing groups and ensure social housing is allocated to those most in need, including those with an assessed housing need.

Services: preventative and person-centred

4.20. Building affordable, more accessible and energy efficient homes makes a significant contribution to supporting health and social care priorities. However, the housing contribution through the provision of preventative support (and care) services, helping people to live independently at home or in a homely setting and helping to prevent unscheduled admissions to hospital and delayed discharge from hospital is equally important. Examples of preventative services provided by housing organisations to support independent living include:

- Housing support services
- Adaptations
- Technology based services
- Budgeting and money management assistance
- Benefits and welfare rights advice
- Energy Advice
- Befriending and advocacy services
- Tenancy sustainment services
- Integrated care and housing

Integrated care and housing

4.21. Several RSLs in the city provide housing and care services together, supporting the provision of the right care in the right place at the right time.

Technology

4.22. Technology Enabled Care (TEC) plays an important role in supporting people to stay in their own homes and reduce the reliance on high cost care, hospital and long term care placements. Over 8,000 people across Edinburgh are supported by the Community Alarm Telecare Service at any one time.

4.23. The new TEC programme will bring together all the TEC services within the IJB to identify synergies with the delivery of these services and widen the access to TEC across all points of service delivery. Introducing technology to support the low / moderate assessed needs will prevent or delay access to formal care. It will also support strategic priorities such as reducing the number of unscheduled hospital admissions in the over 75 age group.

4.24. There is a commitment within the Strategic Plan to improve understanding of the extent to which Technology Enabled Care is currently utilised within the Health and Social Care Partnership and by other partners including housing providers. A strategy for the delivery of Technology Enabled Care in Edinburgh will be developed. The Edinburgh Affordable Housing Partnership Health and Social Care Sub Group will be the main forum for jointly taking forward this area of work.

Energy Advice

4.25. Improving the quality of homes is only one aspect of addressing fuel poverty. The Council's Homes and Energy Strategy also focuses on reducing the impact of energy costs and providing and promoting education and advice, across all tenures. This has been done through a Warm Your Home Campaign and a campaign specifically aimed at private landlords.

4.26. Joint working between housing providers and health services can help to ensure access to services that will support those most at risk of fuel poverty. A Healthy Homes project is being piloted with Home Energy Scotland and Craigmillar Medical Centre, which aims to improve health through the provision of energy advice and energy improvements in people's homes. The pilot involved a Home Energy Scotland adviser spending 5 weeks in the medical centre and following up on referrals.

The outcomes of the Healthy Homes pilot will be evaluated to look at whether Home Energy Scotland can replicate this approach in other localities.

4.27. The provision of aids and adaptations, to help people live independently, is an integrated, preventative service involving a number of Council functions. The responsibility for planning and resourcing some adaptation provision is a **delegated function** under the Public Bodies (Joint Working) (Scotland) Act 2014. However, the Act and accompanying regulations do not prescribe the delivery arrangements for adaptations – this is decided locally.

4.28. Currently, the assessment of the need for aids or the adaptation of a property is carried out by Health and Social Care for adults with social care needs. Where an adaptation for a property is required these adaptations are project managed by the Council's Housing and Regulatory Service. Where the adaptation is to the home of a council tenant it is funded by the Housing Revenue Account (HRA) Capital Programme. The HRA is a ring fenced account which is managed by the Council on behalf of tenants for the purpose of providing services to council tenants and this ring-fence will continue. Adaptations required for homeowners and private tenants homes are supported by grant funding from the Council's general fund. The adaptation process is managed by Housing and Regulatory Services within the Council. The duty to provide grants of 80% or 100% for those living in the private sector, who are assessed as needing adaptations, is still in place under the terms of the Housing (Scotland) Act 2006 but the duty is being delegated to the IJB.

4.29. Funding for adaptations in the homes of Registered Social Landlord (RSL) tenants is supported by Scottish Government grant. This is managed by the Council's Housing and Regulatory Service as part of the wider delegated authority from Scottish Ministers for the management of the Affordable Housing Supply Programme (AHSP). This is not delegated to the IJB.

4.30. In 2014/15 the Council provided over £2.5 million to carry out 760 adaptations for Council and RSL tenants, homeowners and private tenants. In addition, the Council invested £133,164 on 653 minor adaptations in Council homes.

4.31. The project management of adaptations for tenants and homeowners/private tenants will continue to be managed by Housing and Regulatory Services in the Council as this primarily focuses on the project management of property related work. It is more efficient and effective to manage all elements together. A clear reporting line from these management arrangements up to the IJB will be established.

4.32. Assessing the future need and demand for housing adaptations is complex and also needs to be considered alongside availability of care packages where required. In recent years there has been a consistent and ongoing demand for adaptations, which is a demand-led service. Given projections on population growth and the increase in older people and people with disabilities the demand is likely to go up. This needs to be monitored by the IJB and housing partners to take into account future investment in accessible homes and more easily adapted homes, which could reduce the need for adaptations in the longer term.

4.33. The approximate **adaptations budget (capital) for 2016/17** (subject to final budget approval) is:

General Fund	£1 million
Housing Revenue Account	£1.2 million

4.34. The Council is one of 12 local authorities in Scotland working with Link Group Ltd to pilot the Scottish Government's Help to Adapt scheme. This scheme aims to make it easier and safer for older homeowners to use the equity in their own homes to pay for adaptations and to encourage older people to be proactive in planning their future needs.

4.35. The Care & Repair service in Edinburgh currently receives funding through the Homelessness Prevention Commissioning Plan budget. Care and Repair provides a number of valued services to older people and people with disabilities. These include a small repairs service, provision of keysafes, handy person service, trades referral service and the Home from Hospital service which provides adaptations to properties to allow clients to return from hospital.

4.36. Another housing related function that must be delegated is the provision of gardening assistance for people with disabilities and to older people. The Housing Service provides funding through the HRA for its own tenants to receive this service (if they meet the criteria).

Homelessness and Housing Support

4.37. Homelessness and Housing Support functions (with the exception of housing support services in so far as they relate to adults with social care needs) have not been delegated to the IJB. As part of the Council's Transformation Programme, the Homelessness and Housing Support service area now sits within Safer and Stronger Communities, reporting to the Chief Social Worker, providing an opportunity to strengthen the relationship between homelessness and social care services. The reshaping of Council services also provides an opportunity for homeless prevention and housing support activity to become better integrated with a range of locality based services delivering more responsive and effective early intervention, holistic and person centred services, in line with the Inclusive Edinburgh approach.

4.38. The housing option service delivers a range of homelessness prevention activity including homelessness assessment and case management and this will increasingly be delivered in a locality/ community based setting. New housing options pathways to further improve homelessness prevention have been developed and will be delivered through Council transformation.

4.39. Outreach housing options services are provided into hospitals and prison in Edinburgh to support planned moves and avoid delayed discharge in hospital. Further integration of these services will lead to better planning for people without homes leaving an institutional setting. Joint work has also begun between health and homelessness services to better support and avoid frequent attendees at A&E services by people who are known to homelessness services.

4.40. Homeless prevention services have delivered year on year reductions in the number of people who present as homeless in Edinburgh over the last 8 years (overall a 28% reduction between 2006/7 and 2014/15). Nevertheless around 4000 households presented themselves as homeless to the Council in 2014/15. The Council has a statutory duty to provide settled accommodation to the majority of these homeless

households. Only 28% of homelessness presentations in 2013/14 were from people with support needs. This is the result of providing targeted housing support to vulnerable people who are struggling to manage their accommodation and are at risk of homelessness. Housing support is also provided to vulnerable people who have become homeless to support them in temporary accommodation and to settle into new homes.

4.41. Recipients of housing support services include people with mental health issues, people affected by drug and alcohol dependency, people with a physical disability or a medical condition, older people and young people.

4.42. Housing support can be provided as part of housing services in specialist schemes run by social housing landlords, including sheltered and very sheltered housing. It is also provided in supported temporary accommodation managed directly by the Council and commissioned by the Council.

4.43. Visiting housing support services are provided in each neighbourhood by the Council's in-house housing support service and/or commissioned providers. This will continue within the four new localities.

4.44. The Council spends £13m per year commissioning homeless prevention services, which include housing support, housing advice, supported temporary accommodation (including specialist services for young people, domestic abuse, complex care needs).

4.45. Housing support can be delivered alongside personal care and support services. Working at locality level there will be more opportunities for staff providing different types of support to work better together, making the best use of resources and improving outcomes for individuals.

4.46. Shortage of suitable homes to re-house those who become homeless leads to a longer stay in temporary accommodation. The average stay in temporary accommodation has increased from 77.9 days in 2010/11 to 100.7 days in 2014/15 and this upward trend is continuing. 59% of those who had been homeless for more than a year had multiple support needs. The most frequently stated support need was mental health, followed by drug or alcohol dependency.

4.47. It is more difficult to find settled accommodation for people who have complex needs; it can also often be difficult for temporary accommodation to be sustained. Repeat homelessness has remained static despite reductions overall in the number of people presenting as homeless.

4.48. The most effective response will be early intervention to prevent multiple exclusion. Repeat homelessness can be a ‘late marker’ of people with multiple support needs. Early indicators such as substance misuse, mental health problems or a stay in prison need to be addressed to prevent repeat homelessness and the entrenchment of health and other inequalities.

4.49. Life skills development, education, training and support for young people including access to work are vital for homelessness prevention. Over the past 2 years the Council has re-shaped homelessness services for young people resulting in significant reductions in homeless presentations from younger people and care leavers; and also the provision of a ‘foyer approach’ service for young people who are homeless or at risk of homelessness, providing a more holistic service with a focus on pathways into employment.

4.50. Integrated and joined up approaches, such as Total Neighbourhood, with partners from the Council, NHS Lothian, Police Scotland, the Scottish Fire and Rescue Service and a wide range of voluntary organisations, are required to tackle some of the problems which lead to homelessness and are faced by people with complex needs.

4.51. ‘Inclusive Edinburgh’ was set up to review how services are delivered for people with complex needs, who may struggle with homelessness, unemployment, drug and alcohol problems, mental or physical ill-health, who sometimes get involved in crime, and who are often the victims of violence. ‘Inclusive Edinburgh’ examined the combined services delivered by the Council, statutory partners and voluntary organisations to this group of vulnerable people. An 'Inclusive Edinburgh' approach 'getting it right for every person' will inform the establishment of integrated locality based working.

4.52. In addition the 'Inclusive Edinburgh' approach is informing the review of existing housing, health and social work services delivered to people who are homeless and have complex care needs (the existing services based within The Access Point and the Edinburgh Access Practice). These services currently work closely together and are co-located, but the review is expected to deliver a more fully integrated and psychologically informed service based at a city centre location, which will be designed to meet the needs of people who are multiply excluded. It is currently estimated that the live caseload of such a service would be approximately 350-450 people.

Community: supporting locality working

4.53. Housing organisations, including the Council’s Housing Service, have excellent connections within communities across Edinburgh. There is a strong track record of working with tenants and local communities and delivering a wide range of services to help people live independently at home, and connect with their local communities.

4.54. There is an opportunity to involve health and social care staff in projects that are already happening in local communities, as well as establishing new relationships aimed at improving partnership working and identifying new local projects. Partnership projects involving

housing and health and social care staff can also help break down barriers between professions, and encourage improved joint working on individual cases locally as well as supporting **integrated workforce development** and making **best use of capacity across the system**.

4.55. Examples include a housing association in the South West locality which has been successful in getting funding to employ a welfare rights officer to work in different locations, including the local Healthy Living Centre. This allows the local Health Agency and GP practice to refer patients to a welfare rights service that is located within their premises. This removes barriers to health staff referring patients, and barriers for patients accessing the service as well as encouraging improved communication between the agencies involved.

4.56. Housing Associations have a key role identifying and supporting isolated people in communities to help increase their independence, wellbeing and resilience. In Leith, for example, a local housing association works with other local partners to participate in projects such as the Generations Project, bringing older and younger people together to support and learn from one another.

4.57. The Strategic Plan priority on making best use of capacity across the whole system is about the need for health and social care service providers to work collaboratively to deliver the other priorities, making the best use of skills and resources. It means working with citizens, communities, statutory agencies, housing providers and the third and independent sector.

4.58. The Edinburgh Health and Social Care Partnership, through the Strategic Plan, acknowledges that the third sector and social housing providers have a major role to pay in tackling inequalities across the city through the provision of a wide range of services at a local and citywide level and is committed to work with partners including citizens and communities at a local level to determine the approach to tackling inequalities; these will be set out in the plans to be developed for each of the four localities during 2016/17. The Strategic Plan action on establishing local collaborative working arrangements includes a commitment to ensure that links with the housing sector are strengthened.

