Notice of Meeting and Agenda

Edinburgh Integration Joint Board

9.30am Friday 8 February 2019

Dean of Guild Court Room, City Chambers, Edinburgh

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

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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

4.1 Minute of the Edinburgh Integration Joint Board of 14 December 2018 (circulated) submitted for approval as a correct record

4.2 Sub-Group Minutes

4.2.1 Professional Advisory Group – Minute of 20 November 2018 (circulated)

5. Reports

5.1 Rolling Actions Log – February 2019 (circulated)

5.2 Impact of Audit Scotland Report Health and Social Care Integration on Edinburgh Integration Joint Board – report by the IJB Chief Officer (circulated)

5.3 Update on the Progress Review of Older People's Services – report by the IJB Chief Officer (circulated)

5.4 Transformation and Change – Developing the Edinburgh Model – report by the IJB Chief Officer (circulated)

5.5 2018/19 Financial Position and Initial Outlook for 2019/20 – report by the IJB Chief Officer (circulated)

5.6 Communications Action Plan for the EIJB – report by the IJB Chief Officer (circulated)

5.7 Brunton Place Surgery Re-provision – report by the IJB Chief Officer (circulated)

5.8 Edinburgh Integration Joint Board Strategic Plan 2019/2022 – Update – 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, Councillor Melanie Main, Angus McCann, Councillor Susan Webber and Richard Williams.

Non-Voting

Colin Beck, Carl Bickler, Andrew Coull, Lynne Douglas, Christine Farquhar, Helen FitzGerald, Kirsten Hey, Jackie Irvine, Carole Macartney, Ian McKay, Moira Pringle, Judith Proctor, Alison Robertson, Ella Simpson and Pat Wynne.

Item 4.1 - Minutes

Edinburgh Integration Joint Board

9:30 am, Friday 14 December 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, Councillor Ian Campbell, Andrew Coull, Christine Farquhar, Helen Fitzgerald, Kirsten Hey, Martin Hill, Jackie Irvine, Carole Macartney, Councillor Melanie Main, Angus McCann, Moira Pringle, Judith Proctor, Alison Robertson, Ella Simpson, Councillor Susan Webber, Richard Williams and Pat Wynne.

Officers: Colin Briggs, Tom Cowan, Mark Grierson, Jamie Macrae, Nickola Paul and Sarah Stirling.

Apologies: Mike Ash, Lynne Douglas and Alison Robertson.

1. Nari Kallyan Shangho (NKS)

The Joint Board agreed to hear a deputation from Dr Gina Netto and Tatheer Fatima on behalf of the Nari Kallyan Shangho, in relation to the Recommendations from the Health and Social Care Grants Review Programme 2019.

The deputation highlighted the following issues and concerns:

- NKS was an important service to the community that helped Asian women with their difficulties in accessing health services they could not ordinarily due to language, cultural and religious barriers.
- The organisation also provided a broader range of services such as interpretation, health promotion, a crèche, social care and mental health services.
- The organisation would not be able to provide the same quality of services without funding.

- The deputation suggested that the Joint Board consider the success of the organisation in allocating funding.

The Chair thanked the deputation and agreed to engage further with them on the issues raised.

Declarations of Interest

Councillor Ian Campbell declared a non-financial interest in this item as a Trustee of The Alma Project, left the room and took no part in consideration of the item.

Christine Farquhar declared a non-financial interest in this item as a Director of VOCAL and Upward Mobility, and the guardian of a person in receipt of a direct payment, left the room and took no part in consideration of the item.

2. Pilton Community Health Project

The Joint Board agreed to hear a deputation from Malcolm Chisholm on behalf of the Pilton Community Health Project, in relation to the Recommendations from the Health and Social Care Grants Review Programme 2019.

The deputation highlighted the following issues and concerns:

- The Pilton Community Health Project was used by 2,000 people every year and that it provided a vital service to a deprived area of Edinburgh.
- The project provided services in a variety of areas, such as 'Women Supporting Women' for vulnerable women and children in the area, the 'Food for Thought Forum' for food poverty, and 'Living in Harmony' for integration in the area.
- A sufficient area impact assessment had not been provided before considering the funding of the project.
- The project may need to close if funding ceased.
- The deputation suggested that the Joint Board consider providing bridging funding for a year.

The Chair thanked the deputation and agreed to engage further with them on the issues raised.

Declarations of Interest

Councillor Ian Campbell declared a non-financial interest in this item as a Trustee of The Alma Project, left the room and took no part in consideration of the item.

Christine Farquhar declared a non-financial interest in this item as a Director of VOCAL and Upward Mobility, and the guardian of a person in receipt of a direct payment, left the room and took no part in consideration of the item.

3. WHALE Arts

The Joint Board agreed to hear a deputation from Leah Black on behalf of WHALE Arts, in relation to the Recommendations from the Health and Social Care Grants Review Programme 2019.

The deputation highlighted the following issues and concerns:

- WHALE Arts ran a range of free and low cost arts programme whose key beneficiaries were those on low incomes.
- The organisation made a positive contribution to community health and wellbeing.
- The impact on the business of losing funding that would require the organisation to cut back on adult programmes and core salaries.
- The deputation suggested that the Joint Board consider providing feedback to organisations in order to understand the IJB scoring.
- The deputation suggested that the Joint Board consider providing bridging to allow the organisation to adapt their services.

The Chair thanked the deputation and agreed to engage further with them on the issues raised.

Declarations of Interest

Councillor Ian Campbell declared a non-financial interest in this item as a Trustee of The Alma Project, left the room and took no part in consideration of the item.

Christine Farquhar declared a non-financial interest in this item as a Director of VOCAL and Upward Mobility, and the guardian of a person in receipt of a direct payment, left the room and took no part in consideration of the item.

4. Community Ability Network

The Joint Board agreed to hear a deputation from Gus Meechan on behalf of the Community Ability Network (CAN), in relation to the Recommendations from the Health and Social Care Grants Review Programme 2019.

The deputation highlighted the following issues and concerns:

- CAN provided a general advice service in the Craigmillar area, as well as representing clients at tribunals and medical hearings.
- The consultation did not feel meaningful and did not give a sufficient explanation as to why funding had been cut.
- Without funding the organisation would risk closure within a few weeks.
- The deputation suggested that the Joint Board consider providing bridging to allow the organisation to adapt their services.

The Chair thanked the deputation and agreed to engage further with them on the issues raised.

Declarations of Interest

Councillor Ian Campbell declared a non-financial interest in this item as a Trustee of The Alma Project, left the room and took no part in consideration of the item.

Christine Farquhar declared a non-financial interest in this item as a Director of VOCAL and Upward Mobility, and the guardian of a person in receipt of a direct payment, left the room and took no part in consideration of the item.

5. Recommendations from the Health and Social Care Grants Review Programme 2019

On 10 August 2018, the Joint Board had agreed the grants prospectus and associated process for the Health and Social Care Grants Review Programme 2019. The programme opened to applications on 20 August 2018 and closed on 1 October 2018. The report advised the Joint Board of the recommendations from the Health and Social Care Grant Programme 2019/20 to 2021/22.

Part of the programme agreed in August 2018 was an innovation fund of £100,000. The Chair ruled in terms of Standing Order 11.1.1 that this matter should be reconsidered due to due to a material change in circumstances, following completion of the grant application process.

Decision

1) To agree to incorporate the funding associated with the health improvement fund (HIF) and advice into the Edinburgh IJB grant programme.

2) To agree the recommended grant allocations, and:

   i) To instruct the IJB Chief Officer to work with organisations previously funded, but who had been unsuccessful in their grant application, to ensure that service users facing a loss of service were offered appropriate alternative support;

   ii) To instruct the IJB Chief Officer to work with organisations as above to assist with identifying alternative funding sources or restructuring as appropriate;

   iii) To request that successful grant applicants prioritise working with service users affected by grant cessation;

   iv) To use the final integrated impact assessment to inform the work above;

   v) To instruct the IJB Chief Officer to provide progress reports on the points above

3) To delegate responsibility to the Chief Officer to issue grants in line with these recommendations subject to further financial assurance checks.

4) To require that the Chief Officer did not at this time institute the process for the Innovation Fund and to issue grants in line with the recommendations of the Grants Review Steering Group.

5) To establish a collaborative forum to engage with the Third Sector to jointly develop a programme of community led support.

Declarations of Interest

Councillor Ian Campbell declared a non-financial interest in this item as a Trustee of The Alma Project, left the room and took no part in consideration of the item.

Christine Farquhar declared a non-financial interest in this item as a Director of VOCAL and Upward Mobility, and the guardian of a person in receipt of a direct payment, left the room and took no part in consideration of the item.

Ella Simpson declared a non-financial interest in this item as a Director of EVOC.

(References – Edinburgh Integration Joint Board, 10 August 2018 (item 3); report by the Chief Finance Officer, submitted.)

6. Minutes

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board of 28 September 2018 as a correct record.

7. Sub-Group Minutes

Updates were given on Sub-Group and Committee activity.

Decision

1) To note the minute of the meeting of the Audit and Risk Committee of 16 November 2018.

2) To note the minute of the meeting of the Strategic Planning Group of 12 October 2018.

8. Rolling Actions Log

The Rolling Actions Log for 14 December 2018 was presented.

Decision

1) To agree to close the following actions:

(a) Action 1 – Annual Accounts 2016-17

(b) Action 6 – Carers (Scotland) Act 2016

(c) Action 9(1) – 2018/19 Financial Plan

(d) Action 12 – Appointments and Review of Sub-Groups

(e) Action 13 – Rolling Actions Log

(f) Action 17(2) – Evaluation of 2017/18 Winter Plan and Winter Plan 2018/19

(g) Action 19 – Public Bodies Climate Change Duties

2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log – 14 December 2018, submitted.)

9. Draft Edinburgh IJB Strategic Plan 2019-2022

The draft Edinburgh Integration Joint Board Strategic Plan 2019-2022 was submitted and details were provided about its development and content. The overarching Strategic Plan was informed by the work of the Strategic Planning Group to develop the vision, values and priorities for the Joint Board and to agree the cross cutting themes.

Decision

1) To approve the draft plan and appendices and to agree that they could be published for consultation.

2) To agree that the final plan would be reviewed for approval subject to the three month official period of consultation.

3) To agree the engagement plan for the consultation.

4) To agree that a final plan would come back to the February 2019 meeting of the Joint Board with Directions linked to finance, with clear options for the Joint Board to deliberate.

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

10. Carer (Scotland) Act 2016

An update was provided on the pilot in the North-West Locality which started in April 2018 and ran for six months to test new ways of working across partners, team communication, eligibility criteria, assessment of young/adult carers and the allocation of services and funding. Details were also provided of the new business and financial systems developed to support the pilot outcomes.

Decision

1) To endorse the approach taken to the development and testing of the eligibility criteria and Adult Carers Support Plan as the basis for finalising a set of eligibility criteria that the Board would be asked to approve.

2) To thank Kirsten Adamson for her work on the project.

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

11. Baseline Workforce Plan

The Edinburgh Health and Social Care Partnership's inaugural Baseline Workforce plan was submitted. The Plan provided details of current workforce capacity and workforce planning methodology.

Decision

1) To note the Edinburgh Health and Social Care Partnership's inaugural Baseline Workforce plan

2) To note the proposed workforce planning methodology going forward.

3) To note the relevance in connection with financial and service planning arrangements.

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

12. Transitions for Young People with a disability from children's services to adult services Edinburgh Health and Social Care Partnership

Details were provided of the development of the provision of support and planning for young people with a disability. Five actions were outlined that were intended to improve this process for all young people with a disability.

Decision

1) To note and agree the five key action points in relation to young people.

2) To request an update on progress of the five key action points in 12 months.

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

13. Strategic Assessments – New Practices and Re-provision Schemes

The Joint Board's support was sought for the submission of the Strategic Assessments for New Practices and Re-provision Schemes to NHS Lothian Capital Investment Group for consideration by NHS Lothian in the Capital Prioritisation Programme 2019/20.

Decision

1) To note that the new practices and re-provision schemes were identified as priority areas for investment in the Population Growth and Primary Care Assessment 2016-2026, which was supported by the Integration Joint Board on 22 September 2017.

2) To note that a Strategic Assessment was the first part of the Scottish Capital Investment Manual Guidelines with which health boards must comply to inform the Scottish Government of any intended investment proposal.

3) To note that the scored Strategic Assessments had been produced following workshops with the relevant stakeholders for consideration as part of NHS Lothian's Capital Prioritisation Programme 2019/20 in December 2018.

4) To note the Strategic Planning Group considered and agreed the report would go forward to the Edinburgh Integration Joint Board.

(References – Edinburgh Integration Joint Board, 22 September 2017 (item 10); report by the IJB Chief Officer, submitted.)

14. 2018/19 Financial Position

An overview of the financial position for the period to October 2018 and the year end forecast was provided. The conclusion of the financial recovery plan was also provided.

Decision

1) To note that delegated services reported an overspend of £6.7m for the period to the end of October 2018, and that this was projected to rise to £10.3m by the end of the financial year.

2) To acknowledge that ongoing actions were being progressed to reduce the predicted in year deficit to achieve a year end balanced position, but to note that no assurance could be given of the achievement of break even at this time.

3) To remit the Chief Officer, supported by the Chief Finance Officer, to continue to work with colleagues from the City of Edinburgh Council and NHS Lothian to identify options for achieving year end balance.

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

15. Governance Review

The findings and recommendations from the independent review of the governance of the Integration Joint Board were provided, as commissioned by the Chief Officer.

Decision

1) To agree in principle all recommendations in the report, noting there would be resource implications for their full implementation

2) To agree to prioritise the development of a Governance Handbook as set out in the report and task the Chief Officer with the procurement of support to do this within a limit of £30k.

3) To task the Chief Officer to bring a costed action plan in response to the wider recommendations, and a timeline for its implementation, back to the February 2019 meeting of the Joint Board, noting at this stage that there was potential to fund this from a number of sources, including the uncommitted reserves and this would be presented alongside the costed plan

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

16. IJB Records Management Plan

The draft Records Management Plan (RMP) was submitted. The RMP was prepared in compliance with the requirements of the Public Records (Scotland) Act 2011.

Decision

1) To note the report.

2) To delegate scrutiny and oversight responsibilities of the IJB RMP and its associated Improvement Plan to the IJB Audit and Risk Committee.

3) To approve the draft RMP (and associated evidence).

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

17. Performance Report

An overview was provided of the activity and performance of the Edinburgh Health and Social Care Partnership (EHSCP) and certain set aside functions of the Joint Board. An overview of performance covering key local indicators and national measures to the end of September was also provided.

Decision

1) To note the performance of EHSCP and IJB against a number of indicators, both local and national, for the period to September 2018.

2) To agree that a briefing note on actions being taken with regard to sickness absence and financial implications would be circulated to members.

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

18. Additional Investment in Community Capacity in Edinburgh

The Joint Board was asked to issue a direction to the City of Edinburgh Council in respect of additional care at home capacity.

Decision

To remit the Chief Officer to issue the direction to the City of Edinburgh Council.

(Reference – Edinburgh Integration Joint Board, 28 September 2018 (item 8); report by the Chief Finance Officer, submitted.)

19. IJB Risk Register

The IJB Risk Register was submitted, following agreement at the June 2018 meeting that it would be reviewed by the Joint Board every six months. Details were

provided of the processes which were being established to manage, mitigate and escalate risks.

Decision

1) To note the continued development of the IJB risk register and associated action plan.

2) To note that the latest version of the register was scrutinised by the Audit and Risk Committee on 16 November 2018.

3) To note that the Audit and Risk Committee had requested the inclusion of two additional risks.

(References – Edinburgh Integration Joint Board, 15 June 2018 (item 5); report by the IJB Chief Officer, submitted.)

20. Sandra Blake

Decision

To record the Joint Board's thanks to Sandra Blake, who had stepped down from her role on the Edinburgh Integration Joint Board.

Item 4.2.1 - Minutes

Edinburgh Integration Joint Board
Professional Advisory Group

10.00am Tuesday 20 November 2018
Diamond Jubilee Room, City Chambers, Edinburgh

Present:
Colin Beck (Chair), Mike Ash, Robin Balfour, Carl Bickler, Sheena Borthwick, Chris Brannan, Colin Briggs, Andrew Coull, Helen Faulding-Bird, Helen FitzGerald, Amanda Fox, Mark Grierson, Belinda Hacking, Kirsten Hey, Sylvia Latona, Angus McCann, Sandra McNaughton, Nickola Paul and Linda Nicol Smith.

Apologies:
Alasdair FitzGerald, Catherine Mathieson, Alison Meiklejohn, Tracy Sanderson and Linda Nicol Smith.

1. Note of the meeting of the Integration Joint Board Professional Advisory Group meeting of 27 September 2018 and Matters Arising

Decision

To approve the minute of the meeting of the Edinburgh Integration Joint Board Professional Advisory Group of 27 September 2018 as a correct record.

2. Note of the meeting of the Edinburgh Integration Joint Board of 28 September 2018 and Matters Arising

Decision

To note the minute of the meetings of the Edinburgh Integration Joint Board of 27 September 2018.

3. Strategic Commissioning Plan

Colin Briggs, Director of Strategic Planning, and Nickola Paul, Programme Business Manager, Strategic Planning, introduced the overarching Strategic Commissioning Plan, highlighting the vision and values on which the Plan was based, the key enablers to delivering the plan and the timeline. There had been lots of engagement in 2018 and it was hoped that this would continue.

Decision

To thank Colin Briggs and Nickola Paul for the presentation and to note the update.

4. Draft Outline Strategic Commissioning Plan – Mental Health

Colin Beck gave details of the Mental Health Commissioning Plan, Edinburgh Thrive, which was focused on the following workstreams:

- Building Resilient Communities
- A Place to Live – for example, Graded Support: making sure the environment "fits" the person's needs
- Get Help When Needed – fewer beds in acute hospital, more community based provision delivered in partnership
- Closing the Inequalities Gap
- Rights in Mind – for example, peer-led self-help groups and Meeting Treatment Gaps.

During discussion, the following points were raised:

- Prison work was included in the Plan.
- In terms of work with women, the aim was to move away from institutions.
- GPs would have to be involved in the consultation.

Decision

To note the presentation.

5. Draft Outline Strategic Commissioning Plan – Older People

Details were provided of the Commissioning Plan for older people, Ageing Well. This plan focused on keeping people well at home for as long as possible, making sure people were aware of what services were available and how to access them, particularly through work with Social Care Direct, ensuring community-based services were working together and as efficiently as possible, supporting the future of long-term care and exploring and defining requirements for bed-based models of care in the future.

Decision

To thank Andrew Coull and Nickola Paul for the presentation and to note the update.

6. Draft Outline Strategic Commissioning Plan – Learning and Physical Disabilities

Mark Grierson and Angus McCann provided details of the Commissioning Plans for Learning and Physical Disabilities. The Learning Disability plan covered the redesign of the Royal Edinburgh Hospital and was focused on earlier intervention in childhood and smoother transitions from child to adult services, identification of a range of housing and support options for people with learning disabilities, self-directed support and integrated services.

The Physical Disabilities plan would look at the importance of accurate person-centred multi-disciplinary assessment, having clear criteria around services, person-centred goal setting, in-reach and outreach work and workforce training.

Decision

To thank Mark Grierson and Angus McCann for the presentation and to note the update.

7. Draft Outline Strategic Commissioning Plan – Primary Care

Nickola Paul gave an outline of the Primary Care Commissioning Plan, which was shaped around the National Primary Care outcomes framework developed by Scottish Government, and also informed by the Primary Care Improvement Plan.

Decision

To note the update.

8. Long Term Conditions Programme

Amanda Fox, Programme Manager, presented details of the Long Term Conditions Programme, which supported localities to improve care and support for people living with long-term health conditions and those at risk of falls, and provided improvement and implementation support for health and social care practitioners to translate principles into practice. The Programme workstreams cut across all Strategic Commissioning Plan groups – Older People, Primary Care, Mental Health and Disabilities.

Decision

To thank Amanda Fox for the presentation and to note the update.

