Notice of Meeting and Agenda

Edinburgh Integration Joint Board

9.30am Friday 15 June 2018

Dean of Guild Court Room, City Chambers, Edinburgh

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

Contacts:

Email: lesley.birrell@edinburgh.gov.uk / jamie.macrae@edinburgh.gov.uk

Tel: 0131 529 4240 / 0131 553 8242

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 If any

4. Minutes and Updates

4.1 Minute of the Edinburgh Integration Joint Board of 18 May 2018 (circulated) submitted for approval as a correct record

4.2 Sub-Group Minutes

4.2.1 Audit and Risk Committee – Minute of 1 June 2018 (circulated) – submitted for noting

4.2.2 Professional Advisory Group – Minute of 8 May 2018 (circulated) – submitted for noting

4.2.3 Strategic Planning Group – Minute of 11 May 2018 (circulated) – submitted for noting

5. Reports

5.1. Rolling Actions Log – June (circulated)

5.2. Edinburgh Primary Care Improvement Plan – report by the IJB Chief Officer (circulated)

5.3. IJB Risk Register – report by the IJB Chief Officer (circulated)

5.4. Publication of Annual Performance Report – report by the IJB Chief Officer (circulated)

5.5. Attend Anywhere Service – report by the IJB Chief Officer (circulated)

5.6. Edinburgh Integration Joint Board Unaudited Annual Accounts 2017/2018 – report by the IJB Chief Officer (circulated)

6. Motions

6.1. None.

Board Members

Voting

Councillor Ricky Henderson (Chair), Carolyn Hirst (Vice-Chair), Councillor Robert Aldridge, Michael Ash, Councillor Ian Campbell, Martin Hill, Alex Joyce, Councillor Melanie Main, Angus McCann and Councillor Susan Webber.

Non-Voting

Colin Beck, Carl Bickler, Sandra Blake, Andrew Coull, Lynne Douglas, Christine Farquhar, Helen FitzGerald, Alistair Gaw, Kirsten Hey, Ian McKay, Moira Pringle, Judith Proctor, Ella Simpson and Pat Wynne.

Item 4.1

Minutes

Edinburgh Integration Joint Board

9:30 am, Friday 18 May 2018

Dean of Guild Court Room, City Chambers, Edinburgh

Present:

Board Members:

Councillor Ricky Henderson (Chair), Carolyn Hirst (Vice Chair), Councillor Robert Aldridge, Colin Beck, Carl Bickler, Sandra Blake, Councillor Ian Campbell, Andrew Coull, Christine Farquhar, Helen Fitzgerald, Martin Hill, Alex Joyce, Councillor Melanie Main, Ella Simpson, Councillor Susan Webber and Pat Wynne.

Officers: Judith Proctor (Chief Officer), Colin Briggs (Interim Chief Strategy & Performance Manager), Michelle Miller and Moira Pringle (Chief Finance Officer).

Apologies: Michael Ash, Angus McCann, Lynne Douglas and Alistair Gaw (Interim Chief Social Work Officer).

1. Welcome to Chief Officer

Decision

The Chair and Members welcomed Judith Proctor, newly appointed Chief Officer to her first meeting of the Edinburgh Integration Joint Board.

2. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 2 March 2018 as a correct record.

2) To agree that the cross cutting themes aligned to the Outline Strategic Commissioning Plans would be shared with the Reference Boards.

3. Sub-Group Minutes

Updates were given on Sub-Group and Committee activity.

Decision

1) To note the minute of meeting of the Audit and Risk Committee of 27 April 2018 and to reinforce to the Joint Board the Group's concerns regarding reporting against overdue internal audit recommendations and to note that the Chief Officer intended to report back with an action plan to address these in due course.

2) To note the minute of meeting of the Performance and Quality Sub-Group of 7 March 2018.

3) To note the minute of meeting of the Performance and Quality Sub-Group of 25 April 2018.

4) To note the minute of meeting of the Strategic Planning Group of 9 March 2018.

5) To note the minute of meeting of the Strategic Planning Group of 13 April 2018.

4. Rolling Actions Log

The Rolling Actions Log for 18 May 2018 was presented.

Decision

1) To agree to close Action 1 – Programme of Development Sessions and Visits.

2) To agree to close Action 8 – Business Resilience Arrangements and Planning

3) To agree to close Action 11 – Outline Strategic Commissioning Plans for Learning Disability, Mental Health and Older People

4) To include expected completion dates to outstanding actions where possible.

5) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log 18 May 2018, submitted)

5. Business Resilience Arrangements and Planning – Spring Update

An update was provided on the Edinburgh Health and Social Care Partnership's integrated business resilience arrangements. The Partnership's resilience management strategy set out a framework for maintaining essential services and functions during an incident.

The Tactical Resilience Plan was part of the overall management system that established, implemented, operated, monitored, reviewed, maintained and improved business continuity.

It was proposed to undertake a series of resilience training workshops to develop service areas' individual operational resilience plans.

The following points were discussed by members:

- breakdown of information on operational activity
- helpful to have clear guidelines for managers and staff when Met Office "do not travel" warnings were issued during severe weather
- implications for Directions
- important to set out how the Partnership worked with voluntary and third sector partners in terms of building resilience in communities and through locality structures

Decision

1) To note the progress made on the Joint Board's integrated resilience management strategy.

2) To endorse the Tactical Resilience Plan set out in Appendix 1 of the report by the Chief Officer.

3) To agree that an update report be submitted to the Joint Board by the end of 2018.

(References – Edinburgh Integration Joint Board 15 December 2017 (item 5); report by the Chief Officer, submitted)

6. Financial Outturn 2017/18

An overview of the financial position for 2017/18 was provided together with a summary of the reserves to be carried forward into 2018/19.

Additional one off contributions had been agreed by the City of Edinburgh Council and NHS Lothian to mitigate the overspend which would allow the Integration Joint Board to break even in 2017/18.

Decision

1) To note that the City of Edinburgh Council and NHS Lothian had increased their budgets delegated to the Integration Joint Board by £7.5m and £4.9m respectively, subject to noting that the City of Edinburgh Council required to approve the additional non-recurring contribution of £0.4m for 2017/18 as part of their consideration of the unaudited accounts at the full Council meeting on 28 June 2018.

2) To note that, subject to external review, the Integration Joint Board had achieved a breakeven position for 2017/18.

3) To agree that the Integration Joint Board would carry reserves totalling £8.4m (of which £6.5m were committed) into 2018/19.

(References – Edinburgh Integration Joint Board 2 March 2018 (item 9); report by the Chief Finance Officer, submitted)

7. 2018/19 Financial Plan

Decision

1) To note the offers received from the City of Edinburgh Council and NHS Lothian.

2) To note that, whilst the process of due diligence on these offers had concluded, the £4m contribution from NHS Lothian remained outstanding.

3) To remit the Chief Officer to continue the positive dialogue with NHS Lothian and the Council to secure this funding.

4) To note the resultant financial plan based on the budget offers.

5) To agree the draft savings and recovery programme for 2018/19 as set out in Appendix 3 of the report and to agree that additional scrutiny of delivery of this programme was required.

6) To remit the Chief Officer to carry out a review of committed reserve funding with a view to reallocating if appropriate.

7) To note that the Chief Officer intended to arrange a workshop on the overall programme delivery.

8) To agree that the Chief Officer would submit a report to the next meeting of the Joint Board providing an interim update on progress against savings targets.

(References – Edinburgh Integration Joint Board 2 March 2018 (item 9); report by the Chief Finance Officer, submitted)

8. Whole System Delays

An overview was provided of performance in managing hospital discharge against Scottish Government targets, trends across the wider system, identified pressures and challenges and improvement activities. It was acknowledged that performance and delays across the whole system continued to be extremely challenging.

Decision

1) To note the ongoing pressures and delays across the system, including delayed discharges and people waiting for a package of care.

2) To note the range of actions being taken to address these pressures, including securing additional resources in the short term to resolve the current backlog of assessments and people waiting for discharge.

3) To agree that metrics would be incorporated into future reports on whole system delays to provide reassurance to the Joint Board that the actions were appropriately aligned to the expected targets.

(References – Edinburgh Integration Joint Board, 2 March 2018 (item 11); report by the Chief Officer, submitted)

9. Plan for Immediate Pressures and Longer Term Sustainability

The draft Plan developed by the Edinburgh Health and Social Care Partnership to alleviate short term pressures on services and budgets and create the environment to allow longer term sustainable change was presented.

The Plan set out information regarding the current position of numbers of people delayed in hospital, the governance arrangements established to monitor progress against the improvements agreed and the financial context for the work.

Members discussed the following issues arising from their consideration of the draft Plan:

- community planning structures
- relationship between housing and health and social care services
- housing statement workshop
- Community Empowerment Act

Decision

1) To note the actions underway as set out in the draft Plan to alleviate immediate pressures and establish the environment for longer term sustainability.

2) To endorse the medium and longer term actions proposed.

3) To agree that a communications and engagement strategy to complement the Plan would be submitted to a future meeting of the Joint Board.

4) To ask the Project Lead Officer to arrange a presentation to Board Members either at a development session or at a formal meeting on the assessment project.

(Reference – report by the Chief Officer, submitted)

Declaration of Interest

Christine Farquhar declared a non-financial interest in the above item as the former Chair of Upward Mobility and the guardian of a person in receipt of a direct payment.

10. Grants Review Interim Report

The Joint Board had previously agreed the scope, methodology and timescale for the review of health and social care grant programmes.

An update was provided on the progress made to date in respect of the review of the grant programmes. The Grants Review Steering Group were focussing on the following four main key areas:

- Analysis of current usage of grants
- Identification of priorities for future funding

- Principles to underpin the operation of future grants programmes
- Engagement with stakeholders.

Next steps in the delivery of the grants review were also presented.

The Strategic Planning Group had endorsed the approach taken.

Decision

1) To note the progress made in taking forward the grants review.

2) To note that the grants review dovetailed with the development of the strategic commissioning plans and the revised strategic plan.

3) To recognise the challenges and risks inherent in carrying out the review.

4) To endorse the approach taken.

(References – Strategic Planning Group 13 April 2018 (item 6); report by the IJB Interim Chief Finance Officer, submitted)

Declaration of Interest

Ella Simpson declared a non-financial interest as a Director of an organisation in receipt of a grant.

11. Royal Edinburgh Campus and St Stephen's Court

Information was provided on the development of the business case for the Royal Edinburgh Campus and the related commissioning of capacity at St Stephen's Court. The business case included a total of 8 additional beds for mental health. NHS Lothian had undertaken not to progress with the business case unless it had full approval from the four Edinburgh and Lothian Integration Joint Boards.

Members expressed concerns that the Strategic Planning Group had not had sufficient opportunity to scrutinise or discuss the business case prior to its submission to the Joint Board.

Decision

1) To note the progress made in developing the case for the Royal Edinburgh Campus.

2) To agree that NHS Lothian could progress to the next stage of development of the case.

3) To authorise the Joint Board Chair to write to the Chair of NHS Lothian's Finance and Resources Committee noting the Joint Board's approval with an expectation that outstanding issues were resolved and returned to the Joint Board before final design and financial agreement.

4) To approve the commissioning of 16 places in the St Stephen's Court development on the condition that the Strategic Planning Group receives a further business case to their next meeting in June about the further development of the services to be delivered at St Stephen's Court and further engagement with the housing sector.

(Reference – report by the Chief Officer, submitted)

12. The Inclusive Homelessness Service at Panmure St Ann's

The Standard Business Case for the creation of a new operational base for the Inclusive Homelessness Service was presented. The new base would enable the co-location of NHS Lothian, the City of Edinburgh Council and third sector agencies working together to serve the target population.

The Strategic Planning Group had considered the proposed approach.

Decision

1) To note that the Edinburgh Access Practice had to vacate its main surgery in the Cowgate in January 2017 and as a result was compelled to take up sub-optimal accommodation in the basement of the Spittal Street Clinic.

2) To note that the Lothian Capital Investment Group had agreed in May 2016 that Spittal Street did not offer an acceptable long term solution for this service.

3) To note that, to improve outcomes for service users, a new integrated model of complex needs provision in the shape of the Inclusive Homelessness Service had already been approved by the Joint Board.

4) To endorse the selection of the Council-owned property that previously served as the Panmure St Ann's School as the preferred operational base for the Inclusive Homelessness Service.

5) To endorse the accompanying Business Case which sought capital funding of £2.98m from NHS Lothian for the refit of Panmure St Ann's.

6) To endorse the estimated annual running costs of £106,000 arising from the occupancy of Panmure St Ann's of which NHS Lothian had agreed to provide £86,000 and the Council the remaining £20,000.

7) To ask the Council and NHS Lothian to develop a framework for the funding of capital projects that were developed in partnership.

(References – Strategic Planning Group 13 April 2018 (item 8); report by the Chief Officer, submitted)

13. Appointments and Review of Sub-Groups

Information was provided of recent changes to the City of Edinburgh Council membership of the Joint Board and the reappointment of an NHS Lothian member.

Approval was also sought to appoint a replacement NHS Lothian staff representative on the Joint Board and a City of Edinburgh Council voting members to the Audit and Risk Committee.

Decision

1) To note that the Council at its meeting of 15 March 2018 appointed Councillors Robert Aldridge and Ian Campbell to replace Councillors Alasdair Rankin and Derek Howie as voting members of the Joint Board.

2) To note the re-appointment of Alex Joyce by NHS Lothian as a voting member of the Joint Board.

3) To approve the reappointment of non-voting members whose term of office was due to expire.

4) To approve the appointment of Helen Fitzgerald to replace Wanda Fairgrieve as the non-voting NHS Lothian staff representative on the Joint Board.

5) To approve the temporary suspension of the Performance and Quality Sub-Group for a period of six months and to agree that performance monitoring would be brought into the remit of the Strategic Planning Group during this time.

6) To instruct the Chief Officer to bring a paper to a future Joint Board meeting on the wider Board assurance processes and structures.

7) To note that an update report would be presented to the next meeting in June with the final report to be submitted in two cycles (September 2018).

8) To appoint Councillor Aldridge as a members of the Audit and Risk Committee.

9) To note that the Chief Officer would hold early discussions about the appointment of a Chair for the Audit and Risk Committee before making a recommendation to the Joint Board.

10) To note the progress made in recruiting two service user members.

(Reference – report by the Chief Officer, submitted)

14. Calendar of Meetings

A proposed schedule of meetings for the Joint Board for the period August 2018 to August 2019 was presented.

Decision

To approve the schedule of meetings for the period to August 2018 to August 2019.

(Reference – report by the Chief Officer, submitted)

15. Standing Orders – Annual Review

The Joint Board's Standing Orders had been reviewed to ensure they continued to be fit for purpose and reflected Scottish Ministers' guidance.

Decision

1) To note that the Joint Board's Standing Orders remained fit for purpose and to agree that no changes were required.

2) To note that the next annual review of Standing Orders would be presented to the Joint Board in June 2019

(Reference – report by the Chief Officer, submitted)

16. Webcasting of Integration Joint Board Meetings

The City of Edinburgh Council had considered a report on the possibility of extending webcasting to a range of public meetings including the Integration Joint Board.

The Joint Board were invited to consider using the webcasting facilities for its future meetings.

Decision

To agree that Joint Board meetings would be webcast live and archived on a pilot basis for a period of one year subject to review.

(References – Act of Council No.9 of 3 May 2018; report by the Chief Officer, submitted)

17. Update on the Recruitment of the Head of Operations

Decision

To note the appointment of Tom Cowan as the Head of Operations, Edinburgh Health and Social Care Partnership with effect from 4 June 2018.

18. Data Protection Officer

Decision

To note the appointment of Kevin Wilbrahim, Data Protection Officer for the City of Edinburgh Council as the Data Protection Officer for the Integration Joint Board.

19. Motion by Councillor Webber – NHS Attend Anywhere

The following motion was submitted by Councillor Webber:

"Integration Joint Board notes:

1) The development of the national 'Attend Anywhere' programme as part of the Scottish Centre for Telehealth and Telecare's work around video-enabled health and social care.
2) The 'Attend Anywhere' platform allows health care providers the ability to offer patients a video consultation as an alternative to face-to-face appointments.
3) The 'Attend Anywhere' service is utilised by every Health Board in Scotland at this present time except for NHS Lothian.
4) Further notes the potential for increased use of telecare to transform service delivery.
5) Calls for a short report within 1 cycle on the timescales and feasibility of introducing this service, quantifying the risks of adoption and non-adoption, and the costs and benefits associated with implementation in collaboration with NHS Lothian to support IJB services and priorities including the transformation of primary care services."

- moved by Councillor Webber, seconded by Councillor Main

Decision

To approve the motion by Councillor Webber.

20. Michelle Miller

Decision

To record the Joint Board's thanks and appreciation to Michelle Miller for her work and commitment in her role as Interim Chief Officer and to wish her well in her new employment.

Item 4.2.1

Minutes

Audit and Risk Committee

1.00 pm, Friday 1 June 2018
Mandela Room, City Chambers, Edinburgh

Present:

Mike Ash (Chair), Councillor Robert Aldridge, Alex Joyce, and Councillor Susan Webber.

Officers: Jamie Macrae (Committee Services, CEC), Lesley Newdall (Chief Internal Auditor) and Moira Pringle (Chief Finance Officer), Grace Scanlin (Scott-Moncrieff), Cathy Wilson (Operations Manager, Edinburgh Health and Social Care Partnership).

Apologies: Ella Simpson.

1. Appointment of a Chair

Decision

Mike Ash was appointed to Chair the meeting.

2. Minutes

Decision

To approve the minute of 27 April 2018 as a correct record.

3. Outstanding Actions

Decision

To note the outstanding actions.

(Reference – Outstanding Actions, submitted.)

4. Work Programme

Decision

To note the Work Programme and upcoming reports.

(Reference – Audit and Risk Committee Work Programme, submitted.)

5. IJB Risk Register

An update was provided on the Integration Joint Board (IJB) risks along with a summary of the strategic controls and actions put in place to reduce the likelihood of the risks. The Audit and Risk Committee had agreed in February 2018 to the development of separate Risk Registers for the IJB and the Edinburgh Health and Social Care Partnership. Following agreement at that meeting, the IJB Risk Register had been split into three categories:

- Strategic planning and commissioning
- Issuing of directions
- Management and role of the IJB

During discussion, it was highlighted that the adequacy of the current controls was uncertain and that further detail, including dates, would be required in future iterations, particularly for “red” risks. Some descriptors would need to be turned into mitigating controls.

Decision

1) To note the amendments made to the IJB risk register as a result of the Committee’s deliberations in February 2018.

2) To agree that the management actions identified against the current risks provided suitable assurance that these risks were being appropriately managed.

3) To note the continued development of mitigating controls for IJB identified risks.

4) To agree that the IJB risk register be presented to the IJB in June 2018.

(References – IJB Audit and Risk Committee, 9 February 2018 (item 2); report by the Chief Finance Officer, submitted.)

6. Edinburgh Integration Joint Board Unaudited Annual Accounts for 2017/18

The unaudited 2017/18 annual accounts for Edinburgh Integration Joint Board (EIJB) were presented for scrutiny by the Audit and Risk Committee, prior to being presented to the Joint Board on 15 June 2018 for approval and submission to external audit.

Some gaps were highlighted and it was noted that these would be completed before submission to the Joint Board, in particular the Governance Statement.

Decision

1) To note the draft financial statements submitted and the proposed timescale for completion.

2) To note the governance section was not available for scrutiny, but the issues had been discussed and would be reflected in the report to the Joint Board.

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

7. Urgent Business

The Chief Internal Auditor explained that a historic issue had been identified in relation to previous effectiveness of the Internal Audit follow-up process, which had resulted in non-compliance with Public Sector Internal Audit Standards. This would be reflected in the 2017/18 Internal Audit annual opinion report. Upon identification, this issue was addressed through implementation of a manual follow-up process in September 2017, with implementation of a fully automated solution scheduled for July 2018.

Decision

To note the update.

8. Date of next meeting

Decision

To agree that the next meeting would take place at 10am on Monday 23 July.

Item 4.2.2

Minutes

Edinburgh Integration Joint Board
Professional Advisory Group

9.30am Tuesday 8 May 2018
Mandela Room, City Chambers, Edinburgh
Present:
Carl Bickler (Co-Chair), Colin Beck (Co-Chair), Eddie Balfour, Robin Balfour, Sheena Borthwick, Chris Brannan, Colin Briggs, Anne Crandles, Lynne Douglas, Kirsten Hey, Sylvia Latona, Jamie Macrae, Sandra McNaughton, Alison Meiklejohn, Isobel Nisbet, Kate Pestell, Mike Reid, Linda Nicol Smith, David White.

Apologies:
Kath Anderson, Dawn Arundel, Sharon Cameron, Alison Craig, Alasdair FitzGerald, Helen FitzGerald, Philip Galt, Marian Gray, Jen Grundy, Belinda Hacking, Caroline Lawrie, Catherine Mathieson, Ian McKay, Katie McWilliam, Michelle Miller, Mike Ryan, Ciara Webb.

1. Membership

Decision

1) To welcome new members to the Professional Advisory Group.

2) To note recent changes to the Joint Board membership.

2. Note of the meeting of the Integration Joint Board Professional Advisory Group meeting of 6 February 2018 and Matters Arising

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group of 6 February 2018 as a correct record.

3. Note of the meeting of the Edinburgh Integration Joint Board of 26 January 2018 and 2 March 2018 and Matters Arising

Decision

To note the minutes of the meetings of the Edinburgh Integration Joint Board of 26 January 2018 and 2 March 2018.

4. Community Link Worker Network – presentation

Anne Crandles, Community Link Worker Network Manager, was invited to present on the Community Link Worker Network. Details were provided of the locality teams and structure, the team's workload and outcomes following intervention. During discussion, the following points were raised:

- Link Workers used checklists, among other methods, in their interventions.
- Referrals had to come from the Practice Team – locality events had been arranged to get to know partners.
- Link Workers worked with over 18s.
- It was important not to lose of community pharmacies as part of the network.

Decision

To thank Anne Crandles for her presentation and to note the update.

5. Primary Care Improvement Plan – presentation

Details were provided of the Primary Care Improvement Plan, including the timetable for development, through to the submission to the Scottish Government on 1 July 2018, sources of funding, implementation of new programmes and a range of new contract options. During discussion, the following points were raised:

- The response from GPs had been mainly positive, although there was some concern, particularly in rural areas.

- An improvement plan had been developed, and engagement was taking place with GPs and Practice Managers.
- It was expected that Transformation Grants would continue to be offered to practices.
- It was important to be mindful of people with learning disabilities, as seeing the same GP was important.

Decision

To note the update.

6. Outline Strategic Commissioning Plans

An update was provided on the development of the Outline Strategic Commissioning Plans. Reference Boards had been set up for each of the Plans to oversee their development and to lead on engagement, and Chairs had been identified for these groups. The five Plans were expected to be completed by the end of the year. The Professional Advisory Group would have a role in assuring the Plans and assessing risks.

Decision

1) To note the update.

2) To agree that the presentation on the Plans from the IJB Development Session of 27 April 2018 would be circulated to members.

7. IJB Sub-Group Infrastructure workshop outcome

Details were provided of the outcome of a workshop held on 2 April 2018 on the Integration Joint Board scheme of delegation and sub-group infrastructure. One of the outcomes was a proposal to amend the IJB report template allow authors to indicate whether the report has been considered by the Professional Advisory Group or not and if so, detail any feedback received.

Decision

To note the update.

8. Overview of AHP work/governance and professional assurance

An overview was provided of the review of Allied Health Professional (AHP) professional governance, which began in December 2017. Mitigations to ensure that all staff knew who their professional and line managers was undertaken. In addition, an assurance and governance scope was undertaken across all AHP professions in Lothian. To assist the IJB with the professional input required, the AHP Director NHS Lothian was co-opted onto the Joint Board.

Decision

1) To note the ongoing work supported by the AHP Director and Edinburgh senior management team to resolve the professional governance gaps presently in Edinburgh.

2) To note the assurance and governance objective to provide a core governance framework for professions across Lothian to report to the IJBs and assure the safe and effective delivery of service to their population.

3) Acknowledge the importance of professional leadership, governance and assurance at all levels within the partnership to deliver the health & Social care objectives.

9. Learning Disability representation

An update was provided on the reduction of Learning Disability beds as part of Phase 2(b) of the Royal Edinburgh Hospital Re-provision. The service working to get bed numbers down to 30 and the service had begun the process of discharging. The main difficulty was the shortage of packages of care in the city, particularly for people who required a high level of care. The long-term aim was to reduce to 15 beds.

Decision

1) To note the update.

2) That the IJB report on the Royal Edinburgh Campus and St Stephen's Court would be circulated to members when published.

10. Locality Boundaries

An update was provided on locality boundaries following a meeting with the Interim Chief Officer in February. For Adult Mental Health and Substance Misuse, services would be re-sectored by GP clusters. There were some exceptions for people who lived far away or outside of Edinburgh. Other services were not yet confirmed.

Decision

To note the verbal update and to agree that the Co-Chairs would discuss further and feed back to members.

11. Seek, Keep, Treat Development Plan

Details were provided of additional funds of £20m which had been made available for substance misuse services across Scotland, the focus of which would be Seek, Keep,

Treat services, as defined by the Scottish Government, designed to connect with the "hardly reached" people. As part of this, about £2m would be available for Edinburgh.

Decision

To note the update.

12. Joint Inspection of Services for Older People in Edinburgh – Progress Review

An update on the progress review of the Joint Inspection of Services for Older People in Edinburgh was provided, which was based on progress made on the 17 inspection report recommendations and previously evaluated weak or unsatisfactory areas. Details were provided of the review methodology, which included a staff survey and on-site scrutiny.

Decision

To note the update.

13. Third Sector Grants Review

An update was provided on the Third Sector Grants Review, which was due to the need to ensure that any new grants programmes were aligned with IJB priorities and current challenges. Significant engagement was taking place with the Third Sector and there had generally been a positive response to the review. Priorities had been identified based on the Strategic Plan priorities, the Locality Improvement Plan outcomes and the Outline Strategic Commissioning Plan outcomes. The review aimed to move the focus to people and their communities of place and interest.

Decision

To note the update.

14. Next Meetings

Decision

To agree that the Clerk would confirm with the Convener the date for the next meeting of the PAG.

Item 4.2.3

Minutes

Edinburgh Integration Joint Board
Strategic Planning Group

10.00am Friday 11 May 2018
City Chambers, High Street, Edinburgh

Present:

Members: Carolyn Hirst (in the Chair), Councillor Ricky Henderson (Vice Chair), Colin Beck, Sandra Blake, Colin Briggs, Wendy Dale, Christine Farquhar, Stephanie-Anne Harris, Graeme Henderson, Fanchea Kelly, Moira Pringle, Rene Rigby, Ella Simpson and David White.

Apologies: Eleanor Cunningham, Belinda Hacking, Judith Proctor, Michele Mulvaney, Nickola Paul and Michelle Miller, Dermot Gorman.

In Attendance: Nicola McCullogh (A&E Consultant, NHS Lothian), Angela Ritchie (Senior Executive Officer, CEC) and Sarah Ford (Student, Napier University)

1. Minute

Decision

To approve the minute of the Edinburgh Integration Joint Board Strategic Planning Group of 13 April 2018 as a correct record subject to recording an apology for Rene Rigby.

2. Rolling Actions Log

Decision

1) To agree to close Action 4 – Community Engagement Plan.
2) To agree to close Action 6 – Outline Strategic Commissioning Plans.
3) To update the rolling actions log and note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. Grants Review

An update was provided on the progress made to date in respect of the grants review prior to presenting an interim report to the Joint Board. The scope of the grants review agreed by the Joint Board was to focus on tackling inequalities, prevention and early intervention.

The grants review steering group had identified a set of proposed priorities and principles to form the basis for engagement with the third sector. These took into account the priorities in the Strategic Plan, the outcomes from Locality Improvement Plans, and the emerging outcomes in relation to from the outline strategic commissioning plans.
Current grants were committed to 31 March 2018 and new grants would be available from 1 April 2019.

Decision

1) To note the progress made in taking forward the grants review
2) To recognise the challenges and risks inherent in carrying out the review.
3) To endorse the approach being taken.

(References – Strategic Planning Group 9 March 2018 (item 4); verbal update by the Strategic Planning, Service Re-design and Innovation Manager)

4. Directions - Update

A brief update on Directions was provided. Directions were being reviewed, with the potential that some would be removed or amended. A report would be presented to the Joint Board at its June meeting.

Decision
To complete the review of Directions and assign clear performance measures to each by June 2018.

(Reference – Strategic Planning Group 9 March 2018 (item 6)

5. Progress Update on Recommendations from Joint Inspection of Services for Older People

Updates were provided on progress on the three recommendations from the Joint Inspection of Services for Older People for which this Group had oversight.