4.59. As part of the formal consultation on the Strategic Plan and to help develop the Housing Contribution Statement, discussions have taken place with tenant representatives. Tenant representatives expressed an interest in being engaged in discussions on housing, health and social care at a local level and felt there is a valuable role for communities in helping tackle inequalities and address health issues. Housing colleagues can support health and social care colleagues to engage with tenants in local communities. Some specific comments from tenant representatives on integration included:
“Organisations need to work together to support vulnerable people in their tenancies”
“There is a role for communities in helping to reduce the stigma around mental health”
“People don’t always know how to access services – communication and sharing information is very important”.

5. Summary of Actions

5.1 The Housing Contribution Statement includes a number of commitments from housing partners to work with the IJB and other partners to support Strategic Plan priorities. Some of the key areas commitments to joint working are:

- The Council and housing association partners will invest up to £300 million to deliver around 3,000 affordable homes and integrated health, care and support services as part of an ambitious programme to build 16,000 affordable homes over the next 10 years.
- The City Housing Strategy for 2017-22 will be developed in consultation with health and social care partners and will set out housing's contribution to Strategic Plan priorities, with a focus on the groups who can benefit most from the transformation of services as set out in the Strategic Plan.
- Health and Social care partners will also be consulted as part of the Strategic Housing Investment Programme (SHIP) planning process.
- Housing staff within the Council, and housing partners, will continue to be involved in monitoring and developing the JSNA to identify specific housing needs of priority groups identified in the Strategic Plan.

5.2 The table below highlights actions within the Strategic Plan which include specific reference to working with housing partners, acknowledging the significant role housing plays in supporting Strategic Plan priorities. However, the housing sector contributes to many of the other Strategic Plan actions, particularly those where there is a commitment to partnership working.

Strategic Plan Actions with specific housing input

LOCALITIES

Action 1:
From April 2016 the four Health and Social Care Locality Managers will ensure that local health, social care, third, independent and housing sector providers, along with unpaid carer and service user representatives and other local organisations, are able to work effectively together by establishing collaborative working arrangements in each locality.

IMPROVING CARE AND SUPPORT FOR FRAIL OLDER PEOPLE AND THOSE WITH DEMENTIA

Action 21 c:
We will work with housing providers and housing colleagues in the council to identify future needs and support the development of more accessible and affordable housing to meet the needs of frail older people and those with dementia

Action 22

We will:

a) consider the longer term needs for interim care beds currently being provided at Gylemuir House and determine the future model of delivery for this service during 2016

b) update our capacity plans for long stay nursing and residential care home places, including those which care for older people with behaviours that challenge and provide specialist dementia care, alongside our capacity planning for those whose needs cannot be met anywhere but a hospital during 2016.

c) explore the opportunities to use the resources and assets associated with the Royal Victoria and Royal Edinburgh Hospital sites

d) evaluate the need for the development of an Integrated Care Facility model to meet our capacity requirements for the care and support of older people as part of the Hospital Based Complex Clinical Care review and work with the council housing team to deliver homes for older people with higher needs

e) work with neighbouring Integration Joint Boards and the Acute Division of NHS Lothian to allow the closure of Liberton Hospital and release resources for reinvestment in community based services

Action 23 d:
We will work with housing providers to support the development of more dementia friendly housing

TRANSFORMING SERVICES FOR PEOPLE WITH DISABILITIES

Action 27 (part):
During the life of this strategic plan we will

- establish a programme for suitable accessible homes for people with physical disabilities and complex needs within the city's new

build housing programme • implement the redesign of the amputee rehabilitation service with the support of the housing sector
SUPPORTING PEOPLE LIVING WITH LONG TERM CONDITIONS
Action 29 f: We will work with housing options and EdIndex at local level to ensure the right long term solutions are planned with people to enable them to remain living independently
REDESIGNING MENTAL HEALTH AND SUBSTANCE MISUSE SERVICES
Action 36: We will work with partners from the Edinburgh Affordable Housing Partnership, housing colleagues in the council and third, independent and statutory sector partners to ensure we maximise the potential for people to live well in community settings with timely access to inpatient care when required
USING TECHNOLOGY TO SUPPORT INDEPENDENT LIVING AND EFFICIENT AND EFFECTIVE WAYS OF WORKING
Action 38: In 2016/17 we will • improve our understanding of the extent to which Technology Enabled Care is currently utilised within the Health and Social Care Partnership and by our other partners, including housing providers • work with our partners to develop a strategy for the delivery of Technology Enabled Care in Edinburgh
INTEGRATED WORKFORCE DEVELOPMENT
Action 41 In 2016/17 we will establish an Integrated Workforce Development Planning Group with membership drawn from key partners including, as a minimum the NHS, the Council, housing, third and independent sectors and people who use health and social care services in order to develop and oversee the implementation of an integrated workforce development strategy and action plan

Appendix H

Summary of Actions from the Edinburgh Health and Social Care Strategic Plan

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	Localities									
1	**Establish local collaborative working arrangements across partners** *From April 2016 the four Health and Social Care Locality Managers will ensure that local health, social care, third, independent and housing sector providers, along with unpaid carer and service user representatives and other local organisations, are able to work effectively together by establishing collaborative working arrangements in each locality.*									
2	**Establish integrated teams to support flexible working** *Locality managers will establish integrated teams that empower staff to work more flexibly across professional boundaries and to seek solutions and avoid unnecessary referrals on to another team or service, with the aim of providing more seamless and responsive care and support when needed.*									
3	**Establishment of locality hubs** *A priority action for the Partnership is to develop hubs within each locality*									

[1] **Key**: A - Tackling inequalities, B - Prevention and early intervention, C - Person centred care, D - Right care, right place, right time, E-– Best use of capacity across the system, F - Efficient use of resources