9. Next Meetings

- Tuesday 8 January 2019 (Diamond Jubilee Room, City Chambers)
- Thursday 7 March 2019 (Mandela Room, City Chambers)
- Tuesday 28 May 2019 (Diamond Jubilee Room, City Chambers)
- Tuesday 23 July 2019 (Mandela Room, City Chambers)

Rolling Actions Log February 2019

Item 5.1

8 February 2019

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
1	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	March 2019	A report on the programme of Development Sessions for 2019/20 will be presented in March 2018.
2	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	March 2019	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
3	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	February 2019	**Recommended for closure** – on the agenda for 8 February 2019.
4	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	February 2019	**Recommended for closure** – this is covered in the Transformation and Change Programme report on the agenda for 8 February 2019.
5	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. 2) To instruct officers to remit the report to the Integration Joint Board and Corporate Policy and Strategy Committee for further scrutiny.	Chief Officer, Edinburgh Health and Social Care Partnership	March 2019	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
6	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	March 2019	Report will be submitted in March 2019.
7	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	November 2018 February 2019	1) **Closed** – covered at the IJB Development Session on 6 November 2018. 2) **Recommended for closure** – this is included in the Finance Update report on the agenda for February 2019.
8	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	Chief Officer, Edinburgh Health and Social Care Partnership	February 2019	**Recommended for closure** – this is covered in the Transformation and Change Programme

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			development session or at a formal meeting on the assessment project.			report on the agenda for 8 February 2019.
9	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	March 2019	Report will be submitted in March 2019.
10	IJB Risk Register	15-06-18	That the Chief Officer would circulate a briefing note to members on finance structures across the City of Edinburgh Council and NHS Lothian, and the interface between the respective groups.	Chief Officer, Edinburgh Health and Social Care Partnership	April 2019	
11	Publication of Annual Performance Report	15-06-18	That a future development session or workshop would consider what measurements to include in future versions of the report, and how these would be linked with Directions.	Chief Officer, Edinburgh Health and Social Care Partnership	June 2019	A report on the programme of Development Sessions for 2019/20 will be presented in March 2018.
12	2018/19 Financial Position	29-09-18	1) To task the Chief Officer to prepare a Direction to the City of Edinburgh Council in relation to the additional £4m of funding being made available by	Chief Officer, Edinburgh Health and	February 2019	**Recommended for closure** –

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			NHS Lothian in respect of increasing capacity of care at home services. 2) To agree that a report would be presented to the next meeting of the Joint Board detailing the proposed Direction and the early and initial impact of the use of this funding in relation to key areas of pressure.	Social Care Partnership	December 2018	completed in December 2018.
13	Evaluation of 2017/18 Winter Plan and Winter Plan 2018/19	28-09-18	1) That a business case for the expansion of the Hospital at Home service would be presented to the Joint Board by the end of March 2019. 2) That officers would circulate details of the flu vaccination programme to enable members to promote to citizens, colleagues and partner organisation.	Chief Officer, Edinburgh Health and Social Care Partnership	March 2019 October 2018	**2) Closed –** circulated on 8 October 2018
14	John's Campaign	29-09-18	To request an update report in 12 months' time on progress in carrying out the recommendations of the report: 1) To agree that all hosted older peoples in bed services formally sign up to John's campaign.	Chief Officer, Edinburgh Health and Social Care Partnership	September 2019	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
			2) To agree that all local authority care homes sign up to John's campaign. 3) To work in partnership with the independent sector and the voluntary sector to embed John's campaign across all older people's residential services within the Edinburgh. 4) To support the launch of John's campaign in Edinburgh. 5) To agree that the benefits of John's Campaign should be formally measured.			
15	Recommendations from the Health and Social Care Grants Review Programme 2019	14-12-18	To agree to instruct the IJB Chief Officer to provide progress reports on the work with organisations previously funded, but who had been unsuccessful in their grant application, and how service users and the organisations were being supported.	Chief Officer, Edinburgh Health and Social Care Partnership	March 2019	Report will be submitted in March 2019.
16	Draft Edinburgh IJB Strategic Plan 2019-2022	14-12-18	To agree that a final plan would come back to the February meeting of the IJB with Directions linked to finance, with clear options for the IJB to deliberate.	Chief Officer, Edinburgh Health and Social Care Partnership	June 2019	

No	Subject	Date	Action	Action Owner	Expected completion date	Comments
17	Transitions for Young People with a disability from children's services to adult services Edinburgh Health and Social Care Partnership	14-12-18	To request an update on progress of the 5 key action points in 12 months.	Chief Officer, Edinburgh Health and Social Care Partnership	December 2019	
18	Governance Review	14-12-18	To task the Chief Officer to bring a costed action plan in response to the wider recommendations, and a timeline for its implementation, back to the February IJB meeting, noting at this stage that there was potential to fund this from a number of sources, including the uncommitted reserves and this would be presented alongside the costed plan.	Chief Officer, Edinburgh Health and Social Care Partnership	February 2019	**Recommended for closure** – on the agenda for 8 February 2019.
19	Performance Report	14-12-18	To agree that a briefing note on actions being taken with regard to sickness absence and financial implications would be circulated to members.	Chief Officer, Edinburgh Health and Social Care Partnership	March 2019	

Item 5.2

Report

Impact of Audit Scotland Report Health and Social Care Integration on Edinburgh Integration Joint Board
Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) which underpins the formal integration of health and care in Scotland was intended to ensure that health and social care services are integrated in order that people receive the care they need at the right time, in the right setting, with a focus on community-based, preventative care. The act requires Councils and NHS Lothian boards to form new partnerships known as Integration Authorities (IAs). New public bodies were also created as Integration Joint Boards (IJBs).

2. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. To do this, IJBs were set up and the legislation sets out that these IAs should as a minimum include delegated resources to enable good organisational governance, planning, and the resources for the delivery of services delegated to them including social care, primary and community healthcare and unscheduled hospital care for adults.

3. Audit Social published a report "*Health and Social Care Integration – Update on Progress*" on 15 November 2018. The aim of the audit was to "explore the impact public bodies were having on integration of health and social care services". This is the second of three planned audits into the delivery of integration in Scotland.

4. The Audit Scotland report highlights areas where integration is working well and six areas where improvements are required.

5. This report gives an overview on the findings and sets out actions being taken across the Edinburgh Integration Joint Board (EIJB). It also notes that several recommendations from the Audit Scotland report are the responsibility of other organisations and, where possible the action plan sets out current knowledge of actions being taken by them, or where these will be discussed.

Recommendations

6. The Integration Joint Board is asked to:

   i. Note the findings from the Audit Scotland report (Appendix A);

   ii. Note those activities, currently underway in Edinburgh which relate to actions in the Audit Scotland report as set out at Appendix B;

   iii. Note the actions on other organisations as set out in the report and in doing so, direct the Chief Officer to work with both NHS Lothian, the City of Edinburgh Council and Scottish Government to undertake a scoping across the Audit Scotland report findings in relation to its impact and requirements for action in Edinburgh; and

   iv. Request that the Chief Officer report on actions being taken across all organisations in support of the recommendations in the Audit Scotland report in relation to the Edinburgh Integration Joint Board and request a further report on this to come to the Audit and Risk Committee in six months.

Background

7. Integration Authorities have been in place since 2016 and oversee approximately £9 billion of health and social care resources across Scotland.

8. Audit Scotland carried out an audit "to examine the impact that public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014". The main audit questions were:

   - What impact is integration having and what are the barriers and enablers to change
   - How effectively are IAs planning sustainable, preventable, and community-based services to improve outcomes for local people
   - How effectively are IAs, NHS Boards and Councils implementing the reform of health and social care integration
   - How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact

9. Audit Scotland acknowledged through their review that IAs are delivering services in a more collaborative way, however they continue to operate in a challenging environment with financial planning not as streamlined as it could be. It identified that further work was needed within the strategic planning and collaborative leadership field. Governance arrangements and data sharing also needed to be streamlined. Attached is the full report at Appendix A

10. Appendix B sets out a table which details the recommendations from the report and highlights the responsible agency for delivery. It also sets out some current actions being taken in Edinburgh which demonstrate activity in those areas of focus. In respect of the work in Edinburgh this is not a definitive list and it is anticipated that more activity will need to be scoped.

Main report

11. The report recognised that IAs were enabling jointed up and collaborative working which are leading to improvements in performance, however there is a recognition that further work is needed to fully integrate health and social care services. Some of the key barriers are noted below:

- The level of savings required make it difficult for IAs to deliver service redesign with many IAs struggling to achieve financial balance at the year-end. Partner organisations are also working with annual settlements which is making it difficult to develop financial planning in the medium and long term.

- Some delegated services which should be delegated haven't been which will continue to hinder the IJB's ability to change the system. Also compounding this issue is the "set -aside budgets".

- To deliver the level of transformation needed in health and social care, the right leadership and strategic capacity needs to be put in place. Leaders will require support to succeed in improving wider outcomes and work collaboratively across organisational boundaries.

- Ensure that priorities are linked to available resources and demonstrate that new ways of working are sustainable in the longer term and show through commissioning plans how they are shifting from current service to future service re-design.

- Workforce pressures are also a barrier to the implementation of integration.

- Housing services are also essential for the delivery of person centred approaches.
- Having clear governance structures are vital to ensure clear responsibility and accountability for service performance and the quality of care.
- Sharing of information is a vital part of providing effective care that is integrated from the point of view of the people who use services.
- Ensuring engagement with the third and independent sector is valued and acted on.

12. Integration Authorities are addressing some significant issues within the health and social care landscape and introducing more collaborative ways of delivering services, however there is much more to be done to fully integrate health and social care services. Audit Scotland have identified that the following recommendations will go some way to unblock some of the barriers to delivering integration:

    1. Commitment to collaborative leadership and building relationships
    2. Effective strategic planning for improvement
    3. Integrated finances and financial planning
    4. Agreed governance and accountability arrangements
    5. Ability and willingness to share information
    6. Meaningful and sustained engagement

13. The above noted recommendations have actions that need to be delivered by a range of partners, including Scottish Government, COSLA, NHS Boards, Local Authorities, and Integration Authorities. Attached at Appendix B is the actions identified and some of the actions being taken in Edinburgh to resolve some of the barriers.

14. Chief Officers from East, Mid, West Lothian and Edinburgh will work with NHS Lothian and Edinburgh City Council and other relevant parties to scope and understand their response to the recommendations and an update report will come back to Audit and Risk Committee in six months.

Key risks

15. The key risks to fully achieving integration is that the recommendations noted above are not achieved.

Financial implications

16. There are no immediate financial implications arising from this report however there may be implications as possible actions are scoped.

Implications for Directions

17. There are no implications for directions arising from this report.

Equalities implications

18. There are no equalities implications arising from this report.

Sustainability implications

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

Involving people

20. Any action plan arising from the findings of this report will include engagement and consultation with key stakeholders.

Impact on plans of other parties

21. There will be no impact on plans of other parties.

Background reading/reference

Report author

Judith Proctor

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Appendices

Appendix A	Audit Scotland Report - Health and Social Care Integration – Update on Progress
Appendix B	Recommendations

Appendix A

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
November 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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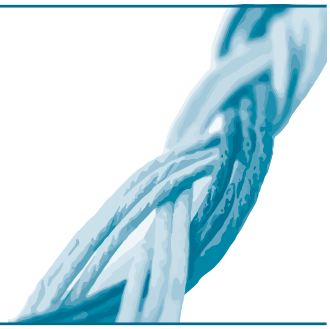

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Links

PDF download

Web link

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of Leigh Johnston, Neil Cartlidge, Christopher Lewis and Lucy Jones, under the direction of Claire Sweeney.

Key facts

Savings Integration Authorities needed to achieve in 2017/18

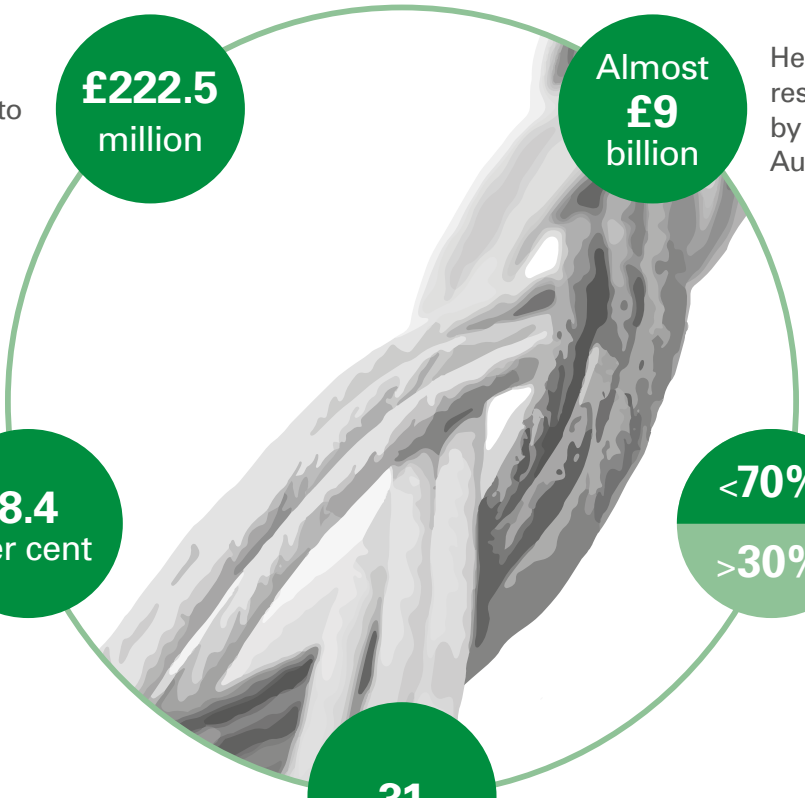
£222.5 million

Almost **£9 billion**

Health and social care resources directed by Integration Authorities

Increase in required savings from 2016/17

8.4 per cent



<70%

>30%

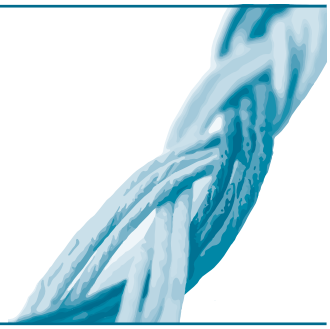
Integration Authority funding comes from the NHS

Funding comes from local authorities

31

Integration Authorities established through partnerships between the 14 NHS boards and 32 councils in Scotland

Summary



Key messages

1 Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

2 Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

3 Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4 Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

- ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA
- monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

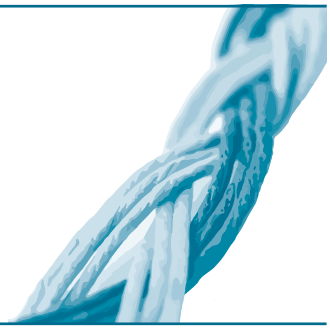
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement

Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.

Introduction



Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) (Exhibit 1, page 9). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our short guide.

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

About this audit

4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.[1] Appendix 1 (page 41) has more details about our audit approach and Appendix 2 (page 42) lists the members of our advisory group who provided help and advice throughout the audit.

What is integration? A short guide to the integration of health and social care services in Scotland

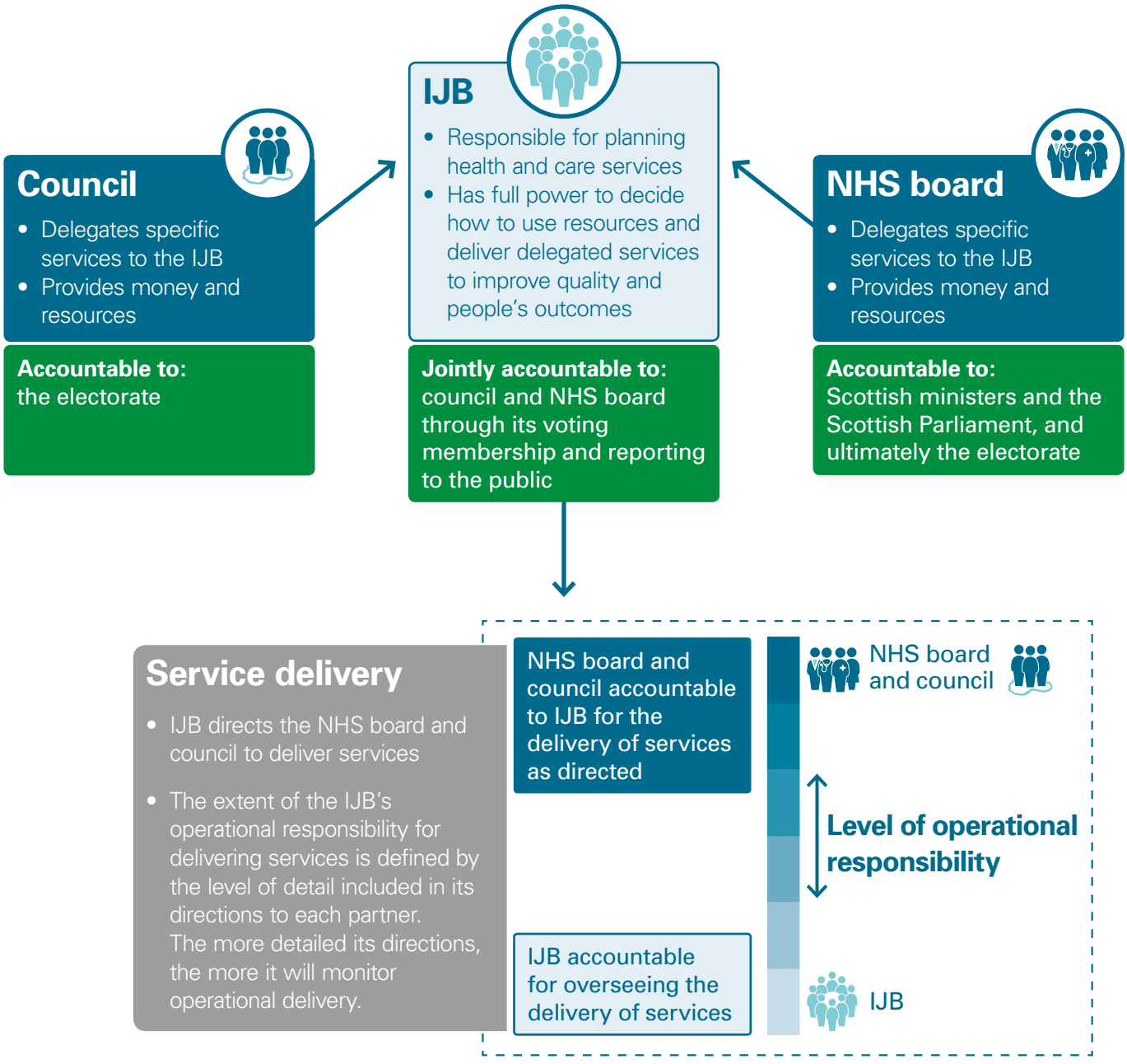
the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.[2] We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1

Integration Joint Boards

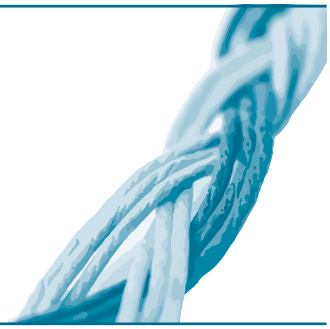
There are 30 Integration Joint Boards across Scotland.



Source: Audit Scotland

Part 1

The current position



Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils (Exhibit 2, page 11). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

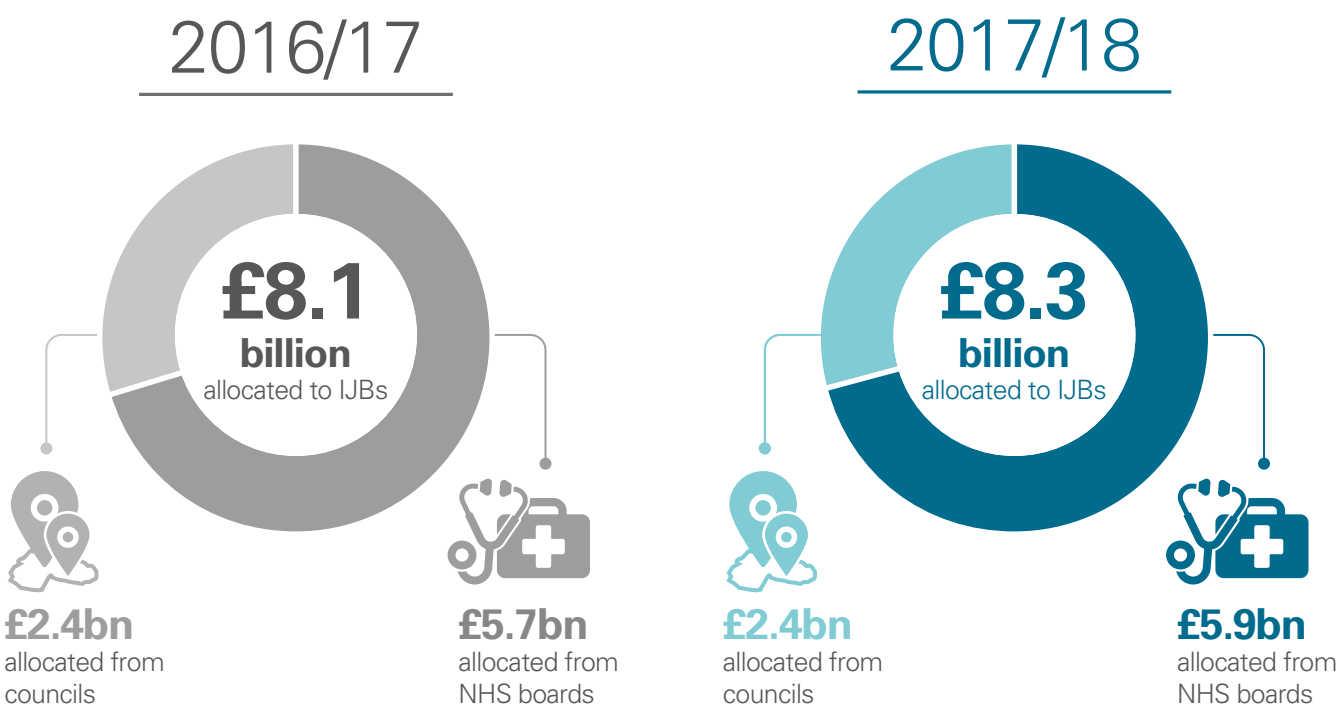
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

there is evidence that integration is enabling joined up and collaborative working

Exhibit 2

Resources for integration

IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.

