Notice of Meeting and Agenda

Edinburgh Integration Joint Board
9.30 am Friday 16 June 2017

Midlothian Suite, Lothian Chambers, Edinburgh

Contacts:

Email: allan.mccartney@edinburgh.gov.uk / ross.murray@edinburgh.gov.uk

Tel: 0131 529 4246 / 0131 469 3870

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. None.

4. Minutes and Updates

4.1. Previous Minutes - 24 March 2017 (circulated) – submitted for approval as a correct record.

4.2. Previous Minutes - 28 April 2017 (circulated) – submitted for approval as a correct record.

4.3. Sub-Group Updates

4.3.1 Audit and Risk Committee

4.3.2 Professional Advisory Group

(a) Note of Meeting of 16 March 2017 (circulated)

4.3.3 Performance and Quality Sub Group

(a) Performance and Quality Sub-Group Update

(b) Notes of Meetings of 22 March, 26 April and 29 May 2017 (circulated)

4.3.4 Strategic Planning Group

(a) Note of meeting of 21 April 2017 (circulated)

5. Reports

5.1. Rolling Actions Log – June (circulated)

5.2. Inspection of Older People's Services – report by the IJB Chief Officer (circulated)

5.3. Whole System Delays – report by the IJB Chief Officer (circulated)

5.4. Primary Care Funding and Investment – report by the IJB Chief Officer (circulated)

5.5. Funding for Acute Medical Unit Royal Infirmary – report by the IJB Chief Officer (circulated)

5.6. Actions to support the opening of the new Royal Edinburgh Building – report by the IJB Chief Officer (circulated)

5.7. Financial Position 2016/17 - report by IJB Chief Officer (circulated)

5.8. Annual Accounts 2016/17 – report by IJB Chief Officer (circulated)

5.9. Responsibilities for Data and Information – report by the IJB Chief Officer (circulated)

5.10. Integration Indicators – report by IJB Chief Officer (circulated)

5.11. Community Justice Outcome Improvement Plan 2017/18 – referral from Health, Social Care and Housing (circulated)

Board Members

Voting
Michael Ash, Shulah Allen, Councillor Ricky Henderson, Carolyn Hirst, Councillor Derek Howie, Alex Joyce, Councillor Claire Miller, Councillor Alasdair Rankin, Councillor Susan Webber and Richard Williams.

Non-Voting
Carl Bickler, Colin Beck, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Kirsten Hey, Beverley Marshall, Angus McCann, Maria McILgorm, Ian McKay, Ella Simpson, Rob McCulloch-Graham, Michelle Miller, Moira Pringle and George Walker.

Item 4.1 Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 24 March 2017
Waverley Gate, Edinburgh

Present:

Board Members: Councillor Ricky Henderson (in the Chair), Councillor Elaine Aitken, Shulah Allen, Colin Beck, Carl Bickler, Sandra Blake, Andrew Coull, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Kirsten Hey, Councillor Sandy Howat, Carolyn Hirst, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Ian McKay, Maria McILgorm, Michelle Miller, Moira Pringle, Ella Simpson, George Walker, Richard Williams, and Councillor Norman Work.

Officers: Colin Briggs, Wendy Dale, Allan McCartney, Ross Murray, Julie Tickle and David White.

Apologies: Mike Ash.

1. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 20 January 2017 as a correct record.

2) To approve the minute of the Edinburgh Integration Joint Board of 17 February 2017 as a correct record.

2. Sub-Group Minutes

Decision

To note the Sub-Group minutes.

3. Rolling Actions Log

The Rolling Actions Log for 24 March 2017 was presented.

Decision

1) To approve the closure of actions 2, 4, 10 and 12.

2) To otherwise note the outstanding actions.

(Reference – Rolling Actions Log – 24 March 2017, submitted.)

4. Annual Review of the Strategic Plan - Presentation

Wendy Dale provided a presentation on the annual review of the Joint Board's Strategic Plan. The presentation covered the following areas:

- The scope of the review.
- Legislative requirements.
- Why an annual review was required.
- Timeline and dependencies.
- Proposed approach to conducting the review.
- Directions related to the Strategic Plan.

Decision

1) To note the proposed approach to updating the strategic plan.

2) To agree to consider the updated plan at the Joint Board Development Session in April 2017 before formal approval at the Joint Board in June 2017.

3) That actions to improve undelivered elements be included in the Annual Performance Report.

(References – minute of the Integration Joint Board 16 September 2016 (item 10); report by the IJB Chief Officer, submitted.)

5. Whole System Delays – Recent Trends

An overview was provided of performance in managing hospital discharge against Scottish Government targets. Key reasons for delay were explained, and a number of workstreams aimed at reducing delays were outlined.

It was advised that the target to reduce the number of individuals awaiting discharge to 50 by the April 2017 census was unlikely to be achieved. A review of the Flow Programme, put in place in March 2016 to deliver a number of specific actions to address the high levels of delayed discharge in Edinburgh, would take place at the end of March 2017 and be overseen by the Flow Programme Board.

Decision

1) To note the current performance in respect of delayed discharge.

2) To note the progress made in reducing the length and number of delayed discharges from hospital.

3) To note the proposed future actions to further improve performance.

4) To note that the Flow Programme Board would be undertaking a review of the Flow Programme at the end of March 2017, following which a revised set of indicators and trajectories would be recommended to the Integration Joint Board.

5) To note the following changes to the report by the Chief Officer:

   5.1) To update paragraph 21 to note that partner providers had increased their capacity by 6.5% across the city.

5.2) To update paragraph 26 to note that the approach would utilise 60 beds rather than 45.

6) That future strategy including actions be presented to the Joint Board at the next formal meeting for approval.

(References – minute of the Integration Joint Board 20 January 2017 (item 6); report by the IJB Chief Officer, submitted.)

6. Funding for Alcohol and Drug Services 2017/18

In 2016/17 the Scottish Government reduced the allocation to Alcohol and Drugs Partnerships (ADPs) by 23% nationally. This resulted in a reduction of £1,550,000 for the Edinburgh Alcohol and Drug Partnership. A balanced budget was achieved for 2016/17 utilising carry forward and through financial support from the Joint Board.

A total of £1,155,00 revenue savings had been identified through service redesign. There were significant risks to identifying further savings. Financial support of £395,000 was sought from the Joint Board on a recurring basis to mitigate against risks.

Decision

1) To continue the report by the IJB Chief Officer to a special meeting of the Joint Board on 28 April 2017 where revised proposals, including detailed risk and impact assessment and alternative funding options, would be presented.

2) That the membership of the Professional Advisory Group be consulted on proposals in advance of consideration by the Joint Board.

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

Declaration of Interests

Christine Farquhar declared a non-financial interest in the above item as a Trustee Director of a Care Provider and a Guardian of a recipient of a direct payment.

Ella Simpson declared a non-financial interest in the above item as EVOC provided support for the Substance Users Network.

7. Review of Integrated Care Fund Projects

Details were provided of the evaluation and review of a number of initiatives funded by the Integrated Care Fund. Approval was sought for the allocation of ongoing funding for projects from the Social Care Fund, based upon recommendations from the Strategic Planning Group.

Decision

1) To note the contribution made to the delivery of better outcomes for citizens through the work carried out by the eight projects reviewed by the Strategic Planning Group.

2) The agree to the recommendations for further funding of the eight projects from the Social Care Fund as set out in the table in paragraph 14.

3) To agree to delegate authority to the Chief Officer and Vice-Chair of the Joint Board in respect of recommendations to be made by the Strategic Planning Group on 31 March 2017 regarding the Step Forward Project.

(References – minute of the Strategic Planning Group 10 March 2017 (item 2); report by the IJB Chief Officer, submitted.)

Declaration of Interests

Christine Farquhar declared a non-financial interest in the above item as a Trustee Director of a Care Provider and a Guardian of a recipient of a direct payment.

Ella Simpson declared a non-financial interest in the above item as EVOC provided support for the Substance Users Network.

8. Financial Position to February 2017

The forecast year end position for the Joint Board and an overview of the financial position for the 11 months to February 2017 was detailed. This showed an 11 month overspend at £6.2m with, equivalent to a year-end overspend of £9.2m.

Decision

To note that a break even position would be delivered through a combination of social care fund monies identified by the Joint Board; provisions made by the City of Edinburgh Council; and the underwriting by NHS Lothian of the projected overspend in the health element of the Joint Board's budgets. These factors amounted to the £6.2m required to enable full closure of the 2016/17 budget.

(References – minute of the Integration Joint Board 20 January 2017 (item 8); report by the IJB Chief Officer, submitted.)

9. Financial Plan Update and Financial Assurance

The level of 2017/18 resources delegated by the City of Edinburgh Council and NHS Lothian and resultant 2017/18 financial plan was presented for approval.

Decision

1) To note the financial assurance work undertaken to date;

2) To agree that budgets delegated from the Council and NHS Lothian be allocated back to partners to operationally deliver and financially manage Joint Board delegated functions;

3) To agree the draft financial plan for 2017/18, including the proposed investments in projects previously funded through the Integrated Care Fund.

4) To remit the Strategic Planning Group to scrutinise the savings proposals to ensure alignment with the strategic plan on behalf of the Joint Board.

5) To request that partners work in conjunction with the Chief Officer and Interim Chief Finance Officer to prepare a medium term financial strategy for Joint Board delegated functions.

6) To agree to receive the annual financial statement following the review of the Strategic Plan.

7) To thank the Interim Chief Finance Officer for her work on the 2017/18 Financial plan.

(References – minute of the Integration Joint Board 20 January 2017 (item 7); report by the IJB Chief Officer, submitted.)

10. Royal Edinburgh Hospital Update

An update on the move from the Royal Edinburgh Hospital to the new Royal Edinburgh Building, including details of measures to prevent admissions, reduce length of stay and facilitate discharge, was provided.

Decision

1) To note the general progress made to address the reduction in beds necessary for people over 65, which had a general RAG status of Green.

2) To note the general progress made to address the reduction in beds necessary for people under 65, which had a current RAG status of Amber/Green.

3) To note the detail and progress surrounding the various work streams that were being developed to reduce further the necessary bed capacity for those under 65.

4) To agree to accept further reports which would be necessary to implement future plans to reduce the number of hospital beds and to support people at home and in the community.

5) To note that mental health facilities for adults over and under 65 were projected to open at the end of June 2017.

6) To request an update to a future meeting of the Joint Board on the impact on patient care.

(References – minute of the Integration Joint Board 20 January 2017 (item 11); report by the IJB Chief Officer, submitted.)

11. Southside Medical Practice Update

An update was provided on efforts to secure alternative GP premises for the 5,000 patients of the Southside Medical Practice in advance of premises becoming unavailable on 30 June 2017. A move to the Conan Doyle Medical Centre had been identified as a solution and an agreement had been reached with the practice on 21 February 2017.

Decision

1) To note the outcome of negotiations which agreed that the practice would move to Conan Doyle Medical Centre in May or June 2017.

2) To note the assurances given in regard to Section 17C funding available to the Conan Doyle practice for a five year period from 1 April 2017.

(References – minute of the Integration Joint Board 17 February 2017 (item 3); report by the IJB Chief Officer, submitted.)

12. Niddrie/ Durham Road Craigmillar Medical Practice Leases

A joint lease existed for Craigmillar Medical Centre, the Craigmillar Medical Practice and the Durham Road Medical Practice with NHS Lothian. Revised responsibilities for each practice to reflect the creation of the Niddrie Medical Practice were submitted for approval.

Decision

1) To agree that the whole lease for the building would be held by NHS Lothian. That two mirror leases for the Craigmillar Medical Practice and the Niddrie Medical Practice be established to reflect their constituent parts of the building.

2) To note that the GP partners of both practices were released from their current liabilities to cover the risk of the neighbouring practice, should that neighbouring partnership fail or cease to exist.

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

Declaration of Interests

George Walker declared a non-financial interest in the above item as the relative of a partner in the Durham Road GP Practice.

13. Parkgrove Medical Centre

In 2016 due to operational difficulties encountered by the East Craigs and Parkgrove Medical Practice it had become necessary for the Joint Board and NHS Lothian to provide support including taking over responsibility for the lease of one of the premises utilised by the practice at 22B Parkgrove Terrace. A view was sought on whether the lease should be extended past its current expiry of 2019.

Decision

1) To advise NHS Lothian to enter into discussions with the landlord about a further 10 year lease to 2029.

2) To ask NHS Lothian to support investment to help develop the building as referred to in paragraph 7 of the report by the IJB Chief Officer.

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

14. Development of a New Practice in the North West Edinburgh Partnership Centre

Details were provided regarding the requirement identified in the North West Edinburgh Partnership Centre Business Case to establish a new medical practice in the North West Partnership Centre building and the associated General Medical Services (GMS) costs.

Decision

1) To agree to the proposal from Muirhouse Medical Group to establish the new practice as a branch and agree the required General Medical Services (GMS) costs to enable this.

2) To note that on 14 March 2017, the Muirhouse Partnership agreed to take 1,318 patients from the Inverleith Medical Practice which would close on 30 June 2017.

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

15. Programme of Development Sessions and Visits

A summary of feedback received from Joint Board members on the programme of development sessions and visits and proposals regarding the frequency of development sessions were submitted.

Decision

1) To note the summary of feedback received on the programme of development sessions and visits that took place during 2016/17.

2) To agree the proposal that the frequency of development sessions should move from bi-monthly to quarterly from June 2017.

3) To agree to receive a programme of development sessions and visits for 2017/18 at the June 2017 meeting of the Joint Board.

4) To note that an induction programme would be developed for new members joining the Joint Board.

(References – minute of the Integration Joint Board 16 September 2016 (item 4); report by the IJB Chief Officer, submitted.)

Item 4.2 Minutes

Edinburgh Integration Joint Board (Special Meeting)

9.30 am, Friday 28 April 2017
City Chambers, Edinburgh

Present:

Board Members: Councillor Ricky Henderson (in the Chair), Councillor Elaine Aitken, Colin Beck, Carl Bickler, Sandra Blake, Wanda Fairgrieve, Christine Farquhar, Councillor Joan Griffiths, Kirsten Hey, Councillor Sandy Howat, Carolyn Hirst, Alex Joyce, Angus McCann, Rob McCulloch-Graham, Ian McKay, Alex McMahon (substitute for Shulah Allen), Michelle Miller, Peter Murray (substitute for Michael Ash) and Moira Pringle.

Officers: Wendy Dale, Ann Duff, Gavin King, Karen Lloyd, Allan McCartney, Ross Murray, Nick Smith and Julie Tickle.

1. Welcome

As it was the last meeting of the Joint Board before the Local Government Election Councillor Ricky Henderson paid tribute to Councillor Elaine Aitken who would be standing down as an elected member. He thanked her for her contribution to the work of the Joint Board.

2. Funding for Drug and Alcohol Services 2017/18

In 2016/17 the Scottish Government reduced the allocation to Alcohol and Drugs Partnerships (ADPs) by 23% nationally. This resulted in a reduction of £1,550,000 for the Edinburgh Alcohol and Drug Partnership. A balanced budget was achieved for 2016/17 utilising carry forward and through financial support from the Joint Board.

On 24 March 2017 the Joint Board continued consideration of a report which identified savings of £702,000 and sought financial support of £395,000 from the Joint Board on a recurring basis to mitigate against risks.

Revised proposals including risk and impact assessments of proposed changes and savings, as well as alternative funding option for services, was submitted.

Decision

1) To agree the allocation of £420,000 to maintain existing levels of service delivery. This included £395,000 to support treatment and recovery services and £25,000 to Regional Infectious Diseases Unit (RIDU) and sexual health services to enable a review to be completed by 30 June 2017. These allocations had been set aside within the Social Care Fund.

2) To note the approach, impact and risks of identifying £600,000 revenue savings in adult treatment and recovery services and £102,000 in RIDU and sexual health services, and that a delay to a decision about these savings would incur costs of £50,000 per month.

3) To approve the alternative funding options set out in paragraph 19 of the Chief Officer's report as an opportunity to offset the reductions in drug/alcohol funding.

4) To keep under review the implementation of detailed service changes and monitor the impact.

(References – minute of the Integration Joint Board 24 March 2017 (item 6); report by the IJB Chief Officer, submitted.)

Declaration of Interests

Carl Bickler declared a non-financial interest in the foregoing item as a General Practitioner who worked with drug users.

Christine Farquhar declared a non-financial interest in the foregoing item as a Director of VOCAL.

Minutes

Edinburgh Integration Joint Board
Item 4.3.2 (a) Professional Advisory Group

9.30am Thursday 16 March 2017
Diamond Jubilee Room, City Chambers, Edinburgh

Present:

Colin Beck (Co-Chair), Carl Bickler (Co-Chair), Eddie Balfour, Julie Gallagher, Sharon Cameron, Alasdair FitzGerald, Belinda Hacking, Kirsten Hey, Andy Jeffries, Alison Meiklejohn, Elaine Hamilton, Graeme Mollon, Steven McBurney and Maggie Scrugham.

Apologies
Kath Anderson, Sheena Borthwick, Aileen Kenny, Caroline Lawrie, Marian Gray, Catherine Mathieson, Ian McKay, Sylvia Latona and David White.

1. Note of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group meeting of 10 January 2017 and Matters Arising

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group of 10 January 2017 as a correct record.

2. Note of the meeting of the Edinburgh Integration Joint Board of 20 January 2017 and Matters Arising

Decision

1) To note the minute of the meeting of the Edinburgh Integration Joint Board of 20 January 2017.
2) To request detailed feedback on District Nursing to be considered at a future meeting of the Professional Advisory Group.

3. Note of the meeting of the Edinburgh Integration Joint Board of 17 February 2017 and Matters Arising

Decision

1) To note the minute of the meeting of the Edinburgh Integration Joint Board of 17 February 2017.
2) To note that in the time that had elapsed since the meeting a location for the Southside Practice in the Conan Doyle Centre had been confirmed.

4. Strategic Planning Group - 10 March 2017

Belinda Hacking provided an update on the most recent meeting of the Strategic Planning Group. The meeting had considered and made recommendations on bids for integrated care funding based on a summary of each proposal.

Decision

Carl Bickler to write to Wendy Dale to highlight the desire to maintain a strong virtual link between the business of the Professional Advisory Group and the Strategic Planning Group.

5. National Health and Social Care Standards

Decision

Stuart McLean to confirm if any comments had been received on the paper circulated in advance of the 10 January 2017 meeting of the Professional Advisory Group.

6. Lothian Hospitals Plan

Carl Bickler invited members to provide comments on the Lothian Hospitals Plan, specifically the importance of maintaining 2 acute receiving hospitals in Edinburgh.

Decision

1) That Carl Bickler submit comments to the Integration Joint Board on behalf of the Professional Advisory Group to request that directions were made to support resilience capacity, including:

    1.1) Supporting community services.

1.2) Maintaining the Western General Hospital as an acute facility and to redevelop the site to ensure it retains capacity as an acute receiving hospital.

2) That the future of Liberton Hospital be considered at a future meeting of the Professional Advisory Group.

7. Joint Inspection

Colin Beck provided an update on the Joint Inspection of the IJB by Health Improvement Scotland (HIS) and the Care Inspectorate (CI). Early feedback had been provided in January 2017 and the full report would be published following the May 2017 Local Government Election. It was anticipated that the report would identify areas for improvement and measures would be implemented to address this.

Decision

To note the update and that actions were ongoing to address issues highlighted in early feedback.

8. Astley Ainsley – Public Transport Plans

Alasdair FitzGerald advised that an issue had been identified regarding the distance between the entrance to the new Astley Ainsley hospital and the nearest bus stop. This was expected to affect patients and an impact assessment had been requested. Alternative options including the use of a shuttle bus and alteration of bus routes had been explored. Discussions were ongoing between the site planners and Lothian Buses.

Decision

1) To note the update.
2) Alasdair FitzGerald to provide form of words to Carl Bickler for the purpose of requesting the support of the Integration Joint Board for a full options appraisal.

9. Locality Boundaries – Post Code versus GP Practice

It was advised that the minutes for the most recent meeting of the Local Business Operating Model Working Group referred to a decision taken by the “LIB” to approve the provision of patient services based on postcodes instead of by GP Practice.

Decision

That Carl Bickler write to Maria Wilson (Chair of Local Business Operating Model Working Group) to seek clarity on the matter.

10. Quality and Performance Group – 22 February 2017

Alison Meiklejohn provided an update on discussions at the Quality and Performance Group meeting of 22 February 2017. Topics had included:

- National care indicators for integration.
- An overview of the approach to whole system flow.
- A Strategic Plan update.
- Constructive challenge.
- Options for the future structure of the group.

Decision

1) To note the update.
2) That a Quality and Performance Group update be added to the agenda for the next meeting of the Professional Advisory Group.
3) To agree that Alison Meiklejohn would fulfil the role of Professional Advisory Group Official Representative at future meetings of the Quality and Performance Group.

11. Date of Next Meeting

Decision

1) That further meetings of the Professional Advisory Group be scheduled for 6 June 2017 and 1 August 2017.
2) To request that group members provide Carl Bickler with any future meeting topics for agenda inclusion.

Item 4.3.3(b)

Note of Meeting
Performance and Quality Sub-Group
22 March 2017
City Chambers, Edinburgh
1:00 pm

Present:

Key Stakeholders

Shulah Allan (Chair), Ian Brooke (EVOC), Philip Brown (Strategy and Insight), Sarah Bryson (Strategic Planning), Eleanor Cunningham (Strategy and Insight), Wendy Dale (Strategic Planning), Keith Dyer (Quality and Compliance Manager), Christine Farquhar (Citizen Member – Carer), Councillor Sandy Howat (Vice Chair), Alison Meiklejohn (PAG Representative), Rene Rigby (Scottish Care), Catherine Stewart (Strategy and Insight).

Apologies:

Carl Bickler(GP/PAC), Sandra Blake (Citizen Member – Carer), Jen Evans (Quality Assurance), Jon Ferrer (Quality Assurance), Yvonne Gannon (Strategy and Insight), Wanda Fairgrieve (Partnership/Union), Kirsten Hey (Partnership/Union), Rob McCulloch-Graham (Chief Officer), Maria McILgorm (Chief Nurse), Ian McKay (GP/Clinical Director), Peter McLoughlin (Strategic Programme Manager), Katie McWilliam (Strategic Planning) Michelle Miller (Chief Social Work Officer), Sheena Muir (Hospital Sites), Moira Pringle (Chief Finance Officer), David White (Strategic Planning and Quality Manager – Primary Care).

Agenda Item No	Agenda Title / Subject / Source	Decision	Action Owner / Responsibility	For information
1	Welcome	No changes.		
2.1	Declarations of Interest	None.		

3.1	Minute of 25 January 2017	To approve the minute subject to the following amendment: Christine Farquhar declared a non financial interest in item 4.1 – *Care National Indicators for Integration – Carers Feeling Supported* as a director/trustee of Vocal.	**Laura Millar**	
3.2	Outstanding Actions	1) To note the Outstanding Actions. 2) To agree to close action 9 (part 1).	**Laura Millar**	
3.3	Work Programme	None.	**Laura Millar/ Eleanor Cunningham**	
3.4	Matters Arising	None.	**Laura Millar**	
3.5	Update on Inspection of Older People's Services in Edinburgh	Officers received feedback on the report which would remain embargoed until May. The improvement plan was under development, and would be shared alongside the report in due course. **Decision** 1) To note the update. 2) To circulate the report to the group when it is available.	**Wendy Dale**	
4.1	Results of the Survey and Discussion on the	A summary of the options, votes and comments was provided (attached as appendix 1). The group identified option 4 as the most suitable - *Establish Executive and Reference Groups, targeted work undertaken by a sub-*	**Keith Dyer**	

	Future of the Group	*group of the Reference Group feeding back to Executive.* The logistics of how to engage with stakeholders, formalising links with strategic planning partnerships, identifying key topics and oversight of the improvement plan coming from the inspection was discussed. **Decision** 1) To note results and comments. 2) To agree to recommend option 4 for the future of the Group and to request the chair and vice chair discuss the proposed revisions with Councillor Henderson ahead of reporting to the IJB. 3) To circulate to the group, all the presentations received so far.		
4.2	Selection of Key Indicators	The aim of the indicators was to provide the group with data to allow identification of any issues and set standards or Social Care. The indicators were split into headings and further highlighted as having come from the 23 core integration indicators, a Social Care internal target or an MSG indicator. Some data was currently being collected from various sources or was already held by the NHS. The group discussed that the data does not necessarily measure quality of care.	**Wendy Dale/ Catherine Stewart**	

		Decision 1) To note the indicators. 2) To invite suggestions from the group for additions or where topics could be merged. 3) To request a map identifying which officers are looking at each area.		
4.3	Annual Performance Report	The report aims to examine achievements throughout the year in relation to the plan and the resulting impact on priorities; it would be published at the end of July following agreement by the IJB in June. An update would be provided for the April meeting of the sub-group however timescales were tight as statistics for the full year run until 31 March. **Decision** 1) To note the update. 2) To circulate the 9 indicators and link to the Ayr report to the sub-group	**Wendy Dale**	
	Date of next meeting	26 April 2017 European Room, City Chambers	**Laura Millar**	

Appendix 1 - Doodle Poll Results – Options for the IJB Performance and Quality Sub-Group Future

Option	Number of Votes
1 - The meeting continues as it currently operates.	0
2 - The meeting is disbanded and the P&Q aspect is absorbed by one or more meetings already operating with a P&Q remit	1
3 – Establish an Executive Group (key agency staff) to hold an overview and feed into a larger Reference Group	4
4 - Establish Executive + Reference Groups, targeted work undertaken by a sub-group of the Reference Group feeding back to Executive	10

Comments…

I have selected option 4 however with reference to option 2, I am unclear what other meetings are referred to here - "absorbed by one or more meetings already operating with a quality/performance remit". Maybe the smaller short life groups/sub groups refered to in option 4 could utilise these groups where appropriate as well as taking members from the larger reference group.

I am aware of the start up of the performance board, and we need to be clear their and our remits. I chose option 4 as I think that is the best suggestion about actually making the meeting work. However I also chose option 2, if whatever changes we put in place now don't work within 6 months I think we have to strong enough to disband at that point.

I believe the sheer size and breadth of the group membership could actually act as an inhibitor to us being able to effectively agree priorities, scrutinise and offer assurance to the IJB. Smaller commissioned groups could focus in and deep dive issues in a much quicker and more efficient way, with clear and overarching accountability being held by a designated lead who would report back to the executive and reference groups.

My view is an overarching one with a focus on what we need to do to successfully integrate services effectively for and with our citizens - i.e. Christie. The key principles we need to focus on, a.s.a.p, are consultation, communication, strategic planning, co-production, workforce involvement, training and education, and a constant, light touch iteration of evaluation and improvement. To do this effectively Perf & Quality sit along side SPG and Commissioning, somewhere in the current "gap" between them.

The group needs more engagement from members so that they will be able to take part in challenging performance and other input. Many group members often appear to be passive recipients of information at present. We also need to enable ways to engage via members with the wider stakeholder group. Finally, now that the wider governance within the Partnership is clearer, we can be clearer about what content the P&Q subgroup needs to lead on.

Item 3.1

Note of Meeting
Performance and Quality Sub-Group
26 April 2017
City Chambers, Edinburgh
1:00 pm

Present:

Key Stakeholders

Shulah Allan (Chair), Ian Brooke (EVOC), Philip Brown (Strategy and Insight), Sarah Bryson (Strategic Planning), Eleanor Cunningham (Strategy and Insight), Wendy Dale (Strategic Planning), Keith Dyer (Quality and Compliance Manager), Christine Farquhar (Citizen Member – Carer), Jon Ferrer (Quality Assurance), Kirsten Hey (Partnership/Union), Councillor Sandy Howat (Vice Chair), Sheena Muir (Hospital Sites), Rene Rigby (Scottish Care), Catherine Stewart (Strategy and Insight).

Apologies:

Carl Bickler(GP/PAC), Sandra Blake (Citizen Member – Carer), Jen Evans (Quality Assurance), Yvonne Gannon (Strategy and Insight), Wanda Fairgrieve (Partnership/Union), Rob McCulloch-Graham (Chief Officer), Maria McILgorm (Chief Nurse), Ian McKay (GP/Clinical Director), Peter McLoughlin (Strategic Programme Manager), Katie McWilliam (Strategic Planning), Alison Meiklejohn (PAG Representative), Michelle Miller (Chief Social Work Officer), Moira Pringle (Chief Finance Officer), David White (Strategic Planning and Quality Manager – Primary Care).

Agenda Item No	Agenda Title / Subject / Source	Decision	Action Owner / Responsibility	For information
1	Welcome	No changes.		

2.1	Declarations of Interest	None.		
3.1	Minute of 22 March 2017	To approve the minute as a correct record.	**Laura Millar**	
3.2	Outstanding Actions	1) To note the Outstanding Actions. 2) To agree to close actions 1 and 6.	**Laura Millar**	
3.3	Work Programme	None.	**Laura Millar/ Eleanor Cunningham**	
3.4	Matters Arising	None.	**Laura Millar**	
3.5	Update on Inspection of Older People's Services in Edinburgh	The report would be embargoed until its publication on 12 May and would form the basis of the next meeting of the group. Officers involved were drafting an improvement plan to mitigate any issues raised. **Decision** 1) To note the update. 2) To circulate the report to the group when it is available.	**Wendy Dale**	
4.1	Proposed Changes to Membership and	The group identified option 4 as the most suitable - *Establish Executive and Reference Groups, targeted work undertaken by a sub-group of the Reference Group feeding back to*	**Wendy Dale**	

	Structure	*Executive.* This would be based on the IJB Audit and Risk Committee model, officers had met with a representative of Councillor Henderson to discuss the proposals. The improvement plan following the performance report would provide the group with a starting point when identifying areas to examine. The merits of a smaller executive were discussed alongside how to ensure there was no overlap with the work of other groups. **Decision** 1) To circulate the actions identified from the improvement plan to the performance report to the group. 2) To clarify the proposed remit and re-circulate to the group. 3) To agree the proposed membership. 4) To request a review of the group after 1 year (prior to reporting to the IJB) and ensure those not included under the new membership were informed of progress.		
4.2	Update on the Annual Performance Report	The group considered the outline of the proposed content of the performance report which aimed to demonstrate the work underway towards achieving the 9 national outcomes. It was acknowledged that the strategic plan is for 3 years therefore officers were gathering evidence to show that progress towards outcomes had been achieved.	**Catherine Stewart** **Eleanor Cunningham**	

		Decision 1) To invite the group to email any points/evidence that they feel should be included in the Performance Report to Catherine Stewart. 2) To request a section in the report which acknowledged challenging areas and outlined what the proposed mitigating actions were.		
4.3	Service User Engagement and Feedback	The effectiveness of how the IJB use service user engagement and feedback was discussed. The various groups within the framework providing a source for service-user feedback were discussed alongside how these could report to this group. It was the consensus that it was not within the remit of the Performance and Quality Sub-group to engage directly with service-users. **Decision** 1) To request the group provide details to officers of any suggestions for existing sources of feedback/data that they are aware of or any gaps. 2) To request a map was drafted linking key themes against existing public voices in that area based on the details provided by group members. 3) To request members consider the role of the group in the qualitative work.	**Eleanor Cunningham**	

	Date of next meeting	29 May 2017 European Room, City Chambers	**Laura Millar**	

Item 4.3.3

Note of Meeting
Performance and Quality Sub-Group
29 May 2017
City Chambers, Edinburgh
1:00 pm

Present:

Key Stakeholders

Shulah Allan (Chair), Sandra Blake (Independent Carer), Ian Brooke (EVOC), Philip Brown (Strategy and Insight), Sarah Bryson (Strategic Planning), Eleanor Cunningham (Strategy and Insight), Wendy Dale (Strategic Planning), Jennifer Evans (Edinburgh Health and Social Care Partnership), Jon Ferrer (Quality Assurance), Maria McIgorm (Edinburgh Health and Social Care Partnership), Alison Meiklejohn (Professional Advisory Group), Moira Pringle (Edinburgh Integration Joint Board), Rene Rigby (Scottish Care), Catherine Stewart (Strategy and Insight).

Apologies:

None

Agenda Item No	Agenda Title / Subject / Source	Decision	Action Owner / Responsibility	For information
1	Welcome	No changes.		

2.1	Declarations of Interest	None.		
3.1	Minute of 26 April 2017	To approve the minute as a correct record.	**Laura Millar**	
3.2	Outstanding Actions	1) To note the Outstanding Actions. 2) To agree to close actions 8, 10 and 11.	**Laura Millar**	
3.3	Work Programme	None.	**Laura Millar/ Eleanor Cunningham**	
3.4	Matters Arising	None.	**Laura Millar**	
3.5	Update on Inspection of Older People's Services in Edinburgh	**Decision** To note that non-elected member had been briefed by the Chief Officer Edinburgh Health & Social Care Partnership regarding the content of the Inspection of Older People's Services in Edinburgh report.	**Wendy Dale**	
4.1	Care Inspection Report	The Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social care for older people in Edinburgh. The joint inspection evaluated, against the nine quality indicators, how well the partnership achieved good personal outcomes for older people and their unpaid carers. The Care Inspectorate made	**Wendy Dale**	

		17 recommendations for improvements which had resulted in a prioritised Improvement Plan. **Decision** 1) To note the presentation. 2) To agree that the Improvement Plan and Quality Indicator 5 would be included on the agenda for the next meeting of the EIJB Performance and Quality Sub-Group		
4.2	Annual Performance Report – Proposed Content	The EIJB Performance and Quality Sub-Group were asked to approve the proposed structure and content of the Annual Performance Report. Further work would be required to identify case studies to ensure that these were reflective of service users experiences. **Decision** 1) To agree to the proposed structure for the Annual Performance Report. 2) To note that group member would feedback illustrative examples that would be included within the Annual Performance Report.	**Eleanor Cunningham**	
4.3	Ministerial Group Indicators for Integration	The Ministerial Strategic Group for Health and Community Care (MSG) agreed to consider quarterly updates on key indicators across health and social care in the following areas: 1. Unplanned admissions	**Eleanor Cunningham/ Wendy Dale**	

		2. Occupied bed days for unscheduled care 3. Accident and Emergency Performance 4. Delayed discharges 5. End of life care 6. The balance of spend across institutional and community services Chief Officers were asked to set their local objectives for each of the indicators for 2017/18 **Decision** 1) To agree the proposed local key objectives across health and social care outlined within Appendix 1 to the report. 2) To note that the proposed key indicators would be submitted to the IJB for ratification. 3) To agree that local data would be examined at future meetings. 4) To note that the national indicators would be circulated to members.		
	Date of next meeting	Laura to confirm.	**Laura Millar**	

Item 4.3.4

Minutes

Edinburgh Integration Joint Board
Strategic Planning Group

10.00am Friday 21 April 2017
City Chambers, High Street, Edinburgh

Present:

Members: Councillor Ricky Henderson (Convener), Colin Beck, Eleanor Cunningham, Wendy Dale, Christine Farquhar, Belinda Hacking, Stephanie-Anne Harris, Fanchea Kelly, Angus McCann, Peter McCormick, Michele Mulvaney, Moira Pringle and Rene Rigby.

Apologies: Graeme Henderson, Rob McCulloch-Graham and Ella Simpson.

1. Minute

The minute of the Edinburgh Integration Joint Board (EIJB) Strategic Planning Group of 31 March 2017 was submitted.

Decision

To approve the minute of the Edinburgh Integration Joint Board (EIJB) Strategic Planning Group of 31 March 2017 as a correct record.

2. Strategic Plan Focus Area Updates 2017/18

Wendy Dale provided an overview of the key areas of work to be taken forward in delivering the strategic Plan in 2017/18. A high-level summary of progress made in

delivering the actions set out in the Plan was submitted to provide context for the planned activity 2017/18.

Locality Working

Information was provided on progress made in 2016/17 towards establishing a new integrated structure that supported collaborative and flexible working in the four localities.

The Group felt it was imperative to capture what differences had been made and what opportunities had been taken since the inception of the Plan. The review was important in terms of reporting progress to the Integration Joint Board and providing the direction of travel for the next year.

There followed a general discussion and exchange of views and the following points were raised:

- Multi Agency Triage Teams (MATTs) had been working on a pilot basis and learning from this would be instrumental in informing the operational model for the Hubs going forward with a focus on avoiding unnecessary admission to hospital and reducing delays in accessing community based support.
- There were many positive outcomes reported in the updates but no indications of where planned progress had not been delivered – there must be areas where completion had not been achieved – this could be more appropriately reflected in the performance report
- Clear linkages needed to be made between the areas of focus updates and the performance report – it was important to highlight what differences had been made since the Plan's inception
- Ongoing issues needed to be captured within the updates – structured delivery plans and timelines needed to focus on services people were receiving on a daily basis and any proposed changes implemented
- The impact of Welfare Reform should be included in the Plan

Decision

1) To note the timeline for delivery as follows:

   Development Session – 28 April 2017
   Performance Report published by 31 July 2017
   Locality Improvement Plans – October 2017

2) To agree that the Plan should focus on the 6 strategic priorities including a contextual paragraph on each together with some of the challenges; a cover sheet to also be prepared for each document setting out its purpose and relationship with other plans and documents.