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	coordinating community resources more effectively in order to: • *maximise support for independent living* • *provide a community response to urgent need and care crises* • *reduce the need for admission to hospital*									
4	**Establishment of clusters** *We will support the development of eight integrated health and social care Clusters based on geographical groupings of GP practices within the four localities to support more flexible ways of working in teams with a focus on prevention, early intervention, anticipating and planning for care needs and long term support.*									
5	**Increased use of anticipatory care planning** *We will work with colleagues across all sectors to identify those with significant needs who are high users of services and improve anticipatory care planning with the aim of reducing emergency admissions.*									
6	**Locality plans** *During 2016/17 we will develop locality plans for each of the four localities that complement the locality improvement plans that are a requirement of the Community Empowerment Act.*									
	Tackling inequalities									
7	**Work with Community Planning Partnership to tackle inequalities**									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	During 2016/17 we will work with our community planning partners to: *a) determine the most effective way of developing and implementing a coordinated approach to tackling inequalities, including health inequalities, across the City* *b) deliver the health inequalities grants programme in line with funding decisions made by the Council and NHS Lothian* *c) asses the impact of the current grants programme on tackling inequalities in order to inform future funding arrangements*									
8	**Strategic approach to tackling inequalities** *As an Integration Joint Board working at a strategic level we will:* *a) improve our understanding of the range and effectiveness of current actions and funding that impact on tackling inequalities in order to inform our future strategic direction* *b) embed tackling inequalities within our strategic and service planning, operational delivery and performance management framework* *c) develop improved intelligence about the distribution of Edinburgh Health and Social Care Partnership services and their uptake by people with protected characteristics and where possible, by people living in poverty* d) *develop a set of 'equalities outcomes' in line with the Equality Act*									
9	**Encourage take up of social prescribing** *We will build on the experience of the Headroom practices and other initiatives to*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	develop the benefits and applications of social prescribing in order to determine where this approach is most effective and how to encourage wider take up as an alternative to traditional health and social care services.									
10	**Support for initiatives to tackle health inequalities** *We will support initiatives such as Inclusive Edinburgh, Headroom, the Patient experience and Anticipatory Care Team (PACT), and the Health Inequalities and Learning Disability Group as part of our approach to gaining a better understanding of the most effective means of addressing health inequalities in the city.*									
11	**Partnership working to tackle inequalities** *During the life of this plan we will:* *a) be an active partner in the locality based multi-agency Leadership Teams designed to tackle inequalities* *b) work closely with NHS Lothian's Public Health service to ensure our approaches to tackling health inequalities are well founded and supported with appropriate evaluations* *c) engage with a wide range of community based organisations at the locality level in a preventative approach which recognises and works alongside community assets*									
12	**Support for people with protected characteristics**									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	a) We will continue to raise awareness and understanding of the challenges that LGBT people can face when accessing health and social care services, using the tools developed by projects such as Edinburgh LGBT Age. *b) We will work with people with protected characteristics to understand their needs better, provide specialist services where appropriate and improve access to mainstream services.*									
	Consolidating our approach to prevention and early intervention									
13	**Approach to prevention** *We will:* *a)* work with partners to map local services, assets and resources that could be used to improve people's health and wellbeing (Action 1) *b)* use locality level forums to assist organisations to come together, build relationships, share ideas and develop collaborative working and ensure the right people offer the right support (Action 1) *c) build on the development of the LOOPS (Local Opportunities for Older People) initiative to enhance the opportunities for older people to retain socially connected and independent lives within the localities where they live and continue to raise awareness across the public, staff and volunteers of opportunities locally* *d) identify local needs, gaps in services and develop co-produced and innovative solutions which build community capacity. Priority areas*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	include: ○ *reducing social isolation* ○ *promoting healthy lifestyles including physical activity* ○ *falls prevention strategy* ○ *supported self management of long term conditions* ○ *support for unpaid carers* ○ *technology enabled care and supporting older people to use technology* ○ *transport options*									
14	**Support for unpaid carers** *During the life of this plan we will:* *a) continue to implement the action plan associated with the Edinburgh Joint Carers Strategy 2014-17* *b) develop a new Edinburgh Integrated Carers' Strategy and establish our new priorities in line with National Carers Policy, new carers legislation and the Integration Joint Board's priorities on prevention and early intervention*									
	Ensuring a sustainable model of primary care									
15	**Work with GPs to improve resilience of practice** *We will continue to gather information from all practices to develop a better understanding of the workforce and to engage with GP practices on their 'resilience' in order to offer support at an earlier stage where a practice is*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	experiencing staffing or other difficulties.									
16	**Supporting practices to work differently** *We will* a) *encourage and support general practice to examine newer ways of working, to review their own workload and pressures, to look at new ways of working to support practice specific demands and to encourage redesign of general practice to meet these new demands* b) *continue to support the 17 Headroom practices to explore new ways of working with economically disadvantaged communities and to test arrangements which can inform the 2017 GP contract*									
17	**Building the wider primary care capacity** *We will do this by:* *a) identifying ways to maximise the contribution of community nurses who support those with healthcare needs, including frail older people living at home and in care homes, as part of developing a sustainable model of care for this group of people* *b) continuing and extending medicines reviews for people taking a large number of medicines (polypharmacy) in care homes and in the community, focused on the high risk groups, linked to "Prescription for Excellence" funding* *c) expanding the primary care pharmacy workforce, salaried and sessional, to*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	work alongside and support GP practices *d) testing and rolling out models of "teach and treat" polypharmacy clinics to assist patients to better manage their own medicines* *e) increasing opportunities for social prescribing for anxiety and depression, for example, as an alternative to prescription medication* *f) considering better ways to inform the public of how to access directly health services which do not require a GP referral*									
18	**Developing premises to meet population growth** *We will work with NHS Lothian to build and expand GP premises to increase capacity, including:* *a) starting construction of 2 new partnership centres in 2016, incorporating GP practices and community services at Firrhill and establishing a new practice in North West Edinburgh* *b) building new premises for Leith Walk and Ratho GP practices in 2016/17* *c) relocating the Edinburgh Access practice (due to tenancy expiring) in 2016* *d) exploring opportunities at up to 4 other practices to extend/refurbish practices to increase capacity* *e) supporting a number of practices to create additional consulting space* *f) exploring potential development opportunities particularly for incorporating practice reprovision in wider healthy living initiatives*									
19	**New models to better meet the needs of frail elderly people at home and in**									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	care homes *We will:* *a) take account of the learning from the Behaviour Support Service and Care Home Liaison pilots, to develop alternative models of support to care homes to ensure primary care and specialist teams engage effectively to allow people to avoid unnecessary hospital admissions* *b) deliver the recommendations of "Promoting Continence in Lothian" report to improve community based support for individuals*									
20	**Improving the interface between primary and secondary care** *To help achieve integration of care pathways at a locality level we will:* *a) work with other Lothian Integration Joint Boards and the acute hospital division of NHS Lothian to develop a single model for acute unscheduled care services across the city, including early assessment at hospital front doors and approaches which provide alternatives to admission and which work effectively with local community services in Edinburgh* *b) work with primary and secondary care colleagues to improve processes for care across the interface and transition between primary and secondary care to improve efficiency and safety, e.g. medication reconciliation and discharge planning* *c) support the implementation of the palliative care redesign programme in partnership across Lothian*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	Improving care and support for frail older people and those with dementia									
21	**Shifting the balance of care** *a) From October 2016 we will commission care at home on a locality basis through new contracts with the independent and third sector, ensuring that local care providers can work closely with local homecare organisers and engage with the locality hubs to maximise flexibility and capacity to meet care needs.* *b) We will also support the development of alternative delivery models across market sectors to deliver cost effective and good quality care at home, through a potential third sector collaborative for example* *c) We will work with housing providers and housing colleagues in the council to identify future needs and support the development of more accessible and affordable housing to meet the needs of frail older people and those with dementia*									
22	**Developing whole system capacity plans to provide the right mix of services** *We will:* *f) consider the longer term needs for interim care beds currently being provided at Gylemuir House and determine the future model of delivery for this service during 2016* *g) update our capacity plans for long stay nursing and residential care home places, including those which care for older people with behaviours that challenge and provide specialist dementia care, alongside our capacity*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	planning for those whose needs cannot be met anywhere but a hospital during 2016. *h) explore the opportunities to use the resources and assets associated with the Royal Victoria and Royal Edinburgh Hospital sites* *i) evaluate the need for the development of an Integrated Care Facility model to meet our capacity requirements for the care and support of older people, as part of the Hospital Based Complex Clinical Care review and work with the council housing team to deliver homes for older people with higher needs* *j) work with neighbouring Integration Joint Boards and the Acute Division of NHS Lothian to allow the closure of Liberton hospital and release resources for reinvestment in community based services*									
23	**Improving support for people with dementia** *We will:* *a) develop an improved pathway for people with dementia from assessment, diagnosis and post- diagnostic support, including effective engagement between Medicine for the Elderly and Old Age Psychiatry Services, to ensure individuals get the specialist support they require in a timely way* *b) develop a plan in response to the intended reduction in old age psychiatry in hospital beds at the Royal Edinburgh Hospital to ensure adequate capacity to provide appropriate discharge planning and personalised care and support in the community for people with mental health problems*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	including dementia *c) provide training for staff in all sectors working with people with dementia* *d) continue to develop the award winning Dementia Friendly Edinburgh programme* *e) work with housing providers to support the development of more dementia friendly housing*									
24	**Embedding rehabilitation, reablement and recovery approaches** *a) We are temporarily increasing the level of care at home capacity to be able to offer timely access to reablement to match needs and ensure that people can move on from reablement with their longer term needs met, so that the reablement capacity is released to support others who can benefit from this service.* *b) We will plan for the right balance of reablement and rehabilitation within our overall capacity planning work and ensure this is a core accessible support service within the locality Hub model going forward.*									
	Transforming services for people with disabilities									
25	**Support for people with learning disabilities** *During the life of this plan we will:* *a) work with partners to establish options for developing a cradle to grave service for people with learning disabilities in Edinburgh to improve*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	support for the transition to adulthood *b) work with NHS Lothian to modernise the learning disability inpatient facilities and develop forensic and positive behaviour support services in the community focused on prevention of admission to hospital* *c) reach agreement with Lothian partners on the allocation of NHS resources as hospital services are redesigned* *d) realign internal day support services for people with learning disabilities into complex care and community based support* *e) work with all providers of day support to develop a framework agreement for these services* *f) evaluate a model of working collaboratively across the NHS, social care, third sector and families to prevent admission to hospital, from either supported accommodation or the family home*									
26	**Support for people with autism** *During the life of this plan we will:* *a) take action to raise awareness of autism amongst front line workers, unpaid carers and the public* *b) develop a care pathway to improve access to diagnosis and post diagnostic support in the first year for adults with autism who do not have a learning disability*									
27	**Support for people with physical disabilities**									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	During the life of this strategic plan we will: • *continue to shift the focus of day and home care services for people with physical disabilities from long term support to rehabilitation and life style management, building confidence, independence, local connections and support for unpaid carers* • *re-align existing day support for people with physical disabilities to move from two sites to a single physical disability hub that will focus on rehabilitation, prevention and condition specific intervention and accommodate Edinburgh Community Stroke Service* • *set up a new contract for the delivery of independent living services in the city that includes information and advice about self-directed support including Direct Payments* • *establish a programme for suitable accessible homes for people with physical disabilities and complex needs within the City's new build housing programme* • *work with people with physical disabilities to develop a joint strategy, informed by the review of Hospital Based Clinical Complex Care, with a clear focus on supporting people to manage their conditions, build confidence and increase their independence* • *develop the business case for the re-provision of specialist and complex rehabilitation services (hosted for Lothian at the Astley Ainslie Hospital) within phase 2 of the Royal Edinburgh Hospital Campus development*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	• *work with primary care and the acute hospital sector to implement the Neurological Care Improvement Plan to support early intervention, self-management and planned access to specialist services when required in a timely way* • *within the framework of the Neurological Care Improvement Plan, continue to progress the redesign of services for people with progressive neurological conditions such as Multiple Sclerosis and Huntington's Chorea, provided through the Lanfine Unit, to include a smaller in-patient provision, a Lothian wide community outreach team and options for flexible breaks from caring* • *implement the redesign of the amputee rehabilitation service with the support of the housing sector* • *further develop the stroke rehabilitation service to improve outcomes for those post-stroke to engage in a range of activities including returning to work* • *work with other Lothian Integration Joint Boards and the acute hospital division to reconfigure stroke services to improve patient outcomes including discharge support*									
28	**Services for people with a sensory impairment** *During the life of this strategic plan we will:* • *implement a new contract for the provision of social work care management and assessment services, specialist equipment and*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	rehabilitation for people with a sensory impairment (including an assessment of those people with sensory impairment at risk of fire and in need of particular fire alarms) • *work jointly to improve the pathway for audiology services focusing particularly on improving access for those people with hidden hearing loss and co-ordination of social support to people at diagnosis* • *determine how early identification of and intervention with people with sight and hearing loss can improve the pathway for eye care services, paying particular attention to those groups whose sensory impairments often go unnoticed* • *establish how the Scottish Government's sensory awareness training tools can best be rolled out in the city to improve quality of life* • *respond to the requirements of the British Sign Language (BSL) Scotland Act 2015 building on the work of the sensory champions*									
	Supporting people living with long term conditions									
29	**Development of a long term conditions strategy** *We will:* *a) continue to use SPARRA and other health and social care data to identify high risk individuals and work with them their families and unpaid carers to agree how best to reduce the risks to their health and wellbeing* *b) work with locality based hubs to deliver holistic, person-centred care for*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	people with complex multiple conditions to effect reductions in hospital bed days, improved anticipatory care planning, self-management and medicines management. *c) carry out multi-disciplinary reviews led by advanced practitioners providing expert clinical advice, including pharmacy input to rationalise medicine regimes by using medication prompting for example to reduce the need for visits* *d) work in partnership with the third sector and NHS Lothian's House of Care Collaborative to deliver an integrated model of self-management, social prescribing and peer support for people with long term conditions* *e) signpost people to digital platforms like Living It Up to benefit from online support to help them stay well and contribute to the community* *f) work with housing options and Edindex at a local level to ensure the right long term solutions are planned with people to enable them to remain living independently*									
30	**Integrated care model for COPD** *We will continue to develop the multidisciplinary/multi agency COPD integrated care model to target patients most at risk of hospital admission/readmission, to extend the reduction in hospital bed days and to use transferable learning in the development of services for complex patients with multi-morbidity in locality based hubs.*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
31	**Improved and consistent pathways for people with diabetes** *Over the life of this plan we will work with the Lothian Diabetes Managed Clinical Network to implement the national Diabetes Action Plan to put in place improved and consistent pathways for people with both type 1 and type 2 diabetes and to increase public awareness of the risks and consequences of this condition.*									
32	**Increased use of anticipatory care plans** *We will increase the quantity and quality of (new and existing) anticipatory care plans, ensuring these are created and shared using electronic Key Information Summaries (KIS) and contain information based on the person's wishes including preferred place of care. We will achieve this through integrated working and by providing training to health and social care professionals.*									
	Redesigning mental health and substance misuse services									
33	**Improving access to services** *We will:* *a) implement the agreed mental health locality partnership model beginning in North East Edinburgh with a focus on the communities of Craigmillar, connecting to Total East and Leith and maximising the opportunities of the "GameChanger" Public Social Partnership being developed with a range of partners focused on the population of this locality which we know has the highest percentage of people with long term health problems*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	b) review the current service model with inpatient service teams to ensure that there is a coherent and effective model of care across community and hospital services in place prior to the opening of the new acute facilities in the phase one redevelopment of the Royal Edinburgh Hospital in December 2016 *c) continue to work with colleagues across Lothian to reduce the waiting times for people who require specialist psychological therapies to meet the Government standard of 18 weeks, including identifying opportunities through our locality model to work more effectively with third sector partners who can offer a wider range of support* *d) through our locality partnership model, seek to maximise the opportunities for shared premises with health and social care, other public sector agencies and the third sector in each of the localities to make it easier for people to access a range of supports in one place*									
34	**Prevention and early intervention** *During 2016 we will redesign wellbeing and preventive services by using approaches that engages citizens, service user and unpaid carer groups and all other partners to focus on co-designing services that meet identified needs. A range of commissioning options will be considered for co-produced and delivered services to be in place by April 2017.*									
35	**Delivery of personalised services to support recovery**									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	The partnership will: *a) significantly improve the rehabilitation pathway for those who have longer term needs for care and support, including the urgent production of a business case to commission and deliver up to 15 community places with 24/7 support, in time for the completion of phase 1 of the Royal Edinburgh Hospital. This builds on the Firrhill development recently commissioned which provides 6 places as part of the Wayfinder Programme.* *b) explore other opportunities for community provision for those with 24/7 community support needs* *c) deliver the new Rivers Centre Public Social Partnership which will provide a new centre for the treatment of people of all ages who lives are adversely affected by the impact of trauma by Spring 2016*									
36	**Support to keep people safe and well** *We will work with partners from the Edinburgh Affordable Housing Partnership, housing colleagues in the council, third, independent and statutory sector partners to ensure we maximise the potential for people to live well in community settings with timely access to inpatient care when required.*									
37	**Substance misuse services** *We will:* *a) review the treatment and recovery pathway for people with substance misuse issues including inpatient and community programmes (Ritson*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	Clinic, Lothian and Edinburgh Abstinence Project (LEAP)) in line with Royal Edinburgh Hospital campus re-development *b) consider the recommendations arising from the business case associated with the pilot Alcohol Related Brain Damage unit by June 2016* *c) implement a model of care within the Recovery Hubs including concepts of key working, lived experience peer supporters and effective group work programmes* *d) explore new harm reduction and recovery approaches based on evidence and experience elsewhere to better engage those who receive drug treatment through their GP* *e) develop a stepped care approach to residential and community based rehabilitation programmes to ensure that people receive the right service to support their recovery* *f) develop and implement a stepped care approach to psychosocial and therapeutic interventions across recovery services, to ensure that services are able to support underlying trauma issues as part of the recovery journey when needed* *g) support the development of the recovery community by creating networking opportunities for people in recovery* *h) work with other Alcohol and Drug Partnerships in Lothian to manage and mitigate the impact of new psychoactive substances on health* *i) work with community planning partners to reassess the availability of alcohol and the link with alcohol related harm within the city to inform*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	Licensing Board Policy									
	Using technology to support independent living and efficient and effective ways of working									
38	**Increased use of Technology Enabled Care (TEC)** *In 2016/17 we will:* *a) improve our understanding of the extent to which Technology Enabled Care is currently utilised within the Health and Social Care Partnership and by our other partners, including housing providers* *b) explore further options for increasing the use of Technology Enabled Care linked to the development of care pathways* *c) undertake horizon scanning to support service delivery across all service areas* *d) explore the options for improved coordination of the staffing and financial resources available to deliver Technology Enabled Care* *e) work with our partners to develop a strategy for the delivery of Technology Enabled Care in Edinburgh* *f) produce business cases in respect of developments to be implemented in each of the three years from 2016/17 onward; opportunities include:* *o an increase in the use of pendant alarms* *o the use of technology for overnight support* *o automated medication prompting and daily wellbeing checks* *o video conferencing within care homes* *o scaling up the use of home monitoring for people with long term*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	conditions ○ *exploring the potential of MyGov technology to support person held records* *g) make applications through the Scottish Government Technology Enabled Care Programme and other available funding sources to support the increased use of technology to both increase independence and support effective and efficient ways of working*									
39	**ICT delivery plan to support integrated working** *During 2016/17 we will work with the ICT services in NHS Lothian and the Council to:* *a) understand the implications of the strategic plan in relation to ICT and wider technology which will allow us to develop an ICT Strategy and implementation plan for the Health and Social Care Partnership* *b) develop a delivery plan in respect of the roadmap based on the areas of focus and assumptions for joint working set out above* *c) ensure that any business cases developed in relation to the strategic plan clearly set out any ICT implications*									
	Improving our understanding of the strengths and needs of the local population									
40	**Development of the Joint Strategic Needs Assessment** *We will continue to develop the Joint Strategic Needs Assessment to support the Edinburgh Health and Social Care Partnership and wider Community Planning Partnership to improve their understanding of the needs and strengths of the*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	population at both locality and citywide levels. In doing so we will take the following actions during the financial year 2016/17: *a) review the membership of the Joint Strategic Needs Assessment Sub-group to ensure that we benefit from the knowledge, experience and information held by our partners, including local people* *b) take account of feedback obtained through consultation on the first iteration of the Assessment* *c) identify and incorporate areas for further or more detailed assessment to support the delivery of other actions within the strategic plan* *d) embed the Joint Strategic Needs Assessment within the broader needs assessment and profiling of localities within Edinburgh as part of the Council's Transformation Programme* *a) move the Joint Strategic Needs Assessment from the current paper format to become a web based tool that supports access to data at a number of levels*									
	Integrated workforce development									
41	**Development of an integrated workforce strategy** *During 2016/17 we will:* *a) bring together the specific actions within this plan that are related to or have implications for our workforce in order to inform the development of an overarching workforce strategy and plan setting out the future staffing*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
	models required to deliver sustainable and affordable high quality health and social care services that keep people safe *b) establish an Integrated Workforce Development Planning Group with membership drawn from key partners including, as a minimum the NHS, the Council, housing, third and independent sectors and people who use health and social care services in order to develop and oversee the implementation of an integrated workforce development strategy and action plan*									
	Living within our means									
42	**Investment and disinvestment in hosted and set aside services** *Whilst hosted and delegated acute services will be operationally delivered by other parties (e.g. NHS Lothian or one of the other three Health and Social Care Partnerships), the Edinburgh Integration Joint Board will have the responsibility for planning these services. We therefore require any material changes to these services, either investment or disinvestment to be discussed and agreed by the Edinburgh Integration Joint Board*									
43	**Plans to achieve financial balance** *We will continue to work with City of Edinburgh Council and NHS Lothian to develop sustainable plans to achieve financial balance, including delivery of savings plans to be implemented from April 2016.*									