Source: Audit Scotland, 2018

Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in Part 2 (page 23). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.[4] However, this masks a much more complex picture of IJB finances. Appendix 4 (page 47) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

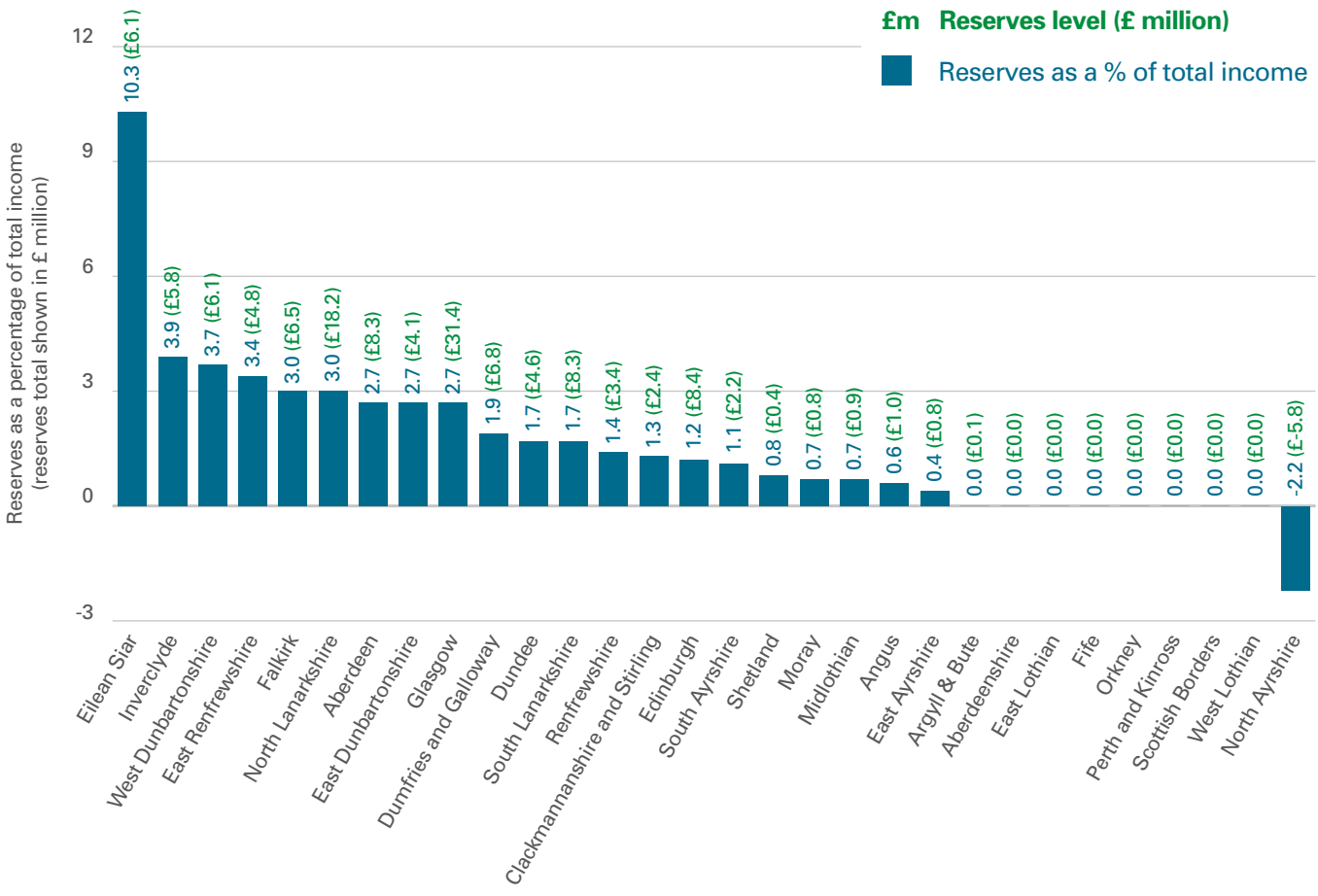
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (Exhibit 3). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Source: Integration Authority annual accounts, 2017/18

Hospital services have not been delegated to IAs in most areas

18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in *NHS in Scotland 2018*, the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.[5] We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.[6]

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress (Exhibit 4, page 16). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.[7]

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs (Exhibit 5, page 18). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target (3a and 3b at Exhibit 5, page 18).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4

Health and wellbeing outcomes and indicators

A significant number of measures are being used to monitor local and national progress.

National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

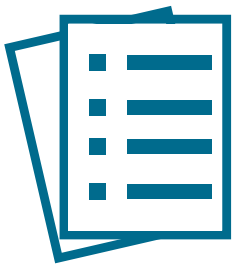
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender equality, reduced inequalities, responsible consumption and production, good health and wellbeing

9 national health and wellbeing outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- 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
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services

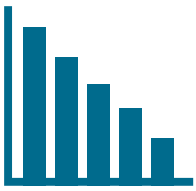
Cont.

Exhibit 4 (continued)



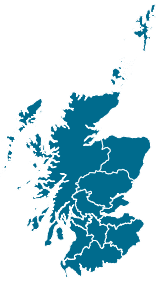
12 principles within the Act

- Be integrated from the point of view of the people who use services
- Take account of the particular needs of service users in different parts of the area in which the service is being provided
- Respect rights of service users
- Protect and improve the safety of service users
- Improve the quality of the service
- Best anticipate needs and prevent them arising
- Take account of the particular needs of different service users
- Take account of the particular characteristics and circumstances of different service users
- Take account of the dignity of service users
- Take account of the participation by service users in the community in which service users live
- Is planned and led locally in a way which is engaged with the community
- Make best use of the available facilities, people and other resources



6 national indicators

- Acute unplanned bed days
- Emergency admissions
- A&E performance (including four-hour A&E waiting time and A&E attendances)
- Delayed discharge bed days
- End of life spent at home or in the community
- Proportion of over-75s who are living in a community setting



Various local priorities, performance indicators and outcomes

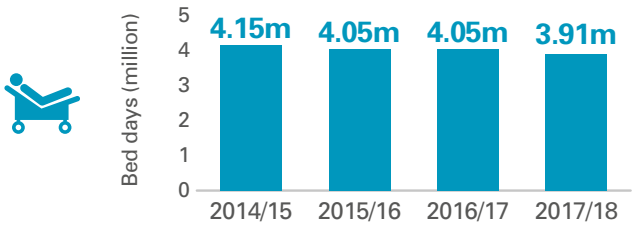
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

National performance shows signs of improvement in some of the six key national indicators.

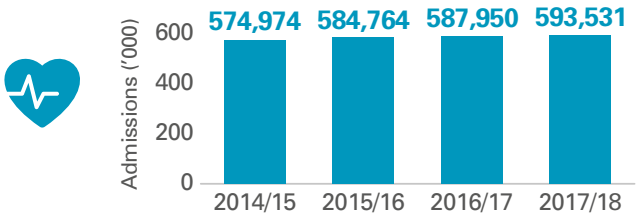
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

The number of acute unplanned bed days has reduced since 2014/15

2. Emergency admissions

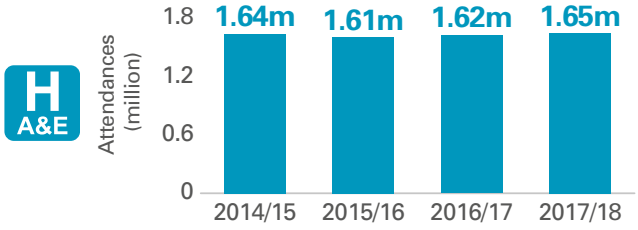


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

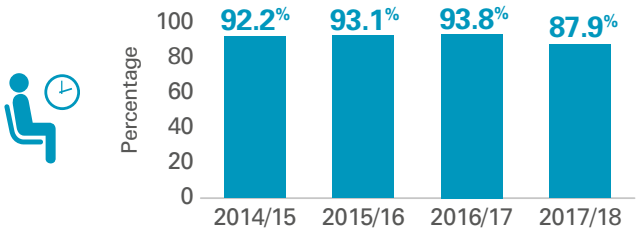


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

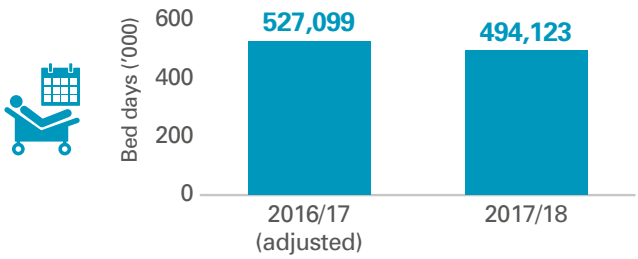
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

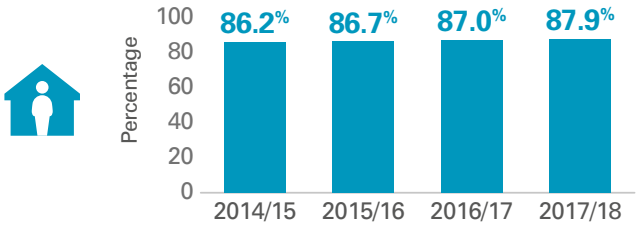
Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Cont.

Exhibit 5 (continued)

5. End of life spent at home or in the community

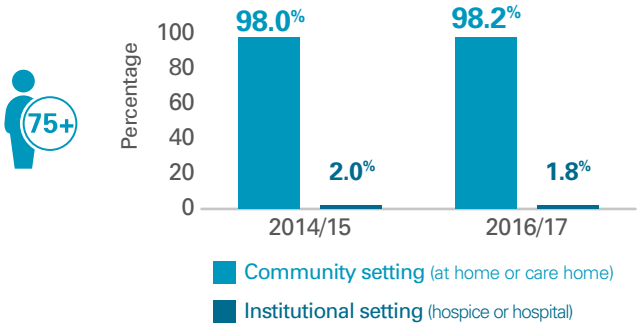


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1
1. These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The specialty of geriatric long stay is excluded.
2. Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
6. Based on data submitted to ISD in August 2018.

Indicator 2
1. ISD published data as at September 2018.

Indicator 3a
1. ISD published data as at August 2018.

Indicator 3b
1. ISD published data as at June 2018.
2. Performance for the month ending March for each year.

Indicator 4
1. ISD published data as at September 2018.
2. 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5
1. ISD published data as at October 2018.

Indicator 6
1. Percentage of 75+ population in a community or institutional setting:
   - Community includes the following:
     - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
     - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
     - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
   - Institutional includes the following:
     - Average population in hospital/hospice/palliative care unit throughout the year.
     - Hospital includes both community and large/acute hospitals.
     - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
2. Figures provided by ISD.

General
1. Population figures used taken from the National Records of Scotland mid-2017 estimates published in 2018.
2. Figures relate to all ages unless otherwise stated.

Source: Information Services Division (ISD) and Scottish Government

Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives (Exhibit 6). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.

Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.

Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Cont.

Exhibit 6 (continued)

Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs .

Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Cont.

Exhibit 6 (continued)

Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.

Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

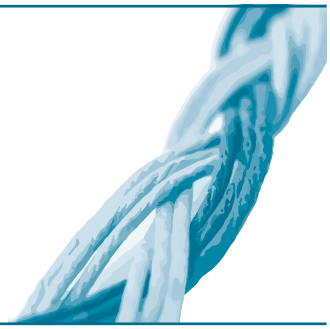
Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

Source: Audit Scotland review of Integration Authorities' Performance Reports, 2018

Part 2

Making integration a success

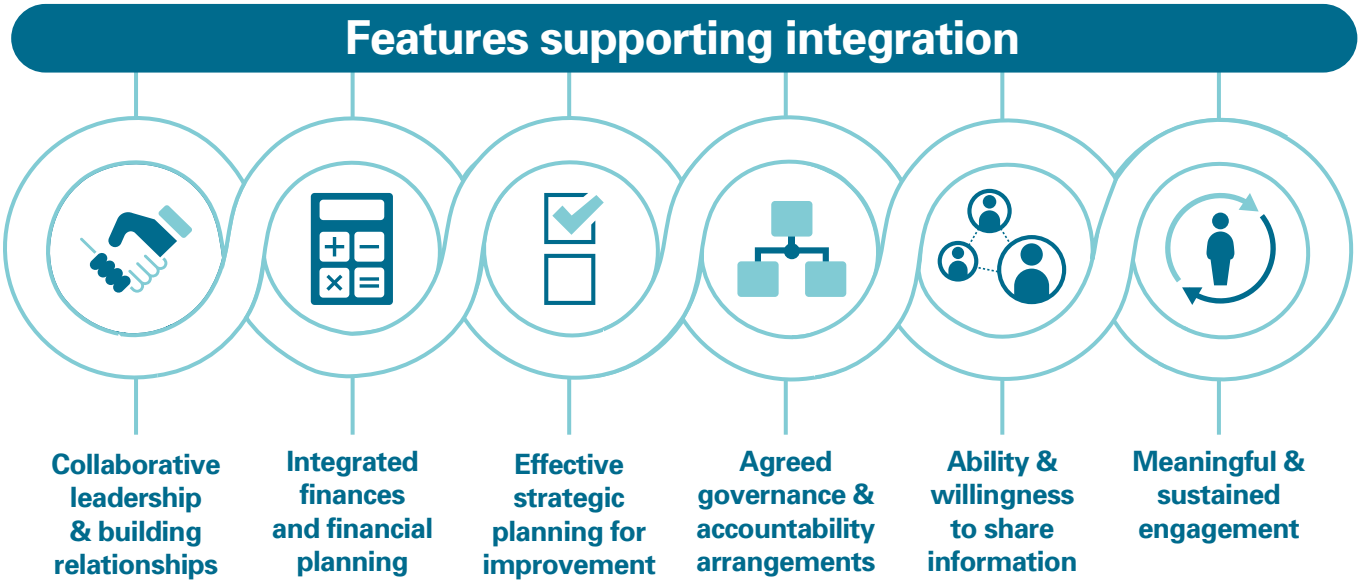


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities (Exhibit 7).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.

- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.

- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment…They change the mind-set from competition to cooperation. They foster dialogue… which can result in new thinking… When leadership involves such a collective endeavour, the way people see their accountability matters.'[8] A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. Exhibit 8 (page 25) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8

Traits of effective collaborative leaders

There are a number of leadership traits which are important in integrating health and social care services.

Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services

Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges

Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care

Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive

Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

Source: Audit Scotland, 2018; from various publications by The Kings Fund; Our Voice; Scottish Government; Health and Sport Committee and the Scottish Social Services Council.

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.

What is integration?
A short guide to the integration of health and social care services in Scotland

IJB membership
(page 10)

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions (Case study 1, page 28).

Case study 1

Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people's outcomes (Case study 2, page 29).

Case study 2

Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.

ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.[9] In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[10] We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. Case study 3 illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3

The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.[11] IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 (Exhibit 9, page 32). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[12] The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

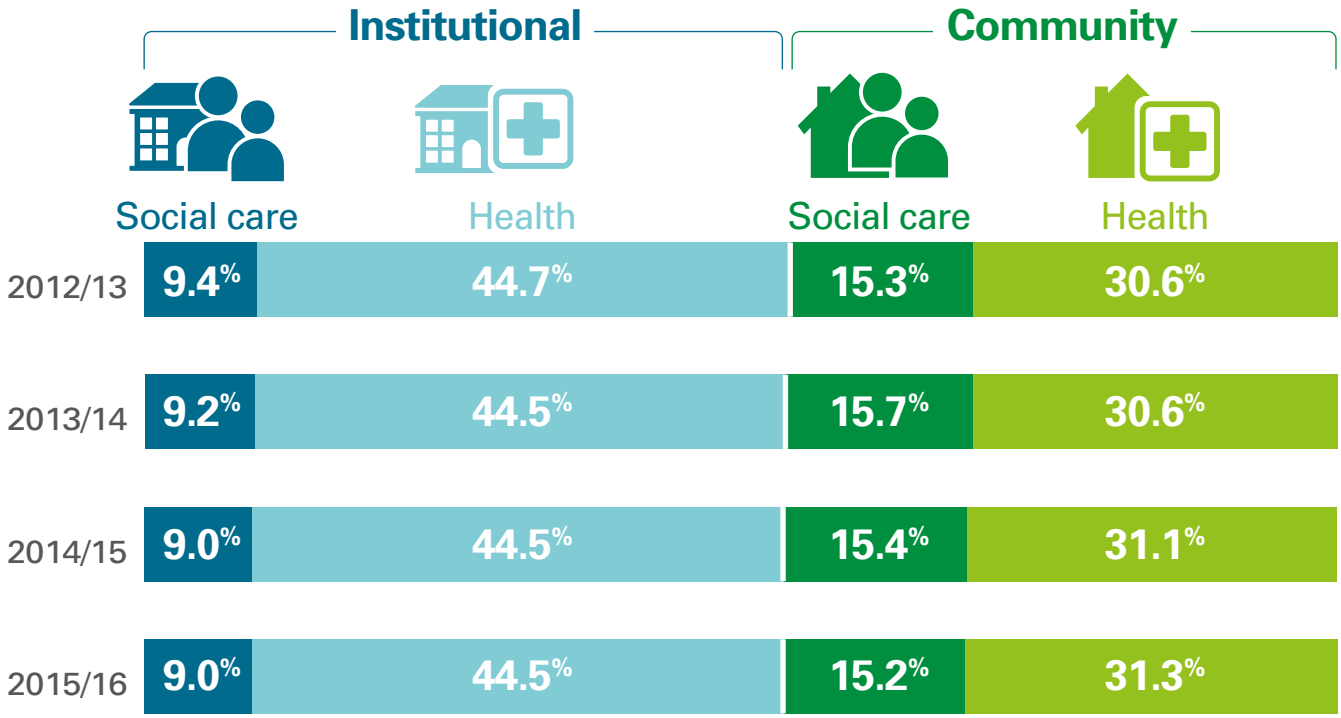
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018

55. Major reforms have benefited from a degree of 'pump priming' money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs' efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change (Case study 4, page 33). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4

South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice…This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community (Case study 5). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery (Case study 6, page 36).

Case study 5

Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6

Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities (Case study 7, page 39). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7

Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

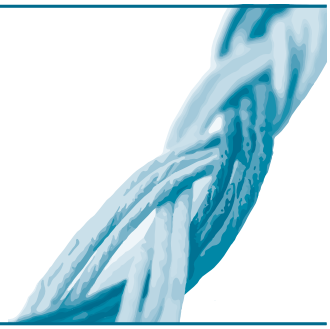
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.

Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.[13] The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



1 More details about the joint inspections are available at the Care Inspectorate website.

2 *Health and social care integration*, Auditor General and Accounts Commission, December 2015.

3 *English local authority reserves,* Chartered Institute of Public Finance and Accountancy, June 2015.

4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.

5 *NHS in Scotland 2018*, Auditor General, October 2018.

6 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

7 National Performance Framework, Scottish Government, June 2018.

8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.

9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

10 *NHS workforce planning*, Auditor General, July 2017.

11 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
  - Chief Officers and Chief Finance Officers
  - Chairs and vice-chairs of IJBs
  - NHS and council IJB members
  - Chief social work officers
  - IJB clinical representatives (GP, public health, acute, nursing)
  - IJB public representatives (public, carer and voluntary sector)
  - Heads of health and social care, nursing, housing and locality managers and staff
  - NHS and council chief executives and finance officers
  - IT, communications and organisational development officers.

Appendix 2

Advisory group members

Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations

Recommendations	Progress
Scottish Government should:	
• work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this: – work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.	IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.
• monitor and publicly report on national progress on the impact of integration. This includes: – measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans – reporting on how resources are being used to improve outcomes and how this has changed over time – reporting on expected costs and savings resulting from integration.	We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way. The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level. The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.
• continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches. There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB.	There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – how the IA will contribute to delivering high-quality care in different ways that better meets people's needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act.	IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.
• develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively.	There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	Progress
Integration Authorities should work with councils and NHS boards to:	
• recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.
• review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners.	We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process. At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.
• establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services.	We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	**Position** (pre-additional allocations) **Overspend/** (underspend)	**Additional allocation/ (reduction)** **Council**	**NHS board**	**Use of reserves**	**Year-end position Deficit/ (Surplus)**
	(£million)	(£million)	(£million)	(£million)	(£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	2.2	0.6	0.6	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.
Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

Update on progress

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Appendix B – Recommendations			
Audit Scotland Action	**Current Edinburgh IJB Activities Relating to Recommendations**	**Responsible Organisation(s)**	**Timescales**
Commitment to collaborative leadership and building relationships			
Ensuring there is appropriate leadership capacity in place to support integration	- Further scoping as part of the agreed Governance Review of the EIJB - Executive Team and wider team development to be scoped and plans	**1. Scottish Government** **2. COSLA**	
Increase opportunities for joint leadership development across health and social care system to help leaders to work more collaboratively together	- Chief Officers Network (Lothian and Scotland wide) - Work with Kings Fund	**1. Scottish Government** **2. COSLA**	
Effective strategic planning for improvement			
Ensure operational plans including workforce, IT and organisational change plans across the system are clearly aligned to the strategic priorities of the IA	- Workforce baseline plan in development under the 6 steps methodology - Review of organisational structures undertaken and new posts of Head of Operations and Head of Strategy and Performance in place - Strategic Plan has been reviewed and will go to consultation - Strategic Transformation Plan to be agreed and implemented – paper to come to IJB in February	**1. Integration Authorities** **2. Local Authorities** **3. NHS Boards**	
Monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014	- Duty of Best Value understood and an element of internal and external audit processes	**1. Integration Authorities** **2. Local Authorities** **3. NHS Boards**	
Ensure there is a consistent commitment to integration across government departments and in policy	- Regular meetings with Scottish Government Officials - IJB demonstrates this through its planning, revision of its Governance and in its regular review of its	**1. Scottish Government**	

Appendix B – Recommendations			
Audit Scotland Action	**Current Edinburgh IJB Activities Relating to Recommendations**	**Responsible Organisation(s)**	**Timescales**
affecting health and social care integration	performance as well as the publication of its Annual Performance Report - IJB targets in relation to the 6 Ministerial Strategic Group measures ('MSG 6')		
Integrated finances and financial planning			
Commit to continued additional pump priming funds to facilitate local priorities and new ways of working which should progress integration		**1. Scottish Government**	
Urgently resolve the difficulties with "set aside" aspects of the Act	- From an IJB perspective EIJB continues to review its use of set aside and the CO and team engage regarding planning of these services - NHS Lothian provides the EIJB with clear information on our proportionate use of these services and budget	**1. Scottish Government** **2. COSLA**	
Support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have a greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care	- Development of budget setting protocol which supports a longer term integrated approach to budget setting. - Medium term financial plan in development alongside a recast transformation programme for Edinburgh.	**1. Integration Authorities** **2. Local Authorities** **3. NHS Boards**	
View finances as a collective resource for health and social care to provide the best possible outcomes for people who need support	- Development of budget setting protocol. - Close links with partner organisation finance links - Regular partnership performance meetings with CEOs from NHSL and CEC, their Director/Head of Finance and the CO and CFO to the EIJB	**1. Integration Authorities** **2. Local Authorities** **3. NHS Boards**	

Appendix B – Recommendations			
Audit Scotland Action	**Current Edinburgh IJB Activities Relating to Recommendations**	**Responsible Organisation(s)**	**Timescales**
Agreed governance and accountability arrangement			
Support Councillors and NHS Board Members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.	- Rollout of IJB induction - Good Governance Institute review of the EIJB's governance and action plan in response to this	1. Scottish Government 2. COSLA	
Agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.	- NHSL and CEC are required to undertake a review of the Integration Scheme	1. Scottish Government 2. COSLA 3. Local Authorities 4. NHS Boards 5. Integration Boards	
Ability and willingness to share information			
Monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.	- Memorandum of Understand (MOU) in place between Council and NHS Lothian	1. Scottish Government 2. COSLA	
Share learning from successful integration approaches across Scotland	- Links with Kings Fund and other Scottish Chief Officers - Engagement with other HSCPs in relation to models and activity we might learn from	1. Scottish Government 2. COSLA 3. Local Authorities 4. NHS Boards	

Appendix B – Recommendations			
Audit Scotland Action	**Current Edinburgh IJB Activities Relating to Recommendations**	**Responsible Organisation(s)**	**Timescales**
		5. Integration Boards	
Address data and information sharing issues, recognising that in some cases, national solutions may be needed.	- IT key workstream of Primary Care - Improvement Plan - Work ongoing to develop new case management tool.	**1. Scottish Government** **2. COSLA** **3. Local Authorities** **4. NHS Boards** **5. Integration Boards**	
Review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in future. They should also ensure mechanisms are in place to collect and report on this data publicity		**1. Scottish Government** **2. COSLA** **3. Local Authorities** **4. NHS Boards** **5. Integration Boards**	
Meaningful and sustained engagement			
Continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered	- Development of Strategic Plans -December IJB through reference groups who developed outputs.	**1. Local Authorities** **2. NHS Boards** **3. Integration Authorities**	

Item 5.3

Report

Update on the Progress Review of Older People's Services

Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. The purpose of this report is to provide an update on the outcome of the progress review of Older People's services in Edinburgh Health and Social Care Partnership (EHSCP). The report provides detail of the proposed approach for taking forward the 17 recommendations made in the inspection report May 2017, which includes an updated improvement plan with clear links to the partnership's transformation and change programme.