3) To agree to feedback comments on the Focus Area Updates to Wendy by the end of the following week.

(Reference – Strategic Plan Focus Area Updates 2017/18, submitted; Proposed Public Summary Document (tabled)

3. Future Operation of the Strategic Planning Group

The Group broke into two smaller groups to discuss the format, focus and effectiveness of the Strategic Planning Group going forward. The following comments were made:

Group 1	Group 2
How do you feel the format of the meetings has worked and would you like to see anything done differently?	
• Detailed, focused on specific points, easier to understand outcomes • Context is important, need to know what, by approving something, you are rejecting • Large membership, would it be better to split into smaller groups for discussion and feedback • Set up seems to be a hybrid between a Council committee and a discussion group • Nature, role, purpose and actions have changed since the Group's inception – needs to become more business like to make some hard decisions • Excellent chairmanship	• Meetings run and chaired well – evident that everyone is given an equal voice and respect • Not sure about relationship with other IJB Groups, cycle of meetings – need to be clear reporting lines between Groups and IJB • Value in owning 6 strategic priorities • Should all Groups be working in the same way, same standards of inclusiveness to ensure feedback and connectivity • Need to formalise a system of reporting back Group's views to IJB • Induction for new members to facilitate early relationship building
Has the Group focused on the right things?	
• Need to focus and have more evidence and context for proposals ie. where have we been, where are we going now • Helpful to have a brief one page covering report attached to documents for consideration, setting out what actions/participation are needed by participants	• How do we know strategy is working – we need feedback from the wider service providers regarding the next stage and moving forward • Need to focus on priorities and simplify relationships with other groups and IJB • Clarity about which group is leading to avoid duplication

• Performance Group should be reporting in to this Group to inform strategic plan content and discussion	• Clarity of links between the sub-groups and their roles, expectations of group members
Are there ways in which we could make the Group more effective?	
• Clarify role of this Group to be sure that the actions in the Strategic Plan are adequate • Develop a web portal to get easy access to key documents • Overall vision for the Group needs to be	• Clear lines of communication vital between Groups and with IJB • Need clarity about who is leading what • Need to simplify process focusing on priorities and relationships • Workshop on role of Advisory Groups

4. Date of Next Meeting

Friday 2 June 2017 @ 10:00am in the European Room, City Chambers, Edinburgh

Item 5.1 – Rolling Actions Log – June 2017

June 2017

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	**Communications and Engagement Strategy 2016 to 2019**	13-05-16	To present an implementation plan to the Joint Board once resources had been identified.	Chief Officer	Not specified	
2	**Rolling Actions Log (ICT Steering Group)**	15-07-16 And 16-09-16	To invite the ICT Steering Group to consider and recommend business-critical ICT issues where the Joint Board might require to issue directions. To ask the ICT Steering Group to report back to the Joint Board on a recommended way forward.	ICT Steering Group	Not specified	
3	**Delivery of the EH&SC Strategic Plan – action plan**	16-09-16	To receive twice yearly reports from the SPG on the delivery of the strategic plan. This would include:	Chief Officer	August 2017	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			• Tracking of ongoing and proposed major programmes/business cases.			
4	**Sub group updates – Audit and Risk**	18-11-16	To note the immediate concern of the Audit and Risk Committee Chair regarding audit capacity and that a proposal on resource be presented to the next meeting of the Joint Board.	Chief Officer	January 2017	
5	**Winter Plan 2016-17 and proposal for future use of Liberton Hospital**	18-11-16	To request that any required directions and related financial information be presented to the next meeting of the Joint Board.	Chief Officer	January 2017	A report on proposed directions for 2017/18 will be submitted to the July meeting of the EIJB
6	**Performance and Quality Sub-Group**	18-11-16	To consider the final draft of the annual performance report at an IJB Development Session prior to being presented for approval at a formal meeting.	Chief Officer	July 2017	
7	**Standing Orders – Annual Review**	20-01-17	To note that the next annual review of Standing Orders would be presented to the Joint Board in January 2018.	Chief Officer	January 2018	
8	**Joint Inspection of Older People**	20-01-17	That the assurance statement be discussed at a future development session	Chief officer	Not specified	To be scheduled in programme of development sessions for agreement at July meeting of EIJB

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
9	**Annual Review of the Strategic Plan**	24-03-17	To agree to consider the updated plan at the Joint Board Development Session in April 2017 before formal approval at the Joint Board in June 2017.	Chief Officer.	July 2017	This will be covered through the reports on Annual Performance 2016/17 and Directions for 2017/18 to be submitted to the EIJB in July
10	**Annual Review of the Strategic Plan**	24-03-17	That actions to improve undelivered elements be included in the Annual Performance report.	Chief Officer	July 2017	The Annual Performance Report will be submitted to the EIJB in July 2017.
11	**Whole System Delays – recent trends**	24-03-17	That future strategy including actions be presented to the Joint Board at the next formal meeting for approval.	Chief Officer	June 2017.	Propose close as report is on the agenda for June meeting
12	**Funding for Alcohol and Drug Services 2017/18**	24-03-17	To continue the report by the IJB Chief Officer to a special meeting of the Joint Board on 28 April 2017 where revised proposals included detailed risk and impact assessment and alternative funding options are presented.	Chief Officer	April 2017	Propose close as report considered at April meeting and decision made
13	**Programme of Development Sessions and Visits**	24-03-17	To agree to receive a programme of development sessions and visits for 2017/18 at the June 2017 meeting of the Joint Board.	Chief Officer	July 2017	Programme to be agreed with new Chair and Vice Chair

Report

Inspection of Older People's Services
Edinburgh Integration Joint Board

16 June 2017

Executive Summary

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

Recommendations

The EIJB is asked to:

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

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

Background

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

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

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

7. The inspection report published the following judgements:

Evaluation Scores:

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

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

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

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

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

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

- increasing numbers of people living with dementia and,

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

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

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

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

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

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

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

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

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

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

Inspection outcomes and progress

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

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

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

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

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

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

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

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

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

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

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

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

    Actions in the improvement plan with priority status -

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

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

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

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

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

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

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

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

Key risks and challenges

Quality Assurance

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

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

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

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

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

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

Care at Home

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

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

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

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

Technology Enabled Care

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

Financial implications

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

The following additional support will be utilised:

Strategy and Insight

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

Organisational Development

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

Contract support and managing purchasing budgets

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

Capital development support

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

Delivery of key processes

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

Assessment and reviews

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

Background reading/references

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

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Contact: Maria McILGorm, Chief Strategy and Performance Officer

E-mail: maria.mcilgorm@nhslothian.scot.nhs.uk | Tel: 0131 469 3916

Appendix 1 – Older Peoples Inspection Quality Indicators

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

Appendix 2 – Inspection Report, 17 Recommendations for Improvement

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

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

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

Partnership Evaluation and Inspection Scores

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

Quality Indicators

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

Background

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

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

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

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

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

Recommendations

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

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

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

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

Date: 26.05.17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 4

Briefing Note

Edinburgh Health and Social Care Partnership

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

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

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

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

Progress

- The IJB will receive a capacity plan.

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

Progress

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

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

Progress

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

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

Progress

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

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

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

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

Progress

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

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

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

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

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

Progress

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

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

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

Recommendation 12
The Partnership should ensure that:

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

Progress

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

Recommendation 13
The Partnership should ensure that:

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

Progress

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

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

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

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

Progress

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

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

Progress

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

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

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

Progress

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

Recommendation 17

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

Progress

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

Report

Item 5.3 - Whole System Delays – Recent Trends Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. The purpose of this report is to update the Integration Joint Board on:

   - the current performance in respect of delayed discharge;
   - actions being taken to reduce the number and length of delays; and
   - actions being taken to improve the monitoring and management of performance

Recommendations

2. The Integration Joint Board is asked to note:

   - the improvement in performance in respect of delayed discharge; and
   - the actions being taken to maintain that improvement

Background

3. Performance in respect of the number of people whose discharge from hospital is delayed and the length of those delays has been an ongoing challenge. Edinburgh has regularly had the highest number of delayed discharges of any Integration Authority in Scotland.

4. A programme of work has been put in place overseen by the Flow Programme Board to address the seemingly intractable problems associated with delayed discharge.

5. Recognising the importance and urgency of the need to reduce the number and length of delayed discharges the Integration Joint Board has asked to receive regular updates on performance.

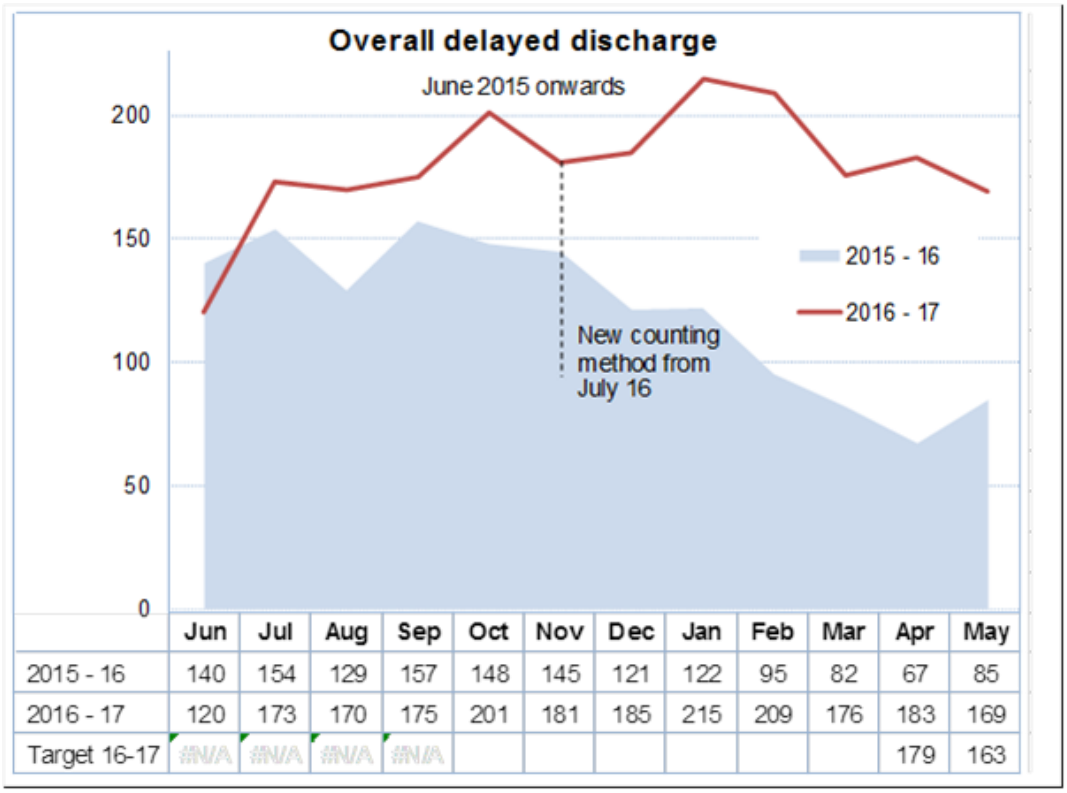
Main report

6. The current target in respect of the number of people whose discharge from hospital is delayed is that this should be no more than 50 for non-complex cases by December 2017. Table 1 below shows the trajectory that has been agreed to reach this target.

2017	May	June	July	Aug	Sep	Oct	Nov	Dec
Non-complex	163	147	131	115	98	82	66	50
Complex	27	24	22	20	17	15	12	10

Table 1 Phased targets for the number of people whose discharge from hospital is delayed

7. Chart 1 below shows the number of people whose discharge from hospital was delayed over the last two years using the monthly census data. The shaded area shows performance for May 2015 to April 2016 and the red line shows levels for the current year. The target trajectory is shown by the green line.



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015 - 16	140	154	129	157	148	145	121	122	95	82	67	85
2016 - 17	120	173	170	175	201	181	185	215	209	176	183	169
Target 16-17	#N/A	#N/A	#N/A	#N/A							179	163

Chart 1: Number of people delayed in hospital May 2016 to April 2017 excluding complex cases.

8. Table 2 below shows the number of complex delays (Code 9) that are excluded from the census reporting.

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
Total	120	173	170	175	201	181	185	215	209	176	183	169
Excluded cases	27	25	23	24	27	23	18	12	13	16	32	34
Of which, Guardian-ship	24	23	20	20	22	16	17	11	12	14	18	19
Grand Total	147	198	193	199	228	204	203	227	222	192	215	203

Table 2: Excluded cases (Code 9)

9. As illustrated in Chart 1 there has been a steady reduction in the number of people whose discharge has been delayed over the last four months. Whist it is difficult to identify any single cause for this there are several factors that are likely to have contributed to the improvement in performance. Firstly, the Multi Agency Triage Team function in each locality is starting to bed down. The MATTs have been meeting daily with an absolute focus on preventing admission to hospital and reviewing every person who has been declared fit for discharge, with a view to the discharge taking place as soon as possible.

10. Detailed performance reports are now available on a locality basis which has allowed performance targets to be set for each locality in respect of delayed discharges. A 'star chamber' meets weekly where Locality and Hub Managers are held to account for performance and any issues having a negative impact on timely discharge can be escalated immediately.

11. The Flow Programme Board has recently reviewed the content of the programme and identified three specific areas for attention:

- Maximising capacity through the care at home contract
- Optimising flow through the hospital system and discharge from hospital
- Technology enabled care as a means of increasing capacity to support people to live independently in the community, avoiding the need for admission to hospital and facilitating timely discharge

12. Lack of capacity in care at home to support discharge from hospital continues to be a significant problem which is why the Flow Board has decided to take an interest in this area. Technology enabled care has the potential to provide innovative ways of supporting people to remain at home which may reduce

some of the pressure on the care at home service. The focus on the work to optimise flow will build on the improvements seen through the operationalisation of the MATTs and the introduction of the 'star chamber' approach to managing performance. Whilst the recent improvements in performance are very welcome it is important not to be complacent and the scrutiny offered by the Flow Board should guard against this.

Key risks

13. Whist the recent reduction in the number of people whose discharge is delayed from hospital is very welcome, there is a risk that the improvement will not be sustained. Close scrutiny through the weekly Delayed Discharge Star Chamber will ensure that any slippage against planned trajectories is picked up and appropriate action put in place.

Financial implications

14. There are no financial implications arising directly from this report.

Involving people

15. As the locality Hubs and Clusters become operational there will be further engagement with local communities to further develop the model.

Impact on plans of other parties

16. The ability of the Edinburgh Health and Social Care Partnership to significantly reduce the number of people currently delayed in hospital and the length of those delays impacts on NHS Lothian and the other three Integration Boards within Lothian. These partners are kept informed of progress by the Chief Officer of the Edinburgh Integration Joint Board through the IJB Chief Officers Acute Interface Group.

Background reading/references

None

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Contact: Wendy Dale

E-mail: wendy.dale@edinburgh.gov.uk

Tel: 0131 553 8322

Report

Item 5.4 - Primary Care Funding and Investment

Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. The purpose of this report is to detail how NHS Lothian sourced funds can be utilised to ensure the stability of primary care in Edinburgh from 2017/18 .

Recommendations

It is recommended that the EIJB:

2. agrees a programme of 'Stability and Transformation' injections into individual GP Practices during 2017/2018;

3. supports the establishment of an Edinburgh primary care Linkworker network. This is a Partnership led project which aims to support more social prescribing;

4. supports investment in additional management capacity to ensure effective implementation and robust evaluation;

5. supports the management of these investments being made through the Edinburgh Health and Social Care Partnership (EHSCP) Primary Care Support Programme; and

6. supports the use of any non recurring flexibility into an agreed group of technological investments (50/50 funding with practices) and to support development work by cluster groups.

Background

7. A full background and rationale to the above recommendations is given in Appendix 1: 'Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence'.

8. The proposals are aimed firmly at the expansion of 'core' primary care capacity, in recognition of the challenges of instability in individual practices over the last three years.

9. The proposals envisage a cohort of primary care professionals; nurses, pharmacists, linkworkers, allied health professionals and others, being 'injected' into c30 practices which has reduced the reliance on medical sessions by up to 10% in most cases and around 15% in more 'transformational' practices.

10. The injections of funding will be made without cost to the practice for six months, then at 50% of the total cost thereafter.

11. The staff will be employees of the EHSCP and current line management arrangements for the respective professions will be used. The relationship with the practice will be set out in a Service Level Agreement which stipulates these arrangements, associated expectations and risk sharing. The members of staff engaged will be expected to become members of the core practice clinical teams and to be directed by the practice on a day to day basis.

12. Discussions will take place with the cluster managers within the four Localities and they are aware of the new workforce detail. As the implementation phase is complete, some may consider taking a stronger role in supporting the management and development of this workforce. If individuals work in more than one practice, every effort will be made to ensure their practices are in the same cluster**.**

Key risks

The following evaluation and review mechanisms are in place to ensure that the risks and issues are managed that may result from the proposals:

13. The governance framework for implementation comes under the EHSCP Primary Care Support Programme. A project group will be established to guide implementation which will report to the Edinburgh Primary Care Management Team. The key decisions about prioritisation of practices to access funding in the first year will be proposed by the Clinical Leads Group, under the chairmanship of the Clinical Director.

14. The approach will be subject to ongoing practice and city wide assessment of impact.

15. The expectations are clear at the outset; that a practice receiving an injection or associated support will be able to reduce the number of medical consultations by c10% and that this will accumulate, practice by practice, to c 4.6% (FYE) across the city by the end of the first year.

16. Furthermore, and critically, that no further practices are forced into a situation where a crisis intervention is required to maintain General Medical Services provision to their list

17. Ideally, practices which receive stability and transformation injections would be able to un-restrict their lists. This expectation needs to be carefully exercised to ensure that instability is not increased.

Financial implications

18. The funding associated with the proposals is in place and set out in Table 4 of page 15 of Appendix 1

Table 4	2017/18	2018/19	2019/20	2020/21
Transformation Fund	£0.66M	-	-	-
LHB	£1.1M	£2.2M	£2.75M	£2.75M
SG additional Allocation	-	?	√	√
GP Income	£0.2M	£0.4M	£0.8M	£1.1M
Lothian-wide investments	(£0.5M)	(£0.5M)	(£0.5M)	(£0.5M)
Total Income Available for flexible pool	**£1.46M**	**£2.1M**	**£3.05M**	**£3.35M**
Additional Capacity created in Consultations	150,000	200,000	225,000	250,000
Associated Cost	£1.5M (4.6%)	£2.1M (6.2%)	£2.4M (7.2%)	£2.7M (8.1%)
Balance available for investment in wider system	£0	£0M	£0.95M	£0.95M

19. In Year 1, the funding will come from the final year of the Scottish Government Transformation and Stability Funds (£0.66M) and the first year of NHS Lothian funding. (£1.14M)

20. Further funding available for direct application to core Primary Care is expected but not presumed. No recurring commitment is made in Year1 which does not come well within the total funding envelope (less GP contributions) available from the beginning of Year 2

21. Furthermore, individual practice investments and contracts will be able to be absorbed into wider service capacity if not continued.

22. If the approach is not able to achieve the impact sought across the system, the staff engaged will be readily deployed into other roles and the H&SCP will not be left with a workforce unable to be redeployed. Further protection is available where any 'unique' roles will be engaged on a fixed term or secondment basis, to protect both the individual and the H&SCP.

Involving people

23. This transformation plan has been discussed at various forums within the Partnership including GP cluster meetings, the Primary Care Joint Management group, and the GP Clinical lead meeting.

24. The plan has also been shared with Lothian Local Medical Committee.

Impact on plans of other parties

25. These investments are designed to stabilise General Practice and re establish a position where all city residents are able to register at a practice which is in their cluster. Where this cannot happen due to restricted lists the most vulnerable groups in society find it most difficult to access healthcare.

Background reading/references

Appendix 1, 'Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence'

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and social Care Partnership

Report author

Contact: David White, Strategic Lead: Primary Care and Public Health

E-mail: david.white@nhslothian.scot.nhs.uk | Tel: 0131 469 3935

Appendix I

Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence (Draft April 17)

Transforming the Primary Care Workforce in Edinburgh

1. Purpose

The Edinburgh Primary Care Strategic Plan identifies key work streams which will take us out of the current deteriorating circumstances for Primary Care & re-establish a stable & effective sector. This paper approaches the immediate workforce capacity element of the challenge, on the basis of what is required and not what funding may be available. The quality of available premises, interface with support services & the increasing availability and reach of ambulatory care models is presumed. The paper notes however, that the available funding is potentially reconcilable with the size of the challenge, depending on decisions made over Transformation funds and LHB Primary Care Investment available from 2017/18. The paper anticipates but does not include assumptions about further Primary Care Funding.

The approach describes the first steps to 'eating the workload elephant' as new resources become available. It describes how we can approach the workforce design required to regain equilibrium across the system. The approach is founded on the conviction that a responsive, flexible and innovative Primary Care sector will prevent unnecessary hospital referrals and admissions, reduce potential 'hand offs', and allow Primary Care to use its influence with the public where it is most effective; at practice level and in the consultation process.

The proposal is firmly in line with the national/GP aspiration to operate 'at the top of the licence', & brings in a flexible range of professionals to help Primary Care become much more of a multi-disciplinary activity. The approach builds on a successful record of collaboration and involvement with GPs at Practice and local level, rather than attempting to solve workload challenges with more remote investments. The innovation and pragmatism of Primary Care is therefore enshrined in the design process.

2. Recommendations

a. The Scottish Government Transformation Funds available in 2017/18 and the LHB investment should be combined into a single funding pot to create a flexible workforce. The Transformation Fund can be replaced in 2018/19 by a combination of additional LHB funding and income from 50% GP contributions to the additional workforce costs.

b. That the centrepiece of Primary Care workforce transformation is the development of a multi-professional flexible workforce for Edinburgh embedded in individual practices or potentially, by groups of practices & by Locality Clusters. This workforce will be initially developed to target

reducing reliance on GP medical sessions by shifting approximately 7% of the current medical consultation workload to a wider multi-disciplinary team over a three year period.

c. Individual practices (currently 7 & building to c30 in 2017) will benefit directly from a mixture of 'stability' & 'transformation' injections. These injections of workforce capacity will be funded 100% for 6 months and 50% by the practice if agreed as effective.

Practices not benefiting directly from these investments in the first two years will benefit indirectly from; less population / registration pressure – stable neighbours – improved access to available medical capacity. All practices will benefit from the establishment of Linkworker Network & Social Prescribing training for reception staff in particular. In addition, the Edinburgh Primary Care Support Team will benefit from a modest investment as we move from supporting a series of crisis situations, to a more preventative approach.

d. To recognise that a range of other key actions surrounding workload management need to be pursued to stabilise Primary Care. Key amongst these is a stronger dialogue with the public over appropriate use of public services and the development of our digital interface. Appendix 1 provides a dynamic summary of the key interventions currently proposed across the system to reduce the medical workload by more than 10% over a longer period.

e. This paper focuses on the replacement/augmentation of c7% of medical sessions across the City over 3-4 years. This additional capacity should be understood as c4.6% relief of current strain in the first year, a balance of relieving pressure & facilitating population growth in the second year & mainly facilitating population growth from year 3 onwards. 1

3. Background

- Since 2007, the City has added 50,000 new citizens to GP lists.

- Since 2007 no commensurate investment has been made in infrastructure or the Primary Care workforce directly associated with older people and mental health. The Primary Care workload has therefore increased in the same way & for the same reasons as in the rest of the UK, but with the additional burden of increased population.

- The City population is highly likely to maintain or increase the rate of growth over the next 20 years. In common with other public services, Primary Care must establish mechanisms to facilitate this growth.

- GMS & prescribing funding streams are linked to population & adjusted to reflect demand, but other Primary Care resources are left to Health Board determination.

- The supply of doctors into Primary Care until approximately 2010/11 was adequate to accommodate any practice based disruption, and certainly to allow practices to recruit new doctors and where appropriate, new partners.

- By 2014 this had changed radically. Jobs advertised in successful Partnerships were no longer attracting suitable applicants & practices began to struggle with filling gaps in cover on a temporary basis due to shortages in available Locums.

- As a result, once stable practices became vulnerable, as established partners absorbed more & more work and responsibility.

- From the standpoint of a newly qualified GP; the prospect of Partnership is currently quite unattractive, despite the universal enthusiasm for the work & the interest in the role of GPs.

- The situation with GPs is mirrored in District Nursing & Health Visiting, key foundations of Primary Care which could otherwise have been augmented & adapted to help with the medical shortages.

- Similarly, Practice Nurses are attracted to Advanced Nurse Practitioner roles, but this can leave difficult to fill vacancies in the Practice Nurse Teams. Supporting the training programme will put further (temporary) pressure on GP capacity during a critical period.

- In contrast, there is a welcome supply of highly trained pharmacists and increasing recognition of the stronger role able to be played by pharmacy across Primary Care.

- The potential for effective linking between the Third Sector and Primary Care has been recognised for many years. Until recently, a coherent framework did not exist to allow the Third Sector to impact at a scale where Primary Care recognised (& funded) capacity in the Third Sector in preference to expansion of more traditional approaches.

- The availability of CPNs is limited although not as severely as GPs/DNs/PNs, and there may be a useful role for a 'Mental Health Worker' which could release capacity by supporting a mixture of frequently consulting patients and those with 'lower level' mental health issues. In addition, there may be an opportunity to test the introduction of psychological interventions at a practice level, making rapid assessments and preventing patients becoming 'frequent flyers'.

4. Problem Definition

4.1 GP consultations are proposed as the currency and starting point for Primary Care Transformation. GPs in Edinburgh will undertake c3, 250,000 consultations during 2017, or 6 visits per citizen per year to their local practice. The supply of doctors & medical sessions into the system is difficult to assess and & predict with confidence, but we are cautiously optimistic that the current compliment of medical sessions available to Edinburgh will remain constant, albeit with fewer GP Principles & more salaried doctors. The yield of clinical sessions per doctor is also declining & this needs to be carefully accounted for.

4.2 The growing imbalance between demand and supply of medical capacity is therefore a result of the additional population & lack of investment (beyond GMS & prescribing) together with aging population, patient expectations etc. It is important that we try to 'size' the gap & define a starting point, alongside the intended impact of our future actions.

4.3 An average demand population (i.e. not particularly deprived nor aged) of 5000 requires an additional 25 medical sessions & 10 Practice Nurse Sessions per week under a traditional approach, or 30 medical sessions & 12 Practice Nurse sessions when leave is factored in. The requirements of a young population, a highly deprived population or an affluent elderly population will be substantially different. There is a backlog of several years of this capacity being missing and the Edinburgh capacity gap can be guaranteed to increase at the equivalent of 30 medical sessions & associated nurse sessions per year.

4.4 At the beginning of 2017, we therefore propose that the problem is quantified as 4 years of 'backlog' together with this year's challenge;

6 consultations per patient per year x5years x 5,000 patients =150,000 consultations

150,000 consultations of capacity is immediately required in 2017/18 to begin to stabilise the system.

This addresses the 'core' Primary Care Team only, and not the shortfall in wider investment across the Health & Social Care system.

4.5 The immediate Edinburgh challenge in 2017 is therefore to create a workforce which will take approximately 150, 000 consultations out of the current GP workload & continue to do so at a rate of c30, 000 consultations per year for the next 5-10years. If the assumption about medical sessions available to the population proves to be optimistic due to an increased rate of Principle retirement, this target will need to be increased.

4.6 Various studies have indicated that it should be possible to reassign around 25% of the current GP workload. The initial proposed 2017 target of 150,000 redirected appointments represents an initial 4.6% shift & the equivalent workload of c20 full time GPs.

5. Solutions

So how do we grow the capacity to replace 150,000 GP appointments in 2017?

There are 2 broad approaches to this;

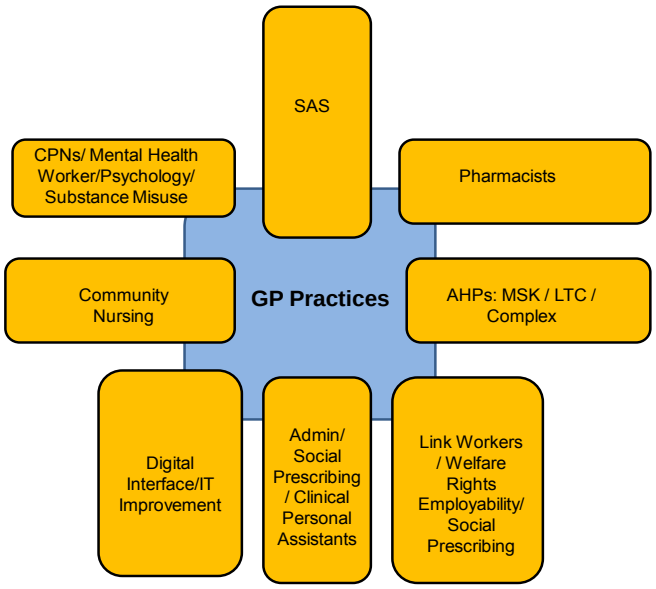
5.1 Firstly, we need to do everything possible to maintain the rate at which GPs, District Nurses & Practices Nurses (& ANPs) are brought into & retained by the system, i.e. 'Recruitment & Retention'. Some of the basic building blocks have already been put into place across Lothian; payment of Golden Hellos in certain practices, Maternity & Paternity leave payments have now been brought into line with other parts of Scotland. Nationally, the Returner & Retainer schemes have been enhanced and a Lothian training course for Practice Nurses has been established.

In addition, other measures have recently been taken to attract doctors; i.e. presence at national recruitment events and the Lothian 'Wisedocs' initiative to retain some sessional commitment from Partners who would otherwise retire. Some practices have been slow to adjust working patterns which are 'family friendly' and this could have an important marginal effect on capacity.

It should be acknowledged that recruitment within Edinburgh will impact on Primary Care stability around Scotland. There is an argument therefore, not to attempt to approach this as a single City.

5.2 Secondly, we have the opportunity to grow a Primary Care Workforce which replaces or augments the requirement for medical sessions per head of population. Diagram 1 (below) illustrates the concept of a growing & flexible workforce which practices can adapt to their own needs, whilst not taking on associated management responsibilities, nor the full financial burden. These staff have traditionally sat out with practice teams, whereas this new workforce will be firmly embedded within practices.

Workforce Fit For Purpose: Developing Primary Care Capacity



5.3 Table 1 (below) gives a subjective impression of which elements of the wider Primary Care Team may be available to help over the next 5 years. 'Sessional yield' is the number of medical sessions which investment in a full time post should be able to reduce per week, e.g. a full time pharmacist should be able to replace 4 medical sessions per week (depending on population type & practice size). To add a further level of understanding, it is likely that a full time experienced pharmacist would release 5 rather than 4 clinical sessions, but a fifth medical session would need to be reinvested to cover supervision, complex patients requiring joint assessment & liaison.

Table 1: Availability of Additional Primary Care Capacity

	2017	2018	2019	2020	2021	2022	Sessional Yield *
GPs	x	x	x	x	x	x	-
Pharmacists	√√	√√	√	√	√	√	4
Practice Nurses	√	√	√	√	√	√	4
Advanced PN	x	x	√	√	√	√	6
District Nurses	x	x	x	√	√	√	?
AHPs e.g. Advanced Scope Physio	√	√	√	√	√	√	4
Mental Health Workers	√	√		√	√	√	2
CPNs	√?	√?	√?	√?	√?	√?	5
Linkworker	√√	√√	√√	√√	√√	√√	2
Paramedics	√?	√?	√?	√?	√?	√?	?

* - Medical sessions released per 1 wte investment

5.4 It is important to note that the list in Table 1 is not designed to be either prescriptive or restrictive. Different professions and professional roles can offer different kinds of capacity, depending on list size, demography and existing investments. If a practice wishes to test a new role the same expectation should apply; if agreed, we will give 6 months of funding & then expect 50% contribution thereafter.

5.5 Table 2 (below) illustrates an example of how c30 medical sessions (required for each year if additional population increase) might be configured as a' supplementary workforce to augment practice capacity across the City for one year and then for 5 years.

Table 2 One Year / Five Years Additional Capacity - City Wide

Year 1		**Sessional Yield**	**Cost**
2.0 wte	Pharmacist x2	8	£90k
1.0 wte	PNx1	4	£45k
1.0 wte	APP (MKS)x1	4	£45k
2.0 wte	CPN x 2	10	£90k
1.0wte	Linkworker	2	£35k
Total		28	**£305k**
Year 5			
8.0 4.0 4.0 8.0 4.0 8.0	Pharmacist Advanced N PR AHP CPN MMW Linkworker	32 20 16 40 8 16	£360k £180 £180 £360 £140 £280
Total		**132**	**£1.5M**

5.6 Different configurations cost slightly differing amounts, but this example gives us a useful supplementary workforce investment figure of c£300k per annum to cover the workload of 5000 patients, once we have reached a stable state. This of course, is in addition to the increased GMS – some of which will be subsequently reinvested to fund this workforce. It also establishes an initial cost of £1.5M to provide the immediate capacity injection required to begin to stabilise Primary Care in Edinburgh.

5.7 It should be emphasised that we foresee the increasing application of technology in helping to manage the workload. This will form part of the 'offer' to practices wishing to access transformational/skill-mix support. We anticipate this element of workload management will feature more strongly for 2018/19. During 2017/18 we will divert some 'slippage' funding to testing further how digital investment could increase productivity. Surgical pods & patient appointment text messaging systems are two examples where we could look to fund 50% of the purchase cost of equipment.

5.8 Appendix1 shows the wider picture and the potential of making a longer term shift in GP workload by application of a range of interventions beyond skill-mix. It is recognised that a flexible practice aligned Primary Care workforce cannot provide this shift in isolation. We need to make progress on the behavioural change/public influence dimension as quickly as possible, to prevent further erosion of the required capacity & stabilise existing practices. It remains to be established whether 20% of GP workload can redirected to other PHCT members, but we are confident that 10% is realistic target over the next 5 years.

5.9 Over time, this transformational workforce could be used to form a bridge between Primary and Secondary care, potentially creating posts which have shared responsibility. At year three, in the outline funding table (table 4), the potential for this flexibility begins to appear. It should be noted that GP Practices cannot be expected to contribute 50% to any investments which do not have a direct impact on their practice workload.

6. Implementation & Management Support

6.1 A practice interested in accessing workforce capacity support would approach the Primary Care Support Team for advice. The team would assess the practice population (and if possible workload) & make a skill-mix proposal based on the practice's demand profile.

6.2 Depending on Practice wishes & assessment a 'stability injection' or 'transformation' proposal would be made. A stability injection would typically be where funding support was sought for a single discipline individual to join the team e.g. ANP / CPN / Pharmacist Both approaches may include the funding of 'headspace' for a session to allow the practice to consider its best options for balancing demand & capacity.

6.3 An example of a 'transformation' proposals provided in Table 3 below. This example is of an average demand practice of 8000 patients using 40 medical sessions per week, requesting support for the replacement of a 5 session partner or a salaried GP.

Table 3 Illustration of Practice Level Investment

Proposed Investment		Sessional Yield (i.e. medical replacement)	Full Cost	Practice Cost i.e. 50% after 6 months
6 sessions	Pharmacist	2	27k	13.5k
5 sessions	CPN	2	22.5k	11k
5 sessions	Linkworker	1	17k	8.5k
Total		5	66.5k	33k

6.4 In short, the proposal is that through the introduction of these three people, the Practice would be able to reduce the GP consultation workload by 5 medical sessions per week. Following local discussion & agreement, a 'Service Level Agreement' (SLA) would be drawn up which would give the Practice full funding for a 6 months 'bedding in' period. A review would take place after 3 months to gauge whether there was confidence in the arrangements working as planned. If agreed, the team would be confirmed and the Practice would start to pay 50% of the direct costs of the posts. The Practice would have the option to set aside elements of the team and retain others before moving to the 50% payment phase.

Note, it may be that only 3 (not 6) months of funding is given for an Advanced Nurse Practitioner where the implementation phase should be much shorter.

6.5 This proposal is designed to ensure close engagement of the Practice in the development of the additional capacity posts as part of their team. Only those Practices who need the additional capacity, & are able & willing to support the development process will be attracted to apply in the first couple of years.

6.6 Once the investment is made, the management of the additional capacity will be through professional management lines, but with oversight of the use of the resource by the Local Integration Cluster. The intention is that each investment will be discrete to a cluster area i.e. a Linkworker who works 3 sessions per week in three different Practices would work for Practices in the same cluster. The Practices, CQL & Cluster Manager would therefore have an overview of how effectively their additional workforce was developing and to ensure learning was quickly shared amongst the Cluster practices.

6.7 The Primary Care Support Team would prioritise competing investment proposals where necessary, with due consideration for the need to balance supports, innovation, ensuring

stability & geographical equity. Appendix II describes a set of criteria against which these decisions can be made.