Ref	Action	Timescale			Priorities supported[1]					
		2016/17	2017/18	2018/19	A	B	C	D	E	F
44	**Decisions regarding investment and disinvestment** *We will develop a robust decision making framework which captures and assesses risk and supports both investment and disinvestment decisions.*									

Lothian NHS Board

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Dear Wendy

Draft response to Edinburgh IJB Strategic Plan V1

Thank you for inviting NHS Lothian to comment on the final draft of the strategic plan for Edinburgh Integration Joint Board (IJB), setting out how health and social care services will be developed to achieve the strategic vision for a caring, healthier, safer Edinburgh across the four co-terminus geographical localities.

NHS Lothian welcomes the six priorities identified in the plan and, the clear congruence with the NHS Lothian strategic aims and the national Health and Wellbeing Outcomes. The direction of travel in the graphic showing where the partnership wants to be by 2020 helpfully reinforces this, and the 12 areas of focus around which the plan is structured are fully supported as key areas to address.

We are pleased to see the plans for delivery of services at locality level, via the emerging mechanisms of locality hubs and GP practice clusters and look forward to seeing evidence of the practical impact on individual care pathways as these develop. While we acknowledge the positive actions, through Total Place and Headroom initiatives, towards prevention, early intervention and self-management, the hospital system has yet to see impact in relation to acute service demand.

The plan emphasises the pressures around primary care capacity in Edinburgh, and the challenges in developing alternative models to support the frail elderly at home and in care homes. We welcome the involvement of the Associate Medical Director for Medicine of the Elderly in this work and look forward to seeing more detailed plans as they emerge. Prescribing spend is a major financial pressure and it will be important that the partnership continues its focus on managing this significant area of spend, working with the other Lothian Partnerships.

NHS
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We welcome the aim to develop a single model for acute unscheduled care services across the City. Commitment of Chief Officers and senior staff across the Acute Hospital Division and the four IJBs to regular and consistent engagement will be essential to progress this. The focus on transitions is welcomed since we know these are common points of failure in our current system.

Improving care pathways for the frail elderly and those with dementia is a high priority for the NHS system, with a real opportunity to reduce avoidable hospital bed days. We welcome the commitment to developing whole system capacity plans. There is a great urgency for the Edinburgh Chief Officer and his team to get a better understanding of this, and put clear plans in place to address the current challenges. The opportunity to release resource from reducing use of Liberton Hospital can only be achieved by clarity from the Partnership on the expected trajectory and timeline for change to admissions and discharges which will allow the hospital division to plan bed reductions and staff changes. The success of the locality hubs, along with achievable capacity plans should be able to deliver real change in this area.

It is disappointing that the key action to commission Care at Home on a locality basis will not take place till October 2016. It will be important to engage with neighbouring IJBs who are facing similar capacity challenges with the aim of recognising and mitigating unintended consequences of partnerships' commissioning plans on one another.

With the expected development of the North West Edinburgh partnership Centre by late 2017, plans for the future use of the Royal Victoria Hospital site should be progressed in 2016, as part of the Partnership's capacity requirements for older people. We look forward to hearing your early decisions on the future accommodation profile for Hospital Based Complex Clinical Care in particular, where certain decisions are now very urgent.

There is also an urgency to develop new pathways which will provide alternatives to admission and support discharge for people with dementia. It is recognised that positive discussions are underway on integrating old age psychiatry into the Locality Hubs, and on plans to increase support to care homes. Achieving the changes needed will require concerted effort jointly with the NHS Lothian Executive Lead and colleagues in the Royal Edinburgh Hospital. It will be important that NHS Lothian receives a clear indication of the improvements required and the implications of this for the services hosted by NHS Lothian through a direction from the IJB.

We welcome the identified key priorities for people with learning disability and the commitment to work with other IJBs on redesign of health services, including reduction in

in-patient numbers. It will be essential to implement a future model which is affordable within current resources, and important to take account of the benefits and risks to the other smaller Lothian partnerships in the Edinburgh's plans. It is likely that shared services will, for very specific service responses, provide a valid and efficient means of achieving greater outcomes for some individuals. We would like to suggest that further consideration is given to building capacity for older adults with learning disability and people with profound and multiple needs, as it is well reported that both these groups forecast significant growth above the rate of population expansion.

The business case for the reprovision of services from the Astley Ainslie Hospital will require a robust assessment by the IJB of the services which require to continue on a hospital site, and to ensure opportunities for integrated pathways with acute services, and community rehabilitation alternatives are fully explored.

The focus on supporting people with long term conditions and multimorbidity is welcomed. As the plan recognises these groups account for more than 60% of hospital bed days and NHS Lothian is keen to see the detailed changes to service models proposed to reduce hospital admissions and improve outcomes. COPD pathway redesign has reduced admissions and length of stay and there is potential to spread learning from this to other long term condition pathways. The pilot ME/CFS service, which has evaluated well, is not mentioned and it would be helpful for the IJB to clarify its position on this.

In mental health we are pleased to note the actions to develop community services including 24/7 supported accommodation. Timescales are short with phase1 of REH reprovision opening in December 2016, and close working with the REAS team will be important given the reduction in beds. Similarly access to psychological therapies remains a challenge and we look forward to more detailed plans emerging to address this.

Substance misuse is a particular challenge for Edinburgh, given the significant reduction in ring fenced funding from Scottish Government for 2016/17. NHS Lothian will work with all three Alcohol and Drug Partnerships and partner agencies to find solutions which minimise impact and deliver efficiencies while recognising the financial reality.

The new NHS Lothian eHealth Strategy highlights the opportunities to better use the technology we have, and the IJB's approach to this is supported and welcomed.

Financial Context

While we welcome the clear focus on living within our means, the plan does not contain any details of the financial recovery and savings plans which the IJB intends will be

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implemented from April 2016; we would be keen to see this detail soon. Discussions are underway involving the four Lothian IJBs on the issue of "fair shares" of the NHS Lothian budget for 16/17. A common financial framework and agreements on collaborating to share health resources in a fair and practical manner which recognises inter-dependency and the impact of each partner's actions on the others requires to be concluded and we appreciate the positive engagement with the IJB and its staff to progress these.

The IJB as the strategic planning authority must take equal cognisance of the quality and sustainability of services covered by the "set aside budgets" as it does of the other delegated services. Minimising the need for any set-aside budget investment will require robust actions by all Lothian IJBs to reduce demand and improve flow of patients. Effective collaboration across the partnerships is essential since positive actions of one partnership may be cancelled out by growth in demand in other areas.

Many of the actions within the Strategic Plan are high level and we are aware that leadership and management changes during 2015 are likely to have delayed the emergence of more detailed plans. However it is important that NHS Lothian is clear of changes required particularly to the "set aside" acute services, and the mental health and other services "hosted" by NHS Lothian. It is hoped that further clarity on any specific directions which the IJB intend to give to NHS Lothian will be provided in advance of the IJB signing off the final plan in March and we look forward to early discussions on this.

In summary, the six priorities and twelve areas of focus in the Edinburgh IJB plan are fully supported and helpfully set the direction for health, social care and other sectors to work together to achieve real change. The challenge for the Lothian system will be to work collaboratively together in a spirit of mutual respect within our limited resources to achieve the shifts in culture and systems required to deliver benefits for all Lothian residents.

Yours sincerely

BRIAN HOUSTON
Chairman

cc *George Walker, Edinburgh Integration Joint Board*
Rob McCulloch-Grahame, Chief Officer Edinburgh Integration Joint Board

Appendix X

Response from the City of Edinburgh Council to the invitation to comment on the second draft of the strategic plan for health and social care services in Edinburgh

To the Chair of the Edinburgh Integration Joint Board

Thank you for the opportunity to comment on the second draft of the Strategic Plan for the Edinburgh Health and Social Care Partnership. Our detailed comments are listed below:

1. The Council welcomes the priorities set out within the plan which are closely aligned with those of the Council and, as the illustration on page 18 makes clear, those of the Edinburgh Community Planning Partnership and NHS Lothian. The diagram setting out the changes that the Integration Joint Board wants to see over time is clear and again aligns with the changes the Council itself would want to see.

2. The 12 areas of focus are well articulated although there is clearly some overlap between them, which is perhaps understandable given the complexity of the health and social care landscape.

3. The Council welcomes the emphasis on locality working and is keen to see how the proposed approach dovetails with its own Transformation Programme. We expect to see the localities model develop in a joined up way and see the Health and Social Care Locality Managers as key members of the Locality Leadership Teams being developed through the Transformation Programme. As both the strategic plan and Transformation Programme are still at early stages of implementation the lack of detail is understandable. However, we would welcome reassurance that the proposal for locality working set out in the strategic plan will complement rather than duplicate our own plans in this area.

4. The requirement for the Integration Joint Board to produce locality plans at the same time as the Community Empowerment Act introduces a requirement for Community Planning Partnerships to produce local improvement plans, could lead to significant duplication of effort and variation in approach. The Council would welcome reassurance that the Integration Joint Board will work in partnership with the Team supporting the Edinburgh Community Planning Partnership, to ensure a streamlined and joined up approach to the production of locality plans.

5. Whilst welcoming the priority given to establishing locality based working, the Council recognises that many people identify more closely with communities of interest rather than the area in which they live. Although the strategic plan gives some detail on the way in which it will support some groups of citizens, primarily those who belong to the traditional social care service user groupings; more detail on the approach to be taken to other communities of interest such as the LGBT and minority ethnic communities is required.

6. The Council welcomes the level of recognition given to the importance of tackling inequalities and the commitment to "*work with our community planning partners to determine the most effective way of developing and implementing a coordinated approach to tackling inequalities' including health inequalities across the City*". This commitment chimes well with our desire to see a more streamlined approach to tackling inequalities with a clear strategy, agreed by all members of the Edinburgh Community Planning Partnership, forming the basis for a joined up approach to this key area of work across the city.

7. We are very aware of the challenges in meeting the social care needs of the growing numbers of frail older people in the city and recognise the problem of building sufficient capacity within both social and primary care to meet these needs. For these reasons the Council fully supports *improving care for frail older people* and *ensuring a sustainable model of primary care* as key areas of focus for the Integration Joint Board. The range of proposed actions together with the proposals for locality working, are welcome developments in this area. What is required now is a plan for the delivery of these proposals at some pace. Whilst the extension of the living wage to staff working for independent providers may help to increase capacity in this area the Council recognises the financial challenge involved.