Recommendations

2. The Integration Joint Board is asked to:

   I. Note the findings of the Progress Review of Older People's Services in Edinburgh which took place during June and July 2018.

   II. Note the EHSCP's plans to align the areas for improvement set out in the progress report through a new strategic transformation model designed to take the focus away from short term, reactive planning to long term sustainable change.

   III. Agree that the report and action plan will be overseen by the Edinburgh Integration Board (EIJB) and its revised governance structures.

Background

3. In May 2017, the Care Inspectorate and Healthcare Improvement Scotland published their joint inspection findings on older people's services In Edinburgh. The purpose of the joint inspection was to find out how well the partnership achieved good personal outcomes for older people and their unpaid carers. The report made 17 recommendations.

4. It is normal practice, within joint inspections, that where a grade of 'weak' is applied, that the inspection team returns within a year to review the levels of

progress made against each recommendation. The review visit is not a further inspection and no new recommendations are set. The progress review visit took place during June and July 2018 and the progress report was finally published in December.

Main report

Progress Review Findings

5. The review highlighted some areas of reasonable or good progress but on the whole there has been limited progress made against the majority of the recommendations.

6. The review recognised good or reasonable progress has been made around improvements to the falls pathways, our joint approach to developing robust quality improvement and assurance systems and processes and also around ensuring risk assessments and management plans are recorded appropriately and were informed by relevant agencies in statutory adult support and protection cases.

Actions, Improvement and Key Updates since the Review Visit

7. The partnership welcomes the feedback from the report and also recognises that the review took place at a time of significant change in the IJB and HSCP and the findings will allow for an opportunity for the HSCP to consider the improvements required as part of the wider transformation and change programme.

8. At the time of the initial inspection, the partnership developed an improvement plan to address the areas for improvement. This was refreshed by the Interim Chief Officer in September 2017 and this formed the basis of the evidence submitted to the inspection team as part of the progress review.

9. Since the review visit the HSCP has placed significant focus on addressing some of its key challenges in performance and now have clear trajectories of improvement for delayed discharges which are monitored closely. There has been a consistent improvement in meeting these targets since they were agreed.

10. In addition, there has been a marked reduction in the number of delays in NHS Lothian acute beds and the number of people waiting for an assessment has also reduced.

11. There have also been significant improvements in relation to people waiting for a Package of Care across NHS Lothian acute sites.

12. The additional investment of funding towards community care capacity has begun to be applied and providers are reporting positively. The additional capacity will support the targeting of delays as well as supporting older people in the community to remain at home.

13. Progress has been made around strategic planning and the development of our Outline Strategic Commissioning Plans, including Older People. In relation to engagement and participation, involving over 750 people in the development of our strategic plans was recognised by Audit Scotland as good practice.

14. Work in collaboration with carers and carer organisations to develop an updated Carers Strategy are progressing and will include how carer's needs are identified, assessed and met. The strategy should be ready for ratification by the IJB early 2019.

15. The first workforce plan has been developed following a '6 step' methodology and a cross system workforce planning group has been established to oversee the workstreams and development.

16. An independent review of the governance arrangements in the partnership has been commissioned and if agreed, the actions will strengthen the strategic leadership and direction and provide the support to deliver a new transformation and change programme in support of the longer term vision and sustainability of the HSCP.

17. The Older People's Working Group (OPWG) have agreed the workstreams to support post diagnostic dementia support , this includes supporting the post diagnostic support service, the National Innovation Test Site in North East Edinburgh (to test the relocation of post diagnostic support in primary care) and scope and support the implementation of improvements to dementia assessment and service pathways.

18. The EHSCP is committed to working towards continual improvement in these areas.

Approach to Improvements

19. It is recognised that the review visit took place at a time of significant change in the partnership. The appointment of a new Chief Officer in May 2018 and a new Head of Operations in June 2018 has allowed for the opportunity to review and refresh the approach to addressing improvement and its wider strategic and transformational change.

20. The progress review reported that the HSCP had failed to take a strategic approach with regards to the improvement plan and the approach taken to address the improvements was more reactive and short term rather than being part of a whole systems approach, with the focus being on individual

recommendations rather than delivering an overall programme of improvement. The recasting of the action plan seeks to ensure a more strategic approach to improvement.

21. A proposal setting out a recasting of the EHSCP's strategic transformation model and vision is also on the IJB's agenda today for consideration. This sets out the plans to reshape the model aligned to the wider revised transformation programme under the '3 conversations' model. The implementation of this model would support the delivery of improvement against the inspection recommendations as part of a 'whole systems' approach and will provide longer term sustainability of good health and care services in Edinburgh.

22. The Executive Team have met with the link inspector to discuss how the partnership will address the areas of weakness set out in the report. A workshop has been arranged for January 2019 for representative from the Care Inspectorate, Healthcare Improvement Scotland and the Executive Team to look at this proposed approach to support the delivery of improvement against the 17 recommendations and the feedback from the progress review.

Key risks

23. The quality of the services we deliver is closely linked to performance and resource, and where some improvements can be made through improved compliance with procedure, the risks will remain if the HSCP is unable to bring the financial position into balance and identify any additional resource requirement to drive forward improvement.

Financial implications

24. The level of unmet need across services and the resource required to make improvements in the areas highlighted will without doubt have significant cost implications to the partnership. This will be a consideration in the partnership's five year sustainable financial plan which will have clear links to the strategic plan and will underpin the '3 conversations' model.

Implications for Directions

25. No directions are required in relation to this update.

Equalities implications

26. The progress review highlights areas of unmet need across services in Edinburgh which is likely to impact on health inequalities for service users.

Sustainability implications

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

Involving people

28. The partnership values the input from service users and third and voluntary sector organisations and is committed to involving the appropriate representatives in the proposed transformation and change model workstreams.

Impact on plans of other parties

29. There is no impact on plans of other parties.

Background reading/references

Edinburgh Health and Social Care Partnership Progress review of joint inspection of older people's services

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/joint_inspections_adults/edinburgh_city_dec_18.aspx

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Appendices

Item 5.4

Report

Transformation and Change – Developing the Edinburgh Model
Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. This report sets out proposals for the further development of the Edinburgh Integration Joint Board's (EIJB) transformation programme and seeks agreement to ring-fence funding from within Integration Joint Board (IJB) reserves to support this ambitious programme of change.

Recommendations

2. The Integration Joint Board is asked to:

   i. Agree the case for change as set out in this paper and to the direction set out for transformation and change within the Edinburgh Health and Social Care Partnership (EHSCP);

   ii. Agree to ring-fence £2m non-recurring funding from reserves to support and fund the change programme;

   iii. Task the Chief Officer with developing further the programme structure and programme support as outlined in the paper;

   iv. Note that the governance reporting of this programme will develop in parallel to the wider IJB governance development agreed at the IJB meeting on the 14th of December 2018; and

   v. Agree regular updates on the development of the programme.

Main report

Introduction

3. It is widely acknowledged that we face unprecedented challenges to the sustainability of our health and care system: resource availability cannot continue to match levels of demand; the population is ageing, and we are facing a

reduction in the working age population which compounds the challenge in workforce supply as never before in recent memory. It is clear that our health and care system must change and must find new ways to meet these challenges. Health and care integration must be a key mechanism to address this.

4. Locally, we know we need to increase the pace and focus for our transformation and change efforts as a Health and Social Care Partnership (HSCP) to address some pressing areas of underperformance – Delayed Discharge, people waiting for care, assessment, and review. But, even more importantly we must increase our efforts as they relate to the wider change in demand, demographics and to create and build a sustainable, high quality health and care system for the future in this city.

5. We have an opportunity to recast our offer to the public as an organisation and shape our services to be fit for the 21st Century. This will involve us thinking and acting in radically different ways and in reframing our relationship with the public, our partners, and our staff to deliver a new Edinburgh model of care and support across the city.

6. The IJB is ambitious and supportive of this agenda. This paper builds on the planning work to date and sets out proposals for a streamlined programme structure for delivering real transformation, proper involvement of our partners and stakeholders, alongside a refreshed decision making and governance process that will enable and ensure decision making at the right level and for clear escalations of decisions that can and should only be made at the IJB. There is an opportunity now to ensure alignment of this transformation with our Strategic Planning ambitions and the next iteration of the draft Strategic Plan.

7. Overall the ambitious aim is to improve outcomes for people and communities and to reshape a health and care system fit for a sustainable future.

Key Aims and Ambitions

8. It can be useful, in refocussing our work, to recall the intent and purpose of the policy and subsequent legislation which brought about the integration of health and social care, Integration Joint Boards and Health and Social Care Partnerships.

9. Far more detail is set out in the legislation and guidance but, summarised, the integration of health and social care was set out to reshape and rebalance the whole health and care system in Scotland, with a specific vision. This was, that by working together and collectively we would be able to create new and sustainable services which keep people independent and well for as long as possible and, where services are needed, they are delivered at or as close to home as possible and are sustainable within a reducing public finance envelope.

10. It was recognised that we face unprecedented change in our health and care system; budgets are under pressure; the population is ageing, and we are facing a reduction in the working age population which compounds the challenge in workforce supply as never before in recent memory. Our health and care system must change and must find new ways to meet these challenges. Health and care integration is seen as a key mechanism to address this.

11. IJBs were set up in order to change the patterns of behaviour, planning and delivery across health and social care and, in large part, to achieve change through a more disruptive approach; deliberately setting strategy, planning and then, utilising delegated budgets directing and commissioning the NHS and Local Authority Partner organisations toward delivering more joined up, community-based models and in doing so, utilising resources 'locked' in traditional silos.

12. Key to delivering these changes is a different approach to working with people, communities, and the professionals within our organisation. We must focus on reducing and reshaping demand, improving people's health, wellbeing, and independence and in supporting professionals and teams to work in a far more joined up and integrated approach than we have ever achieved before. Audit Scotland in its report *Health and Social Care Integration*[i] emphasises the significant shift in the delivery of services required of Integration Authorities toward wellbeing and preventative approaches and shifting care from being hospital based toward the community-based services.

13. We now have an opportunity, in Edinburgh to create a health and care system that's fit for the future and which supports a radical shift in our relationship with the community and which enables and delivers a deeper partnership with our communities and our 3rd and independent sectors. In doing this we need to unlock the resources that are 'stuck' in outmoded forms of institutional care and enable this to be spent on community facing and embedded care and support models. In doing this, we create the capacity for change, a fairer distribution of resources and a more sustainable future for health and care in Edinburgh.

Need for Change

14. The case for integration has been set out in detail in the range of guidance and the economic case which accompany the legislation. The national challenge is also clear:

- Around 2 million people in Scotland have at least one long-term condition;
- 1 in 4 adults in Scotland has a long-term illness or disability;
- People in Scotland are living longer, but more of those people over the age of 75 are living with at least one long-term condition and/or significant frailty; and

- Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years[ii].

15. The Scottish Government estimates that the need for health and care services will rise by between 18% and 29% between 2010 and 2030. Coupled with a shrinking working age population and the known workforce supply challenges, it is clear the current model of health and care cannot be sustained and that it must change. The emphasis of change is toward more preventative and anticipatory approaches and those that are increasingly community-based with acute services being used only when there is no alternative and for as short a period as necessary and safe.

16. Audit Scotland undertook an early review into the changes being brought about through the integration of health and social care in its paper of March 2016. The report; *Changing Models of Health and Social Care*[iii] set out the challenge of increasing demand for services and growth over the next 15 years in Scotland. Among the pressures identified in this were:

- A 12% increase expected in GP consultations;
- A 33% increase in the number of people needing homecare and a 31% increase in those requiring 'intensive' homecare;
- A 35% increase in demand for long-stay care home places; and
- A 28% increase in acute emergency bed days and a 16% increase in acute emergency admissions.

17. These are all areas that we recognise in Edinburgh and our strategic planning work and this transformation and change programme need to consider our need to address these pressures. But we do so against a context of local challenge:

- Increasing pressure in primary care and an ambitious programme of development under the new General Medical Services Contract and our Primary Care Improvement Plan;
- Increasing demand for home care as we develop a future model alongside workforce supply issues in relation to recruitment and retention in the care market. In Edinburgh we have significant and well publicised challenges in availability of home care largely driven by the high cost of living in the city and the generally buoyant economy and jobs market. This has contributed to the challenges we have faced in areas of poor performance around delayed discharge and long waits for care in the community for people;

- Increasing demand for care home places but more beds closing and care homes reporting significant fragility in their operating model;

- Challenge of realising any efficiencies achieved from reducing bed days as we remain an over consumer of these services due to the number of beds days lost to delays.

18. The Audit Scotland report went on to say that based on these estimated increases in demand, the Scottish Government would need an increased annual investment of between £422 and £625 million in health and social care services in order to keep pace. That level of increased investment is simply not available. However, it is against this backdrop of increasing demand and decreasing budgets that the EIJB has had to develop its Strategic Plan and its transformation and change programme.

19. Transformation and change is necessary to make an impact in several directions:

- Absorbing these expected increased demands in the short to medium term with no corresponding increase in base budgets;

- Creating a significant shift in the balance of care and shift in the way people access advice, support, and services to continue to deliver within a reducing budget and with recognised workforce supply challenges;

- Activities and change to reduce demand, increase preventative approaches and promote resilience and wellbeing in the medium to long term;

- Improving people's experience of health and social care services and their health and wellbeing outcomes;

- Changing and developing a new culture within a brand-new organisation and in doing so create new roles, teams, and functions to enable us to meet the challenge;

- Improving the partnership's performance against local and national outcome measures; and

- Development and delivery of savings and efficiency programmes that ensure duty to balance the overall budget at year end.

20. In making these decisions and in taking forward these plans it must also be recognised that change at this scale and development of new models will take time. We may be rightly ambitious to make improvements quickly and in some areas we will. However, we must also be realistic regarding timescales to achieve the scope of change we plan.

21. Change at this scale and at the pace we want to achieve will require dedicated capacity alongside our professionals', teams' and partner engagement and leadership of the programme and its key projects.

22. In doing this, we have an opportunity to bring together and streamline the significant work that has taken place in the EHSCP over recent months and develop a single programme platform to include:

- Delivery mechanism for our Strategic Commissioning plans and ambitions;
- Improvement planning following the joint Inspection report for Older People's Services and associated action plan;
- Financial savings and efficiencies programme.

Key Performance Impacts

23. In the short term, we wish to make clear and sustainable impacts in areas of our current poor performance. Specifically, we know we need to:

- Reduce the number of people delayed in hospital when fit to go home (Delayed Discharge) in time we want to significantly reduce delayed discharges and be ambitious to meet standards around people getting home within 72 hours of being medically fit for discharge;
- Reduce length of stay and bed days lost to delays;
- Reduce unplanned admissions and re-admissions into acute hospitals;
- Reduce number of people waiting for an assessment and the length of time people wait for an assessment – in time we want waiting lists to be a thing of the past through new approaches to the 'front door' and by front loading our first contact with people into an intervention;
- Enable appropriate care capacity to meet needs with timely reviews to ensure we do not over provide for some, and thus be unable to provide for others – **in time we want to work differently and reviews of where people are will change;**
- We want a highly engaged, motivated, and supported workforce, able to utilise the full extent of their professional training and skills. We want to support and nurture high functioning teams that make the most of the skills across this organisation.

Planning to Date

24. A great deal of work has taken place and some of our market shaping ambitions are already set out in the Outline Strategic Commissioning Plans. While these are very useful in setting out our intentions in relation to the sorts of services we will wish to procure across condition specific groups, they will not, as and of themselves, deliver the scale and breadth of transformation we require in our system to both improve current levels of performance, and reshape and transform for the future

25. To that end we must reframe our planning to date within a wider programme of change and set out the investment and resource necessary to deliver this. Finally, we must set out the activities and actions under each and the anticipated impact and measures.

The Approach

26. The proposals for transformation and change within health and social care should be set out against a framework of best evidence of what works in changing health and social care and within principles for best practice in the planning and implementation of new care models. Having said that we must also recognise that there is a dearth of evidence of what works in health and social care integration and as such we need to take a pragmatic approach, using evidence where available but taking managed risk in areas where there is less evidence or in terms of testing good ideas.

27. Principles and approaches set out in the Audit Scotland report '*Changing Models of Health and Social Care'* - Learning from the use of the previous *Reshaping Care for Older People* Change Fund is useful here and the model set out there suggests a focus on:

- Development of a clear business plan detailing timescales, resources, costs, and estimated savings/efficiencies;
- A smaller number of significant models in priority areas and do these well, rather than trying to change too many things at once;
- Allowing sufficient time to test new ways of working and to gather the evidence of what works; and
- Basing models around small, local areas or clusters with groups of staff that know the local population.

28. We propose simplifying our overarching strategic vision and aligning current change and improvement work to a simplified and re-cast programme management approach.

29. This approach – the "3 Conversations" – engages our citizens in a clear and consistent relationship based upon the offer we are able to make alongside their own engagement and investment in their own health and wellbeing (where possible). It aims to establish a co-productive relationship in supporting wellbeing and reducing dependency on the health and care institutions and focus the resources within the system to those who most need them.

30. It is proposed that this '3 Conversations' model is adopted and that this used as a framework for radical, transformative change. In its application, the 3 Conversation model sets out a way of services working with people at the earlier possible point, thereby minimising the need to move further into the system with the intent to support – where possible – the individual to achieve early independence from services and therefore reduce the likelihood for more resolve.

31. The elements to the models are:

    1. Conversation 1 – Listen and Connect

    This element focusses our efforts in relation to Wellbeing, Prevention and Independence, Access and Community Capacity Building.

    2. Conversation 2 – Intensive Work with People in Crisis

    This is where we focus our short term, acute and reablement efforts with people. We will align this with our development of Acute Care at Home and in respect of change work in relation to intermediate care, and our bed base across the City.

    3. Conversation 3 – Build a Good Life

    In this work programme we will develop and further our activity in relation to longer term care and support, complex care and support needs, longer term accommodation and bed-based care as well as opportunities for new housing and support models.

Programme Governance and Structure

32. **Appendix 2** sets out a proposed programme structure with current and future workstreams and enablers mapped across it. Programme Boards will be set up under the senior leadership of a member of the EHSCP's Executive Team and a principle of engagement and participation with partners in the 3rd sector, professionals and clinicians, independent sector, and others, as appropriate – this is shown in **Appendix 1**. Given changes proposed following the review of the IJB's governance as set out in the Good Governance Institute report agreed at the December 2018 IJB, consideration will be given as to appropriate reporting and scrutiny of the programme.

Future Vision - 2020

33. The EIJB Strategic Plan has been reviewed and the Change and Transformation Programme will also be subject to ongoing review and evaluation. However, we must set an agreed direction of travel and a programme that will grow in momentum toward a vision for 2020 and beyond. Some of this is set out in the short and medium-term plan approved by the IJB in May 2018 but a recast of this is proposed here that refines statements of our ambitions and sets out realistic and achievable metrics for improvement.