The five Outline Strategic Commissioning Plans (OSCPs) were discussed at the development session on 27 April 2018 chaired by Councillor Henderson as Chair of the IJB. Work was underway to produce project plans for work associated with the OSCPs.

During discussion the following issues were raised:

- Work to produce the market facilitation strategy was progressing.
- A fundamental discussion was required about how to do things differently and this work would be undertaken by the reference boards

Evidence gathering and engagement was underway for the Care Inspectorate visit planned for June 2018. An Engagement Manager was being recruited for an initial period of two years to co-ordinate this work.

Members were assured that all pieces of work were on track.

Decision

To note the updates as part of the routine reporting process.

(Reference – report by the Strategic Planning Manager, Service Re-design and Innovation, submitted)

6. Outline Strategic Commissioning Plans Update

A brief update on the Outline Strategic Commissioning Plans (OSCPs) was provided. Details were given on the role of the Strategic Planning Group (SPG), the relationship between the IJB Strategic Plan and the OSCPs, the establishment of reference boards for each OSCP, and plans for engagement.

The development session on 27 April had been well attended and there had been lots of positive discussion around the OSCPs. In particular, there had been significant discussion about cross cutting themes and how this could be taken forward.

Decision

1) To agree that the slides for the IJB Development Session on 27 April 2018 would be circulated widely for information after the event.

2) To note that Councillor Ricky Henderson had replaced Councillor Derek Howie as Chair of the Older People's Reference Board.

3) To request regular updates on progress against actions from the Reference Boards to be circulated to members of this Group.

(References – Strategic Planning Group 9 March 2018 (item 5); Outline Strategic Commissioning Plans Update, submitted.)

7. Note of Workshop on IJB Scheme of Delegation and Sub-Group Infrastructure

The outcomes from the workshop to discuss the Joint Board scheme of delegation and sub-group infrastructure were submitted. The following challenges had been identified at the workshop:

- number of frequency of meetings
- lack of clarity about the roles of each sub-group and committee and the linkages between them
- the impact of establishing reference boards
- concern that finance did not get enough scrutiny outside of the formal Joint Board meetings
- currently only the Joint Board itself has the authority to make decisions

During discussion the following points were raised:

- important to ensure existing partnerships were integrated into the work of the reference groups
- this Group should focus on performance of Directions
- consideration required to be given to the housing contribution statement
- going forward this Group would like to see where reports were on their journey ie. context and reasons why papers were being presented at a specific point in time

Decision

To note the report and that the Joint Board would consider a report on appointments to sub-groups and committees at its meeting on 18 May 2018.

(Reference – briefing note, submitted)

8. Strategic Plan Vision Values and Priorities

The Joint Board's current Strategic Plan was due to end on 31 March 2019. A new Strategic Plan would be required from 1 April 2019 to 31 March 2022. A key purpose of the Plan was to set out the Joint Board's vision for health and social care in Edinburgh, the values underpinning that vision and the priorities to be addressed to turn the vision into reality.

The Group discussed and raised the following points:

- public protection and safety did not seem to be explicit in the Plan although it was recognised that this underpinned all areas – the Group agreed it should be included in the key priorities
- shared principles should be included in terms of partnership approach
- noted that the cross cutting principles fitted seamlessly into the values statement
- information should be included about progress and achievements to date and where we want to be in 2020
- important to recognise progress in terms of being people and citizen focussed and not dividing people up into silos – going forward need to recognise further progress with a person's wellbeing would have to be a person centred conversation
- recognised the issues around understanding the limitations in terms of finance and workforce and moving towards shifting the balance of care and responsibility on to communities
- important to set out the big pieces of work the IJB had achieved, what needed to be achieved, what could be funded and what could be delivered by partners through locality working
- include data to support the priorities identified in the Plan to provide an illustration of effect and impact
- recognised the huge progress which had been made in tackling inequalities

Decision

To agree to extend the timing of the June meeting of the Group to allow a more focussed discussion around the strategic shifts

(Reference – report by the Strategic Planning Manager, Service Re-Design and Innovation, submitted)

9. Edinburgh Primary Care Improvement Plan

The Edinburgh health and Social Care Partnership was required to submit a Primary Care Improvement Plan to the Scottish Government by 1 July 2018. The Plan set out the Partnership's planned way forward to implement the new Scottish General Medical Services contract proposals.

The Plan would be presented to the Integration Joint Board at its June meeting.

During discussion the following issues were raised and considered:

- welcomed the collaborative working by GP Sub-Committee representatives and the Edinburgh Primary Care Support Team including locality clinical leads in creating the Plan

- noted that a meeting would be held on 22 May 2018 to discuss the equalities impact assessment and sustainability implications of the Plan
- noted there remained a number of uncertainties in respect of finance for the workstreams set out in the Plan
- travel vaccinations was an ambitious plan and was controversial – there were risks in terms of staffing, funding and timescales
- a risk register required to be developed for all the workstreams
- recognised that finance and workforce were the two major areas of concern in terms of resourcing the Plan
- training for the existing primary care workforce would be essential
- essential to develop a communications strategy to support the Plan for members of the public
- important to include partnership approach and use other partner providers and to strengthen third and private sector links and joined up working

Decision

1) To support the direction of travel set out in the report.
2) To note the development of proposals as further progress in the stabilisation and development of Primary Care across the City.
3) To note the importance of the support of the GP Sub-Group and Lothian New Contract Co-ordinating / Oversight Group to enable the Edinburgh plan to proceed to submission.
4) To note the progress being made with the draft Primary Care Improvement Plan as set out in appendix 1 of the report.
5) To note the summary of actions set out in appendix 2 of the report.
6) To note the actions on the development of the Plan set out in appendix 3 of the report.

(Reference – report by the Chief Officer, Edinburgh Health and Social Care Partnership, submitted)

10. St Stephen's Court and Royal Edinburgh Hospital Update

Information was provided on the development of the business case for the Royal Edinburgh Campus and the related commissioning of capacity at St Stephen's Court. The business case included provision for an additional 8 beds for mental health. The net impact of the development was £902,000 funded from the £1.9m contingency set aside for Phase 1 of the Royal Edinburgh Hospital.

It was anticipated that the property would be available from end June and would be fully occupied in September.

There had been challenges around putting in place the governance arrangements within a short timescale but the detailed business case had been presented to the Reference Board on Mental Health for consideration.

Members expressed concerns that they had not been well sighted on the proposals and that this Group had not had an opportunity to consider and scrutinise the business case in detail.

Decision

1) To note the progress made in developing the case for the Royal Edinburgh Campus.
2) To recommend that the Integration Joint Board agree that NHS Lothian progress to the next stage of the development of the case.
3) To recommend to the Integration Joint Board that the IJB Chair write to the Chair of NHS Lothian's Finance and Resources Committee noting the Joint Board's approval with an expectation that outstanding issues were resolved and returned to the Joint Board before final design and financial agreement.
4) To recommend that the Integration Joint Board approve the commissioning of 16 places in the St Stephen's Court development but to ask the Joint Board to note this Group's concerns that they had not had the opportunity to consider and scrutinise the business case in advance of the proposed way forward being presented to them.

(Reference – report by the Chief Officer, Edinburgh Health and Social Care Partnership, submitted)

11. Agenda Forward Plan

The agenda forward plan was submitted, with proposals for agenda items for the June and July meetings. It was noted that there were no meeting dates confirmed beyond July.

Decision

To agree to defer planning for adapted housing services to the July meeting, given the volume of items on the agenda for June.

(Reference – Agenda Forward Plan – 11 May 2018, submitted.)

12. Any Other Business

The Group recorded their thanks and appreciation to Michelle Miller for her input and commitment to the work of this Group during her tenure as Interim IJB Chief Officer and wished her well for the future.

13. Papers for Information

Decision

1) To note the Grants Review pre-engagement event briefing paper.
2) To note the minutes of the Grants Review Steering Group meetings held on 28 March, 11 April and 24 April 2018.
3) To circulate the slides from the pre-event briefing of 26 April 2018 to members of this Group.
4) To note that details of the follow up event scheduled for 7 June 2018 would be circulated to members of this Group.

14. Dates of Next Meetings

Friday 22 June 2018, 10am to 1pm, Dean of Guild Room, City Chambers
Friday 20 July 2018, 10am to 12pm, Dean of Guild Room, City Chambers

Rolling Actions Log June 2018

Item 5.1

15 June 2018

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	Annual Accounts 2016-17	22-09-17	To request further information on Workforce Planning once this was available.	Chief Officer, Edinburgh Health and Social Care Partnership	December 2018	
2	Financial Update	22-09-17	To agree to receive a detailed action plan, in response to the Financial Update, from the Interim Chief Officer at a future date. That a future Development Session on finance be scheduled.	Chief Officer, Edinburgh Health and Social Care Partnership	Not specified October 2017	2) Covered at the October 2017 Development Session.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
3	Primary Care Population and Premises	22-09-17	To request that a fuller report outlining a comprehensive primary care strategy, covering both revenue and capital requirements, be brought back to the Joint Board in the first quarter of the 2018 calendar year	Chief Officer, Edinburgh Health and Social Care Partnership	June 2018	**Recommended for closure** – on the agenda for 15 June 2018.
4	Locality Improvement Plans	17-11-17	To agree that community planning would be covered at a future development session.	Chief Officer, Edinburgh Health and Social Care Partnership	Autumn 2018	A report on the programme of Development Sessions for 2018/19 will be presented in September 2018.
5	Grants Review – Scope, Methodology and Timescales	17-11-17	To agree to add information on evaluation and lessons learned to the progress report in March 2018 and the final report in July 2018.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
6	Rolling Actions Log	17-11-17	To add the IJB Risk Register to the Rolling Actions Log for reporting back as necessary.	Chief Officer, Edinburgh Health and Social Care Partnership	June 2018	**Recommended for closure** – on the agenda for 15 June 2018, and will be reported annually.

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
7	**Motion by Councillor Main – John's Campaign** (Agenda of 17 November 2017)	17-11-17	The IJB recommends that providers, in public, voluntary and private sectors, of all relevant services within its remit, sign up to John's Campaign by 31st January 2017. A report listing those who have signed up and those who have not signed up with the reasons given will be presented to the Board in two cycles	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
8	**Winter Plan 2017-18**	15-12-17	To issue a Direction to implement the Winter Plan in order to achieve the outcomes set out in the Plan with performance, evaluation and lessons learned being monitored and reported back to a future meeting of the Joint Board.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
9	**Joint Board Membership and Appointments to Committee and Sub-Groups**	15-12-17	1) To delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair, to review the membership of the Audit and Risk Committee and the role description and specification for the Audit and Risk Committee Chair and report back to the Joint Board.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			2) To delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair, to review the membership of the Performance and Quality Sub-Group and the role description and specification for the Performance and Quality Sub-Group Chair and report back to the Joint Board.			**Recommended for closure** – reported to the IJB on 18 May 2018.
10	**Edinburgh Alcohol and Drug Partnership Funding**	26-01-18	That a briefing note be sent to Joint Board members setting out the broader challenges and information on approaches taken by the other Lothian IJBs and the impact of service review, redesign and efficiencies in each area of change.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
11	**Edinburgh Health and Social Care Partnership Communications Action Plan**	26-01-18	To note that a separate engagement/communication plan for the IJB will be presented for consideration and agreement within 6 months.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
12	**Whole System Delays – Recent Trends**	26-01-18	To note that a further report setting out the underlying longer term strategy, improvement plan, projects and actions would be submitted to a future meeting of the Joint Board.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
13	**Financial Performance and Outlook**	02-03-18	To agree to receive an update at the Joint Board meeting on 18 May 2018.	Chief Officer, Edinburgh Health and Social Care Partnership	May 2018	**Recommended for closure** – reported to the IJB on 18 May 2018.
14	**Carers (Scotland) Act 2016**	02-03-18	To request a further report in due course detailing the outcomes of the pilot in the North West locality.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
15	**Integration Joint Board Risk Register**	02-03-18	1) To note the update from the Audit and Risk Committee and agree to receive the Joint Board risk register at its meeting in June 2018. 2) To circulate the current risk register to members	Chief Officer, Edinburgh Health and Social Care Partnership	June 2018	**Recommended for closure** – on the agenda for 15 June 2018.
16	**City of Edinburgh Council Motion by Councillor Miller – Attracting and Retaining Carers** (Agenda for 29 June 2017)	29-06-17	1) Agrees to call for a report into the improvements including pay and conditions that could attract and retain care workers, in comparison to other employment options, and meet the shortfall in care provision, taking into account the results of the research.	Chief Officer, Edinburgh Health and Social Care Partnership	January 2019	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			2) To instruct officers to remit the report to the Integration Joint Board and Corporate Policy and Strategy Committee for further scrutiny.			
17	**Note of Meeting of the Strategic Planning Group of 9 March 2018**	18-05-18	To note that the paper on cross cutting themes would be circulated to all Reference Boards for consideration.	Chief Officer, Edinburgh Health and Social Care Partnership	June 2018	The Cross Cutting Themes paper has been to the reference groups for Disabilities (3 May 18) and Mental Health (26 April 18), it has been to the working group for Older People (24 April 18) and will go to the next meeting of the Primary Care Reference Group (18 July 18). The Older People's Reference group is yet to meet, but the paper will

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
						also be circulated there (20 June 18)
18	**Business Resilience Arrangements and Planning – Spring Update**	18-05-18	That an update report be submitted to the Joint Board by the end of 2018	Chief Officer, Edinburgh Health and Social Care Partnership	December 2018	
19	**2018/19 Financial Plan**	18-05-18	1) To note that the Chief Officer intended to arrange a workshop on the overall programme delivery. 2) To agree that the Chief Officer would submit a report to the next meeting of the IJB providing an interim update on progress against savings targets	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	
20	**Plan for Immediate Pressures and Longer Term Sustainability**	18-05-18	1) To ask that a communications and engagement strategy to complement the Plan be submitted to a future meeting of the IJB. 2) To ask the Project Lead Officer to arrange a presentation to Board Members either at a development session or at a formal meeting on the assessment project.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
21	**Royal Edinburgh Campus and St Stephen's Court**	18-05-18	To ask the IJB chair to write to the chair of NHS Lothian's Finance and Resources Committee noting the IJB's approval, with an expectation that outstanding issues are resolved and returned to the IJB before final design and financial agreement	Chief Officer, Edinburgh Health and Social Care Partnership	Not specified	**Recommended for closure** – letter sent on 18 May 2018.
22	**The Inclusive Homelessness Service at Panmure St Ann's**	18-05-18	To ask the Council and NHS Lothian to develop a framework for the funding of capital projects that are developed in partnership.	Chief Officer, Edinburgh Health and Social Care Partnership	December 2018	
23	**Appointments and Review of Sub-Groups**	18-05-18	To note that the Chief Officer would provide an update report on the review of Board assurance processes and structures to the next meeting in June, with the final report to be submitted in two cycles (September 2018).	Chief Officer, Edinburgh Health and Social Care Partnership	September 2018	Report to be submitted in September 2018.
24	**Motion by Councillor Webber – NHS Attend Anywhere** (Agenda for 18 May 2018)	18-05-18	Calls for a short report within 1 cycle on the timescales and feasibility of introducing this service, quantifying the risks of adoption and non-adoption, and the costs & benefits associated with implementation in collaboration with NHS Lothian to support IJB services and priorities including the transformation of primary care services.	Chief Officer, Edinburgh Health and Social Care Partnership	June 2018	**Recommended for closure** – on the agenda for 15 June 2018.

Item 5.2

Report

Edinburgh Primary Care Improvement Plan (PCIP)
Edinburgh Integration Joint Board

15 June 2018

Executive Summary

1. The Edinburgh H&SCP is required to submit a Primary Care Improvement Plan (PCIP) to the Scottish Government by 1st July 2018, outlining our plans to implement the new Scottish GMS contract proposals. The Strategic Planning Group considered the PCIP at its May meeting and approved the document. The IJB is asked to approve this PCIP.

Recommendations

2. The Integrated Joint Board is asked to:

   i. Approve the proposed submission version of the plan (Appendix 1)

   ii. Note the next steps action plan (appendix 2)

   iii. Note the process required to reach final agreement of the plan (Appendix 4)

   iv. Note that this plan builds on the work carried out by the HSCP over the last 5 years and links to the Primary Care Strategic Commissioning Plan which will be taken forward under the auspices of the Primary Care Reference Board.

   v. Note the approval of the IJB Strategic Planning Group (11.05.18) and the GP Sub-Committee (anticipated as at 11.06.18) and the support of the pan-Lothian GMS Implementation Group.

Background

3. Contractual arrangements for general practitioners are negotiated centrally between the Scottish Government and GP representatives, almost universally the British Medical Association (BMA). These arrangements are extremely

detailed and govern all aspects of remuneration of GPs and funding of general practices, including key issues such as premises, rents, pay rates for staff, etc.

4. General practice in Scotland has been under increasing pressure over the last ten years due to a combination of changes in demography, technology and treatment regimens, and workforce availability.

5. In January 2018 GPs across Scotland voted in favour of a new General Medical Services (GMS) contract which was developed by the BMA and Scottish Government. The contract undertakes to shift work from GPs and GP practices and provide funds which allow services to be developed to enable this transition to happen. At the heart of the new contract is the GP as 'expert medical generalist' giving less care directly to patients and emphasising their roles as clinical leaders and their close working relationships with a wider multidisciplinary team delivering more direct care.

6. All NHS Boards are expected to develop a range of services which allow this to happen, initially over the three year 'Phase 1' of the plan, and this is expressed through the NHS components of HSCPs. The proposed plan for Edinburgh is provided at appendix 1.

7. The date for submission to the Scottish Government is July 2018.

8. The PCIP is subject to approval through a 'tripartite' arrangement between the GP Sub Committee of NHS Lothian, NHS Lothian and the Edinburgh Integration Joint Board. NHS Lothian will exercise its governance responsibilities through the tripartite 'Oversight Group' for all Lothian H&SCP's and GP Sub considered at its meeting on the 11th June, although at the date of writing the outcome is not known.

Main report

9. Since mid 2014, a series of once-stable independent GP practices were no longer able to function without additional support. Around 20 of the city's 72 practices have required additional support and attention to ensure continuity of GMS to all registered patients across the City, and there are currently over 40 practices which have restrictions on their lists.

10. The experience of supporting practices, often facing dissolution, resulted in a series of 'tests of change' in inserting new capacity into these teams. In late 2016 NHS Lothian pledged recurring funding to help with what was widely perceived as a growing crisis. The experience of helping stabilise practices as a reactive measure was fused into a proactive programme of 'Transformation and Stability' and consulted with across the City in early 2017. GPs were supportive, and in

June 2017 the Edinburgh IJB supported five recommendations for the use of the available funds.

11. The success of the Edinburgh Transformation and Stability Programme will be reported separately, but provides the expertise and experience required to implement the local sections of the new contract.

12. The Edinburgh IJB received the Primary Care "outline strategic commissioning plan" at its February meeting, which flagged the forthcoming activities required and issues to be tackled. The Primary Care Strategy is being developed by the Primary Care Reference Board, chaired by Councillor Melanie Main.

13. During March and April in particular, extensive consultation has taken place with primary care colleagues throughout the City about the options for the funding available under the PCIP, and this is outlined at Appendix 4. A small 'Writing Group' benefitted from the considerable input and influence of our two GP Sub appointed colleagues.

14. During May opportunities were taken to raise the awareness of the PCIP across the H&SCP and dedicated meetings were arranged through EVOC with Third sector partners and with Carer representatives.

15. Appendix 4 summarises the main activities undertaken to develop the PCIP.

16. Whilst the formulation of the PCIP is necessarily tightly focussed on augmenting GP workload, the implementation of the new capacity from late summer 2018, will be a much more collaborative exercise. The awareness raising and engagement events have illustrated the advantages of linkages with existing work on HUBs, in mental health and older peoples services, and in ensuring that preventative approaches are enhanced wherever possible.

17. The differential impact of this investment on inequalities remains a contentious issue across the GP community. Practices serving populations with high levels of deprivation or affluent populations with high numbers of elderly people being successfully sustained in the community, may both feel under great pressure. Practices with mixed inner city populations with high turnover, increasing mental health related presentations and divergent ethnicity, can feel their pressure are poorly understood, as can those with high student populations.

18. The importance of investment which alleviates the pressure across all types of practice is vital, and the concept of a 'floor' of common relevant services has been welcomed during the development of the plan.

Key risks

19. Without the clear support of City GPs through the GP Sub reps, the PCIP would not be supported by the Edinburgh GP community and the Scottish Government would require amendments to be made before the funding could be released.

20. Without access to additional New Contract funding into front line primary care capacity, the momentum which has begun to build could be lost and practices could be destabilised again. The consequences of destabilised practices are well understood in terms of patient safety, additional financial support, increased pressure on supporting services and adverse media attention heightening public and patient concern.

21. There is a risk that the shift in workload from medical staff and indeed from nursing is undertaken without due consideration and that patients and staff could be put at risk. The clinical governance structures and support for a programme of challenging change need to be sufficiently robust to manage this effectively. With the T&S (Transformation & Stability) Programme, 'small tests of change' the risk has effectively been internalised by the individual practices. The creation of separately managed services covering several practices requires careful progression.

Financial implications

22. An outline costing of the full implementation of the New Contract quickly builds to a figure of £12-15M for the city. Our current understanding is that about £1.6M will be available (recurring figure) for discretionary investment by EIJB.

23. This new funding adds to the New Contract funding already received and invested in pharmacy and a Linkworker network.

24. The new funding will be applied distinctly from the NHS Lothian funded Transformation and Stability (T&S) Programme. The T&S programme will continue to fund the development of individual practice capacity 'injections' which have 50% contribution to salary costs from the GP practice. The new contract funding will be used for capacity development across clusters and localities. Any underspend will be applied as agreed by the governance structures and reported both to EIJB and to the GPs across the City.

25. The Edinburgh Primary Care Support Team structures allow for this new funding to be applied as agreed across the City, as with the Transformation and Stability Programme funds. It is proposed that these arrangements continue to provide the required governance.

Implications for Directions

26. The IJB will issue a Direction to the effect that NHSL will support, through the HSCP and through central NHSL functions, the further development and implementation of the PCIP in Edinburgh.

Equalities Implications for Directions

27. Equalities implication Equalities Impact Assessment on the main report was undertaken on 22nd May 2018.

Sustainability implications

28. There are no direct environmental considerations arising from this report

Involving people

29. Appendix 4 outlines the efforts which were made to engage and communicate with stakeholders in the timeframe available. The report itself recommends a structured programme of public engagement to explain the adjustments being made to the delivery of Primary Care.

Impact on plans of other parties

30. There is wide recognition that the formation and deployment of a new primary care workforce of c200wte over the next 3 years is challenging to existing H&SCP services already struggling with recruiting sufficient staff to maintain existing levels of service. District Nursing is perhaps the most obvious example. The Chief Nurse is engaged in these discussions.

Report author

Judith Proctor

Chief Officer, Edinburgh Health and Social Care Partnership

Contact: Colin Briggs, Interim Chief Strategy and Performance Officer,

Colin.briggs@nhslothian.scot.nhs.uk

Appendices

1 – Full draft Primary Care Improvement Plan
2 – Next steps action plan
3 – Glossary of terms
4 – Development Action Plan

Edinburgh Primary Care Improvement Plan

June 2018

Edinburgh Primary Care Improvement Plan

Executive Summary

This plan has been created collaboratively by GP Sub-Committee representatives and the Edinburgh Primary Care Support Team, including Locality Clinical Leads. Every GP and Practice manager has had the opportunity to see and input to the early draft, as have representatives of pharmacy, nursing and the link worker network.

The Plan is a key document which allows the Health and Social Care Partnership to set out for scrutiny, its plans for the implementation of the New GMS (General Medical Services) Contract.

The Health and Social Care Partnership (HSCP) Primary Care Improvement Plan (PCIP) will enable the development of the 'expert medical generalist' role, through a reduction in current GP and practice workload. By the end of the 3 year plan, every practice should be supported by expanded teams of NHS Lothian employed health professionals providing care and support to patients. Edinburgh HSCP will employ or fund 30-40 more staff in 2018/18, who will provide additional capacity and continue the transformation of primary care.

The focus on primary care development and resourcing through the new Scottish GP contract is as welcome as it is overdue. The aspirations of the contract are challenging to current practice, and in Edinburgh we believe we are already underway with important aspects of this work.

Equality and equity are fundamental principles, but the playing field is uneven. We must try not to make things worse, but primary care can't afford to wait until there is consensus over a perfect playing surface before we make a start. We need to be pragmatic in the short term and come back to this complex question with an approach which can manage our different perspectives.

The New Contract funding available in 2018/19 for discretionary investment across Edinburgh is understood to be around £1.7M. This quickly builds to £2.2M in 2019/20 and £6.6M the following year. This comes on top of the investments made directly to (most) practices through GMS uplift (c£1.5M) and investments into pharmacy support (c£1.0M). In addition, NHS Lothian has committed £2.85M, building over three years, and used to support our complementary 'Transformation & Stability Programme'.

The cost of fully implementing the new contract has been estimated at £12-14M across the City. By combining the New Contract income and the Transformation and Stability funds we will have a substantial portion of this available over the first three years. We believe we have established a reasonable consensus from our GP community, about where we should **first** focus both attention and resources to have the greatest impact. Our first task is to accelerate and lengthen our first steps and to bring forward the next generation of improvements, which will allow us to provide excellence and stability in Primary Care to Edinburgh's citizens.

Edinburgh Primary Care Improvement Plan

Table of Contents

PART ONE: BACKGROUND AND OVERVIEW

1. Introduction

The Edinburgh Primary Care Improvement Plan is focused on how to stabilise and transform General Medical Services (GMS) over the next three years. The plan therefore has a relatively narrow focus on the workforce and arrangements required to both relieve the current and future pressure on GMS and to accommodate significant population growth. A more inclusive approach to the wider constituents of primary care will be addressed by the first Edinburgh Primary Care Strategic Plan.

2. National Context

Proposals for a new GP contract were published in November 2017 and agreed in January 2018. The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this. A key enabler for this is investment in a wider multi-disciplinary team (MDT) in support of general practice. The new contract offer is supported by a Memorandum of Understanding (MoU) which requires:

> *"The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs".*

Briefly, the major factors contributing to the current instability are:

- Increasing gap between capacity (access) and demographic pressures (rising Edinburgh population, patient demand, increasing numbers of frail elderly and complexity);
- Aging primary care medical and nursing workforce;
- General Practice is currently a comparatively unattractive option for qualifying doctors, and GPs are retiring early;
- Workload, premises and financial risk are significant barriers to GP partnership;
- Poor IT and technology investment and support relevant to primary care;
- Increasing demand on a relatively stable potential locum pool, further undermining the attractiveness of the permanent commitment to a GP Partnership, fundamental for primary care to function effectively.

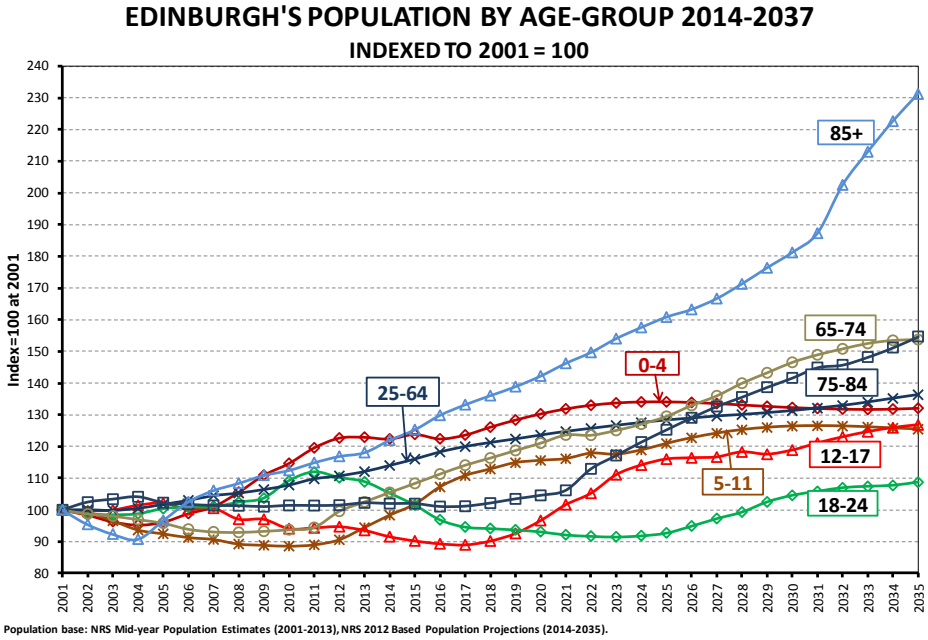
The new Scottish GMS contract has been specifically designed to address these factors and herald a new era for primary care in Scotland. The limitations of the available workforce to fuel the proposed changes are obvious and widely acknowledged. The recent publication of the National Health and Social Care Workforce Plan – Primary Care is

helpful context. Despite this limitation we believe much can be done to shift workload on a short and medium timescale.