8. The approach to supporting people with long term conditions set out in the plan is an interesting one. The Council would be interested to know whether a similar systematic approach of identifying those most at risk and taking action to prevent conditions escalating could also be applied in social care.

9. The proposals relating to mental health and substance misuse services make reference to 'implementing the mental health locality partnership model'. Whilst recognising the need to respond differently to different people with differing needs, the Council would like to understand how the proposed locality model for mental health fits with the wider locality model set out in some detail earlier in the plan.

10. The proposals to make increased use of technology to both increase the independence of vulnerable citizens and support more efficient and effective ways of working for staff are very welcome. Clearly there is a reliance on

expertise from the wider Council to develop and implement these proposals and the Council will continue to support the Health and Social Care Partnership in developing these further. The same is true of the ongoing Joint Strategic Needs Assessment. However, the Council would like to consider how work in this area can dovetail with our own plans to make better use of business intelligence, to support improved planning and delivery of services across the city.

11. The Council is keen to ensure that the arrangements for health and social care integration do not lead to another set of silos. We believe that NHS and social care services need to integrate with other parts of the Council as well as with one another. To this end we would like to see more detail in the plan about joined up working with services such as children and families, community safety, education, housing and homelessness.

12. The section on finance (Living within our means) is comparatively brief and contains little detail. Whilst we understand that this is primarily because of the uncertainty about absolute budgetary amounts at this stage, the Council is very keen to be assured of the financial viability of the Integration Joint Board's plans. We assume that a greater level of detail will be contained in the Financial Plan that the Integration Joint Board is required to produce alongside the strategic plan and look forward to seeing this once it is available.

13. In terms of understanding the impact that the Integration Joint Board hopes to achieve through the implementation of the strategic plan, it would be helpful to see more case studies embedded within the plan, illustrating the impact on citizens.

Item No. 5.7

Report

Workforce Strategy – Update

Edinburgh Integration Joint Board

11 March 2016

Executive Summary

1. The Edinburgh Health and Social Care Partnership (EH&SCP) workforce are critical to our ability to deliver the best people centred care and it is crucial that they are ready for the future with a culture that is based on joined up thinking and working in a responsive and adaptable way.

2. Our Workforce Strategy will set out the vision for our future workforce and this will be informed by the EIJB Strategic Plan and how services are designed to deliver a workforce for integration. Over 2016/17, a Workforce Strategy will be formally developed but work is currently progressing to ensure that organisation structures deliver for integration and change is managed well; that the workforce have access to relevant learning and development opportunities; our leaders are developed to meet the specific challenges; there is commitment and engagement of staff through effective communication mechanisms and team development. Current focus is also on ensuring our systems and processes are as integrated as possible and there are a range of strong partnerships in place especially with the Trade Unions.

Recommendations

3. EIJB members are asked to:

   - note areas of workforce activity to ensure health and social care integration is delivered in Edinburgh and the next steps in the development of a comprehensive Workforce Strategy aligned to the EIJB Strategic Plan;

   - to give further consideration to information on workforce matters that would provide re-assurance around the workforce agenda going forward.

Background

4. A Council/NHS Human Resources and Organisational Development (HR & OD) working group was established over 2 years ago to support the integration of health and social care services. The group continue to be supported by a joint team of senior managers and trade union representatives from the EH&SCP (Council and NHS).

A pan Lothian HR and OD network is also operating to collaborate and identify more efficient and effective practice on workforce matters.

5. The joint HR & OD group developed a work plan that has guided the HR and OD activity in the creation of the EIJB and preparatory work for delivering an integrated health and social care workforce in Edinburgh.

6. A key early development was agreement with the NHS Lothian Partnership representatives and CEC Trade Union representatives to a Memorandum of Understanding that gave a commitment that respective terms and conditions of employment would continue to be applied to staff in each organisation (see Appendix 1).

Main report

7. To date the main focus of the workforce plan has been to support the introduction of the EIJB and support the workforce agenda in the following areas:-

    - Organisational Design and Development – supporting the appointment of the new roles of Chief Officer, Chief Finance Officer, interim Locality Managers and supporting the Chief Officer with the development of the new EH&SCP operating model and organisational structure

    - Supporting the Lothian IJBs with the development and induction arrangements for IJB members pan Lothian

    - Staff Engagement events and communication arrangements to support the introduction of the EIJB, associated structural changes and key messages

    - Leadership Development – Introduction of a Leadership Programme titled “Playing to your Strengths”. This is a 2 day programme for approximately 160 senior leaders across Lothian that has a focus on integration. The first of 4 events took place in November 2015 and was highly evaluated. A further 3 events are planned from March to September 2016. This also provides excellent networking opportunity. A brief outline of the Leadership Development Programme is attached as Appendix 2 and a note of other Leadership Development Options is attached as Appendix 3.

    - Team Development – In collaboration with other Lothian Partnerships, the approach adopted has been to engage Animate Consulting who will work with the Partnerships to develop a framework and toolkit designed to support newly integrated teams. The aim is to develop a person-centred team working culture that supports the vision, values and strategic plan of each Partnership. Edinburgh is considering a pilot site to progress work and it is proposed that the future toolkit will be used internally to maximise the capacity of the Partnership to support new teams and ways of working. A brief outline of the Team Development approach being progressed is attached as Appendix 4.

    - Learning and Development – The City of Edinburgh Council and NHS Lothian developed a joint learning and development action agenda around 6 years ago and there are many areas of integrated learning and development

already in place. An NHS Lothian Learning and Development Adviser has been seconded to the Council for the last 2 years and during this time has mapped existing joint learning and development, explored, developed and implemented new learning and development activities. This has culminated in the creation of a Learning and Development Alliance involving the Council, NHS Lothian, the other 3 Lothian councils, EVOC and Scottish Care. It will also include local further and higher educational institutions. The alliance will meet for the first time on 23 March and its purpose is to make the best use of our combined learning and development resource in the city for the benefit of the health and social care workforce and ultimately the people and communities of Edinburgh and beyond.

8. The current and emerging workforce issues are as follows:-

- Project Plan for Recruitment and Retention of front-line social care staff to raise the profile of care as a career and grow the pool of care workers; working with schools through an academy approach, employing modern apprentices, using recruitment campaigns, exploring flexible working arrangements and gaining better understanding of reasons for turnover through conducting exit interviews/exit surveys.

- The finalisation of the EH&SCP workforce numbers and workforce profile to inform management information and organisational change arrangements.

- Identification of where systems and processes on workforce matters could be more integrated to support more effective operations. Discussions have started with Trade Unions on how to formally engage on a more integrated basis as well as with ICT colleagues on manager access to HR and other people related systems within both organisations.

Next Steps:

9. A future workforce strategy will require to be aligned to the EIJB Strategic Plan that will make use of the capacity across the whole system. It is anticipated that this will be developed during 2016/17 and will be informed by the following:-

- The Edinburgh Health and Social Care Partnership organisational structure based on a locality and centralised operating model where the workforce will be representative of the needs of the service to champion people centred care.

- The Test of change sites and areas of work where good practice is identified.

- Workforce Planning and Integrated Workforce Development approaches to assess resource capacity and capability.

Key developments and enablers to inform the Workforce Strategy are as follows:-

- A pan Lothian Workforce Planning group has been established to progress the 6 step approach to workforce planning, informed by any future requirements specified by the Scottish Government.

- The establishment of a Lothian Learning and Development Alliance group (as paragraph 7) to make best use of the sector learning and development investment and resource.

- The IJB Executive Team chaired by the Chief Officer that will monitor the workforce demand and supply challenges.

- The Transforming Health and Social Care Programme that will provide rigour and structure to support the delivery of service changes

- A Chief Officer, manager and front-line staff engagement session within the 4 localities during March 2016.

Key risks

10. The complexity and scale of the change over two organisations carries a range of risks in relation to the workforce, however the steps identified within the report will assist to mitigate these risks.

Financial implications

11. The work identified in the report will be supported jointly through existing NHS and Council HR& OD resources and where appropriate, in collaboration with other Lothian wide colleagues.

Involving people

12. The NHS Partnership, Trade Unions and third sector are engaged in the various forums and workforce work streams and there is ongoing staff engagement through various engagement mechanisms.

Impact on plans of other parties

13. The work will impact on the NHS and Council work force plans with potential impact on other Council and IJBs mechanisms, but as the report references, there are mechanisms in place on a pan Lothian basis to address these.

Background reading/references

Not applicable

Report author

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Links to priorities in strategic plan

Strategic Plan 1016 – 19 (Draft)	Integrated Workforce Development

Appendix 1

Memorandum of understanding
Position of City of Edinburgh Council and NHS staff working in Health & Social Care

City of Edinburgh Council

1. City of Edinburgh Council staff will continue to be employed on their existing terms and conditions of service as per their current contract of employment. This will incorporate all City of Edinburgh Council's policies and procedures, including employment policies and procedures

2. The City of Edinburgh Council's Code of Conduct for Employees will continue to apply.

3. For City of Edinburgh Council managers who manage staff employed by a different organisation they must manage those staff in accordance with that organisation's employment conditions and policies.

4. All staffing reporting and management arrangements must ensure that there are appropriate arrangements in place for professional leadership and supervision.

5. Each partner organisation still has an obligation to ensure that their agreed partnership and consultation arrangements are applied when taking forward change proposals

6. Arrangements for redeployment during periods of organisational change will have to take into account the policies and procedures within each employer's organisational change policies.

NHS Lothian

7. NHS Lothian staff will continue to be employed on their existing terms and conditions of service as per their current contract of employment. This will incorporate all NHS Lothian's policies and procedures, including employment policies and procedures.

8. The NHS Scotland Staff Governance Standard will continue to apply.

9. For NHS Lothian Managers who manage employees who have a different employer they must manage these staff in accordance with their employer's terms and conditions and policies.

10. All staffing models must ensure that there are appropriate arrangements in place for professional leadership and governance.

11. Each partner organisation still has an obligation to ensure that their agreed partnership and consultation arrangements are applied when taking forward change proposals.

12. Arrangements for redeployment during periods of organisational change will have to take into account the policies and procedures within each employer's organisational change policies.

Edinburgh Health & Social Care Partnership

Leadership Development Programme

Edinburgh's approach over the last year to deliver leadership development to support integration across the health, social care and voluntary sectors has been to create a brief intervention in the form of an evidenced based and successfully evaluated national leadership programme (Playing to your Strengths). This is being delivered locally and in collaboration with West Lothian, East Lothian and Midlothian Partnerships.

We have completed the 1st of four planned programmes and early indications are extremely positive. Feedback has been the value of developing contacts with leaders in other Partnerships, having time out to think about their leadership and listen to the experience of others including a key-note presentation from a senior public sector leader, the strengths-based approach, the positivity of the coaching and a 360 appraisal. The 'brief intervention' nature of the programme was also valued as it was easily achievable in busy lives.

The target audience is Senior leaders from across health & social care and the 3rd Sector within the 4 Health & Social Care Partnerships in the Lothian area. Over the next 6 months there will be 3 further programmes with 40 participants in each cohort – Edinburgh have 16 places in each co-hort so on completion, 64 leaders from Edinburgh will have been through the programme.

Playing to your strengths is a brief intervention consisting of a **one day** development workshop sandwiched between **two 1:1 coaching conversations.**

The purpose of *Playing to your strengths* is to draw attention to people's strengths and resilience so that they can leverage these and lead effectively in times of change. It takes an "assets" or "strengths based" approach advocated by many researchers and practitioners in the field of leadership and psychology, and it has been shown that when leaders play to their strengths they are energised and can channel that energy into driving quality improvements.

The outcome from *Playing to your strengths* is the creation of strengths based personal development plan that will support successful leaders use their strengths and develop complementary competencies to enhance their leadership.

Playing to your strengths recognises that increasing complexity and uncertainty of services cannot necessarily be addressed through a single one-size fits all leadership model. There is no single solution. This means that dealing with uncertainty, ambiguity, and 'grey areas' is now part and parcel of our everyday leadership landscape.

During the development workshop there is also be a session with a senior leader from the Scottish Public Sector, who will invite discussion about the current climate and its demands from leaders. They will also share their route to resilience and invite participants to do the same.

Either side of the workshop participants will have a 2 hr coaching conversation with an experienced coach. The coaching conversation pre workshop is to start thinking about strengths and resilience. The post workshop coaching conversation will take place quickly after the workshop with the intention of leaving people with a tailored strengths based personal development plan to support delivery in their current and future roles.

Participants are also invited to complete a 360 assessment as part of the programme and receive feedback on this at the 2nd coaching session.

Appendix 3

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Working together for a caring, healthier, safer Edinburgh

Appendix 4

Edinburgh Health and Social Care Partnership

Team Development

Creating a framework and toolkit for the development of integrated health and social care teams.