6.8 All staff would be employed by the EH&SCP (with exceptions as agreed) which would retain lead responsibility for formal management responsibilities using established professional lines. The Practice Manager (or lead GP within the Practice) would have responsibilities for work allocation & development of the role with the clinical team.

6.9 When a staff member leaves there is potential for the funding to be reallocated, or for the arrangement to continue. The SLA (Service Level Agreement) between the EH&SCP & Practice will define responsibilities & expectations, i.e. training, absence management etc.

6.10 This is an important opportunity for the new Quality & Integration Clusters network to play a vital role in empowering & supporting the transformation process. If replacing medical sessions in Primary Care, were either less costly or easy, Practices would have done this already. Although there are encouraging early signs, this will be a delicate and testing process of trial and error and a supportive culture is essential.

7. Funding

7.1 Availability of funding is currently limited to a combination of Transformation Fund & LHB allocation in 2017/18 & LHB funding, as set out in Table 4.

Table 4	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Transformation Fund	£0.66M	-	-	-
LHB	£1.1M	£2.2M	£2.75M	£2.75M
SG additional Allocation	-	?	√	√
GP Income	£0.2M	£0.4M	£0.8M	£1.1M
Lothian-wide investments	(£0.5M)	(£0.5M)	(£0.5M)	(£0.5M)
Total Income Available for flexible pool	**£1.46M**	**£2.1M**	**£3.05M**	**£3.35M**
Additional Capacity created in Consultations	150,000	200,000	225,000	250,000
Associated Cost	£1.5M (4.6%)	£2.1M (6.2%)	£2.4M (7.2%)	£2.7M (8.1%)
Balance available for investment in wider system	£0	£0M	£0.95M	£0.95M

7.2 Table 4 shows our best current understanding of the available funding streams. 'Lothian wide investments' shows the presumed contribution of these funds & investments already agreed by all IJBs; phlebotomy, practice nurse training and others to be confirmed. In addition, there is no quantification of the additional funding anticipated from Scottish Government from mid 2018/19 (£500M nationally). It may be that this investment comes ear-marked, rather than an element being subject to local discretion.

7.3 As can be extrapolated from the example in section 5, an additional (to GMS / prescribing) annual investment of £300K is required to replace the equivalent of c30 medical sessions per week for 5000 additional patients each year. As the proposed arrangements mature, it would be expected that 50% of this would be recovered from Practices. The reality is that a modest proportion of the investment will be returned in 2017/18, building to 40% in 2018/19. The principle reasons for this are that some of these investments may 'fail' i.e. GPs do not wish to proceed after 3 months, and some practices will need to be compensated (or not charged) during periods where the agreed service cannot be delivered according to the SLA e.g. absence beyond agreed parameters.

7.4 Table 4 illustrates that after the first two years, the model would start to produce a surplus for investment in the wider system. This is based on the assumption that an initial capacity injection of £1.5M or 4.6% in 2017/18 followed by 2% increase in 2018/19 would be adequate to stabilise the system. This can be accelerated by c1% through additional tranches of £300k being made available as confidence & understanding of workforce augmentation grows with experience.

7.5 At the individual practice level, concern has been expressed over the sustainability of the funding over a longer period. If a practice commits to 50% will they then find that the contribution level is increased to the point where the investment becomes a financial burden? The undertaking is that if the individual leaves their post within the first two years & the practice is willing to continue, then another appointment will be made on the same terms (but not 6 months free).

7.6 This proposal is being developed in line with our understanding of the **likely** shape of the new GP contract. It may be that significant adaptation is required as this becomes more visible later this year.

8. Starting Point

8.1 The proposal to grow a supplementary Primary Care Workforce has already begun, albeit in a fragmented way to date, using resources from the Scottish Government Transformation Fund in 2016/17.

Table 5 (below) shows where we are as at January 2017.

	WTE	Recharge dates (tbc)	Practices	Funding	Potential GP Recharge
GPs					
Pharmacists	94 sessions	? 1.10.17	Wide variety	£423/141k	£70K
AHPs	1.2	01.04.17	B'loch	£60k	£30K
Nurses	1.0		Links	£45k	£27.5K
CPNs	2.0		Mill L./B'loch	£90k	£45K
Linkworkers	6.0	? 01.10.17	Sighthill/ Wester Hailes/Slateford/ Crewe / Muirhouse	£140k	£70K
Nursing Home	2.0	-	Crewe	£30k	-
SAS	??		Crammond B'loch		
Total	104.2				£307.5K

8.2 Table 5 shows the current investments and where we could expect Practices to provide a 50% contribution after an agreed date. The position with pharmacists is that each of the 94 pharmacist sessions may be deployed in practices for a number of reasons; cost reduction, workload augmentation & professional development. GPs will only consider reimbursing 50% where they are confident the session is effectively augmenting their workload. The £423k invested is therefore only potentially partially rechargeable (estimated £141k of which 50% is £70K).

9. Next Steps

This City proposal is building on our experience in supporting practices who have found themselves in difficulty by using this as an opportunity to stabilise & then transform.
We will identify practices & clusters where stabilisation & transformation offers most.

The phases envisaged are;

- March/April - Consultations & draft development
- April - proposal formulated/discussion at LPCMG, PCIB & LMC
- 4th May Primary Care Summit

- Edinburgh Management Team 11th May or 8th June
- 16th June IJB

10. Evaluation

10.1 Appendix 1 sets out the overall evaluation framework. The investments need to establish proven effectiveness to enable confidence in wider application, beyond solutions which work only a in the context of a particular practice team.

10.2 Part of the investment in City wide structures is to ensure there is dedicated support to the group of 'Stabilisation' and 'Transformation' practices to make these changes. This will help us to understand the sessional yield, timescales & relationships with the five different 'demand profiles' which describe almost all city practices. Much of the work involved will initially focus on changing processes & relationships to reduce medical & practice nursing consultations per patient. It is recognised that one of the shifts which may be quickly delivered is creating capacity amongst Practice Nurses to allow more medical consultations to be moved to them.

Edinburgh Clinical Leads; Dr Ian McKay (City)
Dr Robin Balfour (NW)
Dr Carl Bickler (SE)
Dr Mike Ryan (NE)
Dr James Cowan (SW)

David White (Strategic Lead)
Eileen McGuire (Primary Care Manager)

Appendix I:

Edinburgh GP Consultations: 3,250,000 PA – Target 10% shift (or reduction) of 325,000 over 5 years (not adjusted for anticipated population growth)

1. Direct	Workload Reduction	Potential Consultation Reduction	Status	Resource required	Training required	£K	Lead	Anticipated first impact
Intervention Description								
Eye referrals to Optometrists	1%	C32,500	pilot in NW	Capacity exists	Receptionists	£4K	AMCN	2016
NHS 24 Call handling	0%	0		none			EMcG	.
Pharmacy	7%	227,500					SMcB	
- Deflection of presentations to community pharmacy	2%	65,000	Increasingly routine		receptionists		SMcB	2016
-Consultations in practice deflected to practice pharmacist	2%	65,000			GPs		SMcB	2016
-Consultations offered as alternate by independent prescribers	2%	65,000			GPs		SMcB	2016
-Bundle of PGDs	1%	32,500	pilot	test of change underway with cystitis	receptionists		SMcB	
District nursing/home visits H @ H	1%	32,500			district nursing/care home staff		MW	
Advanced nurse practitioners	5%	162,500	training programme established	In place			PMcI	2016
Physio/MSK	2%	65,000			GPs/receptionists		RB/EB	
Link Workers & Social Prescribing	5%	162,500	report commissioned to describe roll out. Several pilots up and running	50WTE approx 25% existing, 50% SG investment & 25% GP investment	3 month training & induction	£2M	AC/DW	Pilots established
Population Education/Additional Carer Support	1%	32,500					MB	
Digital Interface Development	1%	32,500	Minor developments supported as part of Transformation					
Mental Health Consultation	5%	162,500	CPNs in 2 practices	32.0WTE		£1.5M	MR/EMcG	Pilots Established
TOTALS	28%	910,000						
2. Indirect	Minutes per day gained							
IT System Upgrade	30mins per GP							in 2nd year of 3 year programme

Appendix II

	Performer Locum	Performer Provider	Performer Retainer	Performer Salaried (Board)	Performer Salaried (Practice)	Total (2)	Clinical Sessions per week per post	Yield of Clinical Sessions (3)	Clinical Sessions required by Population (4)	Weekly Sesssional Capacity gap	Capacity Gap in annual consults (000)
2012	15	316	31	23	57	443	6.5	2304	2600	296	222
2013	18	313	32	20	64	448	6.4	2294	2625	331	248
2014	14	315	26	22	66	444	6.3	2238	2650	412	309
2015	13	308	25	26	86	460	6.2	2282	2675	393	294
2016	16	310	22	34	93	476	6.1	2323	2700	377	283
?2020 ?	16	305	12	48	120	501	5.6	2244	2800	556	-

1. Average sessional commitment unknown but declining. (Estimated from 6.4 in 2013 – ISD Lothian Survey figures)
2. Availability of doctors
3. Total drs X est'd clinical sessions per post x 0.8 for AL/sick/study
4. Population list size / 200 as working assumption of actual clinical session requirement per week per patient.
5. Sessional capacity gap expressed as consultations ie gap times 15 per session x 50 weeks per year

Appendix III:

Criteria

1. Practice unable to recruit doctors & session / population ratio out of line with demand profile peers.

2. Practice willing to share information on available resources / workload assessment and replace up to 10% of medical sessions.

3. Practice in area of population build-up & willing to keep list unrestricted.

4. Practice has long term future in serving their population.

5. Practice willing to have investment ratified by Cluster & progress / effectiveness scrutinised.

6. Ensuring there is a level of investment in each cluster area to promote approach.

Appendix IV

Edinburgh Transformation Stability Funds (2017-18)										
	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Transformation Funding	£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000	£4,000	£4,000
Stability Funding	£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000	£2,000
Stability Funding	£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000	£2,000
Transformation Funding		£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000	£4,000
Stability Funding		£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000
Stability Funding		£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000
Transformation Funding			£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000
Stability Funding			£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000
Stability Funding			£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000
Transformation Funding				£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000
Stability Funding				£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000
Stability Funding				£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000
Transformation Funding					£8,000	£8,000	£8,000	£8,000	£8,000	£8,000
Stability Funding					£4,000	£4,000	£4,000	£4,000	£4,000	£4,000
Stability Funding					£4,000	£4,000	£4,000	£4,000	£4,000	£4,000
Transformation Funding						£8,000	£8,000	£8,000	£8,000	£8,000
Stability Funding						£4,000	£4,000	£4,000	£4,000	£4,000
Stability Funding						£4,000	£4,000	£4,000	£4,000	£4,000
Transformation Funding							£8,000	£8,000	£8,000	£8,000
Stability Funding							£4,000	£4,000	£4,000	£4,000
Stability Funding							£4,000	£4,000	£4,000	£4,000
Transformation Funding								£8,000	£8,000	£8,000
Stability Funding								£4,000	£4,000	£4,000
Stability Funding								£4,000	£4,000	£4,000
Transformation Funding									£8,000	£8,000
Stability Funding									£4,000	£4,000
Stability Funding									£4,000	£4,000
Transformation Funding										£8,000
Stability Funding										£4,000
Stability Funding										£4,000
Monthly Spend	£16,000	£32,000	£48,000	£64,000	£80,000	£96,000	£104,000	£112,000	£120,000	£128,000
Cumulative Spend		£48,000	£96,000	£160,000	£240,000	£336,000	£440,000	£552,000	£672,000	£800,000
Note; FYE of 10 Transformation /20 stability practices after 6 month trial period; £960K										

Report

Item 5.5 - Expansion of the Acute Medical Unit at the Royal Infirmary of Edinburgh
Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. This paper provides an update on work between Integration Joint Boards (IJBs) and NHS Lothian's acute services on the future shape and function of the medical assessment function of the Royal Infirmary of Edinburgh.

Recommendations

2. It is recommended that the board:

- notes that NHS Lothian has approved capital funding to support the expansion of the acute medical unit (AMU) at the Royal Infirmary of Edinburgh; and
- agrees the directions detailed in section 23 of this report to use additional capacity over winter 2017/18 and working with officers of NHS Lothian to develop a sustainable model of care beyond this.

Background

3. Edinburgh IJB's vision, as articulated in the strategic plan, is for people to live longer, healthier lives in homely settings with a focus on the prevention of hospital admissions and supported self-management. This requires easily accessible alternatives to admission for the frail elderly. Appropriate hospital discharge should be without delay and minimise risk of readmission.

4. The Lothian Hospitals Plan sets out strategic headlines for each of the acute hospital sites. This plan was approved by the NHS Lothian Board in December 2016.

5. Work with the four Lothian IJBs on acute set aside services, including the broad range of unscheduled care services, is therefore now operating within the context of the Hospitals Plan and IJB strategic plans as expressed in IJB Directions to NHS Lothian.

6. The final piece of context is the Health and Social Care Delivery Plan, published in December 2016, which sees a clear expectation that IJBs

will “start to maximise their powers” with regard to unscheduled care. Consequently, the Scottish Government’s six key measures for IJB performance in 2017/18 are focussed on improved unscheduled care performance.

Main report

Increasing demands

7. The strategic headline for the Royal Infirmary of Edinburgh (RIE) is that it will act as South East Scotland’s emergency care centre, incorporating a major trauma centre, inpatient orthopaedics, neurosciences, and tertiary children’s services.

8. This, in turn, means that the RIE is the key engine for delivering on the 4-hour standard for unscheduled care, seeing between 350 and 400 unscheduled attendances a day. This volume makes the RIE the largest unscheduled care centre in Scotland and one of the biggest in Britain. The standard is that 95% of patients should be seen, treated, and either admitted or discharged, within 4 hours of first arrival.

9. The following crucial pieces of intelligence are contained either within the IJB’s joint strategic needs assessment and/or intelligence within NHS Lothian’s acute services;

- Significant population growth across the city up to 2036, with an additional 78,634 (15.5%) residents;
- A 68% increase in the number of citizens aged 75 or above between 2016 and 2036;
- A 25% increase in the number of households within the City of Edinburgh by 2036;
- An 8% increase in overall RIE Emergency Department attendances between 2013/14 and 2016/17; and
- That the current model of care leads to 29.1% of attendances to the emergency department being admitted.

10. Whilst an emergency admission to hospital has significant positive impacts, it can also lead to negative impacts too. The IJB’s strategic plan is focussed on preventing admission wherever possible, and the Health and Social Care Delivery Plan outlines a target for IJBs of a 10% reduction in unscheduled care bed-days by 2018. This would be delivered by: preventing admission; reducing length of stay; and eliminating delayed discharges.

11. Increased attendances will result in increased admissions, assuming no change in the current conversion rate of 29.1% unscheduled care

attendances being admitted. Taking this into consideration it is recognised that the existing acute medical unit (AMU) does not meet the capacity demands now required of the unit, the primary function of which is to rapidly assess and treat patients, with aim of reducing the number of admissions into the ward arc.

The medical assessment function

12. The medical assessment function of any hospital is intended to act as a filter for medical admissions, ensuring that acutely unwell patients are assessed and treated promptly and appropriately, and then moved to the most appropriate setting for further care. The best medical assessment services focus on preventing and finding alternatives to admission.

13. There is increasing evidence that, if this function is not appropriately designed and adequately resourced, patients can be moved on to these other care settings too rapidly. This may mean that patients are "boarded" to the wrong areas of the hospital, with the negative consequences this can have. In the case of frail elderly patients in particular, a long hospital stay can lead to a reduction in independence and confidence, which in turn can lead to longer stays and a greater reliance on external help (from families and/or the health and social care sectors) than might be otherwise indicated.

14. The RIE medical assessment function recognises these important elements and so has this focus on avoiding admission. This has included the development of the primary assessment area (PAA), where patients who can be "turned around" and be offered urgent outpatient appointments are intended to be cared for. This in turn reduces the number of admissions and consequently the risk of patients being boarded or experiencing the other less desirable consequences of admission. Due, however, to the growth in demand at RIE, this area is increasingly frequently "bedded" and unable to deliver the crucial role it was designed to deliver.

15. It is important to keep the difference between "front door" medical assessment functions and "back door" inpatient beds to the forefront of this discussion, as they are designed to deliver very different outcomes. "Front door" capacity, whether outpatient or inpatient, is intended to minimise length of stay and redirect care to more appropriate settings.

16. Significant modelling work has been undertaken by the RIE team to look at what capacity would be required to meet the various aims of the medical assessment function. This work suggests that unless other changes are made to the model of unscheduled care RIE medical assessment front door capacity (AMU) would require to increase by 24 beds by the early 2020s to provide the assessment footprint required,

allowing for more capacity in the front door, with an expected consequent reduction in boarding and “back door” length of stay.

Aligning IJB and NHSL plans

17. The business case provided at Appendix 1 has been in development for some time, and predates the advent of IJBs and the development of the Lothian hospitals plan.

18. During the gestation of the business case there have been productive and helpful discussions between NHSL’s acute services and IJB Chief Officers about how plans should be aligned. To support this, analysis was undertaken which outlined the level of activity which would need to be diverted to avoid further investment in “front door” medical assessment functions. This work has differing implications for each of the four Lothian IJBs. In the case of Edinburgh it evidenced that either plans were required to prevent between 12 and 14 admissions each day or an expansion of the AMU would be required.

19. Whilst each of the four IJBs has differing requirements driven by intended models of care, the Chief Officers are sensitive to the challenges of front door services. As such, they are therefore supportive of the general principle of using NHSL capital to expand capacity, however it is only EIJB who envisage requiring the additional capacity. Discussions between the Chief Officer and NHS Lothian have resulted in the pragmatic view that the IJB is not yet in a place to avoid the level of admissions which would be required. As a result, the additional capacity outlined within the business case would be utilised by Edinburgh IJB for, at least, winter 2017/18. In parallel, the Chief Officer will work with NHS Lothian to develop ambulatory care and alternatives to admission, with a view to informing future capacity requirements.

20. Finally, all involved in discussions have noted that the only acute medical “winter capacity” within the city is ward 15 at the Western General Hospital (WGH). This accommodation is within one of the older buildings on the WGH site which is increasingly not fit for purpose, both physically but also in terms of being “back door” beds, which are not designed to help deliver on the strategic aims of either IJBs or NHS Lothian. There is, therefore, the further possibility that in line with IJB strategic plans and the Lothian Hospitals Plan, ward 15 would no longer be used to provide winter capacity. This in turn would free up the funding previously used for ward 15 to support the AMU expansion, albeit on an interim basis.

The Business Case

21. The business case forms part of a 2014 Initial Agreement which proposed an interim solution of additional investment on the RIE to assist in improving 4 hour compliance: acute medical unit expansion; discharge lounge; two separate areas of investment within the emergency department (ED); and renal medicine ambulatory care model. The case puts in place eight additional front door assessment spaces and frees up the planned assessment area for development in conjunction with IJBs.

22. Recognising the directions issues formally by the East Lothian and Mid Lothian IJBs and that the Edinburgh IJB had not yet formally debated the proposal, the NHS Lothian Finance and Resources Committee approved the business case at its meeting of 10 May 2017.

Directions

23. It is recommended that the IJB direct NHS Lothian as follows:

- Expand the RIE AMU as suggested above. This would be funded on an interim basis from winter monies;
- NHS Lothian acute services to work with Edinburgh H&SCP to work together to explore the feasibility and benefits of developing a locality based admission policy for frail elderly patients, to improve performance and quality of care;
- Explore the feasibility and benefits of a locality-based admission policy for all medical receiving patients;
- NHS Lothian to provide a case outlining the long term sustainability of the current medical receiving model within the city;
- Undertake a review of all the different models including the development of an ambulatory care model in the RIE; and
- Review the services financed through unscheduled care funds and report back to the IJB.

Key risks

24. The main risks associated with the programme are:

- failure to progress could lead to increased revenue costs associated with boarding and elongated lengths of stay;
- a failure to meet the 4 hour unscheduled care standard and targets laid out in the Health and Social Care Delivery Plan;

- that actual demographic changes differ from those projected and that activity projections could be higher or lower than modelled; and
- issues with planning consent and/or reaching agreement with Consort may impact on proposed timescales.

Financial implications

25. The resource implications are summarised in the table below:

Area of Investment	Whole Time Equivalent (WTE)	Cost £k
Revenue costs:		
Pay	19.66	768
Non pay		195
Total revenue	**19.66**	**963**
Projected capital expenditure		**1,200**

26. As noted in above, there is the potential for this resource to be phased funded from winter capacity allocations. The pan Lothian budget for winter amounts to £2.6m, and the pro-rated costs of the AMU expansion for 2017/18 would be £0.25m.

Involving people

27. As above.

Impact on plans of other parties

28. As above.

Background reading/references

29. None.

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Contact: Moira Pringle, Interim Chief Finance Officer

E-mail: moira.pringle@nhslothian.scot.nhs.uk Tel: 0131469 3867

Appendix 1

NHS LOTHIAN STANDARD

BUSINESS CASE

ACUTE MEDICAL UNIT EXPANSION
ROYAL INFIRMARY OF EDINBURGH

2017 v.19

May 2017

CONTENTS

1. EXECUTIVE SUMMARY

1.1.1 Currently, NHS Lothian is not meeting the 4 hour Emergency Care Standard of 95%, consistently. All Health Boards are expected to work towards 98% which the Royal Infirmary of Edinburgh (RIE) will struggle to accomplish in the current bed model.

The target, measures how well the whole health and social care system is performing and requires the engagement, of all partners involved in the delivery of emergency care, and impacts on all specialties across the system.

Other key deliverables which are attributed to this target are to improve reliability, safety, outcomes of care and the patient and carer experience. It is also well recognised that long emergency waits increase the propensity to admit patients, and are also linked to increased mortality rates.

1.1.2 The RIE is the largest of the 4 acute sites and sees circa 46 - 52% of all unscheduled care activity with the main reason for patients breaching being due to "Wait for Bed". This has been a consistent theme since the Emergency Care Standard was introduced.

Patients who are admitted on an unscheduled pathway for medical specialties, will be admitted to the Acute Medical Unit (AMU). This functions as a short stay area before patients are discharged or transferred elsewhere in the RIE, or other sites for specialist care.

1.1.3 Demand in AMU far exceeds the capacity available and NHSL commissioned a bed modelling service from Capita in 2012. A key finding was that the "front door" capacity is 'too small to prevent boarding and delays for either the current clinical model or for the model preferred by clinicians'.

1.1.4 Boarding is a recognised symptom of high levels of occupancy and the problems associated with this practice are:

- Poor patient experience
- Inefficient care- ward rounds take far longer
- Poor communication with clinical teams due to unpredictable timing of ward rounds, lack of familiarity of clinical teams and poorer links with social care
- Increased risk of loss of notes
- Late discharge letters
- Increased length of stay
- Potential for reduced patient safety
- Increased risk of Hospital Acquired Infection (HAI)
- Increase risk of delirium

The Scottish Government also recognised the negative impact of boarding and advised in 2009 "…to work towards eliminating the boarding of patients as a solution to bed occupancy problems. Specifically, the boarding of patients from the Admissions Unit and/ or Emergency Department should never occur".

1.1.5 Another key strategic theme which NHSL requires to work towards is reshaping its services to support the 2020 vision, of more people living at home. This includes reducing the numbers of hospital admissions and discharging patients as soon as possible to allow their ongoing care requirements to continue in the community. At present the current boarding

on the RIE site detracts away from the site fulfilling this requirement, due to the issues highlighted in 1.1.4.

1.1.6 The NHS Lothian strategic plan and the strategic plans of the Lothian Integrated joint Boards (IJBs) have signalled the closure of Liberton Hospital in summer 2017. Both Midlothian and East Lothian H&SC Partnerships have presented plans for reproviding services for those patients in Liberton Hospital and all IJBs have indicated the management of delayed discharges as a high priority. However there will need to be reprovision for those who need hospital settings particularly those from Edinburgh. An expansion of AMU will support the reprovision for these patients.

1.1.7 This business case sets out the requirements for additional investment of both capital and revenue funding to support the expansion of AMU, to assist in contributing to further improvement of the Emergency Care standard, augmenting frailty at the front door, reduce boarding and with the longer term goal of eliminating boarding from AMU and improve the patient experience.

1.1.8 AMU is under intense pressure on a daily basis to create sufficient capacity to meet the capacity demands placed on it from ED. This has resulted in excessive boarding throughout the site, adversely impacting on other services being able to deliver effective care, and resulting in the deferral of electives and the creation of high occupancy levels.

1.1.89 This Standard Business Case (SBC), forms part of the original Buisness Case (BC) for the expansion of AMU, which was to provide in total an additional 21 beds and 2 additional trolley spaces over 9 phases. This SBC sets out Phase 1 of the programme and would deliver 8 additional beds within AMU. It also details the service changes, associated efficiencies, productivity gains that will be achieved by increasing capacity and improving the service.

Of note a further Business Case will be compiled for further expansion of additional beds, once a review and a agreement has been reached for the best fit for both the Department and Site.

1.1.9 The required investment consists of:

- Capital – Construction and Equipment.
- Revenue – Predominantly staffing, but also maintenance and depreciation.

2 THE STRATEGIC CASE

This chapter;
- Sets out the national and local context for the project.
- Describes the scope of the project.
- Describes the objectives and benefits of the project.
- Highlights the constraints and dependencies.

2.1. Strategic Context

2.1.1 National Strategy

In summer 2015, the Scottish Government announced a renewed focus on the 4 hour Emergency care Standard. In recognition that performance against the 98% target had fallen, the government re-introduced a HEAT target of 4 hours for 95% of patients with an expectation that Health Boards would work towards 98%.

In addition the 2020 vision supports more people living longer healthier lives in a homely setting through integration of health and social care with focus on the prevention of hospital admissions and supported self-management. There should be easily accessible alternatives to admission for the frail elderly. Appropriate hospital discharge should be without delay and minimise risk of readmission.

The strategic objectives proposed in this business case have been aligned with the four IJB's strategic plans and directions and in particular "whole systems capacity plans" and "locality workings".

The strategic objectives proposed in this SBC are:
- To implement patient pathways that work towards improving the 4 hour Emergency Care Standard.
- Provide high quality and efficient patient care, thus improving the patient experience
- Support the Scottish Government requirement to "eliminate boarding of patients as a solution to bed capacity problems. Specifically the boarding of patients from the Admissions Unit and/or Emergency Department should never occur."[1]
- Discharging patients as soon as possible to assess their ongoing needs at home, instead of retaining in hospital beyond their acute episode
- Rehabilitating patients in their home, rather than undertaking this in the hospital setting
- Ensure that the clinical accommodation is accessible and is located in proximity to support services.

2.2. Organisational Overview

2.2.1 NHS Lothian Strategy

In April 2014, NHS Lothian Board approved a draft Strategic Plan "Our Health, Our Care, Our Future", which was subsequently issued for public consultation. A subsequent plan has been developed to allow both IJBs with NHSL to work towards 2020 Vision. It is recognised that this is a significant challenge to the

[1] *Dr Woods letter/Dr Becketts report* http://www.shiftingthebalance.scot.nhs.uk/initiatives/sbc-initiatives/emergency-access-delivery-programme/winter-planning/

organisation in delivering this at a period in time, of significant financial challenges.

Areas of focus include:

- Identifying the right configuration for acute services to meet performance targets including 4 hour emergency access, treatment time guarantees and reduction in delayed discharges
- Sustainable shift of balance of care with full health and social care integration with joint responsibility to achieve these standards.
- Phasing out the provision of delayed discharge beds in hospitals, in favour of appropriate levels of social care;
- Reducing the length of stay

The Strategic Plan also outlines the challenges facing unscheduled care services in Lothian. It recognises that the population of over 75s in Lothian will increase by 22% between 2013 and 2020. The fastest rise is in the oldest old. There is an increasing shift in patterns of disease presentation to those with long term conditions with growing numbers of frail older people with multiple conditions, including dementia and functional impairment relying on multiple services often on multiple medications.

2.2.2 Integrated Joint Boards (IJB's)

There are 4 IJBs across NHS Lothian namely Edinburgh, East, Mid and West Lothian. The capacity of acute hospitals to deliver high quality, targeted and timely services depends upon community services being able to prevent inappropriate or avoidable admissions and ensuring the fastest possible discharge.

To enable this to occur IJBs have the responsibility of the strategic overview for unscheduled care, with a view that they will set the direction to avoid patients accessing both front door and in-patient services, where applicable and maximising the efficiency of the hospital systems .There are 3 main areas of focus within the IJBs:

- Admission Prevention
- Facilitating early discharge
- Intermediate care

As described above the IJBs role is key in working within NHS Lothian and assisting in delivering the 4hour emergency care standard by allowing both front and back doors to function across the hospital settings.

2.2.3 Emergency Care Standard

NHS Lothian has been unable to reliably deliver the 4 hour standard for adults, either at a pan Lothian or at site level. Recent clinical evidence on the effect of ED overcrowding on the associated mortality and clinical outcomes of patients[2,3] has increased awareness of the need to address the problem.

NHS Lothian's average performance for 2015 was 93.03%. The RIE takes between 46-52% of all unscheduled care activity across Lothian. Whilst there has been a 0.2% improvement in to the standard, comparing 2015 to 2014, the average performance for 2015 remained considerably short of the target, with a performance of 93.02% for RIE. The main reason for patients breaching was "Wait for Bed", which equated to 44% of all breaches for the site and this has remained a consistent theme since the inception of the Emergency Care Standard.

To address the challenges detailed in 2.2.1-2.2.3.2 there is a requirement for service models to change and be reshaped to provide a robust model of integrated care, with the additional AMU beds at RIE being an important part of this.

2.3 Existing Arrangements

2.3.1 AMU comprises of 48 beds in total, over 6 bays, and a Primary Assessment Area (PAA), with 10 trolley spaces.

The unit facilitates rapid definitive assessment, investigation and treatment for patients admitted urgently or as an emergency with medical conditions. It enables timely access to assessment and decision making by a consultant-led multidisciplinary team. Thus, assessment, care and treatment can be instigated within the first 48-hours of a patient's journey. It enhances patient safety, increases efficiency and dramatically reduces length of stay in the ED . Essentially it acts as a short stay area before patients are discharged or transferred elsewhere in the RIE for specialist care.

There are 3 specialist areas within the unit:

- Bay 1, an 8 bedded monitored unit which has the ability to provide continuous cardiac monitoring.
- Bay 6, a 10 bedded toxicology area, with 4 monitored beds, and specialises in patients who have presented with poisoning/ overdose. Patients with behavioural difficulties secondary to mental health issues or intoxication can be detained within the facility
- PAA, comprises of 10 trolleys, and is responsible for the assessment of medical referrals from primary care (GP) as well as non- acute hospitals and functions between 08:00-20:00 hrs Monday-Friday. The team assesses patients and directs them to the appropriate pathways:
    - Admission into AMU
    - Ambulatory Care
    - Discharge to GP
    - Discharge with follow up in an outpatient setting

Another service which is led by and housed in AMU is Ambulatory Care. Patients identified as suitable by either ED or PAA may be referred to

[2] *Myths versus facts in Emergency Department overcrowding and hospital access block, Richardson, DB, Mountain D MJA Volume 190 Number 7 369-374,*

[3] *Increasing wait times predict increasing mortality for emergency medical admissions Plunkett PK, Byrne DG, Breslin T, Bennett K, Silke B European Journal of Emergency Medicine 2011, 18 : 192-196*

ambulatory care. This allows patients to be discharged home, but re-attend on a planned daily basis for treatment for a specified period.

2.3.2 It is recognised that AMU does not meet the capacity demands now required on the unit. The impact of having insufficient capacity requires the unit to board out to other specialties on a daily basis. PAA is mostly bedded over night for admission of patients who are expected to be discharged early the following morning, this allows AMU to maintain its flow without being full with admitted patients. Frequently this group of patients are not discharged/ transferred until later in the day which impacts on the ability of PAA to deliver a full service resulting in further pressure within the ED as patients are diverted through the ED.

The unit was constructed in 2003, based on 2002 bed modelling. Since that time annual emergency attendances have increase by circa 1% year on year, with the exception of the last 3 years where the increase in attendances has been 8%. This increase in attendance results in a proportional increase in admission, with a current conversion rate of 29.1% of unscheduled care attendances being admitted. It is also worth noting that between 2015 and 2025 the population of Lothian is projected to increase by circa 81,000 people.

As indicated The Royal College of Physicians recommends that an AMU should calculate bed complement as follows:

Average daily intake + 10% for peaks in activity = bed complement

During the 12 months to 31st December 2015 there were a total of 24,149 admissions and transfers into Acute Medical Unit (source MIDAS) this is equivalent to an average of 66 per day compared to an existing bed compliment of 48 beds.

To follow the Royal College of Physicians recommendations the Acute Medical Unit would therefore need an additional 24 beds to provide capacity for an average take of 72 in total, which is summarised in the table below.

RIE - AMU	
Average daily intake	66
+ 10%	6
Recommended bed complement	72
Current Beds (includes Toxicology, excludes PAA)	48
New Beds Required (gap)	**24**

2.4 Business Needs/ Case for Change

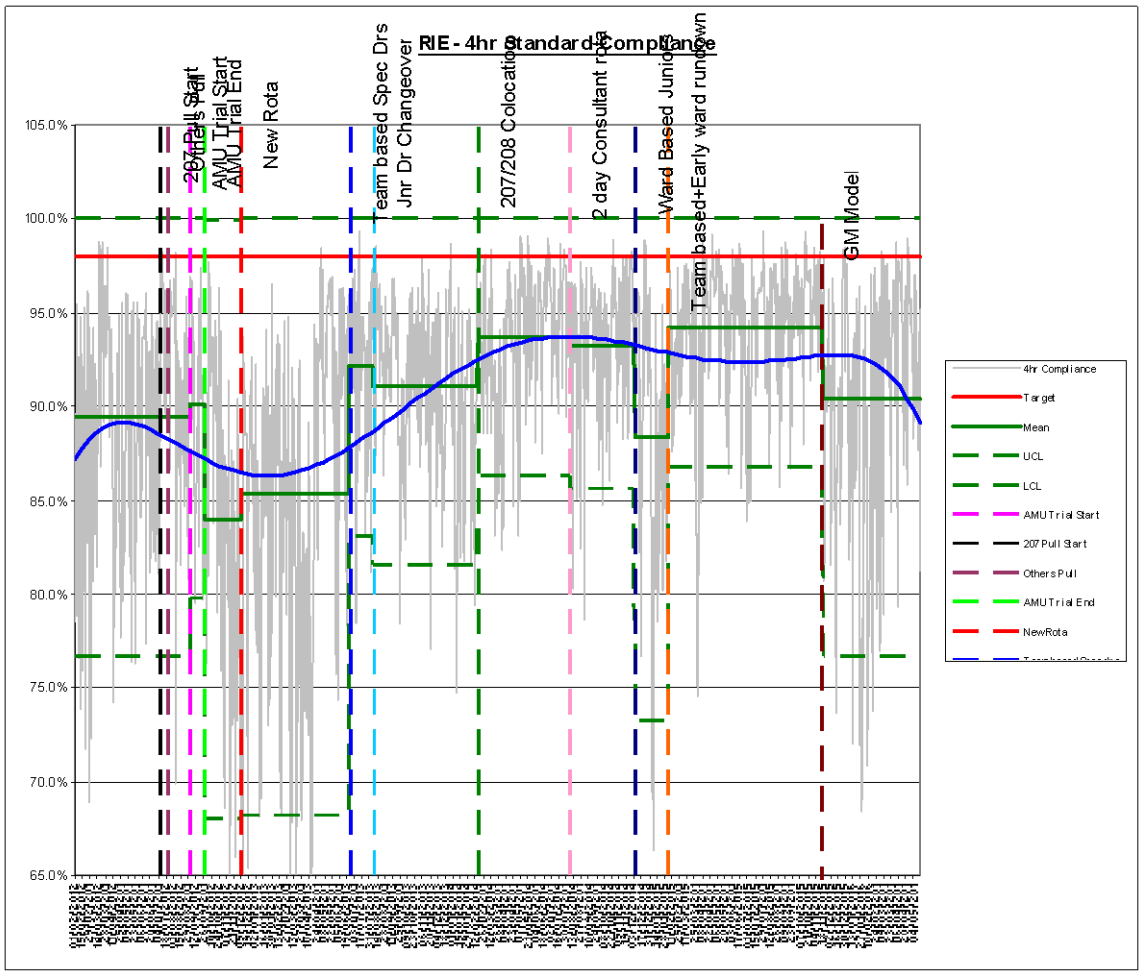
2.4.1 Having insufficient capacity within AMU significantly impacts across the RIE and can also impact on other sites. The main areas of impact are:

- Reduced 4 hour performance
- Increased boarding across the site, which adversely impacts on patient safety
- Increased bed occupancy throughout the site, impacts on HAI
- Discharging occurring later in the day and into the evening
- Poor patient experience

2.4.2 Overall bed pressures on the RIE site lead to a high level of breaches impacting on care provided. The key challenges at the 'front door' are:

- Patient delays within the ED while waiting for a bed
- A significant number of unscheduled GP referrals from the South Edinburgh catchment being diverted to other adult sites
- Patients being admitted and then boarding to inappropriate ward locations
- Primary Assessment Area (PAA) being converted to beds overnight to reduce/ avoid queue in ED overnight
- Patients being boarded overnight to Medical, Surgical Day Cases and Surgical Observation Areas

Whilst it is acknowledged that the site has made steady progress in improving compliance against 4 hours, the site is still unable to consistently maintain performance of 95%, graph 1 depicts 4 hour performance.