3. Local Context

3.1 Needs Assessment

The Shadow HSCP undertook a Strategic Needs Assessment in 2015[1]: It outlines the wider setting but also delineates some of the Primary Care health challenges which will in part be met by the Improvement Plan. The population has already expanded rapidly and further significant increases are anticipated, particularly in older age groups:



Localities differ in their makeup, and the needs assessment highlights the heterogeneity of Edinburgh's population. The challenges include:

- Poverty and low income rates similar to the Scottish average, despite the City's affluence, with a fifth of children living in low income households. Health is poorest in the North East locality: boys born in Greendykes and Niddrie Mains between 2005 and 2009 had a life expectancy more than 25 years less than girls born in Barnton and Cammo.
- Minority and ethnic health and LBGT communities are also at risk of disproportionate ill health and the inverse care law
- The number of older people is increasing, and over a third live alone

[1] Edinburgh Shadow HSCP Joint Strategic Needs Assessment (2015)

- There are just over 400,000 adults aged over 18 in Edinburgh. Of these, the numbers who are supported by the Health and Social Care Department are:

    - 14,056 older people
    - 1,380 people with learning disabilities
    - 1,991 people with physical disabilities
    - 1,300 people with mental health issues
    - 816 people with addictions
    - 1, 153 other vulnerable people

    There are others with complex needs, who are marginalised and find it difficult to access appropriate care.

- The number of people needing palliative care in the community continues to rise and there are needs for service development, including of community nursing teams
- Other key areas include sexual health, BBV prevention and care, and management of long term conditions.
- There are estimated to be over 65,000 carers in Edinburgh, one in five providing over 50 hours of care a week
- The role of the third sector is crucial
- There are variations across the City in unemployment, but some deficits in specific, needed skill sets
- Housing is a key determinant of health and there are significant, and growing, shortages, and extensive requirements for adaptation and support

The HSCP has to consider national health and wellbeing outcomes which include reducing health inequalities: the Improvement Plan must be sensitive to these directives. In its opening sentence the new Scottish GMS contract outlines that "*general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities".* We will consider models and proposals for resource to address these specific issues in a separate paper.

3.2 Workload

The new contract is being introduced at a time of significant pressures in General Practice related to increasing volume and complexity of workload, and challenging workforce availability. While the new contract and Government Memorandum of Understanding (MoU) is explicitly intended to address these issues, short term sustainability challenges remain. The PCIP takes account of action required to address these immediate pressures, as well as developing the longer term strategic direction.

Diagram 1 Indicative Primary Care Workload Increase Edinburgh 2010 – 2018 - 2026

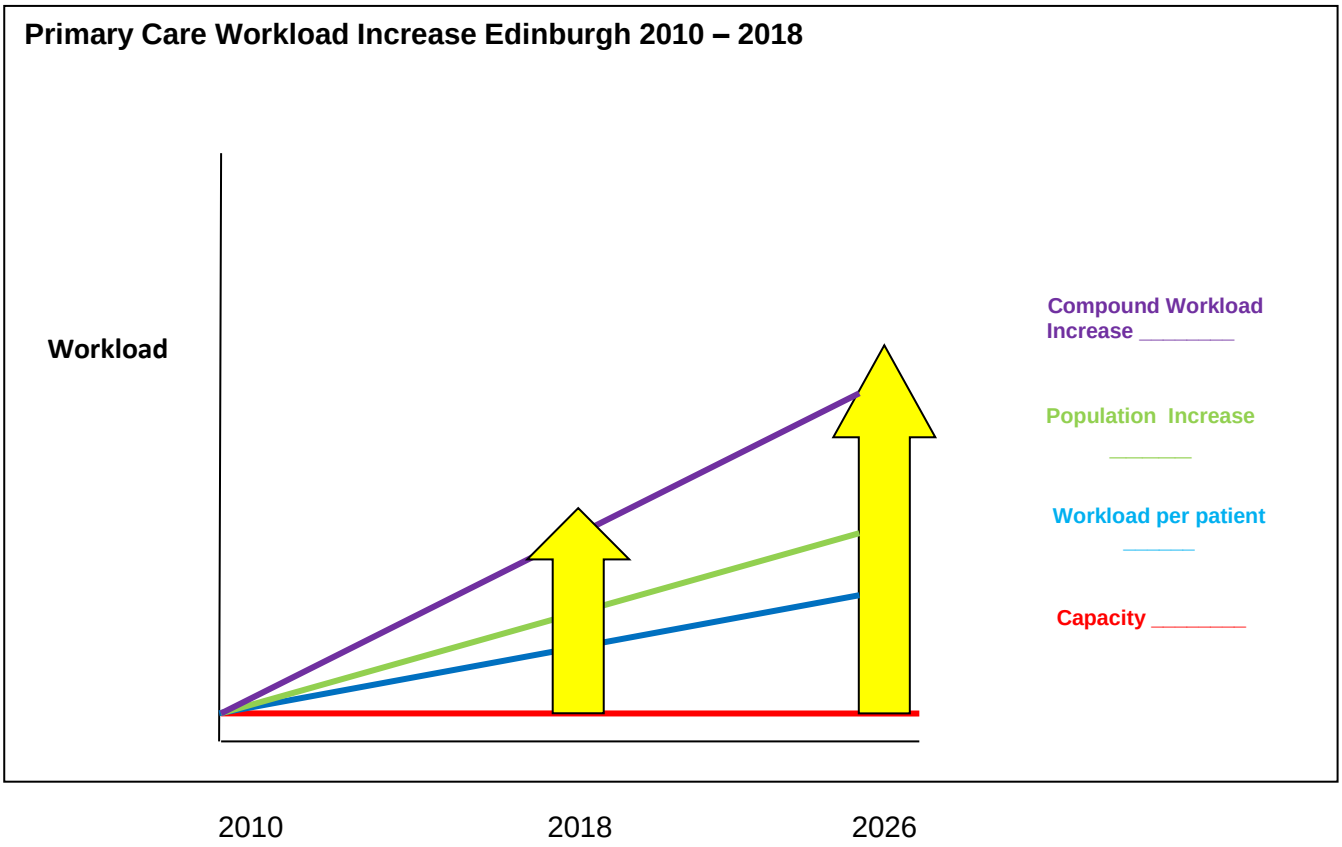


Diagram 1 suggests a representation of capacity and workload over time.

Since then, the average workload per annum per patient has increased (ageing and complexity influence) although slightly offset by a relatively younger incoming population.

The population size has steadily increased by 1% p.a. since 2007 and by 8,000 new additional patients in 2017 alone. The effect is simply projected forward to 2026, to align with the Edinburgh Local Development (Housing) Plan.

Capacity has not strictly flat lined since 2010 as shown in the diagram, but there has been a lack of practice expansion despite significant population increases. Of 72 Edinburgh practices, 9 are now 2c, 5 of which moved recently from GMS as they were unsustainable.

3.3 Other Significant local factors

a) Since 2014 many established Edinburgh practices have become operationally / financially unstable and required additional support. Approximately 20 of out 72 practices are receiving additional support at any given time.

b) A series of ad hoc arrangements were put in place to support unstable practices, initially on an individual basis. The experience of effective intervention was then fused into '**The Edinburgh Primary Care Transformation & Stability Programme'** agreed by Edinburgh Integration Joint Board (IJB) in June 2017. This set out to inject more clinical capacity into primary care in Edinburgh using £2.85m NHS Lothian recurring funds, building over 3 years. The approach aimed to adjust reliance on the medical workforce required to respond to an increased population.

c) As outlined above, the national pressures are magnified in Edinburgh by list growth. In 2007, 500,000 patients were registered and by 2017 this had grown by a further **57,000.** Each year 5-6,000 more people move to Edinburgh and register with a local GP practice. The rate of city growth is established as consistent with the Edinburgh Local Development Plan. This runs to 2026 when the anticipated GP registered population will have risen to 600,000.

d) The most obvious symptom of population pressure across Edinburgh is 'restricted' lists. Many practices now restrict their lists to a number of patients able to join their lists which equals the number of people leaving each week. This limitation on access has been able to be managed locally to ensure there is at least one practice per cluster group with unrestricted access, but after a decade of sustained population growth there are very few practices in the City with the physical capacity and Partner agreement to grow much beyond their current list size.

e) Edinburgh has a buoyant economy with considerable choice for the low – medium skilled workforce.

f) A **'Primary Care Support Team'** has been created by the Edinburgh Health and Social Care Partnership (EH&SCP), bringing together responsibility for strategic development, quality performance, operational support, premises development and prescribing. This coherence gives a good platform of understanding and engagement to develop capacity to implement the new contract.

g) At the inception of the EH&SCP a population needs assessment was undertaken designed to highlight variation in service demand both between and within the newly formed localities. This is underpinned by the categorisation of Edinburgh's 72 general practices into **5 'demand groupings'** based on a combination of the percentage of the practice list +75 years old, and the percentage deemed to be in the lowest quartile of economic deprivation. There is the potential to use this to help direct different types of additional support depending on a practices grouping.

3.4 Local Foundations

Edinburgh H&SCP Primary Care Support team has already undertaken extensive work, which will help with the infrastructure for future change:

- Appraisal of premises to individual practice level, with a realistic and cost-effective approach to support. Practices have engaged in that process and the targeting of over 30 small improvement grants to optimise existing buildings over the last 3 years to cope

with population increase. This has helped practices to be able to growth their list sizes from previously stable bases.

- An assessment of Edinburgh Population and Premises was completed in 2016 with considerable engagement with all GP practices across the City. The paper was presented to the Edinburgh IJB in September 2017 and highlighted the **requirement to invest c£57M** over the current planning period to avoid capacity in several parts of the City being exhausted (see appendices)
- The City Transformation and Stability approach was based on ascertainment of practices' views of what they felt they required, ensuring that GPs are familiar with process and 'bidding' on basis of perceived need, and the options available, much of which appears in the new contract. Of Edinburgh's 72 practices, over 50 have taken up the offer of workforce or technical support through this route.
- The combination of infrastructure augmentation and support to strengthen or 'transform' practice teams has been able to keep limited access to registration for patients. These solutions have been very much 'stop-gap' and a more ambitious response to the growing population is required to ensure access to Primary Care can continue to be available to Edinburgh's new citizens.

All these initiatives give a feel for practice priorities, some mechanisms for implementation (particularly of the new workforce) and a good starting point for engagement.

3.5 Locality Clusters

EHSCP formed four localities as the basis of its operating structure. GP practices aligned themselves with localities as part of the preparation for integration. Each locality then created two GP Quality Clusters made up of geographically contiguous practices. The constituent GP practice clusters defined the population served by the integration cluster teams, thus facilitating common focus and working relationships in the 'engine rooms' of the EH&SCP. The GP clusters, have, and will continue to influence the development of this Plan and provide the local platforms for implementation.

3.6 Local Intentions

In addition to the requirements set out in the national documents, a set of **local** intentions has been developed:

- Plans required by1st July 2018 will outline the relevant areas of change

- Priority in year 1 should be given to tested approaches where impact on GP workload can be evidenced, with reference to the impact of tests of change already established.

- Approaches across Lothian and Scotland should share consistent grading and generic job descriptions for common roles in the new MDTs. Re-design of existing roles within a common framework should allow design to be responsive to local practice circumstances and encourage innovation.

- Recruitment should be co-ordinated across EH&SCP where appropriate. Where it is agreed that services are best provided Lothian wide, then recruitment can be organised on this basis.

- Commitment to working in a collaborative way across HSCPs and with advisory structures.

- Plans should aspire to demonstrate how **all** practices will benefit from additional support recognising that practices will benefit differentially from investments, depending on their population and demand structure.

- Active support should be given for the development of the GP role as expert medical generalist and clinical leader alongside refocusing of activity within practices, as workload shifts.

- Extended multi-disciplinary teams will be developed with all contractual models; 17c, 17j & 2C practices.

- 'Divided We Fall' is a recent Nuffield Trust report offering thoughtful perspective on the potential for increasing fragmentation of Primary Care. In implementing the new contract we will be mindful that the deconstruction of general practice arguably risks losing some of the benefits of our existing system. *Do no harm!*

4. Roles and Responsibilities

4.1 The Memorandum of Understanding (MoU)

The MoU states that:

> *"HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority"*

4.2 The Tripartite Partnership

Development of the Edinburgh Primary Care Improvement Plan will build on established collaborative arrangements with the Lothian Local Medical Committee (LMC) and GP Sub Committee of the Area Medical Committee. The Edinburgh Health and Social Care Partnership HSCP plan will actively involve the nominated GP Sub Committee representatives to enable local agreement, their being seen as key contributors to the Primary Care Support Team. Representation from Edinburgh's 8 GP Quality Clusters on the core PCIP group has also been sought.

Specific contractual changes will be taken forward through the Lothian-wide GMS Oversight Group and associated sub groups. This includes the new Premises Code of Practice and any revised Premises Directions, enhanced services, practice IM&T and implementation of the new regulations, as well as any contractual changes resulting from the transfer of responsibility to the extended multi-disciplinary team. Final changes and implementation arrangements will be agreed with the LMC.

4.3 Other Health and Social Care Partnership (HSCP) Strategic and Improvement Plans

Whilst general medical primary care services are the essential foundation of Localities, they are also supported by an Edinburgh Primary Care Support Team because of the need for strong consistency and links across NHS Lothian and because of the turbulence of the primary care environment identified at sections 2 and 3 above.

This Edinburgh Primary Care Improvement Plan will link to wider HSCP responsibilities for strategic planning and will specifically be reflected in local workforce planning, financial planning and property strategy.

There are significant opportunities for collaboration with older peoples', mental health, Third Sector and acute services which have been raised and noted throughout the development of the Plan, but not yet fully explored. This is a clear intention for the implementation phase.

In addition, the new GMS Contract and the H&SCP share the objective of reducing inequalities in health.

4.4 Multi-disciplinary teams.

The MoU sets out clearly that:

> *"As part of their role as EMGs (Expert Medical Generalist) GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas….will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans. Existing practice staff will continue to be employed directly by practices".*

Plans for developing the multi-disciplinary team will require new and expanded roles and change to existing roles. Staff Partnership involvement in the development of the plans is therefore essential. In addition to engagement on the development of the plans, consideration should be given to engagement on the implementation and development of multi-disciplinary teams to ensure that these work effectively at practice and cluster level.

This should include the full range of practice staff including practice managers who have significant existing skills and knowledge in enabling effective working practices for multi-disciplinary teams.

4.5 GP Quality Clusters

The new GMS contract outlines that GP practices will engage in clusters' quality improvement activities, including providing comparative data and sharing best practice. GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients.

A learning point from the Inverclyde pilot was that *"the pressure to get projects started and gather results quickly meant that the pre-project stage of design of data collection method was omitted, compromising the QI process".* It is crucial that data collection is designed in advance for every workstream.

GPs have emphasised the important role of some specialist staff with QI training to support the evaluation of the impact of the New Contract workforce, its benefits and its shortcomings, both intended and unintended. In particular, having analytical capacity and expertise, married with knowledge of the available primary care data sources, would accelerate the development of the potential of clusters to effectively guide change at scale which involves local GPs directly.

Through the use of Transformation and Stability funds, started in 2017/18, practices are already obliged to share their experiences with Cluster colleagues. This is designed to develop the role of the clusters in supporting and evaluating the development of the MDT and making links with wider network of support.

5. Development of the Improvement Plan

The requirement for engagement in the development of the plans is clearly set out in the MoU:

> *"The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users."*

5.1 Our Key Values

A. That the new GMS contract implementation will brings benefit to all practices and all patients and their communities

B. Transparency over all additional resources available to individual practices/clusters/localities through all sources of non-GMS / enhanced service funding

C. Ongoing meaningful engagement, debate & development of primary care increasingly using the GP Cluster framework.

D. Recognition that addressing health inequalities is a core part of the work of Primary Care, and that inequalities present in many forms. As always changes to the delivery or availability of primary care may have a magnified effect on groups of the population who are less obviously vocal. We will continue to listen closely to our practices about any unintended consequences to vulnerable people as implementation proceeds.

5.2 Involving People

There have been a number of policy initiatives since 1997, which emphasise the importance of Public Involvement and how to apply this[2]. The guidance from the Scottish Government states that involving patients, carers and the public in the planning of services helps to ensure that services are appropriate and relevant to the people who use them.

EH&SCP has an established record of engagement beyond traditional communication and consultation which reflects its commitment to involving people and underpins a wide raft of legislation for Public Involvement. EH&SCP is therefore mindful of its legal duties of involvement and how the outputs from informing, engaging and consulting are evidenced. As the proposed changes are progressed, appropriate and timeous Public Involvement shall be sought. The team shall be guided, advised and supported by the Public Involvement Coordinator.

Dialogue with GPs during the development of the PCIP has highlighted the pressing requirement for alignment of key messages to the public, of the opportunities of creating capacity for regular constructive local interaction and of harnessing 'Realistic Medicine' for the benefit of all.

The EH&SCP will take account of a wide range of opportunities to harvest the benefits of patient experience. We need to consider new ways of gleaning feedback which allows constructive dialogue between Primary Care and the Edinburgh public. A validated survey, would allow comparisons and help ensure representative feedback and inclusion of all groups. The intention would be to develop methods of feedback about the direction of travel, rather than just individual clinicians and practices.

A further dimension of this is the promotion of more effective **self management,** whether through signposting, encouraging awareness of NHS Inform, enhanced patient education and support programmes or improved technology.

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[2] Patient Focus and Public Involvement - December 2001
Consultation and Public Involvement in Service Change – HDL 42 (2002)
Scotland's Health White Paper – Partnership for Care - March 2003
A New Public Involvement Structure for NHS Scotland – March 2003
Informing, Engaging and Consulting the Public in developing Health and Community care Policies and Services CEL ((4) 2010)

Next Steps

- The establishment of a group tasked with the engagement and involvement of people and communities across Edinburgh, about how we reach a better balance between patient demand and our capacity to respond over the next decade.

5.3 Practice Management Leadership Development

The new contract acknowledges the growing role of the Practice Manager and practice management in the effective implementation of new arrangements. Edinburgh has a long standing locality-based network of PMs and contributes to both regional and national networks: that PMs have to be somehow lifted from administrators and reception managers, to embrace a new and more pivotal role, is both outdated and simplistic. The role of PM has been developing rapidly in Edinburgh over the last decade, with antecedents going back much further. Whilst more traditional roles still exist, PMs across the City have been instrumental in the development of their practice clinical teams, in advising the partners on investments in infrastructure (including IT development), in maintaining and enhancing a wide range of relationships and partnership outside the practice, and supporting the performance management and quality dialogue which underpins the development of healthy practice cultures.

Some practices have recognised these changes with the appointment of Business Managers, or supporting Assistant Managers, or inclusion of the PM as an 'associate partner'. There is no doubt that as MDTs develop, PMs will need to ensure that the practice team is co-ordinated and are well supported in managing the inevitable tensions and misunderstandings around the introduction of new roles. Practice managers have already responded enthusiastically to the suggestion of testing new Primary care roles. As practices begin to share resources as clusters/sub-clusters/localities, the practice manager networks should complement the GP Quality Cluster network, and be able to help assess and ensure both workload impact and value for money. The offer of a PM rep to routinely be included in GP Quality Cluster meetings would be a welcome first step.

Practice managers have commented in particular on the difficulties of releasing staff for training. There is increasing recognition of the potential of the traditional receptionist role to undertake a more diverse range of duties including routine clinical tasks eg weighing and BP monitoring to signposting patients to appropriate local resources.

Next Steps

- To engage with PMs to see what additional training or external support might be provided to complement the NES programme (end of 2018)
- To ask PMs whether they consider an increase in time funded to engage in relevant networks would be both feasible and worthwhile. The obvious parallel is to build on the existing PM network to create something like the GP Cluster arrangements to be able to more actively exchange the learning from each practice.
- To consider whether additional training support for practices could be offered to accelerate change.

5.4 GP Leadership Development

Edinburgh Health and Social Care Partnership has an established, effective system of Clinical Leadership of General Practices. Locality Clinical Leads, have leadership responsibility for all Primary Care activity in their respective geographical area.

Each of our four localities is divided into two GP Clusters. Edinburgh GP Cluster groups are deliberately designed around shared, or significantly overlapping populations.

Each GP Cluster has a Cluster Quality Lead, with responsibility for GP cluster quality improvement work as defined in the GP contract.

Cluster Quality Lead roles are new with some variance locally of role and responsibility: some CQLs are invited to sit on H &SCP Locality Management Teams, other CQLs report to Locality Management Teams or Locality Quality Improvement Teams.

The development of clinical leadership across Primary Care should not be confined to CQLs/PQLs. That said, these are important constituents and we need to support encouraging early beginnings to reach their potential. GPs across the City don't yet have the capacity to support their aspirations to learn from their own results and other's experience. Furthermore, there needs to be choice and recognition that a willingness to facilitate a peer focus on clinical quality is not necessarily synonymous with an interest in influencing the management of the locality. The immediate barriers are less a lack of attraction to these roles, but the practical implications of this sacrifice of time away from busy practices.

Next Steps

- A review of the realistic time commitment required from the CQL group – including the opportunity to adjust expectations or perhaps vary expectations between clusters
- Agree what admin support is required to ensure that all clusters are able to function without CQL capacity being used inappropriately.'

5.5 Improvement Plan - summary timetable

Below is a timeline of the development of the PCIP. The summary of development actions taken is at Appendix 3

The nature of General Practice across Edinburgh is diverse and the early part of the development of this plan(March/April) focussed almost exclusively on engagement with Primary Care. In May there were several opportunities for discussion with our closest Partners; including an event for the Third Sector, whilst Carers expressed a preference for engagement at a later stage. May and June have seen the PCIP developed further through our governance processes before submission to Scottish Government.

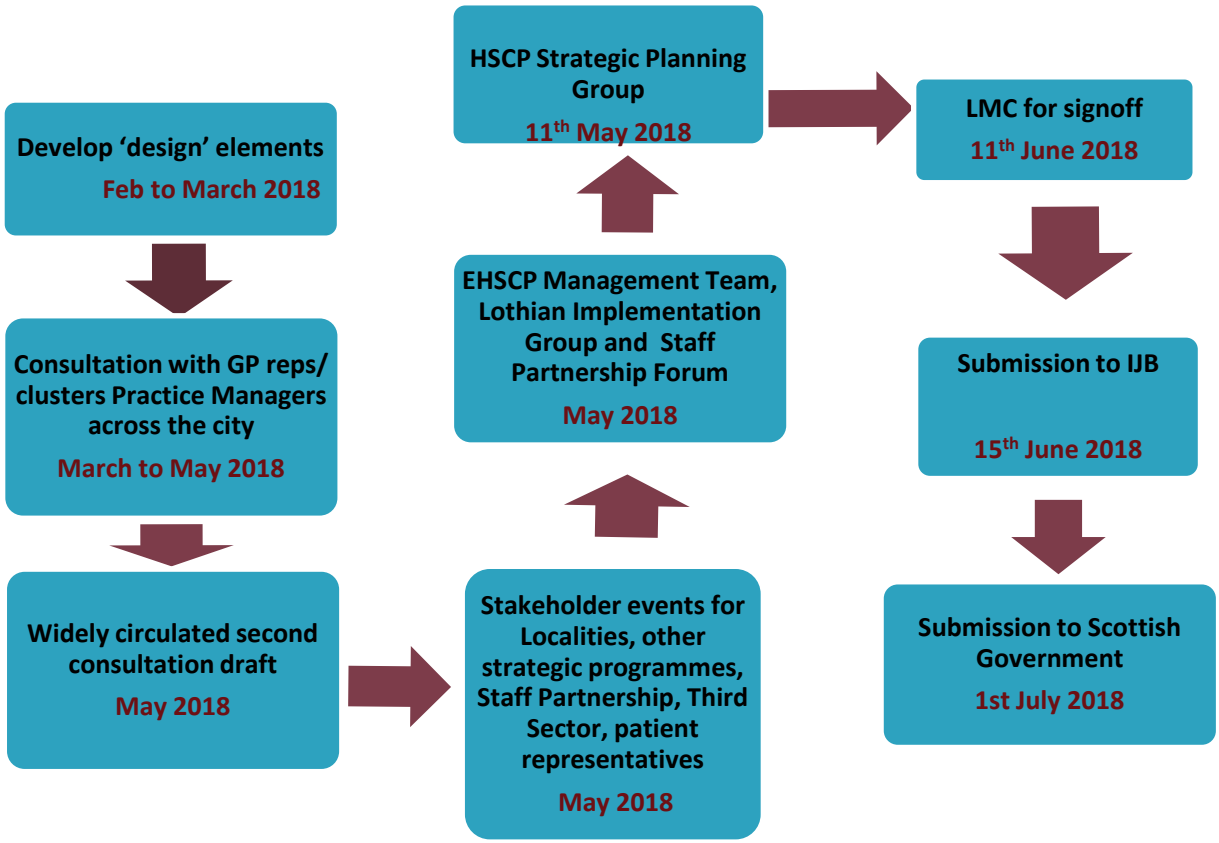


Diagram 2 Timeline for Development, Consultation and Approval of PCIP

PART TWO – IMPLEMENTATION OF SPECIFIC PROGRAMMES

Diagram 3: Proposed Approach

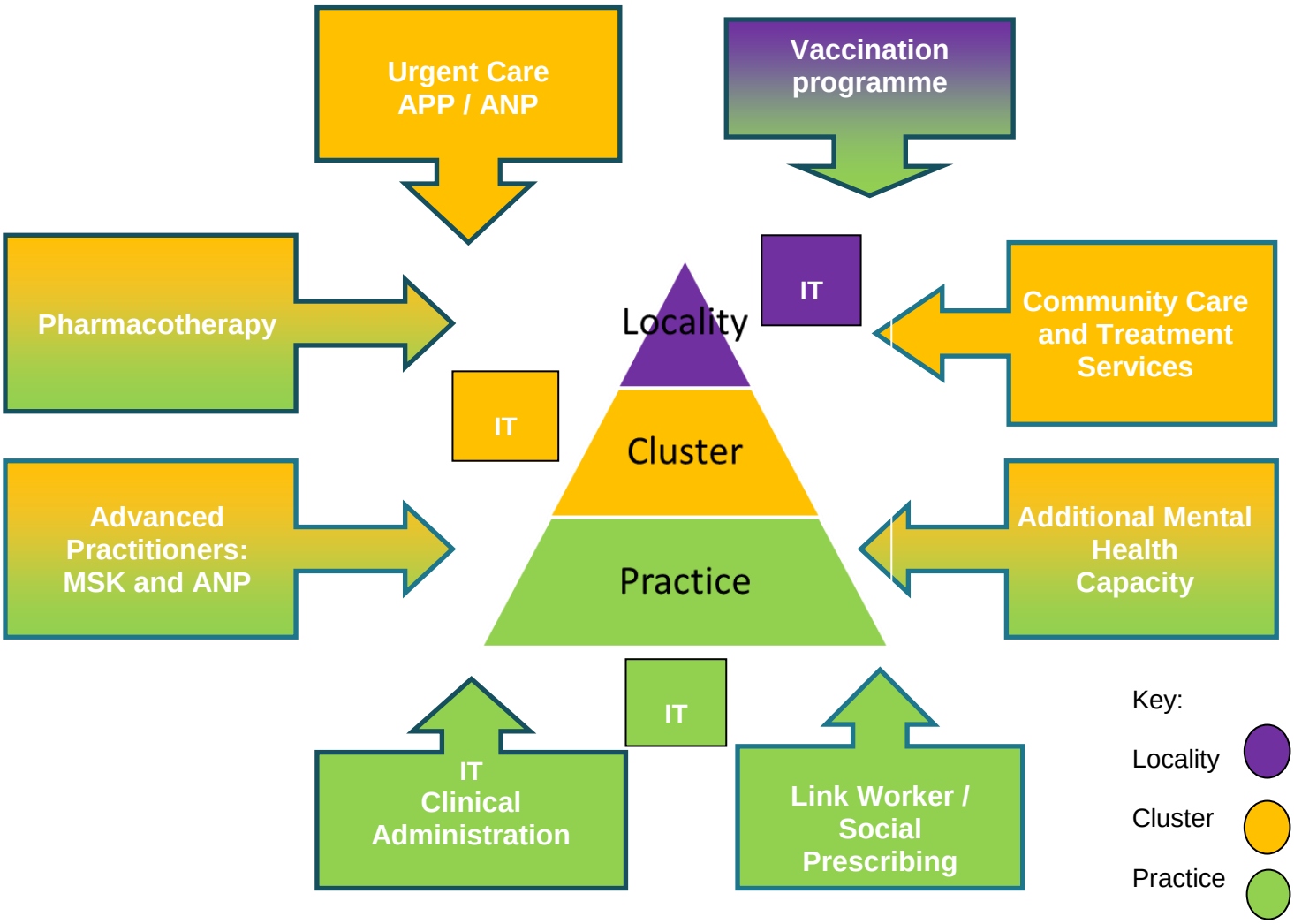


Diagram 3 summarises the overall proposed approach. Work will not be moved in a blanket process but in segments, which will vary according to resource availability and local circumstances. Clinical risk will be carefully assessed and managed in each case.