34. The vision must build over time and upon our ambitions set out in the initial Strategic Plan and any revisions of this;

- We must redouble our efforts to improve **outcomes and experience** for people and we will strive to continue our **performance improvement** impact;

- We will focus on the **cultural change** required in line with our integrated approach and building on shift toward **community-based services, fully integrated teams** and the sorts of **good conversations** and **good relationships** that create and support **high performing teams;**

- This will be delivered through our **Locality Based Approach** and we will build on our approaches to truly integrated working and ensure these are fit for purpose, add value and are simple to access for citizens, and operate in for professionals and clinicians. These will ensure our offer and input is asset based, focussed on independence and wellbeing, and is predicated on supporting people to live at home or in a homely environment for as long as possible;

- We will have a clearly set out plan across those services that we deliver in house and the added value we gain from the higher cost of their delivery. Specifically, we will set out clear parameters and criteria for the use of **in-house home care** being focussed on areas of pressure for people and our partnership. This may support initial **care and support at home on discharge from hospital for people with more complex care** which in turn, will support more stability within external partner provision and reduce emergency readmissions to acute hospital care;

- Our **Locality Leadership** will be working in a co-productive way with communities and neighbourhoods and our third sector partners, supporting approaches to building **community capacity and resilience** that will support us in increasing community-based solutions to increasing demand, social isolation and availability or alternative supports;

- Recognition that services will be supporting a very different population at home with increasing levels of complexity and frailty – as such our community services – especially our **Hospital at Home** model – will be evaluated at scale and proposals for its sustainability come to the IJB;

- Related to this and our ongoing and significant improvement in use of Acute Services we will make more **efficient use of the Acute Sector** and only those with acute medical needs that cannot be cared for in a community setting occupying an acute bed. We will continue to work to prevent admission, divert referrals and ensure speedy discharge for those admitted for treatment and who are ready to go home. In doing so we will be able to **realise the efficiencies we have created and utilise the large set aside budget** toward investing in and sustaining community-based health and care capacity;

- Our **Community Links Worker** programme will be evaluated and be making a difference in supporting people who may otherwise utilise GP or other healthcare or statutory services. We anticipate this impacting loneliness and isolation; supporting our ambitions to signpost people to community services or other forms of community and self-support; and supporting greater family and personal resilience as well as reducing reliance on public services. This will be of benefit in our most **disadvantaged communities**;

- We will consider and review our approach to **Technology Enabled Care (TEC)** ensuring that more people can access this preventative support and stay at home safely. Coupled with this we will continue in our work to identify safe and effective approaches as an alternative to sleepovers;

- There will be a continuing relationship with housing colleagues both within City of Edinburgh Council and with our Registered Social Landlords and we'll develop **housing approaches** to meet the needs of people with complex needs in our communities. This will continue the work we've started on **repatriating those with complex needs** who are cared for out of region and support us in managing a good transition across Children's Services and into Adult Services for young people;

- Our **Localities** will have matured and developed and we'll be realising the benefits of single teams, reduced duplication and streamlining of effort. Teams will be better able to predict need, prevent crises and manage people with more complex needs within the skill mix and resources available in the locality;

- Our **Strategic Plan** and our work with **3rd and Independent Sector Providers** will recalibrate our relationship with providers of care across

the City. We will be working in a more co-productive way with them on the development of our next iteration of the care at home contract and through this maximising **re-enablement approaches, locality commissioning opportunities and self-directed support;**

- We will review our **bed base** within the health and social care partnership, ensuring that the care home service we provide and those within our (non-acute) hospital base are at a level we need and where we need them;

- We will continue to develop new approaches to **Primary Care** and deliver the IJB's vision for a long-term programme of change, delivering a modern, resilient model with a multi-professional, integrated approach, underpinned by greater collaboration and delivery at locality level and underpinned by **technological solutions, predictive and anticipatory approaches, and prevention**

35. While doing all of this we will continue to build the IJB's confidence, capability, and risk appetite to ensure good, robust governance, strategic direction, performance management and scrutiny, putting in place actions in response to the recent governance review.

Resources

Programme management team

36. This transformation represents a significant shift in the paradigm of our "offer and delivery" of health and social care services. Consequently, a change of this scope and scale will need resource to deliver. It's clear that a huge amount of activity is currently underway but also clear that there are some gaps in the project support in place.

37. Overall it is also suggested that there is a gap in leadership and management of this as a *programme* of work that is as a unified, holistic entity made up of many projects, but focusing on the wider agreed objectives of the IJB and our strategic plan. Linked to this, there is a lack of clarity in terms of how significant pieces of work are scoped, proposed, approved, planned and the resources and Executive decision-making support programmed and provided.

38. Significant inroads are also required in relation to delivering a sustainable service model and organisational size and structure in response to the ongoing financial challenges facing the partnership and focused effort and support in savings and change programmes will accelerate our ability to deliver plans.

39. A more detailed plan is in development pending the IJB's formal agreement, however this paper seeks the IJB's agreement in principle to ringfencing £2m of its reserves and to earmark this for the delivery of the change and transformation programme as set out in this paper. If approved this resource will support the

following activities and infrastructure as well as create capacity for further innovation across the programme:

- Programme Management support;
- Evaluation and analysis support;
- Engagement and participation;
- Governance support and development in line with agreed governance review;
- Infrastructure for tests of change;
- Tests of change utilising technology – capacity, capability and equipment; and
- Support for organisational development and culture change.

Delivery Support

40. Our support to deliver on a wide and complex change and savings programme is drawn currently from across the partnership and our partner agencies; the Council and NHS Lothian (NHSL). There is no single team and no clear programme management approach or governance. Coupled with this, change leadership and project management has been given to some of our operational managers at a time of wide ranging operational change and churn. Combined, this presents a twin challenge of lack of both leadership of change capacity, and reduced focus on the operational support to improve performance and address gaps in delivery. Finally, we have further recommendations from the Joint Inspection review visit to address which will also require focus within the context of the wider change and challenges set out above.

41. All of this is under review by the Executive Team as part of the recasting of the transformation plan and reviewing our operational delivery however it's clear from an overview of this that it's not a satisfactory position to be in if we want to deliver change at the scale and pace we do.

Governance

42. As set out above there is an opportunity to refocus the governance structure around a clear programme approach, evaluation model and appropriate resources.

Key risks

43. There is a risk that the IJB's approach to change and transformation is not delivered at the pace required to deliver a sustainable future model of care and support in Edinburgh.

Financial implications

44. The Board is asked to agree a use of some of its reserves to fund this transformation programme. The implication of not funding is linked to the risk set out at 43 above – non or only partial delivery of the IJB's ambitions and savings programmes.

Implications for Directions

45. The IJB will be asked to set a Direction or Directions in relation to changes as a result of this programme. There are no Directions required as an immediate result of this paper.

Equalities implications

46. The programme proposed aims to improve people's health and wellbeing and impact health inequalities.

Sustainability implications

47. The programme supports a shift toward a more efficient health and care service and would be anticipated to have a positive impact on the sustainability of the organisation as well as develop services within a community setting and closer to home.

Involving people

48. The programme would develop clear engagement and participation plans as work progresses and develop co-productive approaches with people, neighbourhoods, and localities.

Impact on plans of other parties

49. The programme will be a positive addition to wider planning across Edinburgh and the Lothians in its focus on early intervention, prevention, wellbeing and people's positive experience of health and care services.

Background reading/references

Health and Social Care Integration, Audit Scotland, December 2015 Finance Committee. 2nd Report, 2013: Demographic Change and an ageing population. Scottish Parliament 2013

[1] *Changing Models of Health and Social Care, Audit Scotland, March 2016*

Report author

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Appendices

Appendix 1	Draft Programme Scope
Appendix 2	Draft Programme Structure

[i] *Health and Social Care Integration*, Audit Scotland, December 2015
[ii] Finance Committee. 2nd Report, 2013: *Demographic Change and an ageing population.* Scottish Parliament 2013
[iii] *Changing Models of Health and Social Care,* Audit Scotland, March 2016

DRAFT SCOPE OF EHSCP TRANSFORMATION PROGRAMME

Appendix 1

8 February 2019

Scope of Programme

- The following slides set out the draft, high level scope of the revised transformation programme
- It is intended that the overall transformation programme be divided into 4 distinct programmes; 3 of these aligned to the stages of the 3 Conversations model and one to address required enablers and cross cutting areas of work
- It is anticipated that this will be a 3 – 5 year programme of change and much work is required upfront to create the resources, structures and culture for success
- Further work is in development, subject to IJB agreement to further define the detailed scope of the programme and plan its delivery
- Work will also take place to finalise membership of the governance boards, to ensure active participation from all key stakeholders

Programme Name: Conversation 1 – Listen and Connect (Access, Wellbeing and Prevention)

Implement a range of wellbeing, early intervention and prevention projects to help build individual and community capacity and resilience and to support individuals to live independently whilst avoiding the need for formal, traditional services. Review and improve access pathways, including redesign of the Social Care Direct model and improved web and digital access.

Projects and Workstreams	WELLBEING AND PREVENTION • Production of an overarching prevention strategy • Full review of grants programme and future approach • Development and implementation of the Carers' Strategy • Review of Family Group Decision Making and options to mainstream	NAVIGATING SERVICES • Develop and roll out accurate and complete community directory • Full review and redesign of "front door" access, including Social Care Direct model • Develop and roll out new digital access options

Programme Name: **Conversation 2 – Work Intensively with People (Crisis Intervention, Short Term and Acute Services)**

Programme will initiate and deliver a range of project activity which will strengthen the operation of the locality hubs, improve pathways from acute to community, enable more effective models of acute and short term care and improve interventions and outcomes for those in crisis.

Projects and Workstreams	COMMUNITY BASED CRISIS MANAGEMENT • Review of the hub operating model • Review of the Hospital at Home service • Review of community based crisis management teams • Alignment to the Flow Centre • Review and redesign of Gylemuir operating model • Review and redesign of palliative care approaches	HOSPITAL BASED CRISIS MANAGEMENT • Review of existing hospital based crisis management • Roll out of "discharge to assess"

Programme Name: Conversation 3 – Build a Good Life (Long Term Care, Complex Care, Accommodation and Bed Based Care)

Programme will oversee delivery of the Long Term, Complex and Bed Based programme, aligned to Conversation 3 in the "Three Conversations" model and to deliver a range of project activity which will improve the capacity and quality of ongoing care options and deliver better outcomes for service users.

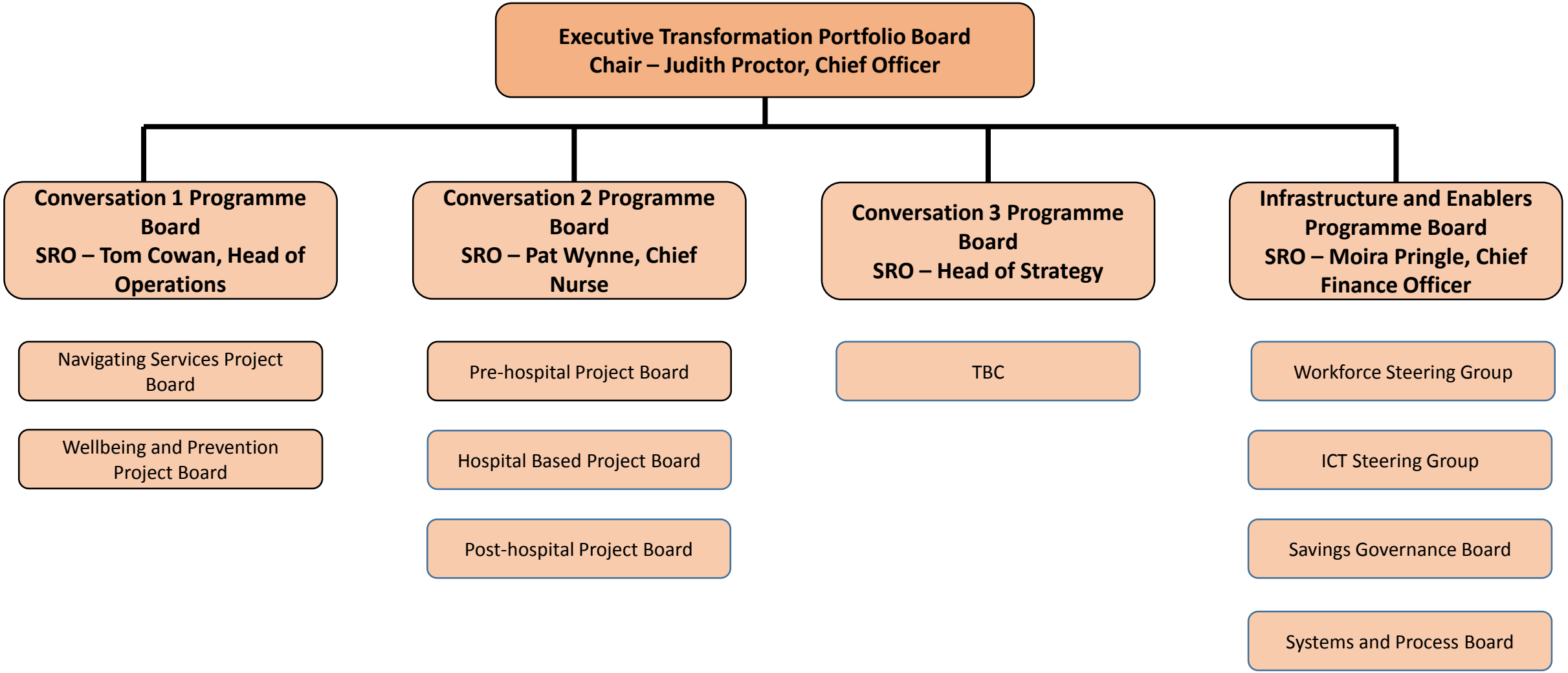
Projects and Workstreams	SUPPORTING PEOPLE TO LIVE AT HOME • Review of care at home contract arrangements • Redesign of efficient assessment and review based policies, processes and ways of working • Development and implementation of overarching strategy for night time support services • Review and redesign of key internal services, for example, day care, home care and respite	SUPPORTING PEOPLE IN BED BASED CARE • Completion of a strategic bed based review setting out future requirements and plan • Review and redesign of internal care home model • Completion of phases 2 and 3 of the Royal Edinburgh masterplan

Programme Name: Cross Cutting Enablers

Programme will ensure that key infrastructure is in place to support the delivery of the Edinburgh Health and Social Care Partnership transformation and change programme. This will include the delivery of cross cutting, enabling projects which will implement improvements in relation to workforce and organisational development, IT and data, finance and business support and key business processes.

Projects and Workstreams	DIGITAL TRANSFORMATION • Development and roll out of a business digital strategy • Development and roll out of a technology enabled care strategy, as a key enabler of prevention • Data improvement project, to include data cleansing and compliance and development of new business operating processes	WORKFORCE, CULTURE AND ORGANISATIONAL DEVELOPMENT • Development and roll out of overarching workforce strategy and plan • Development and delivery of organisational development programme • Workforce redesign, including potential introduction of flexible, generic roles	FUTURE FOCUSED HOUSING • Programme of work with key partners to ensure housing models fit for the future CHARGING POLICY • Development of a new strategic approach to charging for services

Appendix 2 - Proposed Programme Governance Structure



Item 5.5

Report

2018/19 Financial Position and Initial Outlook for 2019/20 Edinburgh Integration Joint Board

Executive Summary

1. The purpose of this report is twofold: to provide the Integration Joint Board (IJB) with an overview of the in year financial position; and to outline the indicative budget offers from partner organisations for 2019/20.

Recommendations

2. The Integration Joint Board is asked to:

   a) note that delegated services are reporting an overspend of £7.7m for the period to the end of December 2018, and that this is projected to rise to £10.0m by the end of the financial year;

   b) acknowledge that, based on ongoing discussions between the Chief Officer, Chief Finance Officer, and colleagues from the City of Edinburgh Council and NHS Lothian, moderate assurance of balanced year end position can be given;

   c) agree the proposal for the use of reserves as set out in paragraph 11; and

   d) note the indicative budget offers from NHS Lothian and the City of Edinburgh Council and the concerns raised by the Chief Officer as detailed in paragraph 14.

Background

3. A forecast overspend on delegated services of £10.1m was reported to the IJB at its meeting in September 2018. This was followed by an update in December when the figure had risen slightly to £10.2m. On both occasions, the board acknowledged the ongoing actions to reduce the predicted in year deficit and that these were not sufficient to provide assurance that a break even position would be achieved. A further update on the in year position is set out in paragraphs 5 to 13 below.

4. This baseline gap will be carried into the next financial year and, whilst neither the Council nor NHS Lothian have either finalised their own financial planning and budgeting processes or made a formal offer to the IJB, the indicative budget offers from both parties are discussed in paragraphs 14 to 16.

In year financial position

5. This report is based on the latest financial monitoring information available from the 2 partners. Cumulatively this shows an overspend of £7.7m against the budgets directed by the IJB. The equivalent projection for the end of the financial year is an overspend of £10.0m, a slight improvement (£0.2m) over the position reported to the board in December. Table 1 below summarises this, with further detail included in appendices 1 (NHS Lothian) and 2 (the Council).

	Year to date			2018/19
	Budget £k	Actual £k	Variance £k	Forecast £k
NHS services				
Core	204,647	205,689	(1,042)	(1,377)
Hosted	60,517	60,196	321	689
Set aside	66,355	68,086	(1,731)	(2,315)
Sub total NHS services	**331,519**	**333,972**	**(2,452)**	**(3,003)**
CEC services	**149,171**	**154,452**	**(5,281)**	**(7,041)**
Total	**480,691**	**488,424**	**(7,733)**	**(10,044)**

Table 1: summary IJB financial position to the end of December 2018

6. The key financial issues underpinning the position remain consistent with those previously reported, namely: care at home, progress with savings and recovery plans and set aside pressures. Further detail on each of these cost drivers is included in the December report to the board. Prescribing, which for some years has been a pressure across all 4 Lothian IJBs has stabilised reflecting the continuation of low item growth and no significant short supply effects on price. The overall forecast is currently being reviewed in line with the latest information available.

7. Progress against each of the schemes in the savings programme was reported to the board in December. This showed schemes valued at £15.4 had been identified and that forecast delivery against these projects equated to £9.7m (or 63%). This picture has not significantly changed and the Chief Officer and management team continue to review current plans to ensure robustness and sustainability as well as attempted to identify alternative in year efficiency opportunities.

8. The December report also set out the actions instigated by the Chief Officer, in line with the integration scheme, to achieve an in year break even position. This concluded that "whilst there are undoubtedly efficiencies which can be delivered in year without detriment to service provision, these are limited in the short term". In this context the Chief Officer and Chief Finance Officer were asked to continue the productive discussion with colleagues in the Council and NHS Lothian.

9. Paragraph 9.4.5 of the integration scheme states "*where a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end,*

and there are insufficient reserves to meet the overspend, then the parties may consider making additional payments to the Integration Joint Board."

10. Recognising this, a review of the reserves has been undertaken. This identified a projected balance of £7.9m at the end of the financial year as summarised in table 2 below.

	£k
Carried forward from 17/18	8,352
New provision 18/19	11,089
Allocated during 18/19	(11,542)
Total	**7,898**

Table 2: projected IJB reserves at 31st March 2019

11. Table 3 below sets out the proposed use of these reserves, based on the recommendation that they are carried forward in full to next financial year and applied as follows:

- £1.9m to be ring fenced to meet committed costs which will be incurred in 2019/20;
- £2m to support transformation as requested in a separate paper to this meeting. This would supplement the £0.8m previously agreed to support digital transformation; and
- In recognition of the scale of the financial challenge facing the IJB in 2019/20 that the balance of £3.2m is carried forward to mitigate, on a non recurring basis, the savings requirement. This is discussed in further detail below.

	£k
Integration costs	260
Care home capacity	1,652
Investment in transformation	2,788
Commitments cfwd to 19/20	3,198
Total	**7,898**

Table 3: proposed use of IJB reserves

12. This proposition has been shared with colleagues in the Council and NHS Lothian. Whilst neither is yet in a position to formally confirm the extent to which they will provide additional support to the IJB, the dialogue has been positive and has given the Chief Officer a degree of confidence that this support will be forthcoming.

13. Although not yet in a fully balanced position, the Council assumption is the overspend will not be recovered by the end of the financial year and NHS Lothian have now provided moderate assurance that a break even position will be achieved by the end of the year. Further, NHS Lothian considered the position of its 4 partner IJBs at the Finance and Resources Committee meeting on 23rd January. Each IJB faces a different set of financial dynamics which NHS Lothian is attempting to balance. To this end, they have requested information to determine the extent to which they will provide additional financial

support to deliver breakeven in the health component of an IJB's budget. As part of this exercise Edinburgh IJB has been asked for clarification of the availability and application of reserves and the proposal set out in this paper has been shared with them in response this request.

Indicative financial settlements for 2019/20

14. Neither partner organisation has yet finalised its budget setting process, consequently no formal budget offers have yet been received by the IJB. The Chief Officer and Chief Finance Officer have been working closely with colleagues as the respective plans are developing. Through this dialogue both the Council and NHS Lothian have advised the indicative budget offers which are built into their current financial planning assumptions. As yet, these do not take account of changes to the provisional local government settlement announced as part of the stage one parliamentary debate on 31st January by the Cabinet Secretary.

15. Table 4 below summarises these indicative offers and were initially shared with the board at the development session on 22nd January 2019. A number of follow up events have been arranged in the run up to the board formally considering the budget, and associated savings plans, in March 2019.

	CEC £k	NHS £k	Total £k
Delegated resource	205,867	438,634	644,501
Anticipated spend	225,261	448,313	673,574
Indicative savings target	**19,394**	**9,679**	**29,073**

Table 4: indicative IJB summary budget for 2019/20

16. Based on these projections the IJB would require to identify savings across all delegated services totalling £29.1m. The board considered the initial propositions at the session on 22nd January and these proposals are being refined and expanded.

17. Although the process of due diligence is ongoing, and the figures outlined above remain indicative, the Chief Officer has advised the board that she is not currently in a position to recommend a budget from the Council at this level on the basis that a savings requirement of this level would have a significant, detrimental impact on outcomes for the people of Edinburgh as well as jeopardising the IJB's transformation plans which are the only way to deliver services which are sustainable in the longer term.

Key risks

18. The key risks outlined in this paper are as follows:

- For 2018/19 – a failure to reach agreement with partner organisations on additional contributions to the IJB; and
- For 2019/20 - the ability of the IJB to set a credible, realistic and deliverable savings programme for 2019/20.

Financial implications

19. Outlined elsewhere in this report.

Implications for directions

20. None.

Equalities implications

21. While there is no direct additional impact of the report's contents, budget proposals will be assessed through the existing Council and NHS Lothian arrangements.