Graph 1:4 hour standard compliance

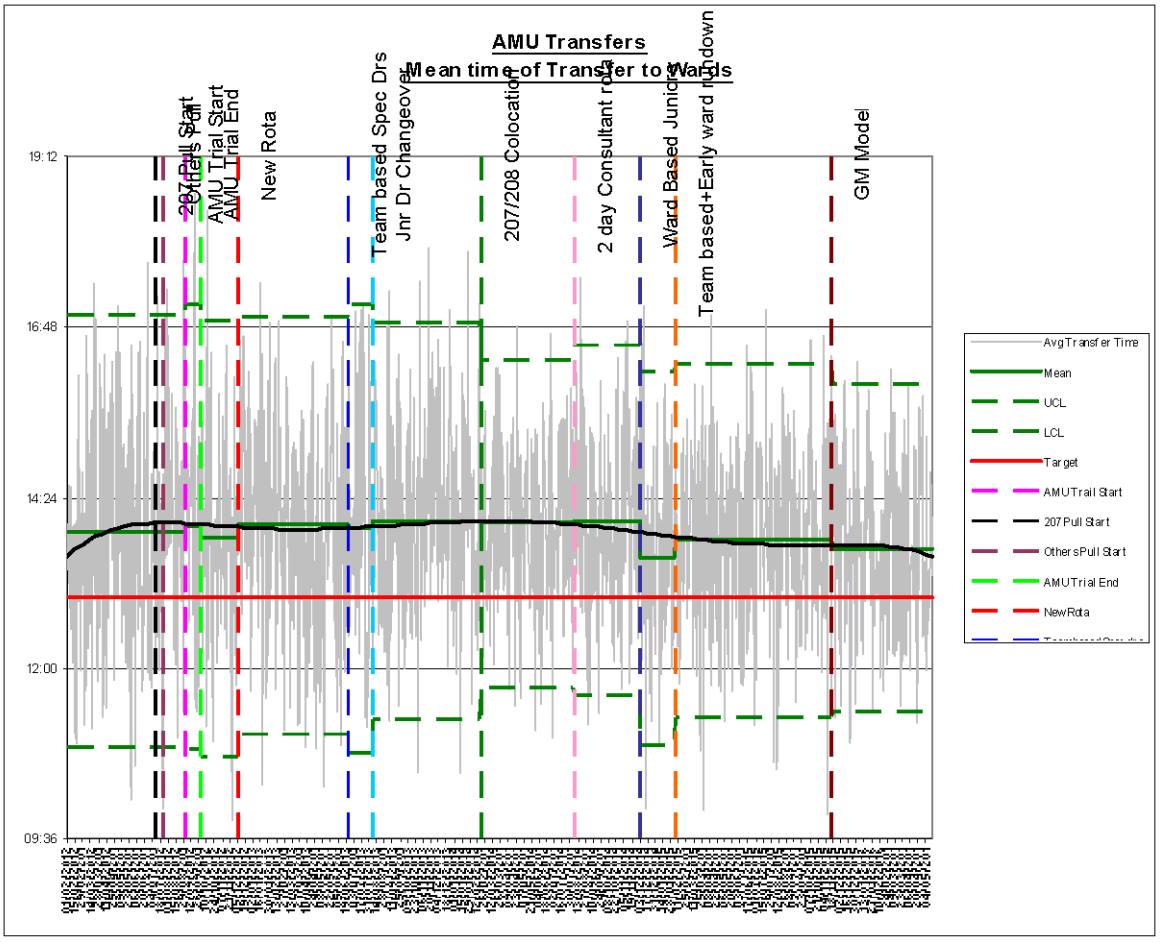
As highlighted earlier the main reason for breaching is "Wait for Bed" into AMU, which accounted for 44% of all breaches in 2015. To attempt to create sufficient capacity the unit requires to board patients out into other areas within the hospital.

2.4.3 The total number of occupied bed days of boarders from General Medicine, which is predominately AMU, for the 12 months for 2015 was 7,159 (Trak). This equates to a daily average of 19.5 occupied beds across the RIE site.

The problems associated with boarding are referenced in 1.1.4 and these are having a recognised impact on the performance of the site and the quality of the patient experience. Some key markers are detailed below.

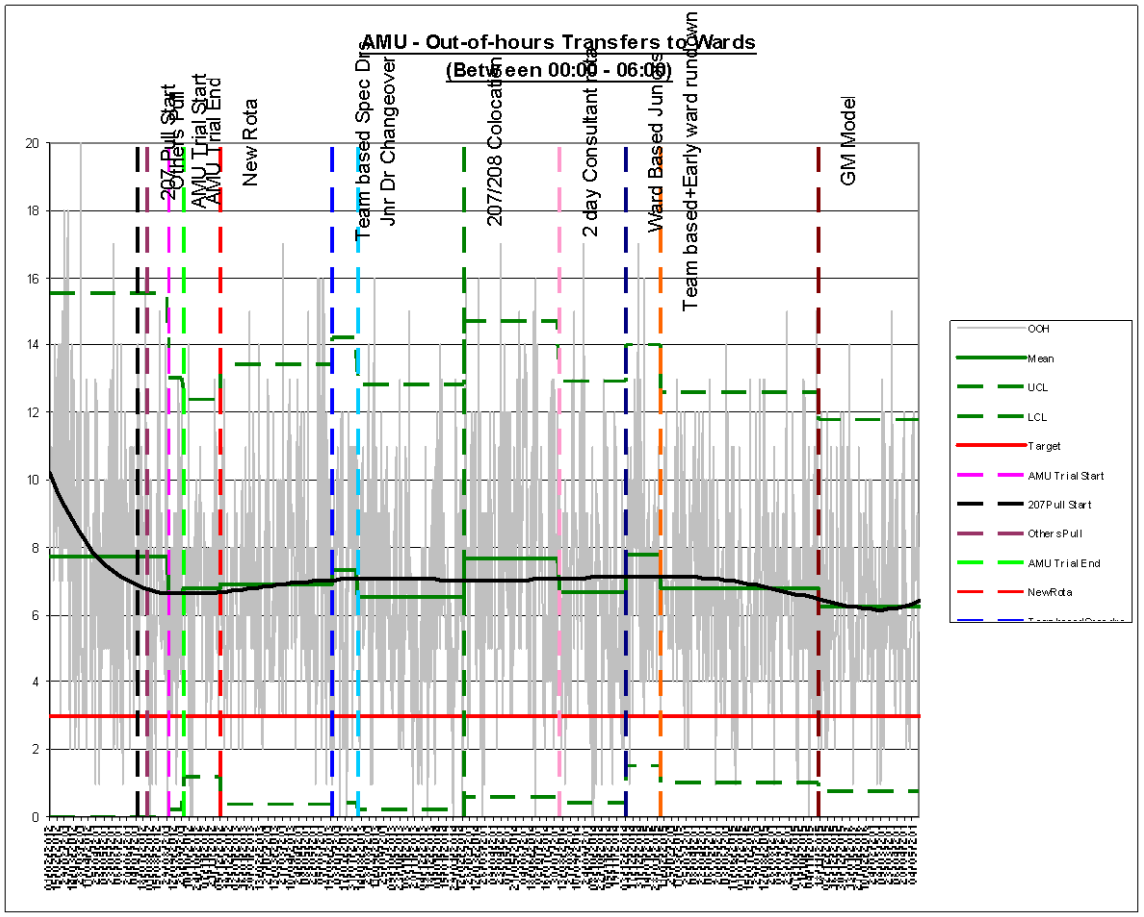
2.4.4 The requirement for consultants to review their patients out with their base is resulting in delays in reviewing patients and in turn leads to a delay in the time of discharge. This subsequently impacts on the site, as discharges occur later in the day and subsequently delays the pulling of patients from AMU.

Graph 2 demonstrates the majority of transfers occur after 14:00 hrs, which impacts on the unit being able to respond to the first predicted peak of activity from the ED, which occurs at 13:00 hrs and contributes to patients breaching "Wait for Beds".



Graph 2: Mean Time of Transfer from AMU

2.4.5 The boarding of general medical patients into other specialties beds impacts on patients accessing the expert care that they require. Additionally it can impact on how the specialties are able to manage their own speciality patients needing access to beds. To attempt to mitigate the impact on these specialties, not all available beds are utilised on site until much later in the day, if flow allows. Additionally some specialties are still discharging patients late into the night, impacting on bed availability. This has a subsequent impact with AMU having to undertake transfers during the out of hours period and overnight. Graph 3 demonstrates transfer activity between 00:00-06:00 hrs, which averages between 6-8 patients.



Graph 3: Out of Hours Transfers

2.4.6 The impact of boarding into specialties can cause disruption and impact on their ability to deliver services, including scheduled procedures. The main speciality on the RIE site which is affected by the deferral of elective surgery is Orthopaedics.

The total number of deferrals for elective surgery for 2015 was 142, of which 80 were in Orthopaedics, with the main reason for deferral being lack of bed capacity. The largest number of these deferrals occurred in February and totalled 23.

This has a significant impact on patients who have prepared themselves for coming in for surgery, including taking time off work, arranging child care etc. It also impacts on the service meeting Treatment Time Guarantee (TTG) targets, putting further pressure on waiting lists. To attempt to prevent this group of patients breaching TTG, a percentage of these patients may have been offered in 2015, to have their procedure carried out in the private sector, which had a significant financial consequences for NHSL.

To put this in context of utilisation of the Private Sector in 2015, by applying an average cost for an orthopaedic procedure at Spire, for example a joint replacement, of £3,650, equates to a cost incurred by NHSL of **£292,000**. Of note NHS Lothian since April 2016 has no longer utilised Private Sector for elective surgery.

It should be noted that the prevention of boarding into orthopaedic areas will support the RIE as it moves towards being a Major Trauma Centre. Additionally it will also assist with the planned move of Orthopaedic Rehabilitation from Liberton into the RIE, to create an integrated Orthopaedic Unit. To assist in reducing boarding, which would include orthopaedic areas,

requires AMU to have sufficient capacity to complete assessments and increase discharge.

2.4.7 As previously mentioned boarding patients into wards, increases bed occupancy levels, which can lead to increased acquisition of Hospital Acquired Infections (HAI).

Analysis has been undertaken by Infection & Prevention Control based on the boarders from General Medicine, boarded outside of their base wards between November 2013- October 2014. It has identified that the conversion rate of HEI is approximately 13 acquisitions, based on 7,159 bed days used for boarding patients. By applying the average cost of £10,000 per patient, it equates to a total spend of **£130,000** to NHSL. This also has a significant impact to the patient's well being

2.5 Investment Objectives

Taking into consideration the points raised in section 2.4, the investment objectives of this development are detailed below.

Investment Objective	Existing Arrangement	Business Need
To deliver a clinical model for the RIE site that significantly reduces patient boarding.	Insufficient front door capacity within Medicine resulting in high levels of boarding and patients not being able to reliably access specialist care. Inpatients lost in the system. RCP report[4]also provides evidence on impact of boarding.	Support delivery of 4 hour emergency care standard Reduced LOS through reduced boarding out with parent ward. Improved mortality/morbidity through more rapid assessment on arrival.
To support delivery of the 4 hour emergency standard to support high quality unscheduled care	Flow is disrupted and so 4 hour standard not currently not reliably met at RIE with consequent impact on quality measures.	Support delivery of the 4 hour emergency care standard
To support the delivery of the 18 week Referral To Treatment access standard through appropriate elective bed capacity	Boarding of medical patients into surgical beds affects reliable planning for elective capacity. Elective planning based on elective capacity not overall combined flow demands.	Supports delivery of 18 week standard with more robust capacity and demand model through decreased boarding into elective capacity.
To support delivery of HAI targets	Inappropriate boarding of patients into other speciality beds increases risk of spread of infection. Insufficient flow to support activity.	Supports delivery of HAI targets by minimising patient movement. It will also provide an additional 3 side rooms, which will allow appropriate patients to be isolated.
To support the NHS Lothian Clinical Strategy with the continuation of RIE as one of three acute sites in NHS Lothian with the continuation of 24/7 medical receiving.	Insufficient capacity to allow appropriate admissions from south side of city to nearest hospital	Assists in delivering balanced unscheduled care capacity across Lothian with RIE playing full part in meeting unscheduled care pressure Fewer patients transferred across town reducing pressure on SAS.
To demonstrate planned bed resources match demand and are linked to peer benchmarks for length of stay and occupancy to demonstrate	Some acute specialties show an opportunity to reduce Length of Stay compared to peer group. Potential to shift some inpatient activity to ambulatory care. Principle opportunities for LOS	Productivity gains from reduced LOS in highlighted specialties offset need for increased investment.

[4] *http://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf*

value for money.	/bed reduction lie with sub acute sites and rehab pathways Lack of co-location of Gen Med wards creates some inefficiencies.	
To support the implementation of the RIE becoming 1 of the 4 Major Trauma Centres and support the transfer of Orthopaedic Rehabilitation from Liberton to RIE	Boarding of patients into orthopaedics affects access to beds which would be used to support Major Trauma and Orthopaedic Rehabilitation	Supports the implementation of the Major Trauma Centre and associated standards. Create an Integrated Orthopaedic Unit. Decreases boarding into Orthopaedics.

2.6 Agreed Service Requirements

2.6.1 Initial Proposal AMU Service

Previous studies have shown that when AMU is able to provide a prompt and efficient multidisciplinary assessment, investigation and management of unscheduled patients with acute illness, that up to 70% of patients includeing those boarded out, can be discharged back to the community without admission to a ward. Studies in Merseyside, Teesside and Dublin have demonstrated that appropriately managed acute medical units have the following beneficial effects:

- Decreased mortality,
- Decreased length of stay and,
- Increased numbers of patients managed in an ambulatory care setting.

With the proposed additional beds, AMU will be the assessment area for the majority of patients with acute medical illness. Some key principles will be:

- Patients should only be admitted to downstream wards when the expected length of stay is to be greater than 48 hours.
- The average length of stay in the unit should be approximately 18 hours as patients should be discharged to the community or to a downstream ward promptly. The current average is 22 hours, with the exception of 25 hours in winter.
- Primary care practitioners should refer direct to PAA rather than referring to the ED. This will alleviate the pressure on the ED and shorten the pathway for patients with acute medical illness.

For the elderly there will be proactive clinical management. The AMU Frailty Model must be seen within a wider context of a more outward focussed MoE service aiming to support the 2020 vision by shifting the balance of care from hospital to community and support the closure of MoE beds. Features of the frailty model include:

- Dedicated Geriatrician input to front door on a daily basis offering support to the frail elderly attending the Emergency Department and early assessment and management of the frail elderly admitted to AMU. They will also provide a single point of contact to locality hubs and GPs offering secondary care support to provide alternative to admissions.
- The reprovision of the new Integrated Older Peoples Service currently based at Liberton Day Hospital to integrate with AMU and enhance the acute assessment of frail elderly in ambulatory and short stay settings increasing the opportunities for senior multidisciplinary assessment and earlier safer discharge and ongoing case management into community settings. Liberton Day Hospital providing an acute assessment setting for frail elderly potential admissions referred by GPs via bed bureau or directly to a single point of contact.

- The Integrated Older Peoples Service incorporates the South Edinburgh Hospital at home service and embedding this service into AMU offers the best opportunity to identify those best suited for supported ongoing management within community settings that would otherwise be provided in hospital. Additionally a virtual ward for South Edinburgh working collaboratively with similar services in Mid and East Lothian including discharge to assess and hospital to home models.
- These services will work closely with the Health and Social Care Partnership locality hubs accessing the whole range of community supports.
- There are opportunities to provide an infrastructure that provides a 24/7 response. With enhanced IT solutions this offers the potential for remote consultations and support to care homes and SAS.

There will continue to be support both at the front door and downstream wards from The Elderly Care Assessment Nursing Team (ECAT) which will offer:

- A robust seven day service
- Improved clinical decision making
- Two staff 7 days 8 am – 8pm and 9am – 5pm
    - Front door including direct transfer from ED
    - Downstream identifying post acute rehab flow
- Supported by Advanced Nurse Practitioner

2.6.2 Bed Modelling

Capita's recommendations were endorsed by the JMT. It was recognised that both WGH and RIE have insufficient acute beds to support the current model of acute care. This applies to both assessment (front door) beds and for acute ward beds.

The work concluded that an agreed model of care for unscheduled medical pathways would seek to achieve a maximum length of stay for assessment beds of 48 hours with a mean of 18 hours with increased rates of ambulatory care activity. Importantly, it concluded that different levels of occupancy should be set to maintain flow across the whole clinical pathway with the lowest levels set for assessment areas to ensure the ability to accommodate flow reliably.

2.6.3 Bed Modelling Validation

Scottish Government benchmarking demonstrated that the supply of beds in NHS Lothian was the lowest in Scotland with a rate of 3.2 per 1,000 population. This translates into operational and clinical pressures where occupancy levels are high. ISD analysis of bed occupancy in NHS Scotland for Acute beds for 2013 and 2014 was 83.3% for both years.

At IA stage, Civil Eyes and Capita validated the assumptions and bed requirements, using benchmarking data from peer hospitals. The bed model is refreshed annually and benchmarked against peer sites. The most recent (2013/14) validates the bed model numbers in the IA, achieving upper quartile performance against a peer group. This is corroborated by work undertaken by NHS Lothian Bed Capacity Model for the RIE.

2.6.4 Future Proofing

The expanded AMU will have staff and facilities to provide a comprehensive frailty model; it will also support business continuity and variations in activity. It will provide 8 of the required 24 beds based on the 2011 Capita recommendations. The next phases would deliver the additional beds, but

would be planned in conjunction, with the Acute Hospital Strategy plans which would include requirements of the unit to meet demands. This plan will also engage with the 4 IJBs and link to their strategies.

2.6.5 Workforce planning principles

The overall vision for the workforce is to ensure the right staff are available in the right place with the right skills and competences to deliver high quality care and services. A workforce plan has been developed and agreed with the clinical management team.

The proposed workforce plan takes into account the bed model and the physical specification for the new development, such as single bedrooms, the impact of increased bathrooms and toilets, and the impact of layout on patient flow.

2.6.6 Workforce Planning Implementation

A recruitment exercise will be required, particularly around nursing and would potentially coincide with winter recruitment.

There will be no organisational change required for existing staff.

2.7 The Royal Infirmary of Edinburgh

2.7.1 Commercial Context

The RIE facility was procured as a PFI contract between the former Royal Infirmary of Edinburgh NHS Trust and Consort Healthcare (ERI) Ltd. The RIE facility was financed, designed and built by Consort Healthcare, and a range of soft and hard facility management services are also provided through the PFI RIE Project Agreement.

The RIE site is leased to Consort Healthcare Ltd for a term of 130 years, thus any site development requires the approval of Consort Healthcare and their lenders, with changes to the project agreement. A Supplemental Agreement (SA) to the RIE Project Agreement will provide a framework for this part of the enabling works.

2.7.2 AMU

The challenge in creating additional assessment beds in RIE is associated with the design of the area and finding space adjacent to the current unit in which to develop more capacity. Taking this into consideration, it has been agreed that Phase 1 of the expansion should go forward separately, to allow teams to review the best fit for the expansion, based on clinical adjacencies. Section 3.3 outlines the options that were considered to date.

Of note, the additional beds within Phase 1, does not involve any other areas within the RIE site and would be created within the existing AMU footprint.

2.7.3 Relocation of services

Some therapy office accommodation in OPD 5 has been relocated elsewhere in RIE, previously as part of preparation for the works.

2.8 Agreed Scope

2.8.1 AMU Construction

The construction phase is planned to take 14 weeks and there will be lead in time for procuring of materials. Additionally due to the previous progress made with Business Case version 17, have been advised that an adjustment can be made to previous building warrant, which should assist in reducing some of the lead in time.

2.8.2 AMU Accommodation

Phase 1 of the project will:

- Provide an additional 8 beds to support the 4 hour standard and reduce boarding.
- Ensure that the clinical accommodation is provided in the most cost efficient way.
- Provide the best fit for purpose facility.
- Provide an effective layout for patient flow.
- Support the reprovision of Liberton patients requiring short stay (< 48 hour) hospital settings particularly those admitted to the acute MoE Liberton wards
- Support the implementation of Major Trauma within the RIE site
- Support the repatriation of Orthopaedic Rehabilitation from Liberton, to create an integrated Orthopaedic Unit at RIE

The detailed design has covered the recommendation contained in HBN 04-01: Adult in-patients facilities. Due to the constraints of the existing footprint, a derogation for room sizes was agreed with the SGHD.

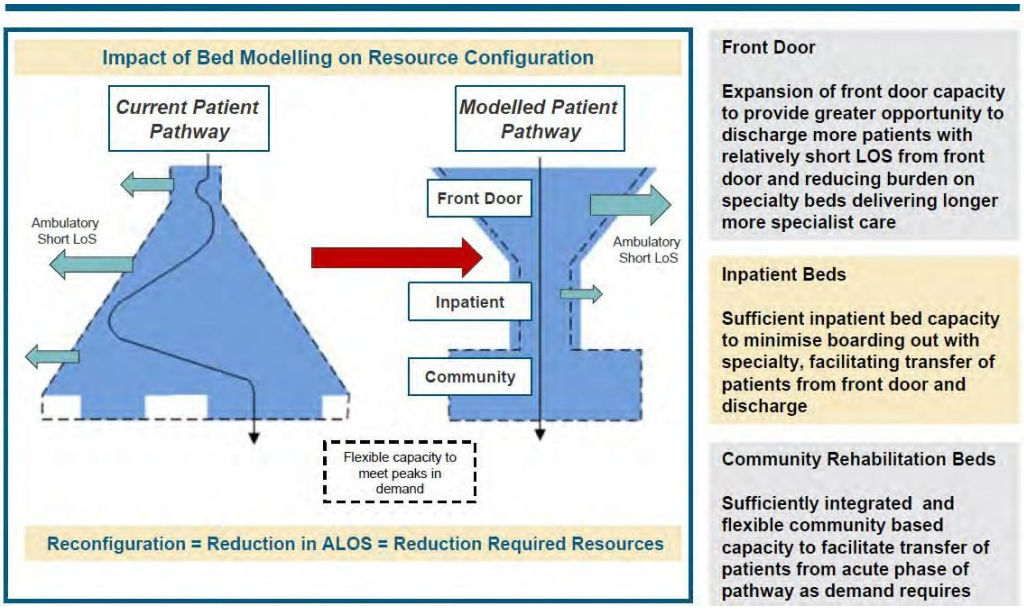
2.9 Benefits

2.9.1 Overall

Phase 1 of an expansion in the AMU bed capacity would realise the following benefits:

- Assist to meeting the 95% 4-hour Emergency Care Standard.
- Assist in supporting the closure of Liberton by summer 2017 in re providing those requiring short stay admission (< 48 hour) to hospital and transfer of Orthopaedic Rehabitation
- Reduce in the risk of overcrowding in the ED.
- Reduce the risk of boarding from AMU and associated adverse impacts
- Support the delivery of the elective Treatment Time Guarantee.
- Reduce the numbers of Unscheduled Care patients being diverted away from the site, although this needs to be taken in the context of the changes with the WGH model.
- Minimise the infection risk to the main arc.
- Reduce the clinical risk to 'direct transfer' patients.
- Ensure that the new accommodation will meet necessary standards and guidance.
- Reduce bed occupancy within wards
- Support the implementation of Major Trauma
- Support the implementation of an integrated Orthopaedic Unit

2.9.2 Impact of additional 8-beds



The diagram below depicts the impact of the proposed expansion on the available capacity and how this will change the patient pathway, with admissions within AMU rather than direct to wards.

The additional capacity will enable AMU to accommodate appropriate patients within AMU rather than being admitted to wards, which will assist in reducing bed occupancy which could release the following benefits:

- Reduce HAI, a 50% reduction would reduce cost associated by £75,000
- Reduce the impact of deferring elective surgery. By reducing 50% reduction in deferrals in Orthopaedics alone equates to £146,000
- Improve flow and responsiveness to patients requiring to be admitted
- Improve compliance against 4 hours, modelling has suggested that performance could improve by 0.2% based on 2015 performance
- Reducing beds in areas which have high levels of boarding. Renal have identified that they could reduce by 4 beds and still maintain an average bed occupancy of 85%. This could release £164,000 in savings, based on staff reduction only.
- Support closure of Liberton releasing funding from that site.

2.10 Strategic Risks

2.10.1 Service Risks

The construction of the additional 8 beds in Phase 1 is not as complex as Phases 2-9, as they are within the AMU footprint. There should be no issues with access and egress for workmen into this part of the hospital.

2.10.2 Commercial Risk

It is necessary that this project is properly facilitated through a SA with Consort to deliver Trust Additional Works Order[s]?.

2.10.3 Organisational Capacity

The Project Manager will be relying on the clinical and service teams to support the delivery of the project, whilst recognising that these teams have a priority for the operational activities within their services.

2.11 Constraints

There is an acute focus on managing these constraints which are:

- TAWO 159 has been constructed
- Delivery of TAWO within the agreed timetable
- Ability to deliver the project within the agreed capital budget.
- Use of existing services/ utilities infrastructure
- The signing of a SA with Consort Healthcare. It is envisaged that the previous SA would amended to capture the changes are only in relation to Phase 1 of the full project brief and could be linked to the Laboratories SA

The environment is constrained, programming for the project has taken any risks into consideration and a detailed pre-tender phasing plan has been developed jointly between NHSL, the design team and Consort.

2.12 Dependencies

The dependencies of the project are:

- The availability and condition of the site; the SA agreement with Consort confirms the programme of works
- The ability of staff to support the project and provide expert clinical advice as and when required.
- The approval of the business case

3. THE ECONOMIC CASE

3.1 Overview

This chapter provides evidence to show that the option selected best meets the service needs.

3.2 Background

The preferred option was selected during the IA process. Since that time, two strands have been progressed in parallel;

- The preferred option has been further developed
- There has been a re-evaluation of other options.
- A feasibility study and detailed design has been concluded.
- Given the complexity of the scheme and the need for detailed planning it has been decided to construct Phase 1 of the total planned 9 phases initially, with a separate Business Case to be compiled for phases 2-9. This will allow the service to review and take into consideration other key strategies including Acute Hospitals Review, IJBs strategic intentions and identifying the best model for the unit.

The option appraisal that was previously carried out is relevant to this SBC.

3.3 Option Appraisal

The long list of options (2012) was:

Option A	Do nothing
Option B	Upgrade PAA to 24 hours beds
Option C	Reconfigure AMU/PAA/Toxicology
Option D	Single Storey New Build adjacent to CAA
Option E	Modular Build Adjacent to ward arc
Option F	Modular build in CAA courtyard

Option A, B and F were discounted at the first stage. Option A, status quo was not an option as provided no benefit. Both options B and F were discounted as cost prohibitive.

Shortlisted Options

Option C, D and E were shortlisted, with option 1 as a baseline comparator. The table on the following page lists the long list of options and outcomes from 2012

	Option A	Option B	Option C	Option D	Option E	Option F
Description	Do Nothing	Upgrade PAA to 24/7 beds And loss of trolley & ambulatory care capacity space	Use OPD 6 for beds – CAA to OPD6, OPD 6 to OPD5, and OPD5 to elsewhere. Conversion of PAA to beds and PAA to OPD6	Single storey New Build adjacent to CAA	Modular build adjacent to end of ward arc	Modular build in CAA courtyard
No of additional beds	0	10 beds	36 beds (incl 16 trolleys)	24 or 38	16	
Meet bed modelling requirements	No	No	Yes	Almost	Yes if linked to 6&7	
SA or TAWO	N/A	TAWO	SA	SA	SA	SA
Consort or NHSL tender	None	Consort	Consort	Consort	Tender	Tender
Length of construction programme	None		21 months	14 or 18 months	Awaiting detailed feasibility	X months plus SA
Disruption	None	Medium	Major	Minimal	Minimal	Medium
Cost	Nil		£3.35M	£6.7 or £9.7m	awaiting costs – circa £3M	Not costed
Cost per bed	N/A		£105k	£279K or £255k	£187.5k per bed	
Feasibility	Yes	Significant operational service disruption	Significant operational disruption plus additional decant costs	Noise disruption and may interfere with RHSC/DCN works	Would require planning permission adding to time delay	Affects light and expensive to crane in. Footprint too small for ward
Comments	Delivers no improvement	Loss of PAA capacity so overall reduction in space	Best location for front door beds	insufficient capital	Interferes with timeline for RHSC/DCN	
Summary	Discount	Discount	**Proceed**	Discount	Discount	Discount

The Preferred Option

Option C's benefits over the others are:

- Provides the additional beds required.
- Provides the first 8 beds in 2017.
- Integrated with other assessment beds.
- Proximal to the Emergency Department and associated services.
- Less disruptive than Option 3.

It should be noted that this business case is concerned with Phases 1 of option 4. More beds would be delivered in future phases

3.4 Benefits Appraisal

The preferred option was derived through discussion with clinical and management teams, architects, quantity surveyors and by applying benefit criteria to each of the options.

3.5 The Preferred Option

The preferred option was option C as it achieves the following:

	Description	Strategic Fit	Benefits Optimisation
Real time assessment	Consultant led teams supporting acute medical and frailty assessment in a real time setting 7 days per week, expediting time to first assessment and improve senior decision making. This model will also provide support to ED and provide a single point of contact within secondary care to support GPs, SAS and locality hubs.	Yes	Reduce % of bed wait breaches. Increase % of patients discharged from AMU
Ambulatory care	Appropriate ambulatory care patients will be triaged directly from GP/Bed Bureau through PAA and onto ambulatory care for management. This will involve selected patients from initial visit and the majority of patients on return visits. This is designed to free-up capacity pressure in PAA enabling the area to improve flow. These patients will include frail elderly benefiting from early senior multidisciplinary assessment to expedite early and safe discharge into community settings for ongoing management.	Yes	Increased follow-up ambulatory activity undertaken as OP not in PAA. Increased ambulatory approach to frail elderly including falls assessment
Alternative to admission pathways	Closer working with flow centre to develop robust multi-speciality pathways around alternatives to admission. This will include multimorbidity management and management of frail elderly within assessment or home settings with hospital at home teams.	Yes	Patient activity diverted from attending PAA to alternative pathway

3.6 Changes to Construction since Initial Agreement

There was no construction plan in the IA, since that time:

- A feasibility study by Keppie Design was undertaken
- A detailed design exercise was completed with users and Keppie Design
- A pre-tender estimate was provided by Capita Symonds
- The pre-tender estimate was reviewed by NHSL advisors, Thomson Gray
- There have been detailed discussions between NHSL and Consort around the terms of the SA.
- For Phase 1 there is no intention to deviate from the initial design

The phasing plan has been revisited as the initial plan had loaded the costs in the front end and delivered the beds in the latter phases.
Construction is scheduled to be undertaken over the financial years 2016/17 and 2017/18.

3.7 Equipment

3.7.1 Equipment Schedules

During detailed design, an equipment schedule has been drawn up to identify the furniture, fittings and equipment required for phase 1. A detailed schedule of equipment to be procured, and equipment to be transferred is being discussed.

Upon completion of the development of the 1:50 Room Layout Drawings, a requirement for some new equipment and furniture was identified and is included in the overall project capital cost.

3.7.2 Equipment Groups

The equipment is categorised into three groups:

Group 1 Items will be supplied and fixed within the terms of the contract by the Principal Contractor. The cost of this equipment is contained within the Capital Price.

Group 2 Items will be supplied by NHSL and fixed by the Principal Contractor.

Group 3 Items will be supplied by NHSL.

Group 2 and 3 Equipment supplied by NHSL will be procured through Health Facilities Scotland using national contracts and conventional competitive tendering.

The Project Manager will be responsible for the logistics, installation, commissioning of all furniture, fitments and equipment and will also be responsible for ensuring that the appropriate training is available.

4. THE COMMERCIAL CASE

4.1 Overview

The construction work is needed to meet the operational and service requirements associated with meeting and maintaining the 4 hour standard.

4.1.1 Procurement Route

Because the construction works are within the existing footprint of the RIE, they are being procured through Consort Healthcare as a capital funded project. Consort will be responsible for providing all aspects of design, construction, and ongoing facilities management throughout the course of the project term.

NHSL will manage the programme of enabling works, carried out by Consort Healthcare.

4.2 Agreed Scope and Services

4.2.1 The scope of the works is within AMU

4.2.2 The contracts will be with traditional contract responsibilities but NHSL will carry the majority of the risk through indemnity provided to Consort to keep the original PFI Project Agreement 'whole'.

4.2.3 The programme of works will be completed by May 2017

4.3 Equipment

An equipment responsibility matrix has been prepared, detailing all equipment by description, group reference, location and responsibility between NHS Lothian and Consort in terms of supply, installation, maintenance and replacement over the course of the operational term.

4.4 Agreed payment mechanism

Unitary Charges (unitary charge) to Consort will be made within the current arrangement. They will continue to be managed and regulated by means of the payment mechanism that will protect NHSL if there are failures in availability or performance.

4.5 Agreed Contractual Arrangements

A Supplemental Agreement (SA) will be signed with Consort Healthcare. Part of any project undertaken at the RIE is to enter into a supplemental agreement (SA), NHSL and Consort have now developed a standard set of Heads of Terms and this sets the context from the SA.

The SA is used to ensure that the contract and indemnity that the Board retains as a consequence of the service enhancement is limited to the project and does not dilute the effectiveness of the Project agreement.

There are certain mechanisms within the SA that can be applied to both the contractor and the service provider should there be a project defect. These are not as onerous as the original project agreement. The maximum penalty is £200 per occasion.

4.6 Advisors

The following teams have advised NHSL on the procurement stages and shall continue to do so to completion of construction works and commissioning:

- Technical – Thomson Gray
- Legal – MacRoberts LLP

HFS provides advice and support on equipment procurement.

5. THE FINANCIAL CASE

5.1 Overview

5.1.1 This chapter:

- Builds on the financial assumptions set out in the Initial Agreement
- Sets out the capital and revenue costs of the proposed development
- Summarises the overall affordability

5.2 Initial Agreement

- The Initial Agreement (IA) made the following assumptions
- The capital cost of the proposals will have to be managed through the 10 year Capital Plan
- NHS Lothian will be required to fund capital charges and additional Consort service charges arising from this development
- There will be an increase in staffing levels and revenue costs arising from the additional capacity being added to reduce boarding levels

5.3 Capital Costs

5.3.1 Summary of Capital Costs

The overall capital costs comprise construction and equipment costs and are summarised by Project in the table below-

AMU ADDITIONAL BEDS PROJECT OVERALL COST SUMMARY

Item	**2014/15**	**Note**
Construction Costs	385,000	1
Consort Costs		
Project Management Fees (Construction)	21,175	2
Admin Fees (Construction)	10,593	3
Legal Fees	32,000	4
Commercial Costs	22,892	5
Building Warrant	1,500	
Sub-Total	**88,161**	
NHSL Costs		
Legal Fees	10,667	
Sub-Total	**10,667**	
TOTAL	**483,827**	
EQUIPMENT	95,170	
OVERALL	**578,997**	

Notes

01) As per analysis provided by Thomson Gray.
02) Based on same % as for full project (5.5%).
03) Based on same % as for full project (2.4%).
04) Legal Fees based on same % as for TAWO 181 construction cost £314K. (8.3%).
05) Based on other costs for TAWO181 prorated for bigger construction cost.
06) Based on 1/3 of Consort Legal Fees as per agreed approach for other projects.

- The construction costs relate to the building works required to implement this service development and
- The fitting of equipment purchased by NHS Lothian.

A tendering exercise took place previously to identify a preferred contractor to undertake this work and this would require to be re-visited. These capital costs are based on pre-tender figures issued in January 2015. Following recent planning with Consort a more realistic cost, would be a **projected Capital spend of £1,200,000**. Capital costs will be updated when the tendering process is complete.

VAT has been excluded on the assumption that NHS Lothian will continue to recover VAT on payments to Consort

The table above splits the construction costs between the different elements of the project:

- TAWO181 – relates to the preparatory works undertaken to allow the relocations of services and staff to enable this development to progress
- TAWO140 – relates to the main construction and redesign works.

The equipment costs relate to a range of items totalling £95k. The high value items include ceiling mounted hoists and patient monitors.