The Diagram shows those elements of activity which are best delivered on a Locality (or larger population) (purple)cluster or sub-cluster basis.(yellow) Much of the new capacity can be directly embedded in augmented practice teams;(green)practices with small list size may need to share workforce resource, or have less than full time appointments.

Work has already been undertaken in Edinburgh to classify all 72 practices into 5 groupings which reflect the different populations served ***(Supporting Info).***

6. Key Elements of the Plan

The main focus of the plan is how the new contract outline model can best be implemented at locality/cluster/practice level to stabilise and transform the primary care workforce. The development of new services to underpin this was defined by the national Primary Care MoU:

- *To detail and plan the implementation of services and functions listed as key priorities below with reference to agreed milestones over a 3 year time period;*
- *To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.*
- *To provide detail on available resources and spending plans (including workforce and infrastructure);*
- *To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.*

The Primary Care Improvement Fund Annual letter anticipates initial priorities of vaccinations, pharmacotherapy and CTACS. Work has already started and should continue to define models and approaches in areas where this is not yet fully developed. This is summarised below for each of the priority areas. There is a clear intention to have a **FLOOR** to services, such that all practices achieve a minimum provision for good practice – for those new contract services that are 'universal,' such as childhood vaccinations. Each area will have an associated implementation workstream. (Supporting info)

6.1 The Vaccination Transformation Programme (VTP)

6.1.1 Childhood Vaccinations

Early discussions have taken place about a Lothian wide co-ordinated approach to the design of the Vaccination Programme led by Public Health. Two Edinburgh test of change pilots for the childhood programme are due to start (Craigmillar and Muirhouse).

It is currently anticipated that Edinburgh will expand existing vaccination teams to gradually remove this workload from all practices. The favoured model would reflect that which has worked well in West Lothian and would involve the extended Community Vaccination Team visiting practices on a rotational basis, and retaining a connection with the Health Visiting (HV) team. The HV team has a crucial public health role, and should be the point of contact for additional information on vulnerable children or those defaulting. This also supports some recurrent themes of the Improvement Plan: maintaining continuity and local team cohesion as far as possible, and optimising local access. The role of the HV in developing knowledge of, and contact with, families over time is also crucial to this. The Scottish Government's national HV programme specifically highlights the unique contribution HVs can make to the Public Health agenda, and specifically their role in the immunisation

programme[3]. Having vaccinations given in practices also means that the Practice IT can be used, avoiding the need for duplicate data entry.

The 2015 list of practice arrangements is being updated and updated. This 2015 list indicates that for Edinburgh practices in terms of Childhood Immunisations:

- 46 are done by HV staff nurses
- 3 are done by a combination of practice staff and HV Staff nurses
- 4 are done by GPs
- 7 are done by Practice Nurses
- c. 12 are unknown

Next Steps – Childhood Vaccinations

- A spreadsheet of Edinburgh practices outlining what staff undertakes childhood vaccinations currently, numbers of children of relevant ages and sessions required for this work (end of May 2018). Outcome of pilots to be known (end of June 2018)
- Agreement of approach and costings on the basis of spreadsheet information (end of July 2018)
- A timetable for practices not currently receiving support to be agreed (July 2018)

6.1.2 Travel Vaccinations

Travel vaccinations potentially represent a more discrete piece of work, but also a significant burden to practices. The intention is to 'fast track' this work, and consider one or two not-for-profit centres, giving advice for a flat fee and all relevant vaccines (including NHS ones – those cannot be charged for).

[3] Universal Health Visiting Pathway in Scotland, Pre-Birth to Pre-School, Scottish Government October 2015.

Next Steps – Travel Vaccinations

- Ask all practices to indicate the average number of travel vaccines done per month, including how many of those are eg family groups where there are time savings (end of May 2018) and what clinical software system they use (Vision or EMIS).
- Liaise with the WGH existing travel clinic to ascertain capacity and potential for expansion
- Establish a new travel vaccine clinic in a central location (Lauriston Place?)
- Agree timetable of travel vaccination work by end of July 2018, aiming for full arrangements in place by the end of 2018. After this, when a patient requests a travel vaccination, the practice should print off the existing vaccination record (this can be readily done in either Vision or EMIS) and give this to the patient to take to the travel vaccination centres.
- The practice needs to be informed of vaccines given: the ideal would be that this is automatically entered by the Travel Clinic Centres into practice electronic records

Next steps - Other Vaccinations

- Flu / pneumococcal vaccinations for the housebound should be done by appropriately resourced District Nursing (DN) teams, accepting that practices will continue to give as many as possible opportunistically. Current arrangements with an external team undertaking these within a small number of programmed sessions does not work well for logistic reasons. DNs already have a strong presence in the community and could efficiently give domiciliary vaccines for those not on their caseload by geographically (and opportunistically) linking them to their existing work
- The remainder of the adult vaccination programme will be scoped in 2019-20 with some workload transfer during that year and fully by 2021.
- Midwives leads should be consulted on the feasibility and timetable for giving all required vaccines (currently flu and pertussis) to pregnant women (September 2018) .
- IT needs development so that recording vaccinations in the GP record is done electronically and automatically.

6.2 Pharmacotherapy Services

The new contract specifies that every practice should receive pharmacy support. This can be either from a Clinical Pharmacist or Pharmacy Technician, and be focussed on quality e.g. improved clinical outcomes, safe cost-effective prescribing and GP workload reduction. The latter should be intrinsic to the programme.

The new GMS contract (page 32) outlines the “core and additional pharmacotherapy services”: By April 2021, every practice will benefit from the Pharmacotherapy Service delivering the core elements described in Table 1.

Table 1 – Pharmacotherapy Services

CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of ‘specials’ and ‘off-licence’ requests	• Monitoring clinics • Medication compliance reviews (patient’s own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

15 Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber.

There is an established programme of investment in Practice Support Pharmacists, and recurring funding for this will be included within the allocation to support the PCIP. Experience to date in Edinburgh strongly supports the pharmacists working as part of the practice team or across two smaller (or lower demand) practices – rather than a group of practices sharing a team. Holding an independent prescriber qualification has proven to be very advantageous in providing an effective contribution to a busy practice team. It will be necessary to ensure that sufficient numbers of GPs continue to be Designated Medical Practitioners (DMPs) to enable practice and community pharmacists to complete

independent prescriber training. This will also grow the team able to provide full level one pharmacotherapy services. It is envisioned that in the future regulations will allow non-medical prescribers to fulfil this function.

Edinburgh's prescribing performance is amongst the most cost effective in Scotland. The cost of medicines per patient per annum in Edinburgh is £147 (December 2017 figures). It is crucial to the financial stability of the H&SCP that the current arrangements and infrastructure to maintain and develop this record are sustained. Pharmacists are currently an integral part of the Edinburgh Primary Care Support Team and aligned to our four localities. The pharmacists contribute to the development of Primary Care alongside their 'technical specialist' role input on medicines governance, cost and quality.

Pharmacotherapy in Edinburgh practices already covers three aspects of care: cost and quality; undertaking long term conditions / polypharmacy clinics and for those with an independent prescribing qualification, an increasing focus on clinical care reducing GP workload. Current investment of the primary care transformation funding (circa ~ £1m) is as follows:

- 17 whole time equivalent clinical pharmacists have been employed by NHS Lothian and deployed across Edinburgh City GP Practices.

- 3.1 whole time equivalent integrated care pharmacy technicians have been employed by NHS Lothian and deployed across Edinburgh City GP Practices.

- Investments have been made in Education, Research and Development including an NHS Lothian wide leadership role to develop training plans and guide clinical pharmacists and technicians through NES general practice competency frameworks and advanced clinical skills training. Where appropriate, post graduate clinical qualifications are being supported including (with joint NES funding) the Independent Prescribing (IP) qualification for all pharmacists in this cohort.

- Pharmacist project management support to roll out Pharmacy First and other Community Pharmacy led initiatives which promote community pharmacy being used as a first port of call for patients with minor ailments/illness and self care advice. This has resulted in 1,000 consultations in NHS Lothian in the first 3 months of rollout, 900 patients were managed in community pharmacy with 10% requiring onward referral to GPs. This will have reduced workload for practices.

- Pharmacist led Quality Improvement work to evaluate clinical pharmacist led physical health monitoring clinics in GP practices, caring for patients under the care of Community Mental Health Teams.

- Pharmacists across Edinburgh are collectively spending up to one third of their GP practice time on specialist and advanced pharmaceutical care services including realistic medicine polypharmacy review and long term conditions management. The remaining time is spent supporting GP practice workload and clinically safe and cost effective prescribing.

The aim will be to widen and deepen provision, aiming for some universal provision at an early stage. A disadvantage of spreading resource equally but thinly is that pharmacy staff can be doing single sessions in a large number of practices, giving no continuity either for them or the practice. This is not professionally ideal or sustaining. The contract specifies that Level 1 work is to be prioritised, reducing GP workload. An early, universal provision also ensures that all practices adapt to this new way of working.

The management arrangements in Edinburgh , where pharmacists are an integral part of the Primary Care Support Team, allow us to ensure the two professions continue to collaborate closely in crafting arrangements for workload shift which are both realistic and sustainable. The success of Edinburgh's prescribing performance has been build on longstanding good relationships throughout the City, and we are well placed to move to an ambitious interpretation of the new opportunities.

The timeline set out in the GMS contract provides the opportunity to test the best way to utilise pharmacists and technicians to support reduced GP workload. Scottish Government have commissioned the University of Strathclyde and the Robert Gordon University to jointly undertake an evaluation of this work. Already underway, this work is expected to report in mid to late 2018. Locally, GP Practice pharmacy teams in Lothian have been contributing to this evaluation responding to qualitative and quantitative questionnaires, compiling workload data in a bespoke database and sharing this with researchers. The researchers are also expected to undertake evaluation with a number of GP practice teams and patients.

Early evaluations of the pharmacist and technician role were published following the pilot of a model of GMS in Inverclyde in 2017. This reassures us that the activity being undertaken will release GP time, but the applicability requires tested on local processes and against outcome measures.

Following this first wave of provision, there will be gradual increase towards the advanced and specialist levels of pharmacotherapy service provision. In Edinburgh, pharmacists and technicians in General Practice are already making use of all available information including SPARRA, the Scottish Therapeutics Utility (STU), and Tableau dashboards of prescribing information. Provision will be defined by levels of experience of employed and trained pharmacists with initial roll out relating to prescribing volume (patients with ≥4 prescriptions on repeat (a QOF indicator so readily searchable); number of hospital admissions and readmissions, care home or domiciliary status, high risk medicines, polypharmacy etc).

Next steps – Pharmacotherapy

- We will assess whether there is capacity to offer regular sessional commitment to every practice for level one work (April 2019), with a specified proportion relating to reduction in GP workload
- We will continue to provide Level 2 and Level 3 services where they currently exist
- We will ensure (and fund through New Contract funds) a network of Designated Medical Practitioners (DMPs) to support pharmacists to become Independent Prescribers
- Using the T&S Programme fund we will assess with a number of individual practices, the impact of augmenting the 'floor' of service provided through New Contract funds

6.3 Community Treatment and Care Services (CTACS).

The contract determines that:

> "Community treatment and care services include many non-GP services that patients may need, including (but not limited to): management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring and related data collection". And: "It is expected that community care and treatment services will be available for use by primary and secondary care. For example, pre-hospital clinic bloods could be carried out for a requesting consultant without having to involve the GP practice staff. The consultant's name would be on the test result to avoid unnecessary GP involvement".

There are advantages to patients having services as close to home (practices) as possible: this is especially important for those who are vulnerable, find it difficult to travel and so on. The EHSCP will look for opportunities and there are obvious sites which might have space: Sighthill, Allermuir, Tollcross, Conan Doyle, Craigmillar and so on. Lauriston might also offer a site. It is recognised that the physical capacity to put this in place is severely limited as a result of Edinburgh's efforts to accommodate the additional population over the last decade, without matching premises investment. There may be individual practices which are able to develop this capacity shared with practice nurses and this should be explored as a helpful staging post. As with other workstreams, the aim should be for local provision and maintaining continuity and team cohesion, wherever possible.

The initial priorities are expected to be agreed as :

i. Hospital work currently 'delegated' to practices including hospital phlebotomy.

ii. Procedures which are time-consuming or require special equipment. These include suture removal, post-operative wound care, ABPI (using the Dopplex® machine these can be done in a few minutes rather than the best part of an hour), ear syringing (often requested by secondary care), spirometry and home BP monitoring.

iii. Chronic ulcer management with CTACS developing a 'hub' of specialism for that, including APBI measurement where appropriate, and involving the Tissue Viability and Lymphoedema teams. Such a service would help maintain quality and innovation, and could be fully integrated with the DN teams too. In the longer term this might also provide a cost-effective means for dermatology specialist outreach for problematic cases.

Initially practice bloods and simple measurements (BP, urinalysis) will continue to be done by practices: these are small, high volume tasks which require joined up IT (eg practices use GPOC-ICE to order tests and ensure results come straight back to the GP. This was achieved in Inverclyde by use of EMIS web).

There will need to be Lothian-wide interface work with secondary care to establish systems by which specialists order tests from CTACS. Those will be paid for by secondary care (agreed at Lothian level) and will require CTACS staff to access TRAK. There will need to be close monitoring of volume and workload transfer so that the services are not overwhelmed.

We propose that the task group considers the establishment of Clinical Administrator posts, funded by secondary care. These will be new staff, who can respond to all requests from patients for results or information generated by specialist services. Currently patients tend (or are encouraged) to ask GPs for these, or have to navigate the complexities of the hospital system. A discussion paper on CTACS development has already been developed.

Next steps - CTACS

- Establish a dedicated task group which will start by surveying possible sites in Edinburgh, both in practices and at Lauriston Place (end June 2018)
- Discuss potential sites through GP Quality Cluster Groups to ensure relevance to each area.
- Begin with hospital procedures currently delegated to GP or time-consuming GP procedures (end October 2018)
- Lothian-wide interface work round hospital procedures delegated to CTACS.
- Practice-ordered bloods and simple measurements (BPs, urinalysis) to remain with practices initially – for review 2019-2020- as require new IT arrangements to be efficient and safe and the new services need to be very cost-effective.
- Establish Clinical Administrator posts, so that patients no longer ask GPs for hospital-generated results. These new posts have the added benefit of helping patients 'navigate' the system.

6.4 Urgent Care (Advanced Practitioners)

Practice sensitive models and approaches are being developed and evidenced. The Lothian practice-based pilots engaged paramedics for first line house calls. These required significant 'start up' work to establish how best to deploy this resource, but then provided a very useful service, releasing GPs from house calls: both the paramedics and practices felt that they rapidly became integral members of the team. Home visits can take a disproportionate amount of GP time and early assessment of the very ill at home may also give more leeway for exploring alternatives to admission, or admitting promptly.
To undertake this work paramedics require additional specialist training and it is estimated that 15 have completed this and a further 15 will do so in 2018 (Notes from meeting with SAS paramedics and NHS Lothian staff, 20/7/17). There were issues which needed to be addressed and these included: that the evidence base for use is limited, that initial induction was time consuming, a vehicle was required, paramedics cannot prescribe (though this is changing on 1st April 2018 for some, but they can follow PGDs and overall this was not an issue on house calls), case load and mix. In the pilot the paramedics worked across more than one practice, and undertook non-house call work, too, including telephone triage and face-to-face consultations. Paramedics also need to spend some ongoing time in the acute sector to maintain those skills.

There is a requirement to maximise the effectiveness of this resource in terms of benefit to GPs (who are the only others able to do this work, and who often 'fit in' unscheduled house calls round scheduled care). Some house calls relate to lack of transport: providing that would also maximise cost-effectiveness.

Next steps – Urgent Care:

A SLWG (City or Lothian) should be quickly established (June 2018) to begin work on the development of this element of the contract. Further potential steps are outlined below as a basis for initial action;

- Establish paramedic availability and interest; administration and governance
- One option is for every practice which might have an interest in a delegated house call service to provide data on house call numbers - suitable for this service
- Practices be asked to indicate which of those house calls could have been potentially managed by bringing the patient to the practice, if appropriate transport was available.
- Paramedic staff to consider an early pilot to manage a defined proportion of afternoon house calls on a cluster-wide basis (end of August 2018). This might benefit those with severe GP timetabling pressures with populations liable to be more chaotic in requesting housecalls, allowing best use of a limited resource. Others may benefit from a specified morning input. The team could then also be available for early evening LUCS work, covering a time when it is difficult for working GPs to reach out-of-hours bases and may provide an incentive for more GPs to do that work.
- By April 2019, aim to cover all appropriate afternoon unscheduled house calls and complete scoping work for covering a proportion of morning calls. This is likely to be limited by practitioner availability as much as funding, so could not be universal. In order to cover this work, include a small number of ANPs would ideally be incorporated in any fledgling service, which will also enrich learning and development for both professional groups.
- (Until we have house call data, we do not yet know what capacity is needed, so this work will need an ongoing scoping and PDSA approach).
- Continue to encourage visiting efficiency by rationalising practice boundaries, particularly round outlying patients.
- Consider transport options to reduce housecall numbers

6.5 Additional Professional Roles

There is a balance to be made between the high impact of investment in a single practice and the more ‘diffused’ allocations to multiple practices. The initial proposal is to keep ‘injecting’ individual practices, keeping the additional resource as close to those as possible, and gradually moving to some collective arrangements where it is clear they are more effective.

Resource allocation will be difficult, when so many practices are in need, and the EHSCP is developing a separate paper and the dedicated 'resources' workstream to address this.

In summary:

- 30 of Edinburgh's 72 practices have benefited (or are set to benefit) from additional staffing capacity 'injections' through the T&S monies which were available to all on a 'bidding' basis;

- Practices have to pay for 50% of ongoing costs after a trial period, which was effective at distinguishing 'need' from 'want', and supporting 'tests of change' across the city.

- The 50% contributions were agreed on the basis they would be 'recycled' to reach a further tranche of practices as confidence in this method of augmentation grows.

- Maximising the use of the new workforce often necessitates new ways of practice working (diverting MSK cases without unnecessarily involving GPs needs good receptionist signposting for instance);

- Factors which need to be taken into consideration with application of new contract funding will include: pressures due to age, multimorbidity or other local circumstances; levels of previous investment; additional funding available to practices through the SAF; that the new workforce available is funding limited and has extensive training needs; the contractual requirements to address health inequalities and admissions avoidance; locally-identified priorities; supporting individual practice resilience (some practices needing urgent help to remain viable)

- To ensure that the GP view particularly round equity and fairness is fully considered, both the GP Sub-Committee representatives and the Cluster Groups will be part of the resources workstream.

- The Clusters will have shared responsibility for quality improvement and assurance support for ALL the workstreams: data round outcomes will need to be considered as part of that process, and also agreed with Cluster leads.

- The Inverclyde pilot indicates that extensive time is needed for planning, data collection, and developing integrated models and relationships: this needs to be factored into workstreams too.

- There will be initial practice survey work for many workstreams as this is the only way to establish what capacity is required.

6.6 Advanced Nurse Practitioners (ANPs)

That Lothian has already established and funded an ANP training programme is very welcome: essentially that lack in Inverclyde meant that only one ANP post was established and is still in the early pilot stage. Edinburgh HSCP will therefore continue to pay its share for this and find additional ways to incentive and support practices as they take on training roles.

ANPs and Advanced Physiotherapy Practitioners (APPs) have both successfully undertaken Care Home work in Lothian. APPs are independent practitioners, accustomed to full case management including diagnosis, and they have proved valuable in Boroughloch Practice. We need to understand how much this reduces GP Care Home workload, which largely relates to frailty, palliative care, withdrawing treatment, multi-morbidity and so on: EHSCP will ascertain from East Lothian the cost-effectiveness of its extensive programme for ANPs to undertake such work. There is an alternative view that Care Home residents are complex patients, many requiring palliative care, and are best served by the GP as expert medical generalist. As an example, a single GP- with adequate generalist DN support - can look after a 75-bedded Care Home in 2 sessions per week. This complex work is crucial to 'Realistic Medicine' and keeping ill and end-of-life patients at home. eFrailty approaches may also provide ways of targeting ANP and other resource: Midlothian is piloting this model.

ANPs also have a crucial role to play in practices, managing patients alongside GPs in the surgery. This represents a very direct way of increasing front line capacity and needs to be expanded. They can also take on complex chronic condition care, traditionally done by GPs eg diabetes management. The Edinburgh T&S investment has already funded several of these posts.

PNs can take on more work traditionally done by GPs, without achieving full ANP status and complementing their role in chronic disease management and health promotion. Examples include minor illness management, triage roles, anticipatory care planning, management of respiratory exacerbations and so on. Releasing time for PNs to take on this work is an important part of our approach to workload management.

Next steps – ANPs:

- Continue to support ANP training in Lothian
- Include some ANP presence in the Urgent Care service
- Further assess cost-effectiveness in Care Home settings
- Further deployment in practices and assessment of impact with existing investments.
- Support new ways of working (with the associated training) for PNs
- Explore new ways of targeting care – eFrailty models.
- Consider funding interested GPs to attend hospital at home training

6.7 Musculoskeletal-focused physiotherapy services

APPs have adopted very successful roles in Edinburgh in other settings (eg Community Respiratory Team) so account will need to be taken of these approaches when considering MSK capacity.

Useful work has already been done in this area: the Inverclyde baseline audit identified that 10-20% of consultations *could* be dealt with by APPs: barriers to this included that both practitioners and practices had to change how they worked. The APPs underwent several months of training in General Practice. Inverclyde reported "a savings in costs associated with 8-10% of GP appointments time" and improvements in GP morale and approach to treating joint problems, though the robustness of the data was questioned.

'Think Physio for Primary Care'[4] outlines that MSK conditions accounts for around a fifth of GP consultations, are the single biggest requirement for repeat GP appointments and that APPs as autonomous practitioners can readily take on this workload. The outcomes are good, and generally orthopaedic referral rates drop. There are established approaches to implementation[5], produced with BMA and RCGP involvement, and which gives detail round both pathways and governance. The work done in Forth Valley for 'first contact' APP involvement was that the service was safe, efficient, accessible and cost-effective, and welcomed by staff and patients. In the 6 month pilot, only 4% were referred on to the GP and the vast majority did not need GP- generated prescriptions.

The full potential for saving of GP time with an APP can only happen with receptionist signposting: there are training and redesign implications for those practices not already doing this. Telephone advice is not considered in these documents but many presentations are repeat consultations due to chronicity or very recent-onset presentations where advice is adequate: an audit in one Edinburgh practice has shown that some MSK consultations can be managed with phone advice only. Therefore APP telephone advice as an option should be assessed as that may further improve cost-effectiveness.

In Edinburgh, tests of changes have been agreed for two particular practices, but it may be that enhancing direct access as a cluster based approach may be preferred, as APP availability will be limited.

[4] Think Physio for Primary Care; Chartered Society of Physiotherapy; Policy Briefing Scotland 2017.
[5] General Practice Physiotherapy posts: A guide for implementation and evaluation. Chartered Society for Physiotherapy; RCGP; British Medical Association.

Next steps –MSK focussed Physiotherapy Services

- Some localities have already asked practices if they wish to have access to an APP. Ask all practices if they are interested, a pre-requisite for involvement being 'front door' signposting (end of May2018).

- Initial telephone management is key, and may be by receptionists (sign-posting) or GPs or APPS (triage and management). Consider piloting telephone advice as part of the service – this would be a means of managing consultations rather than an alternative to the non-specialist led NHS24 MSK line.

- Establish means of referral to others: the Forth Valley pilot indicated that APPs not only referred to orthopaedics but also to falls' services, podiatry, and weight and pain management services too (by September 2018).

- Two practices will run pilots using T&S money for in-house programmes as a test of change, and others to be based at Cluster or Sub-Cluster level (see Diagram 2): one FTE APP per locality by Sept 2018; and adding a FTE per cluster p.a. for the next 3 years, with full review of model each year.

- Take account of academic work on APP implementation in Primary Care (WJ)

- Agree data collection and outcomes – readily available from existing programmes and guidance but would include 'containment' (self-management, no onward or GP referral); patient satisfaction; accessibility; prescribing etc.

6.8 Community Clinical Mental Health Professionals

The experience of embedding Mental Health Professionals in practice teams in Edinburgh has been very encouraging, and more have been recruited through the Transformation and Stability (T&S) fund to join practices. Senior Mental Health Nurses can manage drug misuse patients, and those with mild-moderate anxiety and depression as well as other mental health issues presenting to GPs. Standard disease register coding will not be an adequate marker of workload: many patients present with recurrent symptoms over years, or have psychological or emotional difficulties which are not necessarily coded. The emphasis now is on non-pharmacological approaches for mild or moderate illness, so prescribing patterns will not adequately reflect practice workload either, but will give an indication, as will demographic factors.

Further development of supportive local networks and use of the 'Link Worker network' to inform future development is envisaged. Both Mid- and West Lothian have developed locality hubs where patients can be referred (or self-refer) and these can provide useful links to both third sector resources and secondary care. This model originated in the Fountainbridge area of the City with the development of the Rivers Centre and EHSCP will explore these models further as part of the Mental Health Workstream.

Some GPs report poor provision of standard secondary care mental health services and this context needs to be taken into account, too.

Next Steps - Community Clinical Mental Health Professionals

- Explore ways of ascertaining practice workload which can be undertaken by a Mental Health Professional
- Assess the relative merits of the available models of delivery (August 2018).
- Continue to embed Mental Health Professionals in high need practices (ongoing).
- Establish appropriate model for local networks – and whether those are appropriate for Edinburgh (Nov 2018) - with a view to beginning to establish those by April 2019.
- Consider the potential for extra capacity to be provided through the Third Sector.

6.9 Community Link Worker (CLW) (& including 'care navigation')

Edinburgh has a group of 20 practices with ≥20% deprivation who already have established Link Workers through the Scottish Government (SG) Primary Care Fund. This national investment was accelerated by local investment in a management structure which will focus strongly on supporting these new professionals to be as effective as possible in impacting on practice workload as well as the lives of vulnerable people. The initial ratio of one day per 1000 people on the practice list in quartile four of Scottish Index of Multiple Deprivation (SIMD) will be tested for its efficacy.

The Link Workers in Edinburgh also have responsibilities to support practice staff to effectively 'socially prescribe'. This involves training and enabling the practice team and particularly reception staff to recommend local resources to support patients; a version of 'care navigation'. In addition, further tests of change are taking place with 17C and T&S funding to assess the impact Link Workers can have working with non-deprived populations.

The network has built on the already strong relationships with the Third Sector, particularly in tackling inequalities. The existing network is strengthened through joint delivery with both Welfare Rights and Employability Support where this is already funded by the H&SCP. Over time, a proportion of the available funding may be used to develop relevant capacity as Primary Care develops better understanding and closer links with wider community resources.

A survey of 400 appointment requests at St Triduana's indicated that fully training reception staff in sign posting can remove up to 6% of demand for appointments (against a baseline estimated to be 1-2%). The Linkworker Network capacity (top sliced from LHB funds) has a programme of receptionist signposting training for ALL Edinburgh practices. It is expected that Link Workers will also inform and train reception and other staff in the 20 City practices where they are embedded.

There is much scope for the strengthening of signposting and this would be part of the purpose of the public engagement initiative.

Next Steps – Link Workers

- Establish outcomes – numbers of patients referred, numbers seen, success of onward referral
- Identify a small number of practices for more in depth assessment of success looking at more detailed data and qualitative work too (GP consultation rate before and after intervention, patient engagement and 6 and 12 months; accessibility and so on). (April 2019)
- Access outcomes of the Link Worker in the elderly non-deprived pilot practice (Dec 2018)
- Develop signposting throughout Edinburgh through dialogue with public and dissemination of supporting materials.

6.10 Clinical Administration

Several Edinburgh practices are already testing how clinical administrative work can be shifted from GPs to appropriately-trained and supported A&C staff (Clinical Administration Workers). A particular focus has been on Docman management, and initial feedback is positive. We need to explore the level of competency and associated training which is most effective. Examples of work needing different skill levels include: management of normal results; management of certain groups of low risk abnormal results (particularly for chronic disease management) through simple algorithms; identifying actions and coding from clinical letters; reduction in letters requiring GP attention, management of patients who DNA appointments (some of whom may be high risk).