Sustainability implications

22. There is no direct additional impact of the report's contents.

Involving people

23. As above.

Impact on plans of other parties

24. As above.

Background reading/references

25. None.

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Links to priorities in strategic plan

Managing our resources effectively

Appendices

Appendix 1	Financial position of delegated services provided by NHS Lothian
Appendix 2	Financial position of delegated services provided by City of Edinburgh Council

FINANCIAL POSITION OF DELEGATED SERVICES PROVIDED BY NHS LOTHIAN 2018/19

	Year to date			2018/19
	Budget £k	Actual £k	Variance £k	Forecast £k
Core services				
Community AHPs	6,956	7,222	(266)	(306)
Community hospitals	8,556	8,490	66	173
District nursing	8,387	8,085	302	328
GMS	57,618	58,355	(736)	(980)
Mental health	7,972	7,555	417	416
Other	37,177	38,584	(1,407)	(1,635)
Prescribing	60,476	59,895	581	623
Resource transfer	17,505	17,503	2	4
Sub total core	**204,647**	**205,688**	**(1,042)**	**(1,377)**
Hosted services				
AHPs	4,914	4,674	240	501
Complex care	1,098	1,074	24	212
GMS	4,141	4,144	(4)	296
Learning disabilities	5,815	6,128	(313)	(273)
Unscheduled care	4,353	4,353	(0)	(1)
Mental health	18,025	18,227	(202)	(265)
Oral health services	6,903	6,519	384	268
Other	472	394	78	(408)
Palliative care	1,787	1,805	(18)	(3)
Psychology	3,139	3,102	37	(27)
Rehabilitation medicine	2,429	2,258	171	229
Sexual health	2,418	2,422	(4)	(44)
Substance misuse	2,982	3,054	(72)	(26)
UNPAC	2,040	2,040	(0)	229
Sub total hosted	**60,517**	**60,196**	**321**	**689**
Set aside services				
A & E	4,987	5,078	(91)	(422)
Cardiology	3,248	3,272	(24)	19
Diabetes	797	813	(16)	(1)
Gastroenterology	2,228	2,093	135	(54)
General medicine	18,166	19,329	(1,164)	(1,289)
Geriatric medicine	10,018	9,920	98	65
Infectious disease	4,206	4,258	(52)	140
Junior medical	10,122	10,526	(404)	(659)
Management	1,021	1,083	(62)	(125)
Other	5,183	5,241	(57)	97
Rehabilitation medicine	1,581	1,665	(84)	(95)
Therapies	4,799	4,809	(9)	9
Sub total set aside	**66,355**	**68,086**	**(1,731)**	**(2,315)**
Total	**331,519**	**333,971**	**(2,452)**	**(3,003)**

FINANCIAL POSITION OF DELEGATED SERVICES PROVIDED BY CITY OF EDINBURGH COUNCIL 2018/19

	Year to date			2018/19
	Budget £k	Actual £k	Variance £k	Forecast £k
Employee costs				
Council Paid Employees	**65,018**	**65,059**	**(41)**	(55)
Non pay costs				
Premises	883	883	0	0
Transport	1,504	2,216	(712)	(949)
Supplies & Services	5,759	5,909	(150)	(200)
Third Party Payments	147,177	150,805	(3,628)	(4,837)
Transfer Payments	615	615	0	0
Sub total	**155,937**	**160,427**	**(4,490)**	**(5,986)**
Gross expenditure	**220,955**	**225,485**	**(4,531)**	**(6,041)**
Income	**(71,783)**	**(71,033)**	**(750)**	(1,000)
Total	**149,171**	**154,452**	**(5,281)**	**(7,041)**

Item 5.6

Report

Communications Action Plan for the EIJB

Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. An action plan has been developed in response to the Edinburgh Integration Board's (EIJB) growing requirement to communicate and the opportunities presented to do so by a wide variety of media. This plan will develop over time to reflect new audiences, objectives and communications needs.

2. This plan complements the communications action plan for the Edinburgh Health and Social Care Partnership.

Recommendations

3. The Integration Joint Board is asked to:

   i. Approve the EIJB communication action plan;

   ii. Agree to updates on this as it develops, at least annually.

Background

4. A communications action plan for the Edinburgh Health and Social Care Partnership was presented to the EIJB in January 2018. At that time it was agreed that a separate action plan for the EIJB should be created to respond to the individual needs of the EIJB and its members.

Main report

5. The attached draft communications action plan outlines the objectives and key audiences for EIJB communications.

6. The action plan will continue to develop over time as new audiences, communications needs and mechanisms are identified.

7. The main communications objectives are:

   i. To help people understand the role of the EIJB in the changing landscape of health and social care in Edinburgh.

   ii. To provide the platform to allow EIJB members to engage with key stakeholders.

   iii. To allow access to EIJB meetings for the general public.

   iv. To offer interested parties an opportunity to be heard at EIJB meetings through deputations.

   v. To communicate with other members of the EIJB and have a private way of sharing papers and ideas.

   vi. To support the ongoing development of EIJB members' knowledge through an induction and development programme.

   vii. To provide a mechanism for individual EIJB members to visit health and social care sites providing services to Edinburgh's citizens.

8. The EIJB is already meeting the majority of these objectives and activity is underway to meet the remainder.

9. The most recent activity has been the introduction of a bi-monthly newsletter to stakeholders and the scoping work for creating and launching a new website for the Partnership and EIJB.

Key risks

10. There is little risk in fully engaging stakeholders. There is, however, a high risk of failure to achieve our objectives if we do not engage our wide stakeholder audience.

Financial implications

11. The main financial implications are the commissioning of a website for the EIJB and Partnership and funding is available for these within Chief Officer's delegated authority.

Implications for Directions

12. There are no known implications for Directions.

Equalities implications

13. The communications action plan will increase access and therefore reduce inequality.

Sustainability implications

14. There are no known implications on sustainability.

Involving people

15. Involving people is a key objective of the communications plan, which sets out the activities planned to engage and involve.

Impact on plans of other parties

16. There is no known impact on the plans of other parties.

Background reading/references

Edinburgh Health and Social Care Partnership Communications and Engagement Plan 2016-19.

Report author

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Chief Officer, Edinburgh Health and Social Care Partnership

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Appendices

Appendix 1	Communications Action Plan paper - January 2018

Appendix 1

Draft communications action plan

Edinburgh Integration Joint Board

Background

The Edinburgh IJB's reported lack of a clear communication plan was criticised in the joint inspection report of older people's services. A communications action plan for the Edinburgh Health and Social Care Partnership (EHSCP) was agreed in January 2018 on the understanding that a separate plan would be developed for the EIJB.

This communications plan aims to support Edinburgh Integration Joint Board (EIJB) members in communicating more effectively and create a better understanding of the Edinburgh Integration Joint Board's role among its key stakeholders.

This plan will focus on the EIJB's communications to develop a deeper understanding of the governance arrangements at stakeholder level. It will complement the EHSCP communications plan and aid the growing understanding of integration and the EIJB's role for other audiences.

Communication objectives

The focus will be on these main objectives:

- To help people understand the role of the EIJB in the changing landscape of health and social care in Edinburgh.
- To provide the platform to allow EIJB members to engage with key stakeholders.
- To allow access to EIJB meetings for the general public.
- To offer interested parties an opportunity to be heard at EIJB meetings through deputations.
- To communicate with other members of the EIJB and have a private way of sharing papers and ideas.
- To support the ongoing development of EIJB members' knowledge through an induction and development programme.
- To support the EIJB communicating its intent, priorities, vision and values to the citizens of Edinburgh and HSCP staff.
- To provide a mechanism for individual EIJB members to visit health and social care sites providing services to Edinburgh's citizens.

Communication principles

These principles will guide communications with our key audiences:

- **Clear, concise and inclusive** - language will be accessible, jargon free and easy to read.
- **Open and honest** - ensure complete transparency and understanding by our target audience.
- **Sustainable** - maintain a regular dialogue with target audiences.
- **Targeted** - reach the right audience, in the right place and at the right time.
- **Tested** - to ensure we are using the right language to speak to our audiences.
- **Timely** - respond to the need for information at the right time and ensure we give people enough time to respond to consultations and surveys.
- **Two-way** - listen to people and give them the opportunity to respond or ask questions in a way that suits them.

Key messages

The key messages for the various audiences will be developed by the Chair and Vice-Chair of the EIJB.

Communications timeline

Date	Activity
Ongoing	Development sessions for EIJB members
September 2018 then bi-monthly/timed around EIJB meetings	IJB stakeholder newsletter
September 2018	First webcast of the EIJB meeting
September 2018	Induction for new service user representatives. This will be done on a rolling basis as new members join the EIJB or subgroups
March 2019	Launch of new website to share information
December 2019	Development and launch of interactive functions and the development of a private forum for EIJB members

Key audiences and stakeholders

Stakeholder groups	Type of communications/ what they want or need to know	Responsibility
EIJB members	Confidential papers and sharing of ideas	Chief Officer/Senior Executive Assistant
	Induction to the EIJB for new members	Chief Officer/Senior Executive Assistant
	Continued development and learning for EIJB members	Chief Officer/Senior Executive Assistant
	Informal visit programme to health and social care sites	Chief Officer/Senior Executive Assistant
IJB committees and sub-committees	Regular flow of communication on the work of the EIJB	EIJB
NHS Lothian	Budget allocation	Chief Officer/Chief Finance Officer
	Directions	Chief Officer/Head of Strategic Planning/Chief Finance Officer
	At board and executive level	Chair/Chief Officer and NHS Lothian-nominated voting members
	At a service provision level, visibility of EIJB members through a site visit (quality assurance) programme	Chief Officer/Senior Executive Assistant

Stakeholder groups	Type of communications/ what they want or need to know	Responsibility
City of Edinburgh Council (senior management and elected members)	Budget allocation	Chief Officer/Chief Finance Officer
	Directions	Chief Officer/Head of Strategic Planning/Chief Finance Officer
	At board and executive level	Chair/Chief Officer and NHS Lothian-nominated voting members
	EIJB members through a site visit (quality assurance) programme	Chief Officer/Senior Executive Assistant
Politicians (Scottish Government)	Communication on the EIJB's strategic direction, major successes and issues, influencing, visits by ministers and cabinet ministers etc	Chair/Chief Officer
Other Lothian IJBs	Pan-Lothian issues and strategic planning opportunities across boundaries	Chair/Chief Officer
Chief Officer and EHSCP Executive Team	Detailed discussions on strategy and operational matters	Chief Officer
EHSCP workforce and services	Ensure a general understanding of the EIJB's role	Chief Officer / Executive Team
	Regular contact should be through the Chief Officer, eg EIJB decisions reported in Chief Officer newsletters	Chief Officer/Senior Executive Assistant
	At service level, visibility of EIJB members through an informal visits programme	Chief Officer/Executive Team/Senior Executive Assistant
Partner organisations, eg EVOC, service delivery partners etc	Regular stakeholder engagement on the work of the EIJB	EIJB
	Access to EIJB meetings	Trial of webcasting meetings. IJB meetings are held in public - stakeholders are free to attend.

Stakeholder groups	Type of communications/ what they want or need to know	Responsibility
Media	Proactive and reactive media management and engagement	The EIJB Chair is the spokesperson for strategy and resources for health and social care in Edinburgh. The Chief Officer is the spokesperson for delivery of health and social care services in Edinburgh.
	Access to EIJB meetings	Trial of webcasting meetings. EIJB meetings are held in public - members of the media are free to attend.
Citizens	Provide open access to papers and meetings.	EIJB – the new website will have access to EIJB papers and links to webcasts
	Provide the opportunity for individuals and organisations to have deputations to the EIJB.	EIJB
	Access to EIJB meetings	Trial of webcasting meetings. EIJB meetings are held in public - members of the media are free to attend.
Other stakeholders (to be identified)	Access to EIJB meetings	Trial of webcasting meetings. EIJB meetings are held in public – anyone is free to attend.

Communications tools, resources and channels

Tool/channel	Comment
Dedicated website for the Edinburgh Health and Social Care Partnership	Development of a new website providing private space to host confidential papers and discussions. A more accessible site will give public, stakeholders and staff a better experience and improved access to information on the EIJB and the Partnership.
Intranet site/s	Information on the EIJB for the EHSCP workforce. There are currently separate staff sites hosted by NHS Lothian and City of Edinburgh Council.

Tool/channel	Comment
Webcasting of EIJB meetings – this is currently taking place as a trial	Open access to everyone. Will be of particular interest to stakeholders, media and staff.
Deputations	Deputations by citizens or organisations on specific items on the EIJB agenda.
Stakeholder newsletter	Regular newsletters to key stakeholders
Media relations	Proactive and reactive media engagement and media management.
Executive visibility programme for EIJB members	EIJB members to express interest in any health and social care visits on an individual basis as part of their ongoing learning and development. EIJB members invited to attend staff open access sessions. EIJB members invited to official openings and to attend conferences and events as appropriate
Edinburgh Health and Social Care Partnership twitter account	Gives ability to share information with interested stakeholders/professionals.
Briefings on specific issues	Gives ability to give in-depth briefings to appropriate audiences on specific issues.

Risks, issues and dependencies

The majority of issues relate to obtaining funding or identifying a dedicated resource within the Partnership to develop and sustain communications vehicles and programmes:

Risk, issue or dependency	Mitigation or comment
The executive visibility programme will need a dedicated resource and commitment at senior level.	This programme will be picked up and developed by the Chief Officer's office and align to the recommendations stated in the Governance review paper.
The risks and issues for developing a Partnership website are contained in a separate paper.	The main risk to the development of the website is the cost to develop a truly interactive website. The more complex a website build is, the higher the costing to develop and support.
Increasing the profile of EIJB members with staff may cause confusion on the difference between the EIJB and Partnership	If managed effectively, this gives a good opportunity to explain the EIJB's role.

Monitoring, measurement and evaluation

Each aspect or activity within the plan will be monitored, measured and evaluated for effectiveness.

Principal stakeholder list

Integration Joint Board members

Robert Aldridge
Mike Ash
Colin Beck
Carl Bickler
Ian Campbell
Andrew Coull
Lynne Douglas
Christine Farquhar
Helen FitzGerald
Ricky Henderson
Kirsten Hey
Martin Hill
Carolyn Hirst
Jackie Irvine
Carole Macartney
Angus McCann
Ian McKay
Melanie Main
Moira Pringle
Judith Proctor
Alison Robertson
Ella Simpson
Susan Webber
Richard Williams
Pat Wynne

Audit and Risk Committee

Mike Ash
Robert Aldridge
Nick Bennett
Sarah Bryson
Laura Calder
Christine Farquhar
Lesley Newdall
Moira Pringle
Grace Scanlin
Ella Simpson
Julie Tickle
Susan Webber
Richard Williams
Cathy Wilson

Strategic Planning Group

Alison Allison
Colin Beck
Colin Briggs
Ian Campbell
Eleanor Cunningham
Tom Cowan
Bruce Dickie
Tony Duncan
Christine Farquhar
Dermot Gorman
Mark Grierson
Belinda Hacking
Stephanie-Anne Harris
Nigel Henderson
Ricky Henderson (Vice-Chair)
Carolyn Hirst (Chair)
Linda Irvine-Fitzpatrick
Fanchea Kelly
Carole Macartney
Peter McCormick
Katie McWilliam
Michele Mulvaney
Judith Proctor
Moira Pringle
Rene Rigby
Alison Robertson
Ella Simpson
David White

Professional advisory group

Lorraine Aitken
Kath Anderson
Dawn Arundel
Eddie Balfour
Robin Balfour
Colin Beck
Carl Bickler
Sheena Borthwick
Chris Brannan
Moyra Burns
Patricia Burns
Sharon Cameron
Carol Chalmers
Nikki Conway
Tom Cowan
Alison Craig
Ewan Crawford
Eleanor Cunningham
John Davidson
Katherine Dorman-Jackson
Lynne Douglas
Aisling Downey
David Farquharson
Helen Faulding-Bird
Alasdair FitzGerald
Helen FitzGerald
Andrew Flapan
Susan Fowlie
Philip Galt
David Gow
Marian Gray
Jen Grundy
Belinda Hacking
Kirsten Hey
Jennifer Houliston
Andrew Jeffries
Aileen Kenny
Sylvia Latona
Caroline Lawrie
Peter LeFevre
Angela Lindsay
Ian McKay
Stephen McBurney
John McKnight
Sandra McNaughton
Katie McWilliam
Melanie Main
Catherine Mathieson
Alison Meiklejohn
Graeme Mollon
Isobel Nisbet
Ben Owen
Kate Pestell
Judith Proctor
Mike Reid
Elaine Rogers
Mike Ryan
Tracy Sanderson
Linda NicolSmith
Anne Walker
Linda Walker
Kevin Wallace
David White
Nigel Williams
Emma Wilson
Pat Wynne

Item 5.7

Report

Brunton Place Surgery Re-provision

Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. The purpose of this report is to present the Initial Agreement for the re-provision of Brunton Place Surgery.

2. Since the proposal seeks capital funding from NHS Lothian the Business Case has been prepared in line with the guidance contained in the Scottish Capital Investment Manual.

Recommendations

3. The Edinburgh Integration Joint Board (EIJB) is asked to:

   i. Note that the Brunton Place Medical Practice presently operates from a building with severely restricted space and which is not compliant with modern health care standards.

   ii. Note that the Practice is willing to increase its current patient list from 8,300 to 10,000 if provided with sufficient clinical space to do so.

   iii. Note that NHS Lothian invited Edinburgh Health and Social Care Partnership (EHSCP) to submit an Initial Agreement for this proposal following the conclusion of the 2018-19 Capital Prioritisation Process.

   iv. Note the Initial Agreement was supported by EHSCP Executive Team on 6 December 2018.

   v. Agree to the submission of the Initial Agreement to NHS Lothian Capital Investment Group in accordance with the Capital Prioritisation Process.

Background

4. Brunton Medical Practice provides General Medical Services (GMS) from its surgery at 9 Brunton Place, Edinburgh. The property is owned by the practice partners.

5. The Practice serves 8,300 patients who reside mainly in the inner-city area of the north east locality. Entry to the list has been restricted to 25 new patients per week since 2016.

6. The surgery from which the Practice operates occupies an area of 330 sqm over three floors of a mid terrace Georgian town house. This is an extremely confined space in which to deliver the level of service demanded by the size of the patient list. A typical surgery dealing with this number of patients would be designed with 700sqm+.

7. The lack of space inhibits opportunities for other services to work alongside the General Practice. Confidentiality at reception is difficult to maintain, patients often have to wait in corridors before appointments and there is no staff room or meeting facility.

8. Entry to the building is impaired as there is no disabled access ramp to the building due to the local planning constraints of World Heritage site status. It also lacks a fully compliant disabled toilet. Only three consulting rooms are situated on the ground floor with the remainder requiring the use of stairways. The building is significantly non-compliant with modern disability standards.

9. Consecutive assessments of the property, dating from 1999, have commented that there was no conceivable design solution to bring the building up to current standard and replacement was the only realistic option.

10. As a result, EHSCP has identified the replacement Brunton Place as its joint top priority in the most recent round of capital investment prioritisation and this was approved by NHS Lothian in June 2018. A notional capital funding allocation of £2 million was included in NHS Lothian's Property and Asset Management Plan

11. The recent introduction of the new GP contract has resulted in action to stabilise and transform primary care in Scotland. In June 2018, the EIJB approved a Primary Care Improvement Plan which identified work which could be delivered outside the GMS contract. One element of this was the Community Treatment and Care services (CTACs) concept which depends on space and staff provided by EHSCP to perform this work. The development of a new surgery in a strategic location presents an opportunity to do this when options elsewhere are very limited. Further work needs to be done on the modelling of CTACs, but a typically sized facility could be expected to provide treatments for a combined patient population of c50,000.

12. EHSCP has already approved the report “Population Growth and Primary Care Premises Assessment 2016-2026” which states that additional capacity in General Practice is necessary in order to meet the rising demands from a population that is both increasing in numbers and aging. A major development is currently planned for the nearby Meadowbank site which is within the catchment area of the Brunton practice.

13. In recent years NHS Lothian has supported and delivered some elements of the GameChanger PSP at Easter Road stadium. During this period Hibernian Football Club has encouraged NHS Lothian to consider using the stadium to provide a range of community based clinical services that can benefit from the synergies arising from the health promotion and prevention activities that underpin the GameChanger approach. This is an option for the practice that is considered further in the Initial Agreement.

Main report

14. The project scope is limited to the provision of high quality clinical accommodation with adequate ancillary space for the Brunton Place Practice to serve a list size of 10,000 patients with the inclusion of a CTAC clinical suite that would be sufficient for a catchment of circa 50,000 patients. The proposed accommodation schedule consists of 712 sqm of which 82.3% would be occupied by the Practice and 17.7% by the CTAC.

15. The Initial Agreement identifies two potential sites at Meadowbank and Easter Road, either of which could offer an acceptable location for the delivery of such a project. In both cases the fit out of an existing (or newly developed) property, owned by an external party is the assumed procurement route. The Initial Agreement also indicates that a new build option on a yet unidentified site could offer a better value for money alternative, if a suitable site became available.

16. EHSCP has been approached by the Council to consider locating General Practice within a major development on the Meadowbank site which is subject to the approval of a master plan. If planning consent is obtained it is envisaged that site works would commence in 2021.

17. The location is 0.7 miles from the existing surgery, but site is well served by public transport and the project team can have an input into the design of the property as it develops.

18. The capital cost of fitting out the unit on the Meadowbank site estimated at £3.25 million including VAT. Since the project could not be delivered before 2021 price inflation has been taken into account.

19. The space identified in Easter Road stadium is an internal area of about 800 sqm on the second floor of the north stand. It enjoys good levels of natural light and the consulting rooms could be arranged to offer pitch side views. It also has some potential for future expansion.