5.3.2 Value for Money Analysis

The pre-tender construction costs above were reviewed by Thomson Gray (NHSL cost advisors) in January 2015. They concluded that 'Although there are areas where Thomson Gray have concerns about the costs submitted by Consort / Capita, overall we are generally satisfied that the pricing is competitive and reflects the scope of work proposed it will only be when the current tender process is completed that a fully accurate picture will be available as to the overall project cost'[5].

A Senior Project Specialist from Health Facilities Scotland (HFS) has been appointed as an expert advisor to ensure best value for money. He will also lead on the procurement of equipment.

5.3.3 Capital Affordability

A provision has been made in the 5 Year Property and Asset Management investment programme to meet the projected capital costs. Whilst funding is included in the Capital Plan it should be noted that this plan is currently out of balance.

5.4 Revenue Costs

The IA made no reference to the revenue requirement. The staffing and non pay costs herein have been recently developed with the Business and Service Management Teams.

To assess the revenue implications of the project, the cost of the additional beds/clinical footprint were established. Two elements were examined:

- Cost of clinical services (workforce in the main).

---

5 *TAWO 140A – AMU Additional Beds Project, Review of CONSORT pre-tender Estimate: Thomson Gray, Jan 15*

- Unitary Charge

5.4.1 Key Revenue Assumptions

The revenue implications of the proposed model of care have been costed using current pay scales and reflect appropriate enhancements.

The staff costs reflect:

- The increase in bed numbers.
- New models of care
- Increased clinical activity in AMU

5.4.2 Summary of Revenue Costs

The table below summarises the revenue costs associated with the proposed model of care.

Area of Investment	WTE	Cost £
PAY		
Specialty Doctor	1.00	70,700
Nursing B5	10.47	432,230
Nursing B2	5.24	156,772
Occupational Therapist B5	0.60	22,048
Physiotherapist B4	0.70	21,752
Dietetics B5	0.05	1,605
Speech & language Therapy B5	0.10	3,213
Pharmacist B7	1.00	46,460
Pharmacy Technician B4	0.50	13,527
Sub-total Pay	**19.66**	**768,307**
NON-PAY		
Non-pasy costs		110,000
Facilities Costs		85,000
Sub-total Non_Pay		**195,000**
Total Revenue Costs	**19.66**	**963,307**

The revenue costs identified above are recognised in the 2017/18 Financial Plan on a phased basis from December 2017. No source of funds was specifically identified against this investment, and there remains a significant gap in available resources to deliver the plan as at May 2017.

It is proposed that the revenue funding for the period December 2017 to March 2018 is financed from the overall NHS Lothian Winter Plan, for which total resources of c.£2m are identified.

Options for recurrency of funding beyond March 2018 continue to be explored, including the reprioritisation of resources currently deployed elsewhere to support unscheduled care flow across the Lothian region. It is recognised that any change in application of existing funds will require management of disinvestment timelines and the agreement of relevant Integrated Joint Boards with strategic planning responsibility for unscheduled care services.

The key highlights arising from the proposed model of care are summarised below

5.4.1 Medical Staffing

The current AMU has capacity for 48 patients but operates at 101% capacity, due to PAA having to convert to beds at times of peak flow challenges. There are two consultant physicians on duty between 08.30hrs and 21.300hrs.

Currently there are 24 doctors who participate on the AMU rota each with 3 Direct Clinical Care programmed activities i.e. a total of 72 Direct Clinical Care PA's to support the existing 48 beds.

In addition a further 20 Direct Clinical Care Programmed Activities are available for PAA providing consultant cover from 0800 to 2000 Monday to Friday.

In September 2016 MoE commenced input into the back bays of AMU seeing those identified as frail. This successful service will be expanded into front bays and to support ED in summer 2016. The MoE service consists of a MoE consultant, Advanced Nurse Practitioner and Clinical Fellow. A similar nucleus will provide input into front bays and ED. These services will provide input across 7 days. It is proposed that the current medical staffing within IOPS will be redeployed within AMU so no additional medical staffing is required to support this model. To deliver a high standard multidisciplinary MoE service enhancements in therapy, pharmacy and social work support is highly recommended.

The Geriatricians will also work closely with Elderly Care Assessment Team (ECAT) - a nurse led service identifying frailty at the front door and downstream ward settings to drive multidisciplinary assessment and improved pathways for frail patients in in-patient settings.

The Geriatricians will also work closely with the SAFE-HOME AHP service and will further develop the MDT working for the AHP team in AMU and PAA, they will provide a single point of contact for these areas.

The frailty model at the front door will allow for a range of outcomes;

- Easily accessible clinical advice to ED, PAA and AMU including specialist advice on interface working, management of frailty including delirium, polypharmacy, anticipatory care and end of life decisions.
- Improved liaison with ED to facilitate direct MoE admission on or off site as appropriate.
- Improved and more timely assessment of frail elderly within ED and PAA to allow earlier discharge.
- Collaborative working with AHPs in developing supported discharge models within Edinburgh, East, West and Midlothian.
- Improved access for ECAT to senior decision makers.
- Improved MDT working within AMU allowing more robust assessment and safer more timely discharge.
- Improved knowledge around opportunities within community for extended supports to prevent readmission.
- Opportunities for early next day if needed follow up at Day Hospital in north Edinburgh.
- Enhanced opportunities to identify suitable patients for supported discharge.
- Greater use of hospital at home models to facilitate discharge
- Improved pathways for groups of patients with non-operative fractures

- Improved knowledge of community services and closer working with locality and discharge hubs.

It should also be noted that if and when more beds are commissioned for the remaining phases of this project, that no additional consultants will be required.

The expansion of the Acute Medical Unit will allow an increased assessment time and in context of full multi-disciplinary team including Geriatricians is expected to help increase discharges and reduce boarding numbers.

Specialty Doctors

There are two specialty doctors currently working within the Integrated Older People Service and as part of the revised model to support the additional beds there will be a requirement of 1 additional Specialty Doctor.

Junior Doctors

Currently Acute Medicine and General Medicine (Wards 207 and 208) are supported by a team of 43 Junior Doctors comprising 18 FY1's, 17 FY2's / ST1/2's / GPST's and 8 Registrars.

These Junior Doctors provide 24/7 cover in to Acute Medical Unit, cover for PAA as well as day time cover into Wards 207/208.

There is no specific proposals to increase cover of the Junior Doctors with the increased number of beds. There are currently a GPST and community FY2 based at IOPS and these staff will also be redeployed to the front door. It should be acknowledged that some of these medical staff will support the hospital at home service.

Nursing Staff

The proposed increase in Nursing staff is in line with existing Nurse to bed ratios and significantly reduces the skill mix of qualified to unqualified nurses.

It is noted that the current establishment for AMU has benchmarked below the national benchmark for nursing establishments. However this business case is not intended to address this situation and it is not accounted for in the costing.

Other Staffing

The Other Staffing costs comprise Pharmacy and Allied Health Professional, are required to support the changes in bed numbers.

Non Pay Costs

Non Pay costs have been estimated on the basis of existing spend per bed. It's recognised that the majority of these costs are being incurred across the range of services currently accommodating boarders from the referral process into AMU. There is an expectation that these costs will reduce in wards with boarders as patients are assessed and managed within the expanded AMU

Other Revenue Costs

These costs comprise depreciation, soft FM (patient portering) costs and an estimated increase in the Lifecycle Costs element of the Unitary Charge paid to Consort.

5.5 Overall Affordability for NHS Lothian

This development is linked to the NHS Lothian site rationalisation programme. Whilst the programme is in its early stages, it is recognised that this development is within that overall financial envelope. The timing of the revenue requirement of this development and any releases arising from the programme will impact on the affordability.

6.0 THE MANAGEMENT CASE

6.1 Overview

This section of the SBC describes how the scheme will be successfully delivered.

6.1.1 Governance Framework

The Little France Campus Working Group has been established as a project management interface for all partners on the site to co-operate in establishing arrangement for a safe working environment.

6.1.2 Management Arrangements

Management Arrangements for the Project	
Role	**Name**
Executive Lead	Jim Crombie
Project Manager	Neil McLennan- TBA
Site Director	Lyn McDonald
Operational Manager	Gillian Cunningham
Clinical Service Manager	Gareth Clinkscale
Clinical Service Manager	Billie Flynn
Finance Lead	Andrew Bone
Contractor Lead	John Creedican
Lead Nurse	Linda McIntosh
General Manager	Janice Alexander
Medical Lead	Johanne Simpson / Andrew Coull
This project will report to the Capital Management group which reports to the CMT and F&R Committee.	

6.1.3 Project Manager

A Project Manager (PM) from Capital Planning has been assigned to manage the project on behalf of NHSL. The PM will:

- execute the project plan
- ensure the management and evaluation of the project are carried out
- lead and control the appointments, design, tender, construction, and commissioning stages
- Authorise payments of the project.
- Work closely with the clinical and management teams
- Procure equipment
- Commission beds
- Undertake other roles as and when required
- Act as the main link between:
    - NHSL
    - The Little France Campus Group
    - The Project Director
    - The Clinical and Management Teams
    - Consort Healthcare

6.2 Project Plan

The next table is a 'high level' summary of the construction programme.

Draft High Level Summary of AMU Additional Beds Project		
Main Works TAWO 140A	Contract Awarded	
	Mobilisaton	8 weeks
	Phase 1	14 weeks

Table: Key Milestones from Tendered Construction programme

6.3 Project Management Stakeholders

6.3.1 The key roles of the NHSL PM have been outlined in 6.1.2

6.3.2 The stakeholders in the project are:

- NHS Lothian, comprising Lothian Partnership Forum, clinical management teams and corporate services.
- Statutory authorities and public bodies such as the Health & Safety Executive, City of Edinburgh planning department, Architecture and Design Scotland.

6.3.3 All governance functions are supported by a range of reports, including the Project Progress (dashboard), Risk Register Report, Financial Report and a range of supplementary reports.

6.4 Risk Management

6.4.1 This project sits within the risk management framework for the RHSC/DCN re-provision project.

6.4.2 Five red rated risks applied to this project, and are shown below.

Risk Register for New CAA Additional Beds Project – February 2015

Risk	Mitigation	Probability	Impact	Score	Rate
Late commencement of works due to lack of agreement on SA.	Regular meetings with Consort and regular updates from G Curley.	5	5	25	Red
Lack of reception capacity during first phase of upgrade	Increase use of discharge lounge. Consider any other options	5	4	20	Red
Difficulty in recruiting appropriately skilled staff	Commence liaison with the recruitment team	5	4	20	Red
Health & Social Care unable to support the demand for supporting patients in the community	Commence liason with the IJBs around models of care and expectations of pulling patients	5	4	20	Red
Financial implications of revenue streams, where it is assumed that Liberton bed reductions will off set	Work being progressed detailing how savings associated with Liberton will be attributed	5	5	25	Red

6.5 Workforce Planning

Recruitment planning will need to be undertaken by a member of the Service Management team.

6.6 Commissioning.

6.6.1 The NHSL Project Manager, will develop, monitor and implement the NHSL commissioning and equipping programme.

6.6.2 The Consort Project Manager is responsible for managing the programme for the building and service transfer.

6.7 Post Project Evaluation

Evaluation of the project will begin one month after commissioning: critical success factors will be:

- Contribution to the achievement of 4 hour target of 95%. It is envisaged that 0.2% improvement will come from this project.
- Reduction in mean waiting time in Emergency Department
- Reduction in numbers of breaches attributable to wait for bed and modelling has anticipated a reduction of 1,000 breaches attributed to "Wait for Bed"
- Reduction in numbers of patients boarding, it is estimated that this will reduce by 6 patients boarding on average

In the formal 12-months post-project evaluation, the following issues will also be reported:

- Changes in mean length of stay,
- mortality rates of patients admitted to medical beds
- Ratio of patients managed in an ambulatory setting can be monitored.
- Did the project deliver on time/within budget
- Successes
- Challenges
- Learning for any additional construction phases

6.8 Contingency Plans

Contingency Plans will need to be developed by the service with support from the NHSL PM. These will be delivered through the General Management Structure.

END

PROJECT: AMU,RIE

What are the Current Arrangements: AMU comprises of 48 beds in total, over 6 bays, and a Primary Assessment Area (PAA), with 10 trolley spaces. The unit facilitates rapid definitive assessment, which is currently hindered by a "front door" capacity that is too small and results in patient boarding and delays..

What is the need for change?	What benefits will be gained from addressing these needs?	How do these benefits link to NHSScotland's Strategic Investment Priorities?		What solution is being considered
Identify Links		Identify Links	Prioritisation Score	
Insufficient front door capacity causes delays within the ED and boarding.	Improved efficiency and productivity gains from increasing capacity and improving patient flow	Person Centred	4	Service Scope / Size: Edinburgh Royal Infirmary AMU
Boarding increases length of stay and increases risk of Hospital Acquired Infection.	Ultimately patients can be rehabilitated in their home, rather than undertaking this in the hospital setting.	Safe	4	Service Arrangement: Expansion of AMU facility
Patients are boarded to other, often inappropriate, wards and specialties.	Timely discharge from hospital resulting in reduced bed occupancy and overcrowding.	Effective Quality of Care	4	Service Providers: NHS Lothian and Consort
Boarded patients exert extra pressures within the ED, impacting on ineffective patient care.	Minimised risk of infection.	Health of Population	2	Impact on Assets: Capital grant as PFI site
Failure to consistently meet 4 hour Emergency Care Standard of 95%.	Support the Scottish Government requirement to eliminate boarding as a solution to capacity problems.	Value & Sustainability	3	Value & Procurement: Traditionally funded, approx £0.6m
	High quality and efficient patient care provided, thus improving the overall patient experience.	TOTAL SCORE	17	
	Implementation of patient pathways that work towards improving the 4 hour Emergency Care Standard.			

ITEM 5.6

Report

Actions to support the opening of the new Royal Edinburgh Building.

Edinburgh Integration Joint Board 16 June 2017

Executive Summary

1. The purpose of this paper is to update the Edinburgh Integration Joint Board (EIJB) on the actions to support the transition of the Royal Edinburgh Hospital (REH) inpatient services for people over 65, and for acute inpatient services for adults under 65, as they move into the new Royal Edinburgh Building (REB).

Recommendations

The EIJB is asked to;

2. note the progress made to facilitate the move for adults over 65 to the new REB which has been assessed as having a RAG status of “green”. Royston Care Home is now registered and patients within the Royal Edinburgh Hospital Older Peoples services have now been identified to move to there. Progress around the transfer of patients is being monitored through the weekly delayed discharge meeting;

3. note the progress made to reduce the number of people delayed in acute adult services and the growing risk of over occupancy of adult acute due to a risk in acute admissions and a delay in commissioning community capacity . The current status of this work has a RAG assessment of “red”;

4. note that additional community capacity of between 12 and 15 places is required at Grade 4 or 5 (see Appendix 1 for definition of terms) to enable the move to the new REH which has seven less acute beds on 31 August 2017 and to maintain a bed occupancy within the new bed compliment of 90%. Maintaining the 90% occupancy is dependent on assuring a zero delayed discharge rate which is a risk without sustained additional community capacity.

5. note that work is in progress to secure additional community capacity at Crighton place for four Grade 4 community beds as set out in a previous report to the EIJB on 24 March. The occupancy date for this accommodations is planned for 31 August 2017;

6. delegate authority to the Strategic Planning Group to approve the business case for the proposed development at Niddrie Mains to enable the partnership commission an additional nine Grade 5 places;

7. note that the commissioning of the Niddrie Mains accommodation is being progressed in parallel to the business case process. Funding has been identified in the EIJB's financial plan, however there is a risk that the places will not be available for occupation in time for the move to REB. It is likely that the accommodation will not be ready until end of September 2017, which will require a contingency plan to maintain a ward at the REH to accommodate Edinburgh patients whilst the additional community is being procured; and

8. note that a Public Information Notice was issued on Wednesday 7 June 2017 to identify market interest and shape the market for a longer term plan to provide additional supported accommodation. This will be the subject of further business case(s) which will be presented to the Strategic Planning Group in the first instance.

Background

9. There will be 17 fewer beds overall in the Royal Edinburgh Building. There will be 10 beds removed from services for people over 65 and seven beds removed from acute adult services.

Main report

Adults over 65

10. Services for older people will move into REB in June 2017. The older people's Rapid Response Team (RRT), the Behavioral Support Service and the impact of locality working, provide an effective approach to support people at home and in care homes. This has had a positive impact on reducing the number of admissions to hospital and facilitating timely discharge from hospital. An outcome reporting template is being agreed to measure the impact of the RRT.

11. The longest waits for discharge for older people in the REH, have been for those waiting for a specialist dementia unit. The provision of an extensive staff training programme, the secondment of a Registered Mental Nurse from REH, and the establishment of the required staffing model has resulted in the Care Inspectorate agreeing on 30 May 2017 to the register the 15 beds in the Lauriston Unit within the new Royston Care Home. The transfer of patients from the REH to Royston Care Home is being monitored by the Edinburgh Health and Social Care Patrnership (EHSCP) delayed discharge weekly meetings. The actions outlined above will effectively support the move of services for older people to REB and therefore this work-stream is considered to have a RAG status of "green".

Adults under 65

12. The acute services for people under 65 are due to move to the new REB in August 2017 when remedial anti ligature work is completed.

13. Following a recent increase in admissions, the downward trend in occupied adult acute beds has reversed. As a result, the adult acute bed base is currently in over occupancy. This pressure has resulted in a proposal to accelerate the provision of an additional nine community places (Grade 5). Grade 5 places provide intensive rehabilitation, for a period of 6 to 12 months, within a community environment. Care and support is provided by third sector partners who promote person centered choices and meaningful days. Ongoing clinical care is provided onsite by hospital medical, nursing, allied health professionals and MHO and social work services.

14. This additional capacity would be based on the Grade 5 model currently provided at Firrhill and could be provided on a phased basis. These places would be located in a block of council flats at Niddrie Mains Terrace, Edinburgh. The property is generally in good repair and provides good sized living accommodation for nine people and the associated staff. Window repairs, replacing two baths with a shower, small upgrades and general decoration would be required. City of Edinburgh Council surveyors are establishing the cost of this work. Procurement partners are exploring with EHSCP the options to secure the Niddrie Mains arrangement as soon as possible. Current advice is that the procurement arrangement will not be risk free in terms of compliance.

15. This level of provision would be within the projected overall need for Grade 5 as we move towards the reprovisioning of rehabilitation services at REH. EHSCP in consultation with NHSL will scope the hospital and community capacity required for phase 2 of the REH reprovisioning.

Table 1 – Details of community capacity for 13 people

Location	Number of Places	Expected occupancy Date	RAG Status	Annual revenue costs
Crighton Place	4 Grade4 places	Available 30 August 2017	In progress	£0.1m
Niddrie Mains	9 Grade5 places	Available 30 September 2017	In progress for end Sept but unlikely to be available earlier	£0.6m
Total investment required				**£0.7m**

Mitigating Action:

Detail	Number of Places	Timescales	Costs
To manage delays in commissioning community capacity –Maintain a ward at REH until community capacity available	10 - 15 beds	Aug -Oct 17	Currently being costed.

Key risks

16. Overall the position for adults under 65 has been assessed as “red”. Therefore there are a range of risks associated with this workstream. Including that:

17. temporary hospital beds need to be provided to bridge the time between the move to REB and the additional community places being available. Officers from EHSCP are working with colleagues in NHSL to develop and agree appropriate contingency plans to ensure patient safety;

18. the number of admissions continues to rise, resulting in further over occupancy, and increasing the number of people delayed;

19. there is a mismatch between the available additional capacity in Niddrie Mains and the number of people assessed as requiring care in this setting;

20. staffing a hospital or community based option is not possible due to staffing/recruitment challenges;

21. procurement of the new service is does not meet legal requirements and the risks involved prevent progress.

Financial implications

22. Based on the Firrhill model the full revenue costs for care and support at Niddrie Mains Terrace service operating at full occupancy will be in the region of £0.6m per annum. The cost of rent, fuel and maintenance would be met through benefits and housing benefit.

23. The costs relating to capital investment in the building will be dependent on the procurement option pursued.

Involving people

24. The Edinburgh Mental Health and Wellbeing Partnership and the Wayfinder Public social Partnership have all been involved in the Wayfinder Graded Support plan and the need to develop increased accommodation with support which allows people to leave hospital.

Impact on plans of other parties

25. The delivery of Phase one of the reprovisioning of REH is dependent on the right community supports being available to support “flow”.

Background reading/references

Appendix 1 – Overview of Thresholds of Support Guide

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and Social Care Partnership

Report Author

Contact: Colin Beck, Mental Health and Substance Misuse Manager

E-mail:colin.beck@edinburgh.gov.uk | Tel: 0131 553 8200

Wayfinder PSP Model - Overview of Thresholds

Appendix 1

A WHOLE SYSTEM APPROACH TO SUPPORT
TRANSITIONS: Support from a range of people
CONSISTENCY: To ensure respect, relationships and trust
CULTURE: Need for respect and acknowledgement of people's roles.

PSP event identified below parameters	Grade 1	Grade 2 Visiting (regular)	Grade 3 Visiting (daily)	Grade 4 Core hours	Grade 5 24 hour staffing	Grade 6 24 hour staffing
Graded support A range of support and accommodation. Having a secure base. Support is timely and flexible.	Minimal support through naturally occurring community opportunities Measured by REIS	Regular visiting input from Health, Social Care & Third Sector staff Regular visiting Measured by REIS	Daily visiting input from Health, Social Care & Third Sector Staff. Daily visiting Measured by REIS	Core hours staffing with visiting input consisting of Health, Social Care & Third Sector staff. Measured by REIS	**Alternative to admission to support people in crisis** Crisis response/ Relapse beds Team consisting of Health (inclusive of sessional medic), Social Care & Third Sector staff 24 hour staffing Measured by REIS	High intensity rehabilitation unit 24 hour care from nursing and junior medical staff working with the multi-professional team. Measured by REIS
Person Centred Choice Identifying people's needs not problems Enabling positive risk taking	Symptoms are fully managed and there is no need for support	Person will be managing symptoms however some level of routine monitoring is required to support, engagement in managing mental health. Vulnerable aspect of risk managed. Measured by Camberwell Assessment of Needs and Sainsbury Risk Assessment	Person will be managing symptoms in order to build functional skills. Vulnerable aspect of risk managed. Measured by Camberwell Assessment of Needs and Sainsbury Risk Assessment	Person will be experiencing symptoms which are causing disruption to functional skills. Vulnerable aspect of risk managed. Measured by Camberwell Assessment of Needs and Sainsbury Risk Assessment.	Person will be experiencing a high level of symptoms which are causing significant disruption to functional skills Needs 24 hour staffing, nursing and OT Measured by Camberwell Assessment of Needs and Sainsbury Risk Assessment	Person Is medically unwell and experiencing significant symptoms which have significant impact on functional skills Needs 24 hour medical care Measured by Camberwell Assessment of Needs and Sainsbury Risk Assessment.
Meaningful Days Meaningful Occupations Addressing daily living skills Occupation which supports social inclusion	Further role development in the community.	Build on stable community living skills, routines and meaningful activities through role development. Measured by MOHOST	Maintain community living skills, routines and meaningful activities. Measured by MOHOST	Establish community living skills, routines and meaningful activities. Measured by MOHOST	Initiate community living skills, routines and meaningful activities. Measured by MOHOST	Initiate community living skills, routines and meaningful activities. Measured by MOHOST

Descriptors characterise needs of a 'typical' person; an individual's presentation may not fit all descriptors in one grade; care planning meetings will determine which grade of support best meets individual needs

Report

Item 5.7 - Financial Position for 2016/17 Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. The purpose of this report is to provide the Integration Joint Board (IJB) with an overview of the financial position for 2016/17.

Recommendations

2. Members are asked to note that, subject to external audit review, the Integration Joint Board has achieved a breakeven position for 2016/17.

Background

3. Previous finance updates have advised the board that a break even position would be delivered through a combination of:

   - social care fund monies identified by the IJB;
   - provisions made by the City of Edinburgh Council (CEC); and
   - the underwriting by NHS Lothian (NHSL) of the projected overspend in the health element of the IJB's budgets.

Main report

4. At the end of the financial year the IJB overspent against the budgets delegated by CEC and NHSL by £3.6m. This is after the agreed non recurring contribution of £6.9m from the social care fund was applied. Further one off contributions from NHSL and CEC (£2.5m and £1.1m respectively) were agreed, allowing the IJB to meet its financial targets for 16/17.

5. This position is summarised in the table below with further detail included in appendices 1 (NHSL) and 2 (CEC).

	Budget £k	Actual £k	Variance £k
NHS services			
Core services	250,497	252,816	(2,319)
Non cash limited	49,460	49,460	0
Hosted services	83,042	82,840	202
Set aside services	100,834	101,177	(343)
Sub total NHS services	**483,832**	**486,293**	**(2,461)**
CEC services	**188,456**	**189,596**	**(1,140)**
Gross position	**672,288**	**675,889**	**(3,601)**
Non recurrng contributions			
City of Edinburgh Council			1,140
NHS Lothian			2,461
Net position			**0**

Table: summary IJB financial position for 2016/17

6. In accordance with the position agreed by the IJB in November 2016, the unspent portion of the social care fund will be carried forward. Valued at £3.7m, these monies will be used to support investments aligned to the strategic plan in 2017/18.

7. The key financial issues underpinning the position to the end of March are consistent with those reported throughout the financial year. Those being:

- **prescribing** - an ongoing pressure across all four IJBs in Lothian, driven by the level of growth in both volumes and price beyond those budgeted at the beginning of the year. The overspend of £2.2m for the year is in line with the quarter 1 forecast. For 17/18 NHSL has targeted additional investment through the financial plan to reset the prescribing baseline to reflect the outturn for 16/17. Any further growth in either prices or volumes in 17/18 will therefore result in an overspend. To mitigate this, NHSL has established a £2m fund to support efficient prescribing, the IJB's share of which is c£1.1m;

- **nursing -** increased spend as a result of high levels of patient acuity and staff sickness in older people's services have resulted in. This is partly offset by vacancies in district nursing although this benefit will reverse over the course of 17/18. The Interim Chief Nurse will review the ongoing action plan; and

- delivery of **savings and recovery plans –** although under written in 16/17, efficiencies in council delivered services totalling £6.9m have been carried forward.

8. Whilst a balanced financial plan for 17/18 was presented to, and agreed by, the IJB on 24 March 2017 the challenge of delivering against this should not be underestimated. Delegated resources have been directed back to the two partner bodies and a clear focus will be required to:

- manage services within available budget;
- identify and deliver savings and recovery plans; and
- clearly scope out any investment proposals for agreement by the Strategic Planning Group.

Key risks

9. The key financial risks facing the IJB in 2017/18 and beyond were set out in the financial plan paper presented to the board on 24 March 2017.

Financial implications

10. Outlined elsewhere in this report.

Involving people

11. 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

12. As above.

Background reading/references

13. Financial Plan Update and Financial Assurance report – EIJB 24 March 2017

file:///H:/Item_5.7___Financial_Plan_Update_and_Financial_Assurance%20(2).pdf

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Moira Pringle, Interim Chief Finance Officer

E-mail: moira.pringle@nhslothian.scot.nhs.uk | Tel: 0131 469 3867

Links to priorities in strategic plan

Managing our resources effectively

NHS LOTHIAN ELEMENT OF IJB FINANCIAL POSITION 2016/17

	Budget £k	Actual £k	Variance £k
Core services			
Community AHPs	5,961	5,992	(31)
Community Hospitals	10,064	10,959	(895)
District Nursing	10,611	10,349	262
GMS	72,916	72,699	217
Mental Health	9,614	9,408	206
Prescribing	77,974	80,167	(2,193)
Resource Transfer	51,078	51,072	6
Other	12,279	12,170	109
Sub total core	**250,497**	**252,816**	**(2,319)**
Non cash limited			
Dental	26,446	26,446	0
Opthamology	9,067	9,067	0
Pharmacy	13,947	13,947	0
Sub total non cash limited	**49,460**	**49,460**	**0**
Hosted services			
AHPs	6,830	6,464	366
Complex care	1,780	2,301	(521)
GMS	5,781	5,796	(15)
Learning disabilities	8,875	8,878	(3)
Lothian unscheduled care service	5,986	5,986	0
Mental health	25,484	24,740	744
Oral health services	9,355	9,200	155
Rehabilitation medicine	4,004	3,745	259
Sexual health	3,072	3,010	62
Substance misuse	4,646	5,271	(625)
Other	7,228	7,449	(221)
Sub total hosted	**83,042**	**82,840**	**202**
Set aside services			
A & E (outpatients)	6,533	6,419	114
Cardiology	17,076	16,960	116
Gastroenterology	5,762	5,529	233
General Medicine	32,178	32,764	(586)
Geriatric Medicine	18,882	18,677	205
Infectious Disease	8,296	8,186	110
Rehabilitation Medicine	2,017	2,152	(135)
Therapies	6,063	6,177	(114)
Other	4,027	4,313	(286)
Sub total set aside	**100,834**	**101,177**	**(343)**
Grand total	**483,832**	**486,293**	**(2,461)**
Additional contribution from NHSL			**2,461**
Net postion			**0**

CITY OF EDINBURGH COUNCIL ELEMENT OF IJB
FINANCIAL POSITION 2016/17

	Position to end March 2017		
	Budget £k	Actual £k	Variance £k
External purchasing	127,855	126,604	1,251
Care at home	14,336	14,422	(86)
Community equipment	1,518	1,542	(24)
Day services	14,748	14,829	(81)
Health improvement/health promotion	1,631	1,598	33
Information and advice	3,623	3,782	(159)
Intermediate care	1,611	1,619	(8)
Local area co-ordination	1,480	1,329	151
Reablement	7,810	8,669	(859)
Residential care	22,104	22,594	(490)
Social work assessment and care management	11,509	11,994	(485)
Resource allocation	(21,290)	(21,431)	141
Telecare	700	717	(17)
Other	821	1,328	(507)
Net expenditure	**188,456**	**189,596**	**(1,140)**
Additional contribution from CEC			**1,140**
Net postion			**0**

Report

Edinburgh Integration Joint Board Unaudited Annual Accounts 2016/17
Integration Joint Board

16th June 2017

Executive Summary

1. This paper presents the unaudited 2016/17 annual accounts for Edinburgh Integration Joint Board (EIJB). They will be submitted to external audit before 30 June 2017 with final sign off by the IJB in September.

Recommendations

2. The committee is asked to note the:
   - draft financial statements submitted; and
   - proposed timescale for completion.

Background

3. Integration Joint Boards are required to produce annual accounts. The draft financial statements and timescale for finalising are discussed in the main report below.

Main report

4. It is the responsibility of the Chief Financial Officer, as the appointed "proper officer", to prepare the financial statements in accordance with relevant legislation and the Code of Practice on Local Authority Accounting in the United Kingdom (the Code). This means:
   - maintaining proper accounting records; and
   - preparing financial statements which give a true and fair view of the state of affairs of the board as at 31 March 2017 and its expenditure and income for the year.

5. In Scotland the following deadlines are laid out in the Code:

   - The proper officer is required to submit the unaudited accounts to the appointed auditor by **30 June**;
   - The authority or a committee of that authority whose remit includes audit or governance functions must meet to consider the unaudited annual accounts as submitted to the auditor by **31 August**;
   - The Local Authority Accounts (Scotland) Regulations 2014 require the authority to aim to approve the annual accounts for signature by **30 September**; and
   - To publish them by **31 October**.

6. In accordance with these requirements, the unaudited accounts were considered at the Audit and Risk Committee on 2 June 2017 and, following scrutiny by the IJB, will be submitted to external audit. Dates for consideration and scrutiny of the final accounts will be finalised following confirmation of the membership of the IJB and Audit and Risk Committee. As above, these will need to align with the deadline of 30 September 2017 for signature.

7. Scott-Moncrieff has been appointed as external auditors of EIJB. As such they will give an independent opinion on the financial statements as well as review and report on the arrangements in place to ensure the proper conduct of financial affairs and to manage performance and use of resources.

8. On conclusion of the audit the following documents will be presented by Scott-Moncrieff:

   - **Annual Audit Report**: draws significant matters arising from the audit to the attention of those charged with governance prior to the signing of the independent auditor's report; and
   - **Independent auditors' report**: provides audit opinion on the financial statements.

9. The unaudited (or draft) financial statements for the Edinburgh Integration Joint Board for 2016/17 are attached as an appendix to this report.

Key risks

10. None identified.

Financial implications

11. The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Involving people

12. The draft financial statements have been produced with the support and co-operation of both City of Edinburgh Council and NHS Lothian personnel.

Impact on plans of other parties

13. As above.

Background reading/references

14. None.

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

Report author

Moira Pringle, Interim Chief Finance Officer

E-mail: moira.pringle@nhslothian.scot.nhs.uk | Tel: 0131 469 3867

Edinburgh Integration Joint Board

Unaudited Annual Accounts 2016/17

The Annual Accounts of Edinburgh Integration Joint Board for the year ended 31 March 2017, prepared pursuant to Section 105 of the Local Government (Scotland) Act 1973 and in accordance with the terms of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom 2016/17 and Service Reporting Code of Practice.

CONTENTS

MANAGEMENT COMMENTARY

Introduction

This management commentary provides an overview of the key messages relating to the objectives and strategy of the Edinburgh Integration Joint Board (EIJB). It considers our financial performance for the year ended 31st March 2017 and provides an indication of the issues and risks which may impact upon our finances in the future.

Role and remit

EIJB was established as a body corporate by order of Scottish Ministers on 27th June 2015 under the Public Bodies (Joint Working) (Scotland) Act 2014. As a separate and distinct legal entity from City of Edinburgh Council and NHS Lothian, we are responsible for the planning of 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 arrangements for EIJB's operation, remit and governance are set out in the integration scheme which has been approved by the City of Edinburgh Council, NHS Lothian and the Scottish Government. On the 1st April 2016, functions and associated budget resources for relevant IJB functions were delegated to EIJB from NHS Lothian and the City of Edinburgh Council for the financial year 2016/17.

EIJB meets monthly and is made up of ten voting members: five elected members appointed by City of Edinburgh Council; and five NHS Lothian non-executive directors appointed by NHS Lothian. Non voting members of the Board include the EIJB Chief Officer, Chief Finance Officer, representatives from the third sector and citizen members. Service and staffing representatives are also on the Board as advisory members.

Strategic Plan

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 is to lead, where possible, on tackling health and social inequalities.

Our 3 year strategic plan was approved by the Board on 11th March 2016 and sets out how the health and social care services delegated by the City of Edinburgh Council and NHS Lothian 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. Using our budget of around £600 million, delegated from NHS Lothian and the City of Edinburgh Council, we fund community health and social care services, including GP practices and some elements of acute hospital services.

We intend to deliver our vision for a caring, healthier and 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. Our key priorities (as set out in the strategic plan) and 12 areas of focus to deliver these are shown in the diagram below:

Operational Review

We will be publishing an annual performance report at the end of July 2017 setting out our performance:

- against a range of national and local indicators, including the nine national health and wellbeing indicators;
- in delivering the actions we set out in the strategic plan;
- in managing our budget and delivering best value; and
- through the eyes of others including the people who use our services, our staff and external bodies who inspect our services or make awards

IT WOULD BE THE INTENTION TO UPDATE THIS TO REFLECT THE FINAL PERFORMANCE REPORT.

A brief summary of progress made in delivering the actions within the strategic plan is given below:

Financial Plan

Strong financial planning and management needs to underpin everything that we do to ensure that our limited resources are targeted to maximise the contribution to our objectives. A financial assurance process was undertaken on the 2016/17 funding contributions made available by NHS Lothian and the City of Edinburgh Council. Through this, baseline pressures of £5.8 million were identified in the delegated NHS budget with the council contribution assessed as representing a balanced plan, albeit incorporating a requirement to deliver savings of £15.0 million.

Based on this, the IJB budgeted to deliver partnership services at a cost of £596 million. Funding adjustments during the year increased this budget to £676 million.

Annual Accounts 2016/17

The annual accounts report the financial performance of EIJB. The main purpose is to demonstrate the stewardship of the public funds that have been entrusted to us for the delivery of our vision and strategic priorities. The requirements governing the format and content of IJBs' annual accounts are contained in The Code of Practice on Local Authority Accounting in the United Kingdom (the Code). These annual accounts have been prepared in accordance with this Code.

Financial Performance

EIJB's financial performance is presented in the comprehensive income and expenditure statement, which can be seen on page 19. The balance sheet (page 20) is also presented and sets out the liabilities and assets at 31st March 2017.

During the year we worked closely with NHS Lothian to identify measures to mitigate the funding shortfall described above and, at the year end, the full value of the pressure had reduced to £2.5 million. This was funded by NHS Lothian through their achievement of an overall breakeven position. The cost of NHS delivered services therefore matched the income available. Similarly, following an additional contribution of £1.1m from the City of Edinburgh Council, the health and social care services they provided also achieved a break even position. The combination these one off contributions allowed the IJB to achieve a balanced position for 2016/17.