Under QOF, patients with chronic disease were recalled automatically on the basis of their condition. The new approaches round multi-morbidity, frailty, Realistic Medicine and better stratification of patients with chronic disease (eg complexity, clinical need, disability and vulnerability) bring opportunities for much more tailored work. With this underpinning Practice Nurse teams can bring more appropriate levels of input for patients – more for some, less for others. It also better places teams to get the patient seen by the ‘right person at the right time’, increasingly important as our teams become ever-more multi-disciplinary. These approaches particularly suit House of Care, and the new models of frailty and multi-morbidity working.

One of the tests of change being supported through T&S funding, is the potential for increased automation of the registration and de-registration process. This would potentially free up administrative capacity across all practices, and be of particular benefit to those with high list turnover.

The support of an IT systems manager has proved very effective at one particular practice, allowing practices to maximise the use of their software systems, round recall work, data collection, and everyday activities. This has proved a very efficient and popular development. It could be that this model might be applicable at the Cluster or locality level with local resource provided through the application of New Contract funds. One cluster area has already made this proposal.

Next Steps – Clinical Administration

- Review of pilots and develop a coherent work stream (modelling) for Clinical Administration Workers. There is much room for rationalisation of processes and staff working.
- Review registration and deregistration automation pilots and roll out to all practices.
- Ensure capacity for training staff on IT application
- Ensure adequate IT systems management support to maximise potential and capacity of current IT system

6.11 Supporting Role of GP Quality Clusters

GP Quality Clusters play an essential role in designing and implementing local arrangements and providing a feedback forum for the effective and safe redesign of clinical pathways and associated workload distribution

The SSPC report on quality[6] highlights that:

> *"If the external role [of Quality Clusters] is not quickly developed, there is a risk of new arrangements with IJBs moving forward without GP involvement, worsening the engagement of general practice with the rest of the NHS. This would be detrimental to NHS working across systems, the 2020 vision and to integration of health and social care".*

(Under the Leadership section the need to support Cluster Quality leads in their 'extrinsic' roles was identified as a required action).

[6] Quality after QOF. The Scottish School of Primary Care. 23 March 2016

Next Steps - Development of cluster involvement

- A Cluster Quality Lead (CQL) have been invited and participated in the writing of, and review, of the Implementation Plan.
- Each Cluster was asked to review the PCIP in its Cluster Groups and to seek individual feedback with all constituent practices through PQLs;
- Clusters will be key in co-producing documentation on outcomes, quality improvement and assurance

7. Premises

EHSCP has already undertaken extensive assessment of practice premises suitability and capacity and outlined its proposals for support[7]. There is to be a national survey of all GMS premises in 2018-19, by a Scottish Government-approved surveyor and this will also further inform the Partnership.

The assessment presented to the EIJB in Sept. 2017 highlighted the requirement for an estimated £57M premises investment over the course of Edinburgh's Local Development (Housing) Plan. This would see the replacement of premises for 14 practices and in addition the development of 3 new practices in new premises.

EHSCP will discuss with the Board the additional staff needed for premises management.

The contract specifies that:

- There is initial prioritisation of practices requesting GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41). EHSCP will need to support any practices who assert that these standards are not being met.

[7] Population Growth & Primary Care Premises Edinburgh 2017 – 2026. A Strategic Plan for Growth (March 2017)

- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). Again the EHSCP will work with NHS Lothian to support practices in this process

Next Steps – Premises:

- Continue to keep a register of practice premises and perceived needs. Formally review the SG-led premises survey results
- Jointly HSCPs discuss with the Board the additional staff needed for premises management.
- Establish the priorities for the GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41): support any practices who assert that these standards are not being met.
- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). The EHSCP may need to support practices in this process.
- Continue to develop the Edinburgh Primary Care Support Team Premises work stream to manage and monitor all the above.

8. District Nursing Services

District Nursing is a pivotal part of Primary Care, and although the New Contract does not address District Nursing directly, it is important that District Nurses are understood as integral to the transformation of Primary Care. There is considerable scope for differently organising current services and this work is already embraced within the profession. Some of the elements of the new contract could bring new opportunities if we approach the potential thoughtfully. District Nursing has a long established focus on skill mix, building stronger clinical leadership within teams, better integration and so on. This work could be enhanced and accelerated through the new contract emphasis on ANPs (Urgent care) and CTACS in particular. The design of these new elements should be taken forward with the full and earliest involvement of DN colleagues.

Early suggestions for exploration include: involvement in delivery of flu vacs programme; structure of ulcer care; better locality-based provision with defined competencies in every team (including a nurse prescriber, someone who can verify death, someone who can assess for and sign DNACPR forms); skill mix; committed specified reduction in paperwork; deployment of specialist nurses eg IMPACT nurses, increase anticipatory and complex care expertise; all housebound to be 'automatically' on the DN caseload; every team to have access to practice-based software for prescribing and updating ACPs in GP records, referrals to podiatry, dieticians, physiotherapy, CRT, to be made by DN using practice system. Many of these aspirations are already shared by District Nurses and a matching set of suggestions from DNs is welcomed.

In the longer term, such reorganisation would allow transformative change to a fully integrated nursing team, based round - and very closely associated with local practices, - but with Hubs, CTACS and other cluster and sub-cluster services being integral. This would also allow for much closer working and joint collaboration between PN and DNs. The aspiration is a unified locality provision, with District Nursing and associated services as part of a fully-integrated adult community nursing team.

Next Steps – District Nurses

- Seek advice on how best to approach the potential for long term constructive and dynamic relationship with District Nursing services to complement arrangements already developing within clusters.
- Establish SLWG

9. Generic NHS Lothian Services

9.1 Corporate services

NHS Lothian Corporate services will provide essential support to H&SCPs in the delivery of the New Contract. There needs to be consideration of NHS Lothian corporate function staff with responsibilities now covered by HSCP functions. The HSCPs request that the Oversight Group reviews the support which needs to be responsive to the new HSCP landscape and may include services and functions such as: epidemiology, medical statistics, health care planning, impact assessments, Primary Care data management.

IT support to General Practice in Lothian is a longstanding source of frustration: many report a very poor service, significantly reducing working efficiency and wasting precious clinician hours. Provision in line with other Health Boards would greatly increase GP capacity – we suggest achieving the Scottish norm. We request that the development of national Service levels and performance management agreements be fast-tracked to allow adequate provision for what is currently a hugely under-resourced for the size of the current and future challenge. Our current systems undermine safety and quality.

The new contract places continuity of care as one of the key features of primary care. It is hoped that with greater support from the new workforce, that GPs will have the capacity to focus more on the frail multi-morbid patients with high levels of complexity that benefit most from high levels of continuity of care. There is the risk however, that an increased number of different practitioners delivering care could result in increased fragmentation of the service. (*Divided we fall - The Nuffield Trust by R Rosen*). To minimise these risks it is vital that communication between different health professionals is as effective and efficient as possible. It is therefore imperative that the GP clinical system is the record for all primary care activity, whether this occurs in the practice, CTACs or at any other site in the locality.

For this to happen, there will need to be careful planning of the IT systems for CTACs and other locality based professionals. Information being provided in letter form to be managed through Docman will only add to workload.

HR provision can be slow in response to the often immediate requirements of relatively small teams to maintain vital clinical services. We would like the Lothian Contract Oversight Group to consider an SLA with minimum standards and turnaround times for all processes, and that the emphasis should be on flexible, timely support. An array of standard templates reflecting the roles of the 'new workforce' should be made available for ready adaptation. Many of these already exist.

9.2 Interface Group

The new contract highlights the importance of interface working as a core aspect of managing workload:

> *"We know that workload is currently one of the most challenging aspects of being a GP. We are introducing measures to address this by:*
>
> - *continuing to reduce contractual complexity*
> - *improving efficiency of primary/secondary care interface working*
> - *building a wider primary care multi-disciplinary team" (p24)*

The contract goes on to outline that:

> *"To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the Improving General Practice Sustainability Advisory Group as set out in its report on November 2016.*
>
> *Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary".*

NHS Lothian has been pioneering in this area, having established a Lothian Interface Group with a small number of GPs and Consultants who are aware of the issues and keen to find solutions. However the group has no operational capability, and is resourced for a small number of meetings but not other substantive work.

There is so much to gain in interface working: improved quality, safety, relationships and the possibility of reducing waste and harm. We wish to see closer working between AMC and LIG. We also need to see closer working between LIG and operational boards to implement change

Next Steps – Generic Services

- HR provision reviewed with a new SLA
- Review of other managerial, advisory and data support services
- Adequate IT support to ensure safe and efficient clinical working with the added capacity necessary for New Contract implementation defined
- New Contract implementation becomes a standing item for the Interface Group
- Premises support capacity was highlighted in the premises section.

10. Quality Improvement

There is now an extensive NHS literature and experience on Quality Improvement (QI), and the lessons are clear: quality improvement requires systematic tools, shown to bring benefit, and a coherent organisation-wide approach, embedded in the organisations culture. QI should not be a series of projects or 'add ons' but instead a long-term commitment to change and 'reform from within'[8] The new contract and Improvement Plan provides an opportunity to a systems-wide approach, and we would hope a systems wide commitment to incorporating QI methodology in all the new programmes. Quality of healthcare is traditionally defined as being safe, effective, efficient, patient-centred, timely and equitable and these themes lend themselves well to all the new programmes being envisaged. QI work, done properly, can reduce waste, improve cost-effectiveness and provide encouragement and involvement for teams: it can work as well in the "clinical microsystems which make up the NHS" as bigger organisations.

. We have a unique opportunity to 'get it right first time' and that should be reflected in the initial programme design.

NHS Lothian has developed a welcome infrastructure to QI in Primary Care, outlined in its 3 year plan for Primary Care Quality Improvement Programme[9] (and see: https://qilothian.scot.nhs.uk/primary-care-network-1/) for further detail). We would want to see that work expanded and developed to encompass all clinical changes implemented. This will require additional use of NHS Lothian expertise: data analysts, QI specialists and the use of the Primary Care Data group to specifically consider new contract needs. Other supporting programmes and documents are the sentinel publications from the RCGP[10] and Scottish Government[11] and we would anticipate these being used extensively by Cluster, strategic and operational groups.

The GMS Contract rightly emphasises the 'four pillars' of General Practice: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-

[8] 'Embedding a Culture of Quality Improvement' The King's Fund; Joni JABAL, 2017.
[9] 'Making Healthy Change Happen'. Lothian Quality; Better Health, Better Care, Better Value; April 2018
[10] 'Quality Improvement for General Practice. A guide for GPs and the whole practice team. RCGP 2015
[11] 'Improving Together. A national framework for quality in GP in clusters in Scotland.

ordination (overseeing care). These have made British General Practice supremely effective and cost-effective. 'Divided We Fall', mentioned earlier, distinguishes between fragmentation and segmentation, the latter representing different levels of care depending on need, where that is managed differently or by other teams. The risk is that the new models of wider multidisciplinary team involvement and novel roles compromises generalist care. There are approaches developed in Lothian which should help (House of Care, 'archetypal' patients) which may help, but it is crucial that Cluster work round quality encompasses these aspects of care too.

The new contract specifies that:

> *"GP clusters and quality improvement GP practices will engage, as agreed in GP clusters, in quality improvement activities, including providing comparative data and sharing best practice. GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients" (p55).*

EHSCP recommends establishing a working group, with Public Health and Cluster input, to develop and maintain a framework for Quality improvement and assurance. This year the Lothian Safety SESP requires participating practices to complete a project using the Quality Improvement workbook and that should also feed into this work. Some of this work might be best done at a Lothian-wide level.

Next Steps – Quality

- The 'four pillars' of General Practice need to be maintained: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-ordination (overseeing care). These needs to be considered as part of quality assurance processes.
- GP Clusters need to be integral to quality improvement in the Primary Care Improvement Plan: early identification of necessary data collection is crucial
- The Partnership will continue to support Edinburgh CQLs in undertaking the Quality Academy programme, and extend that to PQLs.
- Further develop Public Health and Cluster input, to develop and clarify the role of clusters and develop a framework for Quality improvement and assurance including the required development of capacity.

11. Funding

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) have been set out in the Primary Care Improvement Fund: Annual Funding Letter 2018-19. This has been based on the following principles set out in the MoU:

> *"Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT"*

The Plan takes account of existing commitments notably Transformation & Stability (T&S) capacity injections and over a longer time period should also develop (post submission) to include funding from previous allocations, notably 17C and 'Next Steps'. We also note the Mental Health Strategy Funding which will deliver 800 more mental health workers (Scotland-wide) in a range of settings, including Primary Care.

The Edinburgh GMS base funding of c£80m has been uplifted by c£1.5m through application of a national formula. Practices have already been informed whether their income has remained stable or has been uplifted. The H&SCP does not have any discretion over these allocations.

Table 2 (below) sets out the anticipated funds available for application over the course of the PCIP.

In 2017/18 the Edinburgh IJB agreed that the NHS Lothian (£1.1m recurring) and the Scottish Government Transformation Funding (£0.66m non-recurring) should be combined to create the Edinburgh Transformation and Stability Fund. £0.5m was top sliced for agreed Lothian wide investments and £0.2M for City management investments required for the T&S Fund itself and the separately funded Link Working Network (leaving an in year balance of £1.1M for City investments directly used to create primary care capacity)

In 2018/19 the Scottish Government Transformation Funding disappeared, but was replaced by an additional £1.1m allocation from NHS Lothian, again top sliced by £0.7m. (Giving a balance of £1.5m available for direct primary care investments).

Recent Government correspondence confirms that **£45.75m will be released to HSCPs nationally** in 2018/19. The anticipated **Edinburgh** (recurring) resource resulting from this is **£3.8m**.

It is presumed that the (c£1m) existing investment in pharmacy support will come from this resource, as will the Link Worker network funding (£0.7M). Vaccination investments require further local clarity, but are presumed to be reserved for additional local capacity.

The GP income line is the income attached to the 50% contributions made when practices have (LHB funded) Transformation and Stability injections dedicated to their teams.

The £2.2m LHB funds for 2018/19 are already committed on T&S investments (& top slices) for 2018/19. A further c£1.7M is expected to be available for flexible investment on City priorities from the new contract funding. **This £1.7M is the initial focus of this Plan** and will allow us to begin work on a range of capacity creating improvements and have confidence in the effective investment of the increasing funds anticipated in subsequent years.

Table 2 Summary of Available Funding & Commitments

	2017/18	2018/19	2019/20	2020/21
SG Transformation Fund	**£0.66M**	**-**	**-**	**-**
LHB Stability Funds (T&S)	**£1.1M**	**£2.2M**	**£2.75M**	**£2.75M**
Lothian-wide investments **ANP training/Diabetes/Phlebotomy**	**(£0.5M)**	**(£0.5M)**	**(£0.5M)**	**(£0.5M)**
H&SCP Capacity **Link Worker Network** **Transformation Project Manager**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**
Sub Total	**£1.1M**	**£1.5M**	**£2.05**	**£2.05**
GP Income from T&S Programme		**£0.4M**	**£0.8M**	**£1.1M**
SG New Contract Funding (TBC) **Pharmacy (in place)** **Link Worker Network (in place)** **Vac Team??** **LHB Management Support** **New Contract income for Local Investment**	**-**	**£3.8M** **(-£1.0M)** **(-£0.7M)** **(-£0.2M)** **(-£0.2M)** **£1.7M**	**£4.5M** **(-£1.0M)** **(-£0.7M)** **(-£0.4M)** **(-£0.2M)** **£2.2M**	**£9.1M** **(-£1.0M)** **(-£0.7M)** **(-£0.6M)** **(-£0.2M)** **£6.6M**
Total Investment Income	**£1 .1M**	**£3.6M**	**£5.05M**	**£9.75M**

In summary, the two principle sources of funding are the New Scottish GMS Contract and the LHB funded Transformation and Stability (T&S) Programme. The T&S Programme will continue to fund practice specific dedicated injections of capacity, whilst the New Contract funding will be used for cluster or sub-cluster (or wider) collective investments during 2018/19. The T&S Programme investments are usually subject to a 50% salary contribution after 6 months if they have successfully replaced or augmented capacity. The collective investments made with the New Contract funds will not require any contributions from practices. This demarcation is anticipated to continue until at least the end of Phase 1 in March 2021. If sufficient funding for the implementation of the new contract is made available, reducing or eliminating these contributions in Phase 2 may be possible. Currently, they are widely regarded as a reasonable mechanism to guide access to limited resources.

Recruiting and deploying new staff into Primary Care with appropriate support needs to develop carefully to be effective. Over 40 new Primary Care staff were introduced in Edinburgh during 2017/18, and current support capacity needs to be increased if this rate is to be sustained. Effective use was able to be made of non-recurring underspends to quickly stabilise practices experiencing difficulties, to invest in new technology and to develop ‘tests of change’ where promising proposals for transformation were supported. Given the restrictions on available workforce in any given year, the H&SCP has already begun the conversation about use of non-recurring resources with City GPs. Some early suggestions have already attracted support for application of non recurring funding:

- Continuation of ‘technology fund’ e.g. acceleration of hypertension monitoring
- Additional CQL/PQL contract implementation capacity
- Additional QI capacity
- Public engagement and information programme
- Training at a variety of levels
- Flexible support for individual practices at risk
- Continuation of some tests of change begun in 2017/18

Diagram 4 Investment Summary – Edinburgh (2018/19)

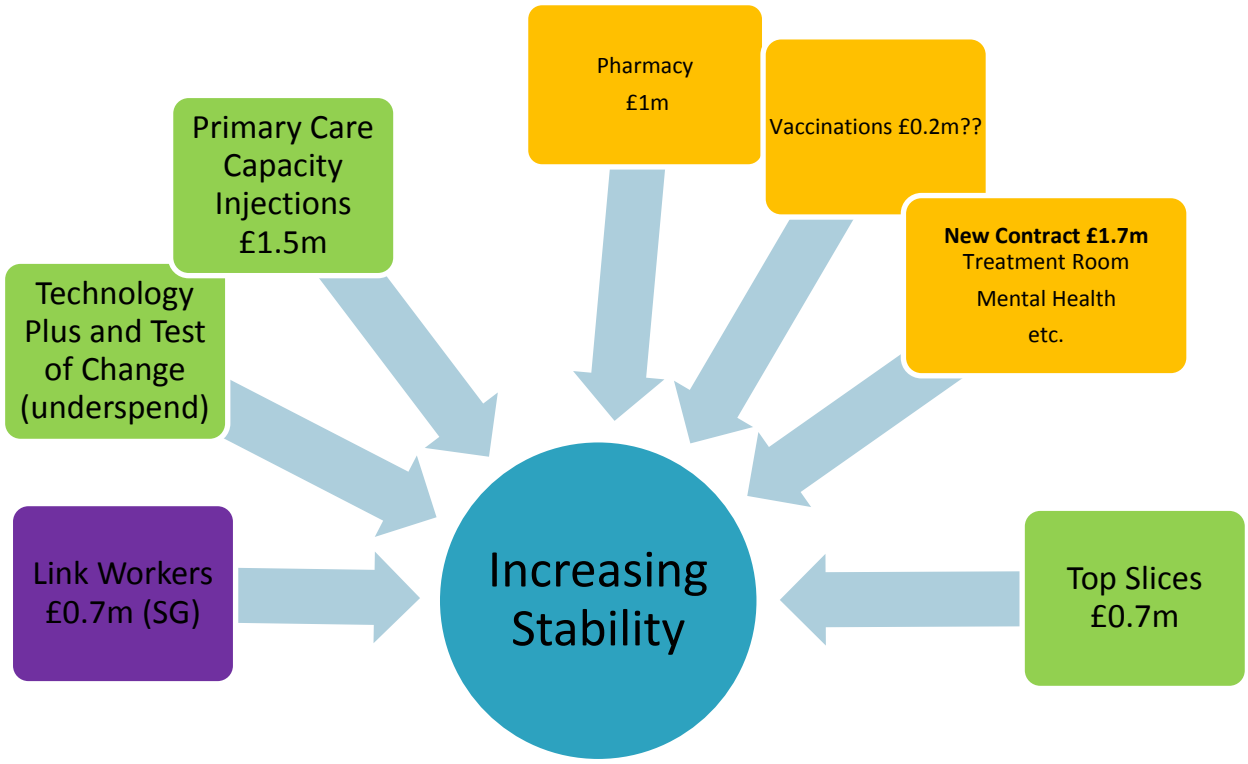


Diagram 4 illustrates how Transformation and Stability Programme funds and new contract funds combine.

12. Implementation

12.1 Progress to date/local background Transformation and Stability (T & S):

In June 2017 the IJB agreed that the Edinburgh Primary Care Support Team would establish the 'Edinburgh Primary Care Transformation and Stability Programme'

The June 2017 IJB paper anticipated the allocation of Edinburgh Link Workers from Scottish Government and the requirement for Programme Management capacity. The Link Worker Network has already been established as a constituent part of the T&S Programme

In the first six months of the Edinburgh Primary Care Transformation Programme, over 50 of the city's 72 practices were aided by either an 'injection' of new staff capacity, or additional workload related technology. Both staff and technology injections have been funded on a 50% basis (excepting Scottish Government Link Workers who are funded 100%, as specified nationally).

Available recurring funding has focused on additional staff, with in-year under spends supporting technology and associated investments to test new approaches as well as relieve particular pressures.

The recurring commitment of this program is £1.5m therefore utilising all of the available recurring funds for 2018/19 (after topslices). Further T&S investments for 2018/19 are therefore reliant on the anticipated income from the 50% contributions which were part of these agreements.

12.2 The New Contract.

The new contract funding will work well alongside the continuation of the 'Transformation and Stability' approach. The Edinburgh decision making and project support are already largely established.

It is proposed that any discretionary primary care funding made available to the HSCP by the Scottish Government in 2018/19 is passed to the Primary Care Support Team to be invested in individual practices, clusters and localities in accordance with the agreed Improvement Plan

Implementation progress will be reported to the NHS Lothian Oversight Group and to the HSCP Management Team on a quarterly basis, with progress report to the Edinburgh IJB in late 2018 / early 2019.

The 2017/18 funding has allowed investment in a Link Worker Network Manager and a Transformation Project Manager post. The Network Manager post was filled briefly on a temporary basis, but neither post has been able to be filled substantially pending a restructuring of the Primary Care Support Team which has been held up as part of the implementation of the EHSCP integration management structure. This capacity is urgently required to support the current and future effective investment of these funds.

In addition to project management capacity, strengthened clinical design capacity is required, both at medical leadership level and redesigning the supporting workforce. GP Sub-Committee representatives have been funded to facilitate proportionate involvement across Edinburgh during the formulation of the PCIP and additional capacity will be required throughout implementation. The capacity and time required for 'bedding in' new roles to practices and larger groupings should not be underestimated and needs to be supported effectively to have the workload impact sought.

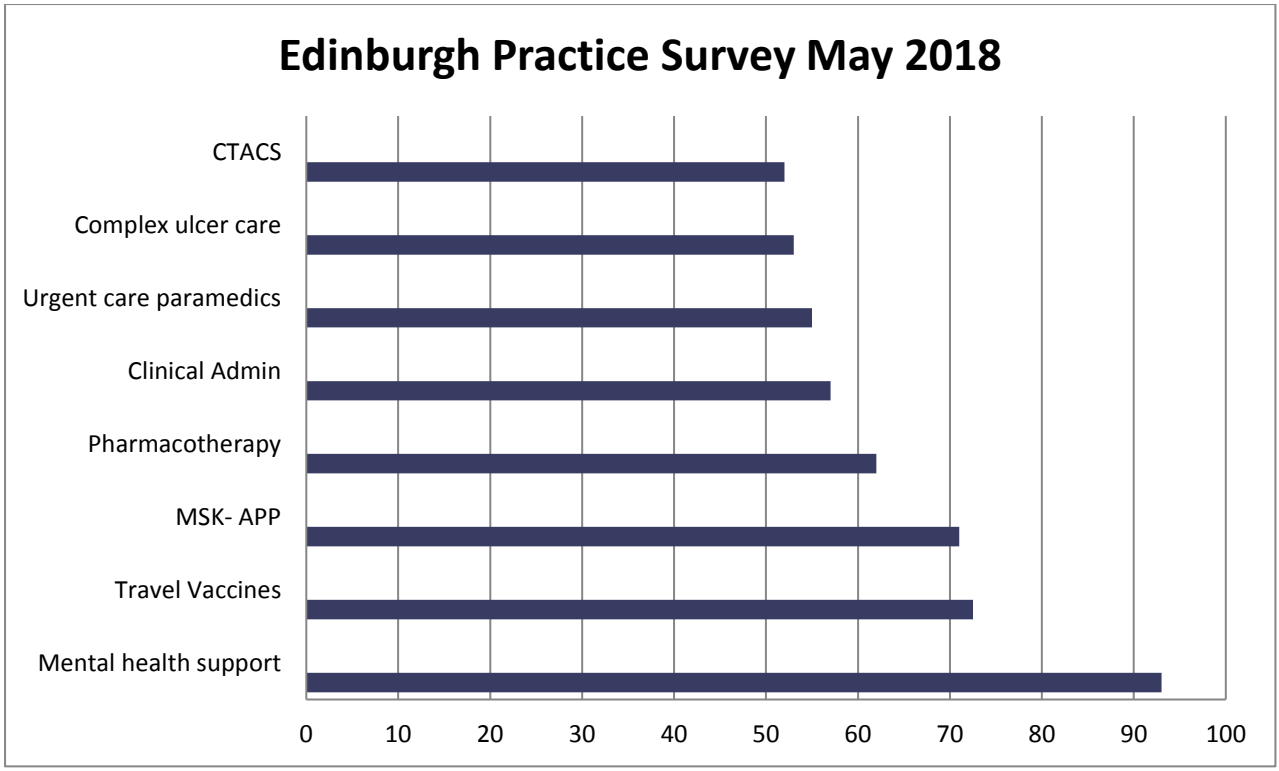
A governance structure has been proposed which would allow mutual support, exchange of ideas and helpful consistency across the four Lothian HSCPs

The obvious challenge is to combine the established T&S Fund support with the new contract resources in a way which strengthens and accelerates impact. An important understanding with practices which took the 50% T&S option was that they would not be disadvantaged in any sense by the roll out of the New Contract.

The availability of the new workforce is a widely held concern. The approach taken with T&S funding ie to utilise a wide range of capacity 'injections' has worked well in the initial stages. This should increasingly be matched with adjustments to national training programmes such as already made with pharmacy. Timescale for implementation will need to respond to the reality of new workforce availability as implementation proceeds.

Engagement with City GPs will continue after the EPCIP is submitted. The priorities for investment of the £1.7m have emerged through a series of meetings with GPs and a structured questionnaire. Funding and timescales will be allocated from the available £1.7M (TBC) against these areas as further work is undertaken to assess feasibility and impact**;**

The Edinburgh-wide practice survey gave the following preferences for the Improvement plan proposals:



Other areas (not covered in the survey) include premises & IT support and further tests of change/workstreams to ensure the other elements of the contract are developed for later implementation. The childhood vaccination programme is an urgent and immediate 2018/19 priority for the Practices who do not currently have this support, as is retention of the current provision for those who do.

It should be noted that the diversity of the City population is such, that a single consistent solution to alleviating workload is not going to be supported or effective or equitable. The application of the new resource will focus on improving or maintaining the floor of services for all practices (eg vaccinations) whilst encouraging local variation and testing the application of different elements of the contract. Again, the role of Cluster groups in helping to guide this investment is anticipated to become increasingly significant.

The national new contract priorities of vaccinations, pharmacotherapy and CTACS development have already been augmented by our early establishment of a Link Worker network. The message from Edinburgh GPs about additional capacity for mental health is

very clear and local work suggests very early benefits from improved clinical admin and signposting.

13. Outcomes, targets and indicators:

There is an urgent need to develop indicators to define how workload is transferred or reduced under the new contract. This is not straight forward when practices face widely varying pressures and have adopted many solutions to those over the years; when patterns of working vary widely, and when the alternative and new workforce is also diverse. We propose that many practices consider their in-house capacity in terms of GP sessions and want to consider that as a possible 'currency' for identifying successful workload transfer. This model also does not require analysis of current GP approaches, but rather sessions saved by the new developments. Using this proposition would promote debate with Lothian HSCP colleagues: the ideal would be co-development of a common model for use across Lothian. We would hope to liaise with Scottish Government and others who have already started examining outcome measures.

Some practices have undertaken internal audit work – for instance coding for reasons for attendance – and then looking at GP workload reduced by having a new advanced practitioner. This, and tally charts, involve additional work, but it may be that a selection of practices undertaking simple measures may provide some indicators for others. It is always difficult to get very busy clinicians to code – even for consultation type – which makes this work more difficult. The Primary Care Data management group is looking at other ways of capturing this information.
There are dangers, too, in generalising to other settings where GPs may work very differently. Outcomes – including workload reduction – are also very practitioner-dependent. Practitioners from specialist settings in particular need to work in very different ways in generalist settings where a different approach to patient care is needed. Some will require extensive training and coaching, and that time needs to be taken into account too.