Edinburgh's approach to team development has been to commission from Animate Consulting (through a competitive bidding process), in collaboration with West Lothian, East Lothian and Midlothian Partnerships, a framework and toolkit designed to support newly integrated teams. The aim is to develop a person-centred team working culture which supports the vision, values and strategic plan of each of the Partnerships.

The Framework will include a diagnostic element to enable teams to identify their collective priorities for development.

The Toolkit will be modular including as a minimum:

- Leadership in an integrated team
- Teams in change and transition
- Culture, values and vision
- Roles, responsibilities, professionalism and governance in integrated teams
- Communication, collaboration, working with difference and dealing with conflict in integrated teams
- Innovation, risk and celebrating success

There will be a range of resources which can be used by teams, individual team members and team leaders to address a particular need and be capable of being used without the need for external support.

Report

Hub Test of Change

Edinburgh Integration Joint Board

11th March 2016

1. Executive Summary

1.1 The purpose of this report is to update the Board on the approach and actions around the implementation of the Hub model, to progress improvements on the whole system pathway and discharge from hospital

2. Recommendations

2.1 To note and support the whole system approach that the Edinburgh Partnership is taking to improve the whole system pathway and discharge from hospital.

3. Background

3.1 An early action that had been agreed on a whole system basis, through Lothian's Winter Plan 2015-16, was a test of change to develop a *Locality Hub* model for older people. The approach fits with the Lothian partners intention of 'doing something differently', and moving away from a bed based model of support for winter.

3.2 This also fits with the national *Living Well in Communities, September 2015,* priority areas on prevention, pathways and delayed discharges, which sees a key action to reduce the number of bed days occupied through delayed discharge, by testing and implementing innovative solutions to redesign whole system responses across all sectors.

3.3 Instead of the traditional long lead in time planning for change on a large scale across Edinburgh, improvement methodology has been utilised to test this change in the South East, (SE) locality, with a dynamic approach of direct application, iteratively developing, reviewing and improving the systems and processes to make the change happen successfully.

3.4 Now that progress on infrastructure set up and application is being achieved, spread will occur in a methodical way in the other three Edinburgh localities.

3.5 This action orientated work streams contribute to five of the priorities agreed in Edinburgh's Strategic Plan:

- Right care, right place, right time
- Prevention and early intervention
- Managing our resources effectively
- Person centred care
- Making best use of capacity across the whole system

4. Main report

4.1 The aim of the Hub model is to change the way of working in Edinburgh, to an assets based approach, optimising all the community resources from all providers, and improve integrated working across Acute, Primary care, Health & Social Care services, ensuring people are in the right place at the right time by:

- Preventing avoidable admission
- Increasing the number of supported discharges to this locality and get patients home
- Developing a co-ordinated, responsive model of care through the locality hub approach

This will allow people to:

- stay at home safely
- be discharged home safely, within 72 hours of discharge decision being made
- receive the right care and support in a responsive manner

4.2 The Edinburgh Partnership took ownership of this test of change in October 2015, including those people who are over 75 years of age, or who are in a care home and are over 65years of age, and have been actively working strategically and operationally through the key elements of the Project Plan to:

- Develop referral mechanisms and pathway: this is complete, and is starting to be tested using real cases

- Identify the Hub infrastructure requirements and costs: this is almost complete. Final structural changes to the Liberton facility are underway. Hub Huddles are now operational after having been tested to ensure timing and information availability is optimised, as well as being clear about where responsive support will occur. Cases are now being actively worked through in South East, with a portfolio of Case Studies being developed for future learning about different actions that may have been taken to support people in a more appropriate environment rather than being admitted to hospital, or actions to expedite discharge arrangements.

- Consider the hub workforce, recruitment and training requirements and costs: Clinical Support Workers have been recruited to enhance this function, with induction underway. Wider discussions are underway to consider the wider workforce changes, with there being a high degree of enthusiasm and willingness encountered thus far, to do things differently

- Identify how impact will be measured, and performance monitored, recorded and reported: a key set of measures have been identified, with our HIS Local Integration Support Team contributing to the development of the performance framework

- Develop a communications strategy, in order that staff and other stakeholders are informed of improvements: this is underway, and will be part of the overarching Strategic Plan communications to identify progress against the agreed priorities

- Identify mechanism for evaluation of the implementation process: HIS colleagues are involved with the Partnership on this

4.3 To progress the South East Test to the whole of Edinburgh, there was a workshop for key clinical staff, managers and other stakeholders on the 29th January to share the early learning, Project Charter and Outline Project Plan. This included sharing the experience of some of the key challenges encountered. Key actions from this session include:

- Each of the Interim Locality Managers in the other three areas are now underway in identifying their Hub base, and setting up their own operational groups
- The Operational and Steering Group membership reflecting the agreement to include older people with metnal mental health within the Hub, and other key stakeholders such as the ambulance service, and workforce development
- The importance of securing project management support, and a case to be made for this
- Agreement on the core measures, and securing the support to administer this
- Each Hub ensuring local engagement with the third and independent sectors
- Ensuring links with the professional advisory committee
- Development of a communication strategy, in line with the Strategic Plan priorities, for both staff and wider communities to help keep people informed of new ways of working
- Agreement to have another learning event in three months to take stock on progress

4.4 The level of willingness of staff in South East to work in a different way has been evident through the energy they have brought to this innovation, with feedback thus far including a feeling of empowerment to try things differently in this iterative improvement process.

5. Key risks

5.1Key risks are associated with patient experience, quality of care, and performance against standards and targets for delays in discharge. In time, the performance information will clearly identify progress made across Edinburgh.

5.2 There is a risk that the partners can't agree a process, principles or methodology for taking improvements forward. Based on the South East experience, this seems low.

5.3 There is a risk that there will be resistance to change operationally in the long term, as this model of working will mean staff will be supported to work in a different way.

6. Financial implications

6.1 There has been start up costs associated with the South East Test of around £210k, for the clinical support worker posts, and SMART Boards for all four localities. There are likely to be additional infrastructure and project management and support costs moving forward, which will be developed.

7. Involving people

7.1 Edinburgh Partnership has engaged with, involved, and consulted with the local population, staff and other stakeholders and had in place a formal consultation process as part of developing the Strategic Plan, with these work streams being key actions to deliver against the agreed priorities within the Strategic Plan.

8. Impact on plans of other parties

8.1 The key impact is on the whole system pathway for older people, which will impact partners within acute care. To this end, the IJB Chair has arranged a whole system *Discharge from Hospital* event for Edinburgh has been arranged for the 8th March 2016, for the senior management teams across the Royal Infirmary and Western General Hospitals, and the IJB Executive Team, to consider the key priorities and impacts for discharge from hospital and other preventative measures.

8.2 This initial event will be followed up by a second stakeholder event that will include colleagues form East and Midlothian as there may be implications for their overarching pathway too, however, they both have

locality hub models now established.

8.3 Additionally, there are links with the Anticipatory Care Plan and High Resource Individuals that is being undertaken across Edinburgh, and this has actively been included win the Hub development work, to ensure appropriate preventative responses too, for those small number of people who use 50% of the Health and Social Care resource a high level of service.

Background reading/references

Living Well in Communities 2015:
http://blogs.scotland.gov.uk/health-and-social-care-integration/2015/12/02/living-well-in-communities/

http://www.google.co.uk/url?url=http://www.ccpscotland.org/hseu/wp-content/uploads/sites/2/2015/10/LWiC-design-proposal.docx&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjw39Ly5fHKAhUJVhQKHWD4CGgQFgggMAQ&usg=AFQjCNG1dfB04c9fCl-iUENVhmS4Ag4bog

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Links to priorities in strategic plan

Priority 2 – Prevention and Early Intervention	People will be supported through appropriate response, to remain at home or in a homely setting
Priority 3 – Person Centred Care	Care and interventions will be wrapped around the individuals, with the most appropriate response form the statutory, third or independent sectors being arranged.
Priority 4- Right	

Care, Right Time, Right Place	People will be supported at home for as long as possible, and will only remain in hospital for as long as is required, with timely discharge being arranged.
Priority 5 – Making best use of the capacity across the system	It is clear form previous recommendations associated with Living Well in Communities and delayed discharge management, that there is room for improvement to make better use of workforce, capacity and financial resources in a more cohesive way
Priority 6 – Managing our resources effectively	As priority 5

Item No. 5.9

Report

Delayed Discharges in Edinburgh

Integration Joint Board

11 March 2016

Executive Summary

1. This report summarises the latest Delayed Discharge ISD Census and the actions in place to support an increased number of discharges from hospital.

2. Additional funding has been made available from Scottish Government to enable specific actions associated with increasing the number of discharges supported.

Recommendations

3. The Integrated Joint Board is recommended to note this position and the actions associated with improving this performance.

Background

4. On the 15th of each month a census is taken and reported to the Information and Statistical Division of the Scottish Government. This shows the number of people delayed in hospital along with the reasons for the delay.

5. In January there were 122 people who were delayed; 61 of whom were delayed for over 2 weeks and 36 over 4 weeks, an overall reduction of 46 from the October census.

6. In January 2016 an agreement was reached with Scottish Government which will provide £2m non-recurring, non recoverable funding in 2015/16 towards the cost of reducing the number of people delayed in hospital. This money will be allocated in two separate tranches, with the final tranche dependent on results.

Main report

7. At the January census, the largest category of delay, 59 people, were those awaiting packages of care to support them in their own home, with a further 26 people awaiting a place in a care home. Of these, 24 people had waited for their package of care, and 7 people for a care home placement for over 4 weeks.

8. In addition to the headline figure there are a number of exclusions for the census count shown as x codes. These codes are used where the situation is classed as 'complex' reflecting the fact that there are either legal processes which are causing the delay such as guardianship, or where there are no suitable facilities available in the NHS Board area. In total there were 59 people excluded, 53 of whom had been delayed longer than 4 weeks and 6 longer than a year.

9. In January an agreement was reached with Scottish Government to provide additional investment to support specific areas to reduce the number of people delayed. The Scottish Government will provide £2m non-recurring, non recoverable funding in 2015/16 towards the cost of this agreement. This money will be allocated in two separate tranches, with the final tranche dependent on results.

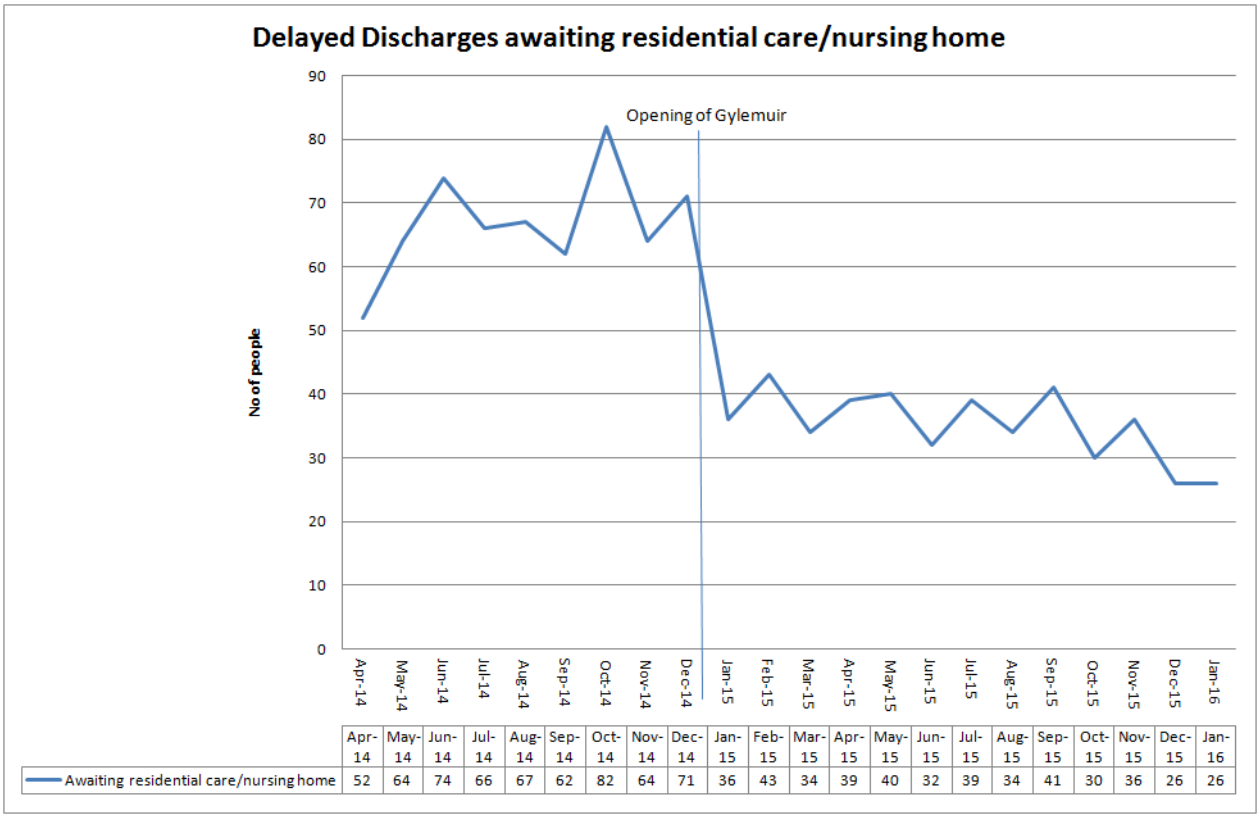
10. It is agreed that the money will be used on a partnership basis to fund the necessary provision of care home places, Reablement in the community and home care. It is not to be used to create additional NHS capacity.