In addition to this we are in a position to carry forward £3.69m of our £20.2m allocation from the social care fund. This money will be used in 2017/18 to support investments aligned to our strategic plan priorities.

Whilst a balanced position was delivered for 2016/17, significant pressures were nonetheless apparent, notably:

- **Prescribing** remains the most significant single financial issue facing delegated NHS services. Pressures on the GP prescribing budget gave rise to an in year overspend of £2.2 million. Significant efforts have been taken to improve this for 2017/18, including prioritisation of additional funding and the introduction of a new pan Lothian effective prescribing fund of £2 million;
- **Nursing** in services for older people where high levels of: vacancies; patient acuity requiring 1:1 close observations; sickness; and the use of bank nurses to achieve safe minimum staffing levels are impacting on costs;
- Delivery of **efficiencies** remains a challenge with £8.1 million of savings relating to services delivered by the City of Edinburgh Council being met on a one off basis in 2016/17. Consequently, these will be carried forward to 2017/18; and
- Continued growth in **demand** reflecting a growing elderly population who are living longer with more complex needs.

It will be important moving forward to 2017/18 and future years that expenditure is managed within the financial resources available and this will require close partnership working between EIJB as service commissioner and the City of Edinburgh Council and NHS Lothian as providers of services.

Financial Outlook, Risks and Plans for the Future

Like many other public sector organisations, we face significant financial challenges and, due to the continuing difficult national economic outlook and increasing demand for services, will need to operate within tight fiscal constraints for the foreseeable future. Pressures on public sector expenditure are expected to continue, both at a UK and Scottish level, meaning NHS Lothian and City of Edinburgh Council will face continued funding pressures for the foreseeable future. This in turn will impact on their ability to resource the functions delegated to the IJB.

Our financial plan for 2017/18 was approved on 24th March 2017 and recognises the relationship between delivery of ongoing financial balance, our ability to make investments in line with strategic plan priorities and the requirement to deliver an ambitious savings programme.

This plan recognises the additional funding, totalling £357m across Scotland, to address social care pressures over the period 2016/17 to 2017/18. Whilst this has been welcomed, we continue to face considerable challenges, many of which have significant financial consequences. Examples include:

- increased demand for services alongside reducing resources;
- impact of demographic changes;
- delays in accessing appropriate services, including social care assessments, reviews and timely discharge from hospital;
- impact of welfare reform on the residents of Edinburgh;
- impact of the living wage and other nationally agreed policies;
- risk that the savings programme does not deliver within the required timescales or achieve the desired outcomes; and
- costs associated with meeting new legislative requirements without adequate resources being put in place.

These risks mean that money is tighter than ever before. It is therefore crucial that we focus on early intervention, prevention and recovery if we are to work within the total annual budget of just over £600 million. Moving into 2017/18, we are working to proactively address the funding challenges presented while, at the same time, providing services for the residents of Edinburgh. Our priorities for the coming year include:

Embedding the locality model to ensure that citizens receive the right care in the right place at the right time – assessment, treatment and support in the community becomes the default model avoiding unnecessary admissions to hospital and reducing delays/waiting times across the system. We will do this through:

- Growing the care and support capacity within the community including the embedding of the care at home contract
- Developing a primary care strategy which will maximise the contribution of the primary care workforce to ensure GP sustainability

Enabling transformation by:

- Increasing the use of Technology Enabled Care
- Improving the end user experience of ICT
- Developing a three year sustainable financial strategy
- Developing an integrated workforce and organisational development strategy

Shifting the balance of care including:

- Producing a frail elderly strategy, including review of interim care, development of intermediate care and use of Liberton and other hospital sites
- Working with housing providers to deliver the ambitions set out in the Housing Contribution Statement
- Completing phase 1 of the Royal Edinburgh Hospital reprovision
- Developing a business case for Royal Edinburgh Hospital phase 2
- Completing the move from Murray Park

Responding to national and local requirements, including:

- the National Health and Social Care Delivery Plan
- Implementing the Carers Act and producing a new carers strategy
- British sign language plan and See Hear Strategy
- Lothian Hospitals Plan including views on acute receiving unit

Chief Officer	**Vice-Chair**	**Chief Finance Officer**
[Date]	**[Date]**	**[Date]**

STATEMENT OF RESPONSIBILTIES

STATEMENT OF RESPONSIBILITIES FOR THE STATEMENTS OF ACCOUNT

Responsibilities of the Edinburgh Integration Joint Board

The Edinburgh Integration Joint Board is required:

- to make arrangements for the proper administration of its financial affairs and to secure that it has an officer responsible for the administration of those affairs. In this Integration Joint Board, that officer is the Chief Finance Officer;
- to manage its affairs to achieve best value in the use of its resources and safeguard its assets;
- ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003); and
- to approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature by the Edinburgh Integration Joint Board on [Date].

Vice-Chair of the Edinburgh Integration Joint Board
[Date]

Responsibilities of the Chief Finance Officer

As Chief Finance Officer, I am responsible for the preparation of the EIJB's statement of accounts which, in terms of the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom ("the Code of Practice"), is required to give a true and fair view of the financial position of the EIJB at the financial year end and its income and expenditure for the year then ended.

In preparing the financial statements I am responsible for:

- selecting suitable accounting policies and then applying them consistently;
- making judgements and estimates that are reasonable and prudent; and
- complying with the Code of Practice and legislation

I am also required to:

- keep proper accounting records which are up to date; and
- take reasonable steps to ensure the propriety and regularity of the finances of the EIJB.

Statement of Accounts

I certify that the Statement of Accounts presents a true and fair view of the financial position of the Edinburgh Integration Joint Board at the reporting date, and its income and expenditure for the year ended 31 March 2017.

Chief Finance Officer
[Date]

REMUNERATION REPORT

The Chief Officer of the Edinburgh Integration Joint Board (EIJB) is a joint appointment between City of Edinburgh Council, NHS Lothian and the EIJB. The terms and conditions, including pay for the post, are those set by the City of Edinburgh Council, who employ the post holder directly and recharge the costs to EIJB and NHS Lothian.

The EIJB Interim Chief Financial Officer is appointed by the EIJB and is supplied without charge by NHS Lothian.

The voting members of the EIJB are appointed by the respective partner bodies (NHS Lothian and City of Edinburgh Council). The voting members from NHS Lothian and City of Edinburgh Council in the period April 2016 to March 2017 were:

G. Walker (Chair) *(resigned 31.01.17)*	NHS	R. Henderson (Vice Chair)	CEC
M. Ash *(appointed 20.01.17)*	NHS	E. Aitken	CEC
S. Allan	NHS	J. Griffiths	CEC
K. Blair *(resigned 18.11.16)*	NHS	S. Howat	CEC
C. Hirst *(appointed 01.02.17)*	NHS	N. Work	CEC
A. Joyce	NHS		
R. Williams	NHS		

G. Walker resigned on 31 January 2017, because of his term as a non-executive director on NHS Lothian ending. G Walker was appointed as a non-voting additional member from 1 February 2017.

No expenses policy has yet been set by the EIJB. Councillors and NHS Non-Executive Directors are able through their parent bodies to reclaim any expenses. In the period to 31 March 2017, no expense claims were made in relation to work on the EIJB. The Chair of the EIJB was in receipt of additional remuneration in 2016/17 relating to his duties for the EIJB £6,758 (2015/16 £6,160). No allowances were paid to other voting members in this period. The remuneration and pension benefits received by all voting members in 2016/17 are disclosed in the remuneration reports of their respective employer.

Remuneration Paid to Senior Officers

	Period to 31/3/2017			**Period to 31/03/2016**
	Salary, fees and allowances (£)	Taxable expenses (£)	Total remuneration (£)	Total remuneration (£)
R. McCulloch-Graham, EIJB Chief Officer (from 26/10/2015)	148,901	-	**-**	**63,806**
Full year equivalent				*148,901*

Pension benefits

Pension benefits for the Chief Officer of the EIJB are provided through the Local Government Pension Scheme (LGPS). For local government employees, the Local Government Pension Scheme (LGPS) became a career average pay scheme on 1 April 2015. Benefits built up to 31 March 2015 are protected and based on final salary. Accrued benefits from 1 April 2015 will be based on career average salary.

The scheme's normal retirement age is linked to the state pension age (but with a minimum age of 65).

From 1 April 2009, a five-tier contribution system was introduced with contributions from scheme members being based on how much pay falls into each tier. This is designed to give more equality between the cost and benefits of scheme membership

The contribution rates for 2016/17 were as follows:

Whole Time Pay rate

Whole Time Pay	Contribution rate
On earnings up to and including £20,500 (2016 £20,500)	5.50%
On earnings above £20,500 and up to £25,000 (2016 £20,500 to £25,000)	7.25%
On earnings above £25,000 and up to £34,400 (2016 £25,000 to £34,400)	8.50%
On earnings above £34,400 and up to £45,800 (2016 £34,400 to £45,800)	9.50%
On earnings above £45,800 (2016 £45,800)	12.00%

If a person works part-time their contribution rate is worked out on the whole-time pay rate for the job, with actual contributions paid on actual pay earned.

There is no automatic entitlement to a lump sum. Members may opt to give up (commute) pension for lump sum up to the limit set by the Finance Act 2004. The accrual rate guarantees a pension based on 1/60th of final pensionable salary and years of pensionable service.

The value of the accrued benefits has been calculated based on the age at which the person will first become entitled to receive a pension on retirement without reduction on account of its payment at that age; without exercising any option to commute pension entitlement into a lump sum; and without any adjustment for the effects of future inflation.

The pension figures shown relate to the benefits that the person has accrued as consequence of their total local government service, and not just their current appointment.

The pension entitlements of the Chief Officer for the period to 31 March 2017 are shown in the table below, together with the employer contribution made to the employee's pension during the year. No accrued pension benefits are included in the table below as the employee has been a member of the pension scheme for less than 2 years.

	In-Year Contribution			Accrued Pension Benefits	
	For year to 31/03/17 £	For period to 31/3/16 £		at 31/3/17 £	at 31/3/16 £
R. McCulloch-Graham, Chief Officer (from 26/10/2015)	31,716	13,654	Pension	n/a	n/a
			Lump Sum	n/a	n/a

The Chair of the EIJB is not a member of the Local Government Pension Scheme or the NHS Pension scheme; therefore, no pension benefits are disclosed.

All information disclosed in the tables in this remuneration report will be audited by Scott-Moncrieff. The other sections of the report will be reviewed by Scott Moncrieff to ensure that they are consistent with the financial statements.

Chief Officer
[Date]

Vice-Chair
[Date]

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

The Edinburgh integration Board (EIJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded and properly accounted for, and that arrangements are in place to secure best value.

In discharging this responsibility, The EIJB and the Chief Officer have put in place arrangements for governance which includes robust internal controls, including the management of risk.

Governance Framework

The governance framework comprises the systems and processes, culture and values, by which the EIJB is controlled and directed. It enables the EIJB to monitor the progress with its strategic priorities and to consider whether those objectives have led to the delivery of appropriate services and value for money.

A key element of the EIJB's governance framework is its formal committee and sub-groups. These groups provide additional layers of governance, scrutiny and rigour to the business of the EIJB. Their different roles covering the wide spectrum of the EIJB's business, allows increased scrutiny and monitoring and the focus and capability to provide the EIJB with the necessary assurance.

Edinburgh Integration Joint Board

The EIJB has been responsible for health and social care functions in Edinburgh since 1 April 2016. The Board consists of 10 voting members of which five are non-executive directors of NHS Lothian and five are councillors from the City of Edinburgh Council. There are also a number of non-voting members both appointed due to the statutory requirements and to provide more varied experience and knowledge to the Board.

Strategic Planning Group

The Strategic Planning Group (SPG) was formally established in May 2016. It is chaired by the vice-chair of the EIJB, and the chair of the EIJB is the vice-chair. This ensures a strong link with the leadership of the EIJB but allows an increased focus. The SPG reviews business cases to ensure they are robust and meet the aims of the strategic plan, provides assurance to the EIJB on whether there has been appropriate consultation and engagement in line with statutory responsibilities. The SPG also oversees the delivery of the strategic plan. The annual review of the Strategic Plan has also commenced and is focussing on the financial plan, directions and annual performance.

Audit and Risk Committee

The Audit and Risk Committee is a key component of creating a strong governance culture. Its role is to assist the EIJB in ensuring that there is a robust framework in place to provide assurance on risk management,

governance and internal control. It also scrutinises internal and external audits and can make recommendations to the EIJB on any matter within its remit.

A work programme including annual approval of IJB Accounts, Internal Audit Charter, Internal Audit Plan and Chief Internal Auditor Opinion has been established. The Committee also annually considers the External Audit Plan and External Auditor's Opinion.

Performance and Quality sub-group

The EIJB has agreed to integrate performance reporting from both the City of Edinburgh Council and NHS Lothian. A performance and quality sub-group was also established which was to provide assurance to the EIJB on the quality of the service being provided. This has recently been reviewed to ensure continuous improvement, in line with the requirements to deliver best value. The sub-group will focus on the delivery of the annual performance report and the review and monitoring of this twice a year.

Flow Board

The Flow Board was specifically created to improve the situation regarding delayed discharge. Delayed discharge had been identified as a significant issue requiring concerted partnership efforts to support improved performance.

Professional Advisory Group

The EIJB has also retained the Professional Advisory Group. This group was created in 2012 and provides professional guidance to the EIJB. It has membership on the Strategic Planning Group and the Performance and Quality Sub-Group.

Officers

As required by the legislation the EIJB has appointed a Chief Officer and a Chief Finance Officer. It has also appointed a Chief Internal Auditor and had put in place an interim Chief Risk Officer to establish risk management in the EIJB. A replacement Chief Risk Officer is expected to be put in place in the near future. The EIJB has also appointed a Standards Officer.

Governance Documentation

The EIJB has agreed the following governance documentation:

- Financial Regulations – Section 95 of the Local Government (Scotland) Act 1973 requires all IJBs to have adequate systems and controls in place to ensure the proper administration of their financial affairs. The EIJB has agreed a set of financial regulations which are supported by a series of financial directives and instructions with clear lines of delegation to the Chief Finance Officer to carry out that function.
- A Code of Conduct for the members of the EIJB has been agreed and made available to all members. Compliance with the Code of Conduct is regulated by the Standards Commission for Scotland. Training is provided to members on the Code of Conduct.

- A set of Standing Orders has been agreed which sets out the rules governing the conduct and proceedings at the EIJB and its committees. The Standing Orders includes rules on the notice of meetings and how voting and debate should be conducted.

Board and Committee Processes

The EIJB and the Audit and Risk Committee both have a rolling actions log which helps the groups monitor the implementation of decisions.

A formal referral process for relevant audit reports has been agreed with the Council's Chief Internal Auditor and the City of Edinburgh Council's Governance, Risk and Best Value Committee. A similar approach has been sought with NHS Lothian. This ensures that audit information can be shared between the three organisations.

A deputation process has been agreed by the EIJB which allows and encourages groups to directly address the Board on issues under consideration.

Risk Management

The EIJB created a risk register in July 2016 which prioritised and scored inherent risks was developed by the IJB Senior Management Team, supported by PwC. The risk register has been continually updated, including having specific development sessions where all members could take part in a discussion on risk appetite. As a result of consideration in the development session, a revised Risk Register was presented to the Audit and Risk Committee on 2 September 2016 alongside actions to ensure the Risk Register remained current and dynamic. These actions included assigning ownership to each risk and submitting the register to the Audit and Risk Committee on a quarterly basis.

The IJB Senior Management Team, supported by PwC, met in February 2017 to further develop the risk register with the aim of fully assigning ownership of each risk. A resultant risk register has been produced which lists 49 risks across the IJB, Edinburgh Health and Social Care Partnership, NHS Lothian and City of Edinburgh Council.

A risk register is in place for the restructure of services overseen by the Locality Implementation Group.

Procurement

The Health and Social Care Partnership Procurement Board exercises oversight of all proposals to award, extend or terminate contracts with third party providers.

Complaints

A review of complaint handling was undertaken in July 2016. The results of this transferred the management of complaints. Further work is necessary to develop a single recording system for the management and co-ordination of complaints to ensure a more efficient and robust system.

Review of Effectiveness

The EIJB has responsibility for reviewing the effectiveness of the governance arrangements including the internal controls.

The Chief Officer has completed an annual assurance questionnaire for the EIJB and the health and social care partnership.

Standing Orders are reviewed annually in a report to the EIJB, to ensure they are up to date and relevant.

The Health and Social Care Partnership's contract management framework is subject to annual internal review.

A quarterly Internal Audit update detailing Internal Audit activity on behalf of the EIJB is submitted to the Audit and Risk Committee.

The Chief Internal Auditor provides an annual audit opinion.

Regular finance monitoring reports are presented to the EIJB and Council and NHS committees. Monitoring arrangements have been effective in identifying variances and control issues and taking appropriate action. This has included allocating funds to offset unachieved saving plans.

The report on the Joint Inspection of Services for Older People identified a number of areas of concern and identified recommendations. It did highlight though that the EIJB had appropriate governance arrangements in place to support the integration of health and social care and that demonstrated a commitment to engage with the community.

Major business continuity risks are reviewed regularly and three business continuity audits have been undertaken in the previous year. Feedback on these has been positive.

Further development

The EIJB has information governance responsibilities under legislation, including the Data Protection Act 1998, the Freedom of Information (Scotland) Act 2002 and the Public Records (Scotland) Act 2011. Arrangements are being developed to ensure EIJB compliance with statutory requirements. Failure to do so could result in reputational damage and financial penalties

Further work is ongoing to review the risk register, embed ongoing review and scrutiny and better reflect the structural changes of integration. The risk register will aim to improve the delineation between EIJB risks and

NHS Lothian and the City of Edinburgh Council risks. The Audit and Risk Committee is expected to agree a further formal refresh of the Risk Register on 2 June 2017.

Work is currently taking place to review internal controls and procedures as part of the continuing work on integration. This review will consider effectiveness, update where necessary and identify any gaps.

Work is ongoing to review the current audit capacity to ascertain whether the current resources allocated to audit work are adequate to provide robust assurance for the EIJB.

Certification

It is our opinion that in light of the foregoing, reasonable assurance, subject to the matters raised above, can be placed on the effectiveness and adequacy of the EIJB's systems of governance.

Chief Officer
[Date]

Vice-Chair
[Date]

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the accounting cost in the year of providing services in accordance with generally accepted accounting practices

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

FOR THE YEAR ENDED 31 MARCH 2017

2015/16			2016/17		
Net Expenditure £000		Note	Gross expenditure £000	Gross income £000	Net Expenditure £000
0	Health services		486,291	-486,291	0
0	Social care services		189,596	-189,596	0
0	Corporate services	2&3	277	-277	0
0	**(Surplus) / deficit on provision of services**		**676,164**	**-676,164**	**0**
0	**Taxation and non-specific grant income and expenditure**				**-3,690**
0	**Net income and expenditure**				**-3,690**

BALANCE SHEET

The Balance Sheet shows the value as of the assets and liabilities recognised by the board. The net assets of the Board are matched by the reserves held by the Board.

BALANCE SHEET AS AT 31 MARCH 2017

31/03/2016		Notes	31/03/2017
£000			*£000*
	Current assets		
47	Short term debtors	4	3,714
	Current liabilities		
-47	Short term creditors	5	-24
0	**Net assets**		**3,690**
0	Usable reserves	6	-3,690
0	**Total reserves**		**-3,690**

I certify that the Statement of Accounts present a true and fair view of the financial position of the Edinburgh Integration Joint Board as at 31 March 2017 and its income and expenditure for the period.

The unaudited financial statements were issued on [Date].

Chief Finance Officer
[Date]

NOTES TO ACCOUNTS

1. ACCOUNTING POLICIES

1.1 General Principles

The Annual Accounts for the year ended 31 March 2017 have been prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17 (the Code) and the Service Reporting Code of Practice. This is to ensure that the accounts 'present a true and fair view' of the financial position and transactions of the Edinburgh Integration Joint Board (EIJB).

1.2 Accruals of Income and Expenditure

The revenue accounts have been prepared on an accruals basis in accordance with the Code of Practice

1.3 VAT Status

The EIJB is a non-taxable person and does not charge or recover VAT on its functions.

1.4 Going Concern

The accounts are prepared on a going concern basis, which assumes that the EIJB will continue in operational existence for the foreseeable future.

1.5 Funding

Edinburgh Integration Joint Board receives contributions from its funding partners, namely NHS Lothian and the City of Edinburgh Council to fund its services.

Expenditure is incurred in the form of charges for services provided to the EIJB by its partners.

1.6 Provisions, Contingent Liabilities and Assets

Contingent assets are not recognised in the accounting statements. Where there is a probable inflow of economic benefits or service potential, this is disclosed in the notes to the financial statements.

Contingent liabilities are not recognised in the accounting statements. Where there is a possible obligation that may require a payment, or transfer of economic benefit, this is disclosed in the notes to the financial statements

The value of provisions is based upon the Board's obligations arising from past events, the probability that a transfer of economic benefit will take place and a reasonable estimate of the obligation.

1.7 Employee Benefits

The Chief Officer is regarded as an employee of the EIJB although their contract of employment is with City of Edinburgh Council. The LGPS is a defined benefit statutory scheme, administered in accordance with the Local Government Pension Scheme (Scotland) Regulations 1998, as amended.

The post is funded by the EIJB however the statutory responsibility for employer pension liabilities rests with the employing partner organisation (City of Edinburgh Council).

The remuneration report presents the pension entitlement attributable to the post of the EIJB Chief Officer but that the EIJB has no formal ongoing pension liability. Edinburgh Integration Joint Board will be expected to fund employer pension contributions as they become payable during the Chief Officer's period of service. On this basis, there is no pensions liability reflected on the EIJB balance sheet for the Chief Officer.

1.8 Cash and Cash Equivalents

The EIJB does not hold a bank account or any cash equivalents. Payments to staff and suppliers relating to delegated services will be made through cash balances held by the partner organisations (NHS Lothian and City of Edinburgh Council). On this basis, no Cash Flow statement has been prepared in this set of Annual Accounts.

1.9 Reserves

Reserves are created by appropriating amounts out of revenue balances. The EIJB has one usable reserve, the General Fund. This fund can be used to mitigate financial consequences of risks and other events impacting on the Boards resources. Monies within this fund can be earmarked for specific purposes.

When expenditure to be funded from a reserve is incurred, it is charged to the appropriate service in that year and thus included in the Comprehensive Income and Expenditure Statement. Movements in reserves are reported in the Movement of Reserves Statement.

1.10 Support Services

Support services are not delegated to the EIJB through the Integration scheme, and are instead provided by NHS Lothian and the City of Edinburgh Council free of charge, as a 'service in kind'. Support services provided mainly comprise the provision of financial management, human resources, legal services, committee services, ICT, payroll and internal audit services.

2. RELATED PARTY TRANSACTIONS

The Edinburgh Integration Joint Board was established on 27 June 2015 as a joint board between City of Edinburgh Council and NHS Lothian. In 2015/16 there were no financial transactions made relating to delegated health and social care functions as functions were not delegated by partners to the Integration Joint Board until 1 April 2016. The income received from the two parties was as follows:

	31/03/2017	31/03/2016
	£000	£000
NHS Lothian	-486,410	-52
City of Edinburgh Council	-189,754	-45
Total	**-676,164**	**-97**

Expenditure relating to the two parties was as follows;

	31/03/2017	31/03/2016
	£000	£000
NHS Lothian	486,398	50
City of Edinburgh Council	189,698	42
Total	**676,096**	**92**

Details of creditor and debtor balances with the partner bodies are set out in the subsequent notes (4 and 5).

3. CORPORATE EXPENDITURE

	31/03/2017	31/03/2016
	£000	£000
Staff Costs	206	92
Other Fees	47	0
Audit Fees	24	5
Total	**277**	**97**

Staff costs relate to the EIJB Chief Officer and EIJB Chair.

EIJB were in receipt of NHS Lothian and City of Edinburgh Council support services in 2016/17 and 2015/16. NHS Lothian and the City of Edinburgh Council have agreed to provide support services, without an onward of recovery. Support services to a value of £x.xxxm have been provided. In 2015/16, in the absence of an SLA or any reliable means of estimating the cost of this support, no charge was made to the EIJB from the parent bodies for these services. This included the provision of an interim Chief Finance Officer, strategic planning services, accommodation, HR and transactional services. These services were provided by both the Council and NHS Lothian.

4. SHORT TERM DEBTORS

	31/03/2017	31/03/2016
	£000	£000
Central Government Bodies	12	3
Other Local Authorities	3,702	44
Total	**3,714**	**47**

5. SHORT TERM CREDITORS

	31/03/2017	31/03/2016
	£000	£000
Central Government Bodies	0	-5
Other Local Authorities	0	-42
Other Bodies	-24	0
Total	**-24**	**-47**

6. MOVEMENT IN RESERVES

	31/03/2017	31/03/2016
	£000	£000
Usable reserves – General Fund brought forward	0	0
Surplus on the provision of services	-3,690	0
Other comprehensive income and expenditure	0	0
Total comprehensive income and expenditure	**-3,690**	**0**
Balance, as at 31 March carried forward	**-3,690**	**0**

7. POST BALANCE SHEET EVENTS

No material events have occurred post the balance sheet reporting date.

8. CONTINGENT LIABILITIES and ASSETS

There are no contingent liabilities or assets to disclose.

9. SEGMENTAL REPORTING

Expenditure on services commissioned by the EIJB Board from its partner agencies is analysed over the following services:

HEALTH SERVICES	Budget £000	Actual Expenditure £000	Variance £000
Core services			
Community AHPs	5,961	5,992	-31
Community hospitals	10,064	10,959	-895
District nursing	10,611	10,349	262
GMS	72,916	72,699	217
Mental health	9,614	9,408	206
Prescribing	77,974	80,167	-2,193
Resource transfer	51,078	51,072	6
Other	12,278	12,170	108
Total core services	**250,496**	**252,816**	**-2,320**
Hosted services			
AHPs	6,830	6,464	366
Complex care	1,780	2,301	-521
GMS	5,781	5,796	-15
Learning disabilities	8,875	8,878	-3
Lothian unscheduled care service	5,986	5,986	0
Mental health	25,484	24,740	744
Oral health services	9,355	9,200	155
Rehabilitation medicine	4,004	3,745	259
Sexual health	3,072	3,010	62
Substance misuse	4,646	5,271	-625
Other	6,566	6,763	-197
Total hosted services	**82,379**	**82,154**	**225**

HEALTH SERVICES	Budget £000	Actual Expenditure £000	Variance £000
Set aside services			
Accident and emergency (outpatients)	6,533	6,419	114
Cardiology	17,076	16,960	114
Gastroenterology	5,762	5,529	233
General medicine	32,178	32,764	-584
Geriatric medicine	18,882	18,677	205
Infectious disease	8,296	8,186	110
Rehabilitation medicine	2,017	2,152	-135
Therapies	6,063	6,177	-114
Other	4,027	4,312	-285
Total set aside services	**100,834**	**101,176**	**-342**
Non Cash Limited			
Therapies	26,447	26,447	0
Ophthalmology	9,067	9,067	0
Pharmacy	13,947	13,947	0
Total Non Cash Limited	**49,461**	**49,461**	**0**
Corporate			
Other	664	684	-20
Reserves	2,457	0	2,457
Total corporate	**3,121**	**684**	**2,437**
Total Health Services	**486,291**	**486,291**	**-**
SOCIAL CARE SERVICES			
External purchasing	127,855	126,604	1,251
Care at home	14,336	14,422	-86
Community equipment	1,518	1,542	-24
Day services	14,748	14,829	-81
Health improvement / health promotion	1,631	1,598	33
Information and advice	3,623	3,782	-159
Intermediate care	1,611	1,619	-8
Local area co-ordination	1,480	1,329	151
Reablement	7,810	8,669	-859
Residential care	22,104	22,594	-490
Social work assessment and care management	11,509	11,994	-485
Resource Allocation	-21,290	-21,431	141
Telecare	700	717	-17
Other	821	1,328	-507
Additional contribution from City of Edinburgh Council	1,140	-	1,140
Total Social Care Services	**189,596**	**189,596**	**-**
TOTAL ALL SERVICES	**675,887**	**675,887**	**-**

10. INDEPENDENT AUDITOR'S REPORT

The Statement of Accounts is subject to audit in accordance with the requirements of Part VII of the Local Government (Scotland) Act 1973.

The Auditor appointed for this purpose by the Accounts Commission for Scotland is:

Nick Bennett, Audit Partner
Scott-Moncrieff
Exchange Place
3 Semple Street
EDINBURGH
EH3 8BL

Item 5.9

Report

Edinburgh Integration Joint Board Responsibilities for Data and Information
Edinburgh Integration Joint Board
16 June 2017

Executive Summary

1. This report sets out the Edinburgh Integration Joint Board's (EIJB) responsibilities in relation to information governance. It highlights progress to date, future considerations and the current actions required to ensure compliance with information governance legislation.

Recommendations

2. The Edinburgh Integration Joint Board is asked to:

    - note progress made to date;
    - approve the proposal to register the Edinburgh Integration Joint Board with the UK Information Commissioner; and
    - note the intention to report to a future Joint board meeting on General Data Protection Regulations requirements and responsibilities.

Background

3. The Edinburgh Integration Joint Board has information governance responsibilities (separate to those of the Council and NHS Lothian) in relation to strategic planning and delegated functions which it determines and directs with its partners. These relate to the Data Protection Act 1998, the Freedom of Information (Scotland) Act 2002, the Environmental Information (Scotland) Regulations 2004 and the INSPIRE (Scotland) Regulations 2011.

Main report

4. Organisations that process personal data are required to comply with the UK Data Protection Act 1998 (DPA). Personal data relates to information that can identify an individual, and processing is concerned with its collection, storage, use, management, sharing and disposal. Compliance with the DPA is regulated by the UK Information Commissioner.

5. Organisations that direct how personal data is processed are defined as data controllers and are required, under the section 17 of the DPA, to register with the UK Information Commissioner. The UK Information Commissioner's Office (ICO) has confirmed that the Edinburgh Integration Joint Board is a data controller. This means that the Board must register the types of personal data it processes and how that data is processed.

6. The City of Edinburgh Council's Information Governance Unit (IGU) has, in consultation with other Lothian IJB Information Governance colleagues, agreed the proposed content of the Edinburgh Integration Joint Board's ICO registration. This is attached as Appendix A to this report and it is recommended the Board approves completion of the registration process.

7. As a data controller, the Board is responsible for responding to Subject Access Requests (SARS) made under Section 7 of the DPA. SARS are requests made by an individual, known as a data subject, to see or obtain a copy of their personal data. Requests must be responded to within 40 calendar days. Discussions are on-going as to how this statutory responsibility will be processed and resourced. It envisaged that the City of Edinburgh Council or NHS Lothian will continue to fulfil this function on behalf of the Edinburgh Integration Joint Board's delegated functions pending discussions.

8. In relation to the joint processing of personal data for the delivery of delegated functions, the Edinburgh Integration Joint Board is a joint data controller, with the City of Edinburgh Council and NHS Lothian. To achieve appropriate governance in this regard, the Edinburgh Integration Joint Board is a signatory to the Pan Lothian Information Sharing Protocol. A memorandum of understanding (MOU) has also been drafted to ensure that responsibilities in relation to the processing of personal data are clearly set out and understood between the Edinburgh Integration Joint Board, the City of Edinburgh Council and NHS Lothian. Once agreed, the MOU will be underpinned by subsidiary agreements to ensure that information governance arrangements support integrated working and practices, and that statutory requirements are fully met. This will include the provision of appropriate privacy notices detailing how people's personal data is processed and used.

9. The General Data Protection Regulations (GDPR) will come into full force on 25 May 2018. GDPR provides a new privacy framework to regulate the processing of personal data and replaces the current UK Data Protection Act 1998.

10. While there are many similarities with the current legislation, there are new and different requirements which will have an impact on data protection governance and processing activities. The statutory emphasis around accountability and governance will require the Edinburgh Integration Joint Board to nominate a Data Protection Officer.

11. A future report will be prepared for the Board setting out GDPR requirements and responsibilities. The report will consider and incorporate the latest guidance issued by the UK Information Commissioner's Office and the Article 29 Working Group in relation to GDPR compliance.

12. The Freedom of Information (Scotland) Act 2002, the Environmental Information (Scotland) Regulations 2004 and the INSPIRE (Scotland) Regulations 2011 provide

a statutory right of access to information held by Scottish Public Authorities, including the Edinburgh Integration Joint Board. Responses to requests must be provided within 20 working days, and applicants who are dissatisfied with a response to a request have a right to seek a review of that decision. They also have a right, if they remain dissatisfied, to appeal to the Office of the Scottish Information Commissioner and ultimately to appeal to the Court of Session on a point of law only.

13. The Edinburgh Integration Joint Board is also required, under Section 23 of The Freedom of Information (Scotland) Act 2002, to maintain a Publication Scheme which sets out the types of information that a Scottish Public Authority routinely makes available (called a 'Guide to Information') and how members of the public can access that information. The Publication Scheme must be approved by the Office of the Scottish Information Commissioner.

14. A Publication Scheme was prepared, on the Edinburgh Integration Joint Board's behalf, by the City of Edinburgh Council's Information Governance Unit which adopted the Scottish Information Commissioner's Model Publication Scheme. The Board received notification on 11 April 2017 that the Publication Scheme submitted had been approved by the Scottish Information Commissioner.

15. As above, discussions are on-going as to how statutory responsibilities will be processed and resourced going forward.

16. The Edinburgh Integration Joint Board is obliged to comply with the Public Records (Scotland) Act 2011 (PRSA). The PRSA is intended to promote better record keeping and requires public authorities to prepare and implement a five-year Records Management Plan (RMP) which sets out proper arrangements for the management of records, including areas identified for improvement. It must be approved by the Keeper of the Records of Scotland, reviewed regularly, and include the 14 record keeping elements outlined in a model RMP provided by the Keeper.

17. It is envisaged that the Edinburgh Integration Joint Board RMP will relate to records held directly by the Board and that records produced as part of a delegated function are covered in the respective RMPs of the City of Edinburgh Council and NHS Lothian. This arrangement will acknowledge that delegated functions are provided on the Edinburgh Integration Joint Board's behalf by each respective authority.

18. The Keeper has embarked on a phased programme to approve Records Management Plans. The Edinburgh Integration Joint Board will not be required to produce an RMP until the request for submission of a draft is made. A further report will be brought to the Board once RMP timescales have been confirmed.

Key risks

19. Failure to comply with information governance legislation can result in the following:

    - Distress or harm to individuals or organisations.
    - Reputational damage to the Edinburgh Integration Joint Board, City of Edinburgh Council and NHS Lothian.

- Financial loss or monetary penalty imposed.
- Detrimental impact on Council business and service delivery.
- Non-compliance with legislation and potential litigation.

20. A review of A review of data integration and sharing was undertaken by Internal Audit on behalf of the Integration Joint Board in May 2017. The report makes recommendations in respect of the need for:

- Roles and responsibilities for the management of access to critical systems; reporting and escalation of issues; and ensuring compliance with legal regulations to be clearly defined and communicated; and
- Processes, such as access management and communication protocols for data sharing to be fully established and embedded.

Action plans are in place to address these recommendations.

Financial implications

21. Failure to comply with the requirements of the Data Protection Act 1998 could result in enforcement action by the Information Commissioner's Office, including imposition of a civil monetary penalty that could result in a fine of up to £500,000 for each breach.

Involving people

22. Information governance legislation upholds the information rights of individuals and ensures that their personal data is processed appropriately and lawfully.

Impact on plans of other parties

23. Information governance arrangements and issues are discussed by the Joint Information Governance Group to ensure a consistency of approach between NHS Lothian, the Lothian Councils and Lothian Integrated Joint Boards.

Background reading/references

Data Protection Act 1998

Freedom of Information (Scotland) Act 2002

Environmental Information (Scotland) Regulations 2004

INSPIRE (Scotland) Regulations 2009

Public Records (Scotland) Act 2011

Office of the Scottish Information Commissioner

Information Commissioner's Office

Report author

Kevin Wilbraham, Records & Information Compliance Manager

E-mail: Kevin.wilbraham@edinburgh.gov.uk| Tel: 0131 469 6174

Rob McCulloch-Graham

Chief Officer, Edinburgh Health and Social Care Partnership

Appendix A

Data Controller: Edinburgh Integration Joint Board

Address:
Health & Social Care Partnership
City of Edinburgh Council
Waverley Court
4 East Market Street
Edinburgh, EH8 8BG

This data controller states that it is a public authority under the Freedom of Information Act 2000 or a Scottish public authority under the Freedom of Information (Scotland) Act 2002

This register entry describes, in very general terms, the personal data being processed by:

Edinburgh Integration Joint Board

Nature of work - Integration Joint Board

Description of processing

The following is a broad description of the way this organisation/data controller processes personal information. To understand how your own personal information is processed you may need to refer to any personal communications you have received, check any privacy notices the organisation has provided or contact the organisation to ask about your personal circumstances.