20. There is a second option at Easter Road which is for a new build surgery on a vacant corner site that is currently used for overflow car parking. This option requires a much higher level of capital investment and is presented in the Initial Agreement for comparative purposes

21. It should be noted that although the Easter Road options are within the current Practice boundary, the location is not well served by public transport and pedestrian routes to it are not straightforward. The existing access to the second floor would require substantial alteration to allow public use as demanded by the standards applied to a new general practice building.

22. To date, no design proposals to improve entry arrangements to the stadium have been formulated and the cost of creating a new entrance and access to the upper floors will add to the overall capital outlay required for the project. The Initial Agreement presents an indicative cost of £3.95 million for this option.

23. Rental costs for each of the options are shown in the Initial Agreement. A rental cost initially was proposed by Hibernian Football Club and was referred by NHS Lothian to the District Valuer's Office. The developers of Meadowbank have also suggested a rental figure. Both initial estimates have helped with the Initial Agreement but require further exploration as part of the Business Case process.

24. At this stage both options remain under active consideration, but an exercise held with the practice partners to review the non-financial benefits did result in a clear preference for Meadowbank based on its superior accessibility. A final choice between the two options cannot be made without obtaining more detailed information on the site opportunities and constraints, design solutions, delivery timescales and the capital and revenue costs. Only when this information becomes available will it be possible to conclude an option appraisal.

25. As a result, the Initial Agreement recommends that both options are carried forward for further investigation in a future Standard Business case which will require NHS Lothian to commit some enabling funding for this purpose.

Key risks

26. The constraints of inadequate General Practice (GP) premises are identified as a risk in the NHS Lothian part of EHSCP's risk register.

27. The Meadowbank option is subject to a planning application as a major development and the outcome of this and the timing of any eventual approval remain uncertain.

Financial implications

28. The project will require a capital investment of between £3.25 and £3.95 million (including VAT) at 2018 prices from NHS Lothian, depending on the option that is selected for delivery. (This is at variance with the original estimate of £2m based on preliminary assessments of the Easter Road option).

29. The proposed creation of accommodation for the CTAC, occupying 17.7% of the total internal area, will result in an additional annual property and facilities costs to EHSCP of between £31K and £42K per annum depending on the option that is selected for delivery. At this early stage in the development of the project, the costs are indicative as rental charges have still need to be negotiated. The facilities costs to be met will be defined by a future service level agreement with NHS Lothian Estates.

Implications for Directions

30. The Integration Joint Board has issued direction EDI_2017/18_4 Primary Care, which includes the following:

    4 d) produce business cases that support the need for capital investment based on agreed priorities

Equalities implications

31. The project will allow all patients to be treated in clinical rooms that are accessible for people with impaired mobility and other disabilities.

Sustainability implications

32. Provision of a new surgery, most likely situated in a property leased by NHS Lothian, will support the sustainability of general practice in the area.

33. The additional c2000 population able to be registered by the re-housed practice is key to continuing to provide access to the growing population.

Impact on plans of other parties

34. The re-location of Brunton Medical Practice may influence the adjustment of the catchment area boundaries of other practices that are currently operating in north east Edinburgh.

Report author

Judith Proctor

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Appendices

Re-provision of Brunton Place Medical Practice Initial Agreement

Proposal for the Reprovision of Brunton Place Medical Practice

NHS Lothian

Initial Agreement

Project Owner: Steven Whitton

Project Sponsor: David White

Date: 29th November 2018

Version: Final Draft

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NHS Lothian

1 Executive Summary

The proposal has already been the subject of a Strategic Assessment approved by both NHS Lothian Capital Investment Group and the Edinburgh Integration Joint Board (EIJB). The Assessment is presented in Appendix I of the Initial Agreement.

The Strategic Case

2.1 Existing Arrangements

2.1.1 Brunton Place Medical Practice provides General Medical Services (GMS) to 8,300 patients, the majority of whom reside in the inner-city area of the north east Edinburgh locality. A map of the catchment area showing the distribution of patient households is contained in Appendix II.

2.1.2 The practice population consists of a relatively large number of working age patients and the profile indicates a relatively low level of deprivation when compared with other practices in the city. One notable feature is the high level of turnover in the patient list which suggests a base population that is comparatively mobile as a result of demographic churn.

2.1.3 Since 2010 the list size has grown by over 1,000, from 7,250 to its current level, and the Practice has had to restrict its acceptance of new patients during much of this period. At the present time it operates a policy of accepting 25 new patients each week which is not sufficient to meet demand. It is also recognised that other neighbouring General Practices also operate restricted lists and do not have the capacity to meet existing demand.

2.1.4 The surgery from which the Practice operates occupies an area of 330 sqm over three floors of a mid terrace Georgian town house. This is an extremely confined space in which to deliver the level of service demanded by the size of the patient list. A typical surgery dealing with this number of patients is usually enjoys at least double the floor area. The lack of space obviously inhibits any opportunities for other services to work alongside General Practice. It also means that confidentiality at reception is difficult to maintain, patients often have to wait in corridors before appointments and no staff room or meeting facility.

2.1.5 There is no disabled access ramp to the building because of the constraints of World Heritage site status nor is there a fully compliant disabled w/c on the premises. Only three consulting rooms are situated on the ground floor with remainder requiring the use of stairways. The building is non-compliant with modern disability standards.

2.1.6 It is apparent that Brunton Place surgery is not a suitable setting for the provision of General Practice. This has been the case for many years and consecutive assessments of the property, dating from 1999, have commented that there was no conceivable design solution to bring the building up to standard and replacement was the only realistic option.

2.1.7 As a result EHSCP has identified the replacement of Brunton Place (along with a solution to increase GP capacity in the outer area of South East Edinburgh) as its joint top priority in the most recent round of capital investment prioritisation and this was approved by NHS Lothian in June 2018. A notional capital funding allocation of £2 million is now included in NHS Lothian's Property and Asset Management Plan for the Brunton Place re-provision.

2.2 Drivers for Change

2.2.1 The population of Edinburgh continues to expand with an additional 55,000 persons expected to reside in the city by 2026, all of whom will seek to register with a local General Practice. Some of this additional demand may be met by the creation of new practices but the majority will have to be absorbed by existing Practices.

2.2.2 EHSCP has already approved the report "Population Growth and Primary Care Premises Assessment 2016-2026" which states that additional capacity in General Practice is necessary to meet the rising demands from a population that is increasing both in numbers and in age. A major residential housing and student accommodation development is currently planned for the nearby Meadowbank site which is within the catchment area of the Brunton practice.

2.2.3 The recent introduction of the new GP contract demands action to stabilise and transform primary care in Scotland. In 2018 the EIJB approved a Primary Care Improvement Plan which identified a range of routine tasks and treatments that could be delivered out-with the GMS contract and by doing so relieve some of the pressures on General Practice. The Community Treatment and Care concept assumes that space and staff are provided by EHSCP to perform this work and the development of a new surgery in a strategic location presents an opportunity to do this when options elsewhere are very limited.

2.2.4 The ability of General Practice to meet service demand is not simply a response to an increasing and more elderly population. It is also a function of Practice resilience and stability. Practices which own their own premises are particularly vulnerable to service disruption and even closures. The new contract seeks to address this by introducing measures that mean over time NHS Boards take on responsibility for all GP accommodation in their areas.

The table below summarises the need for change and the impact it is having on present service delivery.

Table 1: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?
Existing premises are inadequate in size for acceptable levels of service delivery	Practice struggles to meet current patient demand.
Demographic trends leading to increased demand on general practice in Edinburgh.	Additional numbers of patients are seeking to register with a general practice in the locality.
Clinical facilities not compliant with current clinical or disability standards	Practice is restricted in its ability to treat patients with disabilities. Increased risk of adverse incidents.
Implementation of the new GMS contract in Scotland	Practice is unable to accommodate additional services which can support the delivery of the PCIP
Premises are owned by the Practice partners	This may result in future instability if one or more partners seeks equity release on retiral

2.3 Investment Objectives

From the assessment of the current situation and the drivers for change we can identify what has to be achieved in order to deliver the changes required. These are defined as the investment objectives and are summarised in the table below:

Table 2: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Practice struggles to meet current patient demand	To improve service capacity to enable everyone to have access to General Practice.
Additional numbers of patients are seeking to register with a general practice in the locality.	To increase physical capacity to allow an additional 2000 patients to access GMS.
Practice is restricted in its ability to treat patients with disabilities. Increased risk of adverse incidents.	To provide accessible premises from which to deliver services safely and with optimum clinical functionality
Practice is unable to accommodate additional services which can support the delivery of the Primary Care Improvement Plan.	To provide space for appropriate services to support the delivery of GMS
Risk of future instability if one or more partners seeks equity release on retiral	To provide premises which are sustainable and address service needs for the foreseeable future

2.4 Benefits

2.4.1 The Strategic Assessment for Brunton Place Practice was completed in 2015 identifying the need for change, benefits of addressing these needs and their link to the Scottish Government's five Strategic Investment Priorities below:

- Safe;
- Person-Centred;
- Effective Quality of Care;
- Health of Population;
- Value and Sustainability

2.4.2 The above investment objectives and the Strategic Assessment have informed the development of a Benefits Register. In line with the Scottish Capital Investment Manual guidance on `Benefits

Realisation`, this initial register is intended to record all the main benefits of the proposal. A full Benefits Realisation Plan will be developed at Business Case stage.

2.4.3 A summary of the key benefits to be gained from the proposal are described below:-

- Improved quality and physical condition of the healthcare estate
- Improved functional suitability of the healthcare estate
- Increased capacity to address population growth
- Full compliance with statutory standards
- Reduction in the occurrence of adverse incidents
- Fewer emergency admissions to hospital and attendance at A&E
- Improved health of the general population
- More efficient financial and resources performance

2.5 Strategic Risks

. The table below highlights key strategic risks that may undermine the realisation of benefits and the achievement of the investment objectives.

Table 3 Strategic Risks

Risk	Proposed Action/Safeguard
Premises costs are unacceptable to the Practice partners	Inform the Practice of the high level indicative facilities costs in advance of submission of the business case.
Proposed solution not well received by Practice patients	Ensure that patients are aware of the justification for any future re-location
The lease terms for property options are not assessed as offering value for money	Explore other procurement options. If a new build option is selected achieve an acceptable offer before construction commences
Failure to recruit additional staff to deliver the enhanced service	Action to be taken by both EHSCP and NHSL to facilitate GP and nurse recruitment
Project costs exceed allocation in NHS Lothian capital plan	Obtain cost certainty at Business Case stage
Revenue costs of CTAC	Obtain cost certainty at Business Case stage when staffing and property requirements are finalised

2.6 Project Scope

2.6.1 The project seeks to explore ways by which the investment objectives can be achieved by examining the options for the re-provision of Brunton Place Medical Practice in new premises. Any premises solution that is pursued must be both affordable and provide best value for money.

2.6.2 The scope extends to include additional service elements which can potentially underpin the roll out of the new GP contract and the implementation of the Primary Care Improvement Plan. In this particular case the creation of a Community Treatment and Care Centre that can serve patients from a wider catchment area.

2.6.3 The project scope is limited to the provision of high quality clinical accommodation with adequate ancillary space for the Brunton Place Practice to serve a list size of 10,000 patients with the inclusion of a CTAC clinical suite that would be sufficient for a catchment area of circa 50,000 patients. The proposed accommodation schedule consists of 712 sq. m of which 82.3% would be occupied by the Practice and 17.7% by the CTAC. The schedule is presented in Appendix III.

2.6.4 It is reasonable that consideration should be given to how the project could complement other current EHSCP sponsored activities in the area with particular reference to the GameChanger initiative that is underway at Hibernian FC.

2.6.5 As always with proposals of this nature involving the re-provision of General Practices, there may be wider opportunities to generate additional benefits which can arise from addressing the business needs of other Practices that operate in the area. The EHSCP Primary Care Support Team is aware that there are economic benefits in co-locating Practices and that there are also some adjacent Practices that are working in unsatisfactory premises. However, for the purpose of this Initial Agreement the core project scope is restricted to meet the needs of the Brunton Place Practice which has been prioritised by both the NHS Lothian and EHSCP capital planning process.

3 Economic Case

3.1 Do nothing/baseline

3.1.1 The “do nothing” option will be carried forward as a comparator. It assumes that the existing arrangements for the delivery of General Practice to the existing patient list will continue to be provided from the Brunton Place surgery. The problems associated with this arrangement have already been described in section 2.1.

3.1.2 Consideration has been given to a “do minimum” option which could address some of the business needs outlined in section 2.2. In simple terms this would require the surgery to at least double its current operational space ideally at ground floor level and completely remodel its internal layout. No solution of this nature presents itself and this has been the case for many years. The Lothian GP Premises Audit Report produced in 1999 stated that “the building could not be brought up to standard and requires replacement”.

3.2 Engagement with Stakeholders

3.2.1 Practice staff and patients are the key stakeholders in this project. The Practice has been active in visiting other recently upgraded GP surgeries and has participated in the identification of the long-listed options and the assessment of the shortlisted options.

3.2.2 Patients who attend appointments at the existing surgery are inevitably aware of its shortcomings. Some patients have provided a number of comments on the Practice on a review website, examples of which are: -

- “surgery seems unfit for purpose”
- “saturated reception”
-” the surgery is stretched to breaking point”
- “typical overworked and understaffed city centre doctor’s office”

3.2.3 However at this stage there has not yet been any formal engagement on the optimal solution. Meaningful consultation can only take place when the project can demonstrate a range of potential options and proposed design solutions. Location and ease of access are two factors which are likely to figure prominently in any future engagement which will be conducted during the development of the business case.

3.3 Long Listed Options

3.3.1 Table 4 on the following page summarises the long list of options identified by the project group.

-

Table 4: Long-listed options

	Option	Advantages	Disadvantages	
A	Do Nothing	Minimal costs	Does not achieve any of the investment objectives.	Retain
B	Do Minimum	Reduced costs	Constraints of existing premises inhibit any realistic design solutions	Discount
C	Fit out of second floor North Stand, Easter Road Stadium	Proximity to patients' place of residence. Site immediately available Re-inforces GameChanger PSP.	Pedestrian routes to stadium not good Public transport routes limited Patient access to the second-floor area	Retain
D	Fit out of both floors of North Stand, Easter Road Stadium combining accommodation with GameChanger	As above Creates improved access participants in GameChanger activities Benefits from GameChanger synergies	As above Results in a larger take up of space than what is needed for the practice population	Discount
E	Fit out of both floors of North Stand, Easter Road Stadium combining accommodation with GameChanger and another General Practice	As above Allows EHSCP to re-provide another Leith practice currently based in poor accommodation	As above Inclusion of another practice in the project brief not sanctioned by the NHSL prioritisation process. Will require use of subprime space on 1F area	Discount
F	Fit out of suitable NHSL property in the vicinity	Reduced costs	No property available	Discount
G	Fit out of vacant premises at 61 London Road (previously Boots Opticians)	Location well served by public transport. Car parking available.	GIA of 400 sq. m not sufficient for expansion of patient list	Discount
H	Fit out of prebuilt commercial space at Meadowbank	As above for public transport. New development can offer optimum design of new surgery on GF level.	Subject to approval of master plan and not able to be delivered before 2021.	Retain
I	New build by NHS Lothian.	No rental charges.	Increased risk involved in site purchase and construction. No site yet identified. Costs in excess of allocation in capital plan	Retain

3.3.2 All the long-listed options assume the complete re-provision of Brunton Place surgery and in most cases involve the fit out of a suitable existing property in an acceptable location. An option to build a new surgery on a suitable but as yet unidentified site has been included and this assumes that NHS Lothian will develop and own the property.

3.3.3 Several of the options are focused on the possibility of re-providing the surgery inside the North Stand at Easter Road stadium. This builds upon the success of the GameChanger initiative which is currently hosting a range of activities in both the first floor of the North Stand and elsewhere in the stadium. Many of these activities are in fact delivered by third sector partner organisations several of which receive referrals from General Practice in the form of social prescribing. All this activity takes place at the present time without any formal lease agreement with Hibernian Football Club and this arrangement would be expected to continue independently with or without the re-location of the Practice into the stadium.

3.3.4 There are a number of scenarios with Easter Road that merit consideration but the most obvious one is the use of the second floor of the North Stand which offers up to 800 sqm of accommodation. It enjoys good levels of natural light and the consulting rooms could be arranged to offer pitch side views. It also has some potential for future expansion if this became desirable.

3.3.5 The drawbacks of both Easter Road options are that although it is within the Practice catchment boundary the location is not well served by public transport and most pedestrian routes to it are not straightforward. There may also be some restrictions to service delivery when match days occur.

3.3.6 More significantly the existing access to the second floor is far from ideal and will require substantial alterations before it can be made acceptable for public use. A minimum requirement would be to create a new entrance allowing access to an open stairway giving a visible approach to second floor. A new lift would also have to be installed. If this work was carried out it would also realise the benefit of improving access to GameChanger activities on the first floor.

3.3.7 To date no design proposals to improve entry arrangements to the stadium have been formulated and the cost of creating a new entrance and access to the upper floors will add to the overall capital outlay required for the project. The Initial Agreement presents an indicative cost of £3.95 million for this option.

3.3.8 The other main alternative to Easter Road is the Meadowbank site which is 0.7 miles away from the existing surgery but within the Practice boundary. Development of the site is subject to the approval of a master plan that currently proposes 250 residential units and accommodation for up to 900 students. As this is regarded as a major development there are rigorous conditions and extensive consultation standards that have to be met before it can be approved. If planning consent is obtained it is envisaged that site works would not commence before 2021.

3.3.9 The Council has indicated that it would be prepared to offer NHS Lothian a pre-let of space at ground level on the Meadowbank site. The site is well served by public transport and the project team can have an input into the design of the property as it develops.

3.3.10 The capital cost of fitting out the unit on the Meadowbank site is estimated at £3.25 million including VAT. Since the project could not be delivered before 2021 price inflation has been taken into account.

3.4 Short-listed Options and Preferred Way Forward

3.4.1 The table below identifies the short-listed options, retained from the long list, which can now be further assessed in terms of how each can contribute towards the realisation of the benefits associated with the project. This assessment was performed at a meeting attended by the practice partners along with NHSL and EHSCP staff in October 2018.

Table 5: Short Listed Options

Option	Description
Option 1	Do Nothing
Option 2	Fit Out of 2nd Floor Easter Road North Stand
Option 3	Fit out of planned commercial space at Meadowbank
Option 4	New build on a suitable site

3.4.2 The method used for this exercise was to take the anticipated benefits arising from the project to generate a list of success criteria each of which was given a weighted value. The short-listed options were then examined and given a score out of 10 under each of the criteria. The scores are presented in table 6 below.

3.4.3 During this process the scoring panel were aware that there were fundamental gaps in the knowledge relating to the short-listed options. In order to carry out the task the group assumed that an acceptable design solution for entry to the North Stand area was in place and that any option at Meadowbank could be delivered within 3 years. The eventual final scores were heavily skewed by the Practice's view that location and accessibility factors as well as the design potential at Meadowbank were better than at Easter Road.

3.4.4 At this stage both options remain under active consideration and final choice between them cannot be made without obtaining more detailed information on the site opportunities and constraints, design solutions, delivery timescales and the capital and revenue costs. Only when this information becomes available will it be possible to conduct a robust option appraisal.

Table 6 Non-Financial Benefits Scoring

	Weighting	Do Nothing	Fit out of second floor North Stand, Easter Road Stadium	Fit out of prebuilt commercial space at Meadowbank	New Build
Clinical Effectiveness and Service Improvement Does the option meet the service requirements to enable delivery of effective clinical care? Does the option enable co-location with appropriate services that can support GMS delivery?	**25**	75	200	200	200
Accessibility Does the option allow for easy access by users of public transport and facilitate safe and easy access by pedestrians? Will the option allow for appropriate levels of car parking?	**30**	210	120	210	210
Quality of Physical Environment Statutory compliance – Does the option meet all necessary guidance parameters? Does the option provide a suitable working environment including acceptable management of light, air quality, and noise?	**25**	25	125	175	200
Sustainability Will the option enable the service to respond to future demographic trends? Does the option provide an energy efficient infrastructure and working environment?	**15**	30	90	120	120
Deliverability Does the option deliver the development within acceptable timescales? Will the option avoid /minimise disruption to services?	**5**	50	35	35	20
Total Non-Financial Score (out of 1000)		**390**	**570**	**740**	**750**

Indicative costs

3.4.5 Table 7 below details the indicative whole life costs associated with each of the shortlisted options. For further explanation of the determination of the costs in contained in section 5 – the Financial Case.

3.4.6 The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 20 years has been determined for the leased options (1 and 2) in line with the anticipated terms of the lease. A life of 50 year has been estimated for the new build option (Option 3). An annualised cost has been calculated to allow for comparison of the options with differing lives.
- Phasing of the costs reflects the useful life and the programme of works will depend the actual option that is delivered.

3.4.7 The table also indicates the annualised cost per benefit point calculated using the benefits scores outlined above. Ranking the options in this manner results in Option 4 (new build) being ranked 1st, followed by Option 3 (Meadowbank fit out). However, it should be noted that no cost for the acquisition and associated fees for Option 4 is included as there is no information available on this at present. There are also increased risk arising from the purchase of any site, additional construction risks and the responsibility of property ownership. This should therefore impact adversely on the estimate of optimism bias for the new build option.

Table 3: Indicative Costs of Shortlisted Options

Cost (£k)	Do Nothing	Option 2: Refurbishment of Easter Road + Extension (£k)	Option 3 Meadowbank Fit Out (£k)	Option 4: New build on new site (£k)
Capital cost	0	3,184	2,619	4,313
Whole life capital costs	0	3,184	2,619	4,313
Whole life revenue costs	0	601	442	290
Estimated Net Present Value (NPV) of Costs	0	3,785	3,061	4,603
Annualised Cost	-	189	153	92
Benefit Points	390	570	740	750
Annual Cost per Benefit Point	0.00	0.33	0.21	0.12
Rank		**3**	**2**	**1**

3.4.7 Despite the above ranking, the focus of the project remains on the two options that are achievable through the fit out of commercially rented space.

Assessment and identification of preferred solutions

3.4.8 Each of the short-listed options can also be assessed in terms of the extent to which they meet the investment objectives that are outlined in Section 2.3. This confirms that the two fit out options are the options examined in a future Standard Business Case with a preference being for the Meadowbank option but retaining Easter Road as a possible alternative.

Table 8: Assessment of Short Listed Options

	Option 1 Do Nothing	Option 2: Refurbishment of Easter Road	Option 3: Meadowbank Fit Out	Option 4: New build on new site
	Does it meet the Investment Objectives (Fully, Partially, No, n/a):			
Investment Objective 1	Partly	Fully	Fully	Fully
Investment Objective 2	No	Partly	Partly	Partly
Investment Objective 3	No	Fully	Fully	Fully
Investment Objective 4	No	Fully	Fully	Fully
Investment Objective 5	No	Partly	Partly	Partly
	Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)			
Affordability	Yes	Yes	Yes	Unknown
Preferred/Possible/Rejected	Rejected	Possible	Preferred	Rejected

3.4.9 This paper recommends that Option 2 and Option 3 from the short list are carried forward for a more detailed examination in an options appraisal to be presented in a future Standard Business Case where the implementation of the solutions can be further developed and tested for value for money.

3.5 Design Quality Objectives

3.5.1 The project will use the Achieving Excellent Design Evaluation Toolkit (AEDET) to assess design quality throughout the procurement and design process and as part of the Post Project Evaluation.

3.5.2 An initial AEDET workshop will be held prior to the submission of the Business Case once a design team is appointed. The team will work with GPs, patients and EHSCP to identify design criteria to be addressed as a priority at the design develops.

4 Commercial Case

4.1 Procurement Strategy

4.1.1 As this is an Initial Agreement with a proposed solution with a value less than £5m, it is within NHS Lothian's delegated limit and will not require to be submitted to the SGHD for approval.

4.1.2 The total indicative costs for the preferred option at this stage are £*3.25* including VAT. It is anticipated that the procurement of the project will be led by NHS Lothian. The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that Hub South East Scotland (HubSE) will be the best option.

4.1.3 The hub initiative provides the assumed default route for the development of community-based NHS facilities in Scotland. The hub procurement route provides guarantees the delivery of the project will be achieved within a set affordability cap.

4.1.4 HubSE will be commissioned to supply the initial designs and costings that are required to substantiate any future Business Case. Once the Business Case is approved HubSE will be issued with a new project request to deliver the project on behalf of NHS Lothian, in accordance with the requirements of the EHSCP.

4.1.5 Both options under consideration are assumed to require NHS Lothian to agree lease terms with the property owner prior to investing any capital in the required fit out. Of course, subsequently NHS Lothian may elect to seek a revenue funded scheme in which the investment is funded by the property owner in return for a higher rental charge.

4.1.6 The Practice will occupy space that is lease to NHS Lothian and will be responsible for paying its share of any facilities costs.

4.2 Timetable

4.2.1 In view of the decision to keep both options open for further investigation in the Business Case it is not possible to provide a project timetable at this stage. The time impediments relating to the Meadowbank development have already been noted and only when there is certainty that the development will go ahead can a credible programme be developed.

5 The Financial Case

5.1 Capital Affordability

The estimated capital cost associated with each of the short-listed options is detailed in the table below. Construction costs were provided by independent quantity surveyors.

Table 4: Capital Costs

Capital Cost (£k)	Do Nothing	Option 1: Refurbishment of Easter Road + Extension (£k)	Option 2: Meadowbank Fit Out (£k)	Option 3: New build on new site (£k)
Construction	-	1,830	1,482	2,570
Construction Risk	-	50	40	70
Professional Fees	-	460	390	590
Equipment	-	66	61	61
IT & Telephone Costs	-	78	71	71
Site Acquisition	-	-	-	TBC
Inflation	-	110	88	160
Optimism Bias	-	700	576	951
Total Cost (excl VAT)	**-**	**3,294**	**2,707**	**4,473**
VAT	-	659	541	895
Total Capital Cost	**-**	**3,953**	**3,249**	**5,367**

5.1.1 The assumptions made in the calculation of the capital costs are:

- Optimism bias is included at 27% of all capital costs.
- Preliminaries are included at 20% on the refurbishment options and 12% on the new build.
- An inflation allowance of 7.89% has been included using a base date of October 2018 and the construction timeline detailed in Section 6.2.
- VAT has been included at 20% on all costs. No VAT recovery has been assumed. VAT recovery will be further assessed in the SBC.
- Information is not available at present on the availability or cost of acquiring a suitable site for option 3, therefore no cost has been included for this. This has been highlighted as a key risk associated with this option.

5.2 Revenue Affordability

The estimated recurring incremental revenue costs associated with each of the shortlisted options are detailed in the table below. These represent the additional revenue costs when compared to the 'Do Nothing' option.

Table 5: Incremental Revenue Costs

Please note the figures have been redacted due to commercial sensitivity:

Incremental Revenue Cost/year (£k)	Do Nothing	Option 1: Refurbishment of Easter Road + Extension (£k)	Option 2: Meadowbank Fit Out (£k)	Option 3: New build on new site (£k)
Facilities	-			
Property Costs	-			
Depreciation	-			
Total Annual Revenue Cost	**-**			

5.2.1 The assumptions made in the calculation of the revenue costs are:

- The existing practice provides purely GMS services and the practice partners are responsible for all the facilities and property costs associated with providing general medical services through the practice. The future service model is anticipated to include both GMS services and a Community Treatment and Care (CTAC) area.
- All costs associated with the provision of GMS services have been excluded from the above calculation as it is not expected that there will be any revenue implication for overall GMS costs on NHS Lothian.
- The service model for the CTAC area is presently being developed therefore no staffing costs have been included in the above analysis until this has been refined. It is anticipated that any staffing required for this area will be funded through the Primary Care Improvement Fund (PCIP).
- Property (rent, rates, and waste) and facilities costs (domestics) are based on a standard sqm rate applied to the footprint of each of the proposed options. These are for the CTAC area only (anticipated to be 17.7% of the total floor area) as GMS costs will not impact NHS Lothian.
- Depreciation is based on a useful life of 50 years for Option 3 (new build) and assumed to be funded from the existing NHS Lothian depreciation funding allocation. No depreciation has been included for options 1 & 2 as these are anticipated to be leased spaces for which separable assets will not be recognised and depreciated by NHS Lothian.

5.2.2 No funding has been identified for the additional revenue costs at this stage, other than depreciation. Revenue costs will continue to be refined through the SBC process.

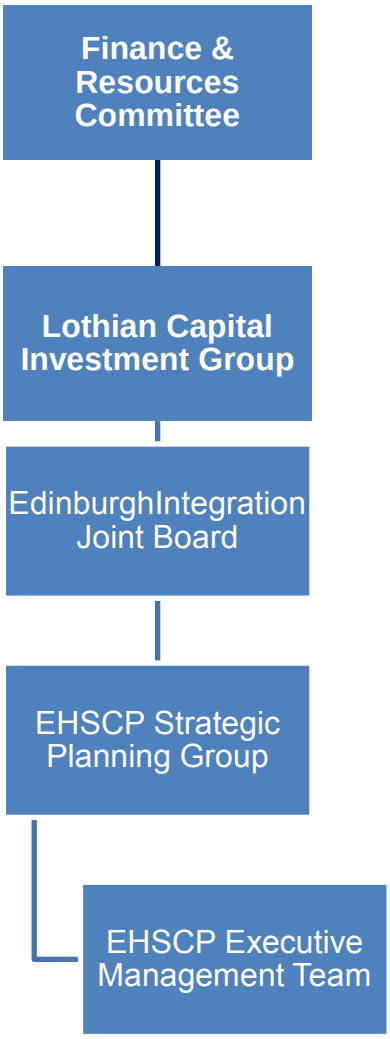
5.3 Overall Affordability

5.3.1 The capital costs detailed above are predicted to be funded through *t*raditional capital funding though NHS Lothian's formula allocation. This project has been prioritised by NHS Lothian and the Edinburgh Health and Social Care Partnership and the estimated costs noted above are included in the NHS Lothian Property and Asset Management Five Year Investment Plan. No funding has been identified for the additional revenue costs at this stage, other than depreciation. All costs will continue to be refined through the SBC process.

- The Management Case

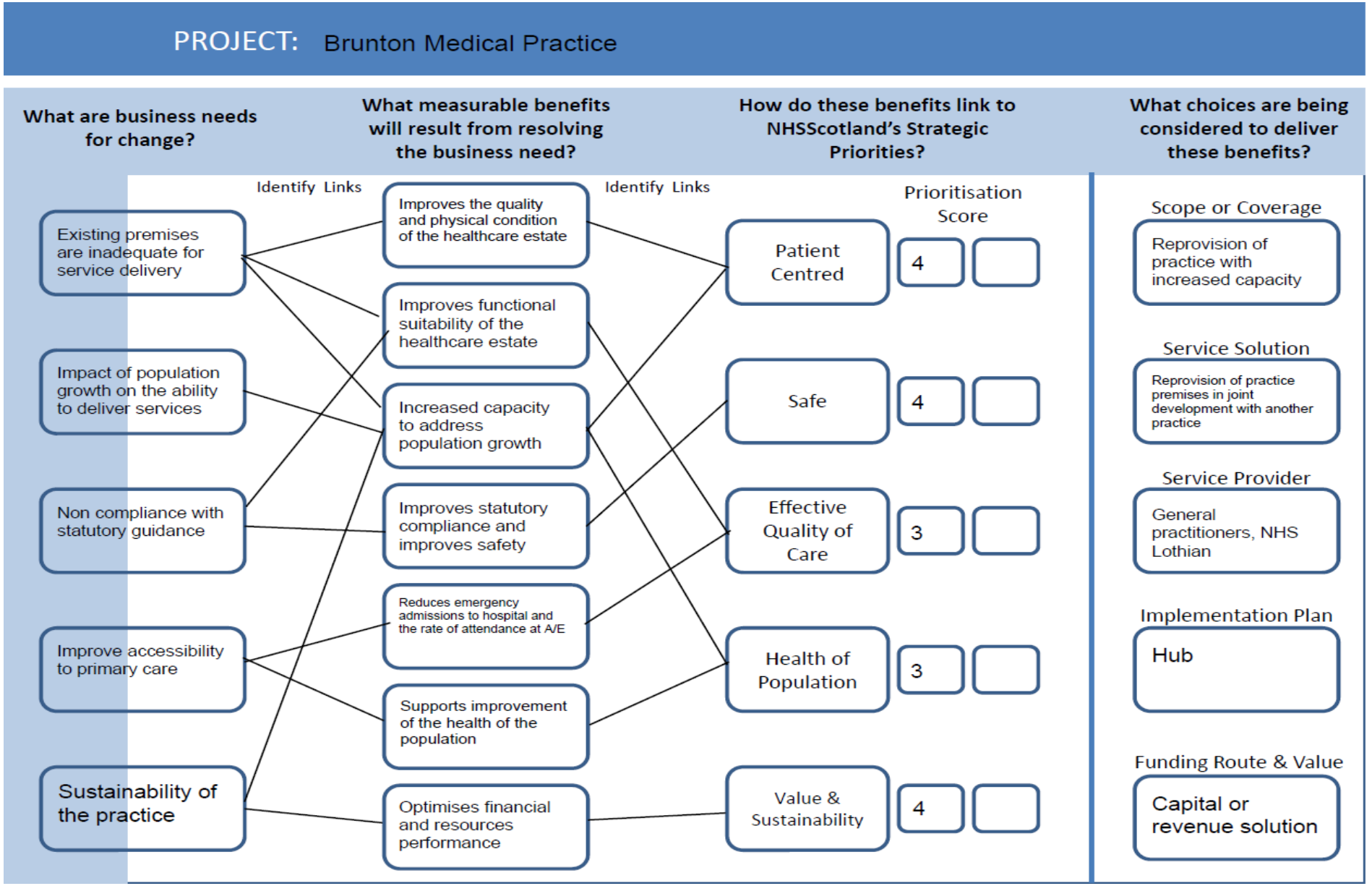
- Governance support for the proposal

The diagram below shows the organisational governance and reporting structure that will be in place to take forward the proposed solution.

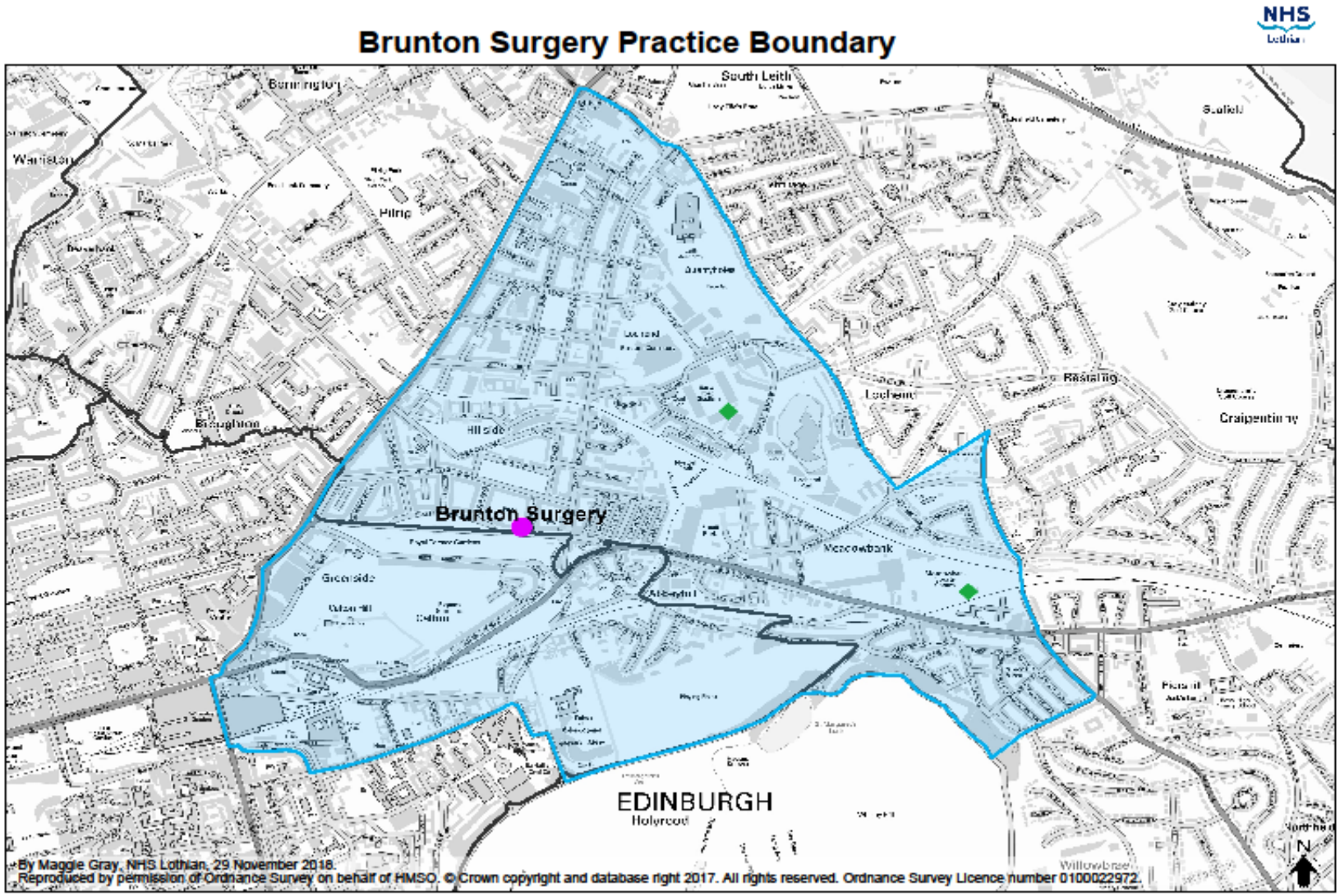


At this early stage when there is no clear certainty on the option to be delivered and its timescales, or procurement route it is premature to make definite statements on the management arrangements.

Appendix 1: Strategic Assessment



Appendix 2: Map



Appendix 3 Schedule of Accommodation

Schedule of Accommodation

For 8 GPs and Approx. 10,000 patients

Room	Qty	Area m^2	Total Area m^2	Comments
Consulting Room	6	15	90	
Minor Surgery	1	18	18	Usage to be reviewed dependent on CTAC
Utility Room				Usage to be reviewed dependent on CTAC
Nurse Consulting Room	3	15	45	Usage to be reviewed dependent on CTAC
Interview/Upset Room	1	9	9	
Main Entrance Lobby	1	10	10	
Reception	1	14	14	
Waiting Area	1	70	70	
Patients WC	2	3	6	
Patients W/Chair WC/ Baby changin	1	5	5	
Records Storage Area	1	20	20	On site because of high turnover
Admin/Secretaries/Data Input etc	1	44	44	7 workstations
Practice Manager	1	12	12	
Meeting/Library Room	1	25	25	
General Storage	2	10	20	
Staff Room	1	18	18	
Kitchen	1	10	10	
Staff WC	2	2	4	
Staff Changing	1	10	10	
DSR	1	10	10	
Disposal	2	6	12	
Communications Room	1	10	10	
Plant Room	1	20	20	
CTAC Suite				
Treatment Rooms	2	18	36	
Interview Rooms	2	9	18	
				Practice Area is 82.35% of dedicated GIA
				CTAC Area is 17.65% of dedicated GIA

Net Area	**536**
Circulation @ 33%	**177**
Total Area	**712**

red font - assumed shared facilities

Item 5.8

Report

Edinburgh Integration Joint Board Strategic Plan 2019-2022 – Update Edinburgh Integration Joint Board

8 February 2019

Executive Summary

1. A draft of the Edinburgh Integration Joint Board (EIJB) Strategic Plan 2019-2022 was presented to the EIJB on 14 December 2018. The EIJB agreed that a completed draft be taken to the EIJB on 8 February 2019 prior to a consultation phase of three months.

2. An EIJB Development Session took place on 22 January 2019 to consider options to mitigate a larger than predicted funding shortfall for financial year 2019/2020. Given the scale of these budgetary pressures and the emerging Edinburgh Health and Social Care Partnership (EHSCP) transformational work, the EIJB considered that additional time was needed to reflect the impact on the draft Strategic Plan 2019-2022. The EIJB Chair and Vice-Chair reaffirmed this decision at the EIJB Agenda Planning Meeting on 24 January 2019. On 25 January 2019, the Chief Officer wrote to EIJB Members outlining the decision and rationale to delay the circulation of the draft Strategic Plan 2019-2022 to enable and ensure alignment of ambitions with the financial reality for the EIJB.

3. It is proposed to take the revised draft of the Strategic Plan 2019-2022 to the EIJB on 29 March 2019 prior to a consultation period of three months.

4. A formal extension to the existing Strategic Plan 2016-2019 will be required until the new Strategic Plan has been published.

Recommendations

5. The Edinburgh Integration Joint Board is asked to:

   i. Note the rationale for extending the time for the production of the next draft of the Strategic Plan 2019-2022.

   ii. Agree the new date of 29 March 2019 for the EIJB to consider the re-drafted Strategic Plan 2019-2022 prior to a consultation period of three months.

iii. Agree the formal extension of the existing Strategic Plan 2016-2019 including Directions until the new Strategic Plan is published.

Background

6. A draft of the Strategic Plan 2019-2022 (which did not include Commissioning Plans and Directions) was presented to the last EIJB on 14 December 2018. The EIJB directed that a completed draft be taken to the EIJB on 8 February 2019, prior to commencing a three-month period of consultation. Since the last EIJB, the Chief Officer has drafted a Transformation Paper, which is to be presented to the next EIJB on 8 January 2019. If approved by the EIJB, the Transformation Paper will fundamentally alter the approach of the Strategic Plan 2019-2022.

7. The City of Edinburgh Council (the Council) budget forecast for financial year 2019/2020 placed a higher than expected budget reduction target on the EHSCP of circa £19M. The predicted budget reduction target from NHS Lothian is expected to be in the region of circa £9.5M. An EIJB Development Session took place on 22 January 2019 to consider options to mitigate the funding shortfall. Given the scale of the budgetary pressure, and the emerging EHSCP transformational work, the EIJB considered more time was required to refine the draft Strategic Plan 2019-2022. The EIJB Chair and Vice-Chair reaffirmed this decision at the EIJB Agenda Planning Meeting on 24 January 2019. The Chief Officer then wrote to EIJB Members informing them of this decision on 25 January 2019.

8. It is proposed that the refined draft Strategic Plan 2019-2022 be submitted to the EIJB for approval on 29 March 2019. A three-month consultation phase would then be instigated before publication expected in June following EIJB approval.

9. The existing Strategic Plan 2016-2019 including Directions would have to be formally extended by the EIJB to cover the period 1 April 2019 to the date of publication of Strategic Plan 2019-2022.

Key risks

10. There is a risk of some internal or external disquiet caused by the delay in consulting on the draft Strategic Plan 2019-2022. Mitigation would be based on the unexpected funding shortfall for financial year 2019/2020 and the implications of the EHSCP emerging transformational work.

Financial implications

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

Implications for Directions

12. The delay will provide time to consider and re-draft the costed Directions in line with the revised budgetary position and transformation.

13. The existing Directions will remain in force until 21 June 2019 with the extension of the Strategic Plan 2016 to 2019.

Equalities implications

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

Sustainability implications

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

Involving people

16. The start of the consultation phase will be delayed by seven weeks.

Impact on plans of other parties

17. The Reference Groups overseeing the five Strategic Commissioning Plans 2019-2022 will be advised on the next steps following consideration of this paper at the EIJB on 8 February.

Background reading/references

18. None.

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Appendices

Appendix 1