11. The agreed target trajectory for delayed discharges per month is shown below:

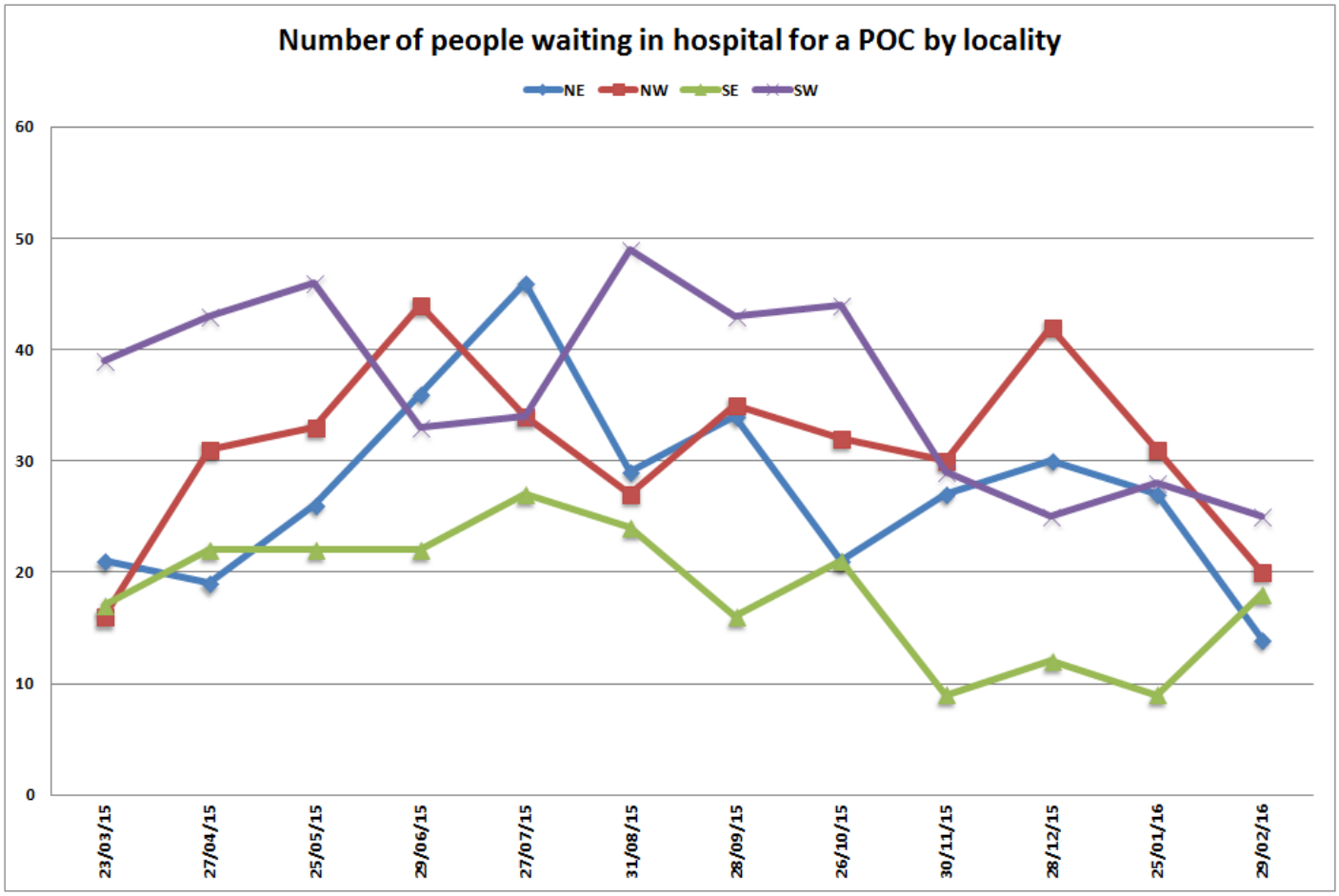
Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
146	133	118	100	80	55	50

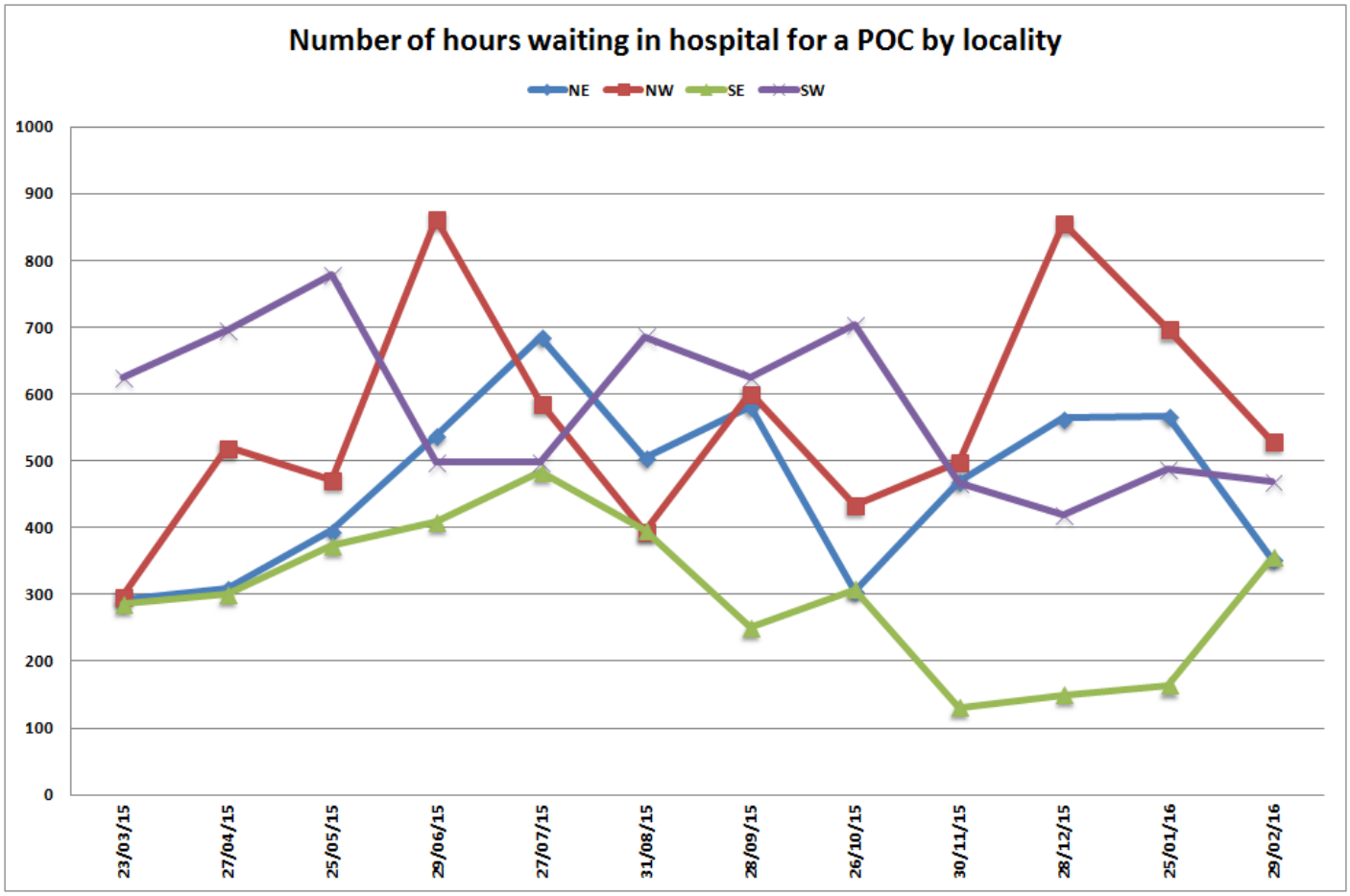
12. The actual number for February 2016 was **95**, which is below the target.

13. The following graph shows the number of delayed discharges awaiting residential care or a nursing home per month, and indicates the impact of Gylemuir House Interim Care Home:



The number of people waiting for packages of care and the number of hours of care those people are waiting for, are shown in the following tables, split by locality. (The figures represent the numbers **on the date** shown, rather than a total per month.)





14. The main investments which will support a reduction in the number of people delayed in hospital awaiting discharge are as follows:

    - 30 additional beds at Gylemuir to bring capacity to 60;
    - Additional staffing in Reablement and mainstream domiciliary care;
    - Development of Locality Hubs within the four IJB localities to enable timely discharge and reduce admission to hospital;
    - Deployment of Clinical Support Workers to ensure the prevention of admission and early discharge pathways are supported.

15. The impact of these investments is being measured in the key categories of delay and requires us to reach a weekly target, as follows:

Care homes	13
Reablement	20
Care at Home (packages of care delivered by non-Council providers)	10
Others (incl. interim/intermediate care)	24

16. The additional capacity at Gylemuir has been achieved to offer 60 interim care home beds allowing people to make longer term arrangements in a more appropriate setting.

17. The Reablement service has been successful in recruiting additional staff with 15 additional staff commencing in February, a further 20 in March and a further 20 expected in April. This will bring the total number of additional staff to 65 since December.

18. The development of locality hubs is underway with a positive impact being achieved not only in supporting timely discharges but most significantly in the prevention of unnecessary admission. A number of people who would otherwise have been admitted to hospital for their care have successfully been supported at home instead. 11 Clinical Support Workers are now in place and will provide additional capacity to support the care needs of people being supported through the hubs.

19. The weekly discharges for the week ending 5th February were as follows: 21 discharges into care homes; 29 to Reablement; 7 to Care at Home (which is defined as packages of care delivered by non-Council providers); and 6 “other”.

20. A key challenge for the partnership is in providing the necessary capacity in care at home. A new ‘hospital to home’ service has commenced this week in addition to the services described above to provide additional short term capacity to support discharges from hospital until longer term arrangements can be put in place. This will provide additional capacity of between 250-300 hours per week phased in over the next few weeks.

21. Additionally, from 29th February 2016, Avenue Care (a Fife-based company) has been picking up approximately 500 hours of care from the North West Reablement team in order to free up capacity in the north west of the city.

Key risks

22. Delayed discharges are a risk to the partnership in providing the right care at the right time. Having patients delayed awaiting care arrangements in acute hospitals means that people who need hospital care may either have this delayed or may not receive this in the most appropriate ward putting outcomes for those patients at risk.

Financial implications

23. Providing long term care arrangements for more people in the community will place an additional cost pressure on the purchasing and provision budgets.

Involving people

24. As we move towards the locality model and develop the Locality Hubs, there will be engagement with local communities and other partners to inform the further development of the model.

Impact on plans of other parties

25. This report outlines the response of the Edinburgh IJB to pressures within acute services and has been delivered in close liaison with NHS Lothian acute services. The Locality Hubs model, which is now in development across all four localities, is being progressed jointly with acute services.

Background reading/references

Lothian Delayed Discharge Partnership Monthly Data Report January 2016
Memorandum of Understanding Reducing Delayed Discharges in Edinburgh

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Links to priorities in strategic plan

Priority 4	Providing the right care in the right place at the right time
Priority 6	Managing our resources effectively

Report

GameChanger Project Update

Edinburgh Integration Joint Board

11 March 2016

Executive Summary

The GameChanger Public Social Partnership is a unique collaborative venture which offers huge potential to all eight Strategic Partnerships in the City. There are a number of specific planned developments which will contribute to the strategic priorities of the Health and Social Care Integrated Care Partnership.

Recommendations

Acknowledge the key role of GameChanger Public Social Partnership in the delivery of strategic priorities.

Recognise the potential contribution of GameChanger to assist with delivering on a number of strategic objectives with a particular focus on preventative approaches and communities and individuals who experience significant health inequalities.

Support the “Healthier” work strand which has a particular, although not exclusive, focus on Leith and the North East locality.