Reasons/purposes for processing information

We process personal information to enable us to:

- oversee the provision of delegated health and social care services in our area
- maintain our accounts and records
- promote our services
- undertake research
- support and manage our employees
- administer our Board

Type/classes of information processed

We process information relevant to the above reasons/purposes. This information may include:

- personal details
- family, lifestyle and social circumstances
- goods and services
- financial details

- employment and education details

We also process sensitive classes of information that may include:

- physical and mental health details
- sexual life
- racial or ethnic origin
- trade union membership
- religious or other beliefs of a similar nature
- offences and alleged offences
- trade union membership

Who the information is processed about

We process personal information about:

- patients and service users
- staff
- suppliers and service providers
- survey respondents
- business contacts
- professional experts and consultants
- offenders and suspected offenders

Who the information may be shared with

We sometimes need to share the personal information we process with the person to whom it relates and also with other organisations. Where this is necessary, we are required to comply with all aspects of the Data Protection Act (DPA). What follows is a description of the types of organisations we may need to share some of the personal information we process with for one or more reasons.

Where necessary or required we share information with:

- NHS Lothian
- Other Lothian Councils: West Lothian Council, Midlothian Council, East Lothian Council
- Other Lothian Integration Joint Boards: West Lothian Integration Joint Board, Midlothian Integration Joint Board, East Lothian Integration Joint Board
- healthcare, welfare and social professionals
- social and welfare organisations
- central government
- local government
- family, associates and representatives of the person whose personal data we are processing
- suppliers and service providers
- financial organisations
- current, past and prospective employers
- voluntary and charitable organisations
- legal representatives
- employment agencies and examining bodies
- survey and research organisations
- security organisations
- police forces

- persons making an enquiry or complaint

Transfers

It may sometimes be necessary to transfer personal information overseas. When this is needed, information will normally be shared within the European Economic Ares (EEA) or other adequate countries under the General Data Protection Regulation (GDPR), and when outwith these countries, with appropriate controls in place.

Report

Item 5.10 - Integration Indicators

Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. In December 2016, the Ministerial Strategic Group for Health and Community Care invited Integration Authorities to set out local objectives against a set of six areas of activity, as a means of measuring progress under integration. This paper sets out the proposed indicators and targets recommended for adoption by the Edinburgh Integration Joint Board (EIJB).

Recommendations

2. The Edinburgh Integration Joint Board is asked to approve the indicators and targets set out in section 5 below, for adoption as a means of measuring progress under integration, in response to the invitation from the Ministerial Strategic Group for Health and Community Care.

Background

3. In December 2016, the Ministerial Strategic Group for Health and Community Care (MSG) agreed to proposals to consider quarterly updates on key indicators across health and social care to allow them to track progress under integration in the following areas:

    - Unplanned admissions
    - Occupied bed days for unscheduled care
    - Accident and Emergency Performance
    - Delayed discharges
    - End of life care
    - The balance of spend across institutional and community services

Chief Officers were invited to set their local objectives for each of the indicators for 2017/18.

4. A key indicator was selected for each of the six areas, using data provided by the Information Services Division (ISD) of NHS Scotland. The selection was made through discussion with colleagues in NHS Lothian and the other Lothian Health and Social Care Partnerships, with the intention of taking a consistent approach, where possible.

Main report

5. The table below sets out each of the proposed indicators and targets along with information about the scale of change required to deliver the targets and current performance in Edinburgh compared with other Health and Social Care Partnerships.

Unscheduled Admissions (all ages) (rate per 1,000 total population)	
Target:	Maintain mean level for 2016 which was 3,206
Scale of change required:	Maintain current performance
Recent comparative performance:	Based upon the average (mean) performance for the period July to December 2017, Edinburgh ranked 3rd lowest out of 32 Partnerships (where low is good).

Occupied Bed Days Unscheduled Care (all ages, acute specialities) (rate per 1,000 total population)	
Target and rationale:	Reduce occupied bed days by 10% for 2018 compared to 2017. This is a Scotland-wide target.
Scale of change needed:	Reduction from a median of 27,915 (November 2014 to Oct 2016) to 25,124. This equates to a saving of 2,792 days per month (the equivalent of 92 beds) which is a significant challenge.
Recent comparative performance	Based upon the six-monthly rolling average (mean) for July to December 2016, Edinburgh was ranked 22nd highest out of 32 (where low is good).

Accident and Emergency Performance: compliance with the four-hour standard	
Target and rationale:	95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment. This is a Scotland-wide target.
Scale of change needed:	Increase the number of patients waiting less than 4 hours.
Recent comparative performance	In February 2017, Edinburgh was ranked 19th highest out of 32 with 92.3%

Delayed Discharge Bed Days (including code 9s) (rate per 1,000 total population)	
Targets:	a) Non-complex codes (i.e. excluding code 9): - 50% reduction in bed days occupied in July to December 2017 compared with July to December 2016 - reduction in the number of people delayed by December 2017 to 50 b) Code 9 - 20% reduction in bed days occupied in July to December 2017 compared with July to December 2016 - 20% reduction in the number of people delayed by December 2017 compared with December 2016
Scale of change needed:	a) From baseline (July to December 2016) for non-complex codes, reduce from 32,476 to 16,238 bed days; and from 177 to 50 people b) From baseline (December 2016) for code 9s: reduce from 4,250 to 3,400 bed days and from 18 to 14 people
Recent comparative performance for bed days only:	For the baseline period (July to December 2016): 6. Non-complex: codes Edinburgh was ranked 4th highest (where low is good). 7. Complex codes: Edinburgh ranked 20th highest (where low is good).

End of Life Care – proportion of the last 6 months of life spent in a large hospital	
Target and rationale:	No more than 10.5% of the last six months of life was spent in a large hospital.
Scale of change needed:	Reduction from baseline performance of 13.3%
Recent comparative performance:	Edinburgh is currently ranked 5th highest (where low is good).

Balance of care: percentage of the population aged 75+ who are in a community setting rather than in a large hospital	
Target and rationale:	Increase the proportion of the population aged 75+ who are in community settings (i.e. at home or in a care home) rather than in a large hospital to 98.2%.
Scale of change required:	In 2015-16 (which is the most recent year for which data is available): 8. 6.4% of people aged 75+ lived in a care home 9. 7.9% lived at home with support 10. 2.0% lived in a large hospital 11. 83.6% lived at home without support
Recent comparative performance:	For 2015-16 Edinburgh was ranked 29th highest out of 32

12. The statistics contained in the tables above have not been officially published by ISD. These figures are provisional and have been released for management purposes only.

13. Lead officers have been identified to own each of the six indicators and take forward programmes of work to support achievement of the targets. Performance is monitored through the Health and Social Care Partnership Performance Board and will be reported to the EIJB Performance and Quality Group on a six-monthly basis.

14. The proposed indicators were discussed by the Performance and Quality Group on 29 May 2017; following which the Group agreed to support the

recommendation of both the indicators and targets for adoption by the EIJB. The Flow Programme Board is also supportive of the indicators and targets being adopted by the EIJB.

15. Whilst important, the six integration indicators are a subset of the national and local indicators against which performance of the Health and Social Care Partnership is measured. More detail on the wider range of indicators will be included in the Annual Performance Report that will be presented to the Board for approval in July.

Key risks

16. Whilst reducing the number and length of delayed discharges remains a significant challenge steady progress has been made in reducing the number of delays over the last few weeks. The most significant challenge in the proposed indicators and targets is the target to reduce occupied bed days by 2,792 days per month, which is a target set for the whole of Scotland. As with the other indicators trajectories are being developed to support incremental improvement alongside clear action plans.

Financial implications

17. It is anticipated that achievement of the targets set out in relation to each indicator will result in efficiencies in some parts of the system but may incur additional costs elsewhere. Financial implications will be identified during the development of detailed action plans.

Involving people

18. The indicators and targets proposed for adoption in this report have been discussed with the Performance and Quality Group the membership of which includes a number of stakeholders including citizens and the third and independent sectors.

Impact on plans of other parties

19. The indicators and targets have been developed through discussions with NHS Lothian and the other three Health and Social Care Partnerships in Lothian.

Background reading/references

None

Rob McCulloch-Graham
Chief Officer, Edinburgh Health and Social Care Partnership

Report Author

Contact: Wendy Dale

E-mail: wendy.dale@edinburgh.gov.uk

Tel: 0131 553 8322

Edinburgh Integrated Joint Board

9.30 am Friday 16 June 2017

Community Justice Outcome Improvement Plan 2017/18 – referral from the Health, Social Care and Housing Committee

Item number	
Report number	Item 5.11
Wards	All

Executive summary

The Health, Social Care and Housing Committee on 18 April 2017 considered a report by the Head of Safer and Stronger Communities and Chief Social Work Officer on Community Justice Outcomes Improvement Plan 2017/18

Links

Coalition pledges	See attached report
Council outcomes	See attached report
Single Outcome Agreement	See attached report
Appendices	See attached report

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Terms of Referral

Community Justice Outcome Improvement Plan 2017/18

Terms of referral

1.1 The Health, Social Care and Housing Committee on 18 April 2017 considered the attached report by the report by the Head of Safer and Stronger Communities and Chief Social Work Officer on Community Justice Outcomes Improvement Plan 2017/18

1.2 The Community Justice (Scotland) Act 2016 introduced a local model for the planning and delivery of community justice services, effective from 1 April 2017. Service planning responsibilities have been transferred from the now abolished Community Justice Authorities to community planning partnerships, and a new national body, Community Justice Scotland, has been created to provide leadership for the community justice sector and assurance to Scottish Ministers on the delivery of improved outcomes.

1.3 The Edinburgh Community Safety Partnership developed the Plan on behalf of the Edinburgh Partnership and is responsible for its implementation. The Plan sets out the ongoing work by partners to prevent and reduce offending through addressing the underlying causes and highlights initiatives to reduce inequalities, improve individuals' resilience, and build strong, safe and inclusive communities.

1.4 The Plan identifies priority areas for improvement to achieve the aspirations for community justice, where people have better access to the services they require such as health and wellbeing, welfare, housing and employability, all of which help prevent and reduce offending.

1.5 The Edinburgh Community Safety Partnership approved the Plan on 1 March 2017 and it was endorsed by the Edinburgh Partnership on 30 March 2017. It has been submitted to Community Justice Scotland.

1.6 The Health, Social Care and Housing Committee agreed:

1.6 .1 To note the Community Justice Outcomes Improvement Plan 2017/18 (the Plan) attached at Appendix 1 of the report by the Head of Safer and Stronger Communities and Chief Social Work Officer

1.6.2 To refer the report to the Integrated Joint Board for information.

For Decision/Action

2.1 The Integrated Joint Board is requested to note the report

Background reading / external references

Health, Social Care and Housing Committee 18 April 2017.

Laurence Rockey

Head of Strategy and Insight

Contact: Blair Ritchie, Assistant Committee Clerk

E-mail: blair.ritchie@edinburgh.gov.uk | Tel: 0131 529 4085

Links

Coalition pledges	See attached report
Council outcomes	See attached report
Single Outcome Agreement	See attached report
Appendices	See attached report

Health, Social Care and Housing Committee

10.00, Tuesday, 18 April 2017

Community Justice Outcomes Improvement Plan 2017/18

Item number	7.3
Report number	
Executive/routine	
Wards	All

Executive Summary

This report presents to Health, Social Care and Housing Committee the Community Justice Outcomes Improvement Plan 2017/18 attached at Appendix 1, which has been developed to support and take forward the new local model for planning and delivering community justice services.

Links

Coalition pledges	P12, P29, P32, P36
Council priorities	CP2, CP3, CP4, CP7
Single Outcome Agreement	SO2, SO4

Report

Community Justice Outcomes Improvement Plan 2017/18

1. Recommendations

1.1 Health, Social Care and Housing Committee is recommended to note the Community Justice Outcomes Improvement Plan 2017/18 (the Plan) attached at Appendix 1.

2. Background

2.1 The Community Justice (Scotland) Act 2016 introduced a local model for the planning and delivery of community justice services, effective from 1 April 2017. Service planning responsibilities have been transferred from the now abolished Community Justice Authorities to community planning partnerships, and a new national body, Community Justice Scotland, has been created to provide leadership for the community justice sector and assurance to Scottish Ministers on the delivery of improved outcomes.

2.2 The Scottish Government's vision for community justice is that Scotland is a safer, fairer and more inclusive nation where we:

- prevent and reduce further offending by addressing its underlying causes; and
- safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens.

3. Main report

3.1 The Edinburgh Community Safety Partnership developed the Plan on behalf of the Edinburgh Partnership and is responsible for its implementation. The Plan sets out the ongoing work by partners to prevent and reduce offending through addressing the underlying causes and highlights initiatives to reduce inequalities, improve individuals' resilience, and build strong, safe and inclusive communities.

3.2 The Plan identifies priority areas for improvement to achieve the aspirations for community justice, where people have better access to the services they require such as health and wellbeing, welfare, housing and employability, all of which help prevent and reduce offending.

3.3 The Plan's outcomes align with the priorities of the Edinburgh Partnership to reduce inequalities, improve opportunities for all, support people to fulfil their potential, and build safer communities.

3.4 The Edinburgh Community Safety Partnership approved the Plan on 1 March 2017 and it was endorsed by the Edinburgh Partnership on 30 March 2017. It has been submitted to Community Justice Scotland.

4. Measures of success

4.1 Reduced inequalities through improved effectiveness of interventions to prevent and reduce offending, and an increase in the proportion of positive outcomes for people with convictions.

5. Financial impact

5.1 The Scottish Government has provided transitional funding of £50,000 for 2017/18 to support the transfer of community justice services to a local model.

6. Risk, policy, compliance and governance impact

6.1 The Scottish Government has prescribed an Outcomes, Performance and Improvement Framework to support robust governance and accountability in the new model. Potential risks to partners, communities or individuals will be identified and managed as part of this process. The Edinburgh Community Safety Partnership will report progress under the national indicators to the Edinburgh Partnership annually.

7. Equalities impact

7.1 A full Equalities and Rights impact assessment has been carried out on the Plan. The Plan advances equality of opportunity through its commitment to improving people's life chances by providing better access to services proportionate to need. It also fosters good relations through the services delivered to support and manage those who have committed offences to successfully reintegrate into the community and fulfil their potential for the benefit of all.

8. Sustainability impact

8.1 Community based sentences for people with convictions include work to improve the environmental landscape for example tidying communal parks and gardens. Employability services and ongoing work to reduce health inequalities and create an inclusive society are included in the Plan, all of which contribute to sustainable development.

9. Consultation and engagement

9.1 The Plan was developed with the full participation of community justice partners and the third sector with feedback from partner workshops and a community justice working group used to inform the Plan. In addition, comments were invited through an online public survey and consultation took place through events held for people with offending backgrounds and their families, and for victims and witnesses of crime.

10. Background reading/external references

10.1 National Strategy for Community Justice

10.2 Community Justice; Outcomes, Performance and Improvement Framework

Michelle Miller

Head of Safer and Stronger Communities and Chief Social Work Officer

Contact: Harry Robertson, Senior Manager Community Justice

E-mail: harry.robertson@edinburgh.gov.uk | Tel: 0131 553 8237

Links

Coalition pledges	P12 Work with health, police and third sector agencies to expand existing and effective drug and alcohol treatment programmes P29 Ensure the Council continues to take on apprentices and steps up efforts to prepare young people for work P32 Develop and strengthen local community links with the police P36 Develop improved partnership working across the Capital and with the voluntary sector to build on the "Total Craigroyston" model

Council priorities	CP2 Improved health and wellbeing: reduced inequalities CP3 Right care, right place, right time CP4 Safe and empowered communities CP7 Access to work and learning
Single Outcome Agreement	SO2 Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health SO4 Edinburgh's communities are safer and have improved physical and social fabric
Appendices	1 Community Justice Outcomes Improvement Plan 2017/18

Edinburgh Community Justice Outcomes Improvement Plan

2017 - 2018

Skills Development Scotland

SCOTTISH FIRE AND RESCUE SERVICE
Working together for a safer Scotland

POLICE SCOTLAND
Keeping people safe

SCOTTISH PRISON SERVICE

Scottish Courts and Tribunals Service

CROWN OFFICE & PROCURATOR FISCAL SERVICE
SCOTLAND'S PROSECUTION SERVICE

NHS Lothian

evoc

Edinburgh Integration Joint Board

EDINBVRGH
YOUR COUNCIL – YOUR CITY

Edinburgh Community Safety Partnership

Community Justice Outcomes Improvement Plan 2017-18

Contents

Introduction

The Community Justice (Scotland) Act 2016 transferred community justice planning responsibilities from Community Justice Authorities to community planning partnerships with effect from 1 April 2017. Edinburgh's Community Safety Partnership, on behalf of the Edinburgh Partnership (community planning) is responsible for the development and implementation of the Edinburgh Community Justice Outcomes Improvement Plan.

The Scottish Government's vision for community justice is that Scotland is a safer, fairer and more inclusive nation where we:

- prevent and reduce offending by addressing its underlying causes
- safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all citizens

The Edinburgh Partnership has four strategic priorities:

- Edinburgh's communities are safer and have improved physical and social fabric
- Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health
- Edinburgh's children and young people enjoy their childhood and fulfil their potential
- Edinburgh's economy delivers increased investment, jobs, and opportunities for all

Edinburgh's Community Justice Outcomes Improvement Plan is based on contextual information, the seven national outcomes and associated indicators, the National Strategy for Community Justice and Edinburgh's Community Plan.

Contextual information

Listed below are the characteristics of the city that provide the local context for planning community justice services are.[1]

- Edinburgh is a city of contrasts, with high levels of both prosperity and poverty.
- Partners seek to deliver universal services proportionate to need.
- Vulnerable people and those living in Scotland's 15% most deprived communities are at greatest risk of crime.
- Although unemployment has been falling across the city, people with offending backgrounds face significant barriers to accessing employment despite the fact that employment contributes to a reduction in reoffending.
- For households on low to moderate incomes, demand for housing continues to outstrip supply.
- Drug and alcohol problems affect the city severely, with an estimated 22,400 adults dependent on alcohol and 6,600 people dependent on heroin and/or benzodiazepines.
- Economic and social costs of crime to communities are significant.
- Supporting a person in prison deepens the social marginality already experienced by many families; support is often provided by women, which may reinforce traditional gender roles and leaves women in custody with few supports.
- Around 300 people in the city are estimated to have complex needs associated with homelessness, addiction, mental health and offending, placing significant demands on services, and for whom, despite significant resource allocation, outcomes are mostly poor.

[1] 'CJOIP contextual information' and 'Feedback from general consultation and engagement activity' available on request. Detailed data is available in Edinburgh's locality profiles.

- Children affected by parental imprisonment are at much greater risk of developing behavioural problems, low attainment levels, school attendance problems, and school expulsion; two thirds of boys with a parent in prison are likely to offend themselves.
- Violent crime levels continue to drop; this is reflected in perception of crime levels; reconviction rates remain constant at just under 30%.

A wide range of engagement and consultation activity is carried out in Edinburgh, by a range of partnerships and organisations, with communities, groups and the general public, on different issues affecting people living and working in the city. Feedback highlights that people strongly support prevention, as a shared responsibility of all services, and tackling inequalities as priorities. Building trust with professionals and longevity of relationships are highlighted as very important by service users. Services need to be able to see the whole picture, not just someone's offending history.

Current service provision has been mapped and is outlined in the transitional plan for the delivery of community justice 2016-17.

Achievements towards the national outcomes and indicators and priority areas for improvement actions

This section provides a high level overview of achievements of community justice partners in Edinburgh in relation to the national outcomes and indicators[2]. This has helped partners identify priorities for improvement action.

STRUCTURAL OUTCOMES

Outcome 1: Communities improve their understanding and participation in community justice

National indicator 1: Activities carried out to engage with communities as well as other relevant constituencies

Community justice partners in Edinburgh carry out a wide range of activities to engage with communities. Feedback informs service development and strategic planning. Engagement with service users is based on the National Standards for Community Engagement and informs service redesign and improvement action. Examples include the residential accommodation service for men who pose a risk of serious harm; the Alcohol Problem Solving Court pilot; the redesign of domestic abuse services; the antisocial behaviour strategy; the Edinburgh Local Policing Plan 2014 -17; and an ongoing awareness raising programme in relation to hate crime.

Direct engagement with people who use services takes place routinely. People who are subject to statutory supervision are encouraged to participate actively in the development of their plans and to reviews of these plans. They complete exit questionnaires and participate in exit interviews at the end of community payback orders, and they provide feedback at the end of programme work. This informs future interventions. Case file audits, Multi-agency Public Protection Arrangements (MAPPA) audits, and practice evaluations have consistently demonstrated that service users' views are taken into account. Service users' views and the response from local communities to assistance given by those undertaking unpaid work are reported each year in the Community Payback Order Annual Report. Family involvement in integrated case management

[2] Most of the evidence/examples listed below fit with more than one outcome and indicator. Information has been placed in line with the descriptors included in the Outcomes, Performance and Improvement Framework.

for serving prisoners is a priority, in recognition of the impact of imprisonment on families and the key role that family members can play in the reintegration of people who are released from custodial sentences.

National indicator 2: Consultation with communities as part of community justice planning and service provision

An online consultation has gathered views on how offending could be further reduced and community facing events have been held, involving people with lived experience.

Public events were held for victims and witnesses and for people involved in the criminal justice system and their families. The victims and witnesses' event resulted in Victim Support (Scotland) becoming a full partner in the Edinburgh Community Safety Partnership and related actions being included in this Plan. The event for people involved in the criminal justice system highlighted that relationships as much as services are valued most, that people are less concerned about which *agency* provides support than the *person* who delivers it, that they value persistence and others not giving up on them, and that, for some, if they had received the right support earlier, they might not have been drawn into the criminal justice system.

Throughout 2017-18, there will be a series of engagement events for people involved in the criminal justice system, linked to their local area. This will inform service delivery, as well as providing a service user perspective for the Community Payback Order Annual Report.

The City of Edinburgh Council's move to a more locality-focused model in 2016 is reflected in community justice and related services' strong locality focus. Each locality will be producing its Locality Improvement Plan by October 2017 and the outcomes will be aligned with those in this Plan. The localities each have a multi-agency community improvement partnership, responding to local expressed need, where priorities are set and aligned to this Plan. City-wide issues, such as motor cycle crime, begging, or hate crime have bespoke community improvement partnerships.

A communications framework has been developed build relationships with key audiences regarding the positive contribution of the Multi-agency Public Protection Arrangements (MAPPA). This framework is reflected in the Scottish Government's draft public consultation strategy on offender management. The framework has been translated into an action plan for Edinburgh, which focuses on raising awareness among the inter-agency workforce.

National indicator 3: Participation in community justice, such as co-production and joint delivery

Partners are committed to using people's lived experience to improve and develop interventions. There are already a number of initiatives that reflect our aspiration to secure the participation of communities.

Community in Motion is a partnership initiative to develop a community-based problem-solving, restorative justice approach in North East Edinburgh. Motivated by the opportunities created by community empowerment and community justice legislation, and the move to locality working, Community in Motion has developed a framework for joint working, increasingly preventative in focus, with more community involvement and an emphasis on restorative and problem solving practices. It is anticipated that the range of initiatives developed in the North East locality will provide a practical model, which can be scaled up across other localities or city-wide.

Violent Offender Watch (VOW) has taken learning from our Total Place experience in engaging local communities to respond to crime in their area. VOW is led by Police Scotland and aims to reduce reoffending by tackling issues of drug/alcohol misuse, accommodation, finance, personal relationships, health, attitudes/behaviour and employment/training. The outcomes are to:

- reduce violent and acquisitive crime

- reduce drug and alcohol-linked offending
- reduce antisocial behaviour
- promote community safety and well-being
- reduce the fear of crime
- encourage offenders to become involved in training and work initiatives

VOW commenced in 2013. In early 2016, the decision was taken to focus on the North East locality working within the Community in Motion framework. Intrinsic to its operation is **Aid and Abet,** a peer-led organisation providing mentoring and support to people leaving prison. Volunteer mentors are all people with lived experience of the criminal justice system, and are in recovery from alcohol or drug addiction. The project has developed with support from Scottish Churches Housing Action since June 2014 and has been providing mentoring services since March 2015.

A **peer mentoring service** in partnership with **Aid and Abet** has been developed as a result of resource transfer funding received from the Scottish Government in September 2016 to support community-based sentences. The service is for people who are subject to Community Payback Orders and aims to improve health/wellbeing and relationship outcomes. All volunteer mentors have lived experience of the criminal justice system. The outcomes for service users are that they will:

- be registered with a GP
- access appropriate health services/treatment to improve physical and mental well-being
- be registered with substance misuse services and in receipt of appropriate treatment/interventions to support recovery
- attend, where appropriate, an organisation designed to address other addiction issues, for example gambling
- be in stable accommodation
- be in receipt of the correct benefits or in employment
- have improved relationships with their families and communities

Just Us is a service user-led group of women with experience of trauma, mental health issues and criminal justice involvement. Statistics indicate that in excess of 80% of women in criminal justice have at least one mental health diagnosis. The aim of the group is to work with professionals to raise awareness and reduce stigma around women involved in the criminal justice system with mental health issues. Just Us has been developed by women who have been involved in the Willow Service (see below).

Alcohol Problem Solving Court

Alcohol sales in Scotland are 20% higher per capita than England and Wales. A disproportionate number of people in the criminal justice system have mental health problems and problems with drug and alcohol misuse. 50% of Scottish prisoners were drunk at the time of their offence. Short-term prison sentences are ineffective, with a 66% reoffending rate. These statistics are the backcloth to the development of an alcohol problem solving court pilot in Edinburgh, which commenced in February 2016. The pilot was developed in response to a request from a Sheriff, and discussions with partners, including the City of Edinburgh Council, NHS Lothian, Police Scotland and Lifeline. The target group is males over 18 years of age, with a pattern of alcohol related offending resulting in frequent appearances in Court, who are appearing on summary procedure and assessed as suitable for a Community Payback Order,

The key elements of the court are: quicker assessment, faster access to treatment, court review, and peer support for those on orders. The outcomes sought are to reduce the use of imprisonment, and to reduce reoffending by impacting positively on the person's health and well-being by:

- reducing alcohol dependency
- reducing harmful consumption of alcohol

- improving mental health
- improving physical health
- reducing accident and emergency attendances
- increasing uptake of education, volunteering and employment

The pilot is being evaluated and the model will be continued throughout 2017-18. Consideration will be given to the appropriateness of this model to other problems.

The Edinburgh and Midlothian Offender Recovery Service (EMORS) is commissioned jointly by the City of Edinburgh Council, Midlothian Council and NHS Lothian. It brings together three services – arrest referral, prison treatment and support, and voluntary throughcare – and takes a recovery-centred approach, working with individuals to build and encourage the creation of recovery capital, helping more people move away from problematic alcohol and drug use and other issues that increase the likelihood of reoffending. By adopting a holistic approach, the service provides robust routes into a range of support services and networks, helping people access support that is right for them. This includes support from people with lived experience of alcohol and drug use.

EMORS has an extensive service user participation strategy and works with people to achieve the following outcomes:

- address substance misuse
- reduce offending behaviour
- improve health, skills and personal resources
- improve social relationships and social support
- improve practical skills

EMORS has recruited peer volunteers in response to service users' feedback that they would like to see more visible recovery within the service.

Community improvement partnerships exist in each locality to respond to local issues, including antisocial behaviour and low level offending, along with city-wide community improvement partnerships, which address wider issues such as motorcycle crime or new psychoactive substances. As the Locality Improvement Plans are developed in 2017-18, the community improvement partnerships will be a vehicle for addressing the priorities for local areas.

Project Halt is police led and has recently been introduced as a response to widespread concern about the level of housebreaking, and associated vehicle theft, in Edinburgh. The project provides a mechanism to divert people from reoffending, based on research about the recurring socio economic factors, which underpin motivation. The key areas addressed, using a partnership approach, are drug abuse, housing, benefits, employment and education.

National indicator 4: Level of community awareness of/satisfaction with work undertaken as part of a CPO

Unpaid work directly and indirectly benefits communities. Beneficiaries regularly provide evidence of their satisfaction with the service, especially the physical differences made to gardens or buildings. They also frequently comment on the team work of the groups, their positive attitude, and their hard work. There has been increased interest in, and referrals for, unpaid work. Public consultation for the Community Payback Order Annual Report 2015-16 highlighted that over 80% of respondents thought that community payback provided people with an opportunity to repay the community for the crimes they had committed and that it helped reduce reoffending.

Partnerships for the other activity element of unpaid work have been developed with a variety of organisations, and there are options to suit all abilities and needs, being as inclusive as possible. Other activity allows people to take the skills, learning and experience gained in unpaid work into activities that help them to sustain progress beyond the period that they have been subject to statutory supervision. Further information is available at national indicator 18 below.

National indicator 5: Evidence from questions to be used in local surveys/citizens panels, etc.

The Edinburgh People Survey (2015) highlights that 63% of respondents agree that the City of Edinburgh Council provides protection and support for vulnerable people (compared to 52% in 2014) and that 83% agree that their neighbourhood is a place where people of different backgrounds get along, broadly consistent with previous years.

An engagement and consultation programme is being carried out across the city in relation to the **Edinburgh Vision 2050** and the **Locality Improvement Plans**. Community safety is one of the key themes. **Family and Household Support Teams** have been established in Edinburgh to provide integrated community safety, housing support and family support services (see below).

National indicator 6: Perceptions of the local crime rate (quantitative)

New questions were introduced to the Edinburgh People Survey in 2015, exploring perceptions of how commonplace various types of crime and antisocial behaviour are perceived to be in neighbourhoods:

- 85% state that violent crime is not common in their neighbourhood.
- 78% state that vandalism and graffiti are not common in their neighbourhood.
- 75% state that antisocial behaviour is not common in their neighbourhood.
- 75% do not consider street drinking and alcohol-related disorder to be a problem in their neighbourhood.
- 84% feel safe in their neighbourhood after dark.

The 2016 Survey results will be used to compare results from previous years and identify areas for improvement. The Survey for 2017 will be carried out in the latter half of the year.

Police Scotland's most recent national survey, 'Your View Counts' conducted in 2016, included 1413 Edinburgh responses. Local priorities were identified as housebreaking, antisocial behaviour, car theft, violent crime, drug dealing and drugs misuse. The survey results will be used to inform the future Edinburgh Local Policing Plan and the delivery of community justice services, including the development of the current services that seek to address these issues.

Outcome 1 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
1	Explore more effective ways of engaging hard to reach groups	Prolific Offenders Sub Group	31 March 2018
2	Develop and implement a communications plan for community and service user engagement to include wider reporting of success stories in community justice	Prolific Offenders Sub Group	31 March 2018

3	Evaluate the initiatives/pilots and use these evaluations to inform the strategy for community justice services	Prolific Offenders Sub Group	31 March 2018
3	All partners will as far as possible ensure that victims of crime receive the support they need, by referring to Victim Support Scotland and/or other partners as appropriate	All sub groups/Victim Support	31 March 2018
4	Highlight benefits to communities of unpaid work projects and raise the profile of those undertaking it	Senior Manager, Community Justice	31 October 2017 (CPO Annual Report)

Outcome 2: Partners plan and deliver services in a more strategic and collaborative way

National indicator 7: Services are planned for and delivered in a strategic and collaborative way

Edinburgh's Reducing Reoffending Partnership was established in 2013 as a strategic group responsible for coordinating a multi-agency response to reoffending, acknowledging that effective reduction in reoffending depends on a complex, multi-agency and multi-sector approach to the delivery of a wide range of both universal and specialist services. The partnership included representation from the City of Edinburgh Council (criminal justice, community safety, housing, and employability services), Police Scotland, NHS Lothian, the Edinburgh Drug and Alcohol Partnership, the Scottish Prison Service and the Edinburgh Voluntary Organisations Council. In 2016, in preparation for the changes introduced by the Community Justice (Scotland) Act 2016, including widening the membership to include all statutory community justice partners, the Reducing Reoffending Partnership was amalgamated with the Edinburgh Community Safety Partnership. The Edinburgh Community Safety Partnership reports to the Edinburgh Partnership (community planning).

Examples of services that are planned and delivered in a strategic and collaborative way include:

Family and Household Support teams were established in 2016 as part of the City of Edinburgh Council's Transformation Programme. The teams deliver effective, joint and collaborative working of community safety, housing support and family support services in each of the four localities. Community police officers are partners in this service. The outcomes for the new service are that:

- communities participate in the creation of a healthy, safe and just city
- people's life chances are improved by addressing their need for education, health, social and financial inclusion, housing and safety
- individuals are resilient and have capacity for change and self management

The outcomes have been developed to align closely with community justice priorities and focus on effective intervention, prevention, and reducing reoffending and antisocial behaviour, with a strong emphasis on restorative practice. To complement and cement the shared vision, both services are managed within the Council's Safer and Stronger Communities under the leadership of the Chief Social Work Officer.

The criminal justice social work **accommodation service** provides an important link between prison and the community for men subject to statutory supervision released from long-term prison sentences. The service addresses both risk and need, on a multi-agency basis. Release planning starts well in advance of liberation, working with the Scottish Prison Service through the integrated case management process. The aim is reintegration, helping residents to move on to their own accommodation and live safely in their community, using as far as possible universal services that are available to all citizens. The July 2016 Care

Inspectorate report assessed the service as very good and commented on the positive links with other agencies to help achieve positive outcomes.

Willow is a partnership between the City of Edinburgh Council, NHS Lothian and the third sector, working with women in the criminal justice system. It aims to reduce offending behaviour and health inequalities; to improve the health, wellbeing and safety of women in the criminal justice system; and to increase their access to services and involvement in their local community. Service users are involved in the design and continuous improvement of the service. Willow facilitates effective, comprehensive and better coordinated responses from public services to address the inequalities faced by women in the criminal justice system. Performance information from Willow demonstrates improvements in women's lives across a range of indicators, including engagement with services, improved problem solving skills, reduction in alcohol and drug use, and a better understanding of how current difficulties relate to previous experiences of trauma. Many women who attend Willow have managed to resume care of their children, which they had previously lost, after making positive changes to their lives.

Willow is featured as an example of good practice in the Angiolini Report and has continued to build on its strengths in intervening years. The service has benefitted from Scottish Government support and resources transferred from the Scottish Prison Service. The success of the project has resulted in the service being oversubscribed and a plan is in place to ensure the capacity issues are addressed.

The **Scottish Prison Service (SPS)** has a Service Level Agreement (SLA) with the City of Edinburgh Council to deliver the prison-based social work service at HMP Edinburgh. While the SLA primarily relates to statutory responsibilities, there has been a long history of close working between the SPS and the City of Edinburgh Council. The social work team provided support around the introduction of women to HMP Edinburgh, most of whom are not statutory prisoners. Social workers work closely with other disciplines in HMP Edinburgh on risk assessment, sentence planning, education, health, and the delivery of programmes.

The Positive Lifestyles Project is a collaboration between Police Scotland and the Scottish Prison Service in HMYOI Polmont, working with through care officers and the third sector to divert young men on the cusp of, or involved in, Serious Organised Crime towards positive lifestyles and to prevent violence within the prison establishment. Prisoners vulnerable to the influences of Serious Organised Crime are identified and supported to achieve their aspirations and reduce the severity and frequency of their offending.

Inclusive Edinburgh was established to address problems faced by people with complex needs who may struggle with homelessness, unemployment, drug and alcohol problems, or mental or physical ill-health, who sometimes become involved in crime, and who are often the victims of violence. The Inclusive Edinburgh review examined the combined services delivered by statutory and voluntary sector partners to this group of vulnerable people, with a view to redesigning services so that partners can respond in a coordinated and psychologically-informed way. The majority of Inclusive Edinburgh cases have exhausted operational service options and require the concentrated effort of senior managers across partner agencies to achieve a breakthrough. The project aims to improve the life chances, health and well being of the most vulnerable, disenfranchised and disengaged citizens whose needs place significant demands on services, but for whom outcomes are mostly poor.

NHS Lothian's Health Promotion Service works with partners and organisations on health initiatives to reduce health inequalities in Edinburgh using a systems approach, which recognises the interaction and interdependence of external and personal factors that influence health. The service employs a range of methods to carry out health promotion work in neighbourhoods and localities.

A multi-agency partnership approach was adopted in the commissioning of the **Edinburgh and Midlothian Offender Recovery Service** for short-term prisoners from the two local authority areas, delivered by Lifeline. The service is funded jointly by the City of Edinburgh Council, Midlothian Council and NHS Lothian, and provides continuity of care, from the point of arrest, throughout an individual's stay in prison, and during the transition period from prison to community. The voluntary throughcare element recognises that transition from prison to community is a critical time, and the service includes prison gate pick up and support out of hours to help individuals manage the challenges they face when returning to their communities on release.