Table 3 (below) begins to demonstrate the relationship between the injection of additional staff into the Edinburgh Primary Care system and how this relates to how pressure/ workload overload is expected to continue to develop. **At this stage we are not confident in the assumptions which underpin the figures – but have left in to illustrate our intentions**.

The first year (2017/18) describes a gap between medical sessions required (based on 1 session per 175 people) and medical sessions available based on Primary Care Contracting Organisation (PCCO) returns. All calculations should be treated with caution and will be revisited, since they can under-estimate or exaggerate the workload and capacity gap. For example, the average list size of 1800 is taken from a full time doctor working 9 clinical sessions to give 200 per doctor session. Furthermore, a ratio of 6.3 sessions per doctor on the Performers List is used from a census of Scottish doctors taken in 2013. The city figure may be materially different.

Table 3: Possible Model showing the Relationship between additional staff capacity and workload/ population increase (excludes SG Funded Linkworkers)

	2017/18	2018/19	2019/20	2020/21
Practice Population	550,000	555,000	560,000	565,000
Performer Medical Sessions Available (weekly est)	2250	2250	2250	2250
Medical Sessions Required[12]	2750	2775	2800	2825
Weekly Deficit Capacity in medical sessions	500	525	550	575
Funding Available see Table 2[13]	£1.1m	£3.6m	£5.05m	£9.75m
Additional WTE	25	84	117	227
Sessional Contribution[14]	75	252	351	681
Outstanding Sessional Deficit	- 425	- 273	- 199	+ 106

Note Linkworker investment (not shown) gives additional 15wte staff and c 15 sessions capacity.

Additional workload saved through technology investment and internal admin improvements also not yet assessed sufficiently robustly to be included.

[12] A planning assumption of 1 medical session per 200 patients has been used
[13] Includes GP income from T&S programme
[14] Average of 3 sessions per WTE has been used to relate impact of non-GP staff to GP workload based on current experience

14. Specific Outcomes (for further development)

The first expectation of the Edinburgh PCIP is to help support the city's practices to move away from what has been a period of unprecedented instability. There are;

Indicators of Stabilisation:

- Ensure no further practice faces situation where their contract needs to be returned (unless part of a planned change)
- Assess whether there is capacity to reduce the number of Edinburgh practices forced to declare their lists as 'restricted' (practices who restrict their lists report reaching a ceiling and must balance the number of registrations and de-registrations to keep the service safe and sustainable; others do not have the premises to expand - or insufficient clinicians - and so on).
- Prevent further practices transferring to 2c (currently 8) or needing 'intensive' support (c12 at any time)
- Increased number of GP partners (baseline 305)
- Reduced number of practices with GP vacancies (baseline to be established)
- Additional population absorbed onto GP lists
- GP wellbeing (use RCGP and other standard resources)

Indicators of capacity increase

- Number of additional staff engaged through either T&S or New Contract – the aim would be for 40 WTE, dependent on funding and personnel.
- Assessment of whether anticipated medical session injection average of 3 session's replacement/augmentation per additional wte is confirmed (range across new workforce).
- Agreement of the Specific outcome measures – delineating progress – and under each of the headlines of the new GMS contract *(with contract page numbers in brackets):*
- To include urgent Care services – number of practices covered per days of week for unscheduled home visits
- Vaccination services (28) – number of practice services transferred (for childhood programme and travel).
- Travel vaccine transfer to be complete by April 2019.
- Pharmacotherapy services (29) – number of new clinical pharmacists / technicians with sessions and number of practices benefitting.
- CTACS (32) – number established, services covered, secondary care workload transferred.
- Premises (39) – number of leases transferred, number of practices taking up GP sustainability loans; review of premises survey.
- GP Clinical IT services (42). There are to be national standards (p43):

- SLA delineating expectations of Lothian IT with implementation date of 30/9/18.
- Central server rollout (number of practices by….).
- Practice IT to receive Scottish average in terms of proportionate spend (primary / secondary care IT) - by Dec 2018
- Fast track of new IT for CTACS allowing staff to access TRAK.

Resources and supporting information

Information on existing programmes and outcomes is available but not attached;

- Edinburgh Health Needs Analysis by Locality (from Strategic Plan 2015)
- Edinburgh Primary Care Transformation & Stability Plan (IJB June 2017)
- Edinburgh Primary Care Premises Assessment (IJB September 2017)
- Edinburgh Strategy for Pharmacy Support to General Practice 2017-19
- Edinburgh Link Worker Network Update
- Edinburgh Primary Care Technology Investment Summary
- Edinburgh Primary Care Government Structure.
- Edinburgh General Practice demand groupings based on 2016 information
-Edinburgh Poll of New Contract preferences for implementation priorities
-Edinburgh draft list of supporting local implementation workstreams

Documents relating to process, governance and current situation:

- Representation and leadership structures and processes
- Clinical governance and quality
- Both overview and granular detail round premises, workforce, practice situations (vulnerability, gaps)
- Publication of detail of values and guiding principles
- Publication of agreed outcomes and data collection
- Documentation of lessons learnt.

Edinburgh Primary Care Improvement Plan (EPCIP)
Summary of Next Steps (29.05.18) – Appendix 2

Next Steps

- The establishment of a group tasked with the engagement and involvement of people and communities across Edinburgh, about how we reach a better balance between patient demand and our capacity to respond over the next decade.

Next Steps

- To engage with PMs to see what additional training or external support might be provided to complement the NES programme (end of 2018)
- To ask PMs whether they consider an increase in time funded to engage in relevant networks would be both feasible and worthwhile. The obvious parallel is to build on the existing PM network to create something like the GP Cluster arrangements to be able to more actively exchange the learning from each practice.
- To consider whether additional training support for practices could be offered to accelerate change.

Next Steps

- A review of the realistic time commitment required from the CQL group – including the opportunity to adjust expectations or perhaps vary expectations between clusters
- Agree what admin support is required to ensure that all clusters are able to function without CQL capacity being used inappropriately.'

Next Steps – Childhood Vaccinations

- A spreadsheet of Edinburgh practices outlining what staff undertakes childhood vaccinations currently, numbers of children of relevant ages and sessions required for this work (end of May 2018). Outcome of pilots to be known (end of June 2018)

- Agreement of approach and costings on the basis of spreadsheet information (end of July 2018)

- A timetable for practices not currently receiving support to be agreed (July 2018)

Next Steps – Travel Vaccinations

- Ask all practices to indicate the average number of travel vaccines done per month, including how many of those are eg family groups where there are time savings (end of May 2018) and what clinical software system they use (Vision or EMIS).

- Liaise with the WGH existing travel clinic to ascertain capacity and potential for expansion

- Establish a new travel vaccine clinic in a central location (Lauriston Place?)

- Agree timetable of travel vaccination work by end of July 2018, aiming for full arrangements in place by the end of 2018. After this, when a patient requests a travel vaccination, the practice should print off the existing vaccination record (this can be readily done in either Vision or EMIS) and give this to the patient to take to the travel vaccination centres.

- The practice needs to be informed of vaccines given: the ideal would be that this is automatically entered by the Travel Clinic Centres into practice electronic records

Next steps - Other Vaccinations

- Flu / pneumococcal vaccinations for the housebound should be done by appropriately resourced District Nursing (DN) teams, accepting that practices will continue to give as many as possible opportunistically. Current arrangements with an external team undertaking these within a small number of programmed sessions does not work well for logistic reasons. DNs already have a strong presence in the community and could efficiently give domiciliary vaccines for those not on their caseload by geographically (and opportunistically) linking them to their existing work

- The remainder of the adult vaccination programme will be scoped in 2019-20 with some workload transfer during that year and fully by 2021.

- Midwives leads should be consulted on the feasibility and timetable for giving all required vaccines (currently flu and pertussis) to pregnant women (September 2018)

Next steps – Pharmacotherapy

- We will assess whether there is capacity to offer regular sessional commitment to every practice for level one work (April 2019), with a specified proportion relating to reduction in GP workload

- We will continue to provide Level 2 and Level 3 services where they currently exist

- We will ensure (and fund through New Contract funds) a network of Designated Medical Practitioners (DMPs) to support pharmacists to become Independent Prescribers

- Using the T&S Programme fund we will assess with a number of individual practices, the impact of augmenting the ‘floor’ of service provided through New Contract funds

Next steps - CTACS

- Establish a dedicated task group which will start by surveying possible sites in Edinburgh, both in practices and at Lauriston Place (end June 2018)
- Discuss potential sites through GP Quality Cluster Groups to ensure relevance to each area.
- Begin with hospital procedures currently delegated to GP or time-consuming GP procedures (end October 2018)

- Lothian-wide interface work round hospital procedures delegated to CTACS.

- Practice-ordered bloods and simple measurements (BPs, urinalysis) to remain with practices initially – for review 2019-2020- as require new IT arrangements to be efficient and safe and the new services need to be very cost-effective.

- Establish Clinical Administrator posts, so that patients no longer ask GPs for hospital-generated results. These new posts have the added benefit of helping patients ‘navigate’ the system.

Next steps – Urgent Care:

A SLWG (City or Lothian) should be quickly established (June 2018) to begin work on the development of this element of the contract. Further potential steps are outlined below as a basis for initial action;

- Establish paramedic availability and interest; administration and governance
- One option is for every practice which might have an interest in a delegated house call service to provide data on house call numbers - suitable for this service
- Practices be asked to indicate which of those house calls could have been potentially managed by bringing the patient to the practice, if appropriate transport was available.
- Paramedic staff to consider an early pilot to manage a defined proportion of afternoon house calls on a cluster-wide basis (end of August 2018). This might benefit those with severe GP timetabling pressures with populations liable to be more chaotic in requesting housecalls, allowing best use of a limited resource. Others may benefit from a specified morning input. The team could then also be available for early evening LUCS work, covering a time when it is difficult for working GPs to reach out-of-hours bases and may provide an incentive for more GPs to do that work.
- By April 2019, aim to cover all appropriate afternoon unscheduled house calls and complete scoping work for covering a proportion of morning calls. This is likely to be limited by practitioner availability as much as funding, so could not be universal. In order to cover this work, include a small number of ANPs would ideally be incorporated in any fledgling service, which will also enrich learning and development for both professional groups.
- (Until we have house call data, we do not yet know what capacity is needed, so this work will need an ongoing scoping and PDSA approach).

Next steps – ANPs:

- Continue to support ANP training in Lothian
- Include some ANP presence in the Urgent Care service
- Further assess cost-effectiveness in Care Home settings
- Further deployment in practices and assessment of impact with existing investments.
- Support new ways of working (with the associated training) for PNs
- Explore new ways of targeting care – eFrailty models.
- Consider funding interested GPs to attend hospital at home training

Next steps –MSK focussed Physiotherapy Services

- Some localities have already asked practices if they wish to have access to an APP. Ask all practices if they are interested, a pre-requisite for involvement being 'front door' signposting (end of May2018).
- Initial telephone management is key, and may be by receptionists (sign-posting) or GPs or APPS (triage and management). Consider piloting telephone advice as part of the service – this would be a means of managing consultations rather than an alternative to the non-specialist led NHS24 MSK line.
- Establish means of referral to others: the Forth Valley pilot indicated that APPs not only referred to orthopaedics but also to falls' services, podiatry, and weight and pain management services too (by September 2018).
- Two practices will run pilots using T&S money for in-house programmes as a test of change, and others to be based at Cluster or Sub-Cluster level (see Diagram 2): one FTE APP per locality by Sept 2018; and adding a FTE per cluster p.a. for the next 3 years, with full review of model each year.
- Take account of academic work on APP implementation in Primary Care (WJ)
- Agree data collection and outcomes – readily available from existing programmes and guidance but would include 'containment' (self-management, no onward or GP referral); patient satisfaction; accessibility; prescribing etc.

Next Steps - Community Clinical Mental Health Professionals

- Explore ways of ascertaining practice workload which can be undertaken by a Mental Health Professional
- Assess the relative merits of the available models of delivery (August 2018).
- Continue to embed Mental Health Professionals in high need practices (ongoing).
- Establish appropriate model for local networks – and whether those are appropriate for Edinburgh (Nov 2018) - with a view to beginning to establish those by April 2019.
- Consider the potential for extra capacity to be provided through the Third Sector.

Next Steps – Link Workers

- Establish outcomes – numbers of patients referred, numbers seen, success of onward referral
- Identify a small number of practices for more in depth assessment of success looking at more detailed data and qualitative work too (GP consultation rate before and after intervention, patient engagement and 6 and 12 months; accessibility and so on). (April 2019)
- Access outcomes of the Link Worker in the elderly non-deprived pilot practice (Dec 2018)
- Develop signposting throughout Edinburgh through dialogue with public and dissemination of supporting materials.

Next Steps – Clinical Administration

- Review of pilots and develop a coherent work stream (modelling) for Clinical Administration Workers. There is much room for rationalisation of processes and staff working.
- Review registration and deregistration automation pilots and roll out to all practices.
- Ensure capacity for training staff on IT application
- Ensure adequate IT systems management support to maximise potential and capacity of current IT system

Next Steps - Development of cluster involvement

- A Cluster Quality Lead (CQL) have been invited and participated in the writing of, and review, of the Implementation Plan.
- Each Cluster was asked to review the PCIP in its Cluster Groups and to seek individual feedback with all constituent practices through PQLs;
- Clusters will be key in co-producing documentation on outcomes, quality improvement and assurance

Next Steps – Premises:

- Continue to keep a register of practice premises and perceived needs. Formally review the SG-led premises survey results
- Jointly HSCPs discuss with the Board the additional staff needed for premises management.
- Establish the priorities for the GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41): support any practices who assert that these standards are not being met.
- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). The EHSCP may need to support practices in this process.
- Continue to develop the Edinburgh Primary Care Support Team Premises work stream to manage and monitor all the above.

Next Steps – District Nurses

- Seek advice on how best to approach the potential for long term constructive and dynamic relationship with District Nursing services to complement arrangements already developing within clusters.
- Establish SLWG

Next Steps – Generic Services

- HR provision reviewed with a new SLA
- Review of other managerial, advisory and data support services
- Adequate IT support to ensure safe and efficient clinical working with the added capacity necessary for New Contract implementation defined
- New Contract implementation becomes a standing item for the Interface Group
- Premises support capacity was highlighted in the premises section.

Next Steps – Quality

- The 'four pillars' of General Practice need to be maintained: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-ordination (overseeing care). These needs to be considered as part of quality assurance processes.
- GP Clusters need to be integral to quality improvement in the Primary Care Improvement Plan: early identification of necessary data collection is crucial
- The Partnership will continue to support Edinburgh CQLs in undertaking the Quality Academy programme, and extend that to PQLs.
- Further develop Public Health and Cluster input, to develop and clarify the role of clusters and develop a framework for Quality improvement and assurance including the required development of capacity.

Appendix 3 – Glossary of Abbreviations

ACPs	Anticipatory Care Plans
ANP	Advanced Nurse Practitioner
APP	Advanced Physiotherapy Practitioner
BP	Blood Pressure
CEC	City of Edinburgh Council
CQL	Cluster Quality Lead
CTACS	Community Treatment and Care Services
DMP	Designated Medical Practitioner
DN	District Nurse
EH&SCP	Edinburgh Health and Social Care Partnership
EMG	Expert Medical Generalist
GP	General Medical Practitioner
HV	Health Visitor
IJB	Integration Joint Board
IM&T	Information Management and Technology
LHB	Lothian Health Board
LMC	Local Medical Committee
LUCS	Lothian Unscheduled Care Service
MoU	Memorandum of Understanding
MSK	Musculoskeletal
NES	NHS Education for Scotland
PCCO	Primary Care Contracting Organisation
PCIP	Primary Care Improvement Plan
PDSA	Plan, Do, Study, Act
PM	Practice Manager

PQL	Practice Quality Lead
QUOF	Quality and Outcomes Framework
SLA	Service Level Agreement
SLWG	Short Life Working Group
STU	Scottish Therapeutics Utility
T&S	Transformation and Stability
WGH	Western General Hospital

Primary Care Improvement Plan (PCIP)
Plan Development Actions

	Action	Key Date(s)	Progress	Lead	Complete
1.	Development of the 'design' elements on 20.02.18 by the Edinburgh Primary Care Support Team incorporating GP Sub-Committee membership	20.2.18	Meeting held Dr M	DW/CLs/ E.McG	√
2.	Consultation with GP reps / clusters Practice Managers across the city	March – May 18	Meetings held/ongoing	DW/CLs	√ (12 presentations made to primary care groups as plan developed)
3.	GP 1st 'open meeting to discuss new GMS Contract and Primary Care Improvement Plan	20.3.18	Open meeting held	DW/CM	√
4.	Writing group meetings	29 March/10 April /others	Meetings held	DW/CM/ R.McD	√
5.	Widely circulated Primary Care consultation draft	13.4.18	Draft circulated for comments	DW/CM/ R.McD	√
6.	Second GP 'open meeting to discuss new GMS Contract and Primary Care Improvement Plan	17.4.18	Meeting held – follow up notes prepared	DW/CM/ R.McD/C Ls	√
7.	Advice sought over Patient Engagement / Carer Engagement	18.4.18	Anne-Marie-Comber/MM asked	DW	√
8.	Primary Care Management team session on PCIP Questionnaire sent to all GPs asking them to indicate preferences under the 'discretionary' contract elements. 55 (from 72) City practices responded with good representation	1 May 18 30/4/18 – sent 24/5/18 – results	Melanie M. attending	DW/MM	√

	from all 5 'demand groupings'.	complete and compiled.			
9.	Prof Advisory Group	08.05.18	Carl emailed 18.4	DW	√
10.	May 2018 draft finalised along with summary paper for governance & re-circulated to GPs & wider stakeholders	8.5.18		DW	√
11.	May 2018 draft available for public comments through CEC portal/NHSL Twitter account	8.5.18	NHS Coms emailed 19.4 & again 9th may	DW	Not actioned
12.	Stakeholder events to ensure that localities, other strategic programmes, Staff Partnership have opportunity to comment	9.5.18 23.5.18	Invite sent 20.4.18	DW/RN	√ (0 & 8 attended sessions)
13.	H&SCP Strategic Planning Group Paper submitted	11.05.18	Wendy asked to put on agenda	WD	√
14.	Submission to EH&SCP Senior Management Team/proxy of the APM on 28th may.	17.05.18	Paper submitted	DW	√
15.	Draft submitted to Lothian Primary Care Contract Implementation (oversight) Group And to second meet	27.4.18 24.5.18 (tbc)	Meeting on 3.5.18	DW	√
16.	3rd & final GP open meeting before submission	16.05.18	Book meeting room, circulate email, tea/coffee	RN	√ (strong GP and PM attendance)
17.	Potential dedicated Carers/Patient/Third Sector events	EVOC 24.5.18 Carers 31.5.18	MM/EVOC/AMC to advise		√
18.	Equality Assessment (EQA)	22.5.18	Sarah bryson /kate burton agreed to establish	NP	√
19.	Writing Group make final changes (invite all CLs)	(24.5.18) 31.05.18	Emailed on 18 April to establish	DW	√
20.	GP Sub for signoff (date for submission)	11.06.18 (4.6.18)		DW	
21.	Staff Partnership Forum (meeting too late for changes to	13.06.18	Noreen/Helen	DW	

	document)		emailed (18.4.18)		
22.	Submission for IJB(Agenda planning meet)	15.06.18 (28.5.18)		DW	
23.	Submission to Scottish Government	01.07.18			

Item 5.3

Report

IJB Risk Register

Edinburgh Integration Joint Board

15 June 2018

Executive Summary

1. The purpose of this report is to provide an update on the Integration Joint Board (IJB) risk register and the proposed framework to manage, mitigate and identify risk.

Recommendations

2. The Committee is asked to:

   a) consider the IJB risk register and how the identified risks have changed since last assessed;

   b) agree whether the management actions identified against the current risks provide suitable assurance that these risks are being appropriately managed; and

   c) note the continued development of mitigating controls for IJB identified risks.

Background

3. Risk management is a means of identifying, evaluating and controlling risks. Effective risk management supports organisations to meet their objectives. As such, risk registers form part of the internal control framework and are a vital component in achieving and maintaining an intelligent framework for performance and governance.

4. The approach taken by the IJB and Edinburgh Health and Social Care Partnership (the Partnership) has evolved over the last few years, reflecting the growing understanding of the differing roles and responsibilities.

5. At its meeting on 9th February 2018 the Audit and Risk Committee endorsed an approach which decoupled IJB and Partnership risks and the development of a risk register for the IJB which reflected its strategic role. This meeting also agreed the methodology to be used, recognising that the risk rating is a two-

part process, which includes reviewing the risk area against an impact/probability matrix and determining the appropriate level of managerial input using an agreed plan of risk management and escalation.

6. A further update reflecting some minor restructuring and rewording was considered by the Committee at its meeting on 1st June 2018. The Committee welcomed this presentation of the register, albeit recognising that further work was required to fully develop the mitigating controls and assess their adequacy.

Main report

7. The initial IJB risk register was developed by the Partnership management team and validated in an IJB development session on 19th August 2016. The register was subsequently updated and presented to the Audit and Risk Committee on 2nd September 2016. At this point, the Partnership was working with 2 other (operational) risk registers, one for Council services and one for NHS Lothian services. Further, both these registers required an element of updating. This combination of factors created an overall complex landscape.

8. In subsequent months, the Partnership management team, supported by PwC, continued to identify and refine the mitigating controls. In February 2017, a workshop was held to develop the risk register further and to assign ownership of each risk. During this process, the extent of the linkages between IJB and Partnership risks was recognised, and it was agreed to capture the risks, responsibilities and ownership in one risk register, rather than hold separate registers for NHS Lothian, the Partnership, the City of Edinburgh Council and the IJB. Whilst this change simplified the process, it increased the number of risks being managed by the IJB.

9. One consolidated risk register was created which prioritised and scored all inherent and residual risks for both the IJB and the Partnership. This risk register, containing 49 identifiable risks, merged both “strategic” and “operational” risks into one document. This was considered and supported by the Audit and Risk Committee on 2nd June 2017 and updated in September 2017.

10. After consulting with the Interim Chief Finance Officer, Chief Internal Auditor, Chief Nurse, representatives from the three Lothian IJBs and the Council’s Risk Officer, it was agreed to develop separate IJB and Partnership risk registers. Consequently an IJB risk register was developed which focused solely on risks related to strategy, scrutiny and performance. The extant risk register was used as the basis for this work and the initial output was discussed at the Audit and Risk Committee meeting on 2nd February 2018. As well as considering the register itself the Committee discussed and supported the methodology to be

used to assess risk and the underpinning framework for risk management and escalation.

11. As agreed by the Audit and Risk Committee the latest iteration of the register (attached as an appendix) has classified each risk against one of three key areas:

    a) Strategic planning and commissioning;

    b) Issuing of directions; and

    c) Management and role of the IJB.

12. This reporting format will be used for producing other summary materials (e.g. papers for committees, senior management team, strategic groups, IJB, etc.).

13. The register will continue to be developed and maintained by the Partnership's Operations Manager with oversight arrangements remaining in place from the Chief Finance Officer.

Key risks

14. The proposed additional and amended risks will assist the Board in meeting its objectives.

Financial implications

15. No direct financial implications.

Implications for Directions

16. There are no specific implications for directions arising from this report.

Equalities implications

17. There are no equality issues within this report.

Sustainability implications

18. No direct sustainability implications.

Involving people

19. The IJB risks were developed following consultation with the Chief Finance Officer, Chief Internal Auditor, Chief Nurse, representatives from the three Lothian IJBs and the Council's Risk Officer.

Background reading/references

20. None

Report author

Judith Proctor

Chief Officer, Edinburgh Health, and Social Care Partnership

Contact: Cathy Wilson
Operations Manager, Edinburgh Health and Social Care Partnership
E-mail: cathy.wilson@edinburgh.gov.uk | Tel: 0131 529 7153

Appendices

Appendix 1	IJB Risk Register

Appendix 1 – IJB Risk Register

Strategic Planning and Commissioning				
ID	**Risk**	**Current Risk Rating**	**Previous Risk Ratings**	**Target Risk Rating**
1	There is a risk that the IJB fails to deliver its strategic objectives because the Council and/or NHS Lothian do not delegate sufficient resource – leading to a requirement to revise the strategic plan.	**High**	**Very high** (March 2018)	**Medium**
2	There is a risk that the IJB has limited ability to influence the decision making over set aside and hosted services which are not managed and delivered by the Partnership because of conflicting requirements – leading to the IJB's inability to drive strategy to help meet its objectives/outcomes.	**High**	**High** (March 2018)	**Medium**
3	There is a risk that the IJB will not achieve its strategic objectives and/or financial targets because delegated services are not delivered by Council and NHS Lothian within available budgets – leading to a requirement to revise the strategic plan.	**Very high**	**Very high** (March 2018)	**High**
4	There is a risk that the IJB has insufficient asset planning arrangements because of a lack of a capital plan – leading to failure or delays in delivering the strategic plan.	**High**	**High** (March 2018)	**Medium**

Issuing of Directions				
ID	**Risk**	**Current Risk Rating**	**Previous Risk Ratings**	**Target Risk Rating**
5	There is a risk that NHS Lothian and the Council do not deliver directions because they are not: • well-articulated • properly understood • realistic/achievable • performance targets are not SMART	**High**	**High** (March 2018	**Low**
6	There is a risk that the IJB directions are not delivered because of the lack of a workforce strategy - leading to a mismatch between workforce requirements and availability.	**High**	**High** (March 2018)	**Low**

Management and Role of the IJB

ID	Risk	Current Risk Rating	Previous Risk Ratings	Target Risk Rating
7	There is a risk that the IJB does not operate effectively as a separate entity because: • there is a lack of clarity about the separate roles of the IJB, HSCP, Council and NHS Lothian; and/or • members lack the necessary skills, knowledge and experience to undertake their role. - leading to a failure to deliver the principles of integration.	**High**	**Medium** (March 2018)	**Low**
8	There is a risk that the IJB does not make best use of the expertise, experience and creativity of the third, independent and housing sectors, and other partners as a result of failing to engage and collaborate appropriately - leading to a negative impact on the delivery of the strategic outcomes and poor relationships.	**High**	**High** (March 2018)	**Low**
9	There is a risk that the IJB lacks the infrastructure to operate effectively because of a failure by NHS Lothian and the Council to meet their obligations under the integration scheme to provide adequate professional, administrative and technical support – leading to failures in governance, scrutiny and performance arrangements.	**High**	**High** (March 2018	**Medium**
10	There is a risk that the IJB receives insufficient or poor-quality assurance from assurance providers to support effective delivery of their scrutiny responsibilities.	**Medium**	**N/A** (new risk)	**Low**

Strategic planning and commissioning

Current risk rating: high

Risk ID:	1
Risk Owner	Interim Chief Strategy and Performance Officer
Date added to register	June 2016
Last revised date:	June 2018
Next review date:	September 2018

There is a risk that the IJB fails to deliver its strategic objectives because the Council and/or NHS Lothian do not delegate sufficient resource – leading to a requirement to revise the strategic plan.

Mitigating Controls:

- Annual financial plan presented to IJB for approval, 5 year plan under development
- Annual due diligence process
- Financial frameworks which support outline strategic commissioning plans
- Ongoing engagement with Head of Finance from the Council and Director of Finance from NHS Lothian

Target Risk: Medium

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures: Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- Sub group/committee/board membership lists
- Records of meetings

Strategic planning and commissioning		
Current risk rating: high	Risk ID:	2
There is a risk that the IJB has limited ability to influence the decision making over set aside and hosted services which are not managed and delivered by the Partnership because of conflicting requirements – leading to the IJB's inability to drive strategy to help meet its objectives/outcomes.	Risk Owner	Interim Chief Strategy and Performance Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- Regular (monthly) Chief Officer meetings attended by all four IJBs and officers from NHS Lothian provide a forum to reach consensus and raise any relevant issues.
- Service specific forums are established to consider and agree major service changes which impact on more than 1 IJB (examples include the working group looking at the closure of Liberton Hospital and the Royal Edinburgh Campus Reprovision Project Board).
- Outline strategic commissioning plans

Target Risk: Medium

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures:	Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- IJB reports
- Feedback from sub groups, particularly the SPG and reference boards
- Papers (including minutes) of meetings

Strategic planning and commissioning

Current risk rating: very high	Risk ID:	3
There is a risk that the IJB will not achieve its strategic objectives and/or financial targets because delegated services are not delivered by Council and NHS Lothian within available budgets – leading to a requirement to revise the strategic plan.	Risk Owner	Chief Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- Finance is a standing item on the IJB agenda.
- Regular financial reports.
- Operational financial monitoring undertaken monthly by both NHS Lothian and the Council.
- Partnership Savings Governance Group meets monthly to scrutinise progress against the Partnership's savings and recovery plans.
- Ongoing dialogue with NHS Lothian's Director of Finance and the Council's Head of Finance.