Support the development of flagship and road map proposals which will includes the preparation of funding applications.

Note that early discussions have commenced with Hearts FC in relation to mutual interests in community-based developments in health, wellbeing, fitness and social support.

Background

Public Social Partnerships (PSPs) are strategic partnering arrangements, based on a co-planning, and co delivery approach, through which the public sector can connect with people, third sector organisations (voluntary organisations, community groups, charities, social enterprises) to share responsibility for designing services focused on responding to service user needs and improving outcomes. The Developing Markets for Third Sector Providers programme forms a key part of the Scottish Government support strategy for the Third Sector and complements other initiatives and activities including

the Procurement Reform programme and the Procurement Reform Bill. The programme, offers a unique opportunity to develop and embed a number of leading market development solutions, including the Public Social Partnership (PSP) model, Community Benefit Clauses (CBC) and the use of Social Value throughout public sector commissioning and procurement in Scotland. The programme is being delivered by Ready for Business, a third sector led consortium called Ready for Business, KPMG, Social Value Lab and MacRoberts. NHS Lothian has four strategic PSPs.

GameChanger is an exciting and innovative PSP led by NHS Lothian, Hibernian Football Club and the Hibernian Community Foundation. The aim is to unlock the power and passion associated with football and to make greater use of all Hibernian's physical, cultural and professional assets, to deliver a better, healthier future for the most vulnerable, disenfranchised or disadvantaged in our communities. Shared values and priorities developed by the GameChanger Management Team has helped shape the 300 generated by over 300 stakeholders into a cohesive set of "flagship" developments and "roadmap" projects which are framed within the five strategic objectives of the Scottish Government: Wealthier and Fairer; Smarter; Healthier; Safer and Stronger; and Greener. Working groups have now been set up to take forward the developments and projects. GameChanger management group have appointed a full-time project manager to build momentum and progress actions.

Main report

The flagship proposal within the Healthier work stream is to develop a health and social care hub within Easter Roar Stadium which has the potential to deliver a range of primary care, mental health and substance misuse services delivered by statutory and 3rd sector agencies. Initial architect drawings and surveys are being undertaken. GPs and health and social care providers are now engaging in preliminary discussions regarding requirements.

To test the concept of people receiving health and social care interventions within a football stadium a number of roadmap initiatives are developing. To date these include

Living it Up and GameChanger
Living Up hosted the first of their health stalls with an opportunity for fans to have their BMI and BP tested at the home match on 23 January. 36 fans signed up and the majority of those also agreed to have health checks. The fans really engaged with the Living it Up / GameChanger team, they thought it was a really good idea – a lot of them were saying they hadn't had BP checked before – or couldn't recall when they last had it checked, others were indicating that men's clinics would be a really good idea. This initiative will now continue at all home matches until the end of season along with advertising both in the stadium through adverting boards and LED screens and in the match day programme. We are now working on developing

GameChanger Market Day
A day long market with local health and social care agencies, community projects, community resources will be held in mid April 2016. This will give members of the public an opportunity to find out about all the resources that are available in the Leith and surrounding area, meet providers and staff, visit the stadium and share their ideas on how we can use the stadium as a community asset.

GameChanger Clinics
Plans are being formulated to run GameChanger Clinics within the Stadium. One stream will be healthy lifestyle clinics which local GP practices can refer to with the other stream being for current clients of local services whose health and wellbeing benefit from the wider facilities the stadium has to offer.

Key risks

Key risks associated with this collaborative venture are maintaining momentum and the associated complex government structures.

Financial implications

Members of the GameChanger have met and are due to meet with a number of major funders with a view to submitting funding applications from April onwards. The discussions planned to date have focused on all aspects of the GameChanger's ambitious programme.

Involving people

GameChanger work strand builds on the existing participation and engagement structures currently in place. Attendance at the initial stakeholder events were open to members of the public, people with lived experience, carer and families and staff from third sector and public sector agencies, academia and the private sector. 95 partners including individuals and organisations) have signed up to the Partnership.

The GameChanger PSP will be formally launched on 16 March 2016 at a parliamentary reception.

Impact on plans of other parties

GameChanger PSP offers unique opportunities to shape the outside environment and community assets to support health gain for patients and wider communities. It has an explicit focus on addressing inequalities and health inequalities and the potential to make a significant impact on the priorities and planned outcomes of all the Edinburgh Strategic Partnerships.

Background reading/references

http://readyforbusiness.org/programme-offering/public-social-partnerships/

GameChanger Phase One report (November, 2015)

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Links to priorities in strategic plan

Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from, current levels of inequality: reduce, and not exacerbate, health inequality.

Preventing poor health and wellbeing outcomes by supporting and encouraging people to achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing; making choices that increase their chances of staying healthy for as long as possible and where they do experience ill health, promoting recovery and self-management approaches.

Practicing person centred care by placing 'good conversations' at the centre of our engagement with citizens so that they are actively involved in decisions about how their health and social care needs should be addressed.

Developing and making best use of the capacity available within the city by working collaboratively with individual citizens, including unpaid carers, communities, the statutory sector, third and independent sectors and housing organisations

Making the best use of our shared resources (e.g. people, buildings, technology, information and procurement approaches) to deliver high quality.

Item No. 5.12

Report

Inclusive Edinburgh: Complex Care Homelessness Service Review Update

Integration Joint Board

11 March 2016

Executive Summary

1. This report updates the Edinburgh Integration Joint Board on the recommendations flowing from the work of Inclusive Edinburgh's Complex Care Homelessness Service review.

Recommendations

2.1 The Integration Joint Board is recommended to note the progress made to develop an innovative, evidence-based 'Getting it Right for Everyone' approach to delivering services for homeless people with complex needs.

2.2 The Board is recommended to approve in principle the proposal to:

2.2.1 appoint a single manager to integrate and coordinate service delivery; and

2.2.2 establish a single location for the delivery of an inclusive homelessness service

2.3 The Board is recommended to note that a full business case for the funding, location, management and integration of a Complex Care Homelessness service will be brought back for approval once proposals for a city centre location are agreed by NHS Lothian's Finance and Revenue Group in May, and then the Council's Property Board.

Background

3. The 'Inclusive Edinburgh' review was set up to tackle some of the problems faced by people with complex needs, who may struggle with homelessness, unemployment, drug and alcohol problems, mental or physical ill-health, who sometimes get involved in crime, and who are often the victims of violence. 'Inclusive Edinburgh' examined the combined services delivered by the Council, statutory partners and voluntary organisations to this group of vulnerable people and has developed recommendations, which promote integrated working, service user involvement, psychologically informed practice and a model of 'Getting it Right for Everyone'.

Main report

4. The 'Inclusive Edinburgh' review will improve the life-chances, health and well being of the most vulnerable, disenfranchised and disengaged citizens whose needs place significant demands on services, and for whom, despite significant resource allocation, outcomes are mostly poor. To achieve this ambition, the review has developed a 'Getting it Right for Everyone' approach. This mirrors the major policy initiative in Scotland for children. The principles for children are equally applicable to adults. The approach promotes a person-centred, outcome-focused, integrated approach to supporting adults achieve their full potential.

5. The 'Inclusive Edinburgh' review identified the need for service integration and where possible a single point of access. The current statutory services – health, social work and housing – are delivered across two sites, with three separate management structures and no overall strategic coherence in service planning and delivery.

6. A successful stakeholder event took place on the 6 May 2015, which reached consensus on the need to generate more effective outcomes by having closer integration of the existing statutory services under one management structure. It was also agreed that voluntary sector organisations should be equal partners in service design and provision.

7. Monthly meetings of a multi-agency, multi-sectoral review group began in August 2015. The review group reports to the Inclusive Edinburgh programme board, which agreed the following work streams to inform this review:

   - Stakeholder Involvement
   - Scoping
   - Accommodation
   - Options Appraisal

Stakeholder Involvement

8. Service users should be key in informing the development of services. On behalf of the review group, Streetwork and Turning Point Scotland carried out a survey of the views of homeless people (Appendix 1).

9. This exercise was complemented by a jointly-run NHS Lothian, housing and social work service user involvement exercise.

10 In order for the service to be inclusive and accessible to people with complex needs, we need to create more effective links between people who need support and the organisations tasked with providing it.

11. To achieve the required change in culture, all staff working with people with complex needs a better understanding of the drivers of behaviours. This requires training for all staff on appreciating the impact of significant psycho-social needs, such as complex trauma on individuals. This will be addressed through the 'Inclusive Edinburgh' Multi-Agency Practice Development training programme (Appendix 2).

12. This approach is consistent with delivering the service as a 'psychologically informed environment', which recognises that some people with significant difficulties struggle to form effective working relationships with services. Therefore, services need to structure themselves in a way that supports staff to foster relationship building as a bridge to more effective engagement. Co-location, single management, full integration, shared priorities and culture shift are all prerequisites for successful transformation.

Scoping

13. This work stream analysed current casework and service provision, which identified 300-350 people where there is evidence of:

- multiple exclusion
- difficulty engaging with services
- poor outcomes
- need for multi-service response with 'skilled stick-ability'
- need for coordinated case management, a lead key worker from health/social work/housing/voluntary services

14. These findings are consistent with the need to build on the current dedication of staff in order to develop a fully psychologically-informed approach, which will promote a shared sense of purpose within the service.

Accommodation

15. There are two key locations from which the majority of public sector provision is delivered: the Edinburgh Access Practice and the Access Point. Both are in poor condition. They are unsatisfactory and potentially unsafe settings.

16. Splitting service provision between two sites is inefficient and can result in service users failing to access the provision they require when it is most needed.

17. Later in 2016, the Access Practice surgery will leave the premises in the Cowgate and the services delivered from that location will be severely impaired unless a suitable alternative is identified.

18. The Accommodation work stream reported the need for:

- space to work with other partner agencies
- co-located city centre premises

- a psychologically informed environment by design that is safe, welcoming and promotes health and well-being.

19. This work stream has identified a Council-owned property on Market Street, which would meet all of these requirements.

Options Appraisal

20. A number of options for service delivery were analysed by the Options Appraisal work stream. The analysis was informed by the findings of each of all of the work streams' membership. The models were in turn scrutinised by the Complex Care Homelessness Review Group.

21. An Options Appraisal event was held on 20 January 2016, attended by approximately 80 stakeholders who carried out a SWOT analysis on two options. The conclusions of this work are that the following are required to improve outcomes for service users and create efficiencies:

- a co-located city centre Inclusive Homeless service, with an integrated management structure across health, housing and social work services
- a shared understanding of purpose to work across services at operational and strategic levels in order to 'Get it Right for Everyone'; this is consistent with developing a psychologically informed approach in order to develop effective working relationships with people who struggle to engage across the pathway
- a strong link between the operational management of the service and planning and commissioning responsibilities in the Council and the Integration Joint Board, in order to lead service redesign to tackle failure demand throughout the Inclusive Homeless pathway
- mixed teams of housing and social work staff with a reduced complement of first line management
- integrated business support services across the co-located partner agencies
- integration and co-location with the voluntary sector to operate an innovative single point of access to 'triage' those who present at the Inclusive Homeless service
- the offer of 'skilled stick-ability' in the form of care co-ordination, advocacy and assertive outreach to those people who struggle to present at the premises
- further consideration of the scope for developing efficiencies through integration with the Harm Reduction Team, who are to be co-located with the existing services.

22. A job description for the proposed Inclusive Homeless Manager post has been agreed by the Complex Care Homelessness review group, and is being evaluated by the Council.

Key risks

23. On-going development of the 'Getting it Right for Everyone' approach will help mitigate the risk of harm to communities and individuals caused by a potential failure to provide effective care and protection to vulnerable children and adults.

24. The project is governed by a multi-agency, multi sector board and its aims are consistent with the Council and the Integration Joint Board's strategic aims.

Financial implications

25. The redesigned service is intended to reduce failure demand through a more inclusive approach. This will have a longer term financial benefit, by reducing 'the revolving door' of demand. Detailed quantification of resource reduction is not possible at this stage.

26. Service integration, service de-cluttering and the development of evidence based practice is an inherently more efficient way of working.

27. Co-location of services in one city centre setting will generate workplace efficiencies. The full financial implications will be included in the business case referred to above.

Involving people

28. The review has engaged service users proactively. The involvement and engagement of people in recovery are key to the success of this review. Consultation has taken place throughout the Council, NHS Lothian, Police Scotland and the Scottish Fire Service; voluntary sector partners; and key stakeholders.

Background reading/references

- Inclusive Edinburgh report to Health, Social Care and Housing Committee, January 2014
- Inclusive Edinburgh Update Report to Health, Social Care and Housing Committee November 2014
- Complex Care Homelessness Stakeholder Event May 2015
- Inclusive Edinburgh Update Report to Health, Social Care and Housing Committee September 2015

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