Effective transition planning for children and young people takes place through close working relationships between the City of Edinburgh Council's **Young People's Service** and adult criminal justice services, Police Scotland and the Scottish Children's Reporter Administration. Strategic direction is provided by the multi-agency young people's sub group of the Community Safety Partnership. The service is multi-disciplinary, working with young people up to the age of 18, including those subject to community payback or through care. Working within the Whole Systems Approach, the Young People's Service can demonstrate an increase in referrals for early and effective interventions, as well as in the number of 16/17 year olds diverted from prosecution in the adult court.

National indicator 8: Partners have leveraged resource for community justice

Community justice partners in Edinburgh recognise the potential that exists within individuals, groups and organisations, and the contribution they can all make to improved community justice outcomes. Some examples of how partners have leveraged this potential are set out below.

- Developing information sharing protocols within the City of Edinburgh Council and between the Council and Police Scotland. Criminal justice social work crime categorisation has been linked with that of Police Scotland to achieve meaningful analysis of prolific offender demographics and crime categorisation. This has informed the development of the services described above, frequently delivered on a multi-agency basis.
- Co-location of services (e.g. Willow, Community in Motion, recovery hubs, Family and Household Support Teams). This has delivered financial and operation efficiencies, but more importantly, has provided more coherent services to communities, often avoiding service users having to repeat their stories or having to visit a number of sites to achieve a resolution to a problem.
- Edinburgh's Child and Adult Protection and Offender Management Committees have multi-agency quality assurance sub groups, where learning from case file audits, practice evaluations, initial case reviews and significant case reviews is shared across agencies. Action plans inform service improvements.

National indicator 9: Development of community justice workforce to work effectively across organisations/professional/geographical boundaries

Community justice partners in Edinburgh understand the development of the workforce as a joint responsibility.

- Learning and development opportunities on child and adult protection, sexual exploitation, human trafficking and MAPPA are jointly delivered by partners to the inter-agency workforce.
- The training plan for criminal justice social work staff in Edinburgh is developed and delivered across local authority boundaries, frequently on a multi-agency basis.
- Capacity and training has been built in to the Caledonian System men's programme to respond to the level of domestic abuse.

- The Willow service for women and the Drug Treatment and Testing Order service are both multi-disciplinary teams, with staff from the City of Edinburgh Council and NHS Lothian. Staff are co-located, locally managed and undertake joint training and development.
- The Alcohol Problem Solving Court pilot has included joint training of criminal justice social workers, NHS staff and third sector partners.
- A range of supports is in place to address the potential impact of work on criminal justice social work staff, particularly with regard to vicarious trauma. Staff have access to practice development sessions on self care, reflective group consultations, external support and consultancy from clinical psychology.

National indicator 10: Partners illustrate effective engagement and collaborative partnership working with the authorities responsible for the delivery of MAPPA

The City of Edinburgh Council is a key partner in the Edinburgh Lothians and Scottish Borders Strategic Oversight Group, which is chaired by Edinburgh's Chief Social Work Officer. A MAPPA Operational Group reports to the Strategic Oversight Group, and brings together the Responsible Authorities to take forward priorities identified by the Strategic Oversight Group.

The Edinburgh Offender Management Committee (OMC) ensures that the statutory responsibilities placed on local partner agencies for the assessment and management of sexual offenders and those who pose a risk of serious harm are discharged effectively. Feedback for Edinburgh from the thematic review of MAPPA was very positive, and no issues were identified for Edinburgh specifically. The OMC reports to the Edinburgh Chief Officers' Group – Public Protection, and each year provides an annual report and a business plan.

The OMC ensures that there are comprehensive policies and procedures for the management of high risk offenders, which take account of key transition points between services and ensure effective partnership working. All policies and procedures are reviewed and updated on an annual basis. All key staff across agencies have been briefed on the new MAPPA Guidance published in March 2016. Arrangements for Category 3 cases have been introduced successfully.

Outcome 2 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
7	Family and Household Support teams and frontline staff to develop a wider understanding the criminal justice sector, links to the wider community justice agenda and the support services available in localities.	Senior Management Team, Safer and Stronger Communities	30 Sept. 2017
7	Criminal justice staff to increase awareness of remit of Family and Household Support teams and interventions available, including the identification of opportunities for more effective support for individuals and families.	Sector Manager, Community Intervention	30 Sept. 2017
7	Develop closer links with Education to prioritise the prevention agenda (link between school exclusions and later offending in young people).	Youth Justice Sub Group	30 Sept. 2017
7	Further consolidate the Willow service model and build capacity across community justice to ensure that matters	Women's Sub Group	31 March 2018

	relating to women in the criminal justice system are appropriately addressed.		
7	Evaluate the impact of the Inclusive Edinburgh initiative.	Senior Management Group, SSC	31 Dec. 2017
8	Maximise the best use of resources for community justice from all partners in a financially challenging climate.	ECSP through quarterly reporting	31 March 2018
9	Identify opportunities to widen staff participation from all sectors in training and development initiatives.	All partners	31 March 2018
9	Work towards a 'one person one plan' (one key contact) model to simplify a service user's journey through multiple interventions.	All Partners	31 March 2018
9	Map all mentoring and community navigating work to facilitate sharing evidence based best practice, and develop opportunities for shared learning.	Prolific Offenders Sub Group	30 September 2017
9	Develop a shared understanding across internal and external partners of the expectations for community justice, including a better understanding of each contributor's strategic role.	Prolific Offenders Sub Group	31 March 2018

Outcome 3: People have better access to the services they require, including welfare, health and wellbeing, housing and employability

National indicator 11: Partners have identified and are overcoming structural barriers for people accessing services

The Willow Service (see above) was highlighted as an example of good practice by the Commission on Women Offenders and is being developed further to improve outcomes for women in the criminal justice system. Willow provides holistic support and facilitates access to services, including parenting support, employability, and health and wellbeing, based on risk and need in a psychologically informed environment.

A number of the services outlined under indicator 3 above, such as the Aid and Abet peer mentoring project, Violent Offenders Watch, the Edinburgh and Midlothian Offender Recovery Service, and the Alcohol Problem Solving Court, support people to access mainstream services such as GPs, health services and treatment to improve physical and mental wellbeing, substance misuse services and interventions to support recovery, and services to address other addiction issues, such as gambling.

Resource workers are integrated into the **Drug Treatment and Testing Order Teams**, focusing on supporting people subject to an order to access services in the community, as well as supports that will help them maintain a stable and offence free lifestyle after the end of statutory supervision. The Drug Treatment and Testing Order II pilot, which manages a lower level of substance misuse offending, which had been running in Edinburgh, has now been rolled out nationally. The pilot saw a higher proportion of women and young people being assisted to address drug misuse at an early stage.

Skills Development Scotland (SDS) works with young people aged 16 to 19 years to help them reach positive destinations. Those who are furthest from the employment market, including those with a history of offending behaviour, receive intensive support from an SDS work coach. An SDS adviser works within HMYOI Polmont and HMYOI Cornton Vale to support young people aged 16 and 17 who are within two months of their release to ensure a plan is in place to support their journey into work. SDS also runs a job club at the Council's Through Care and After Care (TCAC) team premises and the SDS work coach attends the TCAC drop in sessions.

The **Scottish Prison Service** facilitates a work placement programme for prisoners, and placements have been undertaken at Sue Ryder's in Seafield, NHS Western General Hospital and the Salvation Army.

The **visitor's centre at HMP Edinburgh** is run by Barnardo's Scotland on behalf of the Onward Trust. The centre recognises the importance of family contact for prisoners and the impact on families of the imprisonment of a family member, and has for several years provided valuable support to prisoners' families and visitors. It has been the model for similar facilities at other prisons. Prison staff, working in partnership with Barnardo's, now deliver parenting programmes to prisoners. The service is about to commence further work in the community, as well as exploring the possibility of prisoner work placements in the visitor centre.

A **complex needs employability** service, part of the Inclusive Edinburgh initiative, has been co-produced with service users, and the preferred bidder will be announced soon. The service will be up and running during 2017-18. The service will assist people to become employment-ready, as well as helping into employment those who are able to sustain work. Additional initiatives to bring down barriers to employment are referenced under national indicator 18.

Multi-agency work is underway to develop a **preventative approach to online offending** in response to the rising number of convictions for internet-based offending. A communications plan is being developed to support a pilot campaign, which will seek to divert and deter those who may be about commit an offence by downloading or viewing indecent images of children. The deterrence messages will direct potential offenders to a self help resource as well as highlighting the consequences of offending. The campaign will also target those who may be concerned about a family member's behaviour and provide information on where to obtain help and advice.

Work is ongoing in schools to prevent children offending online as well as becoming victims of online offending behaviour, and clear messages are being developed to inform communities on how partners are addressing this issue.

Initiatives to address **access to housing** for prisoners recognise the crucial role of settled accommodation in assisting people to reintegrate into communities on release from custody.

- Sustainable Housing on Release for Everyone (SHORE) is an early intervention approach being developed for prisoners on remand or those serving short-term sentences to provide support with sustaining their tenancy/accommodation until release.
- Project Halt is a multi-agency group co-ordinated by Police Scotland looking to engage with prisoners with a history of housebreaking and support them to reduce their risk of reoffending. Sustainable accommodation is core to these plans.
- Multi-Agency Through-Care Service (MATS) is a multi-agency approach to pre-liberation plans for prisoners, which is being piloted in HMP Edinburgh. It brings together 11 agencies, including Scottish Prison Service Throughcare Support Officers, the voluntary sector (Four Square for housing advice, and Lifeline), Department for Work and Pensions, the Job Centre, Open Secret (a service for prisoners who have suffered abuse), Advocard, Cruise, Shine Women's Mentoring

Service, and employability and addiction support. The initiative will develop a pathway on release for short-term prisoners to support them to access the services they need, including housing.

- Develop Yourself Now and Move on (DYNAMO) arranges planned moves for young prisoners, who stay at Stopover upon release, transition to a Four Square supported training flat, and then move to a secure tenancy. During this time, the person is supported to engage with all relevant agencies.

National indicator 12: Existence of joint-working arrangements such as processes/protocols to ensure access to services to address underlying needs

Identifying key transition points between services and ensuring effective partnership working are key objectives of the Offender Management Committee. This has resulted, for example, in the identification of **Community Justice Adult Support and Protection Leads**, who are first points of contact for any supervising officer who has concerns or is given information about an adult at risk who is subject to statutory supervision.

The escalating concerns procedure has been developed as part of Inclusive Edinburgh and is a multi-agency approach to collaborative, problem-solving interventions to manage individuals or groups presenting particular challenges in local communities who are not adults at risk as defined by the Adult Support and Protection (Scotland) 2007 Act, but who are at risk of harm. This includes those who have dangerous behaviours, which fall outwith the remit of MAPPA, and which make them hard to support or leave them unsupported in the community.

The **Edinburgh and Midlothian Offender Recovery Service** (see above), is delivered by Lifeline. In addition to providing support from point of arrest, through prison and beyond release, Lifeline also manages three addiction recovery hubs, which assist people to address their substance misuse. This approach is based on coordinated working between health services, local authorities, the Scottish Prison Service and other support services to ensure that people can benefit from appropriate pathways from custody to reintegration into communities.

The **Alcohol Problem Solving Court** (see above) uses community payback legislation to provide fast track alcohol assessments where a person's frequent offending behaviour is accompanied by alcohol misuse and, in appropriate cases, community payback supervision supports access to alcohol misuse services. Court reviews ensure judicial oversight of an individual's progress, in line with the drug treatment and testing order model.

The **Drug Treatment and Testing Order (DTTO)** delivers a service to Edinburgh, Midlothian and East Lothian. In common with the Alcohol Problem Solving Court, it is recognised that people with substance misuse problems have an immediate need for support and access to services, and should not have to wait a long time for assessment. The DTTO team has agreed a process with the court for the provision of rapid assessment reports so that the court can make as early a disposal as possible and the person can access services.

The DTTO team and the Willow Service each bring together on a single site staff from the City of Edinburgh Council and NHS Lothian, and have explicit pathways to a range of support services.

In November 2016, the Scottish Violence Reduction Unit introduced the **Navigator** system into the accident and emergency department of the Edinburgh Royal Infirmary. Supported by one year Scottish Government funding, Navigator staff work with health professionals on overnight and weekend shifts at the busiest times, recognising that to be with someone when they are injured, scared or angry and to be able to reach out a helping hand, makes a lasting difference. Interventions are tailored to the needs of the individual and engagement within the hospital is followed up after discharge, with links to local services where required.

There is a strong tradition of criminal justice working across local authority boundaries in Lothian and Borders. **Shared services** include court social work (Edinburgh, Midlothian, East Lothian), DTTO (Edinburgh, Midlothian and East Lothian), Caledonian (Edinburgh, Midlothian, East Lothian, and Scottish Borders), and the Community Intervention Service for Sex Offenders (all five local authorities). This allows for specialist interventions when required, effective sharing of skills and resources, and economies of scale, e.g. where there might not be sufficient volume of demand in one area to allow delivery of a service (e.g. groupwork).

National indicator 13: Initiatives to facilitate access to services

Initiatives to ensure that people who have offended get the support they need, when they need it, in order to encourage desistance include, as highlighted throughout this plan, Willow, the Aid and Abet peer mentoring service, the Alcohol Problem Solving Court pilot, and the outreach service of the residential unit for high risk offenders.

Partnerships for the 'other activities requirement' under community payback orders have been developed with a variety of organisations, twelve of which provide other activity at this time to help facilitate **access to employment** (see national indicator 18 for more information).

Willow staff have played a critical role in shaping national developments regarding the future of the custodial estate for women. As part of the re-provisioning of the estate, five **community custody units are** to be established across the country, and there have been initial discussions between the Scottish Government, the Scottish Prison Service, and the City of Edinburgh Council regarding potential sites in Edinburgh. Based on research and the Willow experience, these units will have as much of an independent feel to them as possible, where women will carry out usual day to day activity and will have staged access to the local community for health services and employability in order to minimise the impact of imprisonment on the lives of the women and their families, including children.

The Scottish Prison Service has created the **Throughcare Support Officer role** to help individuals on their journey to desistance by working with them to prepare for the transition from custody to the community. Partners are working together to improve transitions and outcomes for at least the first twelve weeks following release, as this period is known to be critical and highest risk. In HMP Edinburgh, the co-commissioned Edinburgh and Midlothian Offender Recovery Service (see above) works with Throughcare Support Officers and other partners in this developing area.

National indicator 14: Speed of access to mental health services

The NHS Local Delivery Plan 2016-17 includes a target for 90% of patients to commence psychological therapy-based treatment within 18 weeks of referral. Available data includes the whole community and is available for the NHS Lothian geographical area. Figures published by the Scottish Government (June 2016) show that in the NHS Lothian area, 69.5% of patients commence psychological therapy-based treatment within 18 weeks of referral.

There is a link between mental health and reoffending. This is recognised by the Willow Service, which operates to a trauma-informed model and has psychological services on site. Accessing mental health services is also challenging for men with offending backgrounds and work underway to identify the level of need for mental health services among this client group, with a view to designing a pathway into mental health services. Already, the Edinburgh Payback Programme, a groupwork intervention for men subject to community payback orders, has been re-designed as a Men's Programme, and has drawn on lessons from the Willow service that can be applied to men.

The Health and Social Care Integration Joint Board's Strategic Plan 2016-19 commits to redesigning mental health and substance misuse services to improve access. The Board's strategic approach

recognises the importance of prevention and the advantages of timely access to personalised mental health services to aid recovery and sustain wellbeing. A mental health locality partnership model will be implemented, focusing initially on the population in the North East of Edinburgh as this area has the highest percentage of people with longer term health issues. The model will maximise the opportunities of the 'Gamechanger' Public Social Partnership to improve people's health and life chances.

The Edinburgh Partnership's Community Plan 2015-18 identifies improving Edinburgh's citizens' experiences of health and wellbeing and reducing inequalities in health as a priority. The preventative actions being taken to deliver on this priority are detailed in the Edinburgh Partnership's Prevention Strategic Plan 2015-18.

National indicator 15: Speed of access to drug and alcohol services

The NHS Local Delivery Plan 2016-17 includes a target for 90% of patients to access drug/alcohol treatment within three weeks of referral. Overall, in 2015-16 in Edinburgh, 86% of people waited less than three weeks to start drug/alcohol treatment. 5% waited longer than six weeks. The data includes the whole community.

The Health and Social Care Integration Joint Board's Strategic Plan 2016-19 details actions to deliver on reviewing treatments and recovery pathways for substance misuse services in collaboration with the Edinburgh Alcohol and Drug Partnership. Further actions are set out below.

- Implement inpatient and community programmes (Lothian and Edinburgh Abstinence Project (LEAP)).
- Establish a model of care within Recovery Hubs using lived experience peer supporters.
- Explore new harm reduction and recovery approaches to engage more effectively with people receiving treatment for drug misuse through their GP.
- Develop and implement a stepped care approach to psychosocial and therapeutic interventions across recovery services.

National indicator 16: % of people released from a custodial sentence (quantitative) who are:

- **Registered with a GP**
- **Have suitable accommodation**
- **Have had a benefits eligibility check**

There is no systematic process to collect this information consistently. Input is required from a range of partners to identify need and facilitate access to accommodation as required. The main data source is likely to be the Scottish Prison Service, and will include throughcare, housing, health boards and Scottish Prison Service exit surveys.

Data on the percentage of households presenting as homeless due to 'discharged from prison' is being used as a proxy indicator and shows that this has remained fairly constant over the last four years:

2012-13			**2013-14**			**2014-15**			**2015-16**		
Prison	All	% from prison	Prison	All	% from prison	Prison	All	% from prison	Prison	All	% from prison
152	4315	3,5%	127	4102	3,1%	118	4017	2,9%	122	3638	3,4%

The data does not necessarily include all people who presented as homeless who had been in prison. If people stay with family/others for the first few weeks after release, housing officers may record their cause of homelessness as 'domestic ejection'.

The Scottish Government's Code of Guidance on Homelessness includes recommendations for partners in dealing with prison leavers (2,32) and sets out the local authority's accommodation duties towards applicants who are homeless or threatened with homelessness (chapter 9).

Outcome 3 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
11	Raise awareness of psychologically and trauma informed approaches to service delivery.	Women's Sub Group	31 March 2018
11	Map existing employability services assisting people to become employment ready and identify gaps in provision.	Sector Manager, Community Intervention	30 Sept. 2017
11	Develop the complex needs employability service.	Sector Manager, Community Intervention	30 Sept. 2017
12	Deliver year two of the Alcohol Problem Solving Court and identify other areas where the model might be applied.	Senior Manager, Community Justice/NHS Rep.	31 March 2018
12	Explore options for sustainability of the Navigator Programme.	Senior Manager, Community Justice//NHS Rep.	31 October 2017
12	Improve continuity in health intervention from DTTO to community management on expiry of DTTO.	Sector Manager, City-wide Services	31 March 2018
12	Work with other local authorities to maintain and enhance services across local authority boundaries.	Senior Manager, Community Justice/	31 March 2018
13	Develop a clearer understanding of third sector services, build closer links, and improve collaborative working to remove gaps in service provision.	EVOC/ECSP	31 March 2018
14	Improve speed of access to mental health services in Edinburgh.	NHS Lothian Rep.	31 March 2018
14	Design a pathway to make it easier for men with offending backgrounds to access mental health services.	Prolific Offenders Sub Group	30 Sept. 2017

15	Improve the speed of access to drug and alcohol misuse services.	NHS Lothian Rep.	31 March 2018
15	Establish baseline information for those within the community justice system accessing drug and alcohol services.	Prolific Offenders Sub Group	30 Sept. 2017
16	Liaise with NHS Lothian/Scottish Prison Service to establish baseline figures in relation to GP registration.	Prolific Offenders Sub Group	30 Sept. 2017
16	Liaise with Scottish Prison Service and community justice partners to establish accurate baseline information on prisoners having suitable accommodation and benefits check on release.	Prolific Offenders Sub Group	30 Sept. 2017

Outcome 4: Effective interventions are delivered to prevent and reduce the risk of further offending

National indicator 17: Targeted interventions have been tailored for and with an individual and had a successful impact on their risk of further offending

Interventions tailored with individuals to reduce their risk of further offending are outlined in Edinburgh's transitional plan for the delivery of community justice 2016-17, some of which have been highlighted above. These include the Violent Offender Watch, supervised bail, diversion from prosecution, Drug Treatment and Testing Orders, the Community Intervention Service for Sex Offenders, Willow, the prison based social work team, the Positive Lifestyles Project, community payback orders, the Caledonian system, the residential unit for high risk offenders, the Offender Recovery Service, employability initiatives, the escalating concerns group, Community in Motion, the Young People's Service, Community Improvement Partnerships and the newly established integrated Family and Household Support teams.

The Community Payback Order Annual Report 2015-16 in particular highlights how a range of partners work with criminal justice social work staff to assist offenders subject to community payback to make positive changes in their life. A range of interventions available to case managers supports behavioural and lifestyle change for offenders. Some examples are set out below.

The **Edinburgh Payback Programme** is for men to address general offending, including attitude and lifestyle issues, and reintegration work, which links people to services to support desistance after completion of the order. The programme also provides a module for road traffic offending. Drawing upon the successes of the Willow service, the programme has developed into a service for men where workers from criminal justice, health and other partners help men to address a broad range of needs, such as physical, mental and sexual health, abuse and trauma as well as confidence, self esteem and life skills.

The **Serious Offender Liaison Service (SOLS)** is based at the Orchard Clinic of the Royal Edinburgh Hospital and provides an assessment and consultancy service to criminal justice social work and partner agencies in relation to sexual offending.

The **Learning Disability Service** based at the Royal Edinburgh Hospital supports those with a learning disability who are subject to community payback. The service provides a wide range of support from art therapy to speech and language therapies. It also contributes to the intervention work with sex offenders with a learning disability to change their behaviour. Guidance on relationships and sexual health exists for those caring for people with leaning disabilities, entitled Making Choices Keeping Safe.

The **Scottish Prison Service** delivers activities and interventions that either address offending behaviour or support the needs of people in the care of the Scottish Prison Service. Examples include Alcohol Awareness, Drugs Action for Change, SMART Recovery, Constructs, Moving Forward Making Changes and the Youth Justice Programme targeting general offending behaviour in medium-high risk 16-17 year olds.

National indicator 18: Use of 'other activities requirement' in Community Payback Orders (CPOs)

Partnerships for the 'other activities requirement' have been developed with a variety of organisations. There are options to suit all abilities and needs, being as inclusive as possible. Twelve organisations provide other activity at this time. Examples of the new additions in the past year are set out below.

- Skills Path works with people who have a recognised disability, developing skills and experience, and provides the opportunity for people to move on to paid employment in various sectors.
- Street Soccer Scotland is a non-profit social enterprise, which delivers a range of football related services to socially disadvantaged adults and young people. Through sport, people develop new skills and increase confidence, self-esteem and better self-efficacy. People are shown how to build a portfolio, gain SQAs in communication, and develop first aid skills.
- Veterans First Point has been developed by veterans for veterans. Funded by the Scottish Government and NHS Lothian, it provides a one-stop shop for veterans and their families, helping ex-service personnel to reintegrate to civilian life.
- Youth Build Edinburgh assists young people who experience considerable disadvantage to access sustainable employment and comprehensive training in construction.

Improvement actions for 2017-18 will be to develop other activity work further, not only providing additional opportunities for people, but raising the awareness of the benefits of unpaid work/other activity in local communities and amongst partners. Improved publicity for completed unpaid work projects, through on-site information or local networks will also raise the profile of the benefits to communities and to people undertaking the work.

National indicator 19: Effective risk management for public protection

Partners in Edinburgh have established strong, multi-agency governance arrangements for public protection. Edinburgh's Chief Officers' Group – Public Protection is responsible for the leadership and performance management of the multi-agency aspects of public protection in the city. The Local Police Commander and the Chief Executives of the Council and NHS Lothian are members of the group. Five committees/partnerships (child protection, adult support and protection, offender management, alcohol and drugs, violence against women, multi-agency serious organised crime) manage performance and oversee the quality of services. The Edinburgh, Lothian and Scottish Borders Strategic Oversight Group monitors the operation of MAPPA and makes changes to improve effectiveness where required.

As part of the City of Edinburgh Council's Transformation Programme, Housing and Regulatory Services are introducing a generic housing officer, responsible for a geographical patch of Council tenancies. This will enable housing officers to have oversight of changing household composition in the area and to ensure that the Responsible Authorities under MAPPA routinely receive relevant information. This improves risk management with regard to allocating homes near known sex offenders and other offenders subject to MAPPA.

The young people risk management case conference process, an arrangement similar to MAPPA, is being used to work with young people who pose a significant risk of harm.

Addressing human trafficking and counter terrorism (Prevent and CONTEST) have been added to the public protection remit. Inter-agency guidance has been developed for staff and training takes places on a continuous basis to raise awareness about these issues and enable staff to respond appropriately. Serious and organised crime in the city is addressed on a multi-agency basis.

National indicator 20: Quality of CPOs and DTTOs

As highlighted in the Community Payback Order Annual Report 2015-16, most people who carry out unpaid work recognise that this can be an opportunity to learn a new skill, often as part of a team, as well as giving something back to the community. Some people who have completed their unpaid work hours are now volunteers within the same project. Exit surveys carried out with people who have completed an order highlight positive outcomes in areas including reduction in drug and alcohol use, uptake of employment and training, improved relationships and stable accommodation. As in previous years, many people cite the importance of the relationship with their social worker in helping them to improve their life and stop offending.

Teams delivering community payback and DTTO are subject to the City of Edinburgh Council quality assurance processes, which include case file audits, practice evaluations and focused themed audits, such as violent offenders or MAPPA. All of these processes result in improvement action plans, which are subject to ongoing monitoring. Lessons from Serious Incident Reports, Initial and Significant Case Reviews and actions from audits and practice evaluations are overseen by the Protection Committees' multi agency quality assurance sub groups.

National indicator 21: Reduced use of custodial sentences and remand (quantitative)

- **Balance between community sentences relative to short custodial sentences under 1 year**
- **Proportion of people appearing from custody who are remanded**

The Scottish Courts and Tribunal Service is now represented on the Edinburgh Community Safety Partnership. A system will be established for the relevant data to be provided. The Scottish Prison Service provides figures on prison populations by local authority as a snapshot, which is used for planning purposes.

The Crown Office and Procurator Fiscal Service will link into local authorities' community planning processes on a sheriffdom basis. This will also include work to extend awareness and knowledge of prosecution diversions amongst procurator fiscals to maximise the best use of appropriate community justice interventions.

The Edinburgh Community Safety Partnership is committed to reducing the use of short-term custodial sentences by developing the services outlined in this plan, which enable early intervention when difficulties are identified, have a focus on prevention, and, when people are convicted, have a clear focus on the prevention of re-offending. An important part of this strategy has been to develop credible community-based alternatives to custody that have the support of the courts and local communities.

National indicator 22: The delivery of interventions targeted at problem drug and alcohol use (quantitative)

In 2015-16, across Lothian, 28,972 Alcohol Brief Interventions were delivered against a target of 9,738. 12,179 of these were delivered in priority settings (primary care, maternity services, accident and emergency). A further 16,793 were delivered in wider settings, including higher education, dentistry,

criminal justice, sexual health services, young people's services, and occupational health. Edinburgh continues to deliver on this pan Lothian target and no improvement goals have been set for the Edinburgh Alcohol and Drug Partnership.

National indicator 23: Numbers of police recorded warnings, police diversion, fiscal measures, fiscal diversion, supervised bail, and community sentences (including CPOs, DTTOs and RLOs)

1025 Community Payback Orders were imposed in 2015-16, compared to 1114 in the previous year, consistent with fewer criminal justice social work reports being requested by courts. The Community Payback Order Annual Report provides information on all aspects of community payback, including the nine possible requirements.

The annual aggregate return to the Scottish Government provides detailed information on criminal justice social work reports, bail, diversion, voluntary assistance and statutory throughcare.

All statistical information provided from these and other sources (such as the Level of Service, Case Management Inventory (LS/CMI)) is used to plan and develop services.

Improvement action for 2017-18 is to work with Police Scotland and the Crown Office and Procurator Fiscal Service to establish baseline figures.

National indicator 24: Number of short-term sentences under 1 year

Snapshot data is available regarding males and females in prison by local authority and sentence (undetermined sentence, remand, fine defaulters, less than 3 months, 3 months to less than 6 months, 6 months to less than 2 years, 2 years to less than 4 years, 4 years or over, including life). This information is being used to inform planning.

Outcome 4 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
18	Further develop 'other activity' work to increase opportunities for those subject to Community Payback Orders.	Manager, CPO Unpaid Work Team	31 October 2017 (CPO Annual Report)
21	Establish baseline information and work with the Scottish Courts and Tribunal Service to obtain relevant data for comparison.	Sector Manager, City-wide Services	30 Sept. 2017
21	Work with the Crown Office and Procurator Fiscal Service to extend Procurator Fiscals' knowledge of suitable prosecution diversions opportunities in criminal justice and the third sector.	Sector Manager, City-wide Services	30 Sept. 2017
23	Work with Police Scotland to establish baseline figures for police warnings and diversions.	Sector Manager, City-wide Services	30 Sept. 2017
23	Work with the Crown Office and Procurator Fiscal Service to establish baseline figures for fiscal diversions, supervised bail, and community sentences.	Sector Manager,	30 Sept. 2017

		City-wide Services	

PERSON-CENTRIC OUTCOMES

Outcome 5: Life chances are improved through needs, including health, financial inclusion, housing and safety being addressed.

Outcome 6: People develop positive relationships and more opportunities to participate and contribute through education, employment and leisure activities.

Outcome 7: Individuals' resilience and capacity for change and self-management are enhanced.

National indicators 25, 26 and 27: Individuals have made progress against the outcome.

Local interventions designed to improve person-centric outcomes all follow a holistic approach addressing improved life chances, developing positive relationships and resilience at the same time. Consequently, the person-centric outcomes and related indicators are addressed jointly in this plan, as evidenced above. Outcomes are measured for individuals accessing community justice services. Examples are set out below.

The Caledonian System is the integrated approach to addressing domestic abuse. It combines a programme for male offenders with support services for women and children affected by domestic abuse, as both victims and witnesses. In the **evaluation of the Caledonian System** women reported that they felt safer and men who completed the programme were judged by case workers as posing a lower risk to partners, children and others by the end of the programme.

An evaluation of the **Edinburgh domestic abuse court** roll-out sought feedback from victims. It demonstrates the many successes of the domestic abuse court roll-out and the positive impact that can be achieved through effective support and intervention from all agencies and at every stage of the process.

The **Edinburgh Domestic Abuse Court Advocacy Service** (EDDACS) assists victims of domestic abuse to make informed choices relating to their circumstances, including person-centred work to improve confidence where victims are required to attend court at witnesses.

Performance information from **Willow** has demonstrated improvements in women's lives across a range of indicators, including improved mental health and engagement with services, improved problem solving skills, reduction in harmful behaviours to self and in alcohol and drug use, and a better understanding of the link between current difficulties and previous experiences of trauma. Many have been helped to resume care of their children.

The Care Inspectorate report on the residential unit for those who pose a risk of serious harm (July 2016) highlights that 'service users were supported to access housing, employment/training, health and finance and that outcomes for service users were positive.'

The positive outcomes for people subject to **community payback** are summarised in the exit questionnaires completed at the end of each order. Positive outcomes are cited in many areas, including employment and training, relationships and accommodation, and a reduction in drug and alcohol use.

The **Community Interventions Service for Sex Offenders** (**CISSO**) delivers the accredited programme for convicted sexual offenders: Moving Forward Making Changes. A national outcome evaluation is being planned for 2017. No control group is available therefore the evaluation will assess progress made towards short- and medium-term outcomes, which are expected to contribute towards the long-term outcome of decreasing offending behaviour.

Scottish Government reporting: Performance information for the Caledonian system is reported to the Scottish Government. An evaluation of the programme was conducted in 2016, which accompanies a summary of the key findings.

An annual report on the delivery of social work services in Edinburgh is also submitted. This is a requirement of each local authority to enable monitoring of the national social work landscape.

Edinburgh's Community Payback Order Annual Report 2015-16 is published online; along with other local authorities' annual reports it informs the Scottish Government Summary of Community Payback Order Local Authority Annual Reports 2015-16.

Outcomes 5, 6 and 7 priority areas for improvement actions

Priority area (indicator)	Improvement action	Lead	Completion
25	Indentify opportunities within existing pathways for vulnerable people to have access to health, wellbeing or other relevant interventions.	All	31 March 2018
27	Examine services proven to improve outcomes for individuals and consider whether the successful models can be replicated elsewhere.	Prolific Offenders Sub Group	31 March 2018

Alignment to National Outcomes and Community Planning

The Edinburgh Community Justice Outcomes Improvement Plan supports the Scottish Government's National Outcomes to: tackle the significant inequalities in Scottish society; live our lives safe from crime, disorder and danger; and build strong, resilient and supportive communities. It is being developed in line with the Edinburgh Community Planning Partnership's vision: Edinburgh is a thriving, successful and sustainable capital city in which all forms of deprivation and inequality are reduced.

The Edinburgh Partnership works towards four strategic outcomes:

- Edinburgh's economy delivers increased investment, jobs, and opportunities for all (strategic priority: reducing unemployment and tackling low pay)
- Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health (strategic priorities: shifting the balance of care; reducing alcohol and drug misuse; reducing health inequalities)
- Edinburgh's children and young people enjoy their childhood and fulfil their potential (strategic priorities: improving early support; improving outcomes for children in need; improving positive destinations)
- Edinburgh's communities are safer and have improved physical and social fabric (strategic priorities: reducing antisocial behaviour, violence, harm; reducing reoffending; improving community cohesion, participation and infrastructure; increasing availability of affordable housing; reducing greenhouse gas emissions)

Development of the Community Justice Outcomes Improvement Plan has identified four key themes, which align with the vision for community justice in the National Strategy, and cut across a number of Edinburgh's strategies and improvement plans listed at Appendix1.

- Making communities safer through reducing crime and antisocial behaviour
- Reducing inequalities by improving access to services (health, housing, welfare)
- Building strong and inclusive communities
- Improving individuals' resilience and life chances by creating more opportunities for participation in society (access to employment, education)

Public consultation events have highlighted those themes important to local communities and the Community Justice Outcomes Improvement Plan will feed into the development of the four Locality Improvement Plans, which will be in place by October 2017, and into the Edinburgh City Vision 2050.

Governance Arrangements

Edinburgh's Community Safety Partnership (CSP) has developed the Community Justice Outcomes Improvement Plan on behalf of Edinburgh's Community Planning Partnership. Statutory partners approved the Plan on 1 March 2017. The CSP has responsibility for implementing and monitoring the Plan, including delivering the improvement actions for the structural and person-centred outcomes. The CSP will report progress under the national indicators to the Edinburgh Partnership annually, in addition to carrying out an annual review of the Plan. Edinburgh's reporting structure for community justice is set out below.

Participation statement

The Community Justice Outcomes Improvement Plan has been developed with the full participation of community justice partners and the third sector. Partners who contributed to the Plan's development are listed at Appendix 2.

Feedback from the following activities was used to inform the Plan:

- online public consultation using survey questions and inviting comments
- Community Safety Partnership workshops to explore priority areas
- a short life community justice working group to gather input from partners
- consultation with people with offending backgrounds and their families
- consultation with victims and witnesses of crime and their families

The third sector is represented on the Community Safety Partnership and was included in the short life working group. Additional consultation events are planned with service users and the third sector in 2017/18 to support the Plan's review and further development.

Appendix 1: Sources

Scottish Government National Performance Framework

Edinburgh Partnership Community Plan 2015-18

Edinburgh Partnership Prevention Strategic Plan 2015-18

Integration Joint Board Strategic Plan 2016-19

The City of Edinburgh Council Business Plan 2016-20

Edinburgh Local Policing Plan 2014-2017

Antisocial Behaviour Strategy 2016-19

Local Fire and Rescue Plan for the City of Edinburgh 2017-20

Edinburgh Alcohol and Drug Partnership Strategy and Delivery Plan 2015-18

Integrated Plan for Children and Young People 2015-18

Appendix 2: Partners

The partners are members of Edinburgh's Community Safety Partnership (CSP):

Elected member and chair of the CSP

Chief Social Work Officer, the City of Edinburgh Council

Senior Manager, Community Justice, City of Edinburgh Council

Senior Manager, Integration Joint Board for Health and Social Care

Programme Manager, Edinburgh Alcohol and Drug Partnership

Chief Superintendent, Police Scotland

Area Manager, Scottish Fire and Rescue Service

Governor, HMP Edinburgh, Scottish Prison Service

Strategic Programme Manager, NHS Lothian

Chief Executive, Edinburgh Voluntary Organisations Council

Area Manager, Skills Development Scotland

Procurator Fiscal, Crown Office and Procurator Fiscal Service

Scottish Courts and Tribunals Service