Target Risk: High

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Assurances:

- IJB reports
- Savings Governance Group meeting fortnightly. Action logs circulated.

Adequacy of current control measures:	**Uncertain**

Impact of controls not known at this time and more work is required to identify current situation.

Strategic planning and commissioning		
Current risk rating: high	Risk ID:	4
There is a risk that the IJB has insufficient asset planning arrangements because of a lack of a capital plan – leading to failure or delays in delivering the strategic plan.	Risk Owner	Chief Finance Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- Joint NHS Lothian/Council asset management group has been established to agree on priorities.
- Representation on the Council Property Board and NHS Lothian Finance and Resources Committee.
- Outline strategic commissioning plans

Target Risk: Medium

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures:	Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- IJB reports
- Feedback from sub groups, particularly the SPG and reference boards
- Papers (including minutes) of meetings

Issuing of directions

Current risk rating: high

Risk ID:	5
Risk Owner	Interim Chief Strategy and Performance Officer
Date added to register	June 2016
Last revised date:	June 2018
Next review date:	September 2018

There is a risk that NHS Lothian and the Council do not deliver directions because they are not:

- **well-articulated**
- **properly understood**
- **realistic/achievable**
- **performance targets are not SMART.**

Mitigating Controls:

- Directions emerge from the strategic plan which has been developed in collaboration with NHS Lothian, the Council and other partners.
- Directions themselves are also developed in collaboration with NHS Lothian and the Council.
- Plans are being developed to regularly monitor and report on progress in delivery of the directions.
- Directions can be withdrawn or amended at any time if they are no longer to be appropriate/realistic/achievable.

Target Risk: Low

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures: **Uncertain**

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- Annual performance report
- IJB reports
- Feedback from sub groups, particularly the SPG and reference boards
- Papers (including minutes) of meetings

Issuing of directions

Current risk rating: high

Risk ID:	6
Risk Owner	Chief Nurse
Date added to register	June 2016
Last revised date:	June 2018
Next review date:	September 2018

There is a risk that the IJB directions are not delivered because of the lack of a workforce strategy - leading to a mismatch between workforce requirements and availability.

Mitigating Controls:

- A Workforce Development Steering Group has been established under the leadership of the Chief Nurse to oversee the development and implementation of a Workforce Strategy.
- Third, independent and housing sectors are members of the steering group.

Target Risk: Low

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures: Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- IJB reports
- Feedback from sub groups, particularly the SPG and reference boards
- Papers (including minutes) of meetings

Management and role of the IJB		
Current risk rating: High	Risk ID:	7
There is a risk that the IJB does not operate effectively as a separate entity because: • **there is a lack of clarity about the separate roles of the IJB, Partnership, Council and NHS Lothian; and/or** • **members lack the necessary skills, knowledge and experience to undertake their role.** **- leading to a failure to deliver the principles of integration.**	Risk Owner	IJB Chair
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- Regular development sessions for IJB members.
- Induction session for new IJB members.
- Members are encouraged to actively engage with the Partnership Senior Management Team.
- Board members chair subgroups and reference boards.

Target Risk: Low

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures:	Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- Record of development sessions taking place
- Record of inductions

Management and role of the IJB		
Current risk rating: high	Risk ID:	8
There is a risk that the IJB does not make best use of the expertise, experience and creativity of the third, independent and housing sectors, and other partners as a result of failing to engage and collaborate appropriately - leading to a negative impact on the delivery of the strategic outcomes and poor relationships.	Risk Owner	Interim Chief Strategy and Performance Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- The third, independent and housing sectors represented on a range of IJB sub groups, sub committees and reference boards.
- Significant engagement undertaken as integral part of developing the strategic plan.
- The third, independent and housing sectors involved in the development of the outline strategic commissioning plans and all will have an integral role as these evolve into detailed commissioning plans.
- Development of an engagement strategy underway.
- The third, independent and housing sectors will be represented on the Workforce Development Steering Group

Target Risk: Low

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures:	Uncertain
Impact of controls not known at this time and more work is required to identify current situation.	

Assurances:

- IJB reports
- Feedback from sub groups, particularly the SPG and reference boards
- Papers (including minutes) of meetings
- Lack of deputations

Management and role of the IJB		
Current risk rating: high	Risk ID:	9
There is a risk that the IJB lacks the infrastructure to operate effectively because of a failure by NHS Lothian and the Council to meet their obligations under the integration scheme to provide adequate professional, administrative and technical support – leading to failures in governance, scrutiny and performance arrangements.	Risk Owner	Chief Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- The Chief Officer is a member of the senior management teams in both NHS Lothian and the Council, thus in a position to influence decision making.
- Through regular 1:1 with each respective Chief Executive, the Chief Officer is able to directly raise any issues and seek solutions.

Target Risk: Medium

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures: Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- Feedback from Chief Officer
- Annual assurance process and governance statement

Management and Role of the IJB		
Current Risk Rating: medium	Risk ID:	10
There is a risk that the IJB receives insufficient or poor-quality assurance from assurance providers to support effective delivery of their scrutiny responsibilities.	Risk Owner	Chief Officer
	Date added to register	June 2016
	Last revised date:	June 2018
	Next review date:	September 2018

Mitigating Controls:

- Ensuring quality of assurance – annual Internal Audit opinion that covers the quality of the IA teams involved in providing assurance.
- Annual (NHS Lothian and Council) governance assurance statements from Directors.

Target Risk: Low

	Consequence				
Likelihood	**Neg**	**Min**	**Mod**	**Maj**	**Ext**
Almost Certain	M	H	H	VH	VH
Likely	M	M	H	H	VH
Possible	L	M	M	H	H
Unlikely	L	M	M	M	H
Rare	L	L	L	M	M

Adequacy of current control measures:	Uncertain

Impact of controls not known at this time and more work is required to identify current situation.

Assurances:

- Risk assurance map is needed to outline assurance providers to the IJB and what risk they would cover.
- Need to receive assurance on the services and systems provided by external third parties by obtaining copies of their internal audit reports or professional inspectorate reviews.

Item 5.4

Report

Publication of Annual Performance Report

Edinburgh Integration Joint Board

Friday 15 June 2018

Executive Summary

1. The Public Bodies (Joint Working) (Scotland) Act requires integration authorities to publish an annual performance report for the period April to March, by the 31st July in the year in which the performance period ends. The purpose of this report is to provide the Integration Joint Board with an update on progress in producing the report and seek approval for the proposed process for the report being signed off prior to publication.

Recommendations

2. The Integration Joint Board is asked to:

   i. note the proposed approach to the structure of the annual performance report for 2017/18 and the progress made in developing the report

   ii. agree the proposed approach to ensure that the annual performance report is approved and published by 31st July 2018 as set out in paragraph 9.

Background

3. The annual performance report must provide an assessment of performance in respect of planning and carrying out the integration functions for which the integration authority is responsible. The intended audience is the integration authority and the communities for which it provides services. However, the report will be of interest to a wider range of stakeholders.

4. No national template has been set for the annual performance report, although the minimum requirement is that it includes an assessment of performance against the 23 Core Integration Indicators to support an assessment of performance in respect of the National Health and Wellbeing Outcomes.

5. There is also a requirement that the annual performance report will:

- be written in the context of the integration authorities' strategic plan and financial statement
- provide an analysis of performance at locality level, give details of allocation to, or spend by locality and including a description of how consulting and involving localities has contributed to the provision of services
- provide an analysis of spend by delegated function, including any under and overspends and an explanation for these
- assess whether best value has been achieved in terms of the planning and delivery of services
- provide details of any inspections carried out including any recommendations made and the integration authorities response
- details of any review of the strategic plan that has taken place in the reporting period and the reason for this

Main report

6. Edinburgh along with some but not all integration authorities structured their annual performance report for 2016/17 around the nine National Health and Wellbeing Outcomes. In practice this approach proved to be somewhat cumbersome as there is a degree of overlap between the nine Outcomes and each of the 23 Core Indicators has been linked to more than one of the Outcomes and vice versa.

7. It is therefore proposed that the annual performance report for 2017/18 is structured around the six key priorities within the strategic plan linked to the nine National Health and Wellbeing Outcomes and the 23 core indicators, as set out in Appendix 1. This will provide clear linkages back to the strategic plan whilst evidencing performance in respect of the National Health and Wellbeing Outcomes.

8. The 2016/17 annual performance report identified a number of priorities to be taken forward in 2017/18, reference to the progress made against these priorities will be included in the 2017/18 report.

9. A final draft of the annual performance report for 2017/18 will be available at the end of June, well ahead of the deadline for publication of 31st July 2018. However, the Integration Joint Board does not have a meeting scheduled for July, it is therefore proposed that the draft report is circulated to Board members during the last week of June with a two-week window for comments. Once any

comments have been taken into account the report could be approved by the Chair and Vice-Chair to allow publication to take place by 31st July.

Key risks

10. As the annual performance report will not be completed until the end of June and the Integration Joint Board does not meet in July, there is a risk that the report will not be published by the statutory deadline of 31st July 2018. However, the proposals set out in paragraph 10 above minimise this risk by providing an opportunity for Board members to consider the report prior to approval by the Chair and Vice-Chair.

11. There is a risk that the assessment of performance set out in the annual performance report is not reflected in the findings of the Joint Inspectors when they assess progress against the recommendations from the Joint Inspection of Services for Older People published in May 2017. To minimise this risk officers producing the annual performance report will work closely with those collating evidence for the inspectors in order to present a consistent picture.

Financial implications

12. The annual performance report will detail the financial performance of the Integration Joint Board for the financial year 2017/18, however, there are no direct financial implications arising from this report.

Implications for Directions

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

Equalities implications

14. There are no implications for equalities arising from this report.

Sustainability implications

15. There are no sustainability implications arising from this report.

Involving people

16. The proposals for the development of the annual performance report have been shared with stakeholder members of the Performance and Quality Sub-group.

Impact on plans of other parties

17. The content of this report has no impact on other parties.

Background reading/references

None

Report author

Judith Proctor

Chief Officer, Edinburgh Health and Social Care Partnership

Contact: Wendy Dale, Strategic Planning, Service Redesign and Innovation Manager

E-mail: wendy.dale@edinburgh.gov.uk | Tel: 0131 553 8322

Appendices

Appendix 1	Edinburgh Integration Joint Board Annual Performance Report 2017/18 proposed approach - Linkages between Strategic Plan Priorities, National Health and Wellbeing Outcomes and Core Indicators

Appendix 1

Edinburgh Integration Joint Board Annual Performance Report 2017/18 proposed approach

Linkages between Strategic Plan Priorities, National Health and Wellbeing Outcomes and Core Indicators

Key priorities in the strategic plan	Health and wellbeing outcomes	Core indicators
Tackling inequalities by working with our partners to address the root causes, as well as supporting those groups whose health is at greatest risk from current levels of inequality: • supporting individuals to maximise their capabilities and have control over their lives • creating healthy and sustainable communities that can resist the effects of inequality on health and wellbeing • ensuring that core health and social care services are delivered in such a way as to reduce and not exacerbate health inequality • recognising that some sections of the population need targeted	1 People are able to look after and improve their own health and wellbeing and live in good health for longer. 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. 5 Health and Social Care Services contribute to reducing health inequalities.	1 Percentage of adults able to look after their health very well or quite well 7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life 11 Premature mortality rate

Key priorities in the strategic plan	Health and wellbeing outcomes	Core indicators
support in order to address the cause and effect of inequalities		
Prevention and early intervention Preventing poor health and wellbeing outcomes by supporting and encouraging people to: • achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing; • make choices that increase their chances of staying healthy for as long as possible • utilising recovery and self-management approaches if they do experience ill health	1 People are able to look after and improve their own health and wellbeing and live in good health for longer. 2 People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	12 Emergency admission rate 7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life 16 Falls rate per 1,000 population aged 65+
Person centred care	2 People, including those with disabilities or long-term conditions,	2 Percentage of adults supported at home who agree that they are

Key priorities in the strategic plan	Health and wellbeing outcomes	Core indicators
Practicing person centred care by placing 'good conversations' at the centre of our engagement with citizens so that they are actively involved in decisions about how their health and social care needs should be addressed.	or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. 3 People who use health and social care services have positive experiences of those services, and have their dignity respected.	supported to live as independently as possible 3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided 15 Proportion of last 6 months of life spent at home or in a community setting 5 Percentage of adults receiving any care or support who rate it as excellent or good 6 Percentage of people with positive experience of the care provided by their GP practice 17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
Right care, right place, right time Delivering the right care in the right place at the right time for each individual, so that people:	2 People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable,	13 Emergency bed day rate 14 Readmission to hospital within 28 days

Key priorities in the strategic plan	Health and wellbeing outcomes	Core indicators
• are assessed, treated and supported at home and within the community wherever possible and are admitted to hospital only when clinically necessary • are discharged from hospital as soon as possible with support to recover and regain their independence at home and in the community • experience smooth transitions between services, including from childrens' to adult services • have their care and support reviewed regularly to ensure these remain appropriate • are safe and protected	independently and at home or in a homely setting in their community. 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. 7 People who use health and social care services are safe from harm.	18 Percentage of adults with intensive care needs receiving care at home 19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population 21 Percentage of people admitted to hospital from home during the year, who are discharged to a care home 22 Percentage of people who are discharged from hospital within 72 hours of being ready 9 Percentage of adults supported at home who agree they felt safe
Best use of capacity Developing and making best use of the capacity available within the city by working collaboratively with individual citizens, unpaid carers, communities, the statutory third, independent and housing sectors to deliver timely and appropriate care and support to people with health	6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. 8 People who work in health and social care services feel engaged with the	4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated 8 Percentage of carers who feel supported to continue in their caring role

Key priorities in the strategic plan	Health and wellbeing outcomes	Core indicators
and social care needs, including frail older people, those with long-term conditions and people with complex needs.	work they do and are supported to continuously improve the information, support, care and treatment they provide.	10 Percentage of staff who say they would recommend their workplace as a good place to work
Best use of resources Making the best use of our shared resources (e.g. people, buildings, technology, information and procurement approaches) to deliver high quality, integrated and personalised services, that improve the health and wellbeing of citizens whilst managing the financial challenge.	9 Resources are used effectively and efficiently in the provision of health and social care services.	20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency 23 Expenditure on end of life care

Item 5.5

Report

Attend Anywhere Service

Edinburgh Integration Joint Board

15 June 2018

Executive Summary

1. A motion was raised at the Edinburgh Integrated Joint Board (EIJB) on 18 May 2018 asking for a report to be submitted to the EIJB in one cycle.

2. The motion asked for a report on the feasibility of introducing the 'Attend Anywhere' infrastructure within primary care services, quantifying the risks of adoption and non-adoption, and the costs & benefits associated with implementation, in collaboration with NHS Lothian, to support IJB services and priorities including the transformation of primary care services.

Recommendations

3. The Integration Joint Board is asked to:

    i. Note the current position with the Attend Anywhere platform and the provision of an approved alternative endorsed by NHS Lothian.

    ii. Approve work to support the use of technological solutions within Primary Care is taken forward as a strand of work under the implementation of the Primary Care Improvement Plan once this is approved by the IJB.

Background

4. Attend Anywhere (AA) is a web-based platform that helps health care providers offer video call access to their services as part of their 'business as usual', day-to-day operations to perform a one to one video call between a clinician and patient.

5. Apart from a fast internet connection, all people need to use Attend Anywhere is the Google Chrome web browser on a computer or Android mobile device, or an app on Apple iPads or iPhones. Computer users will also need a web camera (usually built into laptops), and a microphone and speakers.

6. The Attend Anywhere suite of services and software is promoted by its developer as being purpose-built for health. The proof of concept for this product is centrally funded,

but costs for the fuller implementation of the service – should practices wish to adopt it – are unknown at this stage.

7. NHS Lothian have made a policy decision not to adopt the Attend Anywhere platform for a number of reasons as set out in the report below. However NHS Lothian do use an alternative software system called Polycom Cloud Axis, which provides similar functionality to Attend Anywhere.

8. One of the issues with NHS Lothian using the Attend Anywhere platform is that it runs off the Google Chrome Browser which is not included on the list of agreed desktop standards for NHS Scotland.

Main report

9. Polycom CloudAxis is used by NHS Lothian and works by a clinician arranging an appointment via an online portal in a web browser. Once the appointment is arranged, an email is sent to both the clinician and patient with the meeting details. At the appointment time, both the clinician and patient click on the link included within the email provided access to video conferencing allowing a consultation to take place.

10. Meetings can be set up quickly and easily transferred to the clinician's online calendar and all the relevant links for meetings are available when the appointment is opened in the clinician's calendar. Patients can access the software on any device and is configured to work with mobile technology. The tool is free and there are no costs associated with using the product as it is a web interface which allows the creation of ad-hoc secure video calls.

11. The Polycom Cloud Axis has been used by the midwifery team within NHS Lothian for over five years. The service proved that the solution works and is a realistic model for providing patient consultations using video conferencing.

12. However the system is not widely used beyond the Lothian Breast Feeding Service. A number of clinical staff have been given demonstrations of the system, but there has been no take up on the service. There is clearly an opportunity to promote it more widely across the organisation and within primary care.

13. The Polycom Cloud Axis does not provide waiting room functionality which Attend Anywhere has which is where patients would enter once they press the start video call button and music would play showing they have entered the room. The clinician would know that the patient has signed in and is waiting. NHS Lothian are in discussion with other suppliers who can offer this functionality and it may be that once this is secured, that the system becomes more attractive and functionally more acceptable to clinical teams.

14. Other boards have taken the decision to rollout the Attend Anywhere platform and run with Google Chrome, however, as set out in section 8 above, this does not adhere with the NHS standards for desktop software deployment. NHS Lothian have taken a robust stance to protect the whole of the estate in order minimise the risk of loss of access to critical clinical systems and its inherent impact on patient safety.

15. NHS Lothian is actively engaged with the other boards across NHS Scotland to determine a new desktop standard, which is likely to be agreed in May 2018. There are also discussions ongoing between NHS Scotland and Microsoft around a large-scale deployment of Office 365. This solution has a module which offers the functionality of Attend Anywhere and would meet the current and future standards set for NHS Scotland IT infrastructure.

16. Most of the General Practices in Edinburgh are independent contractors. As such, they determine the day to day running of their businesses and decide as partners on the possible introduction of new models of care and support. The introduction of a new model such as the use of video based consultation would require the agreement of practices on a voluntary basis.

17. The IJB is responsible, as part of the introduction of the new General Medical Services (GMS) contract, for the production and publication of a Primary Care Improvement Plan (PCIP) and this will be discussed by the Board at today's meeting.

18. The PCIP is a wide ranging document which has been developed following significant engagement and involvement of GPs, and wider partners. It sets out the opportunities for the use of funding toward technological investments within primary care with relevant support for this at a cluster level. It is proposed that this strand of work supports discussion and potential introduction of video consultation within practices.

Key risks

19. One of the key risks with NHS Lothian using the Attend Anywhere platform is that it runs off the Google Chrome Browser which is not on the list of agreed desktop standards for NHS Scotland and adhering to these standards are key to ensuring that there are no security vulnerabilities.

20. There is also a risk that by not encouraging and promoting the use of new infrastructure and technological solutions that we miss opportunities that may help to reduce pressures within Primary Care in particular.

Financial implications

21. Increasing the take up of the Polycom Cloud Axis would have no additional cost as access to the platform is free.

22. There would be costs associated with delivering a communications and support strategy to increase uptake as well as cost to provide training for staff and patients, however the costs are not clear therefore a full scoping exercise would have to be carried out. It is suggested that this sits as a strand of work within the delivery of the Primary Care Improvement Plan and wider Health and Social Care Partnership transformation and change programme.

Implications for Directions

23. There are none arising from this paper.

Equalities implications

24. A full integrated equalities assessment would have to be carried out on any software change.

Sustainability implications

25. A full sustainability impact assessment would have to be carried out as part of any software change.

Involving people

26. A full communications strategy would have to be developed as part of any rollout of software.

Impact on plans of other parties

27. The Primary Care Improvement Plan implementation will lead on the potential use of technology to underpin primary care services.

Background reading/references

28. The Edinburgh Primary Care Improvement Plan.

Report author

Judith Proctor

Chief Officer, Edinburgh Health, and Social Care Partnership

Contact: Judith Proctor, Chief Officer

E-mail: Judith.proctor@edinburgh.gov.uk | Tel: 0131 553 8201

Appendices

None

Item 5.6

Report

Edinburgh Integration Joint Board Unaudited Annual Accounts 2017/18
Edinburgh Integration Joint Board

15 June 2018

Executive Summary

1. This paper presents the unaudited 2017/18 annual accounts for Edinburgh Integration Joint Board (EIJB). They will be submitted to external audit before 30th June 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 31st March 2018 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 **30th 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 **31st August**;
- The Local Authority Accounts (Scotland) Regulations 2014 require the authority to aim to approve the annual accounts for signature by **30th September**; and
- To publish them by **31st October**.

6. In accordance with these requirements, the unaudited accounts were considered at the Audit and Risk Committee on 1st June 2017 and, following scrutiny by the IJB, will be submitted to external audit. The final accounts will be presented to the Audit and Risk Committee and IJB meetings in September 2018.

7. Scott-Moncrieff, the external auditors, 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 2017/18 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.

Implications for directions

12. None.

Equalities implications

13. None.

Sustainability implications

14. None.

Involving people

15. 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

16. As above.

Background reading/references

17. None.

Report author

Judith Proctor

Chief Officer, Edinburgh Health, and Social Care Partnership

Moira Pringle, 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

Appendices

Appendix 1	Edinburgh Integration Joint Board Unaudited Annual Accounts 2017/18

Edinburgh Integration Joint Board

Unaudited Annual Accounts 2017/18

The Annual Accounts of Edinburgh Integration Joint Board for the year ended 31 March 2018, 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 2017/18 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 2018 and gives 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 planning the future direction of and overseeing the operational delivery of integrated health and social care services for the citizens of Edinburgh. These services are largely delivered by the Edinburgh Health and Social Care Partnership (the Partnership) although some are managed by NHS Lothian on our behalf. These are referred to as "hosted" or "set aside" services. 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.

EIJB meets monthly and has 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.

2017/18 was our second year of operation and we saw a number of changes in the management and governance arrangements with the departure of the EIJB Chief Officer and the establishment of a new interim senior management team as well as a number of changes in voting members following local elections and some new members being appointed by NHS Lothian.

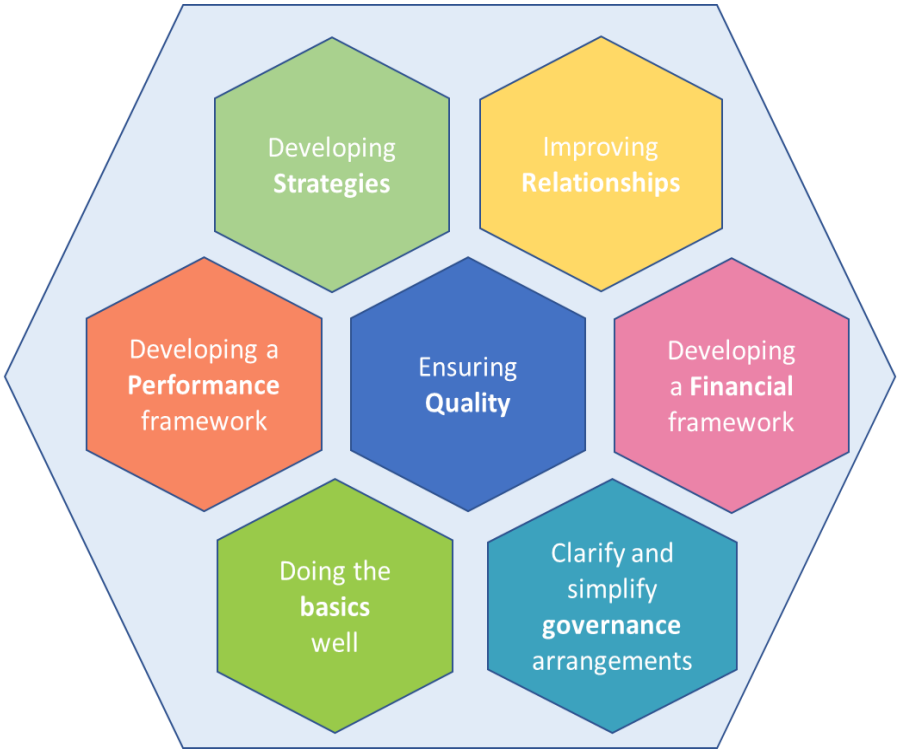
Strategic Plan

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.

We are now in the second year of implementing our 3-year strategic plan which was approved by the Board on 11th March 2016. This plan, which is due for renewal by April 2019, 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 £700 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:

Recognising that certain areas of activity require immediate attention, given their mission criticality, the interim management team for the Partnership committed to bringing greater clarity and focus to the activities of the Partnership, with an emphasis on performance, quality and finance. These immediate priorities are reflected in the "Statement of Intent" which has been shared with the EIJB as well as staff throughout the Partnership. The statement highlighted 7 priorities for the remainder of the financial year and into early 2018/19, these are summarised in the diagram below:



Developing strategies was one of these priorities and consequently the outline strategic commissioning plans were produced for 5 client groups: learning disabilities; mental health; physical disabilities; older people; and primary care. These, supported by a number of cross cutting themes were approved by EIJB in early 2018 and will form the basis for ongoing development of plans which, in turn will inform the new strategic plan.

Operational Review

We will be publishing an annual performance report at the end of July 2018 which will provide a review of the progress made during 2017/18, the second year of operation of the EIJB:

- how we are working to deliver the national health and wellbeing outcomes including our performance against a range of national and local 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.

THIS SECTION WILL BE UPDATED FOLLOWING FINALISATION OF THE PERFORMANCE REPORT.

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

The financial plan sets out how we will ensure our limited resources are targeted to maximise the contribution to our objectives. A financial assurance process was undertaken on the 2017/18 funding contributions made available by NHS Lothian and the City of Edinburgh Council. Through this process a savings requirement of £20.5m against projected income of £615.0m was identified. Funding adjustments during the year increased this budget to £709.5m.

EIJB's financial performance for the year is presented in the comprehensive income and expenditure statement, which can be seen on page 18. The balance sheet (page 19) is also presented and sets out the liabilities and assets at 31st March 2018.

For the year we are reporting a surplus of £4.7m which brings the total value of the EIJB's reserve to £8.4m. The majority of this reserve, £6.5m is "ringfenced" (i.e. set aside for specific purposes), including supporting the "Short Term Improvement Measures" and the "Plan for Immediate Pressures and Longer-Term Sustainability" agreed by the IJB in November 2017 and May 2018 respectively.

The in-year surplus was only achieved by both the City of Edinburgh Council and NHS Lothian agreeing additional one off contributions to EIJB: £7.2m from the Council and £4.9m from NHS Lothian. These additional payments reflected some of the significant and long standing financial pressures we face, notably:

- **Care at home** continues to be the single most significant financial challenge facing the IJB with a reported in year overspend of £7m. Demographic factors continue to drive demand for these services, as this is also evidenced in the continuing growth in direct payments and individual service funds. This level of overspend is in line with financial projections reported throughout the year and has been factored into the baseline position for budget planning for the next financial year. However, as was the case in 17/18, the 18/19 financial plan is predicated on this growth being offset, at least to some extent, by delivery of savings. Whilst the savings programme is continuing to build momentum, achievement in 17/18 fell well short of target and, as such, a focus on delivery forms a key cornerstone of the financial strategy for 18/19;
- **Prescribing** remains the most significant single financial issue facing delegated NHS services. Similar pressures are evident across Scotland, with short supply and high value drugs offsetting lower than anticipated growth in volumes. Pressures on the GP prescribing budget gave rise to an in year overspend of £2.1 million. Significant efforts have been taken to improve this for 2018/19, including prioritisation of additional funding and the continuation of the pan Lothian effective prescribing fund of £2 million;
- Delivery of **savings and recovery plans** remains a challenge with only a marginal contribution was made towards the Council's transformational savings in 2017/18. Equally, NHS service budgets include elements of unachieved savings carried forward from previous years and not delivered in year. Consequently, this will impact on the 2018/19 financial plan; and
- NHS Lothian **set aside** budgets overspent by £2.4m in the year. Junior doctors is the most significant contributory factor where non-compliant rotas are driving costs upwards. Overall set aside now equates to approximately 50% of the overall NHS position and is clearly an issue which requires to be addressed in partnership with NHS Lothian in 2018/19.

It will be important moving forward to 2018/19 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. In this financial climate, EIJB recognises that returning to a balanced position will require major redesign of services, radical changes in thinking and approach, and the involvement of all partners and stakeholders.

Many of the considerable challenges we face have significant financial consequences and we face a complex landscape of interconnected risks. 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 £700 million. Moving into 2018/19, we are working to proactively address the funding challenges presented while, at the same time, providing services for the residents of Edinburgh.

We have identified eight key categories across each of which sustained change is required to achieve the ambitions of the IJB and linked these to actions required in the short, medium and longer term to achieve sustained improvement, given the known demographics of need and likely future resource constraints.

1. Prevention – we need a sustained and meaningful shift of attention and resources towards preventative and early intervention activity that will reduce dependency on acute services and crisis support. Without such a shift, the care and support system as we know it will be unsustainable in the near future, overwhelmed by higher and higher levels of acute need.

2. Wider cultural change – our traditional model of health and social care support is based on expectations that formal care will be provided largely by public services, as part of a long-standing social contract, based on taxation contributions in exchange for universal benefits. Whereas the public funding envelope has reduced significantly in recent years, public expectations regarding the level and standard of provision have not reduced

to the same extent. We need to begin a 'big conversation' with stakeholders about what it is realistic to expect in terms of public service support, and what might be a reasonable contribution to people's care from individuals, their relatives, their neighbours and their communities.

3. A **reduction** is required in the volume of demand and expectation that is generated from initial requests for assistance. We need to redesign the system to create opportunities at each stage in the process for people to receive the right information or support at the right time.

4. This will reduce the **volume** of people waiting for an assessment; it will increase satisfaction rates because people will be able to access relevant and appropriate help either directly or much faster. It will speed up our response times, reduce 'false positives' and align the need for formal care more closely with its availability. This will leave a smaller volume of higher level need for formal care at home, residential and nursing provision, or other specialist care. This smaller volume will allow us to commission higher quality care at a market rate that ensures both capacity and sustainability.

5. This change of landscape must be complemented by a **redesign** of some of our internal, high cost, direct care services. These include Hospital at Home, Reablement, Intermediate Care, and other similar intensive support, including emergency responses.

6. **Workforce development**: effective integration requires a focus on organisational development, leadership and support for staff groups who are being asked to work in a new environment. Health and social care job demand is projected to rise; however, similar growth is forecast in the retail and hospitality sectors, and competition for the low paid workforce between sectors is likely to become fiercer. Edinburgh is already carrying significant recruitment and retention challenges in respect of adult social care. Without radical renegotiation and redesign, we will not have the people to deliver the type and level of care that citizens expect.

7. Our ability to focus on these critical and transformational priorities is dependent not only on financial resources and a timetabled, monitored action plan, but also requires adequate **business support, processes and IT infrastructure**. Further work to develop appropriate support mechanisms is required to be progressed with our partners.

8. **Professional/clinical governance and quality** – the integration of staff groups with different employers, terms and conditions and professional backgrounds, requires careful consideration of a range of HR issues and governance arrangements. Each professional group is subject to the registration requirements of a different governing body and to that body's code of conduct. Notwithstanding these different expectations, the principles of integration require the seamless delivery of coherent, coordinated services.

Linked to the above and emerging from the outline strategic commissioning plans our priorities include:

For people with a learning disability:

- The redesign of the Royal Edinburgh Hospital will require 19 community placements (18 already commissioned); in addition, 15 beds for assessment and treatment will be commissioned from NHS Lothian.

For people with mental health issues:

- Prevention – Place-based and person-centred life course approach improving outcomes, population health and health inequalities
- Access – Responsive and clear access arrangements connecting people to the support they need at the right time

- Taking a whole life approach that improves earlier intervention in childhood for people with behaviours that are challenging, and the development of smoother transitions from children to adult services.
- Adopting an 'Ageing in Place' strategy, which will promote awareness of disability issues in older people's services and aging issues amongst learning disability services.
- Strengthening services that can support people with more complex behavioural or forensic needs in the community, which will lead to the development of four 'locality leadership groups'.
- Identification of a range of housing and support options for people with learning disabilities and people with complex needs with a focus on core and cluster services.
- Reducing the cost of night care by developing a night support service with the option of on-call responders.
- Creating a 'framework' or 'alliance' agreement for accommodation with support across current partners to improve the links between people and providers.
- Key priorities for people with autism (who do not have a learning disability) include:
- Further development of the existing Edinburgh Autism Plan to reflect the emerging new priorities from the next and final stage of the Scottish Strategy for Autism.
- Ongoing advice and information for people with autism, including finding and maintaining housing and work in Partnership with key stakeholders.
- Continuing the Partnership's approach to promoting autism awareness with staff and the general public.

For older people:

- Parity of esteem between mental health and physical illness through collaborative and mature cross sector working across public sector bodies, third sector and private sector
- Sustainability – Ensure the best use of Edinburgh's funding through improving financial and partnership sustainability by - place-based cohesive and collaborative
- Commissioning needs-based care pathways, pooled budgets and more community based models of support, linked to wider Edinburgh's transformation activity; maximising digital health opportunities and investing in new workforce roles
- Culture – Mental health is 'everyone's business', enabling local areas to make decisions for system wide outcomes supported by shared information. This includes mental health and social care, but more broadly, the opportunities to consider the best approach across public services and the third sector, with a focus on community, early intervention and resilience, building on 5 Ways to Well Being
- Evidence and Research – Learning from local, national and international evidence and research and driving transformational change across traditional silos and with a wide range of partners from public, voluntary and private sectors
- Measurement – Standardised outcomes framework with minimum standards, outcomes and access across all providers of health and social care and shared approaches to strengthening communities and voluntary sector effectiveness
- Employers – All employers promote good employment practice for mental health, building capacity for conversations to support suicide prevention

For people with a physical disability:

- Stream 1 – Health and Wellbeing – We want to "take a big step back" by focusing on

  providing alternative and additional services earlier in the pathway, and by ensuring that appropriate information and support are provided to citizens in making choices that reflect their needs more effectively

- Stream 2 – Access and Assessment – We have taken significant steps forward to meet challenges in accessing care, with the establishment of an assessment and review board, which has sponsored the production of a harmonised assessment process. This requires considerable additional work, but has great potential to reduce the size of queues, including investment in Telecare, self-directed support and changes to our support planning approach

- Stream 3 – Short Term Care and Support – We will work collaboratively with our primary care, third, independent and housing sector colleagues to identify different models of care and capacity available to ensure quick and timely discharges from acute services and short-term support required to prevent admission

- Stream 4 – Long Term Care and Support – In light of the significant challenges of acquiring adequate long-term care and support in the community, we will work with the independent, third and housing sectors to create a more coherent design

- The move from the Astley Ainslie Hospital to the redesigned Royal Edinburgh Hospital will offer opportunities to review current bed use and outpatient services.

- Strengthening services that can support people to be more independent in their community.

- Identification of a range of housing and support options for people with physical disability, with a particular focus on core and cluster services.

- Reducing the cost of night care by developing a night support service, with the option of on-call responders.

- Reviewing the number of community navigators

For the primary care improvement plan:

- The main focus of the plan will be how the new contract outline model can best be implemented at locality/cluster/practice level to stabilise and transform the Primary Care workforce.

- In Edinburgh, we have already implemented a Linkworker Network supporting 20 practices in areas of high deprivation as classified using the Scottish Index of Multiple Deprivation (SMID). The relevance and associated resource of Linkworker to a population not classified as deprived is being tested both through 17C funding in NW Edinburgh and by Transformation and Stability injections.

- Following successful 'tests of change' Edinburgh GPs are keen to see rapid expansion of Advanced Nurse Practitioners, pharmacists and CPNs in particular.

- Current tests of change with physiotherapy and clinical admin support are likely to create further demand. (The potential of psychology has not yet been tested).

framework for contracting, with a view to increasing care in the community. We will review how our directly-provided services are run and make recommendations on the future model for improved sustainability and quality. In developing a 'Realistic Care' model, self-management and preventative use of equipment to strengthen earlier reablement activity. We will also be engaging with day care and lunch club providers to improve our wider integration. Our work with service users, carers, and the third sector has also identified that we must make more of the opportunities afforded us by self-directed support.

- Stream 5 – Complex care, Accommodation, and Bed-based services – The IJB has outlined its direction of travel for all services, which is to shift the balance of care from institutions to homely settings in the community. Our ambition is to ensure that people are as close to home as possible, which includes supporting care homes by increasing the number of places available and investing in downstream beds, which can facilitate earlier discharge from hospital.

- 2018/19 will see the first collaborative cluster wide bids for additional capacity.
- 2019/20 is anticipated to see the development of the first cluster services as proposed and funded by the new contract arrangements.

Conclusion

Thus, the IJB faces the twin challenges of: increasing demand for services; and a climate of constrained financial resources. In this context, the development and implementation of a strategic approach to financial planning over the next 3–5 years is essential to support the sustainability of health and social care delivery in Edinburgh.

Judith Proctor	**Ricky Henderson**	**Moira Pringle**
Chief Officer	**Chair**	**Chief Finance Officer**
June 2018	**June 2018**	**June 2018**

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 for Signing].

Ricky Henderson
Chair of the Edinburgh Integration Joint Board
June 2018

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 2018.

Moira Pringle
Chief Finance Officer
June 2018

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 Chief Financial Officer is appointed by the EIJB and is supplied without charge by NHS Lothian and the associated costs are included in the support costs disclosed in note 4.

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 2017 to March 2018 were:

S. Allen *(left 31/12/17)*	NHS	E. Aitken *(left 18/05/17)*	CEC
M. Ash	NHS	R. Aldridge *(appointed 15/03/18)*	CEC
M. Hill *(appointed 01/03/18)*	NHS	I. Campbell *(appointed 15/03/18)*	
C. Hirst	NHS	J. Griffiths *(left 18/05/17)*	CEC
A. Joyce *(re-appointed 10/05/18)*	NHS	R. Henderson (Chair) *(appointed 18.05.17)*	CEC
A. McCann *(appointed 01/01/18)*	NHS	S. Howat *(left 18/05/17)*	CEC
R. Williams *(left 28/02/18)*	NHS	D. Howie *(appointed 18/05/17, left 15/03/18)*	CEC
		M. Main *(appointed 24/08/17)*	CEC
		C. Miller *(left 24/08/17)*	CEC
		A. Rankin *(left 15/03/18)*	CEC
		S. Webber *(appointed 18/05/17)*	CEC
		N. Work *(left 18/05/17)*	CEC

The current voting members from NHS Lothian and City of Edinburgh Council are:

C. Hirst (Vice Chair)	NHS	R. Henderson (Chair)	CEC
M. Ash	NHS	R. Aldridge	CEC
M. Hill	NHS	I. Campbell	CEC
A. Joyce	NHS	M. Main	CEC
A. McCann	NHS	S. Webber	CEC

Councillors and NHS Non-Executive Directors are able through their parent bodies to reclaim any expenses. In the year to 31 March 2018, no expense claims were made in relation to work on the EIJB. The Chair of the EIJB was in receipt of additional remuneration in 2017/18 relating to his duties for the EIJB of £8,464 (£6,807, part year 2016/17). The Vice-Chair of the EIJB was in receipt of additional remuneration in 2017/18 relating to her duties for the EIJB of £8,251 (£0 2016/17). No allowances were paid to other voting members during the year. The remuneration and pension benefits received by all voting members in 2017/18 are disclosed in the remuneration reports of their respective employer.

Remuneration Paid to Senior Officers

	Year to 31/3/2018				Year to 31/3/2017
	Salary, fees and allowances (£)	Compensation for loss of office (£)	Total remuneration (£)	*FYE*	Total remuneration (£)
R McCulloch-Graham, EIJB Chief Officer (to 28/08/2017)	96,844	40,490	**137,334**	*150,390*	148,901
M Miller, EIJB Chief Officer (from 29/08/2017)	88,940	-	**88,940**	*150,390*	n/a
M Pringle, EIJB Chief Finance Officer	77,092	-	**77,092**	*77,092*	74,772

Pension benefits

Pension benefits for the Chief Officer and Chair of the EIJB are provided through the Local Government Pension Scheme (LGPS). Pension benefits for the Chief Finance Officer are provided through the NHS New Pension Scheme (Scotland) 2015.

Local Government Pension Scheme

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 2017/18 were as follows:

Whole Time Pay	Contribution rate
On earnings up to and including £20,700 (2016/17 £20,500)	5.50%
On earnings above £20,700 and up to £25,300 (2016/17 £20,500 to £25,000)	7.25%
On earnings above £25,300 and up to £34,700 (2016/17 £25,000 to £34,400)	8.50%
On earnings above £34,700 and up to £46,300 (2016/17 £34,400 to £45,800)	9.50%
On earnings above £46,300 (2016/17 £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.

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.

NHS Pension Scheme (Scotland) 2015

The NHS Board participates in the NHS Superannuation Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations. The rate of employer contributions is set with reference to a funding valuation undertaken by the scheme actuary. The last four-yearly valuation was undertaken as at 31 March 2012. The next valuation will be as at 31 March 2016 and this will set contribution rates from 1 April 2019. The NHS board has no liability for other employers' obligations to the multi-employer scheme. In 2017-18 members paid tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings.

For NHS employees, the NHS Superannuation Scheme became a career average pay scheme from 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.

Accrued Benefits

The pension figures shown below relate to the benefits that the person has accrued as a consequence of their total local government service, and not just their current appointment.

The pension entitlements of senior officers and current voting members for the period to 31 March 2018 are shown in the table below, together with the employer contribution made to the employee's pension during the year. Where accrued pension benefits are not shown in the table below, this indicates the employee has been a member of the pension scheme for less than 2 years.

	Employer In-Year Contribution			**Accrued Pension Benefits**	
	For year to 31/3/18 **£**	**For year to 31/3/17** **£**		**As at 31/3/18** **£000**	**Difference from 31/3/17** **£000**
R McCulloch-Graham, EIJB Chief Officer (to 28/08/2017)	13,090	31,716	Pension	n/a	n/a
			Lump Sum	n/a	n/a
M Miller, EIJB Chief Officer (from 29/08/2017)	27,860	n/a	Pension	55	n/a
			Lump Sum	105	n/a
M Pringle, EIJB Chief Finance Officer	11,487	11,222	Pension	14	2
			Lump Sum	30	0
R Henderson, Chair	5,314	7,017	Pension	5	0
			Lump Sum	2	0

The Vice 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. Scott Moncrieff will review other sections of the report to ensure that they are consistent with the financial statements.

Judith Proctor
Chief Officer
June 2018

Ricky Henderson
Chair
June 2018

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.

Board and Committee Structures

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. The chair of the Board rotates from NHS Lothian and the City of Edinburgh Council every two years.

The Strategic Planning Group (SPG) was formally established in May 2016. It is chaired by the vice-chair of the EIJB. 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.

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.

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. This group has been reviewed and its role is set to be subsumed by the Strategic Planning 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.

Internal Controls

As required by the legislation the EIJB has appointed a Chief Officer and a Chief Finance Officer. It has also appointed a Chief Internal, a Standards Officer and a Data Protection Officer.

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.

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.

The EIJB created a risk register in July 2016 following a risk management initiative 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. The last significant update was in September 2017 and consolidated strategic and operational risks into one document. In February and March 2018, the EIJB agreed that the risk register should be divided into IJB and Health and Social Care Partnership risks in 2018/19. This would allow the IJB to focus on its roles and responsibilities, concentrating on risks regarding strategy, scrutiny and performance.

A lead has been identified for the co-ordination of business continuity and reports directly to the Chief Officer.

The Health and Social Care Partnership Procurement Board exercises oversight of all proposals to award, extend or terminate contracts with third party providers.

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.

A financial plan is in place which focuses on the impacts of the financial settlements and outlines inherent risks. A new plan is submitted annually.

Insurance against legal liability for neglect, error or omission by any employee in the performance of their duties in relation to work on the IJB is arranged through CNORIS (NHS Lothian's self-insurance scheme). This is reviewed on an annual basis.

A health and safety group has been established with a cross-section of staff in the Partnership making up its membership.

A Savings Governance Board has been established that oversees financial savings and is led by the Chief Finance Officer. It monitors progress against targets and identifies appropriate remedial action.

The Edinburgh Integrated Joint Board (EIJB) has information governance responsibilities in relation to strategic planning and delegated functions which it determines and directs with its partners. To achieve appropriate governance in this area, a memorandum of understanding (MOU) has been agreed between the EIJB, NHS Lothian and the City of Edinburgh Council that ensures responsibilities are clearly set out and understood. 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.

Review of Effectiveness

The EIJB has responsibility for reviewing the effectiveness of the governance arrangements including the internal controls.

This review of effectiveness is informed by:

- The Chief Officer annual assurance for the EIJB and the health and social care partnership.
- Officer management activities;
- The Chief Internal Auditor's annual report and internal audit reports;
- Reports from the Council's external auditor; and
- reports by external, statutory inspection agencies.

The evidence of effectiveness from these sources includes:

- 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.
- The EIJB considers monthly performance reports.

- A resilience plan was created in January 2018 but was not fully developed due to the opportunities for further exploration of incident readiness following the late winter severe weather. Further work is planned for 2018/19.
- 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.
- Progress in implementing recommendations from previous audit reports has been closely tracked by the Chief Officer and the Audit and Risk Committee. However, a validation exercise in late 2017/early 2018 identified that there were some historic audit actions that had not been implemented. An action plan has been created to address the outstanding actions.
- 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.
- Performance monitoring has been comprehensive but improvements were necessary to ensure sufficient focus on key issues and to join up monitoring with the Strategic Plan and Directions. This is due to be resolved by the role of the Performance and Quality Committee being transferred to the Strategic Planning Group.
- The report on the Joint Inspection of Services for Older People identified a number of areas of concern and identified recommendations that an improvement plan has been agreed to address. 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.
- On 29 August 2017, the Chief Officer of the EIJB and the Chief Strategy and Performance Officer left the Health and Social Care Partnership. Interim management arrangements were put in place immediately, and an improvement programme established. The programme was approved by the IJB and additional resources allocated to support the programme, together with formal progress reporting arrangements. A new Chief Officer is in place and the rest of her senior management team will be in place by the summer of 2018.
- There has been significant turnover of members of EIJB, although some of this is stipulated by timescales of appointment, it can have an impact on the quality of scrutiny and decision-making as members adjust to their new role. A period of relative stability in membership would be beneficial.
- Although there has been temporary chairs of the Audit and Risk Committee which has meant the role of the committee could continue effectively; there has not been a permanent chair since September 2017.

Further development

	Issue	Responsible Party	Reporting Date
1	Further improvement and development of the mitigating actions for the new separate EIJB Risk Register	Chief Officer	June 2018 and onwards
2	Development of an Integrated Resilience Management Strategy for the Health and Social Care Partnership	Chief Officer	May 2018
3	Review and changes to responsibilities of sub groups regarding performance monitoring	Chief Officer	May 2018
4	Establishment of an Improvement Programme Board to oversee non-savings related work for the Health and Social Care Partnership	Chief Officer	May 2018
5	Appointment of an Audit and Risk Committee Chair	Chief Officer	August 2018

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.

Judith Proctor
Chief Officer
June 2018

Ricky Henderson
Chair
June 2018

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 2018

2016/17 Net Expenditure £000		Note	Gross expenditure £000	Gross income £000	2017/18 Net Expenditure £000
	Health Services	8			
228,797	Core services		250,957	0	250,957
82,154	Hosted services		86,071	0	86,071
49,461	Non- cash Limited		49,623	0	49,623
101,176	Set aside services		99,410	0	99,410
684	Corporate services		1,257	0	1,257
462,272			487,318	0	487,318
	Social Care Services	8			
126,604	External purchasing		124,670	0	124,670
24,710	Care at home		34,616	0	34,616
14,829	Day services		12,698	0	12,698
22,594	Residential care		22,457	0	22,457
11,994	Social work assessment and care management		13,191	0	13,191
0	Corporate services		527	0	527
12,884	Other		8,918	0	8,918
216,615			217,077	0	217,077
277	Corporate services	3	420	0	420
676,164	**Cost of services**		**704,815**	**0**	**704,815**
-679,854	**Taxation and non-specific grant income and expenditure**	2	**0**	**-709,477**	**-709,477**
-3,690	**Surplus on provision on services**		**704,815**	**-709,477**	**-4,662**

BALANCE SHEET

The Balance Sheet shows the value, as at 31 March 2018, of the assets and liabilities recognised by the Board. The net assets of the Board are matched by the reserves held.

BALANCE SHEET AS AT 31 MARCH 2018

31/03/2017 £000		Notes	31/03/2018 £000
	Current assets		
3,714	Short term debtors	4	8,378
	Current liabilities		
-24	Short term creditors	5	-26
3,690	**Net assets**		**8,352**
-3,690	Usable reserves	MIRS[1]	-8,352
-3,690	**Total reserves**		**-8,352**

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 2018 and its income and expenditure for the period.

Moira Pringle
Chief Finance Officer
June 2018

MOVEMENT IN RESERVES

This statement shows the movement in the year on the different reserves held by the Edinburgh Integration Joint Board.

	31/03/2018	31/03/2017
	£000	£000
Usable reserves – General Fund brought forward	-3,690	0
Surplus on the provision of services	-4,662	-3,690
Total comprehensive income and expenditure	**-8,352**	**-3,690**
Balance, as at 31 March, carried forward	**-8,352**	**-3,690**

NOTES TO ACCOUNTS

1. ACCOUNTING POLICIES

1.1 General Principles

The Annual Accounts for the year ended 31 March 2018 have been prepared in accordance with the Code of Practice on Local Authority Accounting in the United Kingdom 2017/18 (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 her 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 Chief Financial Officer is regarded as an employee of the EIJB, although her contract of employment is with NHS Lothian. NHS Lothian participates in the NHS Superannuation Scheme (Scotland) which is a defined benefit statutory public service pension scheme, with benefits underwritten by the UK Government.

The remuneration report presents the pension entitlement attributable to the posts of the EIJB Chief Officer, Chief Financial Officer and Chair of the EIJB although the EIJB has no formal ongoing pension liability. On this basis, there is no pension liability reflected on the EIJB balance sheet for these posts.

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

The Integration Joint Board is permitted to set aside future amounts of reserves for future policy purposes. These reserves normally comprise: funds which are set aside for specific purposes; and funds which are not earmarked for specific purposes but are set aside to deal with unexpected events or emergencies. They are created by appropriating amounts out of revenue balances. 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.

The EIJB has one usable reserve, the General Fund which can be used to mitigate financial consequences of risks and other events impacting on the Boards resources. The monies within this fund have been earmarked for specific purposes as set out in the financial plan for 2018/19.

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. The income received from the two parties was as follows:

	31/03/2018 £000	31/03/2017 £000
NHS Lothian	-511,593	-486,410
City of Edinburgh Council	-197,357	-193,444
Total	**-708,950**	**-679,854**

Expenditure relating to the two parties was as follows;

	31/03/2018 £000	31/03/2017 £000
NHS Lothian	487,561	486,398
City of Edinburgh Council	216,697	189,698
Total	**704,258**	**676,096**

Details of creditor and debtor balances with the partner bodies are set out in the subsequent notes (4 and 5).

3. CORPORATE EXPENDITURE

	31/03/2018 £000	31/03/2017 £000
Staff Costs	391	206
Other Fees	3	47
Audit Fees	26	24
Total	**420**	**277**

Staff costs relate to the Chief Officer, Chief Finance Officer, EIJB Chair and Vice-Chair.

EIJB is in receipt of NHS Lothian and City of Edinburgh Council support services. NHS Lothian and the City of Edinburgh Council have agreed to provide support services, without an onward recovery. Support services to a value of £0.709m (£0.751m 2016/17) have been provided.

4. SHORT TERM DEBTORS

	31/03/2018	31/03/2017
	£000	£000
Central Government Bodies	-	12
Other Local Authorities	8,378	3,702
Total	**8,378**	**3,714**

5. SHORT TERM CREDITORS

	31/03/2018	31/03/2017
	£000	£000
Other Bodies	-26	-24
Total	**-26**	**-24**

6. POST BALANCE SHEET EVENTS

No material events have occurred post the balance sheet reporting date.

7. CONTINGENT LIABILITIES and ASSETS

There are no contingent liabilities or assets to disclose.

8. PRIOR PERIOD ADJUSTMENT

Prior period figures have been re-stated to exclude the resource transfer between NHS Lothian and the City of Edinburgh Council. The impact on the Comprehensive Income and Expenditure is shown below:

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

	2016/17 Statements £000	Resource Transfer £000	2017/18 Re-stated £000
Health Services			
Core Services	252,816	-24,019	228,797
Social Care Services			
Other	-11,135	24,019	12,884

9. SEGMENTAL REPORTING

Expenditure on services commissioned by the EIJB Board from its partner agencies is analysed over the following services:

	Budget	Actual Expenditure	Variance	Actual Expenditure (re-stated)
	£000	£000	£000	£000
SERVICES PROVIDED BY NHS LOTHIAN				
Core services				
AHPs	7,831	7,492	339	5,992
Community hospitals	11,259	11,303	-44	10,959
District nursing	10,617	10,666	-49	10,349
Geriatric medicine	4,235	4,015	220	0
General medical services	74,579	75,269	-690	72,699
Mental health	9,322	9,195	127	9,408
Prescribing	80,072	82,172	-2,100	80,167
Other	49,426	50,845	-1,419	39,223
Total core services	**247,341**	**250,957**	**-3,616**	**228,797**
Hosted services				
AHPs	6,574	6,438	136	6,464
Complex care	2,379	2,419	-40	2,301
GMS	5,588	5,780	-192	5,796
Hospices	2,329	2,331	-2	0
Learning disabilities	8,569	9,161	-592	8,878
Lothian unscheduled care service	5,765	5,765	0	5,986
Mental health	25,794	25,361	433	24,740
Oral health services	9,218	8,898	320	9,200
Psychology services	4,280	4,194	86	0
Rehabilitation medicine	3,336	3,005	331	3,745
Sexual health	3,147	3,140	7	3,010
Substance misuse	7,079	7,212	-133	5,271
UNPAC	3,640	3,107	533	0
Other	-465	-740	275	6,763
Total hosted services	**87,233**	**86,071**	**1,162**	**82,154**
Non- Cash Limited				
Dental	26,684	26,684	0	26,447
Ophthalmology	9,253	9,253	0	9,067
Pharmacy	13,686	13,686	0	13,947
Total Non-Cash Limited	**49,623**	**49,623**	**0**	**49,461**

	Budget	Actual Expenditure	Variance	Actual Expenditure (re-stated)
	£000	£000	£000	£000
SERVICES PROVIDED BY NHS LOTHIAN				
Set aside services				
Accident and emergency	6,341	6,509	-168	6,419
Cardiology	11,214	11,163	51	16,960
Diabetes	1,204	1,262	-58	0
Gastroenterology	3,288	4,041	-753	5,529
General medicine	24,559	24,972	-413	32,764
Geriatric medicine	13,286	13,100	186	18,677
Infectious disease	7,135	6,792	343	8,186
Junior medical	12,543	13,757	-1,214	0
Management	1,743	1,938	-195	0
Rehabilitation medicine	2,040	2,180	-140	2,152
Respiratory medicine	5,294	5,362	-68	0
Therapies	6,523	6,447	76	6,177
Other	1,805	1,887	-82	4,312
Total set aside services	**96,975**	**99,410**	**-2,435**	**101,176**
Corporate				
Other	1,265	1,257	8	684
Additional contribution from NHS Lothian	4,881	0	4,881	0
Total corporate	**6,146**	**1,257**	**4,889**	**684**
TOTAL SERVICES PROVIDED BY NHS LOTHIAN	**487,318**	**487,318**	**0**	**462,272**
SERVICES PROVIDED BY CITY OF EDINBURGH COUNCIL				
External purchasing	115,623	124,670	-9,047	126,604
Care at home	34,652	34,616	36	24,710
Community equipment	1,801	1,650	151	1,542
Corporate	578	527	51	0
Day services	13,912	12,698	1,214	14,829
Health improvement/health promotion	1,520	1,374	146	1,598
Information and advice	2,069	2,307	-238	3,782
Local area co-ordination	1,490	1,390	100	1,329
Residential care	20,905	22,457	-1,552	22,594
Social work and OT support	2,329	2,739	-410	0
Social work assessment & care management	11,336	10,452	884	11,994
Telecare	19	394	-375	717
Other	3,594	1,803	1,791	3,916
Additional contribution from City of Edinburgh Council	7,249	0	7,249	0
TOTAL SERVICES PROVIDED BY CITY OF EDINBURGH COUNCIL	**217,077**	**217,077**	**0**	**213,615**
Useable Reserves		-8,352	-8,352	-3,690
TOTAL ALL SERVICES	**704,395**	**696,043**	**-8,352**	**672,197**

10. FUNDING ANALYSIS

The expenditure and funding analysis shows how annual expenditure is used and funded from resources in comparison with how those resources are consumed or earned in accordance with generally accepted accounting practice. In essence this demonstrates the difference between expenditure on an accounting basis and a funding basis. For EIJB no such difference applies and the information required is disclosed elsewhere in the financial statements

11. 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
For and on behalf of Scott-Moncrieff
Scott-Moncrieff
Exchange Place 3
Semple Street
EDINBURGH
EH3 